November 27, 2017

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-9930-P: Patient Protection and Affordable Care Act; HHS Notice off Benefit and Payment Parameters for 2019

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 providers, including all of New Jersey's acute care and specialty hospitals as well as hundreds of post-acute providers.

We acknowledge the underlying concerns that the U.S. Department of Health and Human Services and Centers for Medicare and Medicaid Services are attempting to address in proposing the rule. However, we do have several concerns about how certain provisions within the proposal would impact the operational processes surrounding enrollment. NJHA has provided detailed comments regarding these processes below.

Our overarching concern, is CMS' continued efforts to allow for more state oversight. This proposal seems to be based on the premise that states have lost oversight of the health insurance markets, when in fact, that is not the case. In fact, states have arguably been more engaged of late because they are monitoring state-level legislation and regulations to ensure compliance with the federal requirements. The federal level oversight was actually an enhancement, not a detriment, to these already existing efforts especially in light of ongoing budget constraints that have in some cases led to a shortage in the number of personnel needed to provide oversight at the state level. **NJHA is concerned that it is HHS' intent to continue to move most of the oversight for qualified health plan (QHP) certification to the states and eliminate the federal oversight role. We respectfully request that HHS continue to play a role in monitoring state-level oversight measures to ensure appropriate compliance, for example through the use of audit**

mechanisms, to ensure that States are adhering to measures that have been established at the national level.

Additionally, we realize that HHS is attempting to reduce regulatory burdens to ensure that the legislative objectives can be more efficiently achieved, we are concerned that the provisions of this proposal will go beyond that and lead to the erosion of gains consumers have seen in the healthcare market. Below is NJHA's analysis of how the proposal would actually weaken consumer gains in the health insurance market.

Essential Health Benefits - § 156.20

NJHA recognizes that HHS is facing challenges in ensuring that carriers are willing to offer at least one plan selection in each market, and that offering more freedom in the development of essential health benefits may appear to be a way to achieve that goal. However, we are concerned with what appears to be a massive shift in an approach at market stabilization. Specifically, previous regulation and guidance has tried to make incremental changes moving toward a more standardized insurance market. By allowing for the newly proposed approach, HHS is moving toward a more fragmented market by allowing states the opportunity to define an EHB package not only by plans that are already available in the states market currently but to also select an EHB plan based on any one of the other states' EHB plans. The proposal also broadens the scope of the definition of a typical employer plan in the state.

Similar to concerns that have previously been raised about carriers selling plans across state lines, NJHA is concerned that this approach may negatively impact consumer protections that exist at the state level. Carriers will strive to develop EHB plans that meet only the barest of requirements. Furthermore, this concern is only further exacerbated by the rule's proposal to also allow EHB-compliant plans to substitute benefits both within *and between* EHB categories. NJHA is very concerned about the potential to steer consumers with high medical needs away from certain plans, allowing carriers to cherry pick among consumers. Finally, CMS is also proposing that the typical employer plan definition would include self-funded plans sold in one or more states with enrollment of at least 5,000 enrollees. As HHS knows, not all of the requirements of the ACA apply to self-funded plans. Additionally, state-funded plans operate with very little state oversight, because of that **NJHA strongly encourages HHS to not include self-funded plans in the definition of typical employer plan** as these plans are developed specifically for a single entity and are therefore anything but typical. However, does **NJHA supports further investigation of a federal default definition of EHB.**

It is for these reasons that NJHA recommends removing the proposals related to the essential health benefits. In the event CMS does decide to move forward with the proposal **we strongly request that CMS limit the changes by not allowing states to replace EHB categories from other states' EHB-benchmark plan or substitute benefits between EHB categories.**

Meaningful Difference Standards – §156.298

Similar to our concerns regarding the EHBs, specifically those regarding cherry picking, NJHA believes removing the meaningful difference standard is eliminating another provision that not only protects consumers but also educates them regarding what they are purchasing.

Most consumers are not well-educated on the nuances of how a premium is established for a plan. For example, many don't necessarily realize that a carrier can lower a plan's premium by either not covering certain basic services or even more confusing through the use of applying co-insurance to services that typically have a co-pay. Without prohibiting plans from offering products that are not easily recognized as materially different, HHS is provide carriers with yet another way to steer patients toward specific plans. **We request that HHS continue to require the meaningful difference standard.**

Rate Review - §154.103

CMS proposes several changes concerning the rate-review process. Specifically, the rule proposes that; states be allowed to publish proposed and final rate increases on a rolling basis, to reduce the advanced notification that states must give HHS about the posting of rate increases from 30 days to 5 business days, and would increase the threshold for premium rate increases that require plans to submit a narrative justification to 15 percent from 10 percent.

NJHA believes that these provisions are detrimental to consumers' ability to be fully educated on the products that they are purchasing, and undermine consumer protections. Allowing rate increases to be posted on a rolling basis eliminates the likelihood that a consumer can easily compare the rate increases across all products being sold in a particular plan year. Additionally, by lowering the advance notification requirement to HHS, in tandem with raising the threshold for the narrative justification to 15 percent, does away with important consumer protections. **NJHA strongly encourages CMS to eliminate the rate review changes from the proposal.**

Conclusion

The New Jersey Hospital Association appreciates the opportunity to share our concerns and recommendations with CMS on this proposal. As you are aware, NJHA is a member of the American Hospital Association and, as such, NJHA wishes to register its support for the comments submitted by the AHA.

Thank you for your consideration of our comments. We look forward to working with HHS on ongoing healthcare reform implementation efforts. If you have any questions, please contact Theresa Edelstein at 609-275-4102 or tedelstein@njha.com.

Sincerely,

Cathleen D. Bennett

Cathleen D. Bennett
President and CEO