

DEPARTMENT OF THE TREASURY**31 CFR Part 33****DEPARTMENT OF HEALTH AND HUMAN SERVICES****Centers for Medicare & Medicaid Services****45 CFR Parts 147, 155 and 156**

[CMS–9906–P]

RIN 0938–AU60

Patient Protection and Affordable Care Act; Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond Proposed Rule

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS. Department of the Treasury.

ACTION: Proposed rule.

SUMMARY: This proposed rule sets forth proposed revised 2022 user fee rates for issuers offering qualified health plans (QHPs) through Federally-facilitated Exchanges (FFE)s and State-based Exchanges on the Federal platform (SBE-FPs); proposes repeal of separate billing requirements related to the collection of separate payments for the portion of QHP premiums attributable to coverage for certain abortion services; proposes to expand the annual open enrollment period and Navigator duties; proposes a new monthly special enrollment period for qualified individuals or enrollees, or the dependents of a qualified individual or enrollee, who are eligible for advance payments of the premium tax credit (APTC) and whose household income does not exceed 150 percent of the federal poverty level (FPL); proposes to repeal the recent establishment of a Direct Enrollment option for Exchanges; and proposes to modify regulations and policies related to section 1332 waivers.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, by July 28, 2021.

ADDRESSES: In commenting, please refer to file code CMS–9906–P.

Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to <http://www.regulations.gov>. Follow the “Submit a comment” instructions.

2. *By regular mail.* You may mail written comments to the following

address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–9906–P, P.O. Box 8016, Baltimore, MD 21244–8016.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–9906–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT:

Alper Ozinal, (301) 492–4178, Adrienne Patterson, (410) 786–4178, Jacquelyn Rudich, (301) 492–5211, or Nora Simmons, (410) 786–1981, for general information.

Gian Johnson, (301) 492–4323, or Meredyth Woody, (301) 492–4404, for matters related to Navigator program standards.

Robert Yates, (301) 492–5151, for matters related to the Exchange Direct Enrollment option for Federally-facilitated Exchanges, State-based Exchanges on the Federal platform, and State Exchanges.

Carly Rhyne, (301) 492–4188, or Aziz Sandhu, (301) 492–4437, for matters related to open enrollment.

Carolyn Kraemer, (301) 492–4197, for matters related to special enrollment periods for Exchange enrollment under parts 147 and 155.

Nikolas Berkobien, (989) 395–1836, for matters related to standardized options.

Aaron Franz, (410) 786–8027, or Nora Simmons, (410) 786–1981, for matters related to user fees.

Rebecca Bucchieri, (301) 492–4341, for matters related to provision of essential health benefits and separate billing and segregation of funds for abortion services.

Erika Melman, (301) 492–4348, Deborah Hunter, (410) 786–0625, or Emily Martin, (301) 492–4400, for matters related to network adequacy.

Lina Rashid, (202) 260–6098, Michelle Koltov, (301) 492–4225, or Kimberly Koch, (202) 622–0854 for matters related to section 1332 waivers.

SUPPLEMENTARY INFORMATION: Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in

a comment. We post comments received before the close of the comment period on the following website as soon as possible after they have been received: <http://www.regulations.gov>. Follow the search instructions on that website to view public comments. CMS will not post on *Regulations.gov* public comments that make threats to individuals or institutions or suggest that the individual will take actions to harm the individual. CMS continues to encourage individuals not to submit duplicative comments. We will post acceptable comments from multiple unique commenters even if the content is identical or nearly identical to other comments.

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I. Executive Summary

American Health Benefit Exchanges, or “Exchanges,” are entities established under the Patient Protection and Affordable Care Act (ACA)¹ through

¹ The Patient Protection and Affordable Care Act (Pub. L. 111–148) was enacted on March 23, 2010. The Healthcare and Education Reconciliation Act of 2010 (Pub. L. 111–152), which amended and revised several provisions of the Patient Protection

which qualified individuals and qualified employers can purchase comprehensive health insurance coverage through qualified health plans (QHPs). Many individuals who enroll in QHPs through individual market Exchanges are eligible to receive a premium tax credit (PTC) to reduce their costs for health insurance premiums and to receive reductions in required cost-sharing payments to reduce out-of-pocket expenses for health care services. This notice proposes rules and policies designed to promote greater access to comprehensive health insurance coverage through the Exchanges, consistent with applicable law and with the administration's policy priorities detailed in recent Presidential executive orders.

On January 28, 2021, the President issued Executive Order 14009, "Executive Order on Strengthening Medicaid and the Affordable Care Act" (E.O. 14009), which stated the Administration's policy to protect and strengthen the ACA and to make high-quality health care accessible and affordable for every American.² This Executive Order instructed the Secretary of Health and Human Services (hereinafter referred to as "the Secretary"), along with the Secretaries of the Departments of Labor and the Treasury, to review all existing regulations, guidance documents, and other agency actions to determine whether they are consistent with the aforementioned policy, and to consider whether to suspend, revise, or rescind any agency actions that are inconsistent with it.

On January 20, 2021, President Biden issued Executive Order 13985, "On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government" (E.O. 13985),³ directing that as a policy matter, the federal government should pursue a comprehensive approach to advancing equity for all, including people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality. E.O. 13985 also directs HHS to assess whether, and to what extent, its programs and policies perpetuate systemic barriers to opportunities and benefits for people of color and other underserved groups.

and Affordable Care Act, was enacted on March 30, 2010. In this proposed rule, we refer to the two statutes collectively as the "Affordable Care Act" or "ACA."

² 86 FR 7793 (Feb. 2, 2021).

³ 86 FR 7009 (Jan. 25, 2021).

Today, of the 30 million uninsured, half are people of color.⁴ Of those that have insurance, there are frequently barriers to using insurance because of affordability concerns related to premiums, deductibles, copayments, and coinsurance, as well as challenges related to health literacy and the ability for the insured to find and access in-network providers. These barriers to using insurance are particularly problematic for those with chronic conditions and individuals with social risk factors (such as poverty, minority race and/or ethnicity, social isolation, and limited community resources),⁵ which also includes members of underserved communities, people of color, and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality. The COVID-19 public health emergency (PHE) has highlighted the negative effects of these circumstances as COVID-19 has unequally affected many racial and ethnic minority groups, putting them more at risk of getting sick and dying from COVID-19.⁶

As part of its review of regulations and policies under the Executive Orders described in the preceding paragraphs, HHS examined certain policies and requirements addressed in this proposed rule to analyze whether they are consistent with policy goals outlined in the Executive Orders, including whether they might create or perpetuate systemic barriers to obtaining health insurance coverage. The results of our examinations and analyses led to the policies and rules proposed in this rule.

In previous rulemakings, HHS established provisions and parameters to implement many ACA requirements and programs. In this proposed rule, we propose to amend and repeal some of these provisions and parameters, with a focus on making high-quality health care accessible and affordable for consumers. These proposed changes would provide consumers greater access to coverage through, for example, greater education and outreach, improve

⁴ "Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, January–June 2020," National Center for Health Statistics, February 2021, available at <https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur202102-508.pdf>.

⁵ See "Social Risk Factors and Medicare's Value-Based Purchasing Programs," HHS Office of the Secretary of Planning and Evaluation, available at <https://aspe.hhs.gov/social-risk-factors-and-medicare-value-based-purchasing-programs>.

⁶ See Centers for Disease Control and Prevention, "Health Equity Considerations and Racial and Ethnic Minority Groups," updated April 19, 2021, available at <https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/race-ethnicity.html#print>.

affordability for consumers, reduce administrative burden for issuers and consumers, and improve program integrity. As discussed more fully later in the preamble, each of these measures would strengthen the ACA or otherwise promote the policy goals outlined in the Executive Orders described above.⁷

We propose to amend § 147.104(b)(2) to specify that issuers are not required to provide a special enrollment period in the individual market with respect to coverage offered outside of an Exchange to qualifying individuals who would be eligible for the proposed special enrollment period triggering event at § 155.420(d)(16) described below.

We also propose to amend § 155.210(e)(9) to reinstitute previous requirements that Navigators in FFEs be required to provide consumers with information and assistance on certain post-enrollment topics, such as the Exchange eligibility appeals process, the Exchange-related components of the PTC reconciliation process, and the basic concepts and rights of health coverage and how to use it.

We also propose to remove § 155.221(j) and repeal the Exchange Direct Enrollment option which establishes a process for State Exchanges, State-based Exchanges on the Federal platform, and Federally-facilitated Exchanges to work directly with private sector entities (including QHP issuers, web-brokers, and agents and brokers) to operate enrollment websites through which consumers can apply for coverage, receive an eligibility determination from the Exchange, and purchase an individual market QHP offered through the Exchange with APTC and cost-sharing reductions (CSRs), if otherwise eligible.

For the 2022 coverage year and beyond, we propose to amend § 155.410(e) to lengthen the annual open enrollment period for coverage through all Exchanges to November 1 through January 15, as compared to the current annual open enrollment period of November 1 through December 15.

We propose to add a new paragraph at § 155.420(d)(16) to establish a monthly special enrollment period for qualified individuals or enrollees, or the dependents of a qualified individual or enrollee, who are eligible for APTC, and whose household income does not exceed 150 percent of the FPL, in order to provide low-income individuals who generally will have access to a

⁷ Although many of the policies proposed in this rule support the goals outlined in recent Executive Orders, as described later in the preamble discussions related to individual proposals, each of the proposals is supported by statutory authority independent of the Executive Orders.

premium-free silver plan with a 94 percent actuarial value (AV) with more opportunities to enroll in coverage. We also propose to clarify, for purposes of the special enrollment periods provided at § 155.420(d), that a qualified individual who meets the criteria at § 155.305(f), but who qualifies for a maximum APTC amount of zero dollars, is not considered APTC eligible. This approach would ensure that § 155.420 very clearly reflects appropriate special enrollment period eligibility for qualifying individuals who qualify for a maximum APTC amount of zero dollars and for those who become eligible for APTC amounts greater than zero.

In addition, to reflect updated analysis of enrollment and the cost of expanded services offered through the Federal platform, we propose to set the 2022 user fee rate at 2.75 percent of total monthly premiums charged by the issuer for each policy under plans offered through an FFE, and 2.25 percent of the total monthly premiums charged by the issuer for each policy under plans offered through an SBE-FP (rather than 2.25 and 1.75 percent of the total monthly premiums charged by the issuer for each policy under plans offered through an FFE or SBE-FP, respectively, as finalized in part 1 of the 2022 Payment Notice final rule). These proposed 2022 user fee rates are still less than the 2021 user fees currently being collected—3.0 and 2.5 percent of the total monthly premiums charged by the issuer for each policy under plans offered through an FFE or SBE-FP, respectively.

We also propose a technical amendment to requirements at § 156.115(a)(3) pertaining to the provision of the essential health benefits (EHB), to include a cross-reference to the Public Health Service (PHS) Act to make clear that health plans subject to EHB requirements must comply with all of the requirements under Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), including any amendments to MHPAEA.

We also propose to repeal the separate billing regulation at § 156.280(e)(2), which requires individual market QHP issuers that offer coverage of abortion services⁸ for which federal funds are prohibited to separately bill for this portion of the policy holder's premium and to instruct the policy holder to pay for the separate bill in a separate transaction. Specifically, we are proposing to revert to and codify prior

policy finalized in the 2016 Payment Notice⁹ such that QHP issuers offering coverage of abortion services for which federal funds are prohibited again have flexibility in selecting a method to comply with the separate payment requirement in section 1303 of the ACA. Under this proposal, individual market QHP issuers covering abortion services for which federal funds are prohibited would still be expected to comply with all statutory requirements in section 1303 of the ACA and all applicable regulatory requirements codified at § 156.280.

This proposed rule also proposes modifications to the section 1332 Waivers for State Innovation (referred to throughout the preamble to this proposed rule as section 1332 waivers) implementing regulations, including changes to many of the policies and interpretations of the guardrails recently codified in regulation. As outlined in this proposed rule, the policies and interpretations proposed in this rule, if finalized, would supersede and rescind those outlined in the October 2018 “State Relief and Empowerment Waivers” guidance¹⁰ (hereinafter referred to as the “2018 Guidance”) and repeal the previous codification of the interpretations of statutory guidelines in part 1 of the 2022 Payment Notice final rule. HHS and the Department of the Treasury (collectively, the Departments) also propose to modify regulations to set forth flexibilities in the public notice requirements and post award public participation requirements for section 1332 waivers under certain emergent situations. The Departments also propose in this rule processes and procedures for amendments and extensions for approved waiver plans.

II. Background

A. Legislative and Regulatory Overview

Title I of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) added a new title XXVII to the PHS Act to establish various reforms to the group and individual health insurance markets.

These provisions of the PHS Act were later augmented by other laws, including the ACA. Subtitles A and C of title I of the ACA reorganized, amended, and added to the provisions of part A of title XXVII of the PHS Act relating to group health plans¹¹ and health

insurance issuers in the group and individual markets. The term “group health plan” includes both insured and self-insured group health plans.

Section 2702 of the PHS Act, as added by the ACA, establishes requirements for guaranteed availability of coverage in the group and individual markets.¹²

Section 1301(a)(1)(B) of the ACA directs all issuers of QHPs to cover the EHB package described in section 1302(a) of the ACA, including coverage of the services described in section 1302(b) of the ACA, adherence to the cost-sharing limits described in section 1302(c) of the ACA, and meeting the actuarial value (AV) levels established in section 1302(d) of the ACA. Section 2707(a) of the PHS Act, which is effective for plan or policy years beginning on or after January 1, 2014, extends the requirement to cover the EHB package to non-grandfathered individual and small group health insurance coverage, irrespective of whether such coverage is offered through an Exchange. In addition, section 2707(b) of the PHS Act directs non-grandfathered group health plans to ensure that cost sharing under the plan does not exceed the limitations described in sections 1302(c)(1) of the ACA.

Section 1302 of the ACA provides for the establishment of an EHB package that includes coverage of EHBs (as defined by the Secretary), cost-sharing limits, and AV requirements. Section 1302(b) of the ACA directs that EHBs be equal in scope to the benefits provided under a typical employer plan, and that they cover at least the following 10 general categories: Ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Section 1302(d) of the ACA describes the various levels of coverage based on their AV. Consistent with section 1302(d)(2)(A) of the ACA, AV is calculated based on the provision of EHB to a standard population. Section 1302(d)(3) of the ACA directs the Secretary to develop guidelines that allow for *de minimis* variation in AV calculations.

¹² Before enactment of the ACA, HIPAA amended the PHS Act (formerly section 2711) to generally require guaranteed availability of coverage for employers in the small group market.

⁸ These abortion services refer to abortion coverage that is subject to the Hyde Amendment's funding limitations which prohibit the use of federal funds for such coverage.

⁹ 80 FR 10750.

¹⁰ 83 FR 53575.

¹¹ The term “group health plan” is used in title XXVII of the PHS Act and is distinct from the term “health plan” as used in other provisions of title I of ACA. The term “health plan” does not include self-insured group health plans.

Section 1303 of the ACA, as implemented in 45 CFR 156.280, specifies standards for issuers of QHPs through the Exchanges that cover abortion services for which federal funding is prohibited. The statute and regulation establish that, unless otherwise prohibited by state law, a QHP issuer may elect to cover such abortion services. If an issuer elects to cover such services under a QHP sold through an individual market Exchange, the issuer must take certain steps to ensure that no PTC or CSR funds are used to pay for abortion services for which public funding is prohibited.

As specified in section 1303(b)(2) of the ACA, one such step is that individual market Exchange issuers must determine the amount of, and collect, from each enrollee, a separate payment for an amount equal to the actuarial value of the coverage for abortions for which public funding is prohibited, which must be no less than \$1 per enrollee, per month. QHP issuers must also segregate funds for abortion services for which federal funds are prohibited collected through this payment into a separate allocation account used to pay for such abortion services.

Sections 1311(b) and 1321(b) of the ACA provide that each state has the opportunity to establish an individual market Exchange that facilitates the purchase of insurance coverage by qualified individuals through QHPs and meets other standards specified in the ACA. Section 1321(c)(1) of the ACA directs the Secretary to establish and operate such Exchange within states that do not elect to establish an Exchange or, as determined by the Secretary on or before January 1, 2013, will not have an Exchange operable by January 1, 2014.

Section 1311(c)(1) of the ACA provides the Secretary the authority to issue regulations to establish criteria for the certification of QHPs, including network adequacy standards at section 1311(c)(1)(B) of the ACA. Section 1311(d) of the ACA describes the minimum functions of an Exchange. Section 1311(e)(1) of the ACA grants the Exchange the authority to certify a health plan as a QHP if the health plan meets the Secretary's requirements for certification issued under section 1311(c)(1) of the ACA, and the Exchange determines that making the plan available through the Exchange is in the interests of qualified individuals and qualified employers in the state. Section 1311(c)(6) of the ACA establishes authority for the Secretary to require Exchanges to provide enrollment

periods, including the monthly enrollment period for Indians, as defined by section 4 of the Indian Healthcare Improvement Act, per section 1311(c)(6)(D) of the ACA.¹³

Sections 1311(d)(4)(K) and 1311(i) of the ACA require each Exchange to establish a Navigator program under which it awards grants to entities to carry out certain Navigator duties.

Section 1312(c) of the ACA generally requires a health insurance issuer to consider all enrollees in all health plans (except grandfathered health plans) offered by such issuer to be members of a single risk pool for each of its individual and small group markets. States have the option to merge the individual and small group market risk pools under section 1312(c)(3) of the ACA.

Section 1312(e) of the ACA directs the Secretary to establish procedures under which a state may permit agents and brokers to enroll qualified individuals and qualified employers in QHPs through an Exchange and to assist individuals in applying for financial assistance for QHPs sold through an Exchange.

Sections 1313 and 1321 of the ACA provide the Secretary with the authority to oversee the financial integrity of State Exchanges, their compliance with HHS standards, and the efficient and non-discriminatory administration of State Exchange activities. Section 1321 of the ACA provides for state flexibility in the operation and enforcement of Exchanges and related requirements.

Section 1321(a)(1) of the ACA directs the Secretary to issue regulations that set standards for meeting the requirements of title I of the ACA for, among other things, the establishment and operation of Exchanges. When operating an FFE under section 1321(c)(1) of the ACA, HHS has the authority under sections 1321(c)(1) and 1311(d)(5)(A) of the ACA to collect and spend user fees. Office of Management and Budget (OMB) Circular A-25 establishes federal policy regarding user fees and specifies that a user charge will be assessed against each identifiable recipient for special benefits derived from federal activities beyond those received by the general public.

Section 1321(d) of the ACA provides that nothing in title I of the ACA must be construed to preempt any state law that does not prevent the application of title I of the ACA. Section 1311(k) of the

ACA specifies that Exchanges may not establish rules that conflict with or prevent the application of regulations issued by the Secretary.

Section 1332 of the ACA provides the Secretary of HHS and the Secretary of the Treasury (collectively, the Secretaries) with the discretion to approve a state's proposal to waive specific provisions of the ACA, provided the state's section 1332 waiver plan meets certain requirements. Section 1332(a)(4)(B) of the ACA requires the Secretaries to issue regulations regarding procedures for section 1332 waivers.

Section 1402 of the ACA provides for, among other things, reductions in cost sharing for EHB for qualified low- and moderate-income enrollees in silver level QHPs offered through the individual market Exchanges. This section also provides for reductions in cost sharing for American Indians enrolled in QHPs at any metal level.

Section 1411(c) of the ACA requires the Secretary to submit certain information provided by applicants under section 1411(b) of the ACA to other federal officials for verification, including income and family size information to the Secretary of the Treasury.

Section 1411(d) of the ACA provides that the Secretary must verify the accuracy of information provided by applicants under section 1411(b) of the ACA for which section 1411(c) of the ACA does not prescribe a specific verification procedure, in such manner as the Secretary determines appropriate.

Section 1411(f) of the ACA requires the Secretary, in consultation with the Secretary of the Treasury, the Secretary of Homeland Security, and the Commissioner of Social Security, to establish procedures for hearing and making decisions governing appeals of Exchange eligibility determinations.

Section 1411(f)(1)(B) of the ACA requires the Secretary to establish procedures to redetermine eligibility on a periodic basis, in appropriate circumstances, including eligibility to purchase a QHP through the Exchange and for APTC and CSRs.

Section 1411(g) of the ACA allows the use or disclosure of applicant information only for the limited purposes of, and to the extent necessary to, ensure the efficient operation of the Exchange, including by verifying eligibility to enroll through the Exchange and for APTC and CSRs.

Section 5000A of the Internal Revenue Code ("the Code"), as added by section 1501(b) of the ACA, requires individuals to have minimum essential coverage (MEC) for each month, qualify

¹³ The Indian Healthcare Improvement Act (IHCLIA), the cornerstone legal authority for the provision of health care to American Indians and Alaska Natives, was made permanent when President Obama signed the bill on March 23, 2010, as part of the ACA.

for an exemption, or make an individual shared responsibility payment. Under the Tax Cuts and Jobs Act (Pub. L. 115–97, December 22, 2017) the individual shared responsibility payment has been reduced to \$0, effective for months beginning after December 31, 2018. Notwithstanding that reduction, certain exemptions are still relevant to determine whether individuals age 30 and above qualify to enroll in catastrophic coverage under 45 CFR 155.305(h) or 156.155.

1. Program Integrity

In the June 19, 2013 **Federal Register** (78 FR 37031), we published a proposed rule that proposed certain program integrity standards related to Exchanges and the premium stabilization programs (proposed Program Integrity Rule). The provisions of that proposed rule were finalized in two rules, the “first Program Integrity Rule” published in the August 30, 2013 **Federal Register** (78 FR 54069) and the “second Program Integrity Rule” published in the October 30, 2013 **Federal Register** (78 FR 65045). In the December 27, 2019 **Federal Register** (84 FR 71674), we published a final rule that revised standards relating to oversight of Exchanges established by states and periodic data matching frequency. It also added new requirements for certain issuers related to the separate billing and collection of the separate payment for the premium portion attributable to coverage for certain abortion services. In the May 8, 2020 **Federal Register** (85 FR 27550), we published the Medicare and Medicaid Programs, Basic Health Programs and Exchanges interim final rule with public comment (“May 2020 IFC”) and postponed the implementation deadline for those separate billing and collection requirements by 60 days.

2. Market Rules

An interim final rule relating to the HIPAA health insurance reforms was published in the April 8, 1997 **Federal Register** (62 FR 16894). A proposed rule relating to ACA health insurance market reforms that became effective in 2014 was published in the November 26, 2012 **Federal Register** (77 FR 70584). A final rule implementing those provisions was published in the February 27, 2013 **Federal Register** (78 FR 13406) (2014 Market Rules).

A proposed rule relating to Exchanges and Insurance Market Standards for 2015 and beyond was published in the March 21, 2014 **Federal Register** (79 FR 15808) (2015 Market Standards Proposed Rule). A final rule implementing the Exchange and Insurance Market Standards for 2015

and Beyond was published in the May 27, 2014 **Federal Register** (79 FR 30240) (2015 Market Standards Rule). The 2018 Payment Notice final rule in the December 22, 2016 **Federal Register** (81 FR 94058) provided additional guidance on guaranteed availability and guaranteed renewability. In the Market Stabilization final rule that was published in the April 18, 2017 **Federal Register** (82 FR 18346), we released further guidance related to guaranteed availability. In the 2019 Payment Notice final rule in the April 17, 2018 **Federal Register** (83 FR 17058), we clarified that certain exceptions to the special enrollment periods only apply with respect to coverage offered outside of the Exchange in the individual market.

In part 2 of the 2022 Payment Notice final rule in the May 5, 2021 **Federal Register** (86 FR 24140), we made additional amendments to the guaranteed availability regulation regarding special enrollment periods and finalized new special enrollment periods related to timely notice of triggering events, cessation of employer contributions or government subsidies to COBRA continuation coverage, and loss of APTC eligibility.

3. Exchanges

We published a request for comment relating to Exchanges in the August 3, 2010 **Federal Register** (75 FR 45584). We issued initial guidance to states on Exchanges on November 18, 2010. In the July 15, 2011 **Federal Register** (76 FR 41865), we published a proposed rule with proposals to implement components of the Exchanges, and a rule in the August 17, 2011 **Federal Register** (76 FR 51201) regarding Exchange functions in the individual market and Small Business Health Options Program (SHOP), eligibility determinations, and Exchange standards for employers. A final rule implementing components of the Exchanges and setting forth standards for eligibility for Exchanges, including minimum network adequacy requirements, was published in the March 27, 2012 **Federal Register** (77 FR 18309) (Exchange Establishment Rule).

In the 2014 Payment Notice and in the Amendments to the HHS Notice of Benefit and Payment Parameters for 2014 interim final rule, published in the March 11, 2013 **Federal Register** (78 FR 15541), we set forth standards related to Exchange user fees. We established an adjustment to the FFE user fee in the Coverage of Certain Preventive Services under the Affordable Care Act final rule, published in the July 2, 2013 **Federal Register** (78 FR 39869) (Preventive Services Rule). In the 2016 Payment

Notice in the February 27, 2015 **Federal Register** (80 FR 10750), we finalized changes related to network adequacy and provider directories.

In the 2017 Payment Notice in the March 8, 2016 **Federal Register** (81 FR 12204), we finalized six standardized plan options to simplify the plan selection process for consumers on the Exchanges. In the 2017 Payment Notice, we also finalized policies relating to network adequacy for QHPs on the FFEs. In the May 11, 2016 **Federal Register** (81 FR 29146), we published an interim final rule with amendments to the parameters of certain special enrollment periods (2016 Interim Final Rule). We finalized these in the 2018 Payment Notice final rule, published in the December 22, 2016 **Federal Register** (81 FR 94058). The 2018 Payment Notice also modified the standardized options finalized in the 2017 Payment Notice and included three new sets of standardized options. In the March 8, 2016 **Federal Register** (81 FR 12203), the final 2017 Payment Notice codified State-based Exchanges on the Federal platform (SBE–FPs) along with relevant requirements.

In the April 18, 2017 Market Stabilization final rule **Federal Register** (82 FR 18346), we amended standards relating to special enrollment periods and QHP certification. In the 2019 Payment Notice final rule, published in the April 17, 2018 **Federal Register** (83 FR 16930), we modified parameters around certain special enrollment periods and discontinued the designation of standardized options. In the April 25, 2019 **Federal Register** (84 FR 17454), the final 2020 Payment Notice established a new special enrollment period. In the May 14, 2020 **Federal Register** (85 FR 29204), the 2021 Payment Notice final rule made certain changes to plan category limitations and special enrollment period coverage effective date rules, allowed individuals provided a non-calendar year qualified small employer health reimbursement arrangement (QSEHRA) to qualify for an existing special enrollment period, and discussed plans for future rulemaking for employer-sponsored coverage verification and non-enforcement discretion for Exchanges that do not conduct random sampling until plan year 2021.

In part 1 of the 2022 Payment Notice final rule, published in the January 19, 2021 **Federal Register** (85 FR 6138), we finalized a new Exchange Direct Enrollment (DE) option. In part 2 of the 2022 Payment Notice final rule in the May 5, 2021 **Federal Register** (86 FR 24140) we finalized new special

enrollment periods related to untimely notice of triggering events, cessation of employer contributions or government subsidies to COBRA continuation coverage, loss of APTC eligibility, and clarified the regulation imposing network adequacy standards with regard to QHPs that do not use provider networks.

4. Essential Health Benefits

On December 16, 2011, HHS released a bulletin¹⁴ that outlined an intended regulatory approach for defining EHB, including a benchmark-based framework. A proposed rule relating to EHBs was published in the November 26, 2012 **Federal Register** (77 FR 70643). We established requirements relating to EHBs in the Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation Final Rule, which was published in the February 25, 2013 **Federal Register** (78 FR 12833) (EHB Rule). In the 2019 Payment Notice, published in the April 17, 2018 **Federal Register** (83 FR 16930), we added § 156.111 to provide states with additional options from which to select an EHB-benchmark plan for plan years 2020 and beyond.

5. Section 1332 Waivers

In the March 14, 2011 **Federal Register** (76 FR 13553), the Departments published the “Application, Review, and Reporting Process for Waivers for State Innovation” proposed rule¹⁵ to implement section 1332(a)(4)(B) of the ACA. In the February 27, 2012 **Federal Register** (77 FR 11700), the Departments published the “Application, Review, and Reporting Process for Waivers for State Innovation” final rule¹⁶ (hereinafter referred to as the “2012 Final Rule”). In the October 24, 2018 **Federal Register** (83 FR 53575), the Departments issued the 2018 Guidance, which superseded the previous guidance¹⁷ published in the December 16, 2015 **Federal Register** (80 FR 78131) (hereinafter referred to as the “2015 Guidance”), and provided additional information about the requirements that states must meet for waiver proposals, the Secretaries’ application review procedures, pass-through funding determinations, certain analytical requirements, and operational

considerations. In the November 6, 2020 **Federal Register** (85 FR 71142), the Departments issued an interim final rule¹⁸ (hereinafter referred to as the “November 2020 IFC”), which revises regulations to set forth flexibilities in the public notice requirements and post award public participation requirements for waivers under section 1332 during the COVID–19 PHE. In the December 4, 2020 **Federal Register** (85 FR 78572), the Departments published the “Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2022 and Pharmacy Benefit Manager Standards; Updates to State Innovation Waiver (Section 1332 Waiver) Implementing Regulations” proposed rule¹⁹ (hereinafter referred to as the “2022 Payment Notice proposed rule”) to codify certain policies and interpretations of the 2018 Guidance. In the January 19, 2021 **Federal Register** (86 FR 6138), the Departments published the “Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2022; Updates to State Innovation Waiver (Section 1332 Waiver) Implementing Regulations” final rule²⁰ (hereinafter referred to as the “part 1 of the 2022 Payment Notice final rule”) which codified many of the policies and interpretations outlined in the 2018 Guidance into section 1332 regulations.

B. Stakeholder Consultation and Input

HHS has consulted with stakeholders on policies related to the operation of Exchanges. We have held a number of listening sessions with consumers, providers, employers, health plans, advocacy groups and the actuarial community to gather public input. We have solicited input from state representatives on numerous topics, particularly the direct enrollment option for FFEs, SBE–FPs and State Exchanges.

We consulted with stakeholders through monthly meetings with the National Association of Insurance Commissioners (NAIC), regular contact with states, and health insurance issuers, trade groups, consumer advocates, employers, and other interested parties. We considered all public input we received as we

developed the policies in this proposed rule.

C. Structure of Proposed Rule

The regulations outlined in this proposed rule would be codified in 45 CFR parts 147, 155, and 156. In addition, the regulations outlined in this proposed rule governing waivers under section 1332 of the ACA at 45 CFR part 155 subpart N would also be codified in 31 CFR part 33.

The proposed changes to part 147 would specify that issuers are not required to provide a special enrollment period in the individual market with respect to coverage offered outside of an Exchange to consumers who would be eligible for the proposed special enrollment period at § 155.420(d)(16).

The proposed changes to part 155 would repeal the establishment of the Exchange DE option, which permitted State Exchanges, SBE–FPs, and FFEs to use direct enrollment technology and non-Exchange websites developed by approved web brokers, issuers and other direct enrollment partners to enroll qualified individuals in QHPs offered through the Exchange. We propose extending FFE open enrollment to end on January 15 of the applicable year, rather than December 15 of the previous year beginning with the 2022 coverage year and beyond. We also propose to reinstitute previous requirements that Navigators in FFEs be required to provide consumers with information and assistance on certain post-enrollment topics, such as the Exchange eligibility appeals process, the Exchange-related components of the PTC reconciliation process, and the basic concepts and rights of health coverage and how to use it. We further propose to provide a monthly special enrollment period for qualified individuals or enrollees, or the dependents of a qualified individual or enrollee, who are eligible for APTC, and whose household income does not exceed 150 percent of the FPL. Finally, we propose to clarify that, for purposes of the special enrollment periods provided at § 155.420(d), a qualified individual or enrollee who qualifies for APTC, or a dependent whose tax filer can qualify for APTC on their behalf, because they meet the criteria at § 155.305(f), but who qualifies for a maximum APTC amount of zero dollars, is not considered APTC eligible for purposes of these special enrollment periods.

The proposed changes to part 156 would update the user fee rates for the 2022 benefit year for all issuers participating on the Exchanges using the Federal platform. We also propose to

¹⁴ “Essential Health Benefits Bulletin,” December 16, 2011. Available at https://www.cms.gov/CCIIO/Resources/Files/Downloads/essential_health_benefits_bulletin.pdf.

¹⁵ <https://www.govinfo.gov/content/pkg/FR-2011-03-14/pdf/2011-5583.pdf>.

¹⁶ <https://www.govinfo.gov/content/pkg/FR-2012-02-27/pdf/2012-4395.pdf>.

¹⁷ <https://www.govinfo.gov/content/pkg/FR-2015-12-16/pdf/2015-31563.pdf>.

¹⁸ <https://www.federalregister.gov/documents/2020/11/06/2020-24332/additional-policy-and-regulatory-revisions-in-response-to-the-covid-19-public-health-emergency>.

¹⁹ <https://www.federalregister.gov/documents/2020/12/04/2020-26534/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2022-and>.

²⁰ <https://www.federalregister.gov/documents/2021/01/19/2021-01175/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2022>.

repeal the separate billing requirement, which requires individual market QHP issuers that offer coverage for abortion services for which federal funding is prohibited to separately bill policy holders for the portion of the premium attributable to coverage of such abortion services and instruct the policy holder to pay for this portion of their premium in a separate transaction. Finally, we propose to update a cross reference to mental health parity standards in the provision of EHB regulations.

The proposed changes in 31 CFR part 33 and 45 CFR part 155 related to section 1332 waivers would rescind the previous incorporation of certain policies and interpretations announced in the 2018 Guidance into regulation. The proposals related to section 1332 waivers include proposed processes and procedures for amendments and extensions for approved waiver plans. Additionally, the Departments propose to extend certain flexibilities in the public notice requirements and post award public participation requirements for section 1332 waivers during future emergent situations.

III. Provisions of the Updating Payment Parameters and Improving Health Insurance Markets for 2022 and Beyond Proposed Rule

A. Part 147—Health Insurance Reform Requirements for the Group and Individual Health Insurance Markets

1. Guaranteed Availability of Coverage (§ 147.104)

a. Past-Due Premiums

On January 28, 2021, President Biden issued E.O. 14009, “Strengthening Medicaid and the Affordable Care Act,”²¹ directing HHS, and the heads of all other executive departments and agencies with authorities and responsibilities related to the ACA, to review all existing regulations, orders, guidance documents, policies, and any other similar agency actions to determine whether such agency actions are inconsistent with this Administration’s policy to protect and strengthen the ACA and to make high-quality health care accessible and affordable for every American.

In the preamble to the Market Stabilization final rule,²² we stated that, to the extent permitted by applicable state law, an issuer will not violate the guaranteed availability requirements in § 147.104 where the issuer attributes a premium payment made for new coverage to any past-due premiums owed for coverage from the same issuer

or another issuer in the same controlled group within the prior 12-month period before effectuating enrollment in the new coverage. This policy addressed concerns regarding the potential for individuals to take unfair advantage of the guaranteed availability rules. For example, an individual could decline to make premium payments at the end of a benefit year, but still receive periods of unpaid coverage during a grace period before coverage is terminated. We were concerned that despite such failures to pay, such individuals would be able to immediately sign up for new coverage for the next benefit year during the individual market open enrollment period, without making restitution for the periods of unpaid coverage.

HHS currently is reviewing this policy to analyze whether it may present unnecessary barriers to accessing health coverage. In compliance with E.O. 14009, we intend to address this interpretation of guaranteed availability in the 2023 Payment Notice rulemaking.

b. Special Enrollment Periods (§ 147.104(b)(2))

As further discussed in the preamble section regarding the proposed monthly special enrollment period for APTC-eligible qualified individuals with an expected household income no greater than 150 percent of the FPL (§ 155.420(d)(16)), we propose to add a new paragraph at § 147.104(b)(2)(i)(G) to specify that issuers are not required to provide this special enrollment period in the individual market with respect to coverage offered outside of an Exchange. We propose to add this paragraph because eligibility for the special enrollment period is based on eligibility for APTC, as discussed in the § 155.420(d)(16) preamble section, and APTC cannot be applied to coverage offered outside of an Exchange. We request comment on this proposal.

B. Part 155—Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act

1. Standardized Options (§ 155.20)

On March 4, 2021, the United States District Court for the District of Maryland decided *City of Columbus v. Cochran*, No. 18–2364, 2021 WL 825973 (D. Md. Mar. 4, 2021). The court reviewed nine separate policies we had promulgated in the 2019 Payment Notice final rule. The court vacated four of these policies. One of the policies the court vacated was the 2019 Payment Notice’s cessation of the practice of

designating some plans in the FFEs as “standardized options.”²³

We intend to implement the court’s decision as soon as possible, as explained in part 2 of the 2022 Payment Notice final rule.²⁴ We will not be able to fully implement those aspects of the court’s decision regarding standardized options in time for issuers to design plans and for CMS to be prepared to certify such plans as QHPs for the 2022 plan year. With the rule removing standardized options vacated, we will also need to design and propose new standardized options that otherwise meet current market reform requirements and alter the Federal Exchange eligibility and enrollment platform system build (*HealthCare.gov*) to provide differential display of such plans. Web-brokers that are direct enrollment partners in FFE and SBE–FP states will also need time to adjust their respective systems to provide differential display of such plans on their non-Exchange websites.²⁵ We will need to design, propose, and finalize such plans in time for issuers to design their own standardized options in accord with HHS’s parameters and to submit those plans for approval by applicable regulatory authorities and for certification as QHPs. This is not feasible for the upcoming QHP certification cycle for the 2022 plan year. The plan certification process for that year has already begun as of April 22, 2021. CMS’ planning for the QHP certification cycle for the 2022 plan year has taken into account the existing policies that the court vacated, and it is too late now to revisit those factors if the process is to go forward in time for plans to be certified by open enrollment later this year.

Specifically, in the last iteration of standardized options we finalized in the 2018 Payment Notice, we created three sets of standardized options based on FFE and SBE–FP enrollment data and state cost-sharing laws. The basis on which we created these three sets of options as well as a number of other factors in the individual market (for example, states with FFEs or SBE–FPs transitioning to SBEs) have changed considerably since the last iteration of standardized options in 2018. Further, we do not have sufficient time to conduct a full analysis of the changes that have occurred in the last several years necessary to timely design and propose adequate standardized options suitable for the current environment. Additionally, in prior years, we

²³ See 83 FR 16974–16975.

²⁴ See 86 FR 24140, 24264–24265.

²⁵ See 45 CFR 155.220(c)(3)(i)(H).

²¹ 86 FR 7793 (February 2, 2021).

²² 82 FR 18346, 18349 (April 18, 2017).

proposed and finalized standardized option plan designs prior to the start of the QHP certification cycle for the following plan year such that issuers had sufficient time to assess these standardized options and could thus determine if they wanted to offer them and take the steps necessary to do so. Issuers will not have a sufficient amount of time to meaningfully assess any standardized options we would propose and decide whether or not to offer them if such proposals were made effective before the 2023 plan year.

For these reasons, we intend to resume the designation of standardized options and propose specific plan designs in more complete detail in the 2023 Payment Notice. As such, we seek the views of stakeholders regarding issues related to the proposal of new standardized options, including specifically the views of states with FFEs or SBE-FPs regarding how unique state cost-sharing laws could affect standardized option plan designs to assist in our development of such proposals.

2. Navigator Program Standards (§ 155.210)

We propose to amend § 155.210(e)(9) to reinstitute the requirement that Navigators in the FFEs provide information and assistance with regard to certain post-enrollment topics.

Sections 1311(d)(4)(K) and 1311(i) of the ACA require each Exchange to establish a Navigator program under which it awards grants to entities to conduct public education activities to raise awareness of the availability of QHPs; distribute fair and impartial information concerning enrollment in QHPs, and the availability of PTCs and CSRs; facilitate enrollment in QHPs; provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the PHS Act, or any other appropriate state agency or agencies for any enrollee with a grievance, complaint, or question regarding their health plan, coverage, or a determination under such plan or coverage; and provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange. The statute also requires the Secretary, in collaboration with states, to develop standards to ensure that information made available by Navigators is fair, accurate, and impartial. We have implemented the statutorily required Navigator duties through regulations at §§ 155.210 (for all Exchanges) and 155.215 (for Navigators in FFEs).

Further, section 1311(i)(4) of the ACA requires the Secretary to establish standards for Navigators to ensure that Navigators are qualified, and licensed, if appropriate, to engage in the Navigator activities described in the statute and to avoid conflicts of interest. This provision has been implemented at §§ 155.210(b) (generally for all Exchanges) and 155.215(b) (for Navigators in FFEs).

We have also established under § 155.205(d) and (e) that each Exchange must have a consumer assistance function, including the Navigator program, and must conduct outreach and education activities to educate consumers about the Exchange and insurance affordability programs to encourage participation.

We propose to amend § 155.210(e)(9) to reinstitute the requirement that Navigators in the FFEs provide information and assistance with regard to certain post-enrollment topics rather than merely being authorized to do so.

