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Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS–9883–P
P.O. Box 8016
Baltimore, MD 21244-8016
Via Regulations.gov

Re: Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program – File Code CMS-9883-P

To Whom It May Concern:

The following comments on the proposed HHS Notice of Benefit and Payment Parameters (Notice), as published in the Federal Register on February 11, 2026, are submitted on behalf of the New Jersey Department of Banking and Insurance (the Department). By way of background, through its Division of Insurance, the Department regulates the health insurance industry in New Jersey, including performing rate review for the individual market, market conduct examinations, as well as other regulatory functions. In addition, the Department operates "Get Covered New Jersey," which is New Jersey's State-based Exchange (SBE or Exchange) and a division within the Department. New Jersey transitioned to a SBE beginning plan year 2021.

New Jersey also implemented P.L.2020, c.61 on January 1, 2021, to create funding for state subsidies, in addition to advance premium tax credits, for qualified individuals to further improve affordability and demonstrate the value of operating a state Marketplace.

Further, the Department operates the New Jersey Health Insurance Premium Security Program, a reinsurance program under a 1332 Innovation Waiver pursuant to P.L.2018, c.24. The reinsurance program results in rates that are between 10-20% lower than they otherwise would

be and was approved for an initial five-year period and was extended for an additional five-year period, through 2028.

The Department is concerned with the short turnaround time for comments to the proposed rule. Stakeholders have been given a 30-day period to review these extensive proposed changes to the health insurance market. The 30 days to review and provide comment is insufficient for states to fully analyze all of the proposals in the rule proposal. Additionally, the timeline to implement many of the proposed changes, if adopted, will put states in a challenging position. Typically rate and plan management instructions need to be finalized early in the year and rates are typically filed in the Spring. The timing of this proposal does not allow enough time for comment, and to the extent these proposals are adopted, there is not enough time for states to implement the changes. If the policies to which the Department objects below are adopted over those objections, the Department requests that they be delayed until plan year 2028.

The Department appreciates your consideration of the following comments.

1. **Narrowing Eligibility for Noncitizens.**
   The Notice implements H.R.1 by significantly narrowing the categories of noncitizens who are eligible for premium tax credits and cost-sharing reductions. The Notice implements this change by deleting the advance premium tax credit (APTC) and cost sharing reduction (CSR) section for noncitizens ineligible for Medicaid and under 100% of the federal poverty level (FPL), leaving these consumers to buy full price plans. The Notice also implements these H.R.1 changes by creating a new definition of "Eligible Noncitizens" who can qualify for APTC/CSR starting in 2027, excluding many taxpaying noncitizens from receiving APTC/CSR who would otherwise be eligible (income between 100% to 400% of federal poverty level (FPL), as well as a new data verification for the Eligible Noncitizen status with SAVE.

   Department comment: The Department is concerned with the number of uninsured residents that are likely to result from these proposals. The elimination of APTC/CSR is a significant hardship for low-income noncitizen New Jersey residents with income under 100% of FPL, many of which would not be able to afford basic life necessities if they instead paid for full price health coverage. Starting in 2027, these changes will negatively affect the health and wellbeing of even more New Jersey noncitizens whose income is within 100% to 400% of the FPL but who will not be eligible for any federal financial help. Additionally, since such adults will not be eligible for Medicaid, they are likely to be uninsured.

2. **Elimination of the Low-Income Special Enrollment Period**
   The Notice proposes to remove the special enrollment period (SEP) for consumers with income under 150% FPL to align with H.R.1's prohibition on Marketplaces providing

APTC to anyone who enrolls in a plan via a triggering event that is based on a consumer's income level.

Department comment: At income levels under 150% of FPL, there is a high degree of income fluctuation and, thus, churn between Medicaid and the SBE. Consumers who lose Medicaid do get an SEP for loss of coverage. However, due to slow notice speed informing consumers of lost coverage, consumers are often informed of their loss in coverage after their time to obtain Exchange coverage ends. Often times the individual finds out of their loss of Medicaid coverage only when they seek a medical service, such as filling a prescription at a pharmacy. This is why consumers need extra time to enroll under the 150% SEP. Therefore, the Department opposes eliminating this SEP for low-income consumers.

Moreover, often these consumers may have been unfamiliar with the fact that health insurance through the Exchange is only purchasable on an annual basis while Medicaid is available year-round. Many of these consumers were able to gain quality coverage year-round, without the threat of adverse selection, because there was no incentive not to enroll in such low-cost coverage and maintain the enrollment. The SEP was a critical tool in helping low-income consumers maintain health coverage and the Department could not identify an adverse selection impact from the SEP.

