Technology Transfer and Advancement Act of 1995 (15 U.S.C. 272 note) because application of those requirements would be inconsistent with the CAA; and

• Does not provide EPA with the discretionary authority to address, as appropriate, disproportionate human health or environmental effects, using practicable and legally permissible methods, under Executive Order 12898 (59 FR 7629, February 16, 1994).

The SIP is not approved to apply on any Indian reservation land or in any other area where EPA or an Indian tribe has demonstrated that a tribe has jurisdiction. In those areas of Indian country, the rule does not have tribal implications as specified by Executive Order 13175 (65 FR 67249, November 9, 2000), nor will it impose substantial direct costs on tribal governments or preempt tribal law.

List of Subjects in 40 CFR Part 52

Environmental protection, Air pollution control, Incorporation by Reference, Intergovernmental relations, Reporting and recordkeeping requirements, Sulfur oxides.

Authority: 42 U.S.C. 7401 *et seq.*

Dated: November 1, 2018.

Onis ''Trey'' Glenn, III,

Regional Administrator, Region 4.

[FR Doc. 2018–24582 Filed 11–8–18; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 60

[EPA–HQ–OAR–2018–0696; FRL–9986–28–OAR]

RIN 2060–AU33

Adopting Subpart Ba Requirements in Emission Guidelines for Municipal Solid Waste Landfills; Correction

AGENCY: Environmental Protection Agency (EPA).

ACTION: Proposed rule; correction.

SUMMARY: This document corrects the preamble to a proposed rule published in the **Federal Register** on October 30, 2018, regarding the implementing regulations that govern the Emission Guidelines for Municipal Solid Waste (MSW) Landfills. The listed docket number in that preamble was incorrect. Any comments received prior to this correction have been redirected to the correct docket.

DATES: *Comments.* Comments must be received on or before December 14, 2018.

FOR FURTHER INFORMATION CONTACT: For questions about this proposed action, contact Andrew Sheppard, Sector Policies and Programs Division (E143–03), Office of Air Quality Planning and Standards, U.S. Environmental Protection Agency, Research Triangle Park, North Carolina 27711; telephone number: (919) 541–4161; fax number: (919) 541–0516; and email address: *sheppard.andrew@epa.gov.*

SUPPLEMENTARY INFORMATION: In proposed rule FR 2018–23700, in the issue of Tuesday, October 30, 2018, on page 54527, in the third column, correct the docket numbers listed in the **ADDRESSES** section to read:

''**ADDRESSES:** *Comments.* Submit your comments, identified by Docket ID No. EPA–HQ–OAR–2018–0696 at *https://www.regulations.gov.* Follow the online instructions for submitting comments. Once submitted, comments cannot be edited or removed from *Regulations.gov*. See **SUPPLEMENTARY INFORMATION** for detail about how the EPA treats submitted comments. *Regulations.gov* is our preferred method of receiving comments. However, the following other submission methods are also accepted:

• *Email: a-and-r-docket@epa.gov.* Include Docket ID No. EPA–HQ–OAR–2018–0696 in the subject line of the message.

• *Fax:* (202) 566–9744. Attention Docket ID No. EPA–HQ–OAR–2018–0696.

• *Mail:* To ship or send mail via the United States Postal Service, use the following address: U.S. Environmental Protection Agency, EPA Docket Center, Docket ID No. EPA–HQ–OAR–2018–0696, Mail Code 28221T, 1200 Pennsylvania Avenue NW, Washington, DC 20460.

• *Hand/Courier Delivery:* Use the following Docket Center address if you are using express mail, commercial delivery, hand delivery, or courier: EPA Docket Center, EPA WJC West Building, Room 3334, 1301 Constitution Avenue NW, Washington, DC 20004. Delivery verification signatures will be available only during regular business hours.''

In proposed rule FR 2018–23700, in the issue of Tuesday, October 30, 2018, on page 54528, make the following correction to the docket numbers listed in the **SUPPLEMENTARY INFORMATION** section. In the second paragraph of the section, in the first column, revise the docket number in the first sentence to say, ''*Docket.* The EPA has established a docket for this rulemaking under Docket ID No. EPA–HQ–OAR–2018–0696.''

In the third paragraph of the section, in the first column, revise the docket number in the first sentence to say, ''*Instructions.* Direct your comments to Docket ID No. EPA–HQ–OAR–2018–0696.''

In the sixth paragraph of the section, in the third column, revise the docket number in the last sentence to say, ''Send or deliver information identified as CBI only to the following address: OAQPS Document Control Officer (C404–02), OAQPS, U.S. Environmental Protection Agency, Research Triangle Park, North Carolina 27711, Attention Docket ID No. EPA–HQ–OAR–2018–0696.''

Dated: November 2, 2018.

William L. Wehrum,

Assistant Administrator, Office of Air and Radiation.

[FR Doc. 2018–24581 Filed 11–8–18; 8:45 am]

BILLING CODE 6560–50–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Parts 155 and 156

[CMS–9922–P]

RIN 0938–AT53

Patient Protection and Affordable Care Act; Exchange Program Integrity

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

SUMMARY: This proposed rule would revise standards relating to oversight of Exchanges established by states, periodic data matching frequency and authority, and the length of a consumer's authorization for the Exchange to obtain updated tax information. This proposed rule would also propose new requirements for certain issuers related to the collection of a separate payment for the premium portion attributable to coverage for certain abortion services. Many of these proposed changes would help strengthen Exchange program integrity.

DATES: Comments: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on January 8, 2019.

ADDRESSES: In commenting, please refer to file code CMS–9922–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

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–9922–P, P.O. Box 8016, Baltimore, MD 21244–8010.

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–9922–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: Emily Ames, (301) 492–4246, or Christine Hammer, (202) 260–6089, for general information.

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 all 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.

I. Executive Summary

American Health Benefit Exchanges, or ''Exchanges'' (also called ''Marketplaces'') are entities established under the Patient Protection and Affordable Care Act (Pub. L. 111–148), as amended by the Heath Care and Education Reconciliation Act of 2010 (Pub. L. 111–152) (collectively referred to as PPACA) through which qualified individuals and qualified employers can purchase health insurance coverage. Exchanges that were established by states (State Exchanges) include State-based Exchanges (SBEs) which perform eligibility and enrollment functions, as well as State-based Exchanges on the Federal platform (SBE–FPs) that utilize the Federally-facilitated Exchange's infrastructure to perform eligibility and enrollment functions. Many individuals who enroll in qualified health plans (QHPs) through individual market Exchanges are eligible to receive a premium tax credit (PTC) to reduce their costs for health insurance premiums, and receive reductions in required cost-sharing payments to reduce out-of-pocket expenses for health care services. Eligible individuals can receive the estimated amount of the PTC on an advance basis, known as advance payments of the premium tax credit (APTC), in accordance with section 1412 of the PPACA.

Strengthening program integrity with respect to subsidy payments in the individual market is a top priority of this Administration. Key areas of focus include—(1) ensuring that eligible enrollees receive the correct amount of APTC and cost-sharing reduction (CSR) (as applicable), and do not receive APTC or CSRs for abortion coverage and/or services for which such payments are not available under section 1303 of the PPACA; (2) conducting effective and efficient monitoring and oversight of State Exchanges to ensure that consumers are receiving the correct amount of APTC and CSRs in SBEs, and that State Exchanges are meeting the standards of federal law in a transparent manner; and (3) protecting the interests of taxpayers, and consumers, and the financial integrity of Federally-facilitated Exchanges (FFEs) through oversight of health insurance issuers, including ensuring compliance with Exchange requirements, such as maintenance of records and participation in investigations and compliance reviews, and with the requirements of section 1303 of the PPACA.

The Department of Health and Human Services (HHS) has recently made significant strides in these areas. For example, we have implemented policy-based payments in the FFEs and almost all of the SBEs, a critical system change across Exchanges and issuers that ensures the data used to generate APTC and CSR payments to issuers are verified and associated with particular enrollees.

We also recently implemented pre-enrollment verification of eligibility for applicable individual market special enrollment periods for all Exchanges served by the federal eligibility and enrollment platform (the *HealthCare.gov* platform), ensuring that only those who qualify for special enrollment periods receive them. In the HHS Notice of Benefit and Payment Parameters for 2019 Final Rule (83 FR 16930) (April 17, 2018), we established a policy to require documentary evidence for certain consumers who attest to income that is significantly higher than the amount found in the Exchange's income data. This new check will be conducted for applicants for whom trusted data sources (such as the Internal Revenue Service, the Social Security Administration, the Department of Homeland Security, Veterans Health Administration, Peace Corps, the Department of Defense, Experian, and Carahsoft).[1] This new check will not be performed with respect to non-citizen applicants who are ineligible for Medicaid based on their immigration status, as these applicants may be statutorily eligible for APTC with annual household income below 100 percent of the FPL. An accurate eligibility determination is critical for consumers near this threshold to ensure APTC is not paid on behalf of consumers who are statutorily ineligible for APTC.

In late 2017, we developed an innovative approach to provide additional notification to tax filers who, based on Internal Revenue Service (IRS) data, had received APTC for a prior benefit year but failed to reconcile these payments on their tax returns. The notices explained that the tax filer was required to take action to reconcile these prior APTC payments, or APTC associated with all enrollees for whom the individual is the tax filer would be terminated. While HHS was already contacting these affected households through its standard annual notification processes, this supplemental notice provided further clarification and instruction for the tax filer, while adhering to IRS' protocols regarding the safe disclosure of protected federal tax information.

We continue to explore opportunities to improve program integrity. We work on an ongoing basis on improving program oversight and procedures to conduct comprehensive audits of FFE processes to verify their integrity. These efforts further our goal of protecting consumers enrolled in FFEs and safeguarding taxpayer dollars. We review consumer complaints and allegations of fraud and abuse received by the FFE call center from insurers, as well as law enforcement and states. Additionally, we analyze data to identify issues and vulnerabilities, share relevant information with issuers, and identify administrative actions to stop bad actors and protect consumers.

We are proposing several changes targeting these priorities. First, we are planning changes to the current periodic data matching (PDM) processes, which are the processes through which Exchanges periodically examine

[1] One criterion for eligibility for APTC is an income equal to or greater than 100 percent but not greater than 400 percent of an amount equal to the poverty line based on family size.

available data sources to identify changes that would affect enrollees' eligibility for subsidies. Second, we are planning to add an optional authorization to the Exchange application that would allow an individual to authorize the FFE to receive Medicare eligibility and enrollment information about the enrollee. If an applicant provides this authorization and elects to have the Exchange automatically terminate QHP coverage if the applicant is found to be dually enrolled, then the FFE will end enrollees' QHP coverage on their behalf in such a circumstance, even if the enrollee is not receiving APTC or CSRs. Third, we propose to specify that Exchanges must conduct PDM for Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Basic Health Program (BHP), if applicable, at least twice a year, beginning with the 2020 calendar year, to ensure that Exchanges make adequate efforts to discontinue APTC and CSR for those who are eligible for or enrolled in other minimum essential coverage (MEC) and, therefore, are ineligible for APTC or CSRs.