Following a reduction in overall funding available to the FFE Navigator program in 2020, we provided more flexibility to FFE Navigators by making the provision of certain types of assistance, including post-enrollment assistance, permissible, but not required, for FFE Navigators under Navigator grants awarded in 2019 or any later year.²⁶ On June 4, 2021, CMS issued the 2021 Navigator Notice of Funding Opportunity (NOFO), which will make \$80 million in grant funding available to Navigators in states with an FFE for the 2022 plan year.²⁷ With funding for the FFE Navigator program increasing substantially for the 2022 plan year, we believe that there will be sufficient Navigator grant funding available to support the post-enrollment duties we propose to once again require of FFE Navigators. We also believe that this proposal aligns with E.O. 14009 on Strengthening Medicaid and the ACA because it will improve consumers'

²⁶ 84 FR 17511–17514 (April 25, 2019). These post-enrollment topics included: Understanding the process of filing Exchange eligibility appeals; understanding and applying for exemptions from the individual shared responsibility payment that are granted through the Exchange; understanding the availability of exemptions from the requirement to maintain MEC and from the individual shared responsibility payment that are claimed through the tax filing process and how to claim them; the Exchange-related components of the premium tax credit reconciliation process; understanding basic concepts and rights related to health coverage and how to use it; and referrals to licensed tax advisers, tax preparers, or other resources for assistance with tax preparation and tax advice on certain Exchange-related topics.

²⁷ <https://www.cms.gov/newsroom/press-releases/cms-announces-80-million-funding-opportunity-available-navigators-states-federally-facilitated-0>.

access to health coverage information, not only when selecting a plan, but also throughout the year as they use their coverage.²⁸ In addition, this proposal is designed to ensure that consumers would have access to skilled assistance beyond applying for and enrolling in health insurance coverage through the Exchange, including, for example, assistance with the process of filing Exchange eligibility appeals, understanding basic information about PTC reconciliation, and understanding basic concepts and rights related to health coverage and how to use it, such as locating providers and accessing care.

Section 1311(i)(3)(D) of the ACA and 45 CFR 155.210(e)(4) already expressly require Navigators to provide post-enrollment assistance by referring consumers with complaints, questions, or grievances about their coverage to appropriate state agencies. This suggests that Congress anticipated that consumers would need assistance beyond the application and enrollment process, and that Navigators would maintain relationships with consumers and be a source of such post-enrollment assistance.

Consistent with the requirements under section 1311(i)(3)(B) and (C) of the ACA that Navigators distribute fair and impartial information concerning enrollment in QHPs and facilitate enrollment in QHPs, and pursuant to the Secretary's authority under section 1321(a)(1)(A) of the ACA, we propose to reinstitute as a requirement at § 155.210(e)(9)(i) that Navigators in the FFEs must help consumers with understanding the process of filing appeals of Exchange eligibility determinations. We are once again not proposing to establish a duty for Navigators to represent a consumer in an appeal, sign an appeal request, or file an appeal on the consumer's behalf. We believe that helping consumers understand Exchange appeal rights when they have received an adverse eligibility determination when applying for health insurance coverage, and assisting them with the process of completing and submitting appeal forms, would help to facilitate enrollment through the FFEs and would help consumers obtain fair and impartial information about enrollment through the FFEs. We would interpret this proposal to include helping consumers file appeals of eligibility determinations made by an Exchange related to enrollment in a QHP, special enrollment periods, and any insurance affordability program, including eligibility determinations for Exchange

²⁸ 86 FR 7793 (Feb. 2, 2021).

financial assistance, Medicaid, the Children's Health Insurance Program (CHIP), and the Basic Health Program.

Currently, pursuant to § 155.210(e)(9)(ii), Navigators in the FFEs are permitted to provide information and assistance to consumers with regard to understanding and applying for exemptions from the individual shared responsibility payment that are granted through the Exchange, understanding the availability of exemptions from the requirement to maintain minimum essential coverage and from the individual shared responsibility payment that are claimed through the tax filing process and how to claim them, and understanding the availability of the Internal Revenue Service (IRS) resources on this topic. We propose to amend § 155.210(e)(9)(ii) slightly to reinstitute as a requirement that Navigators in the FFEs must help consumers understand and apply for exemptions from the requirement to maintain minimum essential coverage granted by the Exchange. Although consumers who do not maintain minimum essential coverage no longer need to receive an exemption from the individual shared responsibility payment to avoid having to make such a payment, Navigators can still assist consumers age 30 or above with filing an exemption to qualify to enroll in catastrophic coverage under § 155.305(h). We believe that this proposal is consistent with Navigators' duty under section 1311(i)(3)(B) and (C) of the ACA to distribute fair and impartial information concerning enrollment in QHPs, since impartial information concerning the availability of exemptions for consumers age 30 or above to enroll in catastrophic coverage would help consumers make informed decisions about whether or not to enroll in such coverage. This assistance with Exchange-granted exemptions from the requirement to maintain minimum essential coverage would include informing consumers about the availability of the exemption; helping consumers fill out and submit Exchange-granted exemption applications and obtain any necessary forms prior to or after applying for the exemption; explaining what the exemption certificate number is and how to use it; and helping consumers understand and use the Exchange tool to find catastrophic plans in their area.

In addition, we propose to reinstitute as a requirement at § 155.210(e)(9)(iii) that Navigators must help consumers with the Exchange-related components of the PTC reconciliation process and with understanding the availability of

IRS resources on this process. This would include ensuring consumers have access to their Forms 1095-A and receive general, high-level information about the purpose of this form that is consistent with published IRS guidance on the topic. This proposal stems from the requirement under section 1311(i)(3)(B) of the ACA that Navigators distribute fair and impartial information concerning the availability of the PTC under section 36B of the Code.

Consumers who receive premium assistance through APTC may need help with a variety of issues related to the requirement to reconcile the APTC with the PTC allowed for the year of coverage. FFE Navigators would be required to help consumers obtain IRS Forms 1095-A and 8962, and the instructions for both, and to provide general information, consistent with applicable IRS guidance, about the significance of the forms. Navigators would also be required to help consumers understand (1) how to report errors on the Form 1095-A; (2) how to find silver plan premiums using the Exchange tool; and (3) the difference between APTC and PTC and the potential implications for enrollment and reenrollment of not filing a tax return and reconciling the APTC paid on consumers' behalf with their PTC for the year.

Navigators would still not be permitted to provide tax assistance or advice, or interpret tax rules and forms within their capacity as FFE Navigators. However, their expertise related to the consumer-facing aspects of the Exchange, including eligibility and enrollment rules and procedures, would uniquely qualify them to help consumers understand and obtain information from the Exchange that is necessary to understand the PTC reconciliation process. Because this proposal includes a proposed requirement that Navigators provide consumers with information and assistance understanding the availability of IRS resources, Navigators would be expected to familiarize themselves with the availability of materials on *irs.gov*, including the Form 8962 instructions, IRS Publication 974 Premium Tax Credit, and relevant FAQs, and to refer consumers with questions about tax law to those resources or to other resources, such as free tax return preparation assistance from the Volunteer Income Tax Assistance or Tax Counseling for the Elderly programs.

To help ensure consumers have seamless access to Exchange-related tax information beyond the basic information that Navigators can provide,

we propose to reinstitute as a requirement at § 155.210(e)(9)(v) that FFE Navigators must refer consumers to licensed tax advisers, tax preparers, or other resources for assistance with tax preparation and tax advice related to consumer questions about the Exchange application and enrollment process, and PTC reconciliations.²⁹

We interpret the Navigator duties to facilitate enrollment in QHPs in section 1311(i)(3)(C) of the ACA, to distribute fair and impartial information concerning enrollment in QHPs under section 1311(i)(3)(B) of the ACA, and to conduct public education activities to raise awareness about the availability of QHPs in section 1311(i)(3)(A) of the ACA to include helping consumers understand the kinds of decisions they will need to make in selecting coverage, and how to use their coverage after they are enrolled. We have previously stated that one of the overall purposes of consumer assistance programs is to help consumers become fully informed and health literate.³⁰

To improve consumers' health literacy related to coverage generally, and to ensure that individual consumers are able to use their coverage meaningfully, we propose to reinstitute at § 155.210(e)(9)(iv) the requirement that Navigators in the FFEs must help consumers understand basic concepts and rights related to health coverage and how to use it. We also propose to expand our interpretation of this requirement and the activities that fall within its scope. These activities could be supported through the use of existing resources such as the CMS "From Coverage to Care" initiative, which we encourage Navigators to review, and which are now available in multiple languages at <https://marketplace.cms.gov/c2c>. This proposal would improve consumers' access to health coverage information, not just when selecting a plan, but also when using their coverage.

We believe expanding our interpretation of the requirement that Navigators help consumers understand basic concepts and rights related to health coverage and how to use it and

²⁹ We note that we are not proposing to reinstitute at § 155.210(e)(9)(v) the requirement that Navigators must provide referrals to licensed tax advisers, tax preparers, or other resources for assistance with tax preparation and tax advice related to consumer questions about exemptions from the requirement to maintain minimum essential coverage and from the individual shared responsibility payment in light of the fact that the individual shared responsibility payment was reduced to zero for months beginning after December 31, 2018 under the Tax Cuts and Jobs Act (Pub. L. 115-97, December 22, 2017).

³⁰ See 79 FR 30276.

the activities that fall within the scope of this requirement is vital to improving health equity and helping to address social determinants of health, particularly among underserved and vulnerable populations.³¹ Navigators are already required under § 155.210(e)(8) to provide targeted assistance to underserved or vulnerable populations. Underserved and vulnerable populations often experience lower levels of health literacy, which can be a barrier to enrolling in and accessing care.³² Social determinants of health can also create significant disparities in whether and how an individual is able to afford and access health coverage and health care services, including primary and preventive care. As trusted partners and members of local communities, Navigators are uniquely positioned to establish and build trust with individuals and families as they transition from enrolling in health coverage to using and maintaining their coverage throughout the year.

Additionally, Navigators in FFEs are already required under § 155.215(c)(1) to develop and maintain general knowledge about the racial, ethnic, and cultural groups in their service area, including each group's health literacy and other needs, and under § 155.215(c)(2) to collect and maintain updated information to help understand the composition of the communities in the service area. Because the health literacy needs of consumers will vary depending on their circumstances, we are not requiring Navigators to help consumers with specific health literacy topics. Instead, we propose to expand our interpretation of the Navigator duties proposed to be reinstated as requirements at § 155.210(e)(9)(iv) to include, for example, helping consumers understand (1) key terms used in health coverage materials, such as “deductible” and “coinsurance,” and how they relate to the consumer's health plan; (2) the cost and care differences between a visit to the emergency department and a visit to a primary care provider under the coverage options available to the consumer; (3) how to evaluate their health care options and make cost-conscious decisions, including through the use of information required to be disclosed by their health plan as a result of the Transparency in Coverage Final

Rules;³³ (4) how to identify in-network providers to make and prepare for an appointment with a provider—including utilizing tools and resources available through the No Surprises Act³⁴ to make informed decisions about their care; (5) how the consumer's coverage addresses steps that often are taken after an appointment with a provider, such as making a follow-up appointment and filling a prescription; and (6) the right to coverage of certain preventive health services without cost sharing under QHPs—including information and resources related to accessing viral testing and vaccination options supported by Exchange coverage. If this proposal is finalized, CMS intends to make training materials and other educational resources available to Navigators regarding the proposed expanded interpretation of this requirement.

FFE Navigators will continue to be permitted to perform the Navigator duties specified in § 155.210(e)(9) until this proposal, if finalized, becomes effective. If this proposal is finalized, FFE Navigators would be required to perform the Navigator duties specified in § 155.210(e)(9) beginning with Navigator grants awarded after the effective date of this rule, including non-competing continuation awards. For example, if this proposal is finalized prior to Navigator grant funding being awarded in fiscal year (FY) 2022, FY 2021 Navigator grantees will be required to perform these duties beginning with the Navigator grant funding awarded in FY 2022 for the second 12-month budget period of the 36-month period of performance. To the extent FFE Navigators awarded grant funding in FY 2021 are not already performing these duties under their year one project plans when this proposal, if finalized, becomes effective, they can revise their project plans to incorporate performance of the duties specified in § 155.210(e)(9) as part of their non-competing continuation application for their FY 2022 funding. If this proposal is finalized as proposed, we would codify in § 155.210(e)(9) the applicability date to make clear when the Navigator duties specified in § 155.210(e)(9) would once again be required.

We interpret the requirement to facilitate enrollment in a QHP under section 1311(i)(3)(C) of the ACA, and the requirement at § 155.210(e)(2) to provide information that assists

consumers with submitting the eligibility application, to include assistance with updating an application for coverage through an Exchange, including reporting changes in circumstances and assisting with submitting information for eligibility redeterminations. Additionally, Navigators are already permitted, but not required, to help with a variety of other post-enrollment issues. For example, we interpret the requirements in § 155.210(e)(1) and (2) that Navigators conduct public education activities to raise awareness about the Exchange and provide fair and impartial information about the application and plan selection process to mean that Navigators may educate consumers about their rights with respect to coverage available through an Exchange, such as nondiscrimination protections, prohibitions on preexisting condition exclusions, and preventive services available without cost-sharing. We also interpret these requirements, together with the requirement in section 1311(i)(3)(B) of the ACA that Navigators distribute fair and impartial information concerning enrollment in QHPs, and the availability of Exchange financial assistance, to mean that Navigators may assist consumers with questions about paying premiums for coverage or insurance affordability programs enrolled in through an Exchange. Finally, we interpret the requirement in section 1311(i)(3)(D) of the ACA and § 155.210(e)(4) to provide referrals for certain post-enrollment issues to mean that Navigators may help consumers obtain assistance with coverage claims denials.

Certified application counselors (CACs) do not receive grants from the FFEs, and thus may have more limited resources than Navigators. As a result, while we are not proposing to require CACs to further expand their required duties, we encourage CACs to help with activities consistent with their existing regulatory duties and recognize that many of these CACs may already be participating in these post-enrollment activities.

We seek comment on all aspects of this proposal.

3. Exchange Direct Enrollment Option (§ 155.221(j))

In part 1 of the 2022 Payment Notice final rule, we codified § 155.221(j), which established a process for states to elect a new Exchange Direct Enrollment option (Exchange DE option). Under the Exchange DE option, State Exchanges, SBE-FPs, and FFE states may work directly with private sector entities (including QHP issuers, web-brokers,

³¹ 86 FR 7009 (Jan. 25, 2021).

³² Access to Health Services: Healthy People 2020. Office of Disease Prevention and Health Promotion, Department of Health & Human Services. <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/access-to-health>.

³³ 85 FR 72158.

³⁴ Title I of Division BB of the Consolidated Appropriations Act, 2021, Public Law 116–260 (Dec. 27, 2020).

and agents and brokers) to operate enrollment websites through which consumers can apply for coverage, receive an eligibility determination from the Exchange, and purchase an individual market QHP offered through the Exchange with APTC and CSRs, if otherwise eligible. Subject to meeting HHS approval requirements under § 155.221(j)(1) and (2), the Exchange DE option may be implemented in states with a State Exchange beginning in plan year 2022 and in SBE-FP or FFE states beginning in plan year 2023. We also finalized a 2023 user fee rate of 1.5 percent of the total monthly premiums charged by issuers for each policy in FFE and SBE-FP states that elect the Exchange DE option. Since the publication of part 1 of the 2022 Payment Notice final rule, there have been significant changes to policy and operational priorities resulting from recent shifting policy goals, as well as the enactment of new federal laws. Given these changes, as well as a general lack of interest expressed by states in the option, and potential for the Exchange DE option to be misaligned with administration priorities, we propose to remove § 155.221(j) and repeal the Exchange DE option.

On January 20, 2021, President Biden issued the Executive Order, “On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government” (E.O. 13985),³⁵ directing that as a policy matter the federal government should pursue a comprehensive approach to advancing equity for all, including people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality. On January 28, 2021, President Biden issued E.O. 14009.³⁶ Section 3 of E.O. 14009 directs HHS, and the heads of all other executive departments and agencies with authorities and responsibilities related to Medicaid and the ACA, to review all existing regulations, orders, guidance documents, policies, and any other similar agency actions to determine whether they are inconsistent with policy priorities described in Section 1 of E.O. 14009, to include protecting and strengthening the ACA by assisting people who are potentially eligible for coverage, and eliminating unnecessary difficulties to obtaining health insurance. Specifically, this agency review must evaluate whether existing policies or regulations, “. . . undermine

the Health Insurance Marketplace®³⁷ or the individual, small group, or large group markets for health insurance . . .” or “. . . present unnecessary barriers to individuals and families attempting to access Medicaid or ACA coverage . . .”³⁸

Section 2 of E.O. 14009 also requires that the Secretary of HHS consider whether to implement an Exchange special enrollment period for exceptional circumstances pursuant to § 155.420(d)(9) and other existing authorities, for uninsured and underinsured individuals to obtain coverage in light of the special circumstances caused by the COVID-19 pandemic. After E.O. 14009 was issued, HHS used its discretion to make such a special enrollment period available to uninsured and underinsured consumers through *HealthCare.gov* from February 15, 2021, through May 15, 2021. To support outreach, education and enrollment efforts for this special enrollment period, HHS has provided \$2.3 million in additional funding to current Navigator grantees in the FFE.³⁹

All State Exchanges followed suit and implemented corresponding special enrollment periods on similar timelines. HHS later made a decision to extend the ability of consumers to access the special enrollment period through *HealthCare.gov* through August 15, 2021, and many State Exchanges extended their special enrollment periods, as well. As of May 31, 2021, 1.2 million new consumers had selected plans through *HealthCare.gov*, which represents a substantial increase from previous years when special enrollment periods were available primarily for normal qualifying life events.⁴⁰

In addition, Congress recently passed the ARP,⁴¹ which was signed into law on March 11, 2021. The ARP establishes new ACA programs, including a new grant program for Exchange modernization, which appropriates \$20,000,000 in federal funding, which is available until September 30, 2022, to State Exchanges to implement Exchange system, program, or technology updates to ensure compliance with applicable federal requirements. It also modifies eligibility criteria for existing ACA programs. For example, the provisions

³⁷ Health Insurance Marketplace® is a registered service mark of the U.S. Department of Health & Human Services.

³⁸ 86 FR 7793 (Feb. 2, 2021).

³⁹ <https://www.cms.gov/newsroom/press-releases/cms-announces-additional-navigator-funding-support-marketplace-special-enrollment-period>.

⁴⁰ <https://www.cms.gov/newsroom/fact-sheets/2021-marketplace-special-enrollment-period-report-2>.

⁴¹ Public Law 117-2.

in the ARP include a temporary change (for taxable years 2021 and 2022) that allows consumers with household income above 400 percent of the FPL to be applicable taxpayers potentially eligible for PTC, an update to applicable percentage tables to increase the amount of PTC for qualified individuals in all income brackets, and a modification of eligibility for PTC for consumers receiving, or approved to receive, unemployment compensation in 2021. Beginning on April 1, HHS operationalized these new requirements through *HealthCare.gov*, and is providing technical assistance to State Exchanges that are operationalizing these requirements at the state level. Approximately 1.9 million consumers have returned to *HealthCare.gov* to reduce their monthly premiums after APTC by over 40 percent, from \$100 to \$57, on average, while for new consumers selecting plans during the special enrollment period, the average monthly premium after APTC fell by 25 percent.⁴²

There are also new obligations established via other health care-related legislation for which HHS is responsible to implement in coordination with states and other federal Departments. This includes the No Surprises Act,⁴³ which was enacted on December 27, 2020, and establishes an extensive array of federal and state requirements and programs to protect consumers against surprise medical bills.

Given our obligation to review all existing policies and regulations in line with E.O. 14009, E.O. 13985, and recent actions by Congress, including the health care-related provisions of the ARP and other new federal legislation, for which HHS is now responsible or centrally involved in implementing, we have determined that all available resources should be directed to ensuring we are able to efficiently and effectively meet those obligations. Permitting the establishment of the Exchange DE option would detract from those efforts. Furthermore, meeting the new requirements of the health care provisions of the ARP would add complexity to Exchange operations that could reduce the prospects for successful implementation of the Exchange DE option, even if temporarily. For instance, states and DE entities would need to coordinate and implement new procedures to ensure that consumers receive eligibility

⁴² <https://www.cms.gov/newsroom/fact-sheets/2021-marketplace-special-enrollment-period-report-1>.

⁴³ Title I of Division BB of the Consolidated Appropriations Act, 2021, Public Law 116-260 (Dec. 27, 2020).

³⁵ 86 FR 7009 (Jan. 25, 2021).

³⁶ 86 FR 7793 (Feb. 2, 2021).

determinations and are enrolled in coverage in line with the modified PTC eligibility criteria under the ARP, and then, that this temporary modification no longer applies after taxable year 2022. As part of this process, HHS would need to ensure the adoption of appropriate procedures, proper approvals, and ongoing oversight. To foreclose the possibility that federal funding and resources will be diverted from efforts to provide direct benefits to consumers made available under recent legislation to optional programs, we are proposing to repeal the Exchange DE option. This will help ensure that available resources are allocated consistent with administration health care priorities and dedicated to implementation of newly-enacted federal laws that provide greater financial assistance and protections to consumers.

Repealing the Exchange DE option should generally have a minimal impact on states and other interested parties. States with State Exchanges already could engage with direct enrollment entities preceding the addition of § 155.221(j). In addition, the FFE has already implemented the direct enrollment program (including classic direct enrollment and enhanced direct enrollment), which provides broad availability of non-Exchange websites to assist consumers applying for, or enrolling in QHPs through an FFE or SBE-FP with APTC and CSRs, when otherwise eligible.⁴⁴ Additionally, nothing in the previous regulatory framework prohibited State Exchanges from engaging direct enrollment entities similar to the FFE in order to supplement Exchange operations in their states should they so choose. In fact, although we understand that several State Exchanges have engaged with direct enrollment entities to discuss possibilities for collaboration, State Exchanges and other stakeholders nearly universally cautioned against the Exchange DE option in public comments submitted in response to the proposal. In addition, to date, no state has expressed interest in implementing the Exchange DE option.

Finally, in reviewing § 155.221(j) in line with E.O. 13985 and E.O. 14009, and after further consideration of public comments received when the Exchange DE option was proposed, we have determined that the Exchange DE option is inconsistent with policies described in E.O. 13985 and sections 1 and 3 of E.O. 14009. Consistent with many

public comments received when the Exchange DE option was proposed, we believe that shifting away from *HealthCare.gov* or State Exchange websites as the primary pathway to enroll in and receive information about coverage would harm consumers by unnecessarily fracturing enrollment processes among the Exchange and possibly multiple direct enrollment entities operating in a state. Such a shift would be particularly harmful now when over one million consumers have successfully navigated *HealthCare.gov* during the COVID special enrollment period to enroll in Exchange coverage. We also agree with many commenters who noted that a fractured process could foster consumer confusion about how to get covered and what coverage options are available, since consumers could be directed to direct enrollment entities that only offer assistance with a limited selection of products and some of those products may not provide, for example, MEC for consumers.⁴⁵ Many commenters raised concerns that this consumer confusion or limited product selection through direct enrollment entities could also potentially disrupt coordination of coverage with other insurance affordability programs, including Medicaid and CHIP, which is inconsistent with our “no wrong door” policy.⁴⁶ In addition, these consequences could act as an unnecessary barrier to consumers seeking Medicaid or ACA coverage rather than facilitating enrollment, and could have additional downstream impacts including an increased uninsured or underinsured population, or more consumers enrolled in less comprehensive coverage options. Commenters noted that these downstream impacts could lead to health inequities by disparately impacting certain vulnerable groups that tend to have a greater need for comprehensive coverage or rely more heavily on Medicaid and CHIP. These concerns and the accompanying risks to the health and well-being of vulnerable groups and consumers in general are

⁴⁵ Multiple commenters cited the following report as support for their comments related to DE entities offering limited plan selection and potential disruptions to coordination of coverage with other insurance affordability programs: <https://www.cbpp.org/research/health/direct-enrollment-in-marketplace-coverage-lacks-protections-for-consumers-exposes>.

⁴⁶ This policy is intended to ensure that consumers can complete a single eligibility application to receive determinations of eligibility across multiple health insurance affordability programs, including for QHPs, APTC, CSRs, as well as Medicaid and CHIP. See, for example, sections 1311(d)(4)(F) and 1413 of the ACA.

heightened as the COVID-19 PHE continues.

By finding the Exchange DE option inconsistent with recent Executive Orders, to ensure that resources are not diverted from fulfilling requirements under the new health care legislation and other initiatives like the COVID special enrollment period, and because no state has yet expressed interest in implementing the Exchange DE option, we propose to remove § 155.221(j) and repeal the Exchange DE option. As explained in the preamble section regarding user fee rates for the 2022 benefit year (§ 156.50), we also propose to repeal the accompanying user fee rate for FFE-DE and SBE-FP-DE states for 2023. We seek comment on this proposal.

4. Open Enrollment Period Extension (§ 155.410(e))

We propose to amend paragraph (e) of § 155.410, which provides the dates for the annual Exchange open enrollment period in which qualified individuals and enrollees may apply for or change coverage in a QHP. The Exchange open enrollment period is extended by cross-reference to non-grandfathered plans in the individual market, both inside and outside of an Exchange, under guaranteed availability regulations at § 147.104(b)(1)(ii). HHS is specifically proposing to alter the open enrollment period for the 2022 coverage year and beyond so that it begins on November 1 and runs through January 15 of the applicable benefit year.

In previous rulemaking, we established that the open enrollment period for benefit years beginning on or after January 1, 2018 would begin on November 1, 2021 and extend through December 15, 2021. In doing so, we indicated a preference for a shorter month-and-a-half open enrollment period, noting our belief that it provides sufficient time for consumers to enroll in or change QHPs and that an end date of December 15th carries the benefit of ensuring consumers receive a full year of coverage and simplifies operational processes for issuers and the Exchanges.⁴⁷ Accordingly, the annual open enrollment period dates have been set to November 1st through December 15th for the 2018, 2019, 2020, and 2021 plan years. We have observed several benefits using the present open enrollment period dates. Prior enrollment data suggests that the majority of new consumers to the Exchange select plans prior to December 15th so as to have coverage beginning January 1st. After 4 years, we believe

⁴⁴ The FFE direct enrollment pathways are also available in SBE-FP states. See 45 CFR 155.220(l) and 155.221(i).

⁴⁷ See 82 FR 18346 at 18381.

consumers have become accustomed to a December 15th end date for the annual open enrollment period. Consistency in open enrollment dates promotes consumer confidence, and a December end date generally aligns with the open enrollment dates for other health insurance programs such as Medicare and employer-based health plans.

We also observed that consumer casework volumes related to coverage start dates and inadvertent dual enrollment decreased in the years after the December 15th end date was adopted, suggesting that the consumer experience was improved by having a singular deadline of December 15th to enroll in coverage for the upcoming plan year. We note that an extension to January 15th may cause some previously observed consumer confusion to resurface surrounding the need to enroll by December 15th for a full year of coverage versus the final deadline of January 15th to enroll for a plan that would begin on February 1st. This confusion could cause some consumers to miss out on coverage for the month of January altogether. A January 15th end date may also require enrollment assisters allocate budget resources over a longer period of time.

However, after observing the effects of a month-and-a-half open enrollment period over these years, we have also observed negative impacts to consumers that may justify an extension of the open enrollment end date to January 15th. In particular, we have observed that consumers who receive financial assistance, who do not actively update their applications during the open enrollment period, and who are automatically re-enrolled into a plan are subject to unexpected plan cost increases if they live in areas where the second lowest-cost silver plan has dropped in price. These consumers will experience a reduction in their allocation of APTC based on the second lowest-cost silver plan price, but are often unaware of their increased plan liabilities until they receive a bill from the issuer in early January after the open enrollment period has concluded. Extending the open enrollment end date to January 15th would allow these consumers the opportunity to change plans after receiving updated plan cost information from their issuer and to select a new plan that is more affordable to them. We have also observed concerns from Navigators, CACs, and agents and brokers that the current open enrollment period does not leave enough time for them to fully assist all interested Exchange applicants with their plan choices. Extending the open enrollment end date to January 15th

would allow more time for consumers to seek assistance from one of these entities. Together, the impacts of providing consumers with more time to react to updated plan cost information and more time to seek enrollment assistance may improve access to health coverage. The additional time for enrollment assistance provided by this proposal may be particularly beneficial to consumers in underserved communities who may face time or language barriers in accessing health coverage by extending the period in which these consumers can seek in-person assistance to enroll.

We seek comment on whether a January 15th end date would provide a balanced approach to providing consumers with additional time to make informed plan choices and increasing access to health coverage, while mitigating risks of adverse selection, consumer confusion, and issuer and Exchange operational burden. We invite comments from stakeholders that would experience specific benefits or adverse effects from a January 15th end date, and encourage comments on potential impacts to resources, consumer assistance budgets, overall enrollment numbers, premiums, and market stability. We seek comments on whether this extension would incentivize consumers who need coverage to begin on January 1st to still make a choice and enroll by December 15th, while also preserving sufficient time in the remainder of the plan year for issuers and Exchanges to perform other obligations such as QHP certification.

We further invite comments on alternative approaches to extending open enrollment to address coverage gaps or enrollment challenges facing consumers and stakeholders. We also invite comments to address whether HHS should explore the possibility of a new special enrollment period, such as for current enrollees who are automatically re-enrolled and experienced a significant cost increase, to address concerns for specific consumer challenges as an alternative to extending the annual open enrollment period. We are also considering whether approaches such as enhanced noticing or special, targeted outreach would address the needs of consumers who are automatically re-enrolled in areas where the second lowest-cost silver plan drops in value, thereby reducing APTC amounts. We seek comment on how we may improve communications and consumer engagement around potential cost changes for consumers who do not actively re-enroll in coverage. We are also considering if improved education and outreach during the coverage year

to raise awareness of existing special enrollment period opportunities, such as those for loss of coverage or becoming newly eligible or ineligible for financial assistance, may serve consumers who do not enroll or change plans during open enrollment. We seek comment on whether adoption of these or other outreach approaches would be a viable alternate approach to finalizing our proposal to extend the open enrollment end date to January 15th.

We anticipate that if an open enrollment end date of January 15th were finalized, this change would apply to all Exchanges, including State Exchanges for the 2022 coverage year and beyond. We note that in preceding plan years, a majority of State Exchanges have used special enrollment period authority to offer additional enrollment time beyond the end date of December 15th in the Exchanges on the Federal platform. We invite additional comments on State Exchange flexibility, as well as operational challenges relating to State Exchange implementation of the proposed change for 2022 and beyond.

5. Monthly Special Enrollment Period for APTC-Eligible Qualified Individuals With a Household Income No Greater Than 150 Percent of the Federal Poverty Level (§ 155.420(d)(16))

In order to make affordable coverage available to more consumers, we propose to codify a monthly special enrollment period for qualified individuals or enrollees, or the dependents of a qualified individual or enrollee, who are eligible for APTC, and whose household income is expected to be no greater than 150 percent of the FPL.⁴⁸ Section 9661 of the ARP amended section 36B(b)(3)(A) of the Code to decrease the applicable

⁴⁸ Generally, a qualifying individual is not eligible for a PTC if their income is below 100 percent of the FPL. However, there are a small number of consumers with a household income below 100 percent of the FPL who may qualify for APTC. Specifically, section 1401 of the ACA amended section 36B of the Code to provide that a taxpayer with a household income which is not greater than 100 percent of the FPL, and who is a lawfully present immigrant and ineligible for Medicaid due to their immigration status, may qualify for a PTC. Consumers for whom this is the case would be able to qualify for the proposed special enrollment period, as well. Additionally, we note that because individuals would qualify for this special enrollment period based on their household income level, household members who apply for coverage with financial assistance together generally will all qualify for the special enrollment period. However, it is also possible that one household member could trigger the special enrollment period based on a change in their eligibility for APTC—for example, a household member who loses access to an offer of coverage through an employer that is considered affordable based on 26 CFR 1.36B02(c)(3)(v).

percentages used to calculate the amount of household income a taxpayer is required to contribute to their second lowest cost silver plan for tax years 2021 and 2022.⁴⁹ The applicable percentages are used in combination with factors including annual household income and the cost of the benchmark plan to determine the PTC amount for which a taxpayer can qualify to help pay for a QHP on an Exchange for themselves and their dependents.⁵⁰ These decreased percentages generally result in increased PTC for PTC-eligible taxpayers. For those with household incomes no greater than 150 percent of the FPL, the new applicable percentage is zero. As a result of these changes, many low-income consumers whose QHP coverage can be fully paid for with APTC have one or more options to enroll in a silver-level plan without needing to pay a premium after the application of APTC. All of these consumers, if eligible to enroll through an Exchange and to receive APTC, will qualify for CSRs to enroll in a silver plan with an AV of 94 percent.⁵¹

We propose that this special enrollment period be available at the option of the Exchange, in order to allow State Exchanges to decide whether to implement it based on their specific market dynamics, needs, and priorities. Additionally, we propose that Exchanges on the Federal platform will implement this special enrollment period by providing qualified individuals who are eligible with a pathway to access it through the *HealthCare.gov* application. We propose that implementation in Exchanges on the Federal platform be consistent with current special enrollment period policy and operations, in particular such that there is no limitation on how often individuals who are eligible for this special enrollment period can obtain or utilize it.⁵² Consistency in this area will mitigate consumer and other stakeholder confusion and simplify Exchange operations. To provide Exchanges with flexibility to prioritize ensuring that qualifying individuals are able to obtain coverage through this special enrollment period quickly

following plan selection, or to implement this special enrollment period in keeping with their current operations, we propose to add a new paragraph at § 155.420(b)(2)(vii) to provide that the Exchange must ensure that coverage is effective in accordance with paragraph (b)(1) of this section or on the first day of the month following plan selection, at the option of the Exchange.

We also propose to add a new paragraph at § 155.420(a)(4)(ii)(D) to provide that an Exchange must permit eligible enrollees and their dependents to change to a silver level plan, and to amend paragraph § 155.420(a)(4)(iii), which provides other plan category limitations for other special enrollment periods, to provide that these other plan category limitations do not apply to enrollees or dependents who qualify for the proposed special enrollment period.⁵³ While we expect that most consumers who qualify for this special enrollment period will select a silver level plan because based on their household income, they will be eligible to enroll in a silver level plan with an actuarial value of 94 percent, as further discussed below, we believe that ensuring that current Exchange enrollees do so through plan category limitations will help to mitigate adverse selection. Finally, we propose to add a new paragraph at § 147.104(b)(2)(i)(G) to specify that issuers are not required to provide this special enrollment period in the individual market with respect to coverage offered outside of an Exchange, because eligibility for the special enrollment period is based on eligibility for APTC, and APTC cannot be applied to coverage offered outside of an Exchange.

The APTC benefit changes under the ARP make affordable coverage available to more uninsured people. However, if past trends continue, we believe that some consumers who qualify for these benefits under the ARP may continue to forgo enrollment in premium-free coverage due to a lack of awareness of the opportunity to enroll or a misconception about what the coverage would cost. For example, a February 2021 HHS Assistant Secretary for Planning and Evaluation (ASPE) issue brief⁵⁴ indicates that, as of 2018, 20

percent of the uninsured had a household income no higher than \$35,000, which, in 2018, was under 150 percent of the FPL for households with four or more members.⁵⁵ A recent analysis of American Community Survey (ACS) and U.S. Census data also indicates that families with low incomes are more likely to be uninsured, and that in 2019, more than 70 percent of uninsured adults said that they were uninsured because the cost of coverage was too high. It also noted that in 2019, almost 70 percent of uninsured, non-elderly adults had lacked coverage for more than a year, and that this group may be particularly difficult to reach with outreach and education efforts.⁵⁶

Therefore, while HHS will undertake extensive outreach and engagement efforts to promote enrollment during the open enrollment period for 2022 coverage and to help ensure consumer awareness of existing special enrollment periods for which they may qualify, given the established challenges with promoting awareness of access to coverage among low-income consumers, we believe additional enrollment opportunities for low-income consumers are appropriate and in the best interest of low-income consumers. The proposed monthly special enrollment period policy would align with E.O. 14009, which requires federal agencies to identify and appropriately address policies that create barriers to accessing ACA coverage, including access through mid-year enrollment.

In addition to providing certain low-income individuals with additional opportunities to newly enroll in free or low-cost coverage that is available to them, we believe this special enrollment period may help consumers who lose Medicaid coverage regain health care coverage. These consumers can already qualify for a special enrollment period due to their loss of Medicaid coverage, per § 155.420(d)(1). Additionally, Exchanges could provide consumers who do not learn of their opportunity to enroll in Exchange coverage until after their 60-day special enrollment period

⁵⁵ 2017 Federal Poverty Guidelines. ASPE:

<https://aspe.hhs.gov/2017-poverty-guidelines>. We refer to 2017 FPL information to determine APTC eligibility for 2018 because, per 26 CFR 1.36B–1(h), the FPL for computing the PTC for a taxable year is the FPL in effect on the first day of the initial or annual open enrollment period preceding that taxable year. For example, ASPE released 2020 FPL information in January 2020, and so 2020 FPL information applies during the 2020 open enrollment period for 2021 coverage.

⁵⁶ Key Facts about the Uninsured Population: Kaiser Family Foundation; Nov 06, 2020, <https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/>. <https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/>.

⁴⁹ Public Law 117–2.

⁵⁰ See 26 CFR 1.36B–3(g) for more information on the applicable percentage and its relationship to the PTC.

⁵¹ See §§ 155.305(g)(2) and 156.420(a).

⁵² For example, those who qualify for the special enrollment period per § 155.420(d)(8) for qualifying individuals who gain or maintain status as an Indian, as defined by section 4 of the Indian Health Care Improvement Act, may change their plan selection multiple times each month, noting that only the last plan selection before the applicable cutoff date for coverage each month will take effect for the month in question.

⁵³ This provision would not prevent enrollees who qualify for the new special enrollment period from changing to a plan of any category through a special enrollment period that provides this flexibility, including the special enrollment periods at § 155.420(d)(4), (8), (9), (10), (12), and (14).

⁵⁴ Trends in the U.S. Uninsured Population, 2010–2020. Office of the Assistant Secretary for Planning and Evaluation (ASPE), February 11, 2021: <https://aspe.hhs.gov/system/files/pdf/265041/trends-in-the-us-uninsured.pdf>.

has passed with additional time to enroll in health care coverage based on the regulation at § 155.420(c)(4) recently finalized in part 2 of the 2022 Payment Notice final rule to allow a qualified individual, enrollee, or dependent who did not receive timely notice of a triggering event and was otherwise reasonably unaware that a triggering event occurred to select a new plan within 60 days of the date that he or she knew, or reasonably should have known, of the occurrence of the triggering event.⁵⁷ However, whether consumers in these situations are able to benefit from this flexibility may vary, and may require Exchanges to assess eligibility on a case-by-case basis; it may also require consumers who generally have low household income and who therefore may face other barriers to accessing health care coverage, such as low health insurance literacy levels and lack of internet access, to be aware of the potential for an extended enrollment timeframe and to request it from their Exchange. Therefore, while this special enrollment period would not be limited to qualified individuals who have lost Medicaid coverage, we believe that providing access to a monthly enrollment opportunity could help some consumers who lose Medicaid coverage to regain health insurance coverage, especially those who do not initially realize that loss of Medicaid is a special enrollment period triggering event.

Further, after the COVID-19 PHE comes to an end, we expect to see a higher than usual volume of low-income individuals transitioning from Medicaid coverage to the Exchange, for at least several months. This is because states will begin to catch up on a backlog of redeterminations and terminations for Medicaid beneficiaries with increased income following the end of the COVID-19 PHE, after having generally suspended Medicaid disenrollments since March 2020 to comply with the continuous enrollment provisions in section 6008(b)(3) of the Families First Coronavirus Response Act.⁵⁸ Individuals with household income below 150 percent of the FPL frequently experience income fluctuations that cause them to transition between Medicaid, CHIP, and Exchange coverage with financial assistance. Further, the consumer eligibility determination notices sent by state Medicaid and CHIP agencies can vary greatly as far as content, including clarity about the

consumer's next steps to apply for other coverage, where and how to apply, and the timeframes for doing so. Consumers who become ineligible for Medicaid are at risk of being uninsured for a period of time and putting off accessing health care, which can lead to poorer health outcomes, if they are not ultimately able to successfully transition between coverage programs.

For these consumers, 60 days may not be enough time to successfully transition to Exchange coverage, leading to long-term lack of coverage. We believe some of these consumers will benefit from additional time to enroll in Exchange coverage. In some cases, the loss of Medicaid or CHIP coverage comes at a time when consumers are least able to track down new health coverage, but are most in need of it. An example of this can be seen with consumers who lose pregnancy-related Medicaid or CHIP coverage after the postpartum period, posing a health coverage hurdle for new mothers at a time when access to health care is paramount, but their ability to find and enroll in new coverage is limited or impeded by their new childcare responsibilities.

Exchanges that elect to provide this proposed special enrollment period would have the option to require consumers to submit documentation to confirm their eligibility in accordance with their pre- or post-enrollment verification programs. CMS will determine eligibility for this special enrollment period in Exchanges on the Federal platform based on consumers' attested household income. Once an Exchange on the Federal platform grants this special enrollment period to a consumer based on their attested household income, the Exchange would then verify applicants' projected annual household income consistent with 45 CFR 155.320(c).⁵⁹ Specifically, CMS would continue to require consumers whose projected annual household income cannot be verified using a trusted electronic data source to submit documentation to confirm their annual income (currently approved under OMB control number 0938-1207/Expiration date February 29, 2024). However, we would not require submission of household income documentation prior to enrollment, and would not pend the enrollment as part of a pre-enrollment verification process, because we believe that the post-enrollment income verification process already in place is sufficient to ensure program integrity because consumers who do not verify their attested household income through

the post-enrollment verification process will have their APTC adjusted accordingly.