3. Amending Requirements for State Exchanges to Operate a Centralized Eligibility and Enrollment Infrastructure - State Based Exchange Enhanced Direct Enrollment (SBE-EDE)

The Notice proposes to allow for a new Exchange model using a private sector approach relying exclusively on web brokers to run a state Exchange's consumer facing website for eligibility and enrollment. The state Exchange would be responsible for interfacing with the web broker's site for eligibility and Medicaid assessment being performed in the background, collecting the application and enrollment data, reporting to IRS and CMS, maintaining a call center, maintaining a website for consumer information including anonymous shopping, maintaining a Navigator program and ensuring compliance with all Exchange requirements by the web broker, including protection of PII. The Notice does not make clear how manual verification reviews would be performed. HHS says the purpose of this flexibility is to enhance consumer engagement and enrollment strategies by allowing "State Exchanges to develop solutions that address the unique needs of their residents and markets." HHS would require that at least one of a state Exchange's SBE-EDEs would have to display detailed QHP information for all available QHPs in the state.

Department Comment: Given HHS's stated concerns around inappropriate broker activity in recent rule proposals, as well as this Notice ("The persistence of agent, broker, and

web-broker actions to undermine payment integrity highlight the need for continued changes to address improper enrollment"; Notice page 6348), the Department would caution against this important consumer protection function being in in the hands of brokers with commission incentives. The Department is concerned about how consumers would be able to obtain complete, accurate and understandable information about enrollment options under this state Exchange option.

The Department is concerned how consumers would know they are at a safe enrollment website, when there are many broker websites vying to sell consumers "affordable" health insurance, many with similar names and logos that typically seek to mimic the SBE-EDE website as they try to mimic the Exchanges today. The Department is concerned that when the website does not end with ".gov" or something easily distinguishable as the Exchange, consumers cannot trust they are at the right location to divulge their personally identifiable information. Today, consumers struggle when they too quickly click on a link that looks like the Exchange website but is not, disclosing their personal information and believing they are dealing with the Exchange when they are not. Despite their prohibition, consumers in New Jersey have complained from time to time of being sold insurance – short term or supplemental insurance – that was not the Exchange coverage they were told they had purchased, because they trusted an unseen broker on a website that they thought was part of the Exchange. However, consumers in New Jersey can determine they are at the correct website when they see the ".gov" in the domain of Get Covered New Jersey.

HHS previously identified the dangers in the similar optional Direct Enrollment program for state Exchanges. (See 86 F.R. 53429). HHS found that consumers could too easily be directed to less comprehensive coverage options by web brokers, and it found that these websites disproportionately negatively impacted underserved and historically marginalized groups. HHS found that Direct Enrollment entities did not protect and strengthen the ACA and were instead barriers to consumers getting quality, affordable health insurance. Brokers can be influenced by commissions and consumers can end up with coverage that does not cover their healthcare costs.

The dangers from Exchange websites run by brokers are heightened due to the variety of cheaper and less comprehensive coverage options that the Notice proposes to make available to consumers, that will be difficult for consumers to understand and compare. Consumers losing coverage due to lack of financial assistance need guidance to find the most appropriate plan for their needs, and not necessarily the most inexpensive plans that may be confusing to understand and will not cover their care should they experience a significant healthcare need. To the extent consumers may be steered toward leaner plans by brokers, many will find it challenging to meet the cost sharing under those plans; for example, in the case of catastrophic coverage, few consumers can unexpectedly cover the

$10,600 deductible on such plans before coverage is available for a significant healthcare need.

The Department does not support this proposal as it is likely to add website confusion and erode consumer protections that exist with consumers enrolling directly in coverage through the Exchange.

4. Failure To File and Reconcile (FTR)

HHS proposes to remove financial help after one or two years for 2027, and after one year for 2028, of a consumer's failure to reconcile (FTR) their APTCs with their income tax filing, and for the Exchange to provide warning notices to consumers accordingly.

Department Comment: The Department notes that litigation in City of Columbus v. Kennedy ordered a Stay of the proposal to modify the failure to reconcile process due to lack of legal basis. The proposal related to 2027 appears to mimic the proposal subject to the Stay and the Department opposes this proposal for the reasons the Stay was granted. Further, the Department opposes the proposal to tighten the requirements around providing APTC after a consumer's FTR generally, as there is little program integrity benefit at a great cost of increased loss of coverage and uninsurance. Additionally, the Department expresses concern about the timing and logistical challenges of a one-year FTR requirement. This will require the Internal Revenue Service to process tax records timely enough for one-year FTR checks so that consumers can receive accurate results.