We are also proposing changes to improve program integrity related to State Exchanges. To strengthen the mechanisms and tools HHS uses in its oversight of compliance by State Exchanges with federal requirements, including eligibility and enrollment requirements under 45 CFR part 155, subparts D and E, we are proposing changes that provide further specificity to their program reporting requirements. In addition, to ensure proper eligibility determinations and enrollments in SBEs, we are proposing to clarify the scope of the annual programmatic audits that SBEs are required to conduct and submit results of annually to HHS, and include testing of SBE eligibility and enrollment transactions in the annual programmatic audits.

Lastly, we are proposing changes related to the separate payment requirement in section 1303 of the PPACA. To align the regulatory requirements for issuer billing of the portion of the enrollee's premium attributable to certain abortion services with the separate payment requirement applicable to issuers offering coverage of these services, we are proposing changes to the billing and payment collection requirements for QHP issuers in connection with their plans offered through an individual market Exchange that include coverage for abortion services for which federal funding is prohibited.

II. Background

A. Legislative and Regulatory Overview

Sections 1311(b) and 1321(b) of the PPACA provide that each state has the opportunity to establish an Exchange. Section 1311(b)(1) of the PPACA gives each state the opportunity to establish an Exchange that both facilitates the purchase of QHPs by individuals and families, and provides for the establishment of a Small Business Health Options Program (SHOP) that is designed to assist qualified employers in the state who are small employers in facilitating the enrollment of their employees in QHPs offered in the small group market in the state.

Section 1313 of the PPACA describes the steps the Secretary of Health and Human Services (the Secretary) may take to oversee Exchanges' compliance with HHS standards related to Title I of the PPACA and ensure their financial integrity, including conducting investigations and annual audits.

Section 1321(a) of the PPACA provides broad authority for the Secretary to establish standards and regulations to implement the statutory standards related to Exchanges, QHPs, and other standards of title I of the PPACA.

Section 1321(c)(2) of the PPACA authorizes the Secretary to enforce the Exchange standards using civil money penalties (CMPs) on the same basis as detailed in section 2723(b) of the Public Health Service Act (PHS Act). Section 2723(b) of the PHS Act authorizes the Secretary to impose CMPs as a means of enforcing the individual and group market reforms contained in Part A of title XXVII of the PHS Act when a state fails to substantially enforce these provisions.

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

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

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

Section 1411(g) of the PPACA allows the exchange 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.

On October 30, 2013, we published a final rule entitled, ''Patient Protection and Affordable Care Act; Program Integrity: Exchange, Premium Stabilization Programs, and Market Standards; Amendments to the HHS Notice of Benefit and Payment Parameters for 2014,'' (78 FR 65046), to implement certain program integrity standards and oversight requirements for State Exchanges.

Section 1303 of the PPACA, as implemented in 45 CFR 156.280, specifies standards for issuers of QHPs through the Exchanges that cover abortion services for which public funding is prohibited (also referred to as non-Hyde abortion services). The statute and regulations establish that, unless otherwise prohibited by state law, a QHP issuer may elect to cover such non-Hyde 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. 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,[2] which must be no less than $1 per enrollee per month. QHP issuers must also segregate funds for non-Hyde abortion services collected through this payment into a separate allocation account used exclusively to pay for non-Hyde abortion services.

In the 2012 Exchange Establishment Rule, we codified the statutory provisions of section 1303 of the PPACA in regulation at 45 CFR 156.280. On February 27, 2015, we published the Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, (80 FR 10750) (herein after referred to as the 2016 Payment Notice) providing guidance regarding acceptable billing and premium collection methods for the portion of the consumer's total premium attributable to non-Hyde abortion coverage for purposes of satisfying the statutory separate payment requirement.

[2] Section 1303 also specifies how such actuarial value is to be calculated.

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, the actuarial community, and state representatives to gather public input, with a particular focus on risks to the individual and small group markets, and how we can alleviate burdens facing patients and issuers. We consulted with stakeholders through regular meetings with the National Association of Insurance Commissioners, regular contact with State Exchanges through the Exchange Blueprint process and ongoing oversight and technical assistance engagements, and meetings with Tribal leaders and representatives, health insurance issuers, trade groups, consumer advocates, employers, and other interested parties.

III. Provisions of the Proposed Regulations

A. Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act

1. Functions of an Exchange (§ 155.200)

Section 155.200 of the PPACA establishes the functions that an Exchange must perform. Section 155.200(c) of the PPACA specifies that the Exchange must perform oversight and financial integrity functions, specifically that the Exchange must perform required functions related to oversight and financial integrity requirements in accordance with section 1313 of the PPACA. HHS interprets this requirement broadly to include program integrity functions related to protecting against fraud, waste, and abuse, including functions not explicitly identified in section 1313 of the PPACA. We believe SBEs have generally interpreted this requirement broadly as well, as evidenced by their engagement in activities designed to combat fraud and abuse related to the Exchange.

However, questions about the breadth of this function have arisen when Exchanges have sought to understand what uses and disclosures of personally identifiable information (PII) are permitted under § 155.260.[3] Specifically, we have received questions about whether Exchanges are permitted under § 155.260 to disclose applicant PII to certain entities, such as the state departments of insurance, when investigating fraudulent behavior related to Exchange enrollments on the part of agents and brokers. We believe that use and disclosure related to Exchange program integrity efforts, like combatting fraud, currently fall under § 155.200(c), but believe the regulation is not as clear as it could be. Therefore, we propose to revise § 155.200(c) to clarify that the Exchanges must perform oversight functions generally, and cooperate with oversight activities, in accordance with section 1313 of the PPACA and as required under 45 CFR part 155, including overseeing its Exchange programs, Navigators, agents, brokers, and other non-Exchange entities as defined in § 155.260(b). Because this change is a clarification and not a new function, we do not believe it would impose additional burdens on State Exchanges, but instead would help resolve questions about whether states have the necessary tools and authority to enable them to effectively oversee and combat potentially fraudulent behavior. We seek comment on this proposal, including with respect to our understanding of the potential imposition of additional burden on State Exchanges.

2. Verification Process Related to Eligibility for Insurance Affordability Programs (§ 155.320)

Currently, under § 155.330, Exchanges are required to periodically examine available data sources to identify, with respect to enrollees on whose behalf APTC or CSRs are being paid, eligibility or enrollment determinations for Medicare, Medicaid, CHIP, or the BHP, if a BHP is operating in the service area of the Exchange. Individuals identified as enrolled both in Exchange coverage with or without APTC or CSRs and one of these other forms of coverage are referred to as dually enrolled consumers.

If a consumer is eligible for premium-free Medicare Part A or enrolled in Medicare Part A or Part C (also known as Medicare Advantage), all of which qualify as MEC, he or she is not eligible to receive APTC or CSRs to help pay for an Exchange plan or covered services.

The Secretary has broad authority under section 1321(a) of the PPACA to establish regulations setting standards to implement the statutory requirements under title I of the PPACA, including with respect to the establishment and operation of Exchanges, the offering of QHPs through the Exchanges, the establishment of statutory reinsurance and risk adjustment programs, and such other requirements as the Secretary determines appropriate. Additionally, section 1411(g) of the PPACA allows the exchange of certain applicant information as necessary to ensure the efficient operation of the Exchange, including verifying eligibility to enroll in coverage through the Exchange and to receive APTC or CSRs.

Section 155.320(b)(2) specifies that the disclosure to HHS of information regarding eligibility for and enrollment in a health plan that is a government program, which may be considered protected health information (PHI), is expressly authorized for the purposes of verification of applicant eligibility for MEC as part of the eligibility determination process for APTC or CSRs. Section 155.430(b)(1)(ii) requires an Exchange to provide an opportunity at the time of plan selection for an enrollee to choose to remain enrolled in a QHP if he or she becomes eligible for other MEC, or to terminate QHP coverage if the enrollee does not choose to remain enrolled in the QHP upon completion of the redetermination process. As such, we added language to the existing single, streamlined application used by Exchanges using the federal eligibility and enrollment platform to allow consumers to authorize the Exchange to obtain eligibility and enrollment data and, if desired, to end their QHP coverage if the Exchange finds that the consumer has become eligible for or enrolled in other qualifying coverage, such as Medicare, Medicaid/CHIP, or BHP, during periodic checks.

In addition, for plan years beginning with the 2020 plan year, we also plan to add a new authorization to the single, streamlined application used by Exchanges using the federal eligibility and enrollment platform, which will meet Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Pub. L. 104–191) standards regarding how one's PHI is collected and used. This new authorization will expand the current scope of Medicare PDM to individuals in the Exchange population not receiving financial assistance who authorize the FFE to conduct certain PDM for them. Specifically, this new authorization will allow applicants or QHP enrollees, whether or not they have applied for or are receiving APTC or CSRs, to authorize the Exchange, when conducting Medicare PDM, to request PHI from HHS such as their name,

[3] Section 155.260 limits an Exchange's use and disclosure of PII when an Exchange creates or collects personally identifiable information for the purposes of determining eligibility for enrollment in a qualified health plan; determining eligibility for other insurance affordability programs, as defined in § 155.300; or determining eligibility for exemptions from the individual shared responsibility provisions in section 5000A of the Code. One of the permitted uses and disclosures is for the Exchange to carry out the functions described in § 155.200.

Social Security Number, Medicare eligibility or enrollment status, and other data elements the Exchange may determine necessary, to allow the Exchange to determine whether the consumer is simultaneously enrolled in Medicare and, if requested, to act on the enrollee's behalf to terminate QHP coverage in cases of dual enrollment. We note that, because entitlement to premium-free Medicare Part A is based on age and information held by the Social Security Administration (that is, the number of quarters of coverage toward a Social Security benefit under Title II of the Act), the Exchange will not be able to identify through this process any consumer who is eligible for premium-free Part A; we encourage all consumers who are age 65 and older to apply with the Social Security Administration to receive an eligibility determination with respect to Medicare. Our adoption of this new optional authorization to access Medicare enrollment information does not extend to access to Medicaid, CHIP, or BHP information for applicants who are not receiving APTC or CSRs, because these programs are targeted to relatively lower income consumers and we would not expect to identify a significant number of enrollees dually enrolled in one of these programs and an unsubsidized QHP through the Exchange.