Further, CMS' experience administering the verification processes for Exchanges on the Federal platform in accordance with § 155.320(c) shows that submitting documentation quickly to verify income can be especially onerous for those at the lowest income levels who may not have ready access to a computer or smartphone, the internet, a copier or scanner, or funds for postage. As noted above, consumers with household incomes less than 150 percent of the FPL are most likely to experience churn between our health care programs and would be disproportionately affected by the delayed access to coverage that will result while they complete the post-enrollment verification process. For this reason, we are of the view that requiring pre-enrollment verification would needlessly delay access to coverage for a significant portion of eligible consumers; and that it is reasonable and appropriate to allow applicants' enrollments to proceed subject to post-enrollment verification of their household income, if additional documentation is necessary due to inability to verify their household income using a trusted electronic data source.

In addition to outreach and education efforts, we believe that applying plan category limitations to this special enrollment period would help to mitigate adverse selection because it would limit the ability of enrollees to change to a higher metal level plan based on a new health care need and then change back to a silver plan once the health issue is resolved. However, enrollees may still choose to enroll in a silver level plan that is more expensive than their zero dollar option, and, with a monthly special enrollment period, could make this change during the plan year based on a difference in provider network or prescription drug formulary. We believe that enrollees who are interested in changing plans during the year will likely be deterred because such a change will generally mean they lose progress they have made toward meeting their deductible and other accumulators. We seek comment on this proposal and on whether, alternatively, plan category limitations should not be applied. For example, we seek comment on whether to instead exempt the proposed special enrollment period at § 155.420(d)(16) from plan category limitations in order to alleviate the implementation burden on Exchanges, or due to a lack of concern that eligible enrollees would use the proposed

⁵⁷ 86 FR 24220.

⁵⁸ Public Law 116-127. These provisions enabled states to receive the temporary Federal Medical Assistance Percentage increase under that section.

⁵⁹ Public Law 111-148.

special enrollment period to change to a plan category other than silver.

Additionally, we believe that that access to premium-free or very low-cost 94 percent AV coverage will help to mitigate risk of adverse selection, because qualifying individuals will not have an incentive to end coverage when health care services are no longer needed. However, we seek comment on the degree to which the risk of adverse selection increases due to the fact that not all qualifying individuals who have a household income no greater than 150 percent of the FPL will have access to a silver plan with a zero-dollar premium and therefore, due to their small premium for a silver plan, might be more inclined to enroll in coverage due to a health care need and end coverage once this need has been met.

We estimate that this adverse selection risk may result in issuers increasing premiums by approximately 0.5 to 2 percent, and a corresponding increase in APTC outlays and decrease in income tax revenues of approximately \$250 million to \$1 billion, when the enhanced APTC provisions of the ARP are in effect. We describe this impact in more detail and seek comment on it in the regulatory impact analysis (RIA) section later in this proposed rule. We also discuss some of the reasons adverse selection cannot be mitigated in the following paragraphs.

The adverse selection risk presented by the proposal stems, in part, from qualifying individuals who live in states where premiums for Exchange coverage cannot be fully paid for with APTC,⁶⁰ such that these individuals will not have access to a silver plan with a zero-dollar premium. Such individuals include residents of states that require all QHPs in the state to cover services that do not qualify as EHB, or that require coverage of certain abortion services for which federal funding is prohibited, and we estimate that ten states may fall into these categories. The portion of premium attributable to services ineligible for APTC is generally small, but increases with age and family size. Additionally, in a few locations, QHP issuers' plan designs are such that both the lowest-cost silver plan and the second lowest-cost silver plan⁶¹ cover services that do not qualify as EHBs, which makes it impossible for most individuals, including those whose household income does not exceed 150

percent of the FPL, to access a silver plan with a zero dollar monthly premium.

Other household-level variation in access to a silver plan with a zero-dollar premium includes households where some, but not all, applicants are APTC-eligible (for example, a household with one or more members with an offer of other MEC through a job), and households with applicants living in different locations, because Exchanges must determine APTC based on a benchmark plan specific to each location.⁶² In this case, the applicable premium amount will be based on the subscriber's location, and so available APTC may not fully cover a silver plan premium for the policy. Finally, households that include one or more members who attest affirmatively to their smoking status also may not qualify for an APTC amount sufficient to pay the full premium of a silver plan, because consistent with 26 CFR 1.36B-3(e), APTC eligibility is not determined using a benchmark plan that rates for tobacco.⁶³

We seek comment from health insurance issuers and other stakeholders on our position that adverse selection related to this special enrollment period will be mitigated by the availability of free or very low-cost coverage with a 94 percent AV and the application of plan category limitations to this new special enrollment period, or whether the adverse selection risk created by this new special enrollment period cannot be sufficiently mitigated such that its creation may result in significant rate increases. We also solicit comment regarding whether health insurance issuers and other stakeholders have concerns that the policy could cause any adverse selection among higher income individuals with variable hours and income. We also seek comment on whether the requirement that Exchanges verify applicants' projected annual household income post-enrollment, consistent with 45 CFR 155.320(c), is sufficient, or if there are other measures we should put in place to further protect program integrity. We also solicit comment on estimated implementation burdens for Exchanges who elect to provide this additional enrollment opportunity, including whether implementation of this special enrollment period will be possible in time for consumers to benefit from it during the 2022 plan year. We request

comment on whether issuers will have sufficient time to adjust rate filings to account for any increased risk and whether state regulators will have sufficient time to review those filings after a final rule is issued.

We further request comment on whether this proposed special enrollment period should be available indefinitely (as proposed), or whether it should be time-limited. For example, we seek comment on whether we should finalize the proposed special enrollment period to be available only for coverage during years when enhanced APTC benefits are also available, as provided by the section 9661 of the ARP or any subsequent statute. Finally, we request comment on strategies for providing outreach and education for consumers who may be eligible for this special enrollment period, in particular to help qualifying individuals understand and take advantage of the free or very low-cost coverage that is available to them. Within this group, we request comments on strategies for educating consumers who qualify to enroll in a 94 percent AV silver plan about the benefits of enrolling in such a plan even if they are required to pay a small premium, as opposed to electing a premium-free bronze plan with a lower AV.

6. Clarification of Special Enrollment Period for Enrollees Who Are Newly Eligible or Newly Ineligible for Advance Payments of the Premium Tax Credit (§ 155.420(f))

We are proposing new language to clarify that, for purposes of the special enrollment period rules at § 155.420(d), references to ineligibility for APTC refer to being ineligible for such payments or being technically eligible for such payments but qualifying for a maximum of zero dollars per month of such payments. That is, a qualified individual, enrollee, or his or her dependent who is technically eligible for APTC because they meet the criteria at § 155.305(f), but who qualifies for a maximum APTC amount of zero dollars, is also considered ineligible for APTC for purposes of these special enrollment periods, even if they experience a change in circumstance from an APTC ineligible status in accordance with § 155.305(f), such as having other MEC. Currently, the special enrollment periods to which this clarification is applicable are the triggering events at § 155.420(d)(6), but we propose that the clarification apply to all of § 155.420 to ensure consistency, for example, between special enrollment period triggering events at § 155.420(d) and related coverage effective date and

⁶⁰ See section 1303(b)(2)(A) of the ACA and section 36B(b)(3)(D) of the Code.

⁶¹ The second lowest-cost silver plan is the "benchmark plan" used to determine a household's APTC eligibility. See 26 CFR 1.36B-3(d)(1) and (f).

⁶² 26 CFR 1.36B-3(f)(4).

⁶³ As of May 2021, CMS data indicate that 1–8 percent of current enrollees, depending on the state, in Exchanges on the Federal platform are rated for tobacco use.

enrollment window rules at § 155.420(b) and (c), respectively.

We believe that the current special enrollment period rules that reference APTC eligibility at § 155.420(d)(6) could permit inconsistent interpretations of what it means to be newly eligible or ineligible for APTC. Exchange regulations at § 155.305(f)(1) define tax filers as APTC eligible if their expected household income for the benefit year for which coverage is requested is greater than or equal to 100 percent but not more than 400 percent of the FPL and they, or their expected tax dependents for the year, (1) meet the requirements for eligibility for enrollment in a QHP through the Exchange; and (2) are not eligible for MEC, with the exception of coverage in the individual market.

IRS rules at 26 CFR 1.36B–3 govern the APTC amount an individual may receive once they are found eligible for APTC under § 155.420(d)(6). Pursuant to these IRS rules, an Exchange enrollee's monthly APTC amount is the excess of the adjusted monthly premium for the applicable benchmark plan⁶⁴ over 1/12 of the product of the taxpayer's household income and the applicable percentage for the taxable year. Under this formula, if the applicable percentage of 1/12 of a taxpayer's estimated annual household income is higher than the adjusted monthly premium of the relevant benchmark plan, a taxpayer will be eligible generally for APTC under § 155.305(f)(1), but will qualify for a maximum APTC amount of zero dollars under 26 CFR 1.36B–3. Currently, neither § 155.305(f)(1) or 26 CFR 1.36B–3 recognize or explain that an individual generally could be APTC eligible, but not qualify to receive any *amount* in APTC greater than zero. The current text of § 155.420 similarly does not address this issue such that there could exist some ambiguity about what it means to be APTC eligible or ineligible for purposes of the special enrollment periods under § 155.420.

We propose to add text to § 155.420 to clarify that an individual who qualifies for a maximum APTC amount of zero dollars is considered ineligible for APTC for purposes of the § 155.420's special enrollment periods. Specifically, any determination that an individual cannot receive an APTC amount greater than zero dollars is equivalent to being

found APTC ineligible for purposes of special enrollment period eligibility under § 155.420(d). We believe this interpretation comports with the perspective of an applicant for Exchange coverage who will take their available financial assistance amount into account when selecting a QHP for the upcoming coverage year and who may wish to change their QHP partway through a coverage year because of a change in their financial assistance. Because we believe that the current regulation permits this interpretation, but could instead be interpreted to require strict adherence to the listed requirements for APTC eligibility at § 155.305(f) (which does not address situations where a consumer meets these requirements but qualifies for a zero dollar APTC amount), we are proposing regulation text to ensure consistent and correct interpretation of what it means to be determined ineligible for APTC. This reading of APTC ineligibility is also consistent with our discussion of the policy in previous rulemaking. For example, in the 2020 Payment Notice final rule,⁶⁵ we added a new paragraph at § 155.420(d)(6)(v) allowing Exchanges to provide a special enrollment period for qualified individuals who experience a decrease in household income and receive a new determination of eligibility for APTC by an Exchange, and who had MEC for one or more days during the 60 days preceding the financial change.

We believe that this clarification should also apply to special enrollment periods provided in § 155.420(d)(6)(iii) through (v), which include special enrollment periods for individuals who become newly eligible for APTC. Section 155.420(d)(6)(iii) provides a special enrollment period for individuals who are enrolled in an employer-sponsored plan, and who are determined newly eligible for APTC, in part, because they are no longer eligible for qualifying coverage in an eligible-employer sponsored plan in accordance with 26 CFR 1.36B–2(c)(3) (for example, because their employer changed the coverage), and who are allowed to terminate their employer-sponsored coverage. We do not expect that this special enrollment period would be helpful to individuals who qualify for a maximum APTC amount of zero dollars because they would not receive assistance to help pay for monthly QHP premiums. Further, it likely would not benefit individuals currently enrolled in employer-sponsored coverage to change to a QHP without the benefit of an

APTC dollar amount greater than zero, in part because changing plans in the middle of the plan year would cause their deductible and other accumulators to be reset. We seek comments on this proposal.

We believe that this clarification will be especially helpful in light of the removal of the upper APTC eligibility limit on household income at 400 percent of the FPL for taxable years 2021 and 2022 under the ARP.⁶⁶ This is because, with this change, any applicants with household incomes over 400 percent of the FPL may be eligible for APTC, more consumers likely will qualify for APTC technically, but for an APTC amount of zero dollars. This clarification ensures that special enrollment period regulations clearly reflect that enrollees for whom this is the case may qualify for a special enrollment period based on a decrease in their household income, or any other change that makes them newly eligible for an APTC amount of greater than zero dollars.

Additionally, this clarification is important because it helps ensure transparency in terms of why enrollees in certain situations that appear similar would not both qualify for one of the special enrollment periods at § 155.420(d)(6). For example, the new affordability provisions in the ARP allow for a situation where an enrollee with a household income above 400 percent of the FPL is newly determined to qualify for an APTC amount of zero dollars (as opposed to APTC-ineligible simply by virtue of exceeding the household income limit), while another enrollee with a household income above 400 percent of the FPL who is residing in a different service area is newly determined eligible for an APTC amount of more than zero dollars based on the cost of their benchmark plan.⁶⁷ Both enrollees have received new determinations of APTC eligibility based just being enrolled in Exchange coverage and not having another offer of MEC, but only the latter enrollee who is determined eligible for an APTC amount of greater than zero dollars is intended to be eligible for the special enrollment periods at § 155.420(d)(6). We believe the proposed new language provides needed clarity regarding the eligibility parameters of this special enrollment period to enrollees, particularly

⁶⁶ Public Law 117–2.

⁶⁷ In Exchanges on the Federal platform, where most ARP changes to APTC eligibility were implemented on April 1, 2021, enrollees in this situation could change their QHP coverage through the 2021 special enrollment period; however, this enrollment window was not available through all Exchanges.

⁶⁴ Per IRS rules at 26 CFR 1.36B–3(f), the term “benchmark plan” is generally used to refer to the second lowest-cost silver plan, as described in section 1302(d)(1)(B) of the ACA (42 U.S.C. 18022(d)(1)(B)), offered to the taxpayer's coverage family through the Exchange for the rating area where the taxpayer resides.

⁶⁵ 84 FR 17526.

enrollees with household incomes above 400 percent of the FPL.

Exchange regulations at § 155.420(d)(6) provide several special enrollment periods for enrollees and dependents based on a determination that they are newly eligible or newly ineligible for APTC. These special enrollment periods vary in terms of the details of their qualifying events, but all of them are dedicated to ensuring that current Exchange enrollees and other qualified individuals who become newly eligible or ineligible for APTC have an opportunity to re-assess previous decisions about their QHP enrollment, or their decision not to enroll in a QHP, based on gaining or losing eligibility for financial assistance available to them to help lower premiums. Ensuring that Exchanges consistently apply eligibility factors for these special enrollment periods is important under a variety of circumstances. For example, regulations at § 155.420(d)(6)(i) and (ii) provide current Exchange enrollees with an opportunity to change to a different QHP if they are determined newly eligible or newly ineligible for APTC for themselves or their dependents (or have a change in eligibility for CSRs), because such a change may impact the coverage they prefer or the type of coverage they can afford.

Section 155.420(d)(6)(iv) allows individuals to enroll in Exchange coverage if they either experience a change in household income or move to a different state, and as a result become newly eligible for APTC, after they were previously ineligible for APTC solely because of a household income below 100 percent of the FPL and, during the same timeframe, were ineligible for Medicaid because they lived in a non-Medicaid expansion state. Like the other qualifying events at § 155.420(d)(6), this special enrollment period benefits individuals because it allows them to take advantage of APTC for which they were previously ineligible, and we do not believe that it would benefit individuals who newly qualify for APTC but who are not entitled to an APTC amount greater than zero dollars. We also believe that, regarding the group of potentially eligible individuals, increases from a household income of less than 100 percent of the FPL to a household income high enough to qualify for an APTC amount of zero dollars are relatively uncommon.

Finally, § 155.420(d)(6)(v) provides a pathway for individuals who had MEC for at least one of the past 60 days to enroll in Exchange coverage if they experience a decrease in household income and the Exchange newly

determines them eligible for APTC. This special enrollment period was established in the 2020 Payment Notice, specifically to permit individuals enrolled in coverage outside of the Exchange to enroll in Exchange coverage based on newly being able to access APTC.⁶⁸ Because this special enrollment period benefits qualified individuals by allowing them to obtain coverage that permits them to qualify for APTC, we do not believe that individuals who newly qualify for an APTC amount of zero dollars generally benefit from this special enrollment period, and they may even be harmed by changing plans mid-year because this would generally cause their deductible and other accumulators to be re-set.

We seek comment on this proposal, including from State Exchanges, regarding whether this definition of APTC eligibility reflects their current implementation of the special enrollment period qualifying events per § 155.420(d)(6), and if not, whether there are policy concerns about this clarification, or the burden of making related changes to Exchange operations. We also seek comment on whether we should provide Exchanges with flexibility in terms of when they are required to ensure that their operations reflect this definition, and whether Exchanges should be permitted to adopt a more inclusive definition, for example, to consider an individual to be newly eligible or ineligible for APTC for purposes of the special enrollment periods at § 155.420(d)(6) based on a change from a zero-dollar maximum APTC amount to APTC ineligibility for another reason per regulations at § 155.305(f).

Additionally, we seek comment on whether the clarification that a qualified individual, enrollee, or his or her dependent is considered APTC ineligible if they meet the requirements at § 155.305(f), but qualify for a maximum APTC amount of zero dollars, should be applied as proposed to all of the special enrollment period qualifying events at § 155.420(d)(6), or whether it should be limited to only apply to some of them. For example, we seek comment on whether we should only apply this clarification to the special enrollment periods at § 155.420(d)(6)(i) and (ii) and (iv) and (v), to permit individuals whose employer-sponsored coverage is no longer considered affordable or no longer meets the minimum value standard to qualify for a special enrollment period to enroll in Exchange coverage through § 155.420(d)(6)(iii) regardless of whether they qualify for an

APTC amount of greater than zero dollars.

C. Part 156—Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges

1. User Fee Rates for the 2022 Benefit Year (§ 156.50)

In the December 4, 2020 **Federal Register**, we published the proposed 2022 Payment Notice that proposed to reduce fiscal and regulatory burdens across different program areas and to provide stakeholders with greater flexibility. In the January 19, 2021 **Federal Register** (86 FR 6138), we published part 1 of the 2022 Payment Notice final rule that addressed a subset of the policies proposed in the proposed rule. That final rule, among other things, finalized the user fee rates for issuers offering QHPs through the FFE at 2.25 percent of total monthly premiums, and the user fee rate for issuers offering QHPs through SBE-FPs at 1.75 percent of total monthly premiums.

On January 28, 2021, President Biden issued E.O. 14009, “Strengthening Medicaid and the Affordable Care Act,”⁶⁹ directing HHS, and the heads of all other executive departments and agencies with authorities and responsibilities related to the ACA, to review all existing regulations, orders, guidance documents, policies, and any other similar agency actions to determine whether such agency actions are inconsistent with this Administration’s policy to protect and strengthen the ACA and to make high-quality health care accessible and affordable for every American. As part of this review, HHS examined policies and requirements under the proposed 2022 Payment Notice and part 1 of the 2022 Payment Notice final rule to analyze whether the policies under these rulemakings might undermine the Health Benefits Exchanges or the health insurance markets, and whether they may present unnecessary barriers to individuals and families attempting to access health coverage. HHS also considered whether to suspend, revise, or rescind any such actions through appropriate administrative action.

In compliance with E.O. 14009 and as a result of HHS’s review of the proposed 2022 Payment Notice and part 1 of the 2022 Payment Notice final rule, we have reanalyzed the additional costs of expanded services, such as consumer outreach and education in the FFE and SBE-FPs, and Navigators in the FFE in 2022. As explained in part 2 of the 2022

⁶⁸ 84 FR 17526.

⁶⁹ 86 FR 7793 (Feb. 2, 2021).

Payment Notice final rule,⁷⁰ we indicated the intention to propose to increase the user fee rates for the 2022 benefit year in future rulemaking. Therefore, in this rule, HHS proposes new QHP issuer user fee rates for the 2022 plan year: A new FFE user fee rate of 2.75 percent of total monthly premiums, and a new SBE-FP user fee rate of 2.25 percent of monthly premiums. These proposed rates are based on internal projections of federal costs for providing special benefits to FFE and SBE-FP issuers during the 2022 benefit year, taking into account estimated changes in parameters, specifically the increased funding to the FFE Navigator program and consumer outreach and education. HHS is of the view that pursuit of this proposal is necessary for consistency with E.O. 14009 and this Administration's goal of protecting and strengthening the ACA and making high-quality health care accessible and affordable for every American. We believe that expanded outreach and education will lead to broader risk pools, lower premiums, fewer uninsured consumers, and expanded use of Exchange services.

Section 1311(d)(5)(A) of the ACA permits an Exchange to charge assessments or user fees on participating health insurance issuers as a means of generating funding to support its operations. If a state does not elect to operate an Exchange or does not have an approved Exchange, section 1321(c)(1) of the ACA directs HHS to operate an Exchange within the state. Accordingly, in § 156.50(c), we specify that a participating issuer offering a plan through an FFE or SBE-FP must remit a user fee to HHS each month that is equal to the product of the annual user fee rate specified in the annual HHS notice of benefit and payment parameters for FFEs and SBE-FPs for the applicable benefit year and the monthly premium charged by the issuer for each policy where enrollment is through an FFE or SBE-FP. In addition, OMB Circular No. A-25 establishes federal policy regarding the assessment of user fee charges under other statutes, and applies to the extent permitted by law. Furthermore, OMB Circular No. A-25 specifically provides that a user fee charge will be assessed against each identifiable recipient of special benefits derived from federal activities beyond those received by the general public.

Activities performed by the federal government that do not provide issuers participating in an FFE with a special benefit, or that are performed by the federal government for all QHPs,

including those offered through State Exchanges, are not covered by this user fee. As in benefit years 2014 through 2021, issuers seeking to participate in an FFE in the 2022 benefit year will receive two special benefits not available to the general public: (1) The certification of their plans as QHPs; and (2) the ability to sell health insurance coverage through an FFE to individuals determined eligible for enrollment in a QHP.

a. FFE User Fee Rate

For the 2022 benefit year, issuers participating in an FFE will receive the benefits of the following federal activities:

Under Consumer Information and Outreach:

- Provision of consumer assistance tools;
- Consumer outreach and education; and
- Management of a Navigator program.

Under Health Plan Bid Review, Management, and Oversight:

- Certification processes for QHPs (including ongoing compliance verification, recertification, and decertification); and
- Regulation of agents and brokers.

Under Eligibility and Enrollment:

- Eligibility determinations; and
- Enrollment processes.

Activities through which FFE issuers receive a special benefit also include use of the Health Insurance and Oversight System (HIOS), which is partially funded by FFE and SBE-FP user fees, and the Multidimensional Insurance Data Analytics System (MIDAS) platform, which is fully funded by FFE and SBE-FP user fees. In light of E.O. 14009,⁷¹ published on January 28, 2021, the administration has a priority to increase accessibility and affordability of health care for every American. Consistent with increasing accessibility for every American an expanded budget for consumer support activities and Navigators was developed, and HHS conducted additional analytic review which revealed that the user fee rates established in part 1 of the 2022 Payment Notice final rule⁷² need to be increased to sustain essential Exchange-related activities. Based on this new analysis of the increased contract costs and projected premiums and enrollment (including changes in FFE enrollment resulting from anticipated establishment of State Exchanges or SBE-FPs in

certain states in which FFEs currently are operating) for the 2022 plan year, we are proposing to establish the FFE user fee for all participating FFE issuers at 2.75 percent of total monthly premiums.

We seek comment on this proposed FFE user fee rate for 2022.

b. SBE-FP User Fee Rate

As previously discussed, OMB Circular No. A-25 establishes federal policy regarding user fees, and specifies that a user charge will be assessed against each identifiable recipient for special benefits derived from federal activities beyond those received by the general public.

SBE-FPs enter into a Federal platform agreement with HHS to leverage the systems established for the FFEs to perform certain Exchange functions, and to enhance efficiency and coordination between state and federal programs. Accordingly, in § 156.50(c)(2), we specify that an issuer offering a plan through an SBE-FP must remit a user fee to HHS, in the timeframe and manner established by HHS, equal to the product of the monthly user fee rate specified in the annual HHS notice of benefit and payment parameters for the applicable benefit year and the monthly premium charged by the issuer for each policy where enrollment is through an SBE-FP, unless the SBE-FP and HHS agree on an alternative mechanism to collect the funds from the SBE-FP or state.

The benefits provided to issuers in SBE-FPs by the federal government include use of the federal Exchange information technology and call center infrastructure used in connection with eligibility determinations for enrollment in QHPs and other applicable state health subsidy programs, as defined at section 1413(e) of the ACA, and QHP enrollment functions under § 155.400. The user fee rate for SBE-FPs is calculated based on the proportion of FFE costs that are associated with the FFE information technology infrastructure, the consumer call center infrastructure, and eligibility and enrollment services, and allocating a share of those costs to issuers in the relevant SBE-FPs, as issuers in SBE-FPs receive those special benefits and will be able to access the increased consumer support and education.

Similar to the FFE, activities through which SBE-FP issuers receive a special benefit also include use of HIOS, which is partially funded by FFE and SBE-FP user fees, and the MIDAS platform, which is fully funded by FFE and SBE-FP user fees. In light of E.O. 14009,⁷³ the

⁷⁰ 86 FR 24140, 24288.

⁷¹ 86 FR 7793 (Feb. 2, 2021).

⁷² 86 FR 6138 at 6152.

⁷³ 86 FR 7793 (Feb. 2, 2021).

administration has a priority to increase accessibility and affordability of health care for every American. Consistent with increasing accessibility for every American an expanded budget for consumer support activities and Navigators was developed, and HHS conducted additional analytic review which revealed that the user fee rates established in part 1 of the 2022 Payment Notice final rule⁷⁴ need to be increased to sustain essential Exchange-related activities. Based on this new analysis of the increased contract costs and projected premiums and enrollment (including changes in FFE enrollment resulting from anticipated establishment of State Exchanges or SBE-FPs in certain states in which FFEs currently are operating) for the 2022 plan year, we are proposing to establish the SBE-FP user fee for all participating SBE-FP issuers at 2.25 percent of the monthly premium charged by the issuer for each policy under plans offered through an SBE-FP for benefit year 2022. We seek comment on the SBE-FP user fee rate for 2022.

c. 2023 Exchange DE Option User Fee Rate

In the January 19, 2021 **Federal Register** (86 FR 6138), we published part 1 of the 2022 Payment Notice final rule that codified § 155.221(j), which established a process for states to elect a new Exchange DE option. When finalizing this new Exchange option, we also finalized a 2023 user fee rate of 1.5 percent of the total monthly premiums charged by issuers for each policy in FFE and SBE-FP states that elect the Exchange DE option. As explained above, we propose to repeal the Exchange DE option, accordingly we also propose to repeal the user fee rate associated with § 155.221(j) for the FFE-DE and SBE-FP-DEs for 2023. We seek comment on this proposal.

2. Provision of EHB (§ 156.115)

We propose a technical amendment to § 156.115. Section 156.115(a)(3) provides that, to satisfy the requirement to provide EHB, a health plan must provide mental health and substance use disorder services, including behavioral health treatment services required under § 156.110(a)(5), in a manner that complies with the parity standards set forth in § 146.136, implementing the requirements under MHPAEA. Instead of referencing the regulation implementing MHPAEA, we propose to reference section 2726 of the PHS Act and its implementing regulations. We propose this change to

make clear that health plans must comply with all the requirements under MHPAEA, including any amendments to MHPAEA, such as those made by the Consolidated Appropriations Act, 2021,⁷⁵ in order to satisfy the EHB requirements.

3. Network Adequacy (§ 156.230)

As discussed in more detail in the preamble to § 155.20, on March 4, 2021, the United States District Court for the District of Maryland decided *City of Columbus v. Cochran*, 2021 WL 825973 (D. Md. Mar. 4, 2021). One of the policies the court vacated was the 2019 rule's elimination of the federal government's reviews of the network adequacy of QHPs offered through the FFE in certain circumstances by incorporating the results of the states' reviews.⁷⁶

As we explained in part 2 of the 2022 Payment Notice final rule,⁷⁷ we intend to implement the court's decision through rulemaking as soon as possible. However, we also will not be able to fully implement the aspects of the court's decision regarding network adequacy in time for issuers to design plans and for CMS to be prepared to certify such plans as QHPs for the 2022 plan year. We instead intend to address these issues in time for plan design and certification for plan year 2023. Specifically, with the rule vacated, HHS would need to set up a new network adequacy review process, and issuers would need sufficient time before the applicable plan year to assess that their networks meet the new regulatory standard, submit network information, and have the information reviewed by applicable regulatory authorities to have their plans certified as QHPs. Issuers might also have to contract with other providers in order to meet the standard. This is not feasible for the upcoming QHP certification cycle for the 2022 plan year, which began April 22, 2021. We plan to propose specific steps to address federal network adequacy reviews in future rulemaking. We request comments and input regarding how the federal government should approach network adequacy reviews.

⁷⁵ See section 203 of Title II of Division BB of the Consolidated Appropriations Act, 2021, Public Law 116-260 (Dec. 27, 2020).

⁷⁶ This policy was first announced in the 2018 Letter to Issuers in the Federally-facilitated Marketplaces, December 16, 2016, available at <https://wayback.archive-it.org/2744/20200125161008/> <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2018-Letter-to-Issuers-in-the-Federally-facilitated-Marketplaces-and-February-17-Addendum.pdf>. See also 83 FR 17024-17026.

⁷⁷ 86 FR 24140.

4. Segregation of Funds for Abortion Services (§ 156.280)

Section 1303 of the ACA, as implemented in 45 CFR 156.280, specifies standards for issuers of QHPs through the Exchanges that cover abortion services for which federal funding is prohibited. The statute and regulation establish that, unless otherwise prohibited by state law, a QHP issuer may elect to cover such abortion services. If an issuer elects to cover such services under a QHP sold through an individual market Exchange, the issuer must take certain steps to ensure that no PTC or CSR funds are used to pay for abortion services for which public funding is prohibited, as required by statute.

Upon consideration of federal district court decisions invalidating the policy, we are proposing to repeal the separate billing regulation at § 156.280(e)(2)(ii) that requires individual market QHP issuers to send a separate bill for that portion of a policy holder's premium that is attributable to coverage for abortion services for which federal funds are prohibited and to instruct such policy holders to pay for the separate bill in a separate transaction. Specifically, we propose to revert to and codify in amended regulatory text at § 156.280(e)(2)(ii) the prior policy announced in the preamble of the 2016 Payment Notice under which QHP issuers offering coverage of abortion services for which federal funds are prohibited have flexibility in selecting a method to comply with the separate payment requirement in section 1303 of the ACA. Under this proposal, individual market QHP issuers covering such abortion services would still be expected to comply with all statutory requirements in section 1303 of the ACA and all applicable regulatory requirements codified at § 156.280.

Since 1976, Congress has included language, commonly known as the Hyde Amendment, in the Labor, Health and Human Services, Education and Related Agencies appropriations legislation.⁷⁸ The Hyde Amendment, as currently in effect, permits federal funds subject to its funding limitations to be used for abortion services only in the limited cases of rape, incest, or if a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in

⁷⁸ Accordingly, the Hyde Amendment is not permanent federal law, but applies only to the extent reenacted by Congress from time to time in appropriations legislation.

⁷⁴ 86 FR 6138 at 6152.

danger of death unless an abortion is performed. Abortion coverage beyond those limited circumstances is subject to the Hyde Amendment's funding limitations which prohibit the use of federal funds for such coverage.

Section 1303 of the ACA outlines requirements that issuers of individual market QHPs covering abortion services for which federal funds are prohibited must follow to ensure compliance with these funding limitations. Section 1303(b)(2) prohibits QHPs from using any amount attributable to PTC (including APTC) or CSRs (including advance payments of those funds to an issuer, if any) for coverage of abortion services for which federal funds are prohibited. Under sections 1303(b)(2)(B) and (b)(2)(D) of the ACA, as implemented in § 156.280(e)(2)(i) and (e)(4), QHP issuers must collect a separate payment from each enrollee without regard to the enrollee's age, sex, or family status, for an amount equal to the greater of the actuarial value of coverage of abortion services for which public funding is prohibited, or \$1 per enrollee per month. Section 1303(b)(2)(D) of the ACA establishes certain requirements with respect to a QHP issuer's estimation of the actuarial value of abortion services for which federal funds are prohibited including that a QHP issuer may not estimate such cost at less than \$1 per enrollee, per month. Section 1303(b)(2)(C) of the ACA, as implemented at § 156.280(e)(3), requires that QHP issuers segregate funds for coverage of such abortion services collected from enrollees into a separate allocation account used to pay for such abortion services. Thus, if a QHP issuer disburses funds for an abortion for which federal funds are prohibited on behalf of an enrollee, it must draw those funds from the segregated allocation account.

Notably, section 1303 of the ACA does not specify the method a QHP issuer must use to comply with the separate payment requirement under section 1303(b)(2)(B)(i) of the ACA. In the 2016 Payment Notice, we provided guidance with respect to acceptable methods that an issuer of individual market QHPs could use to comply with the separate payment requirement.⁷⁹ We stated that QHP issuers could satisfy the separate payment requirement in one of several ways, including by sending the enrollee a single monthly invoice or bill that separately itemized the premium amount for coverage of abortion services for which federal funds are prohibited; sending the enrollee a separate monthly bill for these services; or sending the

enrollee a notice at or soon after the time of enrollment that the monthly invoice or bill will include a separate charge for such services and specify the charge. We also stated that an enrollee could make the payment for coverage of such abortion services and the separate payment for coverage of all other services in a single transaction.⁸⁰ On October 6, 2017, we released a bulletin that discussed the statutory requirements for separate payment, as well as this previous guidance on the separate payment requirement.⁸¹

The 2019 Program Integrity Rule⁸² prohibited the compliance options that the 2016 Payment Notice previously provided to QHP issuers with regard to the separate payment requirement. Specifically, the 2019 Program Integrity Rule finalized a policy requiring issuers of individual market QHPs offering coverage of abortion services for which federal funds are prohibited to send an entirely separate monthly bill to policy holders just for the portion of the premium attributable to coverage of such abortion services. QHP issuers were required to either send separate paper bills (which could be sent in the same envelope or mailing), or send separate bills electronically (which were required to be in separate emails or electronic communications). The separate billing regulation also required also required QHP issuers to instruct the policy holder to pay for the portion of their premium attributable to coverage of abortion services for which federal funds are prohibited through a separate transaction from any payment made for the portion of their premium not attributable to this coverage. It also required QHP issuers to make reasonable efforts to collect the payments separately. QHP issuers were to begin complying with these billing requirements on or before the QHP issuer's first billing cycle following June 27, 2020. Although HHS recognized that the previous methods of itemizing or providing advance notice about the amounts noted as permissible in the preamble of the 2016 Payment Notice arguably identifies two 'separate' amounts for two separate purposes, HHS also reasoned that the separate billing policy would better align the regulatory requirements for QHP issuer billing of enrollee premiums with the intent of the separate payment

requirement in section 1303 of the ACA.⁸³

HHS announced in the 2019 Program Integrity Rule that it would exercise enforcement discretion to mitigate risk of inadvertent coverage terminations that might result from enrollee confusion in connection with receiving two separate bills for one insurance contract. HHS explained that it would not take enforcement action against a QHP issuer that implemented a policy under which the issuer would not place an enrollee into a grace period and would not terminate QHP coverage based solely on the policy holder's failure to pay the separate bill. The 2019 Program Integrity Rule provided that HHS was adopting this enforcement posture effective June 27, 2020.

In response to the proposal to adopt the separate billing requirement finalized in the 2019 Program Integrity Rule, HHS also received comments expressing concern that lack of transparency into whether QHPs provided coverage of abortion services for which federal funds are prohibited presented the risk that consumers could unknowingly purchase such coverage. To address this risk, HHS announced that as of the effective date of the final rule, February 25, 2020, it would not take enforcement action against QHP issuers that allowed enrollees to opt out of coverage of such abortion services by not paying the separate bill for such services (the opt-out non-enforcement policy). The opt-out non-enforcement policy effectively gave issuers the flexibility to modify the benefits of a plan during a plan year based on an enrollee's desire to opt out of a plan's coverage of such abortion services.

In light of the immediate need for QHP issuers to divert resources to respond to the COVID-19 PHE, HHS published an interim final rule with comment in May 2020 for Medicare and Medicaid Programs, Basic Health Programs and Exchanges (85 FR 27550) ("May 2020 IFC"). The rule delayed by 60 days the date when individual market QHP issuers would be required to begin separately billing policy holders. As finalized at § 156.280(e)(2)(ii), QHP issuers were expected to comply with the separate billing regulation beginning on or before the QHP issuer's first billing cycle following August 26, 2020. The May 2020 IFC noted that a 60-day delay was justified in light of the ongoing litigation in the federal courts of Maryland, Washington, and California challenging the separate billing regulation. The May 2020 IFC also noted that the extended

⁸⁰ 80 FR 10750 (February 27, 2015).

⁸¹ CMS Bulletin Addressing Enforcement of Section 1303 of the Patient Protection and Affordable Care Act (October 6, 2017), available at <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Section-1303-Bulletin-10-6-2017-FINAL-508.pdf>.

⁸² 84 FR 71674 (December 27, 2019).

⁸³ 84 FR 71674, 71693 (December 27, 2019).

⁷⁹ 80 FR 10750 (February 27, 2015).

compliance deadline would only apply to the non-enforcement policy under which issuers would have flexibility to refrain from triggering grace periods or coverage terminations where a policy holder failed to pay the separate monthly bill, delaying when this enforcement posture would become available by 60 days (to August 26, 2020).

On April 9, 2020, the United States District Court for the Eastern District of Washington issued an opinion declaring the separate billing regulation invalid in the State of Washington.⁸⁴ The district court specifically found that the separate billing regulation was in conflict with Washington's "Single-Invoice Statute,"⁸⁵ which requires health insurance issuers in the state to bill enrollees using a single invoice. The district court held that the separate billing regulation did not preempt Washington's Single-Invoice Statute.

On July 10, 2020, the United States District Court for the District of Maryland found the separate billing regulation to be contrary to section 1554 of the ACA and arbitrary and capricious under the Administrative Procedure Act, thus declaring it invalid and unenforceable nationwide.⁸⁶ The district court found the separate billing regulation to be in conflict with section 1554 of the ACA, which, among other key provisions, prohibits the Secretary from promulgating regulations that create any unreasonable barriers to obtaining appropriate medical care or impede timely access to health care services. The district court concluded that the policy imposed an unreasonable barrier because it would make it harder for enrollees to pay for insurance because they must keep track of two separate bills, which is likely to cause confusion and might lead to some enrollees losing health insurance. The district court also held the separate billing regulation to be arbitrary and capricious, finding that HHS failed to provide a reasoned explanation for abandoning the policy that existed prior to the adoption of the current separate billing regulation in the 2019 Program Integrity Rule. The district court also held that the implementation deadline was arbitrary and capricious because HHS failed to consider and adequately address specific, contrary evidence from regulated stakeholders that the implementation deadline for compliance with the separate billing

regulation was unreasonable and would not provide QHP issuers with sufficient time to comply.

On July 20, 2020, the United States District Court for the Northern District of California issued an opinion⁸⁷ holding that the separate billing regulation was arbitrary and capricious, setting it aside nationwide. The district court held that the required mid-year implementation date for issuers to comply with the separate billing regulation would cause substantial transactional costs to states, issuers, and enrollees without any corresponding benefit. The court further found that the 2019 Program Integrity Rule lacked a reasoned explanation for deviating from the prior acceptable methods available to QHP issuers for compliance with the separate payment requirement and for departing from industry billing practice.

HHS initially appealed all three decisions, but those appeals have been placed on hold following the recent change in administration.

The district courts in Maryland and California vacated the 2019 Program Integrity Rule's separate billing regulation in July 2020, in advance of the postponed compliance deadline of August 26, 2020. As such, the timing of the courts' actions could have dissuaded issuers from assuming further costly administrative and operational burdens that would have been required to build the separate billing policy into their billing and IT systems. Further, as the courts' nationwide invalidation of the policy prevented HHS from requiring initial implementation of the separate billing regulation, the potential consumer confusion over payment obligations, which could have inadvertently led to non-payment of enrollee premium and subsequent termination of consumer coverage, was also avoided. We believe it is prudent to reconsider the separate billing policy and its potential effects on consumer coverage.

In light of these developments, and upon consideration of court decisions invalidating the policy, we have reassessed the value of the separate billing policy and no longer believe it is justified in light of the high burden it would impose on issuers, states, Exchanges, and consumers, as well as the high likelihood of consumer confusion and unintended losses of coverage. Nor do we believe section 1303 of the ACA restricts issuers offering coverage of abortion services for which federal funds are prohibited to

collect the required separate payment through a separate bill and instruct consumers to pay for such bill in a separate transaction. Rather, section 1303 of the ACA outlines requirements that issuers of individual market QHPs covering such abortion services must follow to ensure that no public funding is utilized for coverage of such abortion services, including requiring issuers to collect separate payments for this portion of the premium, to segregate the funds, and deposit such funds into separate allocation accounts. As the 2019 Program Integrity Rule acknowledged, section 1303 of the ACA does not specify the method a QHP issuer must use to comply with the separate payment requirement.⁸⁸

To address these concerns, we are proposing amendments to § 156.280(e)(2)(ii) to revert to and codify the policy previously adopted in the 2016 Payment Notice such that QHP issuers offering coverage of abortion services for which federal funds are prohibited may have flexibility in selecting a reasonable method to comply with the section 1303 separate payment requirement. If finalized, acceptable methods for satisfying the separate payment requirement would be outlined at § 156.280(e)(2)(ii) and would include sending the policy holder a single monthly invoice or bill that separately itemizes the premium amount for coverage of such abortion services; sending the policy holder a separate monthly bill for these services; or sending the policy holder a notice at or soon after the time of enrollment that the monthly invoice or bill will include a separate charge for such services and specify the charge.