The Department would like to restate its general concerns about the FTR process. The Department appreciates the ability to communicate with the account holder (rather than the tax filer) because the Department does not believe it is cost beneficial for state Exchanges to incorporate federal tax information (FTI) in their systems. HHS has recognized that state Exchanges do not have the resources, or FTR infrastructure, to perform the complex processes needed to protect FTI in order to align with the federal platform's FTR recheck and direct notice requirements. For the reasons expressed in past Notices and past Comments regarding state difficulties with trying to incorporate processes that are better carried out by the IRS or the federal government, state Exchanges would need to undertake major complex and costly changes to expand the access to FTI so that such confidential data could be more fully incorporated into the Exchange systems and Exchange notices. It is beneficial to both States and the IRS to avoid expansion of access to FTI. The administrative and other costs for expansion of FTI access in Exchange systems would far outweigh the expected gains in accuracy, efficiency, and program integrity for the small percentage of consumers who are found

through these processes to have not reconciled. Generic notices can accomplish the same education and provide instruction while protecting consumers' FTI. Alternatively, we would encourage HHS to consider the role of the IRS and their natural capabilities in working with FTI and their line-of-sight into current tax filing status. The IRS is provided with a monthly list of enrollees who are receiving APTC (the "EOM file") from the Exchanges and could more efficiently implement alternative processes and then inform States which individuals have failed to reconcile.

5. **Renewal of Income Verification Requirement When Data Sources Indicate Income Is Less Than 100% of FPL**

HHS again proposes that Exchanges should create income data matching inconsistencies for consumers not assessed for Medicaid where the attested projected annual household income is over 100% but the data from trusted data sources says annual income in the past was under 100% and the difference is more than a reasonable threshold. HHS proposes that verifying more application income attestations can lead to reduction of fraud by brokers who are creating fake enrollments (Notice page 6346).

Department Comment: The Department notes that the Court in City of Columbus v. Kennedy has stayed implementation of this low-income verification requirement under the previous proposal.

HHS's stated purpose of reducing broker fraud results in a proposal that requires consumers to do more work gathering and uploading paperwork. This fails to support expanded enrollments and increases administrative costs and burdens on consumers and SBEs. More importantly, the impact of this proposal will be low-income enrollees will lose much needed coverage due to administrative barriers created by this proposal. The fact that most people with data matching inconsistencies work with brokers, cited in the Notice on page 6348, points to the need for those consumers to have assistance, due to their unfamiliarity with health insurance or with the application process.

HHS's concern about consumers over-estimating projected annual income is not a problem in New Jersey because of the State's expanded Medicaid program for consumers up to 138% of FPL. As HHS set forth in 90 FR 12963-4 (Marketplace Integrity and Affordability Rule), a federal court previously blocked a similar process finding that lower income consumers generally have a greater administrative burden in obtaining and submitting documentation due to part-time or hourly positions, multiple jobs throughout the year, working in cash industries such as food service where tips may be the larger part of their income, and documentation from employers may be harder to obtain. City of Columbus v. Cochran, 523 F. Supp. 3d 731 at 762-763.

This new verification process would create additional administrative barriers to low-income consumers remaining enrolled and add unnecessary paperwork and technical burdens on SBEs. For states where this program integrity issue is not relevant because there is no incentive to inflate income in order to be eligible for health coverage (where Medicaid has been expanded for adults), Exchanges should be given the flexibility not to implement this proposed new DMI if costs appear to outweigh the accuracy, efficiency and program integrity benefits of the proposed new verification process.

6. Removal of the Requirement to Accept Attestations of Household Income When Tax Data is Unavailable

HHS again proposes that Exchanges should create income data matching inconsistencies for consumers when the IRS is successfully contacted regarding a consumer's income, but no data is returned. The current practice is to accept a consumer's attestation. Again, HHS argues that it is combatting broker fraud leading to unauthorized enrollments by requiring consumers (or their brokers on their behalf) to verify income. (Notice page 6348).

Department Comment: The Department notes that the Court in City of Columbus v. Kennedy stayed implementation of this income attestation verification from the previous proposal.

The Department opposes this proposal as it would remove consumer flexibility, increase coverage losses and will not materially reduce fraud. The Department supports reasonably reducing consumer administrative burden that helps enrolled consumers maintain their financial help and coverage for the coverage year. There are many reasons a consumer's tax data may not be available. There is no reason to penalize this group by requiring extra paperwork hurdles instead of self-attestation, which has worked for SBEs in the past. Attestation of expected income in many circumstances would be reasonable and reduce administrative costs and burdens on consumers. Any possible errors in income attestation would eventually be reconciled at tax time. Therefore, the costs of the extra paperwork for exchanges and consumers far outweigh any possible reduction in fraud or overpayment of PTC.