For consumers who request voluntary termination upon a finding of dual enrollment, the Exchange would terminate coverage after following the current PDM process outlined in § 155.330(e)(2)(i), which requires the Exchange to provide notice of the updated information the Exchange has found and a 30-day period for the enrollee to respond. For example, upon receiving the required notice, the enrollee could (1) return to the Exchange and terminate his or her QHP coverage, (2) revoke the prior authorization for the Exchange to terminate his or her QHP coverage in the event dual enrollment is found, so that he or she would remain enrolled both in the QHP and in Medicare, or (3) notify the Exchange that he or she is not eligible for, or enrolled in, Medicare. For consumers who revoke their prior authorization for the Exchange to terminate their QHP enrollment where the Exchange finds the enrollee is eligible for or enrolled in Medicare, or who disagree that they are eligible for or enrolled in Medicare, the Exchange would only proceed to terminate the enrollee's APTC and CSRs, and not his or her enrollment in QHP coverage through the Exchange, using the process specified in § 155.330(e)(2)(i). Again, as the Exchange cannot identify through this process those consumers who are eligible for but not enrolled in premium-free Part A, we encourage all consumers who are 65 and older to apply with the Social Security Administration to receive an eligibility determination with respect to Medicare.

Based on our experience performing Medicare PDM, we believe that many consumers are inadvertently enrolled in Medicare and QHP coverage at the same time, and that their dual enrollment does not represent an informed decision. For example, we have found that, once consumers are informed of the consequences of their dual enrollment, such as paying full price for a QHP and risk for financial penalties for delaying Medicare Part B enrollment, the majority of consumers end their QHP coverage shortly thereafter. Furthermore, our own internal analyses show that the majority of QHP enrollees who become dually enrolled do so by aging into Medicare and failing to terminate the APTC or CSRs they are receiving through the Exchange (and, if desired, their Exchange coverage itself) during their Medicare initial enrollment period. We believe that Exchanges should play an important role in helping to ensure that consumers, regardless of whether the consumer has applied for, or is receiving, APTC or CSRs through the Exchange, are aware of their dual enrollment, the fact that their QHP coverage may duplicate coverage available to them through Medicare at potentially lower expense, and their potential risk for tax liability for APTC received during months of overlapping coverage (for consumers receiving APTC) or financial penalties (such as the Medicare Part B late enrollment penalty if they delay enrolling in Medicare during their initial eligibility period).

We believe these changes will support HHS's program integrity efforts regarding the Exchanges by helping promote a balanced risk pool for the individual market as Medicare and Medicaid/CHIP beneficiaries tend to be higher utilizers of medical services, ensuring that consumers are accurately determined eligible for APTC and income-based CSRs, and safeguarding consumers against enrollment in unnecessary or duplicative coverage. Such unnecessary or duplicative coverage, coupled with typically higher utilization, generally results in higher premiums across the individual market, leading to unnecessarily inflated expenditures of federal funds on PTC for taxpayers eligible for PTC in the individual market. We also encourage SBEs and enhanced direct enrollment partners to adopt these changes if they are not already using the single, streamlined application. We seek comment on these plans.

3. Eligibility Redetermination During a Benefit Year (§ 155.330)

In accordance with § 155.330(d), Exchanges must periodically examine available data sources to determine whether enrollees in a QHP through an Exchange with APTC or CSRs have been determined eligible for or enrolled in other qualifying coverage through Medicare, Medicaid, CHIP, or the BHP, if applicable. HHS has not previously defined ''periodically.'' Currently, FFEs conduct Medicare PDM and Medicaid/CHIP PDM twice a year. To ensure that all Exchanges are taking adequate steps to check for enrollees who have become eligible for or enrolled in these other forms of MEC, and to terminate APTC and CSRs if so, we propose to add a clearer requirement to conduct Medicare, Medicaid/CHIP, and BHP, if applicable, periodic data matching with regular frequency. Specifically, we propose to add paragraph (d)(3) to specify that Exchanges conduct Medicare, Medicaid/CHIP, and BHP, if applicable, PDM at least twice a year, beginning with the 2020 calendar year. We believe this timeframe will give Exchanges that are not already performing these PDM checks twice a year sufficient time to implement any business, operational, and information technology changes needed to comply with the proposed new requirement. Based on HHS's experience, Exchanges should consider spacing Medicare, Medicaid/CHIP, and BHP, if applicable, PDM checks evenly throughout the year, which we believe would help ensure the greatest number of potentially affected enrollees are identified and notified. Further, we do not anticipate that the proposal—to apply Medicare PDM to those enrollees who are not receiving APTC/CSRs but authorize the Exchange to receive Medicare enrollment information—would add significant costs to performing Medicare PDM. Based on HHS's experience, the dually enrolled unsubsidized population is significantly smaller than the population receiving APTC/CSRs. We believe this policy would likely reduce QHP premiums and improve program integrity for all Exchanges, since Medicare and Medicaid/CHIP beneficiaries tend to have a higher risk profile than a typical Exchange enrollee and, therefore, may have negative impacts on the risk pool because of the typically increased utilization of services expected for these populations,

which include significant numbers of older and disabled beneficiaries or poorer health outcomes associated with lower income statuses.[4] As noted above, this negative effect on the risk pool likely results in higher premiums across the individual market, leading to increased expenditures of federal funds on PTC for taxpayers eligible for PTC resulting from unnecessary or duplicative coverage. So that the FFEs and SBEs may prioritize the implementation of the proposed requirement to conduct PDM for Medicare, Medicaid, CHIP, and BHP (if applicable) eligibility or enrollment at least twice yearly, we are not proposing to require Exchanges to perform PDM for death at least twice in a calendar year. We will consider whether to require this check to be performed at a particular frequency through future rulemaking.

Since most SBEs have shared, integrated eligibility systems with their respective Medicaid programs, Medicaid/CHIP and BHP, if applicable, PDM requirements may be met differently for SBEs than for the FFEs. While there is some variation among SBEs in their Medicaid/CHIP and BHP, if applicable, PDM processes, most SBEs have implemented fully integrated eligibility systems where the design of the system mitigates risk of dual enrollment in, or inconsistent eligibility results regarding, APTC/CSRs and Medicaid/CHIP and BHP, if applicable, coverage by having one eligibility rules engine for eligibility determinations for all these programs. In these SBEs, an individual cannot be enrolled in both a QHP through the Exchange with APTC/CSRs, and Medicaid/CHIP or BHP, if applicable, coverage, at any given time. At paragraph (d)(3), we propose to specify that we will deem these SBEs to be in compliance with the requirement to perform Medicaid/CHIP PDM or BHP PDM, if applicable. SBEs that do not have fully integrated eligibility systems for APTC/CSRs and Medicaid/CHIP would be required to perform Medicaid/CHIP PDM at least twice a year. Similarly, SBEs in states that have implemented the BHP, but where the BHP is not integrated into the state's shared eligibility system, would be required to perform BHP PDM at least twice a year. We anticipate most SBEs will meet or exceed the proposed requirements for Medicaid/CHIP PDM and BHP PDM, if applicable, based on current or planned operations for calendar year 2018, as reported to us through the State-based Marketplace Annual Reporting Tool and through technical assistance engagements. Therefore, we anticipate that the proposed requirement to conduct Medicaid/CHIP PDM and BHP PDM, if applicable, at least twice a year would not result in a significant administrative burden for SBEs that are not deemed to be in compliance (and no administrative burden for those that are so deemed).

Although we believe that compliance by SBEs with these proposed requirements is critically important for program integrity, we are not proposing specific penalties if SBEs do not comply. However, we note that under current authority HHS requires a SBE to take corrective action if it is not complying with federal guidance and regulations. We utilize specific oversight tools (SMART, programmatic audits, etc. as described in the preamble to § 155.1200) to identify issues with, and place corrective actions on Exchanges, and provide technical assistance and ongoing monitoring to track those actions until the Exchange comes into compliance.

Additionally, under section 1313(a)(4) PPACA, if HHS determines that an Exchange has engaged in serious misconduct with respect to compliance with Exchange requirements, it has the option to rescind up to 1 percent of payments due a state under any program administered by HHS until it is resolved. These existing authorities would apply to the proposed periodic data matching requirements in § 155.330(d). If HHS determines it is necessary to apply this authority due to non-compliance by an Exchange with § 155.330(d), HHS would also determine the HHS-administered program from which it will rescind payments that are due to that state.

Lastly, we propose to make a technical correction in § 155.330(d)(1) by adding an additional reference to the process and authority in § 155.320(b). This reference was omitted previously, but the requirements in § 155.320(b), specifying that Exchanges must verify whether an applicant is eligible for MEC other than through an eligible employer-sponsored plan using information obtained by transmitting identifying information specified by HHS to HHS for verification purposes, apply to the PDM process in § 155.330.

4. General Program Integrity and Oversight Requirements (§ 155.1200)

As section 1311 of the PPACA Exchange Establishment grant program has come to a conclusion and State Exchanges are financially self-sustaining, HHS has a need for strengthening the mechanisms and tools for overseeing SBE and SBE–FP ongoing compliance with federal requirements for Exchanges, including eligibility and enrollment requirements under 45 CFR part 155.

HHS approves or conditionally approves a state to establish a State Exchange (either an SBE or SBE–FP) based on an assessment of a state's attested compliance with statutory and regulatory rules. Once approved or conditionally approved, State Exchanges must meet specific program integrity and oversight requirements specified at section 1313(a) of the PPACA, §§ 155.1200 and 155.1210. These requirements provide HHS with the authority to oversee the Exchanges after their establishment. Currently, annual reporting requirements for State Exchanges at § 155.1200(b) include the annual submission of: (1) A financial statement in accordance with generally accepted accounting principles (GAAP); (2) eligibility and enrollment reports; and (3) performance monitoring data.

Additionally, under § 155.1200(c), each State Exchange is required to contract with an independent external auditing entity that follows generally accepted governmental auditing standards (GAGAS) to perform annual independent external financial and programmatic audits. State Exchanges are required to provide HHS with the results of the annual external audits, including corrective action plans to address any material weaknesses or significant deficiencies identified by the auditor. All corrective action plans are monitored by HHS until closed. Currently, the audits must address compliance with all Exchange requirements under 45 CFR part 155.