We are also proposing a technical change to the section heading of § 156.280 to more accurately reflect its contents if the revisions to rule text under § 156.280 are finalized. We propose that it would instead read, "Segregation of funds for abortion services." We seek comment on these proposals.

Under the proposed amendments to the regulatory text at § 156.280(e)(2)(ii), issuers would no longer be required to send separate paper bills or separate electronic communications. Nor would an issuer electing to send separate bills, or utilizing any of the proposed acceptable methods for collecting the separate payment, be required to instruct consumers to pay for the portion of their premium attributable to coverage of abortion services for which federal funds are prohibited in a

⁸⁴ *Washington v. Azar*, 461 F. Supp. 3d 1016 (E.D. Wash. 2020).

⁸⁵ Wash. Rev. Code § 48.43.074.

⁸⁶ *Planned Parenthood of Maryland, Inc. v. Azar*, No. CV CCB-20-00361 (D. Md. July 10, 2020); 5 U.S.C. 706.

⁸⁷ *California v. U.S. Dep't of Health & Hum. Servs.*, 473 F. Supp. 3d 992 (N.D. Cal. July 20, 2020).

⁸⁸ 84 FR 71674, 71683.

separate transaction, or to make efforts to collect these payments separately.

If the proposed amendments to § 156.280 are finalized, we anticipate most issuers covering abortion services for which federal funds are prohibited will decline to send two separate monthly bills, and will choose to collect separate payments by one of the other proposed acceptable methods, as those alternatives minimize administrative complexity for issuers, align with industry billing practice, are less costly and administratively burdensome, and promote a more seamless consumer billing and payment experience. We would encourage any issuer electing to send two separate monthly bills to do so in a manner that minimizes consumer confusion and promotes continuity of coverage. For example, if an issuer still chooses to send two separate monthly bills, we encourage issuers to include both bills in the same mailing, explain on both bills that the total premium due is inclusive of the amount attributable to coverage of such abortion services, and explain that the consumer may pay for both bills in a single transaction. We also encourage issuers sending separate bills to explain to the consumer that non-payment of any premium due, including for the portion of premium attributable to such abortion services, would continue to be subject to state and federal rules regarding grace periods to mitigate risk of inadvertent loss of coverage from failure to pay a portion of the premium due.

Reverting to the proposed policy would provide issuers greater billing flexibility and allow issuers to bill using one of the proposed acceptable methods that would eliminate all risk of inadvertent coverage terminations that could result from consumer confusion due to receiving two monthly bills (one for a miniscule amount) in connection with one insurance policy. If the proposed policies in this rule are finalized, we would discontinue the non-enforcement policies we adopted in the 2019 Program Integrity Rule and the May 2020 IFC, described above. These non-enforcement policies, in large part, were intended to mitigate potential coverage losses resulting from enrollee confusion that leads to enrollees' failures to pay the separate, small monthly bill covering abortion services for which federal funds are prohibited.

In announcing these non-enforcement policies, HHS also noted in the 2019 Program Integrity Rule that the opt-out non-enforcement policy was intended to address commenter concerns regarding insufficient transparency into whether QHPs include coverage of abortion services for which federal funds are

prohibited and the risk that consumers could unknowingly purchase QHPs that include such coverage. As part of this discussion, HHS noted the steps already taken to improve transparency regarding QHP offerings by making it easier for consumers to select QHPs that they believe are best suited to their needs and preferences. For instance, HHS noted that such information is available during plan selection to more readily identify QHPs that offer coverage of such abortion services.⁸⁹ This information continues to be available on *HealthCare.gov*, providing consumers with the requisite information to make an informed choice about their plan selections regarding coverage of such abortion services. Although we acknowledge that there are some states where there may be no QHP available on the Exchange that omits coverage for such abortion services, such plan availability is subject to state law and issuer choice in plan design as permitted under section 1303 of the ACA.

Section 1303(b)(1)(A)(ii) specifies that an issuer shall determine whether or not the plan provides coverage for abortion services for which federal funds are prohibited for the applicable plan year, expressly providing that issuers are able to determine whether to offer coverage for such abortion services, subject to state law. We are of the view that continuing an opt-out non-enforcement policy would conflict with this flexibility in issuer plan design provided under section 1303. The opt-out non-enforcement policy also conflicts with § 147.106(e)(1), which specifies that only at the time of coverage renewal may issuers modify the health insurance coverage for a product offered to a group health plan or an individual, as applicable. It also specifies that any such modification in the individual market must be consistent with State law and be effective uniformly for all individuals with that product. Further, the United States District Court for the Northern District of California cited the opt-out non-enforcement policy in finding that the 2019 Program Integrity Rule lacked a reasoned explanation for deviating from the prior acceptable methods available to QHP issuers for compliance with the separate payment

requirement.⁹⁰ The court explained that inclusion of the opt-out non-enforcement policy, which was not subject to public comment, supported the court's conclusion that HHS changed its prior policy without affording any reasoned explanation for the change. For these reasons, and given that the separate billing requirements finalized in the 2019 Program Integrity Rule have been invalidated, these non-enforcement policies are no longer necessary or feasible long-term, and are therefore discontinued.

We note that individual market QHP issuers covering abortion services for which federal funds are prohibited would still be expected under these proposals to comply with section 1303 of the ACA and all applicable requirements codified at § 156.280. This includes collecting a separate payment from each policy holder per month for an amount equal to the greater of \$1 or the actuarial value of coverage of abortion services for which federal funds are prohibited, continuing to ensure that no federal funding is used to pay for coverage of such abortion services, submitting a segregation plan to the relevant state insurance regulator, and continuing to segregate funds for coverage of such abortion services collected from policy holders into a separate allocation account that is to be used to pay for such abortion services.

We believe the proposed changes to § 156.280(e)(2)(ii) offer issuers options for meaningful compliance with section 1303 and ensure appropriate segregation of funds, without imposing the operational and administrative burdens of the separate billing regulation and without causing additional consumer confusion and unintended losses of coverage. The preamble to the 2019 Program Integrity Rule acknowledged that receipt by a QHP issuer of a single premium payment for the entirety of the policy holder's coverage including abortion services for which federal funds are prohibited did not preclude QHP issuer compliance with the section 1303 separate payment requirement. Although the separate billing regulation required QHP issuers to bill separately and make reasonable efforts to collect the payment separately, it also specified that QHP issuers would not be permitted to refuse a combined payment or terminate the policy on the basis of combined payment. The separate billing policy is ultimately nonessential to QHP issuer compliance with the separate

⁸⁹ Frequently Asked Questions for Agents, Brokers, and Assistants Providing Consumers with Details on Plan Coverage of Certain Abortion Services (November 21, 2018), available at <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQ-on-Providing-Consumers-with-Details-on-Plan-Coverage-of-Certain-Abortion-Services.pdf>.

⁹⁰ *California v. U.S. Dep't of Health & Hum. Servs.*, 473 F. Supp. 3d 992, 1003 (N.D. Cal. July 20, 2020) (citing *Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117, 2125 (2016)).

payment requirement in section 1303 of the ACA. Upon receiving a single premium payment inclusive of the portion of premium attributable to coverage of such services, the QHP issuer may treat that portion as a separate payment and disaggregate the amounts into the separate allocation accounts, consistent with § 156.280(e)(2)(iii). Therefore, we believe requiring QHP issuers to acquire the separate payment through sending separate bills and instructing consumers to pay in separate transactions is more restrictive than necessary, especially in light of the issuer and stakeholder burden and adverse consumer impacts the separate billing regulation could impose.

The 2019 Program Integrity Rule detailed the anticipated financial and operational burdens from the separate billing regulation. Those burdens are discussed in further detail in section V, “Collection of Information Requirements,” and section VII, “Regulatory Impact Analysis,” of that rule. Those burdens included one-time cost estimates for issuers and state Exchanges performing premium billing and payment processing for operational changes such as implementation of the technical build to implement the necessary system changes to support separate billing and receipt of separate payments, which would require significant changes to current billing practice and pose increased challenges given the mid-plan year implementation timeline. The anticipated burden also included ongoing annual costs for sending a separate bill to impacted enrollees, associated record keeping, customer service, and compliance, as well as annual materials costs related to printing of and sending the separate bill. We also acknowledged that the separate billing regulation would impose burden on State Exchange operations due to one-time technical changes such as updating online payment portals to accept separate payments and updating enrollment materials, as well as ongoing annual costs associated with increased customer service, outreach, and compliance.

The Program Integrity Rule also projected that FFEs would incur additional costs due to one-time technical changes and increased call volumes and additional customer services efforts. We also stated that QHP issuers were likely to consider these new costs when setting actuarially sound rates and that this would likely lead to higher premiums for enrollees. We also anticipated increased costs to consumers for the time required to read and understand the separate bills and to

seek help from customer service if necessary, and additional time to read and send separate payments in subsequent months. In total, the projected burden to all issuers, states, State Exchanges performing premium billing and payment processing, the FFEs, and consumers totaled \$546.1 million in 2020, \$232.1 million in 2021, \$230.7 million in 2022, and \$229.3 million annually in 2023 and onwards. It was also anticipated that QHP issuers might consider these new costs when setting actuarially sound rates and that this could lead to higher premiums for enrollees.

Upon reassessing the burden, we also believe the consumer confusion and new logistical obstacles due to the separate billing regulation would disproportionately burden communities who already face barriers to accessing care, such as individuals with limited English proficiency (LEP), individuals with disabilities, rural residents, those with inconsistent or no access to the internet, those with low levels of health care system literacy, and individuals within other marginalized communities. Failure to pay the separate bill entirely due to consumer confusion could also lead to a complete loss of coverage, further exacerbating existing health disparities and jeopardizing health outcomes. The 2019 Program Integrity Rule also acknowledged that the high burden associated with the separate billing regulation might result in issuers withdrawing coverage of abortion services for which federal funds are prohibited altogether to avoid the associated burden, requiring some enrollees to pay for these services out-of-pocket. Based on a 2014 study, the average costs to patients for first-trimester abortion care was \$461, and anywhere from \$860 to \$1,874 for second-trimester abortion care.⁹¹ Transferring these costs to enrollees could disproportionately impact low-income women who may already face barriers to accessing quality health care due to their socioeconomic status, gender, sexual orientation, nationality, or race. We believe proposing repeal of the separate billing regulation would remove these burdensome requirements and obstacles, promoting health equity.

The 2019 Program Integrity Rule reasoned that separate billing was justified to better align with the Congressional intent of section 1303. Although we still believe sending a

separate bill to enrollees for these services is one way in which an issuer may satisfy the separate payment requirement, we no longer believe it is the only method contemplated by the plain reading of section 1303 and believe restricting the acceptable methods for collecting these payments was unnecessary, especially in light of the substantial anticipated burden from the separate billing regulation, the risk of inadvertent coverage terminations that could result from consumer confusion due to receiving two monthly bills, the stakeholder reliance on the prior acceptable methods, and federal district court concerns with barriers to appropriate and timely medical care as well as a lack of corresponding benefits. Consistent with federal district court orders in Maryland and California, we revisited the section 1303 provision in which the separate payment requirement is contained, which is titled “Establishment of allocation accounts,” and is in a larger section titled “Prohibition on the use of Federal funds.”⁹² These sections detail issuer requirements for calculating the actuarial value for the portion of the premium attributable to coverage of abortion services for which federal funds are prohibited, requires issuers to collect separate payments for this portion of the premium, to segregate the funds, and deposit such funds into separate allocation accounts. Notably, these sections do not require that issuers must satisfy these requirements by separately billing policy holders or instructing them to pay in separate transactions.

Section 1303 does not specify the method a QHP issuer must use to collect the separate payment.⁹³ We are therefore proposing a policy that allows issuers to satisfy the separate payment requirement through methods consistent with section 1303 of the ACA, that imposes no more burden on issuers, states, Exchanges, and consumers than is necessary, and that removes unreasonable barriers to obtaining appropriate medical care.

We seek comment on the proposal to repeal the separate billing regulation and amend the regulatory text at § 156.280(e)(2)(ii) to codify the prior policy in the 2016 Payment Notice for satisfying the separate payment requirement in section 1303 of the ACA.

⁹¹ See Roberts, Sarah C.M., Heather Gould, Katrina Kimport, Tracy A. Weitz, and Diana Greene Foster. “Out-of-Pocket Costs and Insurance Coverage for Abortion in the United States.” *Women’s Health Issues*, vol. 24, no. 2 (2014): e211–e218.

⁹² Section 1303(b)(2) and (b)(2)(B) of the ACA.

⁹³ 84 FR 71674, 71683.

IV. Provisions of the Proposed Rule for Section 1332 Waivers—Department of Health and Human Services and Department of the Treasury

A. 31 CFR Part 33 and 45 CFR Part 155—Section 1332 Waivers

Section 1332 of the ACA permits states to apply for a section 1332 waiver to pursue innovative strategies for providing their residents with access to higher value, more affordable health coverage.

Under section 1332, the Secretary of HHS and the Secretary of the Treasury (collectively, the Secretaries) may exercise their discretion to approve a request for a section 1332 waiver only if the Secretaries determine that the proposal for the section 1332 waiver meets the following four requirements, referred to as the statutory guardrails: (1) The proposal will provide coverage that is at least as comprehensive as coverage defined in section 1302(b) of the ACA and offered through Exchanges established under title I of the ACA, as certified by the Office of the Actuary of CMS, based on sufficient data from the state and from comparable states about their experience with programs created by the ACA and the provisions of the ACA that would be waived; (2) the proposal will provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable for the state's residents as would be provided under title I of the ACA; (3) the proposal will provide coverage to at least a comparable number of the state's residents as would be provided under title I of the ACA; and (4) the proposal will not increase the federal deficit. The Secretaries retain their discretionary authority under section 1332 to deny waivers when appropriate given consideration of the application as a whole, even if an application meets the four statutory guardrails.

The Departments are also responsible under section 1332 for monitoring an approved section 1332 waiver's compliance with the statutory guardrails and for conducting evaluations to determine the impact of the section 1332 waiver. Specifically, section 1332 requires that the Secretaries provide for and conduct periodic evaluations of approved section 1332 waivers.⁹⁴ The Secretaries must also provide for a process under which states with approved section 1332 waivers must submit periodic reports concerning the implementation of the state's waiver program.⁹⁵

In October 2018, the Departments issued the 2018 Guidance,⁹⁶ which provided additional guidance for states that wish to submit section 1332 waiver proposals regarding the Secretaries' application review procedures, pass-through funding determinations, certain analytical requirements, and operational considerations.⁹⁷ The 2018 Guidance also included information regarding how the Departments will apply and interpret the section 1332 statutory guardrails when evaluating waiver applications. Furthermore, in part 1 of the 2022 Payment Notice final rule,⁹⁸ the Departments finalized the codification of many of the major policies and interpretations outlined in the 2018 Guidance into the text of relevant section 1332 implementing regulations.

On January 28, 2021, President Biden issued E.O. 14009 directing the Secretaries and the heads of all other executive departments and agencies with authorities and responsibilities related to Medicaid and the ACA to review all existing regulations, orders, guidance documents, policies, and any other similar agency actions to determine whether such agency actions are inconsistent with the policy set forth in section 1 of E.O. 14009.⁹⁹ As part of this review, E.O. 14009 directed agencies to look at demonstrations and waivers, as well as demonstration and waiver policies that may reduce coverage under or otherwise undermine Medicaid or the ACA. As such, the Departments have reviewed both the 2018 Guidance and the policies implemented in part 1 of the 2022 Payment Notice final rule on section 1332 waivers to determine whether they are inconsistent with the policy intention of E.O. 14009 to protect and strengthen Medicaid and the ACA and to make high-quality health care accessible and affordable for every American.

In addition, on January 20, 2021, President Biden issued the Executive Order, "On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government" (E.O. 13985),¹⁰⁰ directing that as a policy matter the federal

government should pursue a comprehensive approach to advancing equity for all, including people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality. As such, the Departments have also reviewed the 2018 Guidance and the policies implemented in part 1 of the 2022 Payment Notice final rule on section 1332 waivers to assess whether, and to what extent, these policies may perpetuate systemic barriers to opportunities and benefits for people of color and other underserved groups.

Upon review, the Departments have determined that the 2018 Guidance and the policies implemented in part 1 of the 2022 Payment Notice final rule on section 1332 waivers are generally inconsistent with the policy intentions of E.O. 14009 and E.O. 13985. As explained in part 1 of the 2022 Payment Notice final rule and later in this proposed rule, the majority of commenters on both the 2018 Guidance and the 2022 Payment Notice Proposed Rule noted that both the 2018 Guidance and the incorporation of its guardrail interpretations into regulations could result in the Departments approving section 1332 waivers that would result in fewer residents in those states enrolling in comprehensive and affordable coverage, and that those interpretations do not represent the best fulfillment of congressional intent behind the statutory guardrails. After further consideration of these comments as part of the Departments' reviews under E.O. 14009 and E.O. 13985, the Departments propose in this rule to modify 31 CFR 33.108(f)(3)(iv)(A–C) and 45 CFR 155.1308(f)(3)(iv)(A–C) to generally remove the language incorporating the interpretation of the statutory guardrails first set forth in the 2018 Guidance into the text of relevant section 1332 regulations that were finalized in part 1 of the 2022 Payment Notice final rule. In addition, the Departments propose new interpretations and proposed amendments to regulations to provide supplementary information about the requirements that must be met for the approval of a section 1332 waiver, the Secretaries' application review procedures, certain analytical requirements, operational considerations, the calculation of pass-through funding, and amendments and extensions of approved waiver plans. These new proposed policies and interpretations, if finalized, would supersede those outlined in the 2018 Guidance and, where applicable, those

⁹⁶ 83 FR 53575 (Oct. 24, 2018).

⁹⁷ The 2018 Guidance superseded guidance issued by the Departments in December 2015, which similarly provided information regarding the Secretaries' application review procedures, pass-through funding determinations, certain analytical requirements, operational considerations, and interpretations of the statutory guardrails. See 80 FR 78131, available at <https://www.govinfo.gov/content/pkg/FR-2015-12-16/pdf/2015-31563.pdf>.

⁹⁸ See 86 FR 6138.

⁹⁹ 86 FR 7793 (Feb. 2, 2021).

¹⁰⁰ 86 FR 7009 (Jan. 25, 2021).

⁹⁴ See section 1332(a)(4)(B)(v) of the ACA.

⁹⁵ See section 1332(a)(4)(B)(iv) of the ACA.

captured in the current section 1332 implementing regulations as finalized in part 1 of the 2022 Payment Notice final rule.

The Departments are of the view that rescinding the 2018 Guidance, repealing the previous codification of its guardrail interpretations in part 1 of the 2022 Payment Notice final rule, and proposing new policies and interpretations aligns with the Administration's goals to strengthen the ACA and increase enrollment in comprehensive, affordable health coverage among the remaining underinsured and uninsured. These proposals would further advance this Administration's goal to increase access to coverage in that it would empower states to develop innovative health coverage options, through section 1332 waivers, that best fit the states' individual needs and provide coverage to their residents. The proposals are also intended to provide more information and clarity regarding the interpretations, processes and procedures the Departments would apply when reviewing new waiver applications and waiver amendment and extension requests, as well as making pass-through funding determinations for approved waivers. All of these proposals are designed to align with the Administration's commitment to protect and expand Americans' access to high-quality, comprehensive and affordable health care coverage and to ensure that systemic barriers to opportunities and benefits for people of color and other underserved groups are not perpetuated. In addition, these proposals would further support the Administration's efforts to build on the ACA to meet the health care needs created by the COVID-19 PHE, reduce individuals' health care costs, and make our health care system less complex to navigate. Through section 1332 waivers, the Departments aim to assist states with developing health insurance markets that expand coverage, lower costs, and make high-quality health care accessible for every American.¹⁰¹ In light of E.O. 13985, the Departments also encourage states to develop waiver proposals that diminish barriers to opportunities and benefits such as health insurance coverage for people of color and other underserved groups. For example, states may include waiver programs that increase plan options for comprehensive coverage, reduce premiums, improve

affordability, as well as address social determinants of health.

As under similar waiver authorities,¹⁰² the Secretaries reserve the right to further evaluate an approved waiver and suspend or terminate an approved waiver, in whole or in part, any time before the date of expiration, if the Secretaries determine that the state materially has failed to comply with the terms and conditions of the waiver or the section 1332 guardrails,¹⁰³ laws and regulations, unless specifically waived.¹⁰⁴ And they must come into compliance with any changes in federal law or regulations affecting section 1332 waivers, unless the provision being changed is expressly waived.¹⁰⁵

1. Coordinated Waiver Process (31 CFR 33.102 and 45 CFR 155.1302)

Regulations at 31 CFR 33.102 and 45 CFR 155.1302 permit, but do not require, states to submit a single application for a section 1332 waiver and a waiver under one or more of the existing waiver processes applicable under titles XVIII, XIX, and XXI of the Social Security Act (the Act), or under any other federal law relating to the provision of health care items or services, provided that the application is consistent with the procedures outlined in the 2012 Final Rule,¹⁰⁶ the procedures for demonstrations under section 1115 of the Act, if applicable, and the procedures under any other applicable federal law or regulations under which the state seeks a waiver.

Similar to the policies outlined in the 2018 Guidance, as well as in guidance previously published in December 2015 (2015 Guidance), the Departments' determination of whether a section 1332 waiver proposal satisfies the statutory guardrails set forth in section 1332 takes into consideration the projected impact of waivers of certain ACA provisions made pursuant to the section 1332 waiver. The Departments also consider related changes to the state's health care system that, under state law, are contingent only on the approval of the section 1332 waiver. For example, the Departments, in making their determination, would take into account the impact of a new, related state-run health benefits program that, under

legislation enacted by the state, would be implemented only if the section 1332 waiver were approved.

The Departments are not proposing any regulatory changes to 31 CFR 33.102 and 45 CFR 155.1302, but are reiterating through this preamble the proposed policy relating to the coordinated waiver process so states understand the process for submission and review of a coordinated waiver. The Departments are of the view that the policies outlined in this proposed rule, which are in line with both the 2018 and 2015 Guidance, further advance E.O. 14009 because these policies aim to protect and strengthen Medicaid and the ACA and to make high-quality health care accessible and affordable for every American by specifying how a state may submit a coordinated waiver. Specifically, under this proposal the Departments would not consider the potential impact of policy changes that are contingent on further state action, such as state legislation that is proposed but not yet enacted that would be in effect during the timeframe for the section 1332 waiver. For example, the Departments would not consider the potential impact of state legislation to expand Medicaid that is not yet enacted. The Departments would also not consider the impact of changes contingent on other federal determinations, including approval of federal waivers (such as waivers under titles XVIII, XIX, or XXI of the Act) pursuant to statutory provisions other than section 1332 of the ACA. Therefore, under this proposal, the Departments would not take into account proposed changes to Medicaid or CHIP state plans that require separate federal approval, such as changes in coverage or federal Medicaid or CHIP spending that would result from a proposed section 1115 demonstration, regardless of whether the section 1115 demonstration proposal is submitted as part of a coordinated waiver application with a section 1332 waiver. Savings accrued under either proposed or current Medicaid or CHIP section 1115 demonstrations would not be factored into the assessment of whether a proposed section 1332 waiver meets the deficit neutrality requirement. The Departments' determination also would not take into account any proposed changes to the Medicaid or CHIP state plan that are subject to federal approval.

Under this proposal, the Departments would, however, take into account changes in Medicaid or CHIP coverage or in federal spending on Medicaid or CHIP that would result directly from the proposed waiver of ACA provisions pursuant to section 1332, holding state

¹⁰² Section 1115 Waiver Demonstrations have similar authority.

¹⁰³ See 31 CFR 33.120(d) and 45 CFR 155.1320(d) and STC 16 at <https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/1332-NH-Approval-STCs.pdf>.

¹⁰⁴ See 31 CFR 33.120(a)(1) and 45 CFR 155.1320(a)(1).

¹⁰⁵ *Ibid.*

¹⁰⁶ See 77 FR 11700, <https://www.govinfo.gov/content/pkg/FR-2012-02-27/pdf/2012-4395.pdf>.

¹⁰¹ <https://www.whitehouse.gov/briefing-room/statements-releases/2021/02/15/statement-by-president-joe-biden-on-the-2021-special-health-insurance-enrollment-period-through-healthcare.gov/>.

Medicaid and CHIP policies constant. For example, if a state section 1332 waiver would result in more or less Medicaid spending, this impact would be considered in the Departments assessment of the section 1332 waiver for the deficit neutrality guardrail.

Nothing in this proposed rule alters a state's authority to make changes to its Medicaid and CHIP policies consistent with applicable law. In addition, this proposed rule does not alter the Secretary of HHS' authority or CMS' policy regarding review and approval of section 1115 demonstrations, and states should continue to work with the Center for Medicaid and CHIP Services (CMCS) on issues relating to section 1115 demonstrations or other Medicaid or CHIP authorities. A state may submit a coordinated waiver application as provided in 31 CFR 33.102 and 45 CFR 155.1302. The waiver applications included in a coordinated waiver application would each be reviewed by the applicable agency component independently according to the federal laws and regulations that apply to each waiver application.

As the Departments receive and review waiver proposals, the Departments will continue to examine the types of changes, contingent on federal approval that will be considered in reviewing section 1332 waiver applications.

2. Section 1332 Application Procedures—Application Timing (31 CFR 33.108(b) and 45 CFR 155.1308(b))

Consistent with regulations at 31 CFR 33.108(b) and 45 CFR 155.1308(b), states are required to submit initial section 1332 waiver applications sufficiently in advance of the requested waiver effective date to allow for an appropriate implementation timeline. In this proposed rule, the Departments are not proposing any regulatory changes to 31 CFR 33.108(b) and 45 CFR 155.1308(b), but are proposing through preamble policies related to the timing of initial section 1332 waiver application submissions that are consistent with policies outlined in the 2018 Guidance. These proposed policies are intended to help states understand the requirements for submitting a section 1332 waiver application sufficiently in advance of the requested waiver effective date to allow for enough time for federal review and to maintain smooth operations of the Exchange in the state. In addition, these proposed policies are intended to help states allow for enough time for implementation of their section 1332 waiver plan, and for affected stakeholders, including issuers of health insurance plans that may be affected by

the waiver plan, to take necessary actions based on the approval of the waiver plan, particularly when the waiver impacts premium rates, if approved. As discussed elsewhere in this proposed rule, some section 1332 waiver plans may require operational changes or accommodations to the federal information technology platform or its operations, and these proposed policies would help ensure the state and the Departments are able to sufficiently plan in advance of the effective waiver date. The proposed policies are as follows:

The Departments strongly encourage states interested in applying for section 1332 waivers, including coordinated waivers with section 1115 demonstrations, to engage with the Departments promptly for assistance in formulating an approach to a section 1332 waiver that meets the requirements of section 1332.

In order to help ensure timely decision-making regarding approval, states should plan to submit their initial section 1332 waiver applications with enough time to allow for public comment (as required by 31 CFR 33.112, 31 CFR 33.116(b), 45 CFR 155.1312, and 45 CFR 155.1316(b)), review by the Departments, and implementation of the section 1332 state plan as outlined in the waiver application. For example, for section 1332 waivers that impact the individual market, submission before or during the first quarter of the year prior to the year health plans affected by the section 1332 waiver would take effect would generally permit sufficient time for review and implementation of both the waiver application and affected plans, depending on the complexity of the proposal. It is important to note that the Departments cannot guarantee approval of a section 1332 waiver submission or a state's request for expedited review and will continue to review applications consistent with the timeline requirements outlined in the regulations and statute.¹⁰⁷ The Departments encourage states to work with the Departments on formulating timeframes that take into account the states' legislative sessions and timing of health plan rate filings if the section 1332 waiver is projected to have any impact on premiums. If a state's section 1332 waiver application includes potential operational changes or accommodations to the federal information technology platform or its operations, additional time for review and implementation of the waiver application may be needed. States

should engage with the Departments early in the process to determine whether federal infrastructure can accommodate technical changes that support their requested flexibilities, as discussed elsewhere in this preamble.

The Departments seek comment on these proposals.

3. Section 1332 Application Procedures—Statutory Guardrails (31 CFR 33.108(f)(3)(iv) and 45 CFR 155.1308(f)(3)(iv))

The Departments are proposing to modify 31 CFR 33.108(f)(3)(iv)(A–C) and 45 CFR 155.1308(f)(3)(iv)(A–C) to remove the interpretations of the comprehensiveness, affordability, and coverage guardrails that were codified in part 1 of the 2022 Payment Notice final rule. In addition, as detailed later in this section of this preamble, the Departments are proposing to adopt new policies and interpretations with regard to the statutory guardrails that, if finalized, would supersede and rescind those outlined in both the 2018 Guidance and part 1 of the 2022 Payment Notice final rule. These proposed guardrail interpretations are largely in line with those in the 2015 Guidance. The Departments are also proposing to modify 31 CFR 33.108(f)(3)(iv) and 45 CFR 155.1308(f)(3)(iv) to remove the reference, as codified under part 1 of the 2022 Payment Notice final rule, to interpretive guidance published by the Departments.

The 2018 Guidance aimed to allow states to pursue section 1332 waivers with the goals of increasing consumer choice and promoting private market competition. In particular, in the 2018 Guidance, the Secretaries explained that their interpretations of the statutory guardrails were meant to remove restrictions that could limit consumer choice by allowing states to provide access to health insurance coverage at different price points and benefits levels, including less comprehensive plans that states considered to be better suited to consumer needs. Specifically, the 2018 Guidance interpreted the comprehensiveness and affordability guardrails to be satisfied if comprehensive and affordable coverage were *available* to consumers, without regard to who would actually enroll in such coverage. In addition, the 2018 Guidance instructed that these two guardrails must be evaluated in conjunction. The 2018 Guidance explained that it is not enough to make available some coverage that is comprehensive but not affordable, while making available other coverage that is affordable but not comprehensive. Thus,

¹⁰⁷ 31 CFR 33.108 and 45 CFR 155.1308; Section 1332(d)(1) of the ACA.

the Departments stated that a state plan would comply with the comprehensiveness and affordability guardrails, consistent with the statute, if it makes coverage that is both comprehensive and affordable *available* to a comparable number of otherwise qualified residents as would have had such coverage available absent the waiver.

In the 2018 Guidance, the Departments also stated that section 1332(b)(1)(C) of the ACA requires that a state's plan under a section 1332 waiver will provide coverage "to at least a comparable number of its residents" as would occur without the waiver.¹⁰⁸ The 2018 Guidance further noted that the text of the coverage guardrail provision of the statute is silent as to the type of coverage that is required. Accordingly, to enable state flexibility and to promote choice of a wide range of coverage to ensure that consumers can enroll in coverage that is right for them, in the 2018 Guidance, the Departments would consider section 1332 waivers to satisfy the coverage guardrail requirement if at least as many state residents were projected to be enrolled in comprehensive and less comprehensive health plans combined under the waiver as would be enrolled without the waiver. Under that interpretation, the Departments could approve a state's section 1332 waiver designed to promote residents' enrollment in less comprehensive or less affordable coverage. As long as a comparable number of residents were projected to be covered as would have been covered absent the waiver, the coverage guardrail would be met.

The policies and interpretations in the 2018 Guidance were in line with the Administration's priorities at the time. In particular, the 2018 Guidance noted that the Secretaries would consider favorably section 1332 waiver applications that advance specific principles including: Providing increased access to affordable private market coverage, encouraging sustainable spending growth, fostering state innovation, supporting and empowering those in need, and promoting consumer-driven health care. The 2018 Guidance, including the interpretations of the guardrails announced therein, aimed to advance these principles and noted that the Secretaries intended to provide states with maximum flexibility within the law to innovate, empower consumers, and expand higher value and more affordable coverage options.

In part 1 of the 2022 Payment Notice final rule, the Departments finalized the 2018 Guidance interpretation of the guardrails into the text of the section 1332 implementing regulations. Specifically, the Departments finalized regulatory language in 31 CFR 33.108(f)(3)(iv)(A) and 45 CFR 155.1308(f)(3)(iv)(A), explaining that the Departments would consider the comprehensive coverage guardrail to be met by a state section 1332 waiver plan if the plan would provide consumers access to coverage options that are at least as comprehensive as the coverage options provided without the waiver, to at least a comparable number of people as would have had access to such coverage absent the waiver. The final rule also added language to 31 CFR 33.108(f)(3)(iv)(B) and 45 CFR 155.1308(f)(3)(iv)(B) providing that the Departments would consider the affordability requirement to be met by a state section 1332 waiver plan that would provide consumers access to coverage options that are at least as affordable as the coverage options provided without the waiver, to at least a comparable number of people as would have had access to such coverage absent the waiver. These modifications also provided, consistent with the 2018 Guidance and the Administration's priorities at the time, that the Departments would consider the comprehensiveness and affordability guardrails met if a section 1332 waiver plan provides *access* to coverage that is as comprehensive and affordable as coverage forecasted to have been available in the absence of the waiver, and is projected to be available to a comparable number of people under the waiver, as opposed to the actual number of people enrolled in comprehensive and affordable coverage as under the 2015 Guidance. The final rule also added regulatory language to 31 CFR 33.108(f)(3)(iv)(C) and 45 CFR 155.1308(f)(3)(iv)(C) providing that, for purposes of the coverage guardrail, "coverage" refers to minimum essential coverage as defined in 26 U.S.C. 5000A(f) and 26 CFR 1.5000A-2, and health insurance coverage as defined in 45 CFR 144.103.

A majority of commenters on both the 2018 Guidance and the 2022 Payment Notice proposed rule were concerned that the 2018 Guidance and its proposed codification would undermine the congressional intent underlying the section 1332 guardrails and effectively codify policy they believe is based on a misapplication of the statutory guardrails. The commenters were concerned that the focus on the

interpretation of the availability of comprehensive and affordable coverage in the 2018 Guidance would result in fewer residents enrolled in comprehensive and affordable coverage. Other commenters asserted that the interpretation of the availability of comprehensive and affordable coverage for the coverage guardrail allows for a disjointed application of the guardrails whereby a state can meet the coverage guardrail, while its waiver plan reduces the overall comprehensiveness and affordability of coverage in a state. A few commenters recommended rescinding and abandoning the 2018 Guidance completely in favor of returning to the prior interpretation of the guardrails described in the 2015 Guidance. In addition, some commenters also expressed concern that alternative coverage options, which would qualify for the purposes of meeting the coverage guardrail under the 2018 Guidance, are not subject to the same limitations as comprehensive coverage in terms of consumer protections. For instance, alternative plan options generally lack financial limitations like out-of-pocket maximums and annual/lifetime limits, and, if consumers covered by alternative plan options experience unexpected, potentially-catastrophic health events, they are likely to pay substantially more out-of-pocket to cover incurred costs. Further, commenters also raised concerns that alternative plans can terminate or deny coverage based on health status, which would tend to affect high-risk individuals. Coupled with the diminished affordability of comprehensive coverage, this possibility puts high-risk individuals at great risk of going without effective coverage.

In this proposed rule, the Departments are proposing changes to 31 CFR 33.108 and 45 CFR 155.1308 to rescind the interpretations of the statutory guardrails announced in the 2018 Guidance and codified in part 1 of the 2022 Payment Notice final rule. The decision to rescind those interpretations is based on further consideration of commenters' concerns that the proposals outlined in this rule are a better interpretation of section 1332(b)(1)(A)-(C), and the Departments' reviews under E.O. 14009, which was intended to strengthen the ACA and expand high-quality health care and E.O. 13985, which was intended to pursue a comprehensive approach to advancing equity for all. After further consideration, the Departments have concluded that the interpretations of section 1332's comprehensiveness, affordability, and coverage guardrails

¹⁰⁸ 83 FR at 53577.

codified in part 1 of the 2022 Payment Notice final rule could permit section 1332 waivers that do not result in a comparable number of residents overall being enrolled in coverage that is at least as affordable and as comprehensive as they would have enrolled in without the waiver. As discussed in more detail later in this section, the Departments' proposed changes are intended to align with the President's instruction in E.O. 14009 to adopt policies to strengthen the implementation of the ACA and remove any barriers that those policies may create for expanding coverage, lowering costs, and making high-quality health care accessible for every American. Furthermore, in line with E.O. 14009, this Administration is focused on ensuring high-quality health care is accessible and affordable for every American. As such, the Departments are of the view that the comprehensiveness and affordability guardrails should focus on the types of coverage residents actually purchase, rather than the types of coverage residents have *access* to.

Upon further consideration of these issues, the Departments have determined that the guardrail interpretations codified in part 1 of the 2022 Payment Notice final rule are inconsistent with the Departments' goal of ensuring individuals *are enrolled* in affordable, comprehensive coverage and not just that there is generalized *access* to such coverage. The plans that could be offered to individuals under section 1332 waivers applying the interpretations codified in the part 1 of the 2022 Payment Notice final rule could allow state section 1332 waivers that would result in more individuals enrolling in medically underwritten plans¹⁰⁹ that offer only limited benefits,

¹⁰⁹Health insurance companies medically underwrite policies to try to ascertain prospective enrollees' health statuses when they are applying for health insurance coverage in order to determine whether to offer these individuals coverage, or at what price, and with what exclusions or limits, to offer coverage. (<https://www.healthcare.gov/glossary/medical-underwriting/>) Since 2014, however, medical underwriting is no longer permitted in the individual or small group markets with respect to non-grandfathered health insurance coverage, due to ACA rules. Instead, all such individual and small group plans are guaranteed issue. Guaranteed issue is a requirement that health plans must permit any individual to enroll regardless of health status, age, gender, or other factors that might predict the use of health services. Guaranteed issue does not limit how much individuals can be charged if they enroll in coverage. (<https://www.healthcare.gov/glossary/guaranteed-issue/>). However, the ACA's community rating protections prevent health insurers from varying premiums within a geographic area based on age, gender, health status or other factors with respect to non-grandfathered health insurance coverage. (<https://www.healthcare.gov/glossary/community-rating/>).

charge higher out-of-pocket costs, or both, which is inconsistent with the goal of the E.O. 14009 to reduce barriers for expanding comprehensive affordable coverage. Allowing more individuals to be in medically underwritten plans could also have a disparate impact on vulnerable populations, especially people of color and those who are in poverty, those who are underserved, and those with pre-existing conditions, which is inconsistent with the goal of E.O. 13985.

Additionally, the Departments are of the view that the section 1332 waiver proposals that could be available under the guardrail interpretations in the 2018 Guidance and codified in part 1 of the 2022 Payment Notice final rule may also not be in line with E.O. 14009. For example, the *Section 1332 State Relief and Empowerment Waiver Concepts Discussion Paper* (November 2018 Discussion Paper)¹¹⁰ included waiver concepts that were intended to foster discussion with states by illustrating how states might take advantage of new flexibilities provided in the 2018 Guidance. The Departments are of the view that some of these waiver concepts which rely upon the 2018 Guidance interpretation of the guardrails, are not in line with E.O. 14009 goals to protect and strengthen Medicaid and the ACA and to make high-quality health care accessible and affordable for every American. For example, the *Adjusted Plan Options* section 1332 waiver concept included in the 2018 Discussion Paper would permit states to have the flexibility to provide state financial assistance for non-QHPs. A section 1332 waiver proposal that includes this concept could potentially increase coverage in non-QHPs and potentially decrease enrollment in comprehensive coverage plans by allowing consumers to use a state subsidy towards catastrophic plans, individual market plans that are not QHPs, or plans that do not fully meet ACA requirements. In reviewing section 1332 waiver policies in light of E.O. 14009, this waiver concept is inconsistent with the goal of E.O. 14009, as it would likely result in consumers enrolling in non-QHPs and plans that do not fully meet ACA requirements, thereby increasing barriers for expanding comprehensive affordable coverage and potentially decreasing enrollment in comprehensive coverage. Further, commenters raised concerns in response to the 2018 Guidance that expressed generalized concern that the

¹¹⁰ <https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Waiver-Concepts-Guidance.PDF>.

2018 Guidance permitted alternative coverage options that can be underwritten and do not meet EHB standards. In addition, commenters were concerned that measures taken to facilitate coverage in alternative plan options (for example, allowing the use of subsidies for such coverage) would result in fewer comprehensive plans on the market, and that those comprehensive plans would become less affordable. In light of the concerns raised by commenters and the E.O.s, the Departments are proposing new policies in this proposed rule that would allow states flexibility to develop waiver plans to meet their needs and expand coverage, lower costs, and increase access to high-quality health care with comprehensive benefits.

Given the current policy goals, as well as the Departments' further consideration of comments received on the 2022 Payment Notice, the Departments are proposing new policies for how the Departments would evaluate whether a state's section 1332 waiver plan satisfies each of the guardrails, as outlined in more detail later in this section. Overall, the Departments are proposing that the "coverage" to be provided and evaluated in each guardrail should be interpreted the same way in each subparagraph of Section 1332(b)(1)(A)–(C) for consistency. Thus, the Departments are proposing in 31 CFR

33.108(f)(3)(iv)(A) through (C) and 45 CFR 155.1308(f)(3)(iv)(A) through (C) to interpret "provide" and "coverage" to mean the same thing for the coverage, comprehensiveness, and affordability guardrails and that, to be approved, a waiver must be projected to provide coverage that is as comprehensive and affordable as would have been provided absent the waiver and to the same number of residents.