7. Comment Solicitation on Eligibility Verification Provisions of H.R.1, Section 71303

H.R.1 eliminates provisional APTC for those who fail to confirm their application information and for those in the process of resolving the paperwork associated with a data matching issue. Beginning in 2028, the rule provides that a month is not a coverage month for an applicant, and therefore no PTC is allowed for the applicant's coverage for

that month, if the month begins before the Exchange verifies the applicant's eligibility to enroll in a QHP and for APTC, using applicable enrollment information that shall be provided or verified by the applicant. The law specifies a minimum set of "applicable enrollment information"; clarifies that a past month may be treated as a coverage month if an Exchange later verifies the applicant's eligibility; specifies that these verification requirements do not impact eligibility to enroll in a QHP; permits the Secretary of the Department of the Treasury to waive the verification requirements when an individual qualifies for an SEP based on a change in family size; and states that Exchanges are permitted to use "any data available to the Exchange and any reliable third-party sources in collecting information for verification by the applicant."

H.R.1 also requires that any plan enrolled in through an Exchange is not considered a QHP, and therefore no PTC is allowed for enrollment in the plan, unless no later than August 1 of the preceding year, the Exchange provides a process for pre-enrollment verification that permits any applicant to verify their household income and eligibility for enrollment in such plan for the upcoming plan year.

HHS seeks comment on operational considerations for State Exchanges, issuers, agents and brokers, navigators and assisters, and consumers; effective rollout and communications; required timelines to comply with the law; anticipated complexity, costs, burden, enrollment impacts, and any State-specific considerations.

Department Comment: The Department would expect that the Eligibility verification provisions of H.R.1, Section 71303, will reduce enrollment, add burdens on consumers ability to access coverage, and present unnecessary operational and paperwork burdens on exchanges to implement.

With regard to implementation timelines, the mandated changes require significant time and funding to implement because of the fundamental change they make in how Exchanges operate. These policies require consumers, who are accustomed to relying on renewal and supplying documentation later, to understand that they must engage with the Exchange prior to the start of the plan year to complete all updates, verifications and documentation submission to receive uninterrupted financial help.

Flexibility in helping consumers maintain their financial help in the first year of this process is requested. Given that planning is only in the initial stages, the Department is not yet sure of its timeline for making the changes. Regardless, treating 2028 as a test year and allowing consumers to have extra time to complete the process would be a significant benefit for such a major change in how Exchanges function and how consumers renew their coverage.

Inevitably many consumers will lose coverage as the burden of paperwork requirements become an obstacle to accessing and affording coverage and care. These individuals, in

many cases, will not be losing coverage because they are not entitled to financial help. They will lose coverage because of an inability to afford coverage while paperwork requirements are resolved.

8. Comment Solicitation on Premium Payment Threshold

HHS seeks comment on whether it should permanently discontinue regulatory options allowing QHP issuers to implement a fixed-dollar and gross percentage-based premium payment threshold for PY 2027 and beyond.

Department Comment: Flexibility around premium payment thresholds is preferred to allow SBEs to tailor their policies around coverage retention, while minimizing fraud and waste. Premium payment thresholds can be a buffer for consumers to remain enrolled regardless of a nominal amount owed, or due to a payment glitch. Allowing SBEs to set their own threshold would provide the flexibility needed.

In addition to flexibility around a premium payment threshold, the Department would also prefer flexibility for carriers to reinstate coverage when a consumer has an unexpected payment malfunction (credit/debit/bank administrative issues or billing confusion), such that a reinstatement could be provided to the consumer in such a situation in which the consumer makes the payment out of time.

9. Expansion of Hardship Exemption Eligibility

CMS proposes to expand the hardship, or "lack of affordability," exemption eligibility to individuals with incomes below 100% or above 250% of the FPL. HHS believes there are a "substantial number of consumers for whom purchasing a QHP relative to a catastrophic plan could cause a financial hardship." (Notice page 6354). In general, HHS has found that the cost of insurance for consumers not eligible for both APTC and CSR, is unaffordable, and therefore, these consumers can have an exemption, like those under 30 years old, to purchase catastrophic coverage. Meanwhile, the federal government has classified catastrophic coverage and bronze plans as high deductible health plans eligible for Health Savings Accounts (HSAs), allowing consumers to set aside some of the plan deductible costs in their HSA account as a tax deduction. HHS advises that States retain discretion to determine how to operationalize this policy—either by adopting the expanded criteria or continuing to delegate exemption processing to HHS.

Department comment: The Department has concerns with the impacts of these proposals on risk pools and individuals. Expanding eligibility for catastrophic plans to those over 30 years of age, particularly while also increasing the out-of-pocket costs for these plans, will impact the individual market risk pool. Older populations tend to have more medical

needs and catastrophic plans are not designed to provide that coverage at an affordable cost due to the high cost sharing associated with those plans notwithstanding their eligibility for HSAs.