HHS designed and developed the State-based Marketplace Annual Reporting Tool (SMART) in 2014 to assist Exchanges in conducting a defined set of oversight activities. The SMART was designed to facilitate State Exchanges' reporting to HHS on how they are meeting federal program requirements and operational requirements set forth in statute, regulations, and applicable guidance that implements the statutory and regulatory requirements, including reporting compliance with Federal eligibility and enrollment program requirements under 45 CFR 155 subparts D and E. The SMART, thus, enables HHS to evaluate and monitor State Exchange progress in coming into compliance with federal requirements where needed. Since then, HHS has come to utilize the SMART, along with

[4] For example, see Urban Institute and Center on Society and Health, How Are Income and Wealth Linked to Health and Longevity? (April 2015), available at *https://www.urban.org/sites/default/files/publication/49116/2000178-How-are-Income-and-Wealth-Linked-to-Health-and-Longevity.pdf.*

the annual programmatic and financial audit reports, as primary oversight tools for identifying and addressing State Exchange non-compliance issues. HHS requires State Exchanges to take corrective actions to address issues that are identified through the SMART and annual programmatic and financial audits, and HHS monitors the implementation of the corrective actions. We propose to modify § 155.1200(b)(2) to reflect that HHS requires State Exchanges to submit annual compliance reports (such as the SMART), that encompass eligibility and enrollment reporting, but also include reporting on compliance across other Exchange program requirements under 45 CFR part 155. We also propose to modify § 155.1200(b)(1) to eliminate the April 1st date in which states must provide a financial statement to HHS, to provide HHS the flexibility to align the financial statement deadline with the SMART deadline, which is set annually by HHS. Because we are proposing to remove the April 1st date, but intend to maintain the requirement that State Exchanges submit the required reports by a deadline, we also propose to modify the introductory text to § 155.1200(b) to specify that State Exchanges must provide the required annual reporting by deadlines to be set by HHS.

We propose to retain the requirement at § 155.1200(c) that an annual programmatic audit be conducted by SBEs and SBE–FPs, but make a minor change from ''state'' to ''State Exchanges'' to be consistent and clear on the entities to which this rule applies. We also propose to add specificity to the annual programmatic audit requirement by proposing a clarification of § 155.1200(d)(2) to make clear that HHS may specify or target the scope of a programmatic audit to address compliance with particular Exchange program areas or requirements. This would provide HHS with the ability to specify those Exchange functions that are most pertinent to a particular State Exchange model (SBE or SBE–FP) and need to be regularly included in the audit; target those Exchange functions most likely to impact program integrity, such as eligibility verifications; and reduce burden on State Exchanges where possible. In addition, we propose to modify § 155.1200(d) by replacing existing paragraph (d)(4) with new paragraphs (d)(4) and (5). These requirements specify that SBEs must ensure that the independent audits implement testing procedures or other auditing procedures that assess whether an SBE is conducting accurate eligibility determinations and enrollment transactions under 45 CFR 155 subparts D and E. Such auditing procedures include the use of statistically valid sampling methods in the testing or auditing procedures.

We believe these proposed changes will strengthen our programmatic oversight and the program integrity of State Exchanges, while providing flexibility for HHS in the collection of information. Through the Paperwork Reduction Act (PRA) process, we are able to make updates and refinements to the SMART reporting tool to align with our oversight and program integrity priorities for Exchanges as they evolve. In addition, allowing HHS to specify the scope of the programmatic audit at § 155.1200(d)(2) would provide us the ability to target our oversight to specific Exchange program requirements based on the particular State Exchange model, our program integrity priorities, and the goal of reducing burden on State Exchanges where possible. For instance, this would allow the audits to focus on SBE compliance with Exchange eligibility and enrollment requirements in 45 CFR 155 subparts D and E, and SBE–FP compliance with Exchange requirements in 45 CFR 155 subpart C. We believe this approach will provide HHS and states with greater insight into SBE and SBE–FP compliance with federal standards in a more cost-effective manner. We believe these two tools, state reporting and independent testing, coupled with our ongoing oversight activities would strengthen program integrity in State Exchanges.

We believe this approach would allow HHS to identify State Exchange non-compliance issues with more precision and efficacy. It would also allow HHS to provide more effective, targeted technical assistance to State Exchanges in developing corrective action plans to address issues that are identified, thus mitigating the need for more drastic or severe enforcement actions against a State Exchange. We believe this approach can reduce administrative burden on State Exchanges while maintaining the traditional role of State Exchanges in managing and operating their Exchanges, with HHS maintaining its role of overseeing State Exchange compliance with federal requirements through structured reporting processes. We seek comment on these proposals.

B. Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges

Segregation of Funds for Abortion Services (§ 156.280)

Since 1976, the Congress has included language, commonly known as the Hyde Amendment, in the Labor, Health and Human Services, Education and Related Agencies appropriations legislation.[5] The Hyde Amendment as currently in effect permits federal funds to be used for abortion services only in the limited cases of rape, incest, or if a woman suffers from a life-threatening 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 danger of death unless an abortion is performed (Hyde abortion coverage). The Hyde Amendment prohibits the use of federal funds for abortion coverage in instances beyond those limited circumstances (non-Hyde abortion coverage). Consistent with the Hyde Amendment, section 1303(b)(2) of the PPACA prohibits the issuer of a QHP that includes non-Hyde abortion coverage from using any amount attributable to PTC (including APTC) or CSRs (including advance payments of those funds to the issuer, if any) for abortions for which federal funds appropriated for HHS are prohibited, ''based on the law as in effect as of the date that is 6 months before the beginning of the plan year involved.'' [6]

Section 1303 of the PPACA outlines specific accounting and notice requirements that QHPs covering non-Hyde abortion services on the Exchanges must follow to ensure that no federal funding is used to pay for those services. Under section 1303(b)(2)(B) of the PPACA, as implemented in § 156.280(e)(2)(i), QHP issuers must collect a ''separate payment,'' from each enrollee in a plan ''without regard to the enrollee's age, sex, or family status,'' for an amount equal to the greater of the actuarial value of the coverage for abortions for which public funding is prohibited or $1 per enrollee per month. Section 1303(b)(2)(D) of the PPACA, implemented in § 156.280(e)(4), provides that the estimation is to be determined on an average actuarial basis and that QHP issuers may take into account the impact on overall costs of the inclusion of such coverage, but may

[5] 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.

[6] Section 1303(b)(1)(B)(I) of the PPACA.

not take into account any cost reduction estimated to result from such services, including prenatal care, delivery, or postnatal care. Section 1303(b)(2)(D) of the PPACA as implemented in § 156.280(e)(4) further states that QHP issuers are to estimate these costs as if the coverage were included for the entire population covered. With respect to the ''separate payment'' requirement, if an enrollee's premium for coverage under the plan is paid through employee payroll deposit (or deduction) under section 1303(b)(2)(B), the separate payments ''shall each be paid by a separate deposit.''

As mentioned above, QHP issuers that offer coverage for non-Hyde abortion may not use APTC to pay for such coverage, or use CSR funds to pay for such services. Pursuant to section 1303(b)(2)(D)(ii)(III) of the PPACA, these QHP issuers may not estimate the premium attributable to the benefit to be less than $1 per enrollee per month, regardless of the actual cost of the benefit. Currently, in certain rare scenarios, the FFE system allocates an amount of APTC to a policy such that the share of the aggregate premium for which the consumer is responsible is too low to meet this minimum standard. We intend to make system changes for open enrollment for plan year 2019 to ensure that the minimum premium amount of $1 per enrollee per month is assigned to all enrollments into plans offering coverage of non-Hyde abortion, so that issuers may separately collect this amount directly from consumers for the portion of the total premium attributable to coverage of non-Hyde abortion services.

Under section 1303(b)(3)(A) of the PPACA as implemented in § 156.280(f), QHP issuers must provide notice to enrollees as part of the Summary of Benefits and Coverage (SBC) at the time of enrollment if non-Hyde abortion services are covered by the QHP. As required under § 155.205(b)(1)(ii), each Exchange must maintain an up-to-date website that provides the SBCs. Section 147.200(a)(4) requires that individual market QHP issuers that provide the SBC electronically must place it in a prominent and readily accessible location on the QHP issuer's internet website. Additionally, pursuant to section 1303(b)(2)(C) of the PPACA, as implemented at § 156.280(e)(3), QHP issuers must segregate funds for non-Hyde abortion services collected from consumers into a separate allocation account that is to be used exclusively to pay for non-Hyde abortion services. Thus, if a QHP issuer disburses funds for a non-Hyde abortion on behalf of a consumer, it must draw those funds from the segregated allocation account. The account cannot be used for any other purpose.

Section 1303 of the PPACA and regulations at § 156.280 do 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 PPACA and § 156.280(e)(2)(i). In the 2016 Payment Notice, we provided guidance with respect to acceptable methods that a QHP issuer offering non-Hyde abortion coverage on the individual market Exchange may use to comply with the separate payment requirement. We stated that the QHP issuer could satisfy the separate payment requirement in one of several ways, including by sending the enrollee a single monthly invoice or bill that separately itemizes the premium amount for non-Hyde abortion services; 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. In the 2016 Payment Notice, we also stated that a consumer may make the payment for non-Hyde abortion services and the separate payment for all other services in a single transaction. On October 6, 2017, we released a bulletin that discussed the statutory requirements for separate payment, as well as this previous guidance with respect to the separate payment requirement.[7]

HHS now believes that some of the methods for billing and collection of the separate payment for non-Hyde abortion services noted as permissible in the preamble to the 2016 Payment Notice do not adequately reflect what we see as Congressional intent that the QHP issuer bill separately for two distinct (that is, ''separate'') payments, one for the non-Hyde abortion services, and one for all other services covered under the policy, rather than simply itemizing these two components of a single total billed amount or notifying the enrollee, at or soon after the time of enrollment, that the monthly invoice or bill will include a separate charge for these services. Although we recognize that itemizing or providing advance notice about the amounts arguably identifies two ''separate'' amounts for two separate purposes, we believe that the statute contemplates issuers billing for two separate ''payments'' of these two amounts (for example, two different checks or two distinct transactions), consistent with the requirement on issuers in section 1303(b)(2)(B)(i) of the PPACA to collect two separate payments. HHS, thus, believes that requiring QHP issuers to separately bill the portion of the consumer's premium attributable to non-Hyde abortion services and instruct consumers to make a separate payment for this amount is a better implementation of the statutory requirement for issuers to collect a separate payment for these services.