Similarly, given the current COVID–19 PHE, this Administration is focused on the response to the PHE and on helping increase enrollment in comprehensive, affordable health insurance coverage. The ARP made numerous changes to the ACA to expand access to health insurance coverage and lower costs. Specifically, the ARP temporarily expanded eligibility for and increased the value of APTC/PTC, enabling previously ineligible consumers to qualify for help paying for health coverage and increasing assistance to eligible individuals already enrolled in Exchange plans. These changes have already increased enrollment through

the Exchanges,¹¹¹ and the Departments are of the view that this law will continue to increase enrollment through the Exchanges as the ARP's enhanced subsidies lower the costs of coverage for millions of Americans and change the incentives to seek and maintain comprehensive health insurance coverage. In addition, increased affordability and expansion of access to comprehensive health insurance coverage will better support enrollment of historically uninsured communities—especially those who have faced significant health disparities—in such coverage, thereby improving access to health care during and beyond the COVID-19 PHE. This Administration has also sought to strengthen the ACA and increase enrollment by directing the establishment of a special enrollment period, which is open from February 15, 2021 through August 15, 2021, for Exchanges using the *HealthCare.gov* platform (COVID special enrollment period). Over 1.2 million Americans have already signed up for coverage on *HealthCare.gov* during the COVID special enrollment period.¹¹² To promote the special enrollment period, CMS is spending approximately \$100 million on outreach and education, including broadcast, radio, and digital advertising to reach the uninsured, and also launched parallel outreach efforts through stakeholders and partners to increase education and awareness across communities on the COVID special enrollment period.¹¹³ Earlier this year, CMS made approximately \$2.3 million in additional funding available to current Navigator grantees in FFEs to support the outreach, education, and enrollment efforts around the COVID special enrollment period.¹¹⁴ Additionally, CMS recently announced that it is making \$80 million in grant

funding available to the FFE Navigator program for the 2022 plan year through the 2021 Navigator Notice of Funding Opportunity.¹¹⁵ This represents an eight-fold increase in funding from the previous year. Taken together, these policies, including the increased subsidies available under the ARP, the COVID special enrollment period, and the increased federal investment in the FFE Navigator program, have already led to, and are expected to continue to lead to, increased enrollment through the Exchanges.

The Departments are of the view that rescinding the 2018 Guidance, repealing the previous codification of its guardrail interpretations in part 1 of the 2022 Payment Notice final rule, and proposing new policies and interpretations aligns with the Administration's goals to strengthen the ACA and increase enrollment in comprehensive, affordable health coverage among the remaining underinsured and uninsured. The Departments are also of the view that during a pandemic, as Americans continue to battle COVID-19 and millions of Americans are facing uncertainty and experiencing new health problems, it is even more critical that Americans have meaningful access to high-quality, comprehensive and affordable health coverage options.

The Departments are also proposing to modify 31 CFR 33.108(f)(3)(iv) and 45 CFR 155.1308(f)(3)(iv) to remove the reference, as codified under part 1 of the 2022 Payment Notice final rule, to interpretive guidance published by the Departments. This proposal is in line with the Departments' efforts to provide supplementary information about the requirements that must be met for the approval of a section 1332 waiver and the Secretaries' application review procedures. Because the Departments are of the view that the 2018 Guidance and the incorporation of its guardrail interpretations into regulations could result in the Departments approving section 1332 waivers that would result in fewer residents in those states enrolling in comprehensive and affordable coverage, that those interpretations do not represent the best fulfillment of congressional intent behind the statutory guardrails, that they are inconsistent with the policy intentions of E.O. 14009 and E.O. 13985, and that it is appropriate to address concerns raised by commenters on the 2018 Guidance, the Departments

propose to remove the reference to the 2018 Guidance.

Under this proposal the Departments would rely upon the statute and regulations, as well as the Departments' interpretive policy statements as outlined in the applicable notice and comment rulemaking, in reviewing section 1332 waiver applications.

The Departments seek comment on these proposals. The Departments also solicit comment on whether there are policies that meet the statutory guardrails of section 1332 waivers that the Departments could consider that would encourage states to find innovative ways to use section 1332 waivers to focus on equity and expand access to comprehensive coverage for their residents. In addition, the Departments considered whether any affected parties could be impacted by the proposed changes in policy interpretations outlined in this rule. The Departments are of the view that both states with approved section 1332 waivers and states that are considering section 1332 waivers would be minimally impacted by these proposed changes in policy. The Departments solicit comment on the impact to stakeholders.

a. Comprehensive Coverage (31 CFR 33.108(f)(3)(iv)(A) and 45 CFR 155.1308(f)(3)(iv)(A))

The Departments are proposing to modify the regulations at 31 CFR 33.108(f)(3)(iv)(A) and 45 CFR 155.1308(f)(3)(iv)(A) to remove the comprehensiveness guardrail interpretations as adopted in part 1 of the 2022 Payment Notice final rule. In addition, the Departments are proposing, through preamble, policies and interpretations relating to the requirements for the comprehensive coverage guardrail that are similar to the policies and interpretations outlined in the 2015 Guidance. Specifically, the Departments are proposing to modify the regulations at 31 CFR 33.108(f)(3)(iv)(A) and 45 CFR 155.1308(f)(3)(iv)(A) such that to satisfy the comprehensive coverage requirement, the Departments, as applicable, must determine that the section 1332 waiver will provide coverage that is at least as comprehensive overall for residents of the state as coverage absent the waiver. The Departments' proposed policies and interpretations related to the comprehensiveness guardrail are as follows:

To meet the comprehensiveness guardrail, health care coverage under a section 1332 waiver would be required to be forecast to be at least as

¹¹¹ 2021 Marketplace Special Enrollment Period Report, June 14, 2021 <https://www.cms.gov/newsroom/fact-sheets/2021-marketplace-special-enrollment-period-report-2>.

¹¹² Data reflects enrollment as of May 31, 2021: <https://www.hhs.gov/about/news/2021/06/14/four-ten-new-consumers-spend-10-or-less-month-healthcaregov-coverage-following-implementation-american-rescue-plan-tax-credits.html>.

¹¹³ On January 28, 2021, CMS announced \$50 million for outreach and marketing for the COVID special enrollment period: <https://www.cms.gov/newsroom/fact-sheets/2021-special-enrollment-period-response-covid-19-emergency>. On April 1, 2021 HHS announced an additional \$50 million to further bolster the COVID special enrollment period campaign and promote the lower premiums under the ARP: <https://www.cms.gov/newsroom/press-releases/hhs-secretary-becerra-announces-reduced-costs-and-expanded-access-available-marketplace-health>.

¹¹⁴ <https://www.cms.gov/newsroom/press-releases/cms-announces-additional-navigator-funding-support-marketplace-special-enrollment-period>.

¹¹⁵ <https://www.cms.gov/newsroom/press-releases/cms-announces-80-million-funding-opportunity-available-navigators-states-federally-facilitated-0>.

comprehensive overall for residents of the state as coverage absent the waiver.

Comprehensiveness refers to the scope of benefits provided by the coverage and would be measured by the extent to which coverage meets the requirements for EHBs as defined in section 1302(b) of the ACA and offered through Exchanges established by Title I of ACA, or, as appropriate, Medicaid or CHIP standards. The impact on all state residents would be considered, regardless of the type of coverage they would have had absent the section 1332 waiver.

Comprehensiveness would be evaluated by comparing coverage under the section 1332 waiver to the state's EHB benchmark (for the applicable plan year), selected by the state (or if the state does not select a benchmark, the default base-benchmark plan) pursuant to 45 CFR 156.100, as well as to, in certain cases, the coverage provided under the state's Medicaid or CHIP programs.¹¹⁶ A section 1332 waiver would not satisfy the comprehensiveness requirement if the waiver decreases: (1) The number of residents with coverage that is at least as comprehensive as the benchmark in all ten EHB categories; (2) for any of the ten EHB categories, the number of residents with coverage that is at least as comprehensive as the benchmark in that category; or (3) the number of residents whose coverage includes the full set of services that would be covered under the state's Medicaid or CHIP programs, holding the state's Medicaid and CHIP policies constant. That is, the section 1332 waiver could not decrease the number of individuals with coverage that satisfies EHB requirements, the number of individuals with coverage of any particular category of EHB, or the number of individuals with coverage that includes the services

¹¹⁶ In April 2018, HHS provided states with substantially more options in the selection of an EHB-benchmark plan. As finalized in the 2019 Payment Notice, starting in the 2020 plan year, HHS provided states with additional flexibility in how they select their EHB-benchmark plan. Instead of being limited to 10 options, states are now able to choose from the 50 EHB-benchmark plans used for the 2017 plan year in other states or select specific EHB categories, such as drug coverage or hospitalization, from among the categories used for the 2017 plan year in other states. Additionally, states are able to build their own set of benefits that could potentially become their EHB-benchmark plan, subject to certain scope of benefits requirements.

covered under the state's Medicaid or CHIP programs.

Assessment of whether a section 1332 waiver proposal meets the comprehensiveness requirement would also take into account the effects across different groups of state residents, and, in particular, effects on those vulnerable and underserved residents, including low-income individuals, older adults, those with serious health issues or who have a greater risk of developing serious health issues, and people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality.¹¹⁷ A section 1332 waiver would be highly unlikely to be approved by the Secretaries under the proposed interpretation outlined in this rule if the waiver would reduce the comprehensiveness of coverage provided to these types of vulnerable or underserved groups, even if the waiver maintained comprehensiveness in the aggregate. Under the proposed interpretation in this rule, this condition generally must be forecast to be met in each year that the section 1332 waiver would be in effect.

Consistent with 31 CFR 33.108(f) and 45 CFR 155.1308(f), the section 1332 waiver application must include analysis and supporting data that establishes that the section 1332 waiver satisfies this requirement. This includes an explanation of how the benefits offered under the section 1332 waiver differ from the benefits provided absent the waiver (if the benefits differ at all) and how the state determined the benefits to be as "comprehensive."

As discussed previously in this section of this preamble, the policies and interpretations of the comprehensiveness guardrail outlined in the 2018 Guidance and codified in part 1 of the 2022 Payment Notice find

¹¹⁷ These groups include individuals who belong to underserved communities that have been denied such treatment, such as Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality. See <https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government/>.

rule, were in line with the Administration's priorities at the time to promote private market competition and increase consumer choice. Under those policies, analysis of comprehensiveness and affordability of coverage under a section 1332 waiver focused on the nature of coverage that is made available to state residents (access to coverage), rather than on the coverage that residents actually purchase. The plans that could be offered to individuals under section 1332 waivers as codified in part 1 of the 2022 Payment Notice final rule could therefore allow for more individuals to enroll in medically underwritten plans that only offer limited benefits, which is inconsistent with the goal of E.O. 14009 to reduce barriers for expanding comprehensive affordable coverage.

In response to the proposal in the 2022 Payment Notice Proposed Rule, commenters raised concerns that alternative plan options (which could include medically underwritten plans) can terminate or deny coverage based on health status, which would tend to affect high-risk individuals.

Commenters asserted that, this possibility puts individuals with greater medical needs at risk of going without effective coverage for their health care needs. Some commenters expressed concern that the potential market effects would have a disparate impact on vulnerable populations, especially low-income consumers and those with pre-existing conditions. Additionally, these commenters expressed concern that a disparate impact on any particular group would not necessarily cause the Departments to deny a section 1332 waiver application, even though the impact on vulnerable population groups would be taken into account.

The Departments are of the view that the current interpretation of the comprehensiveness guardrail is inconsistent with the goal of E.O. 14009 to reduce barriers for expanding comprehensive affordable coverage. The Departments are also of the view that the current interpretation of the guardrail is inconsistent with the goal of E.O. 13985 to pursue a comprehensive approach to advancing equity and could create barriers to health coverage for people of color and underserved groups.

The proposed changes in this rule are intended to align with the President's instructions in E.O. 14009 and E.O. 13985 to adopt policies to strengthen the implementation of the ACA and ensure high-quality health care coverage is accessible and affordable for every American. The Departments are of the view that the proposals outlined in this proposed rule would further support states providing consumers with comprehensive, high-quality health care coverage that will better protect consumers with pre-existing conditions and will help protect consumers from unexpected and expected medical needs. Further, the proposals outlined in this proposed rule would further the goal that consumers with pre-existing conditions, particularly racial and ethnic minorities who are 1.5 to 2.0 times more likely than whites to have major chronic diseases¹¹⁸ and as such pre-existing conditions, maintain comprehensive coverage.

The Departments seek comment on these proposed policies and interpretations related to the comprehensiveness guardrail. The Departments are of the view that this proposal would have minimal impact on both states with section 1332 waivers under development and states with approved waivers. The Departments solicit comment on the impact to stakeholders.

b. Affordability (31 CFR 33.108(f)(3)(iv)(B) and 45 CFR 155.1308(f)(3)(iv)(B))

The Departments are proposing to modify the regulations at 31 CFR 33.108(f)(3)(iv)(B) and 45 CFR 155.1308(f)(3)(iv)(B) to remove the affordability guardrail interpretations as codified in part 1 of the 2022 Payment Notice final rule. In addition, the Departments are proposing, through preamble, policies and interpretations relating to the requirements for the affordability coverage guardrail that are similar to the policies and interpretations outlined in the 2015 Guidance. Specifically, the Departments are proposing to modify the regulations at 31 CFR 33.108(f)(3)(iv)(B) and 45 CFR 155.1308(f)(3)(iv)(B) such that to satisfy the affordability requirement, the Departments, as applicable, must determine that the section 1332 waiver would provide coverage that is at least as affordable overall for residents of the state as coverage absent the waiver. The Departments' proposed policies and

interpretations related to the affordability guardrail are as follows:

To meet the affordability guardrail, health care coverage under the section 1332 waiver would be required to be forecast to be as affordable overall for state residents as coverage absent the waiver.

Affordability refers to state residents' ability to pay for health care expenses relative to their incomes and would generally be measured by comparing each individual's expected out-of-pocket spending for health care and services to their incomes. Out-of-pocket spending for health care includes premiums (or equivalent costs for enrolling in coverage), and spending such as deductibles, co-pays, and co-insurance, associated with the coverage or direct payments for health care. Spending on health care services that are not covered by a health plan or health coverage could also be taken into account if they are affected by the section 1332 waiver proposal. The impact on all state residents would be required to be considered, regardless of the type of coverage they would have had absent the section 1332 waiver. Under the proposed policies and interpretation in this rule, this condition generally must be forecast to be met in each year that the section 1332 waiver would be in effect.

Section 1332 waivers would be evaluated not only based on how they affect affordability on average, but also on how they affect the number of individuals with large health care spending burdens relative to their incomes. Increasing the number of state residents with large health care spending burdens would cause a section 1332 waiver proposal to fail the affordability requirement, even if the waiver would increase affordability for many other state residents. Given that eligibility for comprehensive coverage among the uninsured varies across racial and ethnic groups, the Departments' assessment of whether the proposal meets the affordability requirement would also take into account the effects across different groups of state residents, and, in particular, effects on vulnerable or underserved residents, including low-income individuals, older adults, those with serious health issues or who have a greater risk of developing serious health issues, and people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality.¹¹⁹ A section 1332

waiver would be highly unlikely to be approved by the Secretaries under the proposed policies and interpretations set forth in this rule if it reduces affordability for these vulnerable or underserved groups, even if the waiver would maintain affordability in the aggregate. In addition, a section 1332 waiver would fail to meet the affordability guardrail if it would reduce the number of individuals with coverage that provides a minimal level of protection against excessive cost sharing. In particular, section 1332 waivers that reduce the number of people with insurance coverage that provides both an actuarial value equal to or greater than 60 percent and an out-of-pocket maximum that complies with section 1302(c)(1) of the ACA, would fail to meet this guardrail under the proposed policies and interpretations set forth in this rule. Section 1332 waivers that reduce the number of people with coverage that meets the affordability requirements set forth in sections 1916 and 1916A of the Act, as codified in 42 CFR part 447, subpart A, while holding the state's Medicaid policies constant would also fail under the affordability guardrail.

Consistent with 31 CFR 33.108(f) and 45 CFR 155.1308(f), the section 1332 waiver application must include analysis and supporting data that establishes that the waiver satisfies this requirement. This includes information on estimated individual out-of-pocket costs (premium and out-of-pocket expenses for deductibles, co-payments, co-insurance, co-payments and plan differences) by income, health expenses, health insurance status, and age groups, absent the section 1332 waiver and with the waiver. The expected changes in premium contributions and other out-of-pocket costs and the combined impact of changes in these components should be identified separately. The application should also describe any changes in employer contributions to health coverage or in wages expected under the section 1332 waiver. The application should identify any types of individuals for whom affordability of coverage would be reduced by the section 1332 waiver.

such treatment, such as Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality. See <https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government/>.

¹¹⁸ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3794652/#:~:text=more%20chronic%20diseases.,Racial%2Fethnic%20minorities%20are%201.5%20to%202.0%20times%20more%20likely,seem%20to%20be%20getting%20worse.>

¹¹⁹ These groups include individuals who belong to underserved communities that have been denied

As discussed previously in this section of this preamble, the affordability guardrail interpretation outlined in the 2018 Guidance and codified in part 1 of the 2022 Payment Notice final rule aimed to increase consumer choice to allow states to provide access to health insurance coverage at different prices points and benefits levels. The Departments are of the view that this interpretation of the affordability guardrail is inconsistent with the goal of E.O. 14009 to reduce barriers for expanding comprehensive affordable coverage. The current interpretation could allow for more individuals, including potentially those with pre-existing conditions, to enroll in medically underwritten plans that charge higher out-of-pocket costs, which is inconsistent with the goal of the E.O. to reduce barriers for expanding comprehensive affordable coverage. The proposed changes in this rule are intended to align with the President's instruction in E.O. 14009 to adopt policies to strengthen the implementation of the ACA and ensure high-quality health care is accessible and affordable for every American. The Departments are of the view that the proposals outlined in this proposed rule would further support states providing consumers with comprehensive, high-quality affordable health care coverage that will better protect consumers with pre-existing conditions, and will help protect consumers from unexpected and expected medical needs.

The Departments seek comment on these proposed policies and interpretations related to the affordability guardrail. The Departments are of the view this proposal would have minimal impact on both states with section 1332 waivers under development and states with approved waivers. The Departments solicit comment on the impact to stakeholders.

c. Coverage (31 CFR 33.108(f)(3)(iv)(C) and 45 CFR 155.1308(f)(3)(iv)(C))

The Departments are proposing to modify the regulations at 31 CFR 33.108(f)(3)(iv)(C) and 45 CFR 155.1308(f)(3)(iv)(C) to remove the coverage guardrail interpretations codified in part 1 of the 2022 Payment Notice final rule. In addition, the Departments are proposing, through preamble, policies and interpretations relating to the requirements for the coverage guardrail that are similar to the policies and interpretations outlined in the 2015 Guidance. Specifically, the Departments are proposing to modify the regulations at 31 CFR 33.108(f)(3)(iv)(B) and 45 CFR 155.1308(f)(3)(iv)(B) such that to satisfy

the scope of coverage requirement, the Departments, as applicable, must determine that the section 1332 waiver would provide coverage to a comparable number of state residents under the waiver as would have coverage absent the waiver. The Departments' proposed policies and interpretations related to the coverage guardrail are as follows:

To meet the coverage guardrail, a comparable number of state residents would be required to be forecast to have coverage under the section 1332 waiver as would have had coverage absent the waiver.

Coverage refers to minimum essential coverage as defined in 26 U.S.C. 5000A(f). For this purpose, "comparable" would mean that the forecast of the number of covered individuals is no less than the forecast of the number of covered individuals absent the section 1332 waiver. This condition generally would be required to be forecast to be met in each year that the section 1332 waiver would be in effect.

The impact on all state residents would be considered, regardless of the type of coverage they would have had absent the section 1332 waiver. For example, while a section 1332 waiver may not change the terms of a state's Medicaid coverage or change existing Medicaid demonstration authority, changes in Medicaid enrollment—whether increases or decreases—that result from a section 1332 waiver, holding the state's Medicaid policies constant, would be considered in evaluating the number of residents with coverage under a waiver.

Assessment of whether the section 1332 waiver application covers a comparable number of individuals would also take into account the effects across different groups of state residents, and, in particular, effects on vulnerable or underserved residents, including low-income individuals, older adults, those with serious health issues or who have a greater risk of developing serious health issues, and people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality.¹²⁰ A section

¹²⁰ These groups include individuals who belong to underserved communities that have been denied such treatment, such as Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality. See [https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-advancing-racial-equity-and-support-for-](https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government/)

1332 waiver would be highly unlikely to be approved by the Secretaries if it would reduce coverage for these populations, even if the waiver would provide coverage to a comparable number of residents overall. Finally, analysis under the coverage requirement would need to take into account whether the section 1332 waiver sufficiently prevents gaps in or discontinuations of coverage.

Consistent with 31 CFR 33.108(f) and 45 CFR 155.1308(f), the section 1332 waiver application must include analysis and supporting data that establishes that the waiver satisfies this requirement, including information on the number of individuals covered by income, health expenses, health insurance status, and age groups, under current law and under the waiver, including year-by-year estimates. The application should identify any types of individuals, including vulnerable and underserved individuals, who are more or less likely to be covered under the waiver than under current law.

As discussed previously in this section of this preamble, under the coverage guardrail interpretation outlined in the 2018 Guidance and codified in part 1 of the 2022 Payment Notice final rule, the guardrail is met if at least as many residents are enrolled in health coverage, including both comprehensive and less comprehensive health plans, as would be enrolled absent the waiver. That interpretation was intended to promote choice among a wide range of plans to ensure that consumers can enroll in coverage that is right for them. As such, the interpretations set forth in the 2018 Guidance and codified in part 1 of the 2022 Payment Notice final rule permits states to provide access to less comprehensive or less affordable coverage as an additional option for their residents to choose. Under the current policy, as long as a comparable number of residents are projected to be covered as would have been covered absent the section 1332 waiver, the coverage guardrail would be met. The Departments are of the view that this interpretation of the coverage guardrail is inconsistent with the goal of E.O. 14009 to reduce barriers for expanding comprehensive affordable coverage. The current interpretation could allow for more individuals to enroll in medically underwritten plans that offer limited benefits, charge higher out-of-pocket costs, or both, which is inconsistent with the goal of the E.O. to reduce barriers for expanding comprehensive, underserved-communities-through-the-federal-government/.

high-quality, affordable coverage. The proposed changes in this rule are intended to align with the President's instruction in E.O. 14009 to adopt policies to strengthen the implementation of the ACA and ensure high-quality health care is accessible and affordable for every American. The Departments are of the view that the proposals outlined in this proposed rule would further support states providing consumers with comprehensive, high-quality affordable health care that will better protect consumers with pre-existing conditions and will help protect consumers from unexpected and expected medical costs.

The Departments seek comment on these proposed policies and interpretations related to the coverage guardrail. The Departments are of the view that this proposal would have minimal impact on both states with section 1332 waivers under development and states with approved waivers. The Departments solicit comment on the impact to stakeholders.

d. Deficit Neutrality (31 CFR 33.108(f)(3)(iv)(D) and 45 CFR 155.1308(f)(3)(iv)(D))

The Departments are not proposing to modify the regulations at 31 CFR 33.108(f)(3)(iv)(D) and 45 CFR 155.1308(f)(3)(iv)(D) for the deficit neutrality guardrail, but are proposing, through preamble, policies and interpretations relating to the requirements for the deficit neutrality guardrail consistent with the policies outlined in the 2015 and 2018 Guidance. The Departments' proposed policies and interpretations related to the deficit neutrality guardrail are as follows:

Under the deficit neutrality guardrail, the projected federal spending net of federal revenues under the section 1332 waiver is required to be equal to or lower than projected federal spending net of federal revenues in the absence of the waiver.

The estimated effect on federal revenue would be required to include all changes in income, payroll, or excise tax revenue, as well as any other forms of revenue (including user fees), that would result from the proposed section 1332 waiver. Estimated effects would include, for example, changes in the amounts the federal government pays in PTC, small business tax credits, or other health coverage tax credit; changes in the amount of employer shared responsibility payments and excise taxes on high-cost employer-sponsored plans collected by the federal government; and changes in income and payroll taxes resulting from changes in

tax exclusions for employer-sponsored insurance and in deductions for medical expenses.

The effect on federal spending would include all changes in federal financial assistance (PTC, small business tax credits, or CSRs) and other direct spending, such as changes in Medicaid spending (while holding the state's Medicaid policies constant) that would result from the changes made through the proposed section 1332 waiver. Projected federal spending under the section 1332 waiver proposal would also need to include all administrative costs to the federal government, including any changes in IRS administrative costs, federal Exchange administrative costs, or other administrative costs associated with the waiver or alleviated by the waiver.

Under the proposed policies and interpretations outlined in this rule, section 1332 waivers must not increase the federal deficit over the period of the waiver (which may not exceed 5 years unless renewed) or in total over the 10-year budget plan submitted by the state as part of the section 1332 waiver application. Consistent with the policies in the 2015 Guidance and in the 2018 Guidance, the 10-year budget plan would be required to describe for both the period of the waiver and for the 10-year budget the projected federal spending and changes in federal revenues under the section 1332 waiver and the projected federal spending and changes in federal revenues in the absence of the waiver for each year of the 10 years.

The 10-year budget plan should assume the section 1332 waiver would continue permanently, but should not include federal spending or savings attributable to any period outside of the 10-year budget window. A variety of factors, including the likelihood and accuracy of projected spending and revenue effects and the timing of these effects, would be considered when evaluating the effect of the section 1332 waiver on the federal deficit. A section 1332 waiver that increases the deficit in any given year is less likely to meet the proposed deficit neutrality requirement than one that does not.

Upon consideration, the approach outlined in part 1 of the 2022 Payment Notice final rule is consistent with E.O. 14009 as it will not reduce coverage or otherwise undermine the ACA and Medicaid.

The Departments seek comment on these proposed policies and interpretations related to the deficit neutrality guardrail. The Departments believe this proposal would have minimal impact on both states with

section 1332 waivers under development and states with approved waivers. The Departments solicit comment on the impact to stakeholders.

4. Section 1332 Application Procedures (31 CFR 33.108(f)(4) and 45 CFR 155.1308(f)(4))

a. Actuarial and Economic Analysis (31 CFR 33.108(f)(4)(i-iii) and 45 CFR 155.1308(f)(4)(i-iii))

As required under 31 CFR 33.108(f)(4)(i-iii) and 45 CFR 155.1308(f)(4)(i-iii), states must include actuarial analyses and actuarial certifications, economic analyses, and the data and assumptions used to demonstrate and support the state's estimates that the proposed section 1332 waiver will comply with the statutory guardrails. The Departments are not proposing any regulatory changes to 31 CFR 33.108(f)(4)(i-iii) and 45 CFR 155.1308(f)(4)(i-iii), but are proposing, through preamble, policies relating to the requirements for the actuarial and economic analyses that are similar to the policies outlined in the 2015 and 2018 Guidance. We are proposing these policies to help ensure that the Departments have the appropriate and necessary information to measure the impact of waivers on the guardrails, particularly related to coverage. This information is especially important in light of the goal of E.O. 14009 to provide more comprehensive affordable coverage to consumers. In addition, the Departments encourage states to include in their analysis whether the proposed section 1332 waiver would increase health equity in line with E.O. 13985. The proposed policies are as follows:

Consistent with the 2015 and 2018 Guidance, the determination of whether a proposed section 1332 waiver meets the requirements under section 1332 and the calculation of the pass-through funding amount would be made using generally accepted actuarial and economic analytic methods, such as micro-simulation. The analysis would rely on assumptions and methodologies that are similar to those used to produce the baseline and policy projections included in the most recent President's Budget (or Mid-Session Review), but adapted as appropriate to reflect state-specific conditions. As provided in 31 CFR 33.108(f)(4)(i) and 45 CFR 155.1308(f)(4)(i), the state must include actuarial analyses and actuarial certifications to support the state's estimates that the proposed section 1332 waiver will comply with the comprehensive coverage requirement, the affordability requirement, and the scope of coverage requirement. In this

proposed rule, the Departments propose that, consistent with the 2018 Guidance, these actuarial analyses and certifications should be conducted by a member of the American Academy of Actuaries.

The Departments' analysis of whether a proposed section 1332 waiver meets the requirements under section 1332 would be based on state-specific estimates of the current level and distribution of population by the relevant economic and demographic characteristics, consistent with the 2015 and 2018 Guidance, including income and source of health coverage. It would generally use federal estimates of population growth, and economic growth as published in the Analytical Perspectives volume released as part of the President's Budget (https://www.whitehouse.gov/omb/budget/Analytical_Perspectives) and health care cost growth (<https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/index.html?redirect=/NationalHealthExpendData/>) to project the initial state variables through the 10-year budget plan window. However, in limited circumstances where it is expected that a state will experience substantially different trends than the nation as a whole in the absence of a section 1332 waiver, the Secretaries may determine that state-specific assumptions will be used.

Consistent with the 2018 Guidance and largely similar to the 2015 Guidance, estimates of the effect of the section 1332 waiver would assume, in accordance with standard estimating conventions, that macroeconomic variables like population, output, and labor supply are not affected by the waiver. However, estimates would take into account, as appropriate, other changes in the behavior of individuals, employers, and other relevant entities induced by the section 1332 waiver where applicable, including employer decisions regarding what coverage (and other compensation) they offer and individual decisions regarding whether to take up coverage. The same state-specific and federal data, assumptions, and model are used to calculate comprehensiveness, affordability, and coverage, and relevant state components of federal taxes and spending under the section 1332 waiver and under current law.

The analysis and information submitted by the state as part of the section 1332 waiver application would conform to these standards as outlined in this proposed rule. Consistent with the 2015 and 2018 Guidance, the

application would describe all modeling assumptions used, sources of state-specific data, and the rationale for any deviation from federal forecasts. A state may be required under 31 CFR 33.108(f)(4)(vii) and 45 CFR 155.1308(f)(4)(vii) to provide to the Secretaries copies of any data used for their section 1332 waiver analyses that are not publicly available so that the Secretaries can independently verify the analysis produced by the state.

In this proposed rule, the Departments propose that, consistent with the 2018 Guidance, for each of the guardrails, the state would clearly explain its estimates with and without the section 1332 waiver. The actuarial and economic analyses would be required to compare comprehensiveness, affordability, coverage, and deficit neutrality with and without the section 1332 waiver. The deficit neutrality analysis would specifically examine net federal spending and revenues under the section 1332 waiver to those measures absent the waiver (the baseline) for each year of the waiver. If the state is submitting a section 1332 waiver application for less than a 5-year period, the actuarial analysis could be submitted for the period of the waiver. The Departments, in accordance with their regulations, could request additional information or data in order to conduct their assessments.

The state should also provide a description of the models used to produce these estimates, including data sources and quality of the data, key assumptions, and parameters for the section 1332 waiver. Consistent with the 2018 Guidance, the Departments are not proposing to prescribe any particular method of actuarial analysis to estimate the potential impact of a section 1332 waiver. However, the state should explain its modeling in sufficient detail to allow the Secretaries to evaluate the accuracy of the state's modeling and the comprehensiveness and affordability of the coverage available under the state's section 1332 waiver proposal. As permitted under 31 CFR 33.108(g) and 45 CFR 155.1308(g), the state may be required to provide, upon request by the Secretaries, data or other information that it used to make its estimates, including an explanation of the assumptions used in the actuarial analysis.

The Departments seek comment on these proposals.

b. Implementation Timeline and Operational Considerations (31 CFR 33.108(f)(4)(iv) and 45 CFR 155.1308(f)(4)(iv))

As required under 31 CFR 33.108(f)(4)(iv) and 45 CFR 155.1308(f)(4)(iv), states must include in their applications for initial approval of a section 1332 waiver a detailed draft timeline for the state's implementation of the proposed waiver. In this proposed rule, the Departments are not proposing any regulatory changes to 31 CFR 33.108(f)(4)(iv) and 45 CFR 155.1308(f)(4)(iv). Rather, the Departments are proposing the operational considerations in preamble that states should take into account when developing their waiver application, waiver plan, and implementation timeline. Specifically, the Departments are proposing these operational considerations to provide additional information regarding how HHS and the IRS may be able to support a state in implementing a section 1332 waiver plan so states can take this information into consideration as it relates to their implementation timeline. These proposals would help to ensure that the Departments have the appropriate and necessary information to measure the impact of proposed waivers on the statutory guardrails, particularly related to coverage. This information is especially important in light of the goal of E.O. 14009 to provide more comprehensive affordable coverage to consumers. In addition, the Departments encourage states to include in their analysis whether the proposed section 1332 waiver would increase health equity in line with E.O. 13985. Upon consideration, the approach proposed with regard to operational considerations is revised from the 2018 Guidance with regard to the use of the Exchange information technology platform (the federal platform) and IRS operational considerations to maintain smooth operations of the Exchange consistent with E.O. 14009 and this Administration's goals to protect and strengthen Medicaid and the ACA and to make high-quality health care accessible and affordable for every American.

The Departments seek comment on these proposals.

i. Use of Federal Platform Technology

HHS operates the Federal platform utilized by FFEs and by some State Exchanges for eligibility and enrollment functions. For technical, operational, and fiscal efficiency, the Federal platform is generally designed to support uniform administration across

the states that utilize it. With that noted, HHS would be open to inquiries and further discussion with states that are developing section 1332 waiver proposals and are interested in potential technical collaboration. For example, over the past few years HHS has offered assistance to states implementing state-based reinsurance programs.¹²¹ Currently, states can request that the federal government assist with the calculation of issuers' eligible state reinsurance payments based on the state reinsurance parameters as part of the state's approved section 1332 waiver plan. Under this arrangement, states are still responsible for making reinsurance payments to issuers and otherwise administering and overseeing their programs.

States that are interested in this assistance should notify HHS early in the process about the state's interest and the state's parameters (that is, claims cost-based, conditions-based, or other) for HHS to assess the feasibility of providing this support. Should a final proposal involve any customized or specialized federal technical or operational capabilities, states would be responsible for funding the development and operation of these capabilities under the Intergovernmental Cooperation Act (ICA).¹²² Under the ICA, a federal agency generally may provide certain technical and specialized services to state governments, so long as the state covers the full costs of those services. Accordingly, where a state intends to rely on HHS for technical services related to its section 1332 waiver proposal, the state would be required to cover HHS's costs. For example, states implementing state-based reinsurance programs that request technical or specialized services from HHS with respect to calculating state reinsurance payments are responsible for the federal costs associated with providing this service, including development, implementation, maintenance, operations, and customer support. For this reason, under this proposal, should HHS and a state agree to such technical or specialized services to support an approved section 1332 waiver plan, the Departments would not consider costs for HHS services covered under the ICA as an increase in federal spending resulting from the state's waiver plan for

purposes of the deficit neutrality analysis.

As noted in the preamble of this proposed rule for the deficit neutrality guardrail, costs associated with changes to federal administrative processes that are not covered under the ICA would be taken into account in determining whether a waiver application satisfies the deficit neutrality requirement. Regulations at 31 CFR 33.108(f)(4) and 45 CFR 155.1308(f)(4), require that such costs be included in the 10-year budget plan submitted by the state. As specific section 1332 waiver proposals are submitted, HHS would work closely with states to determine which federal costs are covered under the ICA (and thus are not subject to deficit neutrality guardrail), and which are not covered under the ICA (and thus are subject to the deficit neutrality guardrail).

ii. IRS Functionality

Certain changes that affect IRS administrative processes may make a section 1332 waiver proposal infeasible for the Departments to accommodate. At this time, the IRS generally is not able to administer different sets of federal tax rules for different states. As a result, while a state may propose to entirely waive the application of one or more of the federal tax provisions listed in section 1332 for taxpayers in the state, it is generally not feasible to design a section 1332 waiver that would require the IRS to administer a program that alters these provisions for taxpayers in the state.

In some limited circumstances, the IRS may be able to accommodate small adjustments to the existing systems for administering federal tax provisions. However, it is generally not feasible to have the IRS administer a different set of PTC eligibility or PTC computation rules for individuals in a particular state. Thus, states contemplating a waiver proposal that includes a modified version of a federal tax provision could consider waiving the provision entirely and creating a subsidy program administered by the state as part of a section 1332 waiver proposal.

In addition, a section 1332 waiver proposal that partly or completely waives one or more federal tax provisions in a state may create administrative costs for the IRS. As noted in the preamble for the deficit neutrality guardrail of this proposed rule, costs associated with changes to federal administrative processes would be taken into account in determining whether a waiver application satisfies the deficit neutrality requirement. Regulations at 31 CFR 33.108(f)(4) and

45 CFR 155.1308(f)(4), require that such costs be included in the 10-year budget plan submitted by the state. States contemplating to waive any part of a federal tax provision should engage with the Departments early in the section 1332 waiver application process to assess whether the waiver proposal is feasible for the IRS to implement, and, if applicable, to assess the administrative costs to the IRS of implementing the waiver proposal.

5. Public Input on Waiver Proposals (31 CFR 33.112 and 45 CFR 155.1312)

Section 1332(a)(4)(B)(i) of the ACA, and regulations at 31 CFR 33.112 and 45 CFR 155.1312, require states to provide a public notice and comment period for a section 1332 waiver application sufficient to ensure a meaningful level of public input prior to submitting an application. In this proposed rule, the Departments are not proposing any regulatory changes to 31 CFR 33.112 and 45 CFR 155.1312. Under the current requirements, as part of the state's public notice and comment period, a state with one or more federally-recognized tribes must conduct a separate process for meaningful consultation with such tribes.¹²³ In addition, a state must make available, at the beginning of its public notice and comment period, through its website or other effective means of communication, a public notice that includes all of the information outlined in 31 CFR 33.112(b) and 45 CFR 155.1312(b). The state must also update this information, as appropriate. After issuance of this notice and prior to submission of a new section 1332 waiver application, the state must conduct public hearings and provide interested parties an opportunity to learn about and comment on the contents of the state's section 1332 waiver application.¹²⁴ Because section 1332 waiver applications may vary significantly in their complexity and breadth, the regulations provide states with flexibility in determining the length of the comment period required to allow for meaningful and robust public engagement. Consistent with federal civil rights law, including Section 1557 of the ACA, Section 504 of the Rehabilitation Act of 1973, and Title II of the Americans with Disabilities Act, section 1332 waiver applications must be posted online in a manner that is accessible to individuals with disabilities. To assist with ensuring website accessibility, states may look to

¹²¹ As of plan year 2021, HHS is providing this support for six states: Colorado, Delaware, Maryland, New Hampshire, North Dakota, and Pennsylvania.

¹²² Public Law 90-577 found here: <https://www.govinfo.gov/content/pkg/STATUTE-82/pdf/STATUTE-82-Pg1098.pdf>.

¹²³ See 31 CFR 33.112(a)(2) and 45 CFR 155.1312(a)(2).

¹²⁴ See 31 CFR 33.112(c) and 45 CFR 155.1312(c).

national standards issued by the Architectural and Transportation Barriers Compliance Board (often referred to as “section 508” standards”),¹²⁵ or alternatively, the World Wide Web Consortium’s Web Content Accessibility Guidelines (WCAG)¹²⁶ 2.0 Level AA standards.

Through this preamble, the Departments are proposing policies and interpretations for the state public notice requirements. More specifically, the Departments propose to maintain the current standard that the state comment period for a section 1332 waiver application should generally be no less than 30 days.¹²⁷ The Departments are of the view that a general standard requiring a minimum 30 day comment period will be sufficient to allow for meaningful and robust public engagement on a state’s waiver application and reiterate that a longer period may be appropriate for complex proposed waiver plans.

Section 1332(a)(4)(B)(iii) of the ACA and its implementing regulations¹²⁸ also require the federal government to provide a public notice and comment period, once the Secretaries receive an application. The period must be sufficient to ensure a meaningful level of public input and must not impose requirements that are in addition to, or duplicative of, requirements imposed under the Administrative Procedure Act, or requirements that are unreasonable or unnecessarily burdensome with respect to state compliance.¹²⁹ Under existing regulations, 31 CFR 33.108(f) and 45 CFR 155.1308(f), a submitted section 1332 waiver application will not be deemed received until the Secretaries have made the preliminary determination that the application is complete. As with the comment period described in this preamble, the length of the federal comment period should reflect the complexity of the section 1332 waiver proposal and the Departments similarly propose that the

federal comment period should also generally not be less than 30 days.¹³⁰

The Departments seek comment on these proposals.

6. Modification From the Normal Public Notice Requirements (31 CFR 33.118, 31 CFR 33.120, 45 CFR 155.1318, and 45 CFR 155.1320)

In the November 2020 IFC,¹³¹ the Departments revised regulations to set forth flexibilities in the public notice requirements and post award public participation requirements for waivers under section 1332 during the COVID–19 PHE. In this proposed rule, the Departments are proposing to extend these changes beyond the COVID–19 PHE to allow similar flexibilities in the event of future natural disasters; PHEs; or other emergent situations that threaten consumers’ access to health insurance coverage, consumers’ access to health care, or human life. The Departments propose to consider a situation to be “emergent” if it is both unforeseen and urgent. The Departments are not proposing any changes or soliciting further comments at this time with respect to the flexibility made available in the November 2020 IFC during the COVID–19 PHE. The Departments further clarify that states with approved section 1332 waivers and states seeking approval for proposed waivers will continue to have flexibility to submit requests to the Departments to modify certain public participation requirements during the COVID–19 PHE.¹³²

In the 2022 Payment Notice proposed rule,¹³³ CMS similarly proposed an extension of COVID–19 policy flexibilities, specifically the calculation of plan average premium and state average premium requirements for extending future premium credits (“temporary premium credits”), which was originally published in the November 2020 IFC.¹³⁴ In part 2 of the 2022 Payment Notice final rule, HHS finalized these policies to extend

beyond the COVID–19 PHE, to be available, if permitted by HHS, during a future declared PHE.¹³⁵ In developing the policies in this rulemaking, the Departments considered extending the section 1332 flexibilities adopted in the November 2020 IFC only to future declared PHEs, but are of the view that these flexibilities, as proposed in this proposed rule to be available on a broader basis in different times of emergent situations, will allow states to use or modify their waivers to respond to state or local emergent situations that may not rise to the level of a national declared PHE. The Departments are of the view that this best aligns with the overall statutory purpose and goals for section 1332 waivers, which are meant to allow states to craft their own unique solutions to respond to the specific health care needs in their respective markets. If the Departments were to limit these flexibilities only to future declared national PHEs, states may not be able to utilize or modify their section 1332 waivers as a tool to address state or local emergent situations or state designated emergencies which may similarly threaten consumers’ access to health insurance coverage, consumers’ access to health care, or human life.