In New Jersey, catastrophic coverage, which under the provisions of the Affordable Care Act is not eligible for any financial help, is not always cheaper than bronze level coverage, for which a consumer might receive APTC, and which have lower out-of-pocket costs. In New Jersey, many bronze plans are cheaper than some of the catastrophic plans available through the Exchange and the deductibles and maximum out of pocket costs are under $10,600 (the 2026 deductible for a catastrophic plan). Therefore, while this expansion of catastrophic plans will likely entice a significant number of those over age 30, with or without a good understanding of the cost sharing implications, it will also likely draw healthier populations away from the metal level plans to catastrophic plans. This could negatively impact the risk pool for metal level plans.

From a consumer perspective, the Department believes that HHS should focus on helping consumers get quality, affordable coverage that will help them when they have unexpected medical needs as well as with any chronic conditions. Coverage options with high out of pocket costs, particularly for age groups over 30, will be difficult for consumers to manage, even with an HSA which presents its own complexity, and will not contribute to their remaining healthy and financial solvent in the event of a major illness as health insurance should.

10. Annual Programmatic Audit

HHS proposes to reduce duplication between the current annual programmatic audit and the proposed new state Exchange Improper Payment Measurement program by reducing the need to address the eligibility and enrollment sections, 45 CFR Parts D and E, in the programmatic audit.

Department Comment: The Department supports reasonable compliance oversight and appreciates removal of duplicate monitoring and reporting burdens for the Exchange.

11. State Exchange Improper Payment Measurement (SEIPM) program

HHS proposes to establish the SEIPM to measure improper payments of APTC administered by State Exchanges. HHS proposes to start the extensive audit process in January 2027 for 2026, and to continue the process annually. HHS believes that its proposed timeline would allow state Exchanges to establish the operational infrastructure and baseline processes to support the SEIPM, such as conducting comprehensive system

assessments to identify data collection and reporting capabilities; developing or modifying existing information systems to capture and transmit the required SEIPM data elements; establishing internal policies and procedures for data validation and quality assurance; training staff on the SEIPM requirements and reporting protocols; and conducting testing and validation of new systems and processes before the effective date. HHS will require information submission of: (1) the program documentation that would be used to inform the review criteria; (2) the universe, which would be a summary listing of the tax households that received APTC payments for the respective plan year, from which HHS would select a random sample; (3) tax household data which would be the detailed level of data for each sampled tax household. The state Exchange would be required to submit to HHS its universe of: (1) Exchange assigned policy identifier; (2) tax household grouping identifier; (3) SSN inconsistency indicator; (4) citizenship inconsistency indicator; (5) lawful presence inconsistency indicator; (6) annual income inconsistency indicator; (7) non-employer sponsored minimum essential coverage inconsistency indicator; (8) employer sponsored minimum essential coverage inconsistency indicator; (9) incarceration inconsistency indicator; (10) residency inconsistency indicator; (11) number of tax household members; and (12) APTC amount paid over the duration of the plan year.

Department Comment: Completing the incredibly detailed reporting around Improper Payment Pre-Testing and Assessment (IPPTA), which was designed as a pre-cursor to audits, was a very time-consuming and resource intensive challenge for the Exchange. The list of work that HHS believes Exchanges should do to prepare for and participate in SEIPM does not acknowledge the amount of substantive work that HHS is requiring Exchanges to do to comply with its 2027 and 2028 eligibility and enrollment updates. Further, not having received the State's IPPTA results makes it more difficult to fully comment on the new proposed audit processes.

The Department questions HHS's assumptions about the level of automation each state has implemented, and the complexity of the apples-to-oranges transformation required for the IPPTA/SEIPM process. CMS appears to continue to underestimate the complexity and burden of this process on States and how that can exponentially increase as data is gathered on cases with layered historical changes with sometimes multiple household composition and demographic changes in a single day. While it is true that several States managed to assemble data for the IPPTA process, this is not conclusive that it will be an effective tool. It is important that CMS be aware that the IPPTA process required extensive manual effort by SBEs to populate the data request form. Additionally, CMS should take into consideration that differently selected cases with varying complexity might be overwhelming for a State.

The Department encourages HHS to pursue a more efficient method for checking how an Exchange is performing without requiring an overly burdensome oversight process. For example, the level of detail requested is excessive and requiring the submission of consumers' personal documentation to CMS as part of the sample review also should be reconsidered. By the time the results are issued, laws and/or systems will have changed. The ACA was designed to rely on the IRS to catch up with consumers who receive an overpayment of APTC. The IRS might also better provide APTC incorrect payment rates for those who are provided with APTC that significantly differs from their actual income. State Exchanges are currently overburdened with managing compliance with major changes to consumer eligibility and enrollment and to how Exchanges renew coverage. HHS should not burden Exchanges with such an intensive audit program while Exchanges are under strain to complete H.R.1's mandated substantive updates. This audit process should be delayed and scaled back to a more reasonable, less burdensome process. In the alternative, the process should be delayed for a year to allow SBEs more resources to make the major changes required to implement H.R.1.