As such, we are proposing an amendment at § 156.280(e)(2) relating to billing and payment of the consumer's portion of the premium attributable to non-Hyde abortion services to reflect this interpretation of the statute. Specifically, we are proposing that, if these policies are finalized, as of the effective date of the final rule, QHP issuers (1) send an entirely separate monthly bill to the policy subscriber for only the portion of premium attributable to non-Hyde abortion coverage, and (2) instruct the policy subscriber to pay the portion of their premium attributable to non-Hyde abortion coverage in a separate transaction from any payment the policy subscriber makes for the portion of their premium not attributable to non-Hyde abortion coverage. We believe that these proposals would better align the regulatory requirements for QHP issuer billing of enrollee premiums with the separate payment requirement in section 1303 of the PPACA. If these proposals are finalized, QHP issuers would no longer be permitted to send the enrollee a single monthly invoice or bill that separately itemizes the premium amount for non-Hyde abortion services, or send 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 in order to meet the separate payment requirement. Instead, QHP issuers would have to send a separate bill and instruct enrollees to send a separate payment in the manner specified by the final rule.[8] We invite comment on these proposals.

To better align the regulatory requirements for issuer billing of enrollee premiums with the separate payment requirement in section 1303 of the PPACA, our proposal would require

[7] 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.*

[8] We noted above the situation where, as a result of APTCs, the out-of-pocket premium payable by the consumer is less than $1 per enrollee per month. Under this proposed rule, and to ensure compliance with section 1303, if the QHP includes non-Hyde abortion coverage, the QHP issuer would be required to bill the consumer at least $1 per enrollee per month.

the QHP issuer to send this separate bill in a separate mailing with separate postage. If a QHP issuer sends bills electronically, we propose that it provide consumers with the two bills in separate emails or other electronic communications. We believe this approach will help reduce consumer confusion about receiving two separate bills in a single envelope. For example, consumers may inadvertently miss or discard a second paper bill included in a single envelope, increasing terminations of coverage for failure to pay premiums. The QHP issuer would also be required to produce an invoice or bill that is distinctly separate from the invoice or bill for the other portion of the consumer's premium that is not attributable to non-Hyde abortion coverage, whether in paper or electronic format. We solicit comment on any operational issues that may arise from this aspect of the proposed rule.

We also seek comment on ways to mitigate any possible confusion, for example through an annual notice or standard explanatory language on each of the two monthly bills. To meet the requirements of this new proposal, QHP issuers would be required to instruct policy subscribers to pay the separately billed or invoiced portion of the premium for non-Hyde abortion coverage in a transaction separate from the transaction for payment of the other portion of the premium that is not attributable to non-Hyde abortion coverage and make reasonable efforts to collect the payment separately, such as by including a separate payment stub on each of the separately mailed bills or invoices (if sent on paper) or providing a separate payment link in the separate email or electronic communication with a separate payment field on the payment web page for each separate payment to be collected (if sending an electronic bill, or accepting electronic payments regardless of how the bills were transmitted). Under this proposal, consumer non-payment of any premium due (including non-payment of the portion of the consumer's premium attributable to non-Hyde abortion coverage) would continue to be subject to state and federal rules regarding grace periods. In the event that a policy subscriber does not follow the separate payment instructions, however, and pays the entire premium in a single transaction (both the portion attributable to non-Hyde abortion coverage, as well as the portion attributable to coverage for other services), the QHP issuer would not be permitted to refuse to accept such a combined payment on the basis that the policy subscriber did not send two checks as requested by the QHP issuer, and to then terminate the policy, subject to any applicable grace period, for non-payment of premiums. We believe that potential loss of coverage would be an unreasonable result of a consumer paying in full but failing to adhere to the QHP issuer's requested payment procedure. Under our new interpretation, a QHP issuer would thus be required to accept a combined payment, to the extent necessary to avoid this result.

QHP issuers that do receive combined consumer premiums covering the portion attributable to non-Hyde abortion coverage as well as the portion attributable to coverage for other services in one single payment would treat the portion of the premium attributable to non-Hyde abortion services as a separate payment for which the QHP issuer would be expected to disaggregate into the separate allocation account used solely for these services. We would expect the QHP issuer in this scenario to again explain to the consumer the separate payment requirement in the law, and take steps to inform the consumer not complying with this policy that he or she should do so in future months, including documentation of such outreach and educational efforts. Again, if the consumer still declines to do so, however, the combined payment must be accepted to avoid a loss of coverage. Likewise, QHP issuers would not be permitted to refuse to accept separate premium payments paid to the issuer in a single return envelope (for example, two separate checks returned to the issuer in a single return envelope) on the basis that the consumer did not separately return each premium payment in a separate mailing. We seek comment on these proposals.

We are also proposing a technical change, to Section 156.280(e)(2)(iii) as redesignated, to insert appropriate cross reference to the explanation of the separate payments.

Consistent with § 156.715, HHS has broad authority to perform compliance reviews to monitor FFE issuer compliance. HHS conducts compliance reviews throughout the year, and issuer notification of selection for a review may occur at any time during the year. Detailed examples of regulatory and operational areas that will be reviewed are included in the *Key Priorities for FFM Compliance Review,* which is updated each year with new key oversight priorities.[9] Consistent with this authority, we propose updating our compliance reviews governing QHP certification to include new reviews of FFE issuer compliance with § 156.280, including the segregation of funds requirement and the new proposals for separate billing of the portion of the consumer's premium attributable to coverage of non-Hyde abortion services as specified in this rule. FFE issuers subject to these compliance reviews should maintain all documents and records of compliance with section 1303 of the PPACA and these requirements in accordance with § 156.705, and should anticipate making available to HHS the types of records specified at § 156.715(b) that would be necessary to establish their compliance with these requirements. For example, FFE issuers subject to compliance reviews for § 156.280 should anticipate supplying HHS with documentation of their estimate of the basic per enrollee per month cost, determined on an average actuarial basis, for coverage of non-Hyde abortion services; detailed invoice and billing records demonstrating they are separately billing in a separate mailing or separate electronic communication and collecting the portion of the premium attributable to coverage of non-Hyde abortion services as specified in this rule; and appropriately segregating the funds collected from consumers into a separate allocation account that is used exclusively to pay for non-Hyde abortion services. We believe the addition of these compliance reviews will help to address remaining issuer compliance issues, if any, previously identified by the 2014 U.S. Government Accountability Office report.[10] We seek comment on this proposal.

As is the case with many provisions in the PPACA, states are the entities primarily responsible for implementing and enforcing the provisions in section 1303 of the PPACA related to individual market QHP coverage of non-Hyde abortion services. Section 1303(b)(2)(E)(i) of the PPACA, as implemented at § 156.280(e)(5), designates the state insurance commissioners as the entities responsible for monitoring, overseeing, and enforcing the provisions in section 1303 of the PPACA related to QHP segregation of funds for non-Hyde abortion services. However, as stated in

[9] CCIIO Examinations, Audits and Reviews of Issuers: Issuer Resources, *available at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Exams_Audits_Reviews_Issuer_Resources-.html.*

[10] U.S. Government Accountability Office, ''Health Insurance Exchanges: Coverage of Non-excepted Abortion Services by Qualified Health Plans,'' (Sept. 15, 2014), available at *http://www.gao.gov/products/GAO-14-742R.*

2017 guidance,[11] where we are charged with directly enforcing these statutory requirements in the FFEs, we intend to do so fully in instances of issuer non-compliance. We call upon states that operate their own Exchanges to fully enforce these requirements as codified in the federal regulations governing the Exchanges. To the extent such a state operating its own Exchange fails to substantially enforce these requirements, HHS would expect to enforce them in the state's place. However, as states remain the primary enforcers of these requirements, we propose that HHS involvement in enforcement would be limited to ensuring that federal funds are appropriately managed. For example, HHS enforcement would be limited to instances where it becomes clear that the state department of insurance is not overseeing the requirement for the QHP issuer to determine the actuarial value of the coverage of non-Hyde abortions, to separately bill (and collect) premium of at least $1 per enrollee per month for such coverage, or to segregate funds effectively; a state department of insurance or other entity notifies HHS of suspected misuse of federal funding for coverage of non-Hyde abortion services; or the state's enforcement actions are inadequate and fail to result in compliance from the QHP issuer. The Office of Personnel Management may issue guidance related to these provisions for multi-state plan issuers.[12]

We remind issuers that pursuant to § 156.280(e)(5)(ii), any issuer offering coverage of non-Hyde abortions services on the Exchange must submit a plan to its state department of insurance that details the issuer's process and methodology for meeting the requirements of section 1303(b)(2)(C), (D), and (E) of the PPACA (hereinafter, ''separation plan'') to the state health insurance commissioner. The separation plan should describe the QHP issuer's financial accounting systems, including appropriate accounting documentation and internal controls, that would ensure the segregation of funds required by section 1303(b)(2)(C), (D), and (E) of the PPACA. Issuers should refer to § 156.280(e)(5)(ii) for more information on precisely what issuers should include in their separation plans to demonstrate compliance with these requirements.

As mentioned previously, consistent with HHS's authority under § 156.715, we propose monitoring FFE issuer compliance with the requirements under § 156.280 by requiring QHP issuers in FFEs to show documentation of compliance with the requirement to estimate the basic per enrollee per month cost, determined on an average actuarial basis, for coverage of non-Hyde abortion services and charge at least $1 per enrollee per month for such coverage, as well as with the segregation of funds requirements when undergoing compliance reviews, including detailed records and documentation demonstrating compliance with the separate billing (including mailing, as applicable) and collection requirements proposed in this rule, as well as the segregation of funds requirements. We also remind issuers offering medical QHPs in the FFEs that they must already attest to adhering to all applicable requirements of 45 CFR part 156 as part of the QHP certification application, including those requirements related to the segregation of funds for abortion services implemented in § 156.280.[13] If the separate billing and premium collection proposals at § 156.280(e)(2) are finalized as proposed, issuers in the FFE completing this attestation would also attest to adhering to these new separate billing and collection requirements. As part of the QHP certification process, issuers in states with FFEs where the States perform plan management functions must also complete similar program attestations attesting to adherence with § 156.280.[14] Issuers in states with SBEs that offer QHPs including non-Hyde abortion coverage should contact their state for attestation requirements as part of the QHP certification process.

We seek comment on these proposals.

IV. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA), 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 the Office of Management and Budget (OMB) for review and approval. This proposed rule contains information collection requirements (ICRs) that are subject to review by OMB. A description of these provisions is given in the following paragraphs.

In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the PRA 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 ICRs:

A. ICRs Regarding General Program Integrity and Oversight Requirements (§ 155.1200)

The burden associated with State Exchanges meeting the proposed program integrity reporting requirements in § 155.1200 have already been assessed and encompassed through SMART currently approved under OMB control number: 0938–1244 (CMS–10507). This proposed rule does not impose any new burden or add any additional requirements to the existing collection.

