factors in setting the induced demand multiplier, such as whether or not the state expanded Medicaid, or whether or not the state offers a basic health plan. The availability of expanded Medicaid or a Basic Health Program impacts the pool of individuals eligible for premium tax credits and thus who seeks coverage in a qualified health plan. We would like more information about how demand is affected by Medicaid expansion and basic health plans, and whether or not induced demand was affected when CSR payments were discontinued and silver loading was implemented.

Calculation of Plan Average Premium and State Average Premium Requirements for Extending Future Premium Credits

We support the proposed methodology of recognizing future premium refunds, holidays, or reductions in the risk adjustment program as the result of a public health emergency. We also support the proposed application of the methodology when a state requests a reduction of the transfer payments in the small employer market.

State Flexibility in Risk Adjustment

State regulators support the Department's proposals related to state adjustments to federal risk adjustment payments. We support approval of Alabama's request for an adjustment to its 2022 payments. Further, we support the proposal to allow states to request approvals for adjustments for multiple benefit years. Allowing for requests of up to three years will not only contribute to stability and predictability in state markets, it will also reduce burden on states and the Department in preparing and reviewing requests for adjustments. We believe the proposal contains sufficient flexibility to allow appropriate responses if a state's market conditions change during the course of a multi-year adjustment approval.

Audits and Compliance Reviews of Issuers of Reinsurance-eligible Plans (153.410)

We appreciate the need to perform audits and compliance reviews for the transitional reinsurance program, and for those reviews to be conducted as seamlessly as possible. States are well suited to assist HHS to ensure timely and accurate compliance. To provide such assistance, states would need to be made aware of upcoming reviews and be kept abreast of their progress as the reviews occur, including identification of those issuers that are non-responsive, those that are not conforming to prescribed data formats, or any other issues that impede the review. States should also be informed of the final results of such reviews in a timely manner, including notice of any moneys that are being refunded.

Exemptions from HHS-RADV (153.630)

While we fully support an exemption from risk adjustment data validation audits for issuers who are the sole issuer in the state market risk pool, we believe the Department should further consider the proposal to exempt issuers who only offer small-group carryover coverage in the benefit year. It is possible that the small-group carryover business could represent a significant portion of the marketplace for a calendar year. It is our understanding that HHS-RADV audits occur for an issuer on average every three years. We ask the Department to consider the case of an issuer with only carryover business and that has not been selected for a RADV audit within the past two years. Such an issuer should still be considered for audit during the year they are exiting. If the issuer has been selected for a RADV audit within the previous two years, we support excluding them from 4(on o)suerState regulators support

IVA Requirements (153.630)

We agree there is a potential conflict of interest for an IVA entity to audit a company for which it serves as the issuer's TPA. We support the proposed controls over selecting an IVA entity to avoid such conflicts.

Timeline for Collection of HHS-RADV Payments and Charges

The Department proposes that the HHS-RADV timeline be adjusted back to what it used to be and that it would no longer allow an adjustment for HHS-RADV in the URRT. The need for an adjustment to the URRT to account for HHS-RADV has thus far been infrequent and difficult to justify. However, there may be reasonable and justifiable adjustments related to past HHS-RADV audits that affect future rating, and we ask that states continue to be allowed to determine if the adjustment is reasonable and justifiable.

EDGE Discrepancy Materiality Threshold (153.710)

We support increasing the minimum threshold from $10,000 to $100,000 (or 1% of the total estimated transfers in the market risk pool). We view a threshold of $10,000 to be too low to be material.

Definitions of QHP Issuer Direct Enrollment Technology Provider and Agent or Broker Direct Enrollment Technology Provider (155.20)

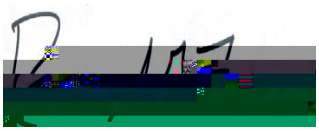
We also offer support for the proposal to require that QHP issuer direct enrollment technology providers be subject to the requirements applicable to QHP issuers and to HHS oversight. Technology providers play an important role in shaping the experience of consumers; their design and implementation choices impact the information available to consumers and the choices consumers make. State regulators have found that enforcing consumer protection laws with regard to technology providers and web-brokers can be challenging when insurance regulation is not directly applicable to them. Making regulations more clearly applicable when they act as downstream or delegated entities for QHP issuers will help hold technology providers accountable for key standards. We urge the Department to continue to work closely with state regulators on addressing inaccurate and misleading marketing practices from all entities, whether they are QHP issuer direct enrollment technology providers, web-brokers, or other organizations.

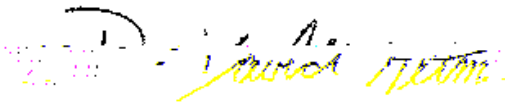
Direct Enrollment Entity Plan Display Requirements (155.221)

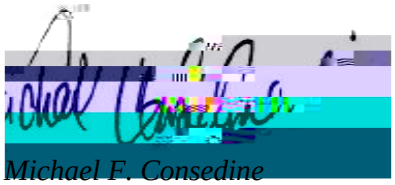
The Notice contains proposals to give direct enrollment entities greater flexibility in displaying information for qualified health plans on the same webpage as plans that are not qualified health plans. The proposal would allow display of both types of plans only when consumers indicate they have access to Health Reimbursement Arrangements with employers (and for dental plans). We recognize the need to provide consumers with access to HRAs information on all relevant options. Nonetheless, state regulators are concerned by the recent activity of market actors who mislead or confuse consumers about the attributes of plans that are not QHPs, including at times

Special Enrollment Period Verification (155.420)

We understand the Department's intent to reduce the potential for anti-selection effects by implementing pre-enrollment verification of eligibility for certain special enrollment periods (SEPs) and we have heard anecdotally from issuers that SEPs appear to be approved more often than expected. However, some states have concerns that such a policy could hinder or delay access to coverage unnecessarily for some applicants. CMS has not offered evidence to suggest that SEPs have negatively impacted individual market risk pools. We encourage CMS to provide such justification if it moves forward in supporting the federally-facilitated exchange implementing validation for 75% of new SEP enrollees. In addition, we ask for flexibility on the SEP pre-enrollment verification processes for state-based exchanges. SBEs may not have the $108 million in resources CMS expects to be required to implement rigorous validation for such a high percentage of enrollees







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