February 19, 2019

VIA ELECTRONIC SUBMISSION

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244
Attention: CMS-9930-P

Re: CMS-9926-P: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020

Dear Ms. Verma:

The New Jersey Hospital Association appreciates the opportunity to offer comments in response to the above-referenced rule proposal on behalf of its more than 400 members, including all of New Jersey's acute care and specialty hospitals as well as hundreds of post-acute providers.

We appreciate that the U.S. Department of Health and Human Services and Centers for Medicare and Medicaid Services commitment to "promote a consumer-driven health care system in which consumers are empowered to select and maintain health care coverage of their choosing." However, **NJHA strongly believes that the proposal will negatively impact consumers and states.** Our overarching concern is that, as CMS itself notes, the changes within the proposal will cause consumers to not maintain coverage. Specifically, language indicates that "some of the 100,000 individuals estimated to not enroll in exchange coverage as a result of the proposed change […] may purchase short-term, limited-duration insurance, though a majority is likely to become uninsured." Additionally, states that have in good faith developed market innovations at CMS' urging will be disproportionality penalized by this proposal. [1] NJHA has several concerns about how certain provisions within the proposal would actually achieve that goal, which are detailed below.

[1] https://www.federalregister.gov/documents/2018/10/24/2018-23182/state-relief-and-empowerment-waivers

Provisions Related to Cost-Sharing- § 156.130

The proposal includes a change to the formula for determining the ACA's premium adjustment factor. This factor is what determines the annual adjustment in the amount subsidized marketplace enrollees contribute to plan premiums, the cap on annual out-of-pocket spending, the amount insurers pay via the health insurance tax, and the fine for employers who fail to offer affordable coverage to their employees. HHS estimates the proposed change in formula will result in net premium increases of over $180 million per year and a decline of approximately 100,000 marketplace enrollees each year starting in 2020 and continuing through 2023 when the projection ends.[2]

Because of this projection, it is unclear that this change provides consumers with choice or the ability to maintain coverage. It will be doubly punitive to New Jersey residents because as part of the state's market stabilization efforts, residents are subjected to a penalty for not carrying insurance.

Additionally, states that developed innovative models under 1332 waivers will be unduly penalized by this change because it will result in a reduction of premium tax credits. In New Jersey, where CMS approved a 1332 waiver establishing a reinsurance program, funding for the reinsurance program is directly tied to savings from the advance premium tax credits. That pass-through funding was based on the formula that currently exists remaining consistent; therefore, funding for the reinsurance program will be negatively impacted.

As CMS notes, the change from using employer-sponsored to private health insurance premiums in the premium adjustment percentage calculation will result in faster premium growth. **For these reasons NJHA strongly urges CMS to maintain the current formula based on employer-sponsored premium increases and not include private enrollee premium increases.**

Guaranteed renewability of coverage § 147.106

In an attempt to encourage the use of generic drugs, CMS is proposing that insurers be allowed to make drug formulary changes mid-year and also exclude brand name drugs from essential health benefits.

NJHA urges caution to ensure that patients maintain access to critical drug therapies, and are not unduly at risk for unexpected high out-of-pocket costs. While it may be reasonable to allow plans to make mid-year changes to their formularies if a generic-equivalent becomes available, we urge CMS to maintain and enforce important consumer protections. Patient safety and access to high quality care are top priorities for our members. We urge CMS to protect continuity of care for patients and provide for coverage of a drug deemed medically necessary by a prescribing practitioner for a specific patient. In addition, we expect the agency will continue to protect patients in need of certain drugs through a robust and timely appeals process.

[2] See table 16, page 308 of the proposal

Finally, in response to CMS' request for comment on whether this policy should preempt any state laws that could conflict with its application, **NJHA urges CMS to continue its policy of allowing states more oversight of the insurers and not interfere with state decisions on this matter.**

Auto-Enrollment

CMS seeks comment on whether to continue to allow automatic re-enrollment, which currently occurs when marketplace enrollees take no action during open enrollment to dis-enroll or select a new plan. During the recent 2019 open enrollment period, 1.8 million people in states relying on federally-facilitated exchanges were automatically re-enrolled. One of the agency's concerns with this practice is that it disincentivizes consumer engagement. The agency assumes that, without this practice, consumers will become better shoppers and look for the best plan that meets their needs. However, this may not be the case. These consumers have the option to shop for the best plan for themselves and their families already, but choose not to for various reasons. Taking away automatic reenrollment risks dropping millions from coverage who ultimately do not re-enroll. Losing these individuals in the insurance risk pools could have a detrimental effect on the stability of the marketplaces, further putting coverage at risk.

Health care coverage is essential for an individual's physical, mental and financial health, as well as the health of the community. **Maintaining the coverage gains made over the last decade is vitally important to the health of patients, communities and the hospitals and health systems that care for them. We urge the agency not to take action in the future that could cause a significant setback.**

As an alternative, we encourage the agency to provide more resources to help inform consumers about their coverage options. Specifically, we encourage the agency to sufficiently fund outreach and enrollment efforts. These resources are vital sources of information for individuals on how to shop for, enroll in and use their health care coverage. Such assistance is particularly needed in vulnerable communities with traditionally low health care literacy.

Silver-Loading

CMS expresses concerns with the practice of "silver loading," where health plans raise silver plan premiums to finance the statutorily-required but unfunded cost-sharing reductions (CSR). In doing this, health plans concentrate the necessary premium increase in one type of plan, allowing consumers to avoid the additional premium costs if they choose a non-silver plan, such as bronze or gold. While not taking any action at this time, the agency notes its support of a legislative solution to provide appropriate funding for the CSR payments, thus eliminating the need for health plans to silver load. The agency, however, seeks comments on whether to take action on its own to address this issue should Congress fail to act. Any future action would occur through the notice and comment rulemaking process.

NJHA strongly supports congressional action to fund the CSRs. Absent legislative action, we oppose any administrative action to prohibit silver loading. Fully funding the CSR payments would help to ensure the stability and affordability of the marketplaces. As the agency notes, without these payments, health plans face an additional cost that ultimately gets passed back to the

consumer through higher premiums. Today, health plans in states that allow silver loading are able to protect consumers by limiting the premium increases to silver plans. Subsidized consumers who enroll in the higher-cost silver plans are protected from the increase because the tax credit increases correspondingly. As previously mentioned, unsubsidized consumers are able to purchase gold or bronze level plans without experiencing the impact on their premiums. Spreading the cost across all plans would raise the cost for both subsidized and unsubsidized enrollees and may create a cost barrier for some consumers. We urge the agency not to threaten consumers' access to coverage or the stability of the marketplaces by taking any action to address silver loading.

Cost Transparency

NJHA applauds and offers strong support of CMS's intention to address consumers' understanding of out-of-pocket costs. Specifically, we believe requirements for insurers to disclose a consumer's anticipated costs for particular services upon request and within a set timeframe should be implemented. This type of transparency would greatly benefit patients' decision-making process.

Conclusion

The New Jersey Hospital Association appreciates the opportunity to share our concerns and recommendations with CMS on this proposal.

Thank you for your consideration of our comments. If you have any questions, please contact Theresa Edelstein at 609-275-4102 or tedelstein@njha.com.

Sincerely,

Theresa Edelstein, MPH, LNHA
Vice President
Post-Acute Care Policy & Special Initiatives