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

In the preamble to § 156.280, we explain that the proposals to require separate issuer billing for, and collection of, the portion of the premium attributable to non-Hyde abortion coverage would be subject to future HHS compliance reviews of FFE issuers, requiring issuers in the FFE to maintain and submit records showing compliance with these requirements to HHS. We have determined that the requirements associated with compliance reviews have already been assessed and encompassed by the Program Integrity: Exchange, Premium Stabilization Programs, and Market Standards; Amendments to the HHS Notice of Benefit and Payment Parameters for 2014; Final Rule II ICR currently approved under OMB control number: 0938–1277 (CMS–10516).

To show compliance with FFE standards and program requirements, all

[11] 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.*

[12] Section 1334(a)(6) of the PPACA requires that at least one multi-state plan in each Exchange excludes coverage of non-Hyde abortion services. Currently, no multi-state plan options cover non-Hyde abortion services. *See* OPM's Frequently Asked Questions: Insurance, *available at https://www.opm.gov/faqs/QA.aspx?fid=fd635746-de0a-4dd7-997d-b5706a0fd8d2&pid=8313a65b-c5b8-4d58-a58f-9d81f26856a2.*

[13] 2019 Qualified Health Plan Issuer Application Instructions, *available at: https://www.qhpcertification.cms.gov/s/2019QHPInstructionsVersion1.pdf?v=1.*

[14] State Partnership Exchange Issuer Program Attestation Response Form, *available at: https://www.qhpcertification.cms.gov/s/SuppDoc_SPE_Attestationsed._revised_508.pdf?v=1.*

issuers seeking QHP certification in FFE states are required to submit responses to program attestations as part of their QHP application. This response already includes an attestation that the issuer agrees to adhere to the requirements related to the segregation of funds for abortion services implemented in § 156.280. We have determined that the requirements associated with QHP certification have already been assessed and encompassed by the Establishment of Exchanges and Qualified Health Plans; Exchange Standard for Employers approved under OMB control number 0938–1187 (CMS–10433). Therefore, proposed § 156.280(e)(2) adds no new ICRs as it relates to program attestations.

In § 156.280(e)(2), we propose that QHP issuers must send an entirely separate monthly bill in a separate mailing or separate electronic communication to the policy subscriber for only the portion of premium attributable to non-Hyde abortion coverage, and instruct the policy subscriber to pay the portion of their premium attributable to non-Hyde abortion coverage in a separate transaction from any payment the policy subscriber makes for the portion of their premium not attributable to non-Hyde abortion coverage. Based on 2018 QHP certification data in the FFEs and SBE–FPs, we estimate that 15 QHP issuers offered a total of 111 plans with coverage of non-Hyde abortion services in 7 States. In SBEs, we estimate that 60 QHP issuers offered a total of approximately 1,000 plans offering this coverage across 10 SBEs. In total, this leads to an estimated 75 QHP issuers offering a total of 1,111 plans covering non-Hyde abortion services across 17 states. As such, the ICRs associated with these proposals would create a new burden on QHP issuers and plans and are subject to the Paperwork Reduction Act. Salaries for the positions cited below were taken from the May 2017 National Occupational Employment and Wage Estimates United States Department of Labor's Bureau of Labor Statistics (BLS) (*http://www.bls.gov/oes/current/oes_nat.htm*) based on the listed national median hourly wage. All wages on the following pages are inflated by 100 percent to account for the cost of fringe benefits and overhead costs.

We anticipate that populating the enrollee information on the separate electronic or paper bill, transmitting the separate electronic or paper bill in a separate mailing or separate electronic communication, and processing the enrollee's separate electronic or mailed payment, will be an automated process that occurs monthly after a computer programmer adds this functionality to the QHP issuer's billing and payment operating system. We estimate that, on a one-time basis, a computer programmer will require 10 hours to add this functionality to an affected QHP issuer's systems (at a rate of $84.16 per hour) for a total burden of 10 hours. We estimate that this will result in a one-time cost of $841.60 per QHP issuer that offers plans that cover non-Hyde abortion services to meet this reporting requirement. This would be a one-time cost, such that the overall burden for all 75 QHP issuers would be 750 hours, with an associated total cost of $63,120.

Because an estimated 75 QHP issuers offered a total of 1,111 plans with coverage of non-Hyde abortion services across 17 states, we estimate that the total number of QHP issuers that offer plans with coverage of non-Hyde abortion, for which they would be required to send separate bills in a separate mailing or separate electronic communication and collect separate payments as proposed at § 156.280(e)(2), would be 75 per year, for a total one-time burden of 750 hours. Below is the estimate of the burden imposed on a single QHP issuer subject to the reporting requirements of this rule. The aggregate burden for 3 years will be same as for 1 year: $841.60 per respondent and $63,120 for all respondents.

Labor category	Respondents	Responses	Burden per response (hours)	Wage rate (p/hr) including 100% fringe benefits	Total annual burden per response (hours)	Labor cost of one-time reporting ($)	Total one-time cost for all respondents ($)
Computer programmer to add automated billing & payment processing functionality ...	75	75	10	$42.08	10	$841.60	$63,120
Total	75	75	10	42.08	10	841.60	63,120

Although we anticipate that populating the enrollee information on the separate electronic or paper bill and transmitting that bill in a separate mailing or separate electronic communication would be an automated process, we estimate that a general office clerk working for an affected QHP issuer would require 2 hours monthly (at a rate of $30.28 per hour) per plan to determine which enrollees are enrolled in plans that cover non-Hyde abortion and to oversee the process of sending a separately packaged complete and accurate bill in a separate mailing or separate electronic communication to these enrollees for the portion of their premium attributable to that coverage, for an annual burden of 24 hours. This estimate includes the amount of time the office clerk would spend determining which enrollees prefer paper billing versus electronic billing, and ensuring that the bills are complete and accurate and are being sent in a separate mailing or separate electronic communication. We estimate that it would cost $726.72 annually per plan that covers non-Hyde abortion services to meet the reporting requirement, with a total annual burden for all 1,111 plans of 26,664 hours and an associated total annual cost of $807,385.92.

We similarly anticipate that processing the payment made by enrollees for this portion of their premium would be an automated process. However, we estimate that a general office clerk working for an affected QHP issuer would require 2 hours monthly (at a rate of $30.28 per hour) per plan to review for accuracy the separate payment an enrollee in a plan covering non-Hyde abortion services sends for the portion of their premium attributable to that coverage and to process any payments or paper checks made by enrollees through the mail, for an annual burden of 24 hours. This estimate includes the amount of additional time the office clerk would need to spend reviewing for accuracy the separate payments returned in separate mailings from the payments received for the portion of the policy subscriber's premium not attributable to non-Hyde abortion. We estimate that it would cost $726.72 annually per plan that covers non-Hyde abortion services to meet the reporting requirement, with a total annual burden for all 1,111 plans

of 26,664 hours and an associated total cost of $807,385.92.

As such, we estimate that the total number of plans for which QHP issuers would need to send separate bills in a separate mailing or separate electronic communication and collect separate payments as proposed at § 156.280(e)(2) would be 1,111 per year, for a total burden of 53,328 hours to meet these reporting requirements per year. Below is the estimate of the burden imposed on a single plan subject to the reporting requirements of this rule. The aggregate burden for 3 years will be $4,360.32 per respondent and $4,844,315.52 for all respondents.

Labor category	Respondents	Responses	Burden per response (hours)	Total annual burden per response (hours)	Wage rate (p/hr) including 100% fringe benefits	Labor cost of reporting annually ($)	Total annual cost for all respondents ($)
General office clerk for preparing and sending the bill	1,111	1,111	2	24	$30.28	$726.72	$807,385.92
General office clerk for receiving and processing the separate payment	1,111	1,111	2	24	30.28	726.72	807,385.92
Total	2,222	2,222	4	48	60.56	1,453.44	1,614,771.84

C. 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. The requirements are not effective until they have been approved by OMB.

We invite public comments on these information collection requirements. If you wish to comment, please identify the rule (CMS–9922–P) and, where applicable, the ICR's CFR citation, CMS ID number, and OMB control number.

To obtain copies of a supporting statement and any related forms for the proposed collection(s) summarized in this notice, you may make your request using one of following:

1. Access CMS's website address at *https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing.html.*

2. Email your request, including your address, phone number, OMB number, and CMS document identifier, to *Paperwork@cms.hhs.gov.*

3. Call the Reports Clearance Office at (410) 786–1326.

See this rule's **DATES** and **ADDRESSES** sections for the comment due date and for additional instructions.

V. 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.

VI. Regulatory Impact Statement

We have examined the impact 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. 96–354), section 1102(b) of the Social Security 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), the Congressional Review Act (5 U.S.C. 804(2)), and Executive Order 13771 on Reducing Regulation and Controlling Regulatory Costs (January 30, 2017).

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 regulation: (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 must be prepared for major rules with economically significant effects ($100 million or more in any 1 year), and an ''economically significant'' regulatory action is subject to review by the Office of Management and Budget (OMB). As discussed below regarding their anticipated effects, these proposals are not likely to have economic impacts of $100 million or more in any 1 year, and therefore do not meet the definition of ''economically significant'' under Executive Order 12866. However, OMB has determined that the actions are significant within the meaning of section 3(f)(4) of the Executive Order. Therefore, OMB has reviewed these final rules and the Departments have provided the following assessment of their impact.

A. Need for Regulatory Action

HHS is committed to promoting program integrity throughout its programs to ensure that federal statutory requirements are met and federal monies are not being inappropriately spent. Ensuring that consumers receive the correct amount of APTC and CSRs at the time of enrollment or re-enrollment is a top priority for us, and necessitates regulatory action. Accurate and up-to-date eligibility determinations help reduce the possibility that an individual or family is paying a premium amount that is either higher or lower than they should have to, the latter of which could result in the individual or family needing to pay a large amount back to the federal

Treasury on their federal income tax returns. We propose a number of changes in this rule to help mitigate the risk of federal dollars incorrectly leaving the federal Treasury in the form of APTC during the year. To further improve program integrity and ensure that individuals receiving APTC/CSRs are appropriately enrolled in insurance affordability programs, we are also proposing to specify that Exchanges must conduct Medicare PDM, Medicaid/CHIP PDM, and BHP PDM, if applicable, pursuant to § 155.330(d)(1)(ii), at least twice a year beginning with the 2020 calendar year. We also believe this policy would likely reduce QHP premiums and improve program integrity for all Exchanges, since Medicare and Medicaid/CHIP beneficiaries tend to have a higher risk profile than a typical Exchange enrollee and, therefore, may have negative impacts on the risk pool because of the typically increased utilization of services expected for these populations, which include significant numbers of older and disabled beneficiaries or poorer health outcomes associated with lower income statuses.[15] As noted above, this negative effect on the risk pool results in higher premiums across the individual market, leading to increased expenditures of federal funds on PTC for taxpayers eligible for PTC resulting from duplicative coverage.