12. QHP Certification of Non-Network Plans

CMS proposes to allow non-network plans to receive QHP certification beginning with plan year 2027 by demonstrating a sufficient choice of providers in a manner consistent with sections 1311(c)(1)(B) and (C) of with the ACA. Unlike network-based plans, non-network plans do not rely on a contracted set of providers that agree in advance to specific terms and negotiated payment rates, nor do they condition or differentiate benefits to enrollees based on whether the issuer has a network participating agreement with a provider that furnishes covered services. Instead, these plans set specific benefit amounts for covered services and communicate those benefit amounts to enrollees who may then seek covered services from any provider. Under this proposal, non-network plans would be required to ensure access to a range of providers that accept the non-network plan's benefit amount as payment in full, including ECPs and providers that specialize in mental health and substance use disorder services, to ensure that services will be accessible without unreasonable delay. This proposed policy aims to reduce overall health care costs by (1) empowering enrollees to utilize price transparency information to shop for lower prices and negotiate directly with providers, thus fostering increased competition, and (2) eliminating substantial administrative overhead associated with traditional network management, potentially resulting in lower premiums.

Department Comment: While such plans are prohibited by state law, the Department expresses concern with the proposal to utilize non-network plans. The primary concern is that this proposal could leave consumers with significant surprise bills for out-of-pocket costs. This proposal puts the onus on consumers to identify the benefit amount allowed for a given service, identify available providers, and engage in direct negotiations with

providers to attempt to obtain pricing that aligns with the allowed benefit amount. The proposal fails to acknowledge the disparity in negotiating power between health plans and individual plan enrollees, and presumes consumers have the time and resources to engage in the level of research needed to identify the allowed benefit for a given service, identify available providers, and engage in pricing discussions, which many do not. There is a strong possibility the proposal will result in increased out-of-pocket costs for consumers who are unable to find or negotiate lower prices, requiring them to make up the difference between the provider's pricing for a service and the allowed benefit amount. Moreover, the proposal may reduce the ability of consumers to utilize the services of their current or preferred providers, if those providers have not agreed to accept the issuer's benefit amount or if they are unwilling to negotiate a lower price. Although it is suggested the proposal may result in lower premiums, there is a strong likelihood that any savings in premiums will be offset by higher out-of-pocket costs, as well as the increased time and resource investments needed for members to understand the allowed benefit amount, identify available providers, research pricing data, and engage in pricing negotiations.

13. Maintaining EHB Alignment and Increasing State Accountability –

Prohibiting Issuers from Including Routine Non-Pediatric Dental Services as an EHB

CMS proposes to prohibit issuers from including routine non-pediatric (adult) dental services as an EHB. CMS believes this reversal of the policy finalized in the 2025 Payment Notice better aligns with statutory requirements under section 1302(b)(2)(A) of the ACA, which directs that the scope of EHB be equal to the scope of benefits provided under a typical employer plan.

Department Comment: The Department opposes any changes that limit the ability of states to define what constitutes an essential health benefit (EHB) in a manner consistent with the needs of their residents and opposes any changes that would limit coverage for services that will be beneficial to the health of the individuals in the state. Allowing coverage for non-pediatric dental services as an EHB is an option that can help ensure access to dental care for individuals who may not otherwise have employer-sponsored dental benefits coverage and who cannot otherwise access or afford standalone dental coverage. Maintaining good oral health is a key component in fostering good health overall. Allowing adult dental services to be classified as an EHB provides states with the option to create an alternative means to ensure comprehensive access to oral health care that can affect a meaningful difference in peoples' lives.

Cost Defrayal of State-Mandated Benefits

CMS proposes revisions to states' responsibilities when mandating benefits beyond the federally required EHB package. Beginning with plan year (PY) 2027, CMS proposes that any state-required benefit would be considered "in addition to EHB"—and thus not EHB—if it is required by state action after December 31, 2011, applies to the small group and/or individual markets, is specific to required care, treatment, or services, and is not mandated for compliance with federal requirements. Under this proposed policy, states would be required to defray the cost of these additional benefits for enrollees in QHPs offered through the Exchange, regardless of whether the benefit is embedded in the state's EHB-benchmark plan.