In addition, the flexibilities outlined in this proposed rule are similar to those available under section 1115 demonstrations. Existing regulations at 42 CFR 431.416(g), relating to demonstration programs under section 1115 of the Act, provide that CMS may waive, in whole or in part, the state and federal public notice requirements to expedite a decision on a proposed 1115 demonstration or 1115 demonstration extension request that addresses a natural disaster, PHE, or other sudden emergency threat to human life. The Departments are of the view that using a similar standard for section 1332 waivers will provide states the necessary flexibility to enable them to quickly respond to various emergent situations. For example, some states have used flexibilities for section 1115 demonstrations in emergent situations to address threats to human life such as mudslides and wildfires which were state designated emergencies.

The Secretaries value the importance of the public input process, but also intend to propose to provide reprieve from certain requirements, where appropriate, in emergent situations. Allowing the Secretaries to modify the public notice and post award requirements, as proposed in this rule, would allow states to seek emergency relief in support of the development of

¹²⁵ For more information on 508 standards see here: <https://section508.gov/manage/program-roadmap>.

¹²⁶ For more information, see the WCAG website at <http://www.w3.org/TR/WCAG20/>.

¹²⁷ Notwithstanding this proposal, we clarify that states with approved waivers and states seeking approval for proposed waivers would continue to have flexibility to submit requests to the Departments to modify certain public participation requirements during the COVID–19 PHE. See 31 CFR 33.118 and 45 CFR 155.1318. Also see the November 2020 IFC, 85 FR 71142. As detailed below, in this rulemaking, the Departments propose to extend similar flexibilities during future emergent situations.

¹²⁸ See 31 CFR 33.116 and 45 CFR 155.1316.

¹²⁹ See section 1332(a)(4)(B)(iii) of the ACA, 31 CFR 33.116(b) and 45 CFR 155.1316(b).

¹³⁰ Notwithstanding this proposal, the Departments clarify that states with approved waivers and states seeking approval for proposed waivers would continue to have flexibility to submit requests to the Departments to modify certain public participation requirements during the COVID–19 PHE. See 31 CFR 33.118 and 45 CFR 155.1318. Also see the November 2020 IFC, 85 FR 71142. As detailed below, in this rulemaking, the Departments propose to extend similar flexibilities during future emergent situations.

¹³¹ 85 FR 71142 See <https://www.federalregister.gov/documents/2020/11/06/2020-24332/additional-policy-and-regulatory-revisions-in-response-to-the-covid-19-public-health-emergency>.

¹³² See 85 FR 71142.

¹³³ See 85 FR at 78597–78598 and 78608–78609.

¹³⁴ 85 FR 54820.

¹³⁵ 86 FR at 24182–24183 and 24202–24203.

quick and innovative ways to ensure consumers across the country have access to health care coverage in the face of unforeseen threats to that coverage. As was noted in November 2020 IFC, HHS and the Department of the Treasury are concerned that past trends that threaten the stability of the individual market risk pool may return, leading some issuers to cease offering coverage on the Exchanges in some states and counties and leading other issuers to increase their rates, leaving some geographic areas with limited or no affordable Exchange coverage options. Permitting the Secretary of HHS and the Secretary of the Treasury to modify the public notice procedures, in part, will help states seeking section 1332 waivers to address such circumstances more quickly and develop innovative ways to ensure consumers have access to affordable health care coverage. Specifically, in this proposed rule, the Departments propose to modify 31 CFR 33.118 and 45 CFR 155.1318 to broaden the Secretaries' authority to modify, in part, the otherwise applicable public notice procedures to expedite a decision on a proposed section 1332 waiver request that is submitted or would otherwise become due during emergent situations, when a delay would undermine or compromise the purpose of the proposed waiver request and be contrary to the interests of consumers. The amendments to these regulations further clarify that these proposed flexibilities would be available in future natural disasters; PHEs; and other emergent situations that threaten consumers' access to health insurance coverage, consumers' access to health care, or human life, rather than being limited to only the duration of the COVID-19 PHE. These amendments could also allow states to better utilize section 1332 waivers in emergent situations.

The Departments also propose to modify 31 CFR 33.120(c)(2) and 45 CFR 155.1320(c)(2) to provide the Secretaries with similar authority to modify, in part, otherwise applicable post award public notice requirements for an approved waiver outlined in 31 CFR 33.120(c) and 45 CFR 155.1320(c) when the application of the post award public notice procedures would be contrary to the interests of consumers during a natural disaster; PHE; or other emergent situations that threaten consumers' access to health insurance coverage, consumers' access to health care, or human life, rather than limiting this flexibility only to the duration of the COVID-19 PHE. These proposals

expand on policies published in the November 2020 IFC that are limited to the COVID-19 PHE.

a. Public Notice Procedures and Approval (31 CFR 33.118 and 45 CFR 155.1318)

Section 1332(a)(4)(B) of the ACA provides that the Secretaries shall issue regulations providing a process for public notice and comment at the state level, including public hearings, and a process for providing public notice and comment at the federal level after the section 1332 waiver application is received by the Secretaries, that are both sufficient to ensure a meaningful level of public input. Current regulations at 31 CFR 33.112 and 45 CFR 155.1312 specify state public notice and participation requirements for proposed section 1332 waiver requests, and 31 CFR 33.116(b) and 45 CFR 155.1316(b) specify the public notice and comment period requirements under the accompanying federal process.

As explained in the November 2020 IFC, the Departments recognize that the current section 1332 waiver regulations regarding state and federal public notice procedures and comment period requirements may impose barriers for states pursuing a proposed waiver request during an emergent situation, such as the COVID-19 PHE or a future natural disaster; PHE; or other emergent situation that threatens consumers' access to health insurance coverage, consumers' access to health care, or human life. It is the mission of the Departments to enhance and protect the health and well-being of all Americans. As such, the Departments are proposing to extend the existing flexibilities codified in regulations to protect public health and access to health insurance coverage and care during the COVID-19 PHE to also apply in the event of a future emergent situation, such as a natural disaster; a PHE; or other emergent situations that threaten consumers' access to health insurance coverage, consumers' access to health care, or human life. These flexibilities have been important during the COVID-19 PHE and support efforts to prevent the spread of COVID-19 by limiting the need for in-person gatherings related to section 1332 waivers during the PHE. Extending these flexibilities beyond the COVID-19 PHE to future emergent situations is important to similarly help states as they may face uncertainty as to whether their waiver request will be approved in time, given the otherwise applicable state and federal public notice procedures or public participation requirements, to expeditiously reform their health

insurance markets and to protect consumers during a future emergent situation. Some states may not consider more robust changes because they are concerned that the current section 1332 waiver application requirements are too time-consuming or burdensome to pursue during a future emergency or other emergent situation. Therefore, the Departments are of the view that providing similar flexibility to modify certain public notice procedures and participation requirements during a future emergent situation will protect public health and health insurance markets, and will increase flexibility and reduce burdens for states seeking to use section 1332 waivers as a means of innovation for providing coverage, lowering premiums, and improving their health care markets.

Permitting the Secretaries to modify the public notice procedures, in part, when a delay would undermine or compromise the purpose of the proposed section 1332 waiver request and be contrary to the interests of consumers will help states seeking section 1332 waivers to address such circumstances more quickly to ensure consumers have access to affordable health care coverage throughout the emergent situation. As such, the Departments are of the view that, if certain safeguards are met, it is in the best interest of the public to provide states applying for section 1332 waivers with the option to request to modify public notice procedures during an emergent situation. Based on the Departments' experience with the current COVID-19 PHE, the Departments are of the view that it is appropriate and reasonable to propose to make similar flexibilities available in future emergent situations.

The Departments are therefore proposing to modify 31 CFR 33.118(a) and 45 CFR 155.1318(a) to provide that the Secretaries may modify, in part, the state public notice requirements specified in 31 CFR 33.112(a)(1), (b), (c), and (d) and 45 CFR 155.1312(a)(1), (b), (c), and (d) and the federal public notice requirements specified at 31 CFR 33.116(b) and 45 CFR 155.1316(b) to expedite a decision on a proposed section 1332 waiver request during an emergent situation, when a delay would undermine or compromise the purpose of the proposed waiver request and would be contrary to the interests of consumers. The proposed amendments to 31 CFR 33.118(a) and 45 CFR 155.1318(a) further specify that these flexibilities would be limited to emergent situations, including natural disasters; PHEs; or other emergent situations that threaten consumers'

access to health insurance coverage, consumers' access to health care, or human life.

As noted earlier in this section of the preamble, the existing flexibility made available in the November 2020 IFC¹³⁶ for the COVID-19 PHE will continue to apply. The Departments also clarify that, similar to the November 2020 IFC, this rule does *not* propose to allow states to waive 31 CFR 33.112(a)(2) and 45 CFR 155.1312(a)(2), which requires states to conduct a separate process for meaningful consultation with federally-recognized tribes. The Departments note that tribal consultation is subject to separate requirements in accordance with Executive Order 13175,¹³⁷ which mandates the establishment of regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

In addition, the Departments clarify that a state cannot use this flexibility to request to eliminate public notice and participation procedures. Instead, this is a targeted proposal intended to extend the existing COVID-19 PHE flexibilities to future emergent situations to remove potential barriers and allow both the federal government and states flexibility to respond to emergent situations as they unfold. It is limited to permitting states to request to modify, in part, certain otherwise applicable public notice and participation requirements.

Examples of the public notice and participation procedures that currently apply that, under this proposal, a state may seek to have waived or modified during a future emergent situation include the requirement that states notify the public and hold hearings prior to submitting an application, that the state hold more than one public hearing in more than one location, and that the Departments provide for public notice and comment after an application is determined to be complete. States may also seek to modify the state and/or federal comment periods to be less than 30 days and to host public hearings virtually rather than in-person.

In addition, the Departments are of the view that these flexibilities are necessary to allow states flexibility to respond to rapid changes in the event of a future emergent situation and note that these proposals align with existing flexibilities available for public health programs that do not apply to section 1332 waivers. For example, when the

President declares a disaster or emergency under the Stafford Act or the National Emergencies Act and the Secretary of HHS declares a PHE under section 319 of the Public Health Service Act, section 1135 of the Act allows the Secretary of HHS to temporarily waive or modify certain Medicare, Medicaid, and CHIP requirements to ensure: (1) Sufficient health care items and services are available to meet the needs of individuals enrolled in these programs in the emergency area(s) and time periods; and (2) providers who give such services in good faith can be reimbursed and exempted from sanctions (absent any determination of fraud and abuse). However, section 1135 of the Act does not apply to or otherwise provide the Departments with authority to waive or modify requirements regarding section 1332 waivers when similar events cause similar impacts in the private health insurance markets. The proposed modifications to the Departments' section 1332 waiver regulations outlined in this rule are designed to generally align with the section 1135 flexibilities, but would be available in broader circumstances than emergencies or disasters declared under the Stafford Act or the National Emergencies Act and public health emergencies declared under section 319 of the Public Health Service Act. The Departments are proposing to apply this flexibility to include other emergencies at the state or local level to allow states to better address all of the various emergent situations that may impact their state health insurance markets and residents access to coverage and care.

Consistent with the existing framework for state modification requests related to the COVID-19 PHE, for a state request to modify the state or federal public notice requirements to expedite a decision on a proposed section 1332 waiver request during an emergent situation to be approved, the state must meet the requirements outlined in 31 CFR 33.118(b) and 45 CFR 155.1318(b). Under this proposal, the Secretaries could approve a state's request to modify the federal and/or state public notice procedures, in part, in future emergent situations if the state meets all of the following requirements:

- The state requests a modification in the form and manner specified by the Secretaries.
- The state acted in good faith, and in a diligent, timely, and prudent manner in the preparation of the request for the modification for the section 1332 waiver, and the waiver application request, as applicable.

- The state details in its request for a modification, as applicable, the justification for the requested modification from the state public notice procedures, and the alternative public notice procedures it proposes to implement at the state level, including public hearings, that are designed to provide the greatest opportunity and level of meaningful public input from impacted stakeholders that is practicable given the emergency circumstances underlying the state's request for a modification.

- The state details in its request for a modification, as applicable, the justification for the request and the alternative public notice procedures it requests to be implemented at the federal level.

The Departments also propose that the state, as applicable, implements the alternative public notice procedures at the state level if the state's modification request is approved and, if required, amends the section 1332 waiver application to specify that it is the state's intent to comply with those alternative public notice procedures in the state's modification request. These are the same requirements that apply under the existing framework for state modification requests related to the COVID-19 PHE and are currently captured in 31 CFR 33.118(b)(1) through (4) and (f) and 45 CFR 155.1318(b)(1) through (4) and (f).¹³⁸

Any state submitting a proposed section 1332 waiver application during a future emergent situation could submit a separate request to the Secretaries to modify, in part, certain otherwise applicable state and/or federal public notice and public participation requirements or could include such a request in its section 1332 waiver application request.

Consistent with the framework for COVID-19 PHE state modification requests, the Secretaries' review and consideration of a modification request for future emergent situations would vary based on the state's circumstances, its modification request, and the complexity and breadth of the state's proposed section 1332 waiver request. For example, during the COVID-19 PHE, many states prohibited in-person public gatherings or established stay-at-home orders due to the public health

¹³⁶ See 85 FR 71142, <https://www.federalregister.gov/documents/2020/11/06/2020-24332/additional-policy-and-regulatory-revisions-in-response-to-the-covid-19-public-health-emergency>.

¹³⁷ See 85 FR 71142, 71178.

¹³⁸ To effectuate the extension of these flexibilities to future emergent situations, the Departments propose to amend 31 CFR 33.118(b)(3) and 45 CFR 155.1318(b)(3) to replace the current reference to "public health emergency" with "the emergent situation." This criterion otherwise remains the same.

threat.¹³⁹ States seeking new section 1332 waiver(s) that had such prohibitions in effect at the time they would have otherwise had to conduct public notice were unable to hold two in-person public hearings prior to submission of their section 1332 waiver applications. In similar future emergent situations, this approach would allow the Secretaries to grant the state's request to hold the two public hearings virtually, rather than in-person, or to hold one public hearing at the state level, rather than two public hearings at the state level, if the state's request meets other applicable requirements. As another example, the Secretaries may agree with a state's determination that, due to emergent circumstances that have arisen related to a natural disaster, there is insufficient time for the state to provide public notice and hold any public hearings at the state level prior to submitting its section 1332 waiver application as would otherwise be required by 31 CFR 33.112(a) and 45 CFR 155.1312(a), and grant the state's request to provide public notice and hold public hearings at the state level after the state's submission of its application if the state's request meets other applicable requirements.

In situations where the Departments approve a state's modification request to provide public notice and host the state-level hearings on a different timeframe or setting, such as after the submission of a state's waiver application request, the state would be required to amend the application request as necessary to reflect public comments or other relevant feedback received during the alternative state-level public notice procedures. The Departments would evaluate a state's request for a modification of the public participation requirements and issue their modification determination within approximately 15 calendar days after the request is received. In assessing whether a state acted in good faith, and in a diligent, timely, and prudent manner in the preparation of the modification request for the waiver, and for the section 1332 waiver application, the Departments would evaluate whether the relevant circumstances are sufficiently emergent. The Departments propose in new proposed 31 CFR 33.118(g) and 45 CFR 155.1318(g) that the Departments will consider circumstances to be emergent when they could not have been reasonably

foreseen. In addition, the Departments propose to assess "reasonable foreseeability" based on the specific issues that a section 1332 waiver proposes to address and other relevant factors, and would not make this assessment based solely on the number of days a state may have been aware of such issues. Other relevant factors that the Departments would consider include the specific circumstances involved, the nature and extent of the future emergent situation, and whether the state could have predicted the situation. To assist the Departments with making this assessment the Departments also propose to capture a new requirement at 31 CFR 33.118(b)(5) and 45 CFR 155.1318(b)(5) to require a state submitting a modification request must also explain in its request how the circumstances underlying its request result from a natural disaster; PHE; or other emergent situations that threaten consumers' access to health insurance coverage, consumers' access to health care, or human life could not be reasonably have been foreseen and how a delay would undermine or compromise the purpose of the waiver and be contrary to the interests of consumers.

The Departments remind states that any public participation processes must continue to comply with applicable federal civil rights laws,¹⁴⁰ including taking reasonable steps to provide meaningful access for individuals with limited English proficiency and taking appropriate steps to ensure effective communication with individuals with disabilities, including accessibility of information and communication technology. It is also important for states to remember that virtual meetings may present additional accessibility challenges for people with communications and mobility disabilities, as well as to those who lack broadband access. The Departments expect states to take these considerations into account when seeking flexibility to modify the public participation requirements as the overall statutory and regulatory obligation to ensure a meaningful level of public

¹⁴⁰ The HHS Office for Civil Rights enforces applicable federal civil rights laws that prohibit discrimination on the basis of race, color, national origin, sex, age, or disability, as well as laws protecting the exercise of conscience and religious freedom, including the Religious Freedom Restoration Act (42 U.S.C. 2000bb through 2000bb-4). HHS's requirements are subject to these laws, and states may have obligations under these laws to protect conscience, prohibit coercion, and to ensure the free exercise of religion. U.S. Department of Health & Human Services, Office for Civil Rights, Conscience and Religious Freedom, <https://www.hhs.gov/conscience/index.html> (last visited Aug. 20, 2020).

input during the public notice and comment period would continue to apply. By way of example, ensuring effective communication during a future emergent situation when the otherwise applicable public notice and participation requirements are modified may include providing American Sign Language interpretation and real-time captioning as part of a virtual hearing, and ensuring that the platform used to host the hearing is interoperable with assistive technology for those with mobility difficulties. The Departments especially encourage states to strive to obtain meaningful input from potentially affected populations, including low-income residents, residents with high expected health care costs, persons less likely to have access to care, and members of federally-recognized tribes, if applicable, as part of any alternative public participation process.

Consistent with the framework for COVID-19 PHE state modification requests, the Secretary of HHS would publish on the CMS website any modification determinations within 15 calendar days of the Secretaries making such a determination, as well as the approved revised timeline for public comment at the state and federal level, as applicable.¹⁴¹ In addition, the state would be required to publish on its website any modification requests and determinations within 15 calendar days of receipt of the determination, as well as the approved revised timeline for public comment at the state and Federal level, as applicable.¹⁴²

The Departments seek comment on these proposals.

b. Monitoring and Compliance (31 CFR 33.120 and 45 CFR 155.1320)

As section 1332 waivers are likely to have a significant impact on individuals, states, and the federal government, the 2012 Final Rule established processes and methodologies to ensure that the Secretaries receive adequate and appropriate information regarding section 1332 waivers (consistent with section 1332(a)(4)(B)(iv) of the ACA). As part of the Departments' monitoring and oversight of approved section 1332 waivers, the Secretaries monitor the state's compliance with the specific terms and conditions of the waiver, including, but not limited to, compliance with the guardrails, reporting requirements, and the post

¹⁴¹ See 31 CFR 33.118(d) and 45 CFR 155.1318(d).

¹⁴² See 31 CFR 33.118(e) and 45 CFR 155.1318(e).

¹³⁹ <https://khn.org/morning-breakout/states-declare-emergencies-ban-large-gatherings-as-coronavirus-sweeps-the-nation/>. <https://www.axios.com/states-shelter-in-place-coronavirus-66e9987a-a674-42bc-8d3f-070a1c0ee1a9.html>.

award forum requirements.¹⁴³ Under 31 CFR 33.120(c) and 45 CFR 155.1320(c), to ensure continued public input within at least six months after the implementation date, and annually thereafter, states are required to hold a public forum at which members of the public have an opportunity to provide comments on the progress of the program authorized by the section 1332 waiver and to provide a summary of this forum to the Secretary of HHS for the Departments' review as part of the quarterly and annual reports required under 31 CFR 33.124 and 45 CFR 155.1324. Under 31 CFR 33.120(c)(1) and 45 CFR 155.1320(c)(1), states are required to publish the date, time, and location of the public forum in a prominent location on the state's public website at least 30 days prior to the date of the planned public forum. In the November 2020 IFC, the Departments added 31 CFR 33.120(c)(2) and 45 CFR 155.1320(c)(2) to provide that the Secretaries may waive, in part, post award public notice requirements during the COVID-19 PHE when certain criteria were met.

In this rulemaking, the Departments propose to modify 31 CFR 33.120(c)(2) and 45 CFR 155.1320(c)(2), to extend the flexibilities currently provided during the COVID-19 PHE to permit the Secretaries to modify in part, certain post award public notice requirements in 31 CFR 33.120(c) and 45 CFR 155.1320(c) for approved waivers during a future emergent situation when the application of the post award public notice procedures would be contrary to the interests of consumers. Extending these flexibilities beyond the COVID-19 PHE to future emergent situations is important to help states as they may face similar uncertainty as to whether they are able to comply with the otherwise applicable post award requirements in such situations. For example, the state post award procedures generally require an in-person gathering. Based on the Departments' experience with the current COVID-19 PHE, the Departments are of the view that it is appropriate and reasonable to propose to make similar flexibilities available in future emergent situations as those circumstances may also limit the ability for the state to host in-person gatherings. The Departments are not proposing any changes or soliciting further comments at this time with respect to the flexibility made available in the November 2020 IFC in response to the COVID-19 PHE. States with

approved section 1332 waivers will continue to have flexibility to submit requests to the Departments to modify certain post award public notice requirements during the COVID-19 PHE.¹⁴⁴

Consistent with the framework for state modification requests related to the COVID-19 PHE, under this proposal, the Secretaries could similarly approve a state request to modify the post award public notice procedures, in part, when the application of the post award public notice requirements would be contrary to the interest of consumers during the future emergent situation. The Departments propose to amend the title in 31 CFR 33.120(c)(2) and 45 CFR 155.1320(c)(2) and to amend the text at 31 CFR 33.120(c)(2)(i) and 45 CFR 155.1320(c)(2)(i) to replace the references to "the public health emergency" with "an emergent situation." Amendments are also proposed to the last sentence of 31 CFR 33.120(c)(2)(i) and 45 CFR 155.1320(c)(2)(i) to replace the language that limits these flexibilities to the COVID-19 PHE to reflect the broader proposed applicability to emergent situations, including natural disasters; PHEs; or other emergent situations that threaten consumers' access to health insurance coverage, consumers' access to health care, or human life. In addition, the Departments propose that the Secretaries could approve a state's post award modification request if the state meets all of the following requirements:

- The state requests a modification in the form and manner specified by the Secretaries.
- The state acts in good faith, and in a diligent, timely, and prudent manner to comply with the monitoring and compliance requirements under the regulations and specific terms and conditions of the section 1332 waiver and to submit and prepare the request for a modification.
- The state details in its request for a modification the reason(s) for the alternative post award public notice procedures it proposes to implement at the state level, including public hearings, that are designed to provide the greatest opportunity and level of meaningful public input from impacted stakeholders that is practicable given the emergent circumstances underlying the state's request for a modification.

These are the same requirements that apply under the existing framework for state post award modification requests related to the COVID-19 PHE currently captured in 31 CFR 33.120(c)(2)(ii)(A)

through (C) and 45 CFR 155.1320(c)(2)(ii)(A) through (C).

Under this proposal, a state may request to modify the otherwise applicable public participation requirements to host the public forum for an approved section 1332 waiver that would take place or become due during an emergent situation virtually rather than as an in person gathering. When reviewing state modification requests, the Departments would remain focused on ensuring the public is informed about the implementation of programs authorized by section 1332 waivers and has a meaningful opportunity to comment on its implementation.

Consistent with the framework for COVID-19 state modification requests, the Secretaries would evaluate a state's request for a modification of certain post award public participation requirements during a future emergent situation and issue their modification determination within approximately 15 calendar days after the request is received.¹⁴⁵ The state would be required to publish on its website any modification requests and determinations by the Departments within 15 calendar days of receipt of the determination, as well as information on the approved revised timeline for the state's post award public notice procedures, as applicable.¹⁴⁶ Since the state is already required to post materials as part of post award annual reporting requirements, such as the notice for the public forum and annual report, states would be responsible for ensuring that the public is aware of the determination to modify the public notice procedures and would be required to include this information along with the other information required under 31 CFR 33.120(c)(1) and 45 CFR 155.1320(c)(1) for the alternative procedures in a prominent location on the state's public website.

The Departments are of the view that post award public forums are critical to ensure that the public has a regular opportunity to learn about and comment on the progress of section 1332 waivers. Based on the Departments' experience during COVID-19 PHE, the Departments believe it is appropriate and reasonable to propose to provide similar flexibilities and permit states to request to modify certain post award public participation requirements in future emergent situations. States that receive approval to modify, in part, these post award public notice procedures would

¹⁴³ See section 1332(a)(4)(iv) and (v). Also see 31 CFR 33.120 and 45 CFR 155.1320.

¹⁴⁴ See 85 FR 71142.

¹⁴⁵ See 31 CFR 33.120(c)(2)(ii)(D) and 45 CFR 155.1320(c)(2)(ii)(D).

¹⁴⁶ See 31 CFR 33.120(c)(2)(ii)(E) and 45 CFR 155.1320(c)(2)(ii)(E).

still need to meet all other applicable requirements specified in 31 CFR 33.120(c) and 45 CFR 155.1320(c). For example, if the state receives a modification approval that permits it to hold the post award public forum virtually instead of in person, the state must still publish the notice of its post award public notice on the state's public website and use other effective means to communicate the required information to the public. The public notice must include the website, date, and time of the public forum that will be convened by the state, information related to the timeframe for comments, and how comments from the public on the section 1332 waiver must be submitted. The Departments remind states that they still must also comply with applicable federal civil rights requirements, including laws pertaining to accessibility, if the Secretaries approve a modification from post award public notice procedures. For example, a state that receives approval to host the required public hearing(s) virtually would need to ensure the hearings are accessible to individuals with disabilities and individuals with limited English proficiency (LEP) so members of the public can participate and submit comments. The state should also track how many people are attending these forums, if possible.

In assessing whether a state acted in good faith, and in a diligent, timely, and prudent manner when reviewing a state's post award modification request, the Departments would evaluate whether the relevant circumstances are sufficiently emergent. The Departments propose in 31 CFR 33.120(c)(2)(iii) and 45 CFR 155.1320(c)(2)(iii) that the Departments will consider circumstances to be emergent when they could not have been reasonably foreseen. In addition, the Departments propose that to assess "reasonable foreseeability" based on the specific issues that a section 1332 waiver proposes to address and other relevant factors, and would not make this assessment based solely on the number of days a state may have been aware of such issues. Other relevant factors that the Departments would consider include the specific circumstances involved, the nature and extent of the emergent situation, and whether the state could have predicted the situation. To assist the Departments with making this assessment the Departments also propose to capture a new requirement at 31 CFR 33.120(c)(2)(ii)(F) and 45 CFR 155.1320(c)(2)(ii)(F) to require a state submitting a post award modification request must also explain in its request

how the circumstances underlying its request result from a natural disaster; PHE; or other emergent situations that threaten consumers' access to health insurance coverage, consumers' access to health care, or human life and could not be reasonably have been foreseen and how application of the post award public notice requirements would be contrary to the interests of consumers.

The Departments seek comment on this proposal.

7. Monitoring and Compliance (31 CFR 33.120 and 45 CFR 155.1320)

The Departments are proposing to modify 31 CFR 33.120(a)(1) and (2) and 45 CFR 155.1320(a)(1) and (2) to remove the reference, as codified under part 1 of the 2022 Payment Notice final rule, to interpretive guidance published by the Departments. This proposal is in line with the Departments efforts to provide supplementary information about the requirements that must be met for the continued oversight and monitoring of an approved section 1332 waiver. Because the Departments are of the view that the 2018 Guidance and the incorporation of its guardrail interpretations into regulations could result in the Departments approving section 1332 waivers that would result in fewer residents in those states enrolling in comprehensive and affordable coverage, that those interpretations do not represent the best fulfillment of congressional intent behind the statutory guardrails, that they are inconsistent with the policy intentions of E.O. 14009 and E.O. 13985, and that it is appropriate to address concerns raised by commenters on the 2018 Guidance, the Departments propose to remove the reference to the 2018 Guidance. Under this proposal the Departments would rely upon the statute and regulations, as well as the Departments' interpretive policy statements as outlined in the applicable notice and comment rulemaking, in monitoring approved section 1332 waivers.

8. Pass-Through Funding (31 CFR 33.122 and 45 CFR 155.1322)

Section 1332(a)(3) of the ACA directs the Secretaries to pay pass-through funding to the state for the purpose of implementing the state section 1332 waiver plan and outlines accompanying requirements for making the pass-through funding determination. In this proposed rule, the Departments propose new regulation text at 31 CFR 33.122 and 45 CFR 155.1322 to codify in regulation details regarding the Departments' determination of pass-through funding for approved section

1332 waivers. More specifically, the Departments are proposing to codify in regulation that, with respect to a State's approved section 1332 waiver, the amount of federal pass-through funding would equal the amount, determined annually by the Secretaries, of the PTC under section 36B of the Code, the small business tax credit (SBTC) under section 45R of the Code, or cost-sharing reductions under ACA part I of subtitle E (collectively referred to as federal financial assistance), that individuals and small employers in the state would otherwise be eligible for had the State not received approval for its section 1332 waiver. This would include any amount not paid due to an individual not qualifying for federal financial assistance or qualifying for a reduced level of such financial assistance. The pass-through amount would not be increased to account for any savings other than the reduction in federal financial assistance. The pass-through amount would be reduced by any net increase in federal spending or net decrease in federal revenue if necessary to ensure deficit neutrality. The pass-through estimates take into account experience in the relevant state and the experience of other states with respect to participation in an Exchange and credits and reductions provided under such provisions to residents of the other states. This amount would be calculated annually by the Departments and could be updated by the Departments as necessary to reflect applicable changes in Federal or State law. The proposed regulations further state, consistent with the statute,¹⁴⁷ that any pass-through funding can only be used for purposes of implementing the state's approved section 1332 waiver plan.

Consistent with the Departments' existing regulations at 31 CFR 33.108(f)(4) and 45 CFR 155.1308(f)(4), state section 1332 waiver applications are required to provide analysis and supporting data to inform the Department's estimate of the pass-through funding amount and the waivers' predicted impact on the deficit neutrality guardrail. For states that do not utilize a FFE, this includes information about enrollment, premiums, and federal financial assistance in the state's Exchange by age, income, and type of policy, and other information as may be required by the Secretaries. Consistent with the Departments' existing regulations at 31 CFR 33.124 and 45 CFR 155.1324, states with approved section 1332 waivers must comply with state reporting requirements in accordance with the

¹⁴⁷ See section 1332(a)(3) of the ACA.

terms and conditions of the state's section 1332 waiver. If pass-through funding is being sought as part of the state's section 1332 waiver plan, states may also be required to submit data as outlined in the states terms and conditions for the Departments to calculate pass-through funding. The Departments are not proposing any changes to these waiver requirements.

In addition, these proposals do not change the existing requirements codified in 31 CFR 33.108(f)(3)(iii) and 45 CFR 155.1308(f)(3)(iii) for the state's section 1332 waiver application to include a description of the provisions for which the state seeks a section 1332 waiver and how the waiver is necessary to facilitate the state's waiver plan. Further, under this proposed rule, the Departments propose that, as part of the state's waiver plan if the state is seeking pass-through funding, the state waiver application should include an explanation of how, due to the structure of the section 1332 state plan and the statutory provisions waived, the state anticipates that individuals would no longer qualify for federal financial assistance or would qualify for reduced federal financial assistance, as a result of the section 1332 waiver.¹⁴⁸ In addition, the Departments propose the state would also need to explain in its application how the state intends to use that funding for the purposes of implementing its section 1332 state plan.

The Departments seek comment on these proposals including the proposed adoption of the new regulatory text on pass-through funding for approved section 1332 waivers.

9. Periodic Evaluation Requirements (31 CFR 33.128 and 45 CFR 155.1328)

The Departments are proposing to modify 31 CFR 33.128(a) and 45 CFR 155.1328(a) to remove the reference, as codified under part 1 of the 2022 Payment Notice final rule, to interpretive guidance published by the Departments. This proposal is in line with the Departments efforts to provide supplementary information about the requirements that must be met for the periodic evaluation requirements of an approved section 1332 waiver. Because the Departments are of the view that the 2018 Guidance and the incorporation of its guardrail interpretations into regulations could result in the Departments approving section 1332 waivers that would result in fewer

¹⁴⁸ While this rule generally proposes to supersede and rescind the 2018 Guidance, the Departments are proposing these standards which align with the approach outlined in the 2018 Guidance.

residents in those states enrolling in comprehensive and affordable coverage, that those interpretations do not represent the best fulfillment of congressional intent behind the statutory guardrails, that they are inconsistent with the policy intentions of E.O. 14009 and E.O. 13985, and that it is appropriate to address concerns raised by commenters on the 2018 Guidance, the Departments propose to remove the reference to the 2018 Guidance. Under this proposal the Departments would rely upon the statute and regulations, as well as the Departments' interpretive policy statements as outlined in the applicable notice and comment rulemaking, in conducting periodic evaluations of approved section 1332 waivers.

10. Waiver Amendment (31 CFR 33.130 and 45 CFR 155.1330)

The Departments are proposing new regulations at 31 CFR 33.130 and 45 CFR 155.1330 to delineate the process by which a state is permitted to submit an amendment to an approved section 1332 waiver. The proposed new regulations also capture a proposed definition of section 1332 waiver amendment. While the statute does not specifically mention amendment requests, some states with approved section 1332 waivers have indicated interest in amending their current approved waiver plans. Further, in response to previously received comments on the 2012 final rule, the Departments acknowledged that information regarding section 1332 waiver amendments and renewals would be needed in the future¹⁴⁹ and the Departments have received several inquiries from states on these topics. In addition, there may be situations where states pursuing proposed section 1332 waiver plans are interested in amending an application that has been submitted to the Departments for review. The Departments propose that the framework outlined in this rule would only apply to amendments to approved section 1332 waiver plans and would not apply to changes to an initial section 1332 waiver application submitted to the Departments but unapproved.¹⁵⁰ A state is not authorized to implement any aspect of the proposed amendment

¹⁴⁹ See 77 FR 11700, <https://www.govinfo.gov/content/pkg/FR-2012-02-27/pdf/2012-4395.pdf>.

¹⁵⁰ In circumstances where a state wants to amend its waiver application before the Departments have approved the waiver plan, the Departments intend to work with the state to ensure there is an adequate, meaningful opportunity for public notice and comment taking into account the particular circumstances of the situation and the state's waiver application (such as the changes to the proposed waiver, timing, etc.).

without prior approval by the Departments.

In this rule, the Departments set forth a proposed procedural framework for submission and review of amendment requests for an approved section 1332 waiver. The Departments are of the view that this additional information will help states with approved section 1332 waiver plans better plan for and prepare for potential amendments to their state waiver plans. The Departments also intend to continue providing information and details regarding the section 1332 waiver amendment process in the specific terms and conditions for an approved waiver plan. The proposals outlined later in this section are intended to align with the current amendment request process outlined in recent specific terms and conditions (STCs) for states with approved waivers.¹⁵¹

a. Definition of Waiver Amendment

For purposes of these requirements, the Departments propose to define the term "section 1332 waiver amendment" as a change to a section 1332 waiver plan that is not otherwise allowable under the STCs of an approved waiver, a change that could impact any of the section 1332 statutory guardrails or a change to the program design for an approved waiver. Such potential changes include, but are not limited to, changes to eligibility, coverage, benefits, premiums, out-of-pocket spending, and cost sharing. The Departments propose to codify this definition in new proposed 31 CFR 33.130(a) and 45 CFR 155.1330(a).

b. Waiver Amendment Process

To request a waiver amendment, the Departments propose that the state must submit a letter in electronic format to the Departments to notify them in writing of its intent to request an amendment to its approved section 1332 waiver plan(s). The state would be required to include a detailed description of all of the intended change(s), including the proposed implementation date(s), in its letter of intent. The state is encouraged to submit the letter of intent at least 15 months prior to the section 1332 waiver amendment's proposed implementation date and to engage with the Departments early on in their development of a potential waiver amendment. The state may want to submit this letter of intent more than 15 months prior to the section 1332 waiver

¹⁵¹ For example, see STC 9 in New Hampshire's Approval Letter and STCs: <https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/1332-NH-Approval-STCs.pdf>.

amendment's proposed implementation date, depending on the complexity of the amendment request, the timeline for implementation, among other factors.

The Departments would review the state's letter of intent request. The Departments propose that, within approximately 30 days of the Departments' receipt of the letter of intent, the Departments would respond to the state and confirm whether the change requested is a section 1332 waiver amendment, as well as identify the information the state needs to submit in its waiver amendment request. This written response would also include whether or not the proposed section 1332 waiver amendment(s) would be subject to any additional or different requirements. For example, depending on the complexity of the section 1332 amendment request, scope of changes from the approved waiver plan, operational/technical changes, or implementation considerations, the Departments may impose requirements similar to those specified in 31 CFR 33.108(f) and 45 CFR 155.1308(f) for initial section 1332 waiver applications. The preamble regarding section 1332 waiver amendment content that follows further describes the proposed content requirements for section 1332 waiver amendment requests.

Under the proposed section 1332 waiver amendment framework, the state should generally plan to submit its waiver amendment request no later than nine months prior to when the proposed amendment would take effect in order to allow for sufficient time for review of the waiver amendment request. Similar to the regulations at 31 CFR 33.108(a) and 45 CFR 155.1308(a) for new section 1332 waiver applications, the Departments propose that applications for waiver amendments of a section 1332 waiver must be submitted in electronic format to the Departments. Similar to the regulations at 31 CFR 33.108(b) and 45 CFR 155.1308(b) for new section 1332 waiver applications, the Departments propose that the state is required to submit the section 1332 waiver amendment request sufficiently in advance of the requested waiver implementation date, particularly when the waiver plan impacts premium rates, to allow for an appropriate review and implementation timeframe. Depending on the complexity of the section 1332 amendment request, the state may want to submit the amendment application earlier than nine months prior to implementation. In developing the implementation timeframe for its section 1332 waiver amendment request, the Departments propose that

the state must maintain uninterrupted operations of the Exchange in the state and provide adequate notice to affected stakeholders and issuers of health insurance plans that would be (or may be) affected by the amendment to take necessary action based on approval of the section 1332 waiver amendment request. As detailed later in this section of this preamble, these are operational details that the state would be required to address as part of its waiver amendment request. In addition, as reflected in the new proposed regulations at 31 CFR 33.130(a) and 45 CFR 155.1330(a), a state would not be authorized to implement any aspect of the proposed amendment without prior approval from the Secretaries.

In this rule, the Departments are proposing a similar process for section 1332 waiver amendment requests as is outlined for new section 1332 waiver applications in 31 CFR 33.108 and 45 CFR 155.1308. In line with these requirements, the Departments are proposing to define the type of information and what information a state is required to provide to the public prior to the submission of a section 1332 waiver amendment request to the Departments. Similar to new section 1332 waiver applications, the Departments propose to evaluate the state's section 1332 waiver amendment request and may approve the request if the waiver, as amended, meets the statutory guardrails as defined in Section 1332(b)(1)(A)–(D) and other applicable requirements. In general, states are permitted to have a waiver plan that consists of different components or parts. Under this proposal, states would be permitted to propose an amendment, which could build on an approved section 1332 waiver plan. The Departments are proposing that a state's approved section 1332 waiver plan and the proposed waiver amendment request should be analyzed together, and the state would receive pass-through funding for implementation of the amended waiver plan (including the amendment, if approved) if the amended waiver plan yields federal financial assistance savings, net of any reductions necessary to ensure deficit neutrality. For example, if a state has an approved reinsurance program for plan year 2021 through 2025, and is seeking approval for a waiver amendment request to begin in 2023, the analysis in the section 1332 waiver amendment request should demonstrate that the reinsurance program combined with any proposed amendments meets the guardrails. In comparing scenarios with

and without the section 1332 waiver, the Departments propose to consider the without-waiver scenario to include neither the reinsurance program nor the section 1332 waiver amendment request and the with-waiver scenario to include the combined impact of the reinsurance program and the section 1332 waiver amendment request. In terms of pass-through funding, the Departments propose that, if the section 1332 waiver amendment request described in the example above is approved and determined to yield additional reductions in federal financial assistance (in the form of PTC, CSR, or SBTC), the state would continue to receive pass-through funding annually for combined reductions in federal financial assistance for the entire section 1332 waiver plan, rather than receiving a separate pass through funding amount for the reinsurance component of the waiver and a separate pass-through funding amount for the waiver amendment component. As noted in the above preamble on pass-through funding, such amounts could be updated by the Departments, as necessary, to reflect applicable changes in state or federal law.