As part of our efforts to strengthen program integrity with respect to subsidy payments in the individual market, we also believe improvements should be made to our ability to conduct effective and efficient oversight of State Exchanges to ensure consumers receive the correct amount of APTC and CSRs (as applicable). As section 1311 of the PPACA Exchange Establishment grant program has come to a conclusion and State Exchanges are financially self-sustaining, HHS has a need to strengthen the mechanisms and tools for overseeing ongoing compliance by State Exchanges with federal program requirements, including eligibility and enrollment requirements under 45 CFR part 155. For these reasons, we are proposing to add specificity to the reporting requirements for State Exchanges at § 155.1200 to focus on activities that speak to compliance with Exchange program requirements, including eligibility and enrollment requirements. We are also proposing changes at § 155.1200 to clarify the scope of annual programmatic audits that State Exchanges are required to conduct, and include new requirements that focus on ensuring proper eligibility determinations and enrollments in SBEs. It is our intent that these changes would enable us to better identify and address State Exchange non-compliance issues.

HHS believes that some of the methods for billing and collection of the separate payment for non-Hyde abortion services noted as permissible in the preamble to the 2016 Payment Notice do not adequately reflect what we see as Congressional intent that the QHP issuer bill separately for two distinct (that is, ''separate'') payments as required by section 1303 of the PPACA. To remedy this, we are proposing at § 156.280(e)(2) that: (1) QHP issuers send an entirely separate monthly bill to the policy subscriber for only the portion of premium attributable to non-Hyde abortion coverage, and (2) instruct the policy subscriber to pay the portion of their premium attributable to non-Hyde abortion coverage in a separate transaction from any payment the policy subscriber makes for the portion of their premium not attributable to non-Hyde abortion coverage. We believe that these proposals are necessary to better align the regulatory requirements for QHP issuer billing of enrollee premiums with the separate payment requirement in section 1303 of the PPACA. HHS believes that requiring QHP issuers to separately bill the portion of the policy subscriber's premium attributable to non-Hyde abortion services and instruct policy subscribers to make a separate payment for this amount is a better interpretation of, and would result in greater compliance with this interpretation of, the statutory requirement for QHP issuers to collect a separate payment for these services.

B. Anticipated Effects

Revising § 155.200(c) to clarify that the Exchanges must perform oversight functions or cooperate with activities related to oversight and financial integrity requirements is a clarification and not a new function. Therefore, it would not impose additional burdens on State Exchanges.

Our proposal that Exchanges conduct Medicare PDM, Medicaid/CHIP PDM, and BHP PDM, if applicable, at least twice a year beginning with the 2020 calendar year, merely adds specificity to the existing requirement that Exchanges must periodically examine available data sources to determine whether Exchange enrollees have been determined eligible for or enrolled in other qualifying coverage such as Medicare, Medicaid, CHIP, or the BHP, if applicable. Therefore, we expect the costs associated with this proposal to be minimal. However, SBEs that are not already conducting PDM with the frequency proposed, or deemed in compliance with the Medicaid, CHIP, and BHP (where applicable) PDM requirements, would likely be required to engage in IT system development activity in order to communicate with these programs and act on enrollment data either in a new way, or in the same way more frequently. Thus, there may be additional associated administrative cost for these SBEs to implement the proposed PDM requirements. We anticipate a majority (about eight) of the twelve SBEs would be exempt from the requirement to perform Medicaid, CHIP, and BHP (where applicable) PDM because they have shared, integrated eligibility systems, as they would be deemed in compliance with this requirement. However, at this point we are not able to confirm the exact number because we have not yet set specific criteria and process to assess and confirm which SBEs would be exempt, and would need additional operational information from SBEs to confirm our assessment. We would establish and engage in that process after finalization of the rule. For an SBE not already conducting Medicare, Medicaid/CHIP, and BHP PDM at least twice a year, and that does not already have a shared, integrated eligibility system with its respective Medicaid/CHIP, and BHP (where applicable) programs, we estimate that it would cost approximately $1,740,000 per SBE to build such capabilities in their system. These costs would be incurred by the SBE as they are required to be financially self-sustaining and do not receive federal funding for their establishment or operational activities.

We believe these changes will support HHS's program integrity efforts regarding the Exchanges by helping promote a balanced risk pool for the individual market as Medicare and Medicaid/CHIP beneficiaries tend to be higher utilizers of medical services, ensuring that consumers are accurately determined eligible for APTC and income-based CSRs, and safeguarding consumers against enrollment in unnecessary or duplicative coverage. Such unnecessary or duplicative coverage, coupled with typically higher utilization, generally results in higher premiums across the individual market, leading to unnecessarily inflated expenditures of federal funds on PTC for taxpayers eligible for PTC in the individual market.

[15] For example, see Urban Institute and Center on Society and Health, How Are Income and Wealth Linked to Health and Longevity? (April 2015), available at *https://www.urban.org/sites/default/files/publication/49116/2000178-How-are-Income-and-Wealth-Linked-to-Health-and-Longevity.pdf.*

We expect our plan to permit HHS to verify applicant eligibility for or enrollment in MEC in order for HHS to perform the periodic checks required under § 155.330(d) for those consumers who provide consent to the Exchange to obtain their eligibility and enrollment data, and, if desired, to end their QHP coverage if found dually enrolled in other qualifying coverage, to have minimal economic impact. Based on HHS's experience, the dually enrolled unsubsidized population is significantly smaller than those receiving APTC or CSRs. This plan would help expand the scope of the population that is part of Medicare PDM, rather than adding new Exchange requirements.

We do not anticipate the proposed changes to § 155.1200 will result in any additional cost for the State Exchanges because the changes leverage an existing reporting mechanism, the annual State Based Marketplace Reporting Tool, for meeting eligibility and enrollment reporting requirements in § 155.1200(b). Additionally, State Exchanges are already required to annually contract with, and budget accordingly for, an external independent audit entity to perform an annual financial and programmatic audit as required under § 155.1200(c). We believe the proposed requirement that HHS be able to specify the scope of annual programmatic audits to focus on the program areas that are most pertinent to a State Exchange model (SBE or SBE–FP), or have the greatest program integrity implications, would allow State Exchanges to utilize the funds that they already allocate to contracting with an external independent audit entity in the most cost-effective manner.

In § 156.280, we propose to amend billing and premium collection requirements related to the separate payment requirement for abortions for which public funding is prohibited pursuant to section 1303 of the PPACA, as implemented at § 156.280. Specifically, the proposals described at § 156.280(e)(2) would require QHP issuers offering non-Hyde abortion coverage through an Exchange to send an entirely separate monthly bill in a separate mailing or separate electronic communication to the policy subscriber for only the portion of premium attributable to non-Hyde abortion coverage, and instruct the policy subscriber to pay the portion of their premium attributable to non-Hyde abortion coverage in a separate transaction from any payment the policy subscriber makes for the portions of the premium not attributable to coverage for non-Hyde abortion services. These proposals aim to better align the regulatory requirements for QHP issuer billing of premiums with the separate payment requirement in section 1303 of the PPACA.

As reflected in the associated ICRs for the proposals at § 156.280(e)(2), we recognize that QHP issuers that cover non-Hyde abortion services may experience an increase in burden if these proposals are finalized. We anticipate that QHP issuers would need to invest additional time and resources to develop a separate invoice for non-Hyde abortion services, separately mail with separate postage the bill for the portion of the premium attributable to non-Hyde abortion coverage or separately email or electronically send the separate bill, as well as additional time and resources for receipt and processing of the separate payment through a separate transaction as proposed at § 156.280(e)(2). Specifically, we anticipate QHP issuers would need to invest time and resources to oversee the process of sending in a separate mailing or separate electronic communication a complete and accurate bill to these enrollees for the portion of their premium attributable to that coverage, to review for accuracy the separate payment a policy subscriber in a QHP covering non-Hyde abortion sends for the portion of their premium attributable to that coverage, and to process separate payments, whether made electronically or by mail. We also anticipate that QHP issuers would need to add functionality to their operating systems to develop an automated process to populate the enrollee information on the separate bill, transmit the separate bill in a separate mailing or separate electronic communication, and process the separate payment.

Based on 2018 QHP certification data in FFEs and SBE–FPs, 15 QHP issuers offered a total of 111 plans with coverage of non-Hyde abortion services in 7 states. In SBEs, we estimate that 60 issuers offered a total of 1,000 QHPs offering non-Hyde abortion coverage across 10 SBEs. In total, this leads to an estimated 75 QHP issuers offering a total of 1,111 QHPs covering non-Hyde abortion services across 17 states. This rule could significantly increase the administrative burden for QHP issuers covering non-Hyde abortion services in developing, sending, and processing the separate invoices required under this proposal.