CMS suggests this proposal would restore previously established standards to mitigate premium increases for unsubsidized enrollees, stabilize a predictable insurance market, provide clearer rules for state and issuer responsibilities, and increase cost transparency to assure that states, rather than consumers, bear the financial responsibility for additional mandated benefits.

Department Comment: The Department strongly opposes this proposal as it is vaguely defined and lacks clarity in terms of process and scope. The ability to define, and add to, the state's essential health benefits (EHBs) is a core means for states to ensure their residents have access to the care and services needed in their communities, as well as to ensure that the composition of the state's EHBs is commensurate with the current health care landscape. The ability to add new EHBs allows states to incorporate coverage for new and emerging treatment modalities, as well as to adapt to innovations in technologies, best practices and treatment guidelines. Requiring states to defray the costs of any health coverage mandate adopted after December 31, 2011, essentially requires states to either roll back fifteen years of advancement in health care policy or absorb the monetary cost of ensuring residents have continuing access to the care and services they have come to rely on. Adopting this policy will materially hurt the lives of individuals, either because they are losing coverages they depend on or because the costs of defrayal would impact other essential public services.

The Department further opposes the decision to pause pending applications to update state EHB-benchmark plans and the proposal to roll back the processes that make it easier for states to update their EHB-benchmark plans to incorporate new benefits. In many other contexts, CMS acknowledges that states are in the best position to determine their own needs and the needs of their communities and residents. The establishment of EHBs that are designed to serve the health care needs of each state and its communities and residents is in complete alignment with the realities and philosophies undergirding the federalist system of government; a fact which is underscored by the fact that most coverage mandates are established legislatively, and therefore represent the work product of a representative government. Any policy that limits state discretion in this area

potentially harms individuals and undermines the discretionary authority afforded to states in the regulation and oversight of health policy.

If this proposal is not abandoned it should be delayed until further clarity can be provided to stakeholders and States regarding process, scope and more information can be gathered to understand the impacts of the proposal.

14. Increasing Sustainability of the Federal Exchange

Repeal Standardized Plan Options and Non-Standardized Plan Option Limits and Exceptions Process

CMS proposes to discontinue (1) the requirement for FFE and SBE-FP issuers to offer standardized plan options in the individual market, and (2) the limit on the number of non-standardized plan options that may be offered by FFE and SBE-FP issuers, and the related exceptions process. To minimize potential disruption related to this proposal, CMS proposes to permit issuers to choose whether to discontinue existing standardized plan options and the chronic and high-cost condition plans originally offered through the non-standardized plan exceptions process altogether or continue offering them with either the same or modified cost sharing. These proposed policies would reduce issuer and HHS burden and regulatory complexity and enhance flexibility for issuers to innovate in plan design, according to the proposal.

Department Comment: The Department generally opposes this proposal. The use of standardized plans helps ensure consumers are able to readily compare plans and identify the health benefits coverage that best aligns with their own needs and the needs of their families. When the market is flooded with multiple plan options, the details of which can be a challenge to distinguish, any benefits from making additional options available are vastly offset by the work needed to try to parse and understand the myriad offerings. Moreover, increasing the number of available plan options presumes consumers have vastly more time and resources to invest in shopping for health benefits coverage than most, in fact, do. The use of standardized plans helps simplify the shopping experience and allows consumers to more readily make apples-to-apples comparison across plans and issuers. Moreover, it is expected that the use of standardized plans helps limit administrative costs for issuers, which should result in lower pricing across the Marketplace.

Additional CSR Data in Rate Filings

CMS proposes to require issuers that load rates to account for unreimbursed CSRs for the applicable rating year to submit certain information related to CSR loading in the Unified Rate Review Template and the Actuarial Memorandum for each year in which CSRs are

not funded beginning with PY 2027 rate filings. This continues the current requirement implemented by guidance and FAQ.

Department Comment: The Department notes that this information is already collected and would like to better understand the purpose of expanding the data issuers are required to report. The Department is concerned that the additional administrative costs of collecting and reporting these data for issuers, which is estimated to be $400 million in the first year, will be passed on to consumers in the form of higher premiums, further exacerbating the ability of consumers to afford quality, comprehensive health coverage. The Department is also concerned that this may be a precursor to limiting cost sharing reductions for consumers, or potentially impact silver-loading, which will further undermine their ability to afford and utilize needed health services.