Similar to the requirements in 31 CFR 33.108 and 45 CFR 155.1308, the Departments also propose that the public must have a meaningful opportunity to provide input at the state and federal level on waiver amendment requests. Section 1332(a)(4)(B) of the ACA requires the Secretaries to issue regulations that provide a process for public notice and comment at the State level, including public hearings, that is sufficient to ensure a meaningful level of public input. The Departments propose that a state pursuing a section 1332 waiver amendment must conduct the state public notice process that is specified for new applications at 31 CFR 33.112 and 45 CFR 155.1312. As such, to ensure a meaningful level of public input the comment period would generally need to be no less than 30 days. The Departments also propose that it would be permissible for a state to use its annual public forum required under 31 CFR 33.120(c) and 45 CFR 155.1320(c) for the dual purpose of soliciting public input on a proposed section 1332 waiver amendment request and on the progress of its approved waiver plan. This policy proposal is in line with the flexibility the Departments permitted in the 2012 Final Rule section 1332 regulations¹⁵² to allow for states to use Medicaid tribal consultation to also satisfy the requirements as set forth in 31 CFR 33.112(a)(2) and 45 CFR

¹⁵² See 77 FR at 11706.

155.1312(a)(2), that require a State with one or more Federally-recognized tribes within its borders to conduct a separate process for meaningful consultation with the tribes as part of the State section 1332 waiver public notice and comment process. The Departments are of the view that allowing states to use the annual public forum for the dual purpose of soliciting public input on the state's proposed section 1332 waiver amendment request and on the progress of its approved waiver plan would create a more efficient process for both the state and the public to provide a meaningful level of input. Furthermore, this proposal would allow a state to explain to the public how the state's proposed section 1332 waiver amendment would interact with the state's approved waiver plan, and thus would be beneficial to the public in understanding the impact of the state's proposed waiver amendment.

In this rule, the Departments are proposing a similar federal public notice and approval process for section 1332 waiver amendment requests as is outlined for new section 1332 waiver applications in 31 CFR 33.116 and 45 CFR 155.1316. In line with these requirements, the Departments propose that following a determination that a state's section 1332 waiver application request for a section 1332 waiver is complete, the Secretaries will provide for a public notice and comment period that is sufficient to ensure a meaningful level of public input and the comment period would generally be no less than 30 days. The Departments would make available through an HHS website the complete section 1332 waiver amendment request, information relating to how and where written comments may be submitted, and the timeframe during which comments will be accepted. Additionally, the Departments will make available public comments received on the section 1332 waiver amendment request during the Federal public notice and comment period. The Departments are of the view that these proposals would increase transparency of the federal review process and create a clear path for states and the Departments to determine if the information submitted is sufficient to continue review and when to start a federal public comment period on the state's proposed waiver amendment. In addition, the Departments are of the view that these proposals provide the public with a meaningful opportunity to provide input on a section 1332 waiver request in line with the intent of the statute.

c. Waiver Amendment Content

The Departments propose that a state that wants to pursue a section 1332 waiver amendment request must furnish information and analysis regarding the state's proposed waiver amendment that is necessary to permit the Departments to evaluate the request. The proposed information and analysis is similar to the existing requirements for new section 1332 waiver applications.¹⁵³ As such, the Departments propose that a section 1332 waiver amendment request must include the following:

- (1) A detailed description of the requested amendment, including the impact on the guardrails, and related changes to the section 1332 waiver program elements as applicable, including sufficient supporting documentation;
- (2) An explanation and evidence of the process used by the state to ensure meaningful public input;
- (3) Evidence of sufficient authority under state law(s) in order to meet the ACA section 1332(b)(2)(A) requirement for purposes of pursuing the section 1332 waiver amendment;
- (4) An updated actuarial and/or economic analysis demonstrating how the section 1332 waiver, as amended, will meet the section 1332 statutory guardrails;
- (5) An explanation of the estimated impact, if any, of the section 1332 waiver amendment on pass-through funding; and
- (6) Any further requested information and/or analysis that is determined necessary by the Departments to evaluate the section 1332 waiver amendment.

For the required updated actuarial and/or economic analysis, the Departments propose that such analysis must identify the "with waiver" impact of the requested amendment on the statutory guardrails. Such analysis would also be required to include a "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using data from recent experience, as well as a summary of and detailed projections of the change in the "with waiver" scenario. In addition, as described above, the Departments propose that the analysis submitted by the state with its section 1332 waiver amendment request must demonstrate how the state's approved section 1332 waiver plan, combined with any proposed amendments, impacts the guardrails.

The Departments solicit comments on these proposals, including whether the

proposed framework for section 1332 waiver amendment requests should be codified in regulation.

11. Waiver Extension (31 CFR 33.132 and 45 CFR 155.1332)

Section 1332(e) of the ACA provides that no section 1332 waiver may extend over a period of longer than 5 years unless the state requests continuation of its waiver, and such request shall be deemed granted unless the Departments, within 90 days after the date of its submission, either deny such request in writing or inform the state in writing with respect to any additional information which is needed in order to make a final determination with respect to the request. Recognizing that several of the existing section 1332 waivers were approved in 2016 and 2017 to begin in plan years 2017 and 2018, respectively, the Departments are proposing new regulations at 31 CFR 33.132 and 45 CFR 155.1332 to codify section 1332(e) of the ACA and are also proposing, in preamble, the proposed framework for section 1332 waiver extensions. Further, in response to previously received comments, the Departments acknowledged that information regarding section 1332 waiver amendments and renewals would be needed in the future¹⁵⁴ and the Departments have received several inquiries from states on these topics. As such, in this proposed rule the Departments are proposing new regulations at 31 CFR 33.132 and 45 CFR 155.1332 to permit, but not require, states to submit a section 1332 waiver extension request to continue an approved waiver plan. These proposed new regulations also provide that an extension request shall be deemed granted unless the Secretaries, within 90 days after the date of the state's submission of a complete section 1332 waiver extension request, either deny such request in writing or inform the State in writing with respect to any additional information needed to make a final determination with respect to the request. This proposed rule also sets forth, in preamble, a proposed procedural framework for submission and review of extension requests for approved section 1332 waiver plans. The Departments are of the view that this additional information will help states with approved section 1332 waiver plans better plan for and prepare for potential extensions to their waiver plans. The Departments also intend to provide information and details regarding the section 1332 waiver

¹⁵³ See 31 CFR 33.108 and 45 CFR 155.1308.

¹⁵⁴ See 77 FR 11700, <https://www.govinfo.gov/content/pkg/FR-2012-02-27/pdf/2012-4395.pdf>.

extension process in the STCs for an approved waiver plan. These proposals are intended to align with the extension request process outlined in recent STCs for states with approved section 1332 waivers.¹⁵⁵

The Departments propose to define a section 1332 waiver extension as an extension of an approved waiver under the existing waiver terms. As detailed further later in this section of this preamble, if a state wants to make changes to the existing terms of an approved section 1332 waiver, the proposed waiver amendment request framework outlined in this rulemaking would apply. The Departments propose that states with approved section 1332 waivers that want to pursue a waiver extension would be required to inform the Departments if the state will apply for extension of its waiver at least one year prior to the waiver's end date. To request a section 1332 waiver extension, the Departments propose that the state must submit a letter of intent in an electronic format to the Departments to notify them in writing of its intent to request a waiver extension of its approved waiver plan(s). The Departments would then review the state's letter of intent request. The Departments propose that, within approximately 30 days of the Departments' receipt of the letter of intent, the Departments will respond to the state and confirm whether the extension request will be considered as an extension request or whether any changes requested result in the need for a waiver amendment request instead. The Departments will also identify the information the state needs to submit in its section 1332 waiver extension request. The Departments also propose that section 1332 waiver extension requests must also be submitted in electronic format to the Departments, consistent with the format and manner requirements applicable to initial waiver applications under 31 CFR 33.108(a) and 45 CFR 155.1308(a).

Furthermore, the Departments propose that the Departments may request an updated economic or actuarial analysis for the requested extension period in a section 1332 waiver extension request. Given that the Departments receive periodic reports from states with approved section 1332 waivers under 31 CFR 33.124 and 45 CFR 155.1324, in some circumstances the Departments may not need and therefore would not require full new

analysis (as required under 31 CFR 33.108(f)(4) and 45 CFR 155.1308(f)(4) for initial section 1332 waiver applications) and instead may rely on the updated analyses provided as part of these periodic reports. In other instances, depending on the complexity of the section 1332 waiver and the extension request, the Departments may require additional data and information to be submitted to review the extension request.

The Departments propose to evaluate the state's section 1332 waiver extension request and may approve the request if it meets the statutory guardrails as defined in section 1332 (b)(1)(A)–(D) and meets other applicable requirements. The Departments propose that a state waiver extension request may be required to include the following information:

(1) Updated economic or actuarial analyses for the requested extension period in a format and manner specified by the Departments;

(2) Preliminary evaluation data and analysis from the existing section 1332 waiver program;

(3) Evidence of sufficient authority under state law(s) in order to meet the ACA section 1332(b)(2)(A) requirement for purposes of pursuing the requested extension;

(4) An explanation of the process followed by the state to ensure meaningful public input on the extension request at the state-level; and,

(5) Other information as requested by the Departments that is necessary to reach a decision on the requested extension.

As noted above, the Departments would identify the specific information a state needs to include as part of its section 1332 waiver extension request in the response to the state's letter of intent. Further, the Departments have proposed a requirement that the updated economic or actuarial analyses for the requested extension period would be in a format and manner specified by the Departments. The Departments will also rely on available data, such as the analyses provided as part of the periodic reports required under 31 CFR 33.124 and 45 CFR 155.1324, when evaluating a state's waiver extension request if appropriate.

The Departments also propose that it would be permissible for a state to use its annual public forum required under 31 CFR 33.120(c) and 45 CFR 155.1320(c) for the dual purpose of soliciting public input on a proposed section 1332 waiver extension request and on the progress of its approved waiver plan. This policy proposal is in line with the flexibility the Departments

permitted in the 2012 section 1332 regulations¹⁵⁶ to allow states to use Medicaid tribal consultation to also satisfy the requirements as set forth in 31 CFR 33.112(a)(2) and 45 CFR 155.1312(a)(2), that require a state with one or more federally-recognized tribes within its borders to conduct a separate process for meaningful consultation with such tribes as part of the state section 1332 waiver public notice and comment process. The Departments are of the view that allowing states to use the annual public forum for the dual purpose of soliciting public input on an extension request and on the progress of its approved section 1332 waiver would create a more efficient process for both the state and for the public to provide a meaningful level of input.

In this rule, the Departments are proposing a similar federal public notice and review process for a section 1332 waiver extension request as is outlined for new section 1332 waiver applications in 31 CFR 33.116 and 45 CFR 155.1316. The Departments propose that the Departments will review a state's section 1332 waiver extension request and make a preliminary determination as to whether it is complete within approximately 30 days after it is submitted. In line with these requirements, the Departments propose that after determining that the section 1332 waiver extension request is complete, the waiver extension request would be made public through the CMS website, and a 30-day federal public comment period would commence while the extension request is under review. The Departments will make available through the CMS website the information relating to how and where written comments may be submitted and the timeframe during which comments will be accepted.

Additionally, the Departments will make available public comments received on the section 1332 waiver amendment request during the Federal public notice and comment period. The determination that the section 1332 waiver extension request is complete would also mark the beginning of the 90-day clock outlined in section 1332(e) of the ACA for the Secretaries to deny or request more information regarding the continuation, or extension, of the state's approved waiver plan. If, after the extension request has been determined complete, the Departments find that content is missing, additional information is required, or the state needs to respond to public comments received during the federal comment period, the Departments would notify

¹⁵⁵ For example, see STC 10 in New Hampshire's Approval Letter and STCs: <https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/1332-NH-Approval-STCs.pdf>.

¹⁵⁶ See 77 FR at 11706.

the state and an additional review period would begin once the Departments have received the requested information from the state. The Departments propose that this additional review period would be no longer than 90 days. The Departments are of the view that these proposals increase transparency of the federal review process and creates a clear path for states and the Departments to determine if the information submitted is sufficient to continue review and when to start a federal public comment period. In addition, the Departments are of the view that this proposal provides the public with a meaningful opportunity to provide input on a section 1332 waiver extension request in line with the intent of the statute.

The proposed section 1332 waiver extension request process would be separate from the waiver amendment framework described earlier in this rulemaking. A section 1332 waiver extension request under proposed 31 CFR 33.132 and 45 CFR 155.1332 would only be available for an extension of the existing terms of an approved waiver plans and would not be applicable if the state was seeking to make substantive changes to its approved waiver plan beyond a continuation of the term of the waiver. If a state also seeks to make substantive changes to its approved section 1332 waiver plan along with seeking an extension, the Departments would treat those changes as amendments and the framework outlined in this preamble for waiver amendment requests would apply.

The Departments solicit comments on these proposals including whether the proposed framework for section 1332 waiver extension requests should be codified in regulation.

V. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to OMB for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.

- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are soliciting public comment on each of these issues for the following sections of this document that contain information collection requirements (ICRs).

A. ICRs Regarding Navigator Program Standards (§ 155.210)

The data collection requirements for FFE Navigator grantees are currently approved under OMB control 0938–1215/Expiration date: October 31, 2023 (Cooperative Agreement to Support Navigators in Federally-facilitated Exchanges). The proposal to once again require FFE Navigators to provide consumers with information and assistance with regard to certain post-enrollment topics does not increase the number of reports that Navigator grantees are required to submit. Additionally, we do not anticipate changes to the data elements related to the proposed expansion of required Navigator duties to be significant. We note that since the 2020 Payment Notice made assistance with the topics at § 155.210(e)(9) permissible, but no longer required, many Navigator grantees have continued to report on these activities as part of their weekly, monthly, and quarterly metric reports to HHS. Therefore, we do not project the information collection burden to increase.

B. ICRs Regarding Segregation of Funds for Abortion Services (§ 156.280)

We are proposing an amendment to § 156.280(e)(2)(ii) to repeal the separate billing requirement governing payments for QHPs that offer coverage of abortion services for which federal funds are prohibited. Specifically, we are proposing to revert to and codify in amended regulatory text at § 156.280(e)(2)(ii) the prior policy in the 2016 Payment Notice such that QHP issuers offering coverage of abortion services for which federal funds are prohibited again have flexibility in selecting a method to comply with the separate payment requirement in section 1303 of the ACA. If finalized, acceptable methods for satisfying the separate payment requirement would include sending the policy holder a single monthly invoice or bill that separately itemizes the premium amount for coverage of abortion services for which federal funds are prohibited; sending the policy holder a separate monthly bill for these services; or sending the policy holder a notice at or soon after the time of enrollment that

the monthly invoice or bill will include a separate charge for such services and specify the charge. We believe these proposals will remove the burden associated with the separate billing regulation, as detailed below.

The 2019 Program Integrity Rule¹⁵⁷ estimated that the total one-time burden to implement the separate billing regulation for the 94 issuers that were offering coverage for abortion services for which federal funds are prohibited at the time of finalization would be 2,961,000 hours for a total cost of approximately \$385 million. We anticipated the one-time burden for the 3 State Exchanges that performed premium billing and payment processing and had QHP issuers that offered coverage for abortion services for which federal funds are prohibited to be 94,500 hours for a total cost of approximately \$12.3 million. In the May 2020 IFC,¹⁵⁸ we reaffirmed these one-time estimates and anticipated that this one-time burden would still be incurred primarily in 2020, despite the 60-day delay to the implementation deadline.

The 2019 Program Integrity Rule also estimated ongoing annual costs for implementing the separate billing regulation. We estimated the total annual burden in 2020 for all 94 issuers would be 1,133,640 hours with an equivalent cost of approximately \$50.1 million. From 2021 onwards, we estimated the total annual burden for all 94 issuers to be approximately 2,267,280 hours with an associated cost of approximately \$100.2 million. We estimated that for the 3 State Exchanges performing premium billing and payment processing, the total annual burden would be approximately 36,180 hours with an equivalent cost of approximately \$1.6 million in 2020 and 72,360 hours with an associated cost of approximately \$3.2 million starting in 2021. We predicted in the May 2020 IFC that delaying the implementation of the deadline for the separate billing regulation by 60 days would result in a reduction to this annual burden in 2020 of 389,940 hours with an equivalent cost reduction of approximately \$17.4 million for all 97 issuers and State Exchanges performing premium billing and payment processing.

In addition, the Program Integrity Rule estimated that issuers and State Exchanges performing premium billing and payment processing would need to print and send approximately 1.82 million separate paper bills per month in 2020, incurring monthly costs of approximately \$91,200. The Program

¹⁵⁷ 84 FR 71674 (December 27, 2019).

¹⁵⁸ 85 FR 27550 (May 8, 2020).

Integrity Rule estimated the total cost for all issuers and State Exchanges to be approximately \$547,225 in 2020. In 2021, we estimated that the annual cost for all issuers and State Exchanges to send separate paper bills would be approximately \$1,070,129 and that, in 2022, the annual cost would be approximately \$1,045,808. In the May 2020 IFC, we anticipated that delaying the implementation of the deadline for the separate billing regulation by 60 days would reduce the cost of printing separate bills in 2020 by approximately \$182,400.

We are not aware of any issuers or State Exchanges performing premium billing and payment processing that have incurred costs to implement these requirements. Therefore, if finalized, repealing the separate billing regulation would also remove the associated ICRs and the anticipated burden on QHP issuers and State Exchanges that perform premium billing and payment processing. Thus, if finalized as proposed, we will request discontinuation of the ICRs associated with the repealed separate billing regulation (OMB control number: 0938–1358 (Billing and Collection of the Separate Payment for Certain Abortion Services (CMS–10681)).

C. ICRs Regarding Section 1332 Waivers (31 CFR Part 33 and 45 CFR Part 155)

In this proposed rule, the Departments propose modifications to the section 1332 waiver implementing regulations, including changes related to the interpretation of the statutory guardrails, section 1332 waiver amendment and extension requests, and new language related to pass-through funding for approved section 1332 waiver plans. As outlined in this proposed rule, the policies and interpretations proposed in this rule, if finalized, would supersede and replace prior finalized policies and interpretations. The Departments also propose to modify regulations to set forth flexibilities in the public notice requirements and post award public participation requirements for section 1332 waivers during emergent situations, building off of the flexibilities provided during the COVID–19 PHE. However, this rule does not propose to alter any of the requirements related to section 1332 waiver applications, compliance and monitoring, or evaluation in a way that would impose any additional costs or burdens for states seeking waiver approval or those states with approved waiver plans that have not already been captured in prior burden estimates. The Departments anticipate that

implementing these provisions would not significantly change the associated burden currently approved under OMB control number: 0938–1389/Expiration date: February 29, 2024.

D. Submission of PRA-Related Comments

We have submitted a copy of this proposed rule to OMB for its review of the rule's information collection and recordkeeping requirements. These requirements are not effective until they have been approved by the OMB.

We invite public comments on these potential ICRs. If you comment on these information collections, that is, reporting, recordkeeping or third-party disclosure requirements, please submit your comments electronically as specified in the **ADDRESSES** section of this proposed rule.

Comments must be received on/by July 28, 2021.

VI. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

VII. Regulatory Impact Analysis

A. Statement of Need

This rule proposes revised FFE and SBE–FP user fees for the 2022 benefit year. It also proposes to repeal the Exchange DE option; and includes proposed changes related to open enrollment; Navigator program standards; and separate billing and segregation of funds for abortion services. In addition, it clarifies a provision related to special enrollment periods for enrollees that are newly eligible or ineligible for APTC. Finally, relating to section 1332 waivers, it proposes several changes, including the repeal of the incorporation of many policies and interpretations from the 2018 Guidance into the section 1332 waiver implementing regulations. These policies are consistent with providing more accessible and affordable health care through the individual and small group markets.

HHS is proposing to extend the annual individual market open enrollment period in order to provide individuals with a longer opportunity to enroll in coverage, which will expand access to health insurance coverage.

Similarly, HHS is proposing to reinstitute prior requirements that FFE Navigators provide information and assistance with regard to certain post-enrollment topics and help consumers understand basic concepts and rights related to health coverage and how to use it in order to make coverage more accessible to consumers. In addition, HHS is proposing to repeal the separate billing regulation at § 156.280(e)(2)(ii) that required individual market QHP issuers to send a separate bill for that portion of a policy holder's premium that is attributable to coverage for abortion services for which federal funds are prohibited and to instruct such policy holders to pay for the separate bill in a separate transaction. This proposal, if finalized, would reduce administrative burden on issuers, states, Exchanges, and consumers, as well as consumer confusion and unintended losses of coverage.

B. Overall Impact

We have examined the impacts of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980; Pub. L. 96354), section 1102(b) of the Act, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995; Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999), and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Section 3(f) of Executive Order 12866 defines a “significant regulatory action” as an action that is likely to result in a rule: (1) Having an annual effect on the economy of \$100 million or more in any 1 year, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or state, local or tribal governments or communities (also referred to as “economically significant”); (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the

rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order.

A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects (\$100 million or more in any 1 year). We estimate that this rulemaking is "economically significant" as measured by the \$100 million threshold, and hence also a major rule under the Congressional Review Act. Accordingly, we have prepared a Regulatory Impact Analysis that to the best of our ability presents the costs and benefits of the rulemaking.

The provisions in this proposed rule aim to expand consumer access to affordable health care. They would extend the annual open enrollment period, expand Navigator duties, repeal the Exchange DE option, provide more

funding for FFE Navigators and consumer outreach and education, and reduce administrative burden and confusion for consumers. These provisions would also reduce regulatory burden for states and administrative costs for Exchanges and issuers. Through the improvements in enrollment accessibility and increased affordability for consumers, these proposed provisions are expected to increase access to affordable health coverage.

The proposed user fee rates in this proposed rule are higher than those previously finalized for 2022 in part 1 of the 2022 Payment Notice final rule,¹⁵⁹ which could increase premiums for consumers. In accordance with Executive Order 12866, HHS believes that the benefits of this regulatory action justify the costs.

¹⁵⁹ 85 FR 6138.

C. Impact Estimates of the Proposed Rule Provisions and Accounting Table

In accordance with OMB Circular A-4, Table 1 depicts an accounting statement summarizing HHS's assessment of the benefits, costs, and transfers associated with this regulatory action.

This proposed rule implements standards for programs that will have numerous effects, including allowing consumers to have continued access to coverage and health care and stabilizing premiums in the individual and small group health insurance markets and in the Exchanges. We are unable to quantify all benefits and costs of this proposed rule. The effects in Table 1 reflect qualitative impacts and estimated direct monetary costs and transfers resulting from the provisions of this proposed rule for health insurance issuers and consumers.

TABLE 1: Accounting Statement

| | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|-------------|---------------|----------------|
| Benefits: | | | | |
| Qualitative: | | | | |
| <ul style="list-style-type: none"> Consumers will benefit from a longer open enrollment period, as they will have a greater opportunity to enroll in coverage. The special enrollment period clarification will benefit any individual who experiences a decrease in household income that makes them newly eligible for an APTC amount of greater than zero dollars. Consumers will benefit from repeal of the separate billing regulation, as they will no longer be subject to confusing billing processes. APTC-eligible qualified individuals whose household income does not exceed 150 percent of the FPL will benefit from the new special enrollment period, as they will have more opportunities to enroll in coverage throughout the year. | | | | |
| Costs: | Estimate | Year Dollar | Discount Rate | Period Covered |
| Annualized Monetized (\$/year) | -\$270.1 million | 2020 | 7 percent | 2021-2025 |
| | -\$267.3 million | 2020 | 3 percent | 2021-2025 |
| Quantitative: | | | | |
| <ul style="list-style-type: none"> Reduction in costs to all issuers, states, State Exchanges performing premium billing and payment processing, the FFE, and consumers due to the separate billing regulation of approximately \$407.05 million in 2021, \$230.7 million in 2022, and \$229.3 million annually in 2023 and onwards. In addition to annual costs, the reduction in costs in 2021 includes a reduction in cost to reflect the one-time implementation changes that issuers, states, States Exchanges performing premium billing and payment processing, and the FFEs would have incurred if the separate billing policy had been implemented in 2020. Because the separate billing policy was not implemented in 2020 due to courts invalidating the policy, these one-time costs could have been incurred in 2021, had the separate billing policy remained applicable. | | | | |
| Qualitative: | | | | |
| <ul style="list-style-type: none"> Increased costs due to increases in providing medical services (if health insurance enrollment increases). | | | | |
| Transfers: | Estimate | Year Dollar | Discount Rate | Period Covered |
| Annualized Monetized (\$/year) | \$480.9 million to \$1.2309 billion | 2021 | 7 percent | 2022-2026 |
| | \$481.5 million to \$1.2315 billion | 2021 | 3 percent | 2022-2026 |
| Quantitative: | | | | |
| <ul style="list-style-type: none"> Increase in transfers from the issuers to federal government by approximately \$200 million in 2022 and approximately \$240 million in 2023 onwards due to changes in user fee rates and state transitions from FFEs to SBE-FPs or from SBE-FPs to SBEs. A potential 0.5 to 2 percent increase in premiums in 2022 and onwards as a result of the monthly special enrollment period for APTC-eligible qualified individuals whose household income does not exceed 150 percent of the FPL, with a corresponding potential increase in APTC/PTC annual outlays and decrease in income tax revenues of approximately \$250 million to \$1 billion. | | | | |

This RIA expands upon the impact analyses of previous rules and utilizes the CBO analysis of the ACA's impact on federal spending, revenue collection, and insurance enrollment. In addition to utilizing CBO projections, HHS conducted an internal analysis of the effects of its regulations on enrollment and premiums. Based on these internal analyses, we anticipate that the quantitative effects of the provisions proposed in this rule are consistent with our previous estimates in the 2021 Payment Notice for the impacts

associated with APTC and FFE user fee requirements.

1. Navigator Program Standards (§ 155.210)

We propose to amend § 155.210(e)(9) to reinstitute the requirement that FFE Navigators provide consumers with information and assistance with regard to certain post-enrollment topics. In FFEs, Navigators will continue to be permitted to undertake the Navigator duties specified in § 155.210(e)(9) until this proposal, if finalized, becomes effective. If this proposal is finalized,

FFE Navigators would be required to perform the Navigator duties specified in § 155.210(e)(9) beginning with Navigator grants awarded after the effective date of this rule, including non-competing continuation awards. If this proposal is finalized prior to Navigator grant funding being awarded in FY 2022, FY 2021 Navigator grantees will be required to perform these duties beginning with the Navigator grant funding awarded in FY 2022 for the second 12-month budget period of the 36-month period of performance. To the extent Navigators awarded grant

funding in FY 2021 are not already performing these duties under their year one project plans when this proposal, if finalized, becomes effective, they can revise their project plans to incorporate performance of the duties specified in § 155.210(e)(9) as part of their non-competing continuation application for their FY 2022 funding.

These duties were previously required of Navigators in all Exchanges before the 2020 Payment Notice amended § 155.210(e)(9) and made assistance with these post-enrollment topics permissible for FFE Navigators, but not required, beginning with FFE Navigator grants awarded in 2019. Despite no longer being required, the majority of FFE Navigators continue to provide information and assistance to consumers and report metrics on the post-enrollment topics outlined in § 155.210(e)(9) and we anticipate positive feedback from Navigators and other stakeholders in response to this proposal. Additionally, by reinstating the requirements at § 155.210(e)(9), we would be able to both require applicants to include plans for performing these post-enrollment activities as part of their annual applications for new or continued Navigator grant funding, as well as include Navigator assistance with these post-enrollment activities as part of their performance evaluations. All costs associated with reaching these consumers in FFEs would be considered allowable costs that would be covered by the Navigator grants for the FFEs and that may be drawn down as the grantee incurs such costs.

2. Exchange Direct Enrollment Option (§ 155.221(j))

We propose to remove § 155.221(j) and repeal the Exchange DE option, which allows states to use direct enrollment technology to transition to private-sector-focused enrollment pathways operated by QHP issuers, web-brokers, and agents and brokers, instead of or in addition to a centralized eligibility and enrollment website operated by an Exchange. We anticipate that repealing the Exchange DE option would have minimal impact on stakeholders since no resources have been expended by states or HHS on implementing it. Any potential costs and burdens associated with the Exchange DE option would be eliminated. These include costs to develop consumer-facing enrollment functionality and meet eligibility application technical requirements, as well as to maintain back-end eligibility determination functionality and other back-end eligibility services; start-up and implementation costs to develop

the appropriate privacy and security infrastructure and business controls; as well as costs related to ongoing oversight and monitoring of DE entities and maintaining the individual interfaces and transactions with each DE entity. We also anticipate that repealing the Exchange DE option could mitigate potential negative downstream impacts raised by commenters when it was proposed, including an increased uninsured and underinsured population.

3. Open Enrollment Period Extension (§ 155.410(e))

We are proposing to extend the individual market annual open enrollment period for all Exchanges from November 1 through January 15th for the 2022 coverage year and beyond. We do not anticipate a significant impact on the Exchange risk pool to result from this change. Consumers would benefit from a longer open enrollment period without additional demand placed on them. A lengthened open enrollment period may lead to increased enrollments which could impose additional costs on Exchanges and enrollment assisters to conduct outreach and assist new consumers. However, this change could also reduce outreach costs on Exchanges and enrollment assisters by spreading out enrollments over a greater length of time, resulting in opportunities for efficiency and increased health coverage.

4. Monthly Special Enrollment Period for APTC-Eligible Qualified Individuals With a Household Income No Greater Than 150 Percent of the Federal Poverty Level (§ 155.420(d)(16))

We propose to codify a monthly special enrollment period for qualified individuals or enrollees, or the dependents of a qualified individual or enrollee, who are eligible for APTC, and whose household income is expected to be no greater than 150 percent of the FPL. We propose that this special enrollment period be available at the option of the Exchange in order to allow State Exchanges to decide whether to implement it based on their specific market dynamics, needs, and priorities. We also propose that Exchanges on the Federal platform will implement this special enrollment period by providing qualified individuals who are eligible with a pathway to access it through the *HealthCare.gov* application.

To provide Exchanges with flexibility to prioritize ensuring that qualifying individuals are able to obtain coverage through this special enrollment period quickly following plan selection, or to

implement this special enrollment period in keeping with their current operations, we propose to add a new paragraph at § 155.420(b)(2)(vii) to provide that the Exchange must ensure that coverage is effective in accordance with paragraph (b)(1) of this section or on the first day of the month following plan selection, at the option of the Exchange. We also propose to include plan category limitations by adding a new paragraph at § 155.420(a)(4)(ii)(D) to provide that an Exchange must permit eligible enrollees and their dependents to use the special enrollment period to change to a silver level plan; and to amend § 155.420(a)(4)(iii), which provides other plan category limitations for other special enrollment periods, to provide that these other plan category limitations do not apply to enrollees and dependents who qualify for the proposed special enrollment period.¹⁶⁰ Finally, we propose to add a new paragraph at § 147.104(b)(2)(i)(G) to specify that issuers are not required to provide this special enrollment period in the individual market with respect to coverage offered outside of an Exchange, because eligibility for the special enrollment period is based on eligibility for APTC, and APTC cannot be applied to coverage offered outside of an Exchange.

A monthly special enrollment period available through Exchanges for APTC-eligible qualifying individuals whose household income does not exceed 150 percent of the FPL would provide more opportunities for certain low-income APTC and CSR-eligible consumers to take advantage of the financial assistance available to them. As discussed in the preamble for this rulemaking, we believe that the benefit to providing these opportunities outweighs adverse selection concerns. Further, we believe the risk of adverse selection is mitigated to some degree by most qualifying individuals having access to a premium-free silver plan after application of APTC with a 94 percent actuarial value, because consumers eligible for a premium-free plan covering such a significant portion of health care services would likely already be enrolled if they were aware of their eligibility for such coverage. Additionally, we believe that those for whom this is the case are not likely to move in and out of coverage once they have enrolled, for example to end

¹⁶⁰ This provision would not prevent enrollees who qualify for the new special enrollment period from changing to a plan of any category through a special enrollment period that provides this flexibility, including the special enrollment periods at § 155.420(d)(4), (8), (9), (10), (12), and (14).

coverage once an immediate health care need is met, which may also limit some adverse selection risk. We also believe that applying plan category limitations to this special enrollment period would help to mitigate adverse selection because it would limit the ability of enrollees to change to a higher metal level plan based on a new health care need and then change back to a silver plan once the health issue is resolved. We also believe that enrollees who are interested in changing plans during the year through this special enrollment period would likely be deterred because such a change would generally mean they lose progress they have made toward meeting their deductibles and other accumulators. However, enrollees may still choose to enroll in a silver level plan that is more expensive than their zero dollar option, and, with a monthly special enrollment period, could make this change during the plan year based on a difference in provider network or prescription drug formulary.

Therefore, we request comment on practices, including education and outreach, that could help ensure that consumers who are eligible for this special enrollment period enroll in the zero-dollar premium silver plan that is available to them. We also seek comment on the remaining risk for issuers; for example, on the extent to which there is risk related to consumers who become aware of the availability of the proposed special enrollment period after they become sick and seek to enroll because they need medical care. Based on the possibility that consumers could enroll through the special enrollment period only after they need to use health care services, we seek comment on whether issuers may account for this risk through premium increases. We estimate a 0.5 to 2 percent increase in premiums when the enhanced APTC provisions of the ARP are in effect in states where this special enrollment period is implemented, due to increased adverse selection risk, resulting in an estimated \$250 million to \$1 billion increase in APTC/PTC outlays and decrease in income tax revenues nationwide, and we seek comment on this estimate.

We also seek comment on potential risk that individuals, including those who enroll in coverage due to a health event, later experience a household income change or change their primary place of residence such that they are no longer eligible for a silver plan with a zero dollar premium, and that these individuals will end coverage at that point. Because this special enrollment period has the potential to introduce new adverse selection risk into the

individual market, CMS also seeks comment generally on the impact on premiums of this policy in Exchanges where it is implemented, and potential regulatory tools that could mitigate these risks.

For example, Exchanges that implement this special enrollment period could try to mitigate some risks with a robust outreach and education campaign to promote awareness of the special enrollment period. However, because the proposed special enrollment period would be based on projected annual household income level, and Exchanges rely on applicants to report their most up to date household income information, it may be difficult for Exchanges to assess which individuals might be eligible for outreach and education purposes and could make targeted marketing and outreach difficult. We therefore seek comment on practices that could help mitigate this challenge, and ways to improve outreach to low-income consumers more generally. Relatedly, we seek comment on how Exchanges could help to mitigate potential confusion on the part of stakeholders that provide enrollment assistance, such as HHS Navigator grantees, and agents and brokers. We seek comment on how Exchanges and stakeholders that provide enrollment assistance could develop effective outreach and education campaigns to target this population.

Finally, we request comment on level of effort for Exchanges to implement this special enrollment period, especially within the amount of time required to make it available to consumers during the 2022 plan year.

5. Clarification of Special Enrollment Period for Enrollees Who Are Newly Eligible or Newly Ineligible for Advance Payments of the Premium Tax Credit (§ 155.420(f))

We are proposing new language to clarify, for purposes of the special enrollment period rules at 45 CFR 155.420, that a qualified individual, enrollee, or his or her dependent, who qualifies for APTC because they meet the criteria at § 155.305(f), but who qualifies for a maximum APTC amount of zero dollars, is not considered APTC eligible, even when they have previously been APTC ineligible for another reason, such as having other MEC. We believe that the current special enrollment period rules that reference APTC eligibility at § 155.420(d)(6) could permit inconsistent interpretations of what it means to be newly eligible or ineligible for APTC when an individual is found

to be eligible generally to receive APTC, but for a specific APTC amount of zero dollars. We believe that this clarification will help ensure that the special enrollment periods at § 155.420(d)(6) are available to individuals as intended: those determined to be newly eligible for an APTC amount greater than zero dollars.

We believe that this change will not be relevant to a significant number of individuals in Exchanges on the Federal platform, but that for the reasons described in preamble, it will be important in light of the removal of the upper APTC eligibility limit on household income at 400 percent of the FPL for taxable years 2021 and 2022 under the ARP.¹⁶¹ More specifically, this definition makes clear that an individual who becomes newly eligible for a maximum APTC amount of zero dollars, and who enrolls in Exchange coverage, for example, through the 2021 special enrollment period available to consumers in states on the Federal platform, would qualify for a special enrollment period per § 155.420(d)(6)(i) or (ii) if, later in the plan year, they become newly eligible for an APTC amount greater than zero dollars based on a decrease in their household income. This clarification may be helpful for any individual who experiences a decrease in household income that makes them newly eligible for an APTC amount of greater than zero dollars to understand.

As of March 1, 2021 (prior to the passage of the ARP), approximately 7.25 million enrollees through Exchanges on the Federal platform were APTC eligible, but only 36,000 (or 0.5 percent) were APTC eligible with a maximum APTC amount of zero dollars. However, just under 119,000 enrollees through Exchanges on the Federal platform reported a household income that was greater than 400 percent of the FPL. HHS analysis indicated that roughly 35,000 of this greater than 400 percent FPL population would automatically be considered APTC eligible with a maximum APTC amount of zero dollars once the 400 percent FPL limit on household income had been removed and these enrollees were no longer considered APTC ineligible simply by virtue of exceeding that limit, doubling the number of potentially impacted enrollees through Exchanges on the Federal platform even before to the passage of the ARP. Additionally, as of March 1, 2021, HHS identified roughly 501,000 enrollees that did not report any household income on their application; some of these enrollees may

¹⁶¹ Public Law 117–2.

also be newly eligible for APTC under the new rules. Currently, after passage of the ARP and CMS' removal of the 400 percent FPL limit on household income regarding qualifying individuals applying for coverage through an Exchange on the Federal platform, the number of enrollees who did not provide household income has decreased slightly, to just under 472,000, and the number of enrollees reporting a household income greater than 400 percent of the FPL has increased to over 191,000. The number of enrollees eligible for a maximum APTC amount of zero dollars has also increased slightly, to just under 42,000 individuals.¹⁶² We expect these trends continue during 2022 in Exchanges on the Federal platform and likely in other State Exchanges, as well, making this clarification especially relevant at that time.

We seek comment on this proposal, including from State Exchanges regarding whether this definition of APTC eligibility reflects their current implementation of the special enrollment period qualifying events per § 155.420(d)(6), and if not, whether there are policy concerns about this clarification, or concerns about the burden of making related changes to State Exchanges' operations. We also seek comment on whether any group of individuals who may qualify for one or more of the special enrollment periods at § 155.420(d)(6) could be harmed by this clarification, and if so, how such harm could be mitigated.

6. FFE and SBE-FP User Fees (§ 156.50)

We are proposing an increased FFE user fee rate of 2.75 percent for the 2022 benefit year, which is higher than the 2.25 percent FFE user fee rate finalized in part one of the 2022 Payment Notice. We also propose to increase the SBE-FP user fee rate to 2.25 percent for the 2022 benefit year from the 1.75 percent SBE-FP user fee rate finalized in part 1 of the 2022 Payment Notice final rule.¹⁶³ Based on our estimated costs, enrollment (including anticipated transitions of states from the FFE and SBE-FP models to either the SBE-FP or State Exchange models), premiums for the 2021 and 2022 benefit years, and proposed user fee rates, we expect transfers from the issuers to federal government to be increased by

approximately \$200 million in plan year 2022.

We are proposing to repeal the 2023 benefit year user fee rate for the Exchange DE option in FFE and SBE-FP states, which was finalized in part 1 of the 2022 Payment Notice final rule. No state entity has approached HHS to consider this option. Since this option has not been implemented in any state, we do not expect any changes to user fee transfers from issuers to the federal government due to this rescission.

7. Segregation of Funds for Abortion Services (§ 156.280)

We propose to amend the separate billing regulation at § 156.280(e)(2)(ii) that governs payments for QHPs that provide coverage of abortion services for which federal funds are prohibited. Under this proposal, we would revert to prior policy that allowed QHP issuers offering coverage of such abortion services flexibility in selecting a method to comply with the separate payment requirement in section 1303. If finalized, acceptable methods for satisfying the separate payment requirement would include sending the policy holder a single monthly invoice or bill that separately itemizes the premium amount for coverage of such abortion services; sending the policy holder a separate monthly bill for these services; or sending the policy holder a notice at or soon after the time of enrollment that the monthly invoice or bill will include a separate charge for such services and specify the charge.

The 2019 Program Integrity Rule extensively detailed the anticipated financial and operational burdens from the separate billing regulation. We believe these proposals will remove the significant burden associated with the separate billing regulation. Those burdens included costly estimates for issuer implementation of the technical build to implement the necessary system changes to support separate billing and receipt of separate payments, which would require significant changes to current billing practice and pose increased challenges for some states and issuers given the mid-plan year implementation timeline. These activities included planning, assessment, budgeting, contracting, building and testing their systems; as well as one-time changes such as billing-related outreach and call center training. The burdens also included ongoing costs related to sending a separate bill, such as those related to identifying impacted enrollees, ensuring billing accuracy, reconciliation, quality assurance, record keeping, document retention, support for enrollees who

enter grace periods for non-payments, customer service, outreach, and compliance. Issuers would also be expected to assume annual materials costs related to printing of and sending the separate bill. We anticipated that State Exchanges would experience increased burden associated with one-time technical changes such as updating online payment portals to accept separate payments and updating enrollment materials and notices that reference binder payments, and ongoing costs related to increased customer service, outreach, and compliance.