Based on 2018 QHP Certification data in FFEs and SBE–FPs, there were approximately 300,000 enrollees across the 111 QHPs covering non-Hyde abortion coverage. In SBEs, we estimate that there were approximately 1,000,000 enrollees across the approximate 1,000 QHPs offering non-Hyde abortion coverage. If finalized, these requirements would also increase burden on those 1,300,000 consumers, related to paying the portion of the premium attributable to non-Hyde abortion services through a separate paper check or electronic transaction; that burden, however, is contemplated by the specific language of section 1303 which requires a QHP issuer ''to collect from each enrollee in the plan . . . a separate payment'' for the coverage of non-Hyde abortion services. In order to develop a preliminary estimate of the consumer cost of this proposed provision, we assume that a policy subscriber reading their separately received paper or electronic bill and writing out an additional paper check or filling in the necessary information for completion of a separate electronic payment adds approximately ten minutes per month to a policy subscriber's' monthly payment process for payment of their QHP premiums, for a total of 2 hours per year. Based on the May 2017 National Occupational Employment and Wage Estimates United States Department of Labor's Bureau of Labor Statistics (BLS) (*http://www.bls.gov/oes/current/oes_nat.htm*), using the listed national mean hourly wage for the 25th percentile,[16] it would cost a policy subscriber $11.91 for an additional hour of burden, or approximately $1.98 for an additional 10 minutes of burden. As such, the 10 minute monthly estimated burden for filling out a separate check or online payment for a policy subscriber would be $1.98, and the yearly added burden for each policy subscriber would be $23.76. We note that many consumers are enrolled on the Exchange for an average of 10 months. For those enrollees, the annual consumer burden would be $19.80 for a total annual burden of $25,740,000. However, in total for all affected enrollees in QHPs covering non-Hyde abortion enrolled in plans for 12 months, we estimate that it would annually cost $30,888,000 for policy subscribers to comply with these proposals. This estimate excludes the cost of consumer learning (which may have significant upfront costs and could also continue to be resource intensive on an ongoing basis given the potential confusion of consumers in receiving multiple bills. In some cases, these may entail costs not just to consumers but

[16] The 25th percentile mean hourly wage most closely resembles the group of consumers likely to be affected by this proposal as most enrollees enrolled in QHPs on the Exchange are between 100% and 400% of the federal poverty level.

also to QHP issuers, such as in increased volume of requests for customer service assistance and follow up needed to consumers to pay their full bill). However, HHS believes that, if finalized as proposed, the proposed changes would better align the regulatory requirements for QHP issuer billing of premiums with the separate payment requirement in section 1303 of the PPACA. As such, HHS believes that this outweighs the estimated consumer burden. We solicit comments on the impact of the proposed policy at § 156.280(e)(2) and on whether other impacts should be considered or quantified.

We request comment on both our assessment of the need for the regulatory action and an explanation of how the regulatory action will meet that need, as well as our assessment of the potential costs and benefits of the regulatory action. To be sure our analysis is as accurate as possible with respect to any additional costs to states, issuers, or other entities, we encourage robust comment in this area.

The RFA requires agencies to analyze options for regulatory relief of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Individuals and states are not included in the definition of a small entity. We are not preparing an analysis for the RFA because we have determined, and the Secretary certifies, that this proposed rule would not have a significant economic impact on a substantial number of small entities.

Section 202 of the Unfunded Mandates Reform Act of 1995 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 2018, that threshold is approximately $150 million. This rule will have no consequential effect on state, local, or tribal governments or on the private sector.

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. This proposed rule does not impose substantial direct costs on state and local governments or preempt state law. However, we believe the rule has Federalism implications.

In HHS's view, this regulation has Federalism implications due to our proposal that Exchanges conduct Medicare, Medicaid/CHIP, and, if applicable, BHP PDM at least twice a year, beginning with the 2020 calendar year. However, HHS believes that the Federalism implications are substantially mitigated because the proposed requirement sets only a minimum frequency with which Exchanges must conduct Medicare, Medicaid/CHIP, and, if applicable, BHP PDM, which is already required to be conducted periodically; SBEs would continue to have the flexibility to conduct PDM with greater frequency.

Additionally, the proposed changes to State Exchange oversight and reporting requirements in § 155.1200 have Federalism implications since those rules would require State Exchanges to submit certain reports to HHS and require them to enter into contracts with an external independent audit entity to perform audits, and incur the associated costs. However, HHS believes that the Federalism implications are substantially mitigated because the proposed changes do not impose new requirements on State Exchanges, but rather add specificity to the existing requirements.

This proposed rule is subject to the Congressional Review Act (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 General for review.

Executive Order 13771, titled Reducing Regulation and Controlling Regulatory Costs, was issued on January 30, 2017. Section 2(a) of Executive Order 13771 requires an agency, unless prohibited by law, to identify at least two existing regulations to be repealed when the agency publicly proposes for notice and comment, or otherwise promulgates, a new regulation. In furtherance of this requirement, section 2(c) of Executive Order 13771 requires that the new incremental costs associated with new regulations shall, to the extent permitted by law, be offset by the elimination of existing costs associated with at least two prior regulations. OMB Guidance Implementing Executive Order 13771 (April 5, 2017) defines a regulatory action as (1) a significant regulatory action as defined in section 3(f) of Executive Order 12866, or (2) a significant guidance document (for example, significant interpretive guidance) that has been reviewed by OMB under the procedures of Executive Order 12866 and that, when finalized, is expected to impose total costs greater than zero. This proposed rule, if finalized as proposed, is expected to be an E.O. 13771 regulatory action. Details on the estimated costs appear in the preceding analysis.

C. Regulatory Review Costs

If regulations impose administrative costs on private entities, such as the time needed to read and interpret this proposed rule, we 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 similar Exchange-related CMS rules will be the number of reviewers of this proposed rule. We acknowledge this assumption may understate or overstate the costs of reviewing this rule. It is possible that not all commenters will review the rule in detail, and it is also possible that some reviewers will chose not to comment on the proposed rule. For these reasons, we consider the number of past commenters on similar CMS rules will 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 recognize that different types of entities may be affected by only certain provisions of this proposed rule, and therefore, for the purposes of our estimate, we assume that each reviewer reads approximately 50 percent of the rule.

Using the wage information from the Bureau of Labor and Statistics (BLS) for medical and health service managers (Code 11–9111), we estimate that the cost of reviewing this rule is $107.38 per hour, including overhead and fringe benefits.[17] We estimate that it would take approximately 1 hour for the staff to review the relevant portions of this proposed rule. Based on previous and similar CMS rules, we assume that 321 entities will review this proposed rule. Therefore, we estimate that the total cost of reviewing this regulation is approximately $34,469 ($107.38 × 321 reviewers).

This may underestimate the review costs, since not all reviewers may have submitted comments. In addition, stakeholders may need to do a detailed analysis in order to implement the unanticipated provisions of this rule will need additional time and personnel, which will vary depending

[17] *https://www.bls.gov/oes/current/oes_nat.htm.*

on the extent to which they are affected. To estimate an upper bound, we assume that on average 530 issuers and 50 states will spend 10 hours each, 100 other organizations will spend 5 hours each and 100 individuals will spend 1 hour each to review the rule. Under these assumptions, total time spent reviewing the rule would be 6,400 hours with an estimated cost of approximately $673,024.

In accordance with the provisions of Executive Order 12866, this proposed rule was reviewed by the Office of Management and Budget.

List of Subjects

45 CFR Part 155

Administrative practice and procedure, Advertising, Brokers, Conflict of interests, Consumer protection, Grants administration, Grant programs—health, 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, Technical assistance, Women and youth.

45 CFR Part 156

Administrative practice and procedure, Advertising, Advisory committees, Brokers, 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, Loan programs—health, Medicaid, Organization and functions (Government agencies), Public assistance programs, Reporting and recordkeeping requirements, State and local governments, Sunshine Act, Technical assistance, Women, Youth.

For the reasons set forth in the preamble, the Department of Health and Human Services proposes to amend 45 CFR parts 155 and 156 as set forth below:

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

■ 1. The authority citation for part 155 is revised to read as follows:

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

■ 2. Section 155.200 is amended by revising paragraph (c) to read as follows:

§ 155.200 Functions of an Exchange.

* * * * *

(c) *Oversight and financial integrity.* The Exchange must perform required functions and cooperate with activities related to oversight and financial integrity requirements in accordance with section 1313 of the Affordable Care Act and as required under this part, including overseeing its Exchange programs, assisters, and other non-Exchange entities as defined in § 155.260(b)(1).

* * * * *

■ 3. Section 155.330 is amended by revising paragraph (d)(1) introductory text and adding paragraph (d)(3) to read as follows:

§ 155.330 Eligibility redetermination during a benefit year

* * * * *

(d) * * *

(1) *General requirement.* Subject to paragraph (d)(3) of this section, the Exchange must periodically examine available data sources described in §§ 155.315(b)(1) and 155.320(b) to identify the following changes:

* * * * *

(3) *Definition of periodically.* Beginning with the 2020 calendar year, the Exchange must perform the periodic examination of data sources described in paragraph (d)(1)(ii) of this section at least twice in a calendar year. SBEs that have implemented a fully integrated eligibility system that determines eligibility for advance payments of the premium tax credit, cost-sharing reductions, Medicaid, CHIP, and the BHP, if a BHP is operating in the service area of the Exchange, will be deemed in compliance with paragraphs (d)(1)(ii) and (d)(3) of this section.

* * * * *

■ 4. Section 155.1200 is amended by—

■ a. Revising paragraphs (b) introductory text, (b)(1) and (2), (c) introductory text, and (d)(2) and (3);

■ b. Redesignating (d)(4) as paragraph (d)(5);

■ c. Adding a new paragraph (d)(4); and

■ d. Revising newly redesignated paragraph (d)(5).

The revisions and addition read as follows:

§ 155.1200 General program integrity and oversight requirements.

* * * * *

(b) *Reporting.* The State Exchange must, at least annually, provide to HHS, in a manner specified by HHS and by applicable deadlines specified by HHS, the following data and information:

(1) A financial statement presented in accordance with GAAP,

(2) Information showing compliance with Exchange requirements under this part 155 through submission of annual reports,

* * * * *

(c) *External audits.* The State Exchange must engage an independent qualified auditing entity which follows generally accepted governmental auditing standards (GAGAS) to perform an annual independent external financial and programmatic audit and must make such information available to HHS for review. The State Exchange must:

* * * * *

(d)* * *

(2) Compliance with subparts D and E of this part 155, or other requirements under this part 155 as specified by HHS;

(3) Processes and procedures designed to prevent improper eligibility determinations and enrollment transactions, as applicable;

(4) Compliance with eligibility and enrollment standards through sampling, testing, or other equivalent auditing procedures that demonstrate the accuracy of eligibility determinations and enrollment transactions; and

(5) Identification of errors that have resulted in incorrect eligibility determinations, as applicable.

PART 156—HEALTH INSURANCE ISSUER STANDARDS UNDER THE AFFORDABLE CARE ACT, INCLUDING STANDARDS RELATED TO EXCHANGES

■ 5. 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, 26 U.S.C. 36B, and 31 U.S.C. 9701.

■ 6. Section 156.280 is amended by —

■ a. Redesignating paragraph (e)(2)(ii) as (e)(2)(iii);

■ b. Adding a new paragraph (e)(2)(ii); and

■ c. Revising newly redesignated paragraph (e)(2)(iii).

The revisions and addition read as follows:

§ 156.280 Segregation of funds for abortion services.

* * * * *

(e) * * *

(2) * * *

(ii) Send to each policy subscriber (without regard to the policy subscriber's age, sex, or family status) in the QHP separate monthly bills for each of the amounts specified in paragraphs (e)(2)(i)(A) and (B) of this section, and

instruct the policy subscriber to pay each of these amounts through separate transactions. If