Further Align Affordability and Coverage Incentives between Catastrophic and Metal Level Health Plans

CMS proposes standards under which catastrophic plans may have terms of multiple consecutive years of up to 10 years and seeks comment on whether to issue similar standards for metal-level plans. Related to that proposal, CMS proposes to allow issuers to make plan-level adjustments to the index rate for such catastrophic plans, and to allow issuers of such plans to apply the applicable cost-sharing for each plan year in the contract, prorated monthly. Also, multi-year catastrophic plans would be permitted to utilize value-based insurance designs to cover preventive services over and above those that currently must be covered under certain recommendations and guidelines, before an enrollee satisfies their deductible or hits their out-of-pocked maximum. Additionally, to address an issue that has arisen in the implementation of section 1302(c) through (e) of the ACA, CMS proposes to change the permissible cost-sharing parameters for bronze plans and to update cost-sharing requirements for catastrophic plans, beginning in PY 2027. These proposals would improve consumers' access to affordable health care coverage and provide consumers the flexibility to tailor their coverage to their needs, according to the proposal.

Department Comment: The Department opposes developing incentives to encourage enrollment in catastrophic coverage over metal tier coverage. Catastrophic coverage attracts healthier people to less-meaningful coverage, thereby distorting risk pools and increasing costs throughout the market. Increased enrollment in catastrophic coverage is also likely to reverse recent gains in helping people to avoid, and in reducing existing, medical debt.

The Department notes that this proposal lacks the details needed to fully understand and vet what these initiatives would look like and how they would be implemented. The Department is particularly concerned as to how a policy with multiple consecutive terms

of up to 10 years would be implemented and what the end goals would be of issuing coverage of this nature. It is not clear this would be any benefit to consumers, nor is it clear how it would benefit issuers. The proposal also lacks details as to what plan-level adjustments to index rates to reflect the full term of multi-year plans would be allowed, but the potential variation among plans and plan designs, as well as to premium rates, is likely to foster further consumer confusion when attempting to select a plan. Because of the ambiguities in these proposed modifications to catastrophic plans, as well as the uncertainty that any benefits would derive to either consumers or carriers, The Department also opposes applying any such modifications to metal tier plans.

The Department is further concerned with the proposal to modify cost sharing limitations for catastrophic plans, including to allow higher maximum out-of-pocket amounts and increased deductible amounts, as well as to limit the services covered under the plan until 130% of the maximum annual limit on cost sharing is reached. The proposal indicates the purpose of these proposals is to accommodate increases in actuarial value and create meaningful differences in catastrophic and bronze-level plans in order to encourage healthier consumers to select catastrophic coverage. As noted above, The Department opposes any measure that would incentivize individuals to enroll in catastrophic coverage, as this is not meaningful health coverage, will work to distort risk pools, and will likely result in increased medical debt as consumers struggle to cover cost sharing under the catastrophic plans. The increases to deductibles and cost sharing amounts and the limits on coverage for services will further erode the limited value of catastrophic coverage and will result in those who select a catastrophic plan paying even more out of pocket before benefits are covered. This will significantly harm consumers who purchase catastrophic coverage believing it is equivalent to metal-level coverage and later experience a significant medical event.

Moreover, CMS indicates in the proposal a concern about consumers increasingly enrolling in bronze coverage over catastrophic coverage options. The Department believes increased enrollment in metal-level coverage to be a positive trend that should be encouraged and supported through policy initiatives that maximize the value and utility of such coverage while minimizing out-of-pocket costs for consumers.

Finally, The Department notes that the proposed effective date of these modifications, which would take effect in Plan Year 2027, affords little time for states to incorporate these changes into their rate and plan design guidance, limited time for issuers to incorporate the changes into their plan design and rate filings, and limited time for states to review and ensure issuer filings are compliant with the revised standards. The Department believes the proposed implementation schedule is unworkable.

Comment Solicitation on Potential Changes to the MLR Standard

CMS seeks comment on the impact of the Federal MLR standard on individual market costs and premiums, whether to amend regulations to enable HHS to adjust the MLR standard in the individual market (including in states that do not request an MLR adjustment), and how to reduce burden for states interested in requesting an adjustment to the MLR standard for their individual market.

Department Comment: The Department would like to better understand how MLR standards are affecting individual market costs and potentially destabilizing the individual market in individual states, as well as what types of modifications are proposed that would adjust for this. The Department will continue to apply its own MLR requirements regardless of modifications made to the federal MLR and would strongly oppose unilateral federal action to revise the MLR in New Jersey, which would undermine the constitutional right retained by the states to regulate health policy, including health benefits coverage requirements.

Conclusion

The New Jersey Department of Banking and Insurance is committed to ensuring our consumers have access to quality, affordable health insurance that protects them and maintains stability in our marketplace. The Department supports policies that will accomplish these goals and encourage state innovation and flexibility to meet the unique needs of the state and its market. Thank you for considering these comments on proposals that will directly impact New Jersey residents, New Jersey's individual market, and the continued operations of New Jersey's state-based exchange.

Sincerely,

Susan Ochs,
Acting Commissioner