We also stated in the 2019 Program Integrity Rule that QHP issuers were likely to consider these new costs when setting actuarially sound rates and that this would likely lead to higher premiums for enrollees. Specifically, we estimated there would be an approximate premium impact of up to 1.0 percent in plan year 2021 and each year thereafter states with QHP issuers offering coverage of abortion services for which federal funds are prohibited. We also estimated that enrollment would be slightly reduced in the impacted states as a result of the increase to premiums. In plan year 2021 and each year after, we estimated that APTC amounts would increase up to \$146 million when premium rates reflect the projected additional administrative and operational expense burdens.

We also projected in the 2019 Program Integrity Rule that the FFE would incur additional costs due to one-time technical changes and increased call volumes and additional customer services efforts. We estimated that the FFE would incur a one-time cost of \$750,000 in 2020 and ongoing annual costs of approximately \$400,000 in 2020, \$800,000 in 2021, \$600,000 in 2022, and \$400,000 in 2023 onwards to implement the separate billing policy.

We also anticipated that all impacted State Exchanges would incur one-time costs of \$9 million in 2020 for necessary technical changes such as updating online payment portals to accept separate payments and updating enrollment materials. In addition, we estimated that State Exchanges would incur ongoing annual costs associated with increased customer service, outreach, and compliance totaling \$2.4 million in 2020, \$4.8 million in 2021, \$3.6 million in 2022, and \$2.4 million 2023 onwards for all impacted State Exchanges.

We also anticipated increased costs to consumers for the time required to read and understand the separate bills and seek help from customer service, and additional time to read and send separate payments in subsequent

¹⁶² These figures are drawn from internal CMS analysis as of late May, 2021, almost two months after CMS updated *HealthCare.gov* to reflect the removal of the 400 percent FPL limit on household income on applicants applying for coverage with APTC.

¹⁶³ 85 FR 6138.

months. For the estimated 2 million policy holders in plans offering coverage of abortion services for which federal funds are prohibited, the Program Integrity Rule estimated a total annual cost for of 2.9 million hours in 2020 with an associated annual cost of \$35.5 million. We decreased this estimated burden slightly in the May 2020 IFC to account for a burden reduction of approximately 337,793 hours with an equivalent cost savings of approximately \$4.2 million. For subsequent years, we estimated in the 2019 Program Integrity Rule that the annual enrollee burden would be approximately 2 million hours with an associated annual cost of approximately \$25.1 million.

In total, the projected burden to all issuers, states, State Exchanges performing premium billing and payment processing, the FFE, and consumers due to the separate billing policy regulation totaled \$546.1 million in 2020, \$232.1 million in 2021, \$230.7 million in 2022, and \$229.3 million annually in 2023 and onwards.

We also believe the consumer confusion and new logistical obstacles due to the separate billing regulation would disproportionately harm and burden communities who already face barriers to accessing care and that any potential coverage losses caused by the separate billing regulation could further exacerbate existing health disparities and jeopardize health outcomes. Further, issuers dropping coverage of abortion services for which federal funds are prohibited as a result of the burden associated with the separate billing regulation could transfer out-of-pocket costs for this coverage to enrollees, which may disproportionately impact low-income women who already face barriers to accessing quality health care.

Upon reassessing the separate billing policy and in light of the legal developments, we no longer see a discernable benefit to requiring separate billing that would be sufficient to outweigh its burdens. If finalized, we anticipate repeal of the separate billing regulation would remove the associated burdens to issuers, states, Exchanges, and consumers by allowing issuers to continue the billing practices and collection methods previously adopted and relied upon since publication of the 2016 Payment Notice.

8. Section 1332 Waivers

In this proposed rule, the Departments propose modifications to the section 1332 waiver implementing regulations, including new proposed policies and interpretations of the

guardrails. We also propose new process and procedures for amendment and extension requests for approved section 1332 waiver plans. As outlined in this proposed rule, the policies and interpretations proposed in this rule, if finalized, would supersede and replace prior finalized policies and interpretations. The Departments also propose to modify these regulations to set forth flexibilities in the public notice requirements and post award public participation requirements for section 1332 waivers during future emergent situations. However, this rule does not propose to alter any of the requirements related to state innovation waiver applications, compliance and monitoring, or evaluation in a way that would create any additional costs or burdens for states submitting proposed waiver applications or those states with approved waiver plans that has not already been captured in prior burden estimates. The Departments are of the view that both states with approved section 1332 waivers and states that are considering section 1332 waivers would be minimally impacted by these proposed changes in policy. The Departments anticipate that implementing these provisions would not significantly change the associated burden currently approved under OMB control number: 0938-1389/Expiration date: February 29, 2024. The Departments are of the view that section 1332 waivers could help increase state innovation, which in turn could lead to more affordable health coverage for individuals and families in states that consider implementing a section 1332 waiver program.

9. Regulatory Review Cost Estimation

If regulations impose administrative costs on private entities, such as the time needed to read and interpret this proposed or final rule, we should estimate the cost associated with regulatory review. Due to the uncertainty involved with accurately quantifying the number of entities that will review the rule, we assume that the total number of unique commenters on the 2022 Payment Notice proposed rule will be the number of reviewers of this proposed rule. We acknowledge that this assumption may understate or overstate the costs of reviewing this rule. It is possible that not all commenters reviewed the 2022 Payment Notice proposed rule in detail, and it is also possible that some reviewers chose not to comment on that proposed rule. For these reasons, we thought that the number of past commenters on the 2022 Payment Notice proposed would be a fair estimate of the number of reviewers

of this rule. We welcome any comments on the approach in estimating the number of entities which will review this proposed rule.

We also recognize that different types of entities are in many cases affected by mutually exclusive sections of this proposed rule, and therefore for the purposes of our estimate we assume that each reviewer reads approximately 50 percent of the rule. We seek comments on this assumption.

Using the wage information from the Bureau of Labor Statistics (BLS) for medical and health service managers (Code 11-9111), we estimate that the cost of reviewing this rule is \$114.24 per hour, including overhead and fringe benefits.¹⁶⁴ Assuming an average reading speed, we estimate that it would take approximately 1 hour for the staff to review half of this proposed rule. We assume 245 entities will review this proposed rule. For each entity that reviews the rule, the estimated cost is approximately \$114.24 (1 hour × \$114.24). Therefore, we estimate that the total cost of reviewing this regulation is approximately \$27,989 (\$114.24 × 245 reviewers).

D. Regulatory Alternatives Considered

In developing the policies contained in this proposed rule, we considered numerous alternatives to the presented proposals. Below we discuss the key regulatory alternatives that we considered.

We considered taking no action related to our proposal to add a new paragraph at § 155.420(d)(16), to provide a monthly special enrollment period for qualified individuals or enrollees, or the dependent of a qualified individual or enrollee, who are eligible for APTC, and whose household income is expected to be no greater than 150 percent of the FPL. However, we believe that many consumers will benefit from having additional opportunities to enroll in low-cost Exchange coverage, and that those who do not enroll during the open enrollment period are likely to have been unaware of their option to enroll in a plan with no monthly premium through the Exchange.

We also considered other strategies to help individuals who may benefit from the proposed special enrollment period, some of whom qualify for another, existing special enrollment period. For example, consumers who do not receive timely notice of an event that triggers eligibility for a special enrollment period, and otherwise were reasonably unaware that a triggering event occurred under § 155.420(d)(1) may be able to

¹⁶⁴ https://www.bls.gov/oes/current/oes_nat.htm.

benefit from a policy finalized at § 155.420(c)(5) in the 2022 Payment Notice that requires the Exchange to provide 60 days from the date that the consumer knew or reasonably should have known of the occurrence of the triggering event.¹⁶⁵ Exchanges could leverage this provision to help enable consumers to maintain coverage after losing Medicaid. We solicit comment regarding additional strategies to help consumers maintain coverage.

We considered taking no action related to our proposal to clarify, for purposes of the special enrollment period rules at § 155.420, that a qualified individual, enrollee, or his or her dependent who qualifies for APTC because they meet the criteria at § 155.305(f), but who qualifies for a maximum APTC amount of zero dollars, is not considered APTC eligible. However, we believe that consumers and other stakeholders will benefit from clarity on this issue because it improves transparency of Exchanges' implementation of the special enrollment period qualifying events provided at § 155.420(d)(6). Increased transparency will allow consumers to better understand the eligibility criteria for special enrollment periods provided by § 155.420(d)(6) and may help Exchanges and other stakeholders to more effectively message rules that determine eligibility. We also considered applying this clarification only to some of the special enrollment period qualifying events at § 155.420(d)(6), such as only to those at paragraphs (d)(6)(ii)–(iii), to permit some individuals to access a special enrollment period based on newly becoming eligible for a maximum APTC amount of zero dollars after previously having been APTC ineligible for another reason. We believe that applying this definition to all of the qualifying events in § 155.420(d) is simpler and makes sense based on the nature of the qualifying events. However, we have solicited comment on whether Exchanges and other stakeholders agree with this approach, or believe that another definition of APTC eligibility should apply to certain qualifying events at § 155.420(d)(6).

We considered restoring user fee rates to their 2021 levels at 3 percent and 2.5 percent of total monthly premium for issuers in the FFE and SBE-FPs, respectively. However, based on our analysis of estimated 2022 enrollment, premiums, and contract costs, we determined that this increase would be unnecessary to finance the Exchange essential functions.

Regarding the section 1332 waiver proposals in this rule, the Departments considered rescinding the 2018 Guidance and the regulatory updates and policies finalized in part 1 of the 2022 Payment Notice final rule such that the Departments would rely on the statute for review and approval of section 1332 waiver applications. The Departments did not choose this option because not proposing policies, interpretations and standards to help explain the program requirements would lead to uncertainty for states considering section 1332 waiver applications. The Departments also considered codifying the policies and interpretations in the 2015 Guidance in regulation, but determined proposing new policies and interpretations (some of which align with previous guidance and rulemaking) was the clearest way to explain the proposed requirements for submission and approval of section 1332 waivers.

E. Regulatory Flexibility Act (RFA)

The Regulatory Flexibility Act (5 U.S.C. 601, *et seq.*), requires agencies to prepare an initial regulatory flexibility analysis to describe the impact of the proposed rule on small entities, unless the head of the agency can certify that the rule will not have a significant economic impact on a substantial number of small entities. The RFA generally defines a “small entity” as (1) a proprietary firm meeting the size standards of the Small Business Administration (SBA), (2) a not-for-profit organization that is not dominant in its field, or (3) a small government jurisdiction with a population of less than 50,000. States and individuals are not included in the definition of “small entity.” HHS considers a rule to have a significant economic impact on a substantial number of small entities if at least 5 percent of small entities experience a change in revenues of more than 3 to 5 percent.

In this proposed rule, we propose revised 2022 user fee rates, which will impact issuer rate setting. We believe that health insurance issuers and group health plans would be classified under the North American Industry Classification System code 524114 (Direct Health and Medical Insurance Carriers). According to SBA size standards, entities with average annual receipts of \$41.5 million or less would be considered small entities for these North American Industry Classification System codes. Issuers could possibly be classified in 621491 (HMO Medical Centers) and, if this is the case, the SBA size standard would be \$35 million or

less.¹⁶⁶ We believe that few, if any, insurance companies underwriting comprehensive health insurance policies (in contrast, for example, to travel insurance policies or dental discount policies) fall below these size thresholds. Based on data from MLR annual report¹⁶⁷ submissions for the 2019 MLR reporting year, approximately 77 out of 479 issuers of health insurance coverage nationwide had total premium revenue of \$41.5 million or less. This estimate may overstate the actual number of small health insurance companies that may be affected, since over 67 percent of these small companies belong to larger holding groups, and many, if not all, of these small companies are likely to have non-health lines of business that will result in their revenues exceeding \$41.5 million. The user fee rates proposed in this rule are lower than the 2021 benefit year user fee rates by 0.25 percent, and these new proposed rates are higher than the previously finalized 2022 benefit year user fee rates by 0.5 percent. Therefore, these user fee rates would only impact premium revenue for these issuers by approximately 0.25 percent, since no issuer has effectuated payments under the previously finalized user fee rates, and this impact is below HHS's 3 to 5 percent significance threshold stated above.

In this proposed rule, we also propose to codify a new monthly special enrollment period for certain APTC-eligible individuals. Because this special enrollment period has the potential to introduce new adverse selection risk into the individual market, we seek comment in the RIA on the impact on premiums of this policy in Exchanges where it is implemented. We estimate that this policy could result in an increase in premiums of 0.5 to 2 percent when the enhanced APTC provisions of the ARP are in effect, and this impact is below HHS's 3 to 5 percent significance threshold stated earlier in this preamble.

In addition, the other proposals in this rule would either reduce costs or have no cost impact. Therefore, we do not expect the proposed provisions of this rule to affect a substantial number of small entities. We do not believe that this threshold will be reached by the requirements in this proposed rule or final rule. Therefore, the Secretary has determined that this proposed rule will not have a significant economic impact

¹⁶⁶ <https://www.sba.gov/document/support-table-size-standards>.

¹⁶⁷ Available at <https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html>.

on a substantial number of small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a metropolitan statistical area and has fewer than 100 beds. While this rule is not subject to section 1102 of the Act, we have determined that this proposed rule would not affect small rural hospitals. Therefore, the Secretary has determined that this rule would not have a significant impact on the operations of a substantial number of small rural hospitals.

F. Unfunded Mandates Reform Act (UMRA)

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of \$100 million in 1995 dollars, updated annually for inflation. In 2021, that threshold is approximately \$158 million. Although we have not been able to quantify all costs, we expect the combined impact on state, local, or Tribal governments and the private sector to be below the threshold.

G. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on state and local governments, preempts state law, or otherwise has federalism implications. In our view, while this proposed rule would not impose substantial direct requirement costs on state and local governments, this regulation has federalism implications due to potential direct effects on the distribution of power and responsibilities among the state and federal governments relating to determining standards relating to health insurance that is offered in the individual and small group markets.

In compliance with the requirement of Executive Order 13132 that agencies examine closely any policies that may have federalism implications or limit the policy making discretion of the states, we have engaged in efforts to consult with and work cooperatively with affected states, including participating in conference calls with

and attending conferences of the NAIC, and consulting with state insurance officials on an individual basis.

While developing this rule, we attempted to balance the states' interests in regulating health insurance issuers with the need to ensure market stability. By doing so, we complied with the requirements of Executive Order 13132.

Because states have flexibility in designing their Exchange and Exchange-related programs, state decisions will ultimately influence both administrative expenses and overall premiums. States are not required to establish an Exchange. For states that elected previously to operate an Exchange, those states had the opportunity to use funds under Exchange Planning and Establishment Grants to fund the development of data. Accordingly, some of the initial cost of creating programs was funded by Exchange Planning and Establishment Grants. After establishment, Exchanges must be financially self-sustaining, with revenue sources at the discretion of the state. A user fee is assessed on issuers under all existing Exchange models, including State Exchanges where the user fee is assessed by the state, SBE-FPs, and the FFEs. We have solicited comment on the proposed user fee rate of 2.75 percent of monthly premiums for issuers in FFEs and 2.25 percent of monthly premiums for issuers in SBE-FPs.

H. Congressional Review Act

This proposed rule is subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801, *et seq.*), which specifies that before a rule can take effect, the federal agency promulgating the rule shall submit to each House of the Congress and to the Comptroller General a report containing a copy of the rule along with other specified information, and has been transmitted to the Congress and the Comptroller for review. This proposed rule, if finalized as proposed, is expected to be a "major rule" as that term is defined in 5 U.S.C. 804(2), because it is likely to result in an annual effect on the economy of \$100 million or more.

List of Subjects

31 CFR Part 33

Health care, Health insurance, Reporting and recordkeeping requirements.

45 CFR Part 147

Age discrimination, Citizenship and naturalization, Civil rights, Health care,

Health insurance, Individuals with disabilities, Intergovernmental relations, Reporting and recordkeeping requirements, Sex discrimination.

45 CFR Part 155

Administrative practice and procedure, Advertising, Age discrimination, Brokers, Civil rights, Citizenship and naturalization, Conflict of interests, Consumer protection, Grant programs-health, Grants administration, Health care, Health insurance, Health maintenance organizations (HMO), Health records, Hospitals, Indians, Individuals with disabilities, Intergovernmental relations, Loan programs-health, Medicaid, Organization and functions (Government agencies), Public assistance programs, Reporting and recordkeeping requirements, Sex discrimination, State and local governments, Technical assistance, Taxes, Women, Youth.

45 CFR Part 156

Administrative practice and procedure, Advertising, Advisory committees, Age discrimination, Alaska, Brokers, Citizenship and naturalization, Civil rights, Conflict of interests, Consumer protection, Grant programs-health, Grants administration, Health care, Health insurance, Health maintenance organization (HMO), Health records, Hospitals, Indians, Individuals with disabilities, Intergovernmental relations, Loan programs-health, Medicaid, Organization and functions (Government agencies), Prescription drugs, Public assistance programs, Reporting and recordkeeping requirements, Sex discrimination, State and local governments, Sunshine Act, Technical assistance, Women, Youth.

For the reasons set forth in the preamble, the Department of the Treasury proposes to amend 31 CFR subtitle A as set forth below:

PART 33—WAIVERS FOR STATE INNOVATION

- 1. The authority citation for part 33 continues to read as follows:

Authority: Sec. 1332, Pub. L. 111-148, 124 Stat. 119.

- 2. Amend § 33.108 by revising paragraphs (f)(3)(iv) introductory text and (f)(3)(iv)(A) through (C) to read as follows:

§ 33.108 Application procedures.

* * * * *

(f) * * *

(3) * * *

(iv) The analyses, actuarial certifications, data, assumptions, targets, and other information set forth in paragraph (f)(4) of this section sufficient to provide the Secretary and the Secretary of Health and Human Services, as applicable, with the necessary data to determine that the State's proposed waiver satisfies the general requirements for approval under section 1332(b)(1) of the Affordable Care Act consistent with the provisions of this paragraph (f)(3)(iv):

(A) As required under section 1332(b)(1)(A) of the Affordable Care Act (the comprehensive coverage requirement), will provide coverage that is at least as comprehensive as the coverage defined in section 1302(b) of the Affordable Care Act and offered through Exchanges established under the Affordable Care Act as certified by the Office of the Actuary of the Centers for Medicare & Medicaid Services based on sufficient data from the State and from comparable States about their experience with programs created by the Affordable Care Act and the provisions of the Affordable Care Act that the State seeks to waive. To satisfy the comprehensive coverage requirement, the Secretary and the Secretary of Health and Human Services, as applicable, must determine that the coverage under the State plan is forecasted to be at least as comprehensive overall for residents of the state as coverage absent the waiver;

(B) As required under section 1332(b)(1)(B) of the Affordable Care Act (the affordability requirement), will provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable as the provisions of Title I of the Affordable Care Act would provide. To satisfy the affordability requirement, the Secretary and the Secretary of Health and Human Services, as applicable, must determine that the coverage under the State plan is forecasted to be as affordable overall for state residents as coverage absent the waiver;

(C) As required under section 1332(b)(1)(C) of the Affordable Care Act (the scope of coverage requirement), will provide coverage to at least a comparable number of its residents as the provisions of Title I of the Affordable Care Act would provide. To satisfy the scope of coverage requirement, the Secretary and the Secretary of Health and Human Services, as applicable, must determine that the State plan will provide coverage to a comparable number of state

residents under the waiver as would have coverage absent the waiver; and

- * * * * *
- 3. Amend § 33.118 by—
- a. Revising the section heading;
- b. Revising paragraph (a);
- c. Revising paragraph (b)(3);
- d. Adding paragraph (b)(5);
- e. Adding paragraph (g).

The revisions and additions read as follows:

§ 33.118 Modification from the normal public notice requirements during an emergent situation.

(a) The Secretary and the Secretary of Health and Human Services may modify, in part, the State public notice requirements under § 33.112(a)(1), (b), (c), and (d) and the Federal public notice procedures under § 33.116(b) to expedite a decision on a proposed section 1332 waiver request during an emergent situation, when a delay would undermine or compromise the purpose of the proposed waiver request and be contrary to the interests of consumers. These flexibilities are limited to emergent situations, including natural disasters; public health emergencies; or other emergent situations that threaten consumers' access to health insurance coverage, consumers' access to health care, or human life.

(b) * * *
(3) The State must, as applicable, detail in its request for a modification from State-level notice procedures under paragraph (a) of this section the justification for the request as it relates to the emergent situation and the alternative public notice procedures it proposes to implement at the State level, including public hearings, that are designed to provide the greatest opportunity and level of meaningful public input from impacted stakeholders that is practicable given the emergency circumstances underlying the State's request for a modification.

* * * * *
(5) The State must explain in its request for a modification from State-level notice procedures under paragraph (a) of this section how the emergent circumstances underlying its request results from a natural disaster; public health emergency; or other emergent situations that threaten consumers' access to health insurance coverage, consumers' access to health care, or human life could not reasonably have been foreseen and how a delay would undermine or compromise the purpose of the waiver and be contrary to the interests of consumers.

* * * * *

(g) The Departments will consider circumstances to be emergent when they could not have been reasonably foreseen. The Departments will assess "reasonable foreseeability" based on the specific issues that a section 1332 waiver proposes to address and other relevant factors, and will not make this assessment based solely on the number of days a State may have been aware of such issues.

- 4. Amend § 33.120 by—
- a. Revising paragraph (a);
- b. Revising paragraph (c)(2)(i); and
- c. Adding paragraphs (c)(2)(ii)(F) and (c)(2)(iii).

The revisions and additions read as follows:

§ 33.120 Monitoring and compliance.

(a) *General.* (1) Following the issuance of a final decision to approve a section 1332 waiver by the Secretary and the Secretary of Health and Human Services, as applicable, a State must comply with all applicable Federal laws and regulations, unless expressly waived. A State must, within the timeframes specified in law and regulation come into compliance with any changes in Federal law and regulation affecting section 1332 waivers, unless the provision being changed is expressly waived.

(2) The Secretary and the Secretary of Health and Human Services will examine compliance with Federal and regulatory requirements consistent with § 155.1308(f)(3)(iv) when conducting implementation reviews under paragraph (b) of this section.

* * * * *
(c) * * *
(2) * * * (i) The Secretary and the Secretary of Health and Human Services may modify, in part, State post award requirements under this paragraph (c)(2) for an approved section 1332 waiver request during an emergent situation, when the application of the post award public notice requirements would be contrary to the interests of consumers. These flexibilities are limited to emergent situations, including natural disasters; public health emergencies; or other emergent situations that threaten consumers' access to health insurance coverage, consumers' access to health care, or human life.

(ii) * * *
(F) The State must explain in its request for modification under this paragraph (c)(2) how the emergent circumstances underlying its request results from a natural disaster; public health emergency; or other emergent situations that threaten consumers' access to health insurance coverage, consumers' access to health care, or

human life and could not reasonably have been foreseen and how the application of the post-award public notice requirements would be contrary to the interests of consumers.

(iii) The Secretary and the Secretary of Health and Human Services will consider circumstances to be emergent when they could not have been reasonably foreseen. The Secretary and the Secretary of Health and Human Services will assess “reasonable foreseeability” based on the specific issues that a section 1332 waiver proposes to address and other relevant factors, and will not make this assessment based solely on the number of days a State may have been aware of such issues.

* * * * *

■ 5. Section 33.122 is added to read as follows:

§ 33.122 Pass-through Funding for Approved Waivers.

(a) *Pass-through Funding.* With respect to a State’s approved section 1332 waiver, under which, due to the structure of the approved State waiver plan, individuals and small employers in the State would not qualify for or would qualify for a reduced amount of premium tax credit under section 36B of the Internal Revenue Code, small business tax credit under section 45R of the Internal Revenue Code, or cost-sharing reductions under ACA part I of subtitle E for which they would otherwise be eligible, the Secretary and the Secretary of the Health and Human Services shall provide for an alternative means by which the aggregate amount of such credits or reductions that would have been paid on behalf of participants in the Exchanges had the State not received such waiver shall be paid to the State for purposes of implementing the approved State waiver plan. Such amount shall be determined annually by the Secretary and the Secretary of Health and Human Services, taking into consideration the experience of other States with respect to participation in an Exchange and credits and reductions provided under such provisions to residents of the other States. This amount can be updated to reflect applicable changes in Federal or State law.

(b) [Reserved]

■ 6. Amend § 33.128 by revising paragraph (a) to read as follows:

§ 33.128 Periodic evaluation requirements.

(a) The Secretary and the Secretary of Health and Human Services, as applicable, shall periodically evaluate the implementation of a program under a section 1332 waiver consistent with

§ 33.108(f)(3)(iv) and any terms and conditions governing the section 1332 waiver.

* * * * *

■ 7. Section 33.130 is added to read as follows:

§ 33.130 Waiver Amendment.

(a) *Amendment to an approved section 1332 waiver.* A State may request an amendment to an approved section 1332 waiver from the Secretary and the Secretary of Health and Human Services. A section 1332 waiver amendment is considered a change to an approved section 1332 waiver plan that is not otherwise allowable under the terms and conditions of an approved waiver, a change that could impact any of the section 1332 statutory guardrails or a change to the program design for an approved waiver. A state is not authorized to implement any aspect of the proposed amendment without prior approval by the Secretary and the Secretary of Health and Human Services.

(b) [Reserved]

■ 8. Section 33.132 is added to read as follows:

§ 33.132 Waiver Extension.

(a) *Extension.* A State may request continuation of an approved section 1332 waiver, and such request shall be deemed granted unless the Secretary and the Secretary of Health and Human Services, within 90 days after the date of submission of a complete waiver extension request to the Secretary and the Secretary of Health and Human Services, either denies such request in writing or informs the State in writing with respect to any additional information that is needed in order to make a final determination with respect to the request.

(b) [Reserved]

For the reasons set forth in the preamble, under the authority at 5 U.S.C. 301, the Department of Health and Human Services proposes to amend 45 CFR subtitle A, subchapter B, as set forth below.

PART 147—HEALTH INSURANCE REFORM REQUIREMENTS FOR THE GROUP AND INDIVIDUAL INSURANCE MARKETS

■ 9. The authority citation for part 147 continues to read as follows:

Authority: 42 U.S.C. 300gg through 300gg–63, 300gg–91, and 300gg–92, as amended, and section 3203, Pub. L. 116–136, 134 Stat. 281.

■ 10. Amend § 147.104 by—

■ a. Revising paragraphs (b)(2)(i)(E) and (F); and

■ b. Adding paragraph (b)(2)(i)(G).

The revisions and addition read as follows:

§ 147.104 Guaranteed availability of coverage.

* * * * *

(b) * * *
(2) * * *
(i) * * *

(E) Section 155.420(d)(12) of this subchapter (concerning plan and benefit display errors);

(F) Section 155.420(d)(13) of this subchapter (concerning eligibility for insurance affordability programs or enrollment in the Exchange); and

(G) Section 155.420(d)(16) of this subchapter (concerning eligibility for advance payments of the premium tax credit and household income, as defined in 26 CFR 1.36B–1(e), that is expected to be no greater than 150 percent of the federal poverty level).

* * * * *

PART 155—EXCHANGE ESTABLISHMENT STANDARDS AND OTHER RELATED STANDARDS UNDER THE AFFORDABLE CARE ACT

■ 11. The authority citation for part 155 continues to read as follows:

Authority: 42 U.S.C. 18021–18024, 18031–18033, 18041–18042, 18051, 18054, 18071, and 18081–18083.

■ 12. Amend § 155.210 by revising paragraph (e)(9) to read as follows:

§ 155.210 Navigator program standards.

* * * * *

(e) * * *

(9) The Exchange may require or authorize Navigators to provide information and assistance with any of the following topics. In Federally-facilitated Exchanges, Navigators are required to provide information and assistance with all of the following topics:

(i) Understanding the process of filing Exchange eligibility appeals;

(ii) Understanding and applying for exemptions from the requirement to maintain minimum essential coverage granted through the Exchange;

(iii) The Exchange-related components of the premium tax credit reconciliation process, and understanding the availability of IRS resources on this process;

(iv) Understanding basic concepts and rights related to health coverage and how to use it; and

(v) Referrals to licensed tax advisers, tax preparers, or other resources for assistance with tax preparation and tax advice related to consumer questions about the Exchange application and

enrollment process, and premium tax credit reconciliations.

* * * * *

§ 155.221 [Amended]

- 13. Amend § 155.221 by removing paragraph (j).
- 14. Amend § 155.410 by revising paragraph (e)(3) and adding paragraph (e)(4).

The revision and addition read as follows:

§ 155.410 Initial and annual open enrollment periods.

* * * * *

(e) * * *

(3) For the benefit years beginning on January 1, 2018 to January 1, 2021, the annual open enrollment period begins on November 1 and extends through December 15 of the calendar year preceding the benefit year.

(4) For the benefit years beginning on or after January 1, 2022, the annual open enrollment period begins on November 1 of the calendar year preceding the benefit year and extends through January 15 of the benefit year.

* * * * *

- 15. Amend § 155.420 by—
- a. Revising paragraph (a)(4)(ii)(C);
- b. Adding paragraph (a)(4)(ii)(D);
- c. Revising paragraph (a)(4)(iii) introductory text; and
- d. Adding paragraphs (b)(2)(vii), (d)(16), and (f).

The revision and additions read as follows:

§ 155.420 Special enrollment periods.

* * * * *

(a) * * *
(4) * * *
(ii) * * *

(C) No later than January 1, 2024, if an enrollee or his or her dependents become newly ineligible for advance payments of the premium tax credit in accordance with paragraph (d)(6)(i) or (ii) of this section, the Exchange must allow the enrollee or his or her dependents to change to a QHP of any metal level, if they elect to change their QHP enrollment; or

(D) If an enrollee or his or her dependents qualify for a special enrollment period in accordance with paragraph (d)(16) of this section and are not enrolled in a silver-level QHP, the Exchange must allow the enrollee and his or her dependents to change to a silver-level QHP if they elect to change their QHP enrollment;

(iii) For the other triggering events specified in paragraph (d) of this section, except for paragraphs (d)(2)(i), (d)(4), and (d)(6)(i) and (ii) of this section for becoming newly eligible or

ineligible for CSRs and paragraphs (d)(8), (9), (10), (12), (14), and (16) of this section:

* * * * *

(b) * * *
(2) * * *

(vii) If a qualified individual or enrollee, or the dependent of a qualified individual or enrollee, who is eligible for advance payments of the premium tax credit, and whose household income, as defined in 26 CFR 1.36B–1(e), is expected to be no greater than 150 percent of the federal poverty level, enrolls in a QHP or changes from one QHP to another one time per month in accordance with paragraph (d)(16) of this section, the Exchange must ensure that coverage is effective in accordance with paragraph (b)(1) of this section or on the first day of the month following plan selection, at the option of the Exchange.

* * * * *

(d) * * *

(16) At the option of the Exchange, a qualified individual or enrollee, or the dependent of a qualified individual or enrollee, who is eligible for advance payments of the premium tax credit, and whose household income, as defined in 26 CFR 1.36B–1(e), is expected to be no greater than 150 percent of the federal poverty level, may enroll in a QHP or change from one QHP to another one time per month.

* * * * *

(f) For purposes of this section, references to eligibility for advance payments of the premium tax credit refer to being eligible for such advance payments in an amount greater than zero dollars per month. References to ineligibility for advance payments of the premium tax credit refer to being ineligible for such payments or being eligible for such payments but being eligible for a maximum of zero dollars per month of such payments.

* * * * *

- 16. Amend § 155.1308 by revising paragraphs (f)(3)(iv) introductory text and (f)(3)(iv)(A) through (C) to read as follows:

§ 155.1308 Application procedures.

* * * * *

(f) * * *
(3) * * *

(iv) The analyses, actuarial certifications, data, assumptions, targets, and other information set forth in paragraph (f)(4) of this section sufficient to provide the Secretary and the Secretary of the Treasury, as applicable, with the necessary data to determine that the State’s proposed waiver satisfies the general requirements for approval

under section 1332(b)(1) of the Affordable Care Act consistent with the provisions of this paragraph (f)(3)(iv);

(A) As required under section 1332(b)(1)(A) of the Affordable Care Act (the comprehensive coverage requirement), will provide coverage that is at least as comprehensive as the coverage defined in section 1302(b) of the Affordable Care Act and offered through Exchanges established under the Affordable Care Act as certified by the Office of the Actuary of the Centers for Medicare & Medicaid Services based on sufficient data from the State and from comparable States about their experience with programs created by the Affordable Care Act and the provisions of the Affordable Care Act that the State seeks to waive. To satisfy the comprehensive coverage requirement, the Secretary and the Secretary of the Treasury, as applicable, must determine that the coverage under the State plan is forecasted to be at least as comprehensive overall for residents of the state as coverage absent the waiver;

(B) As required under section 1332(b)(1)(B) of the Affordable Care Act (the affordability requirement), will provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable as the provisions of Title I of the Affordable Care Act would provide. To satisfy the affordability requirement, the Secretary and the Secretary of the Treasury, as applicable, must determine that the coverage under the State plan is forecasted to be at least as affordable overall for state residents as coverage absent the waiver;

(C) As required under section 1332(b)(1)(C) of the Affordable Care Act (the scope of coverage requirement), will provide coverage to at least a comparable number of its residents as the provisions of Title I of the Affordable Care Act would provide. To satisfy the scope of coverage requirement, the Secretary and the Secretary of the Treasury, as applicable, must determine that the State plan will provide coverage to a comparable number of state residents under the waiver as would have coverage absent the waiver; and

* * * * *

- 17. Amend § 155.1318 by—
- a. Revising the section heading;
- b. Revising paragraphs (a) and (b)(3); and
- c. Adding paragraphs (b)(5) and (g).

The revisions and addition read as follows:

§ 155.1318 Modification from the normal public notice requirements during an emergent situation.

(a) The Secretary and the Secretary of the Treasury may modify, in part, the State public notice requirements under § 155.1312(a)(1), (b), (c), and (d) and the Federal public notice procedures under § 155.1316(b) to expedite a decision on a proposed section 1332 waiver request during an emergent situation, when a delay would undermine or compromise the purpose of the proposed waiver request and be contrary to the interests of consumers. These flexibilities are limited to emergent situations, including natural disasters; public health emergencies; or other emergent situations that threaten consumers' access to health insurance coverage, consumers' access to health care, or human life.

(b) * * *

(3) The State must, as applicable, detail in its request for a modification from State-level notice procedures under paragraph (a) of this section the justification for the request as it relates to the emergent situation and the alternative public notice procedures it proposes to implement at the State level, including public hearings, that are designed to provide the greatest opportunity and level of meaningful public input from impacted stakeholders that is practicable given the emergency circumstances underlying the State's request for a modification.

* * * * *

(5) The State must explain in its request for a modification from State-level notice procedures under paragraph (a) of this section how the emergent circumstances underlying its request result from a natural disaster; public health emergency; or other emergent situations that threaten consumers' access to health insurance coverage, consumers' access to health care, or human life could not reasonably have been foreseen and how a delay would undermine or compromise the purpose of the waiver and be contrary to the interests of consumers.

* * * * *

(g) The Secretary and the Secretary of the Treasury will consider circumstances to be emergent when they could not have been reasonably foreseen. The Secretary and the Secretary of the Treasury will assess "reasonable foreseeability" based on the specific issues that a section 1332 waiver proposes to address and other relevant factors, and will not make this assessment based solely on the number

of days a State may have been aware of such issues.

- 18. Amend § 155.1320 by—
- a. Revising paragraph (a);
- b. Revising the paragraph heading for paragraph (c)(2);
- c. Revising paragraph (c)(2)(i); and
- d. Adding paragraphs (c)(2)(ii)(F) and (c)(2)(iii).

The revisions and additions read as follows:

§ 155.1320 Monitoring and compliance.

(a) General. (1) Following the issuance of a final decision to approve a section 1332 waiver by the Secretary and the Secretary of the Treasury, as applicable, a State must comply with all applicable Federal laws and regulations, unless expressly waived. A State must, within the timeframes specified in law and regulation come into compliance with any changes in Federal law and regulation affecting section 1332 waivers, unless the provision being changed is expressly waived.

(2) The Secretary and the Secretary of the Treasury will examine compliance with Federal and regulatory requirements consistent with § 155.1308(f)(3)(iv) when conducting implementation reviews under paragraph (b) of this section.

* * * * *

(c) * * *

(2) *Modification from the normal post award requirements during an emergent situation.* (i) The Secretary and the Secretary of the Treasury may modify, in part, State post award requirements under this paragraph (c)(2) for an approved section 1332 waiver request during an emergent situation when the application of the post award public notice requirements would be contrary to the interests of consumers. These flexibilities are limited to emergent situations, including natural disasters; public health emergencies; or other emergent situations that threaten consumers' access to health insurance coverage, consumers' access to health care, or human life.

(ii) * * *

(F) The State must explain in its request for a modification under paragraph (c)(2) of this section how the emergent circumstances underlying its request results from a natural disaster; public health emergency; or other emergent situations that threaten consumers' access to health insurance coverage, consumers' access to health care, or human life and could not reasonably have been foreseen and how the application of the post award public notice requirements would be contrary to the interests of consumers.

(iii) The Secretary and the Secretary of the Treasury will consider circumstances to be emergent when they could not have been reasonably foreseen. The Secretary and the Secretary of the Treasury will assess "reasonable foreseeability" based on the specific issues that a section 1332 waiver proposes to address and other relevant factors, and will not make this assessment based solely on the number of days a State may have been aware of such issues.

* * * * *

■ 19. Section 155.1322 is added to subpart N to read as follows:

§ 155.1322 Pass-Through Funding for Approved Waivers.

(a) *Pass-through Funding.* With respect to a State's approved section 1332 waiver, under which, due to the structure of the approved State waiver plan, individuals and small employers in the State would not qualify for or would qualify for a reduced amount of premium tax credit under section 36B of the Internal Revenue Code, small business tax credit under section 45R of the Internal Revenue Code, or cost-sharing reductions under ACA part I of subtitle E for which they would otherwise be eligible, the Secretary and the Secretary of the Treasury shall provide for an alternative means by which the aggregate amount of such credits or reductions that would have been paid on behalf of participants in the Exchanges had the State not received such waiver shall be paid to the State for purposes of implementing the approved State waiver plan. Such amount shall be determined annually by the Secretary and the Secretary of the Treasury, taking into consideration the experience of other States with respect to participation in an Exchange and credits and reductions provided under such provisions to residents of the other States. This amount can be updated to reflect applicable changes in Federal or State law.

(b) [Reserved]

■ 20. Amend § 155.1328 by revising paragraph (a) to read as follows:

§ 155.1328 Periodic evaluation requirements.

(a) The Secretary and the Secretary of the Treasury, as applicable, shall periodically evaluate the implementation of a program under a section 1332 waiver consistent with § 155.1308(f)(3)(iv) and any terms and conditions governing the section 1332 waiver.

* * * * *

■ 21. Section 155.1330 is added to subpart N to read as follows:

§ 155.1330 Waiver Amendment.

(a) *Amendment to an approved section 1332 waiver.* A State may request an amendment to an approved section 1332 waiver from the Secretary and the Secretary of the Treasury. A section 1332 waiver amendment is considered a change to a section 1332 waiver plan that is not otherwise allowable under the terms and conditions of an approved waiver, a change that could impact any of the section 1332 statutory guardrails or a change to the program design for an approved waiver. A state is not authorized to implement any aspect of the proposed amendment without prior approval by the Secretary and the Secretary of the Treasury.

(b) [Reserved]

■ 22. Section 155.1332 is added to subpart N to read as follows:

§ 155.1332 Waiver Extension.

(a) *Extension.* A State may request continuation of an approved section 1332 waiver, and such request shall be deemed granted unless the Secretary and the Secretary of the Treasury, within 90 days after the date of submission of a complete waiver extension request to the Secretary and the Secretary of the Treasury, either

denies such request in writing or informs the State in writing with respect to any additional information that is needed in order to make a final determination with respect to the request.

(b) [Reserved]

PART 156—HEALTH INSURANCE ISSUER STANDARDS UNDER THE AFFORDABLE CARE ACT, INCLUDING STANDARDS RELATED TO EXCHANGES

■ 23. The authority citation for part 156 is revised to read as follows:

Authority: 42 U.S.C. 18021–18024, 18031–18032, 18041–18042, 18044, 18054, 18061, 18063, 18071, 18082, and 26 U.S.C. 36B.

■ 24. Amend § 156.115 by revising paragraph (a)(3) to read as follows:

§ 156.115 Provision of EHB.

(a) * * *

(3) With respect to the mental health and substance use disorder services, including behavioral health treatment services, required under § 156.110(a)(5) of this subpart, comply with the requirements under section 2726 of the Public Health Service Act and its implementing regulations.

* * * * *

■ 25. Amend § 156.280 by revising the heading and paragraph (e)(2)(ii) to read as follows:

§ 156.280 Segregation of funds for abortion services.

* * * * *

(e) * * *

(2) * * *

(ii) An issuer will be considered to satisfy the obligation in paragraph (e)(2)(i) of this section if it sends the policy holder a single monthly invoice or bill that separately itemizes the premium amount for coverage of abortion services described in paragraph (d)(1) of this section; sends the policy holder a separate monthly bill for these services; or sends the policy holder a notice at or soon after the time of enrollment that the monthly invoice or bill will include a separate charge for such services, and specifies the charge.

* * * * *

Xavier Becerra,

Secretary, Department of Health and Human Services.

Mark Mazur,

Deputy Assistant Secretary (Tax Policy), Department of the Treasury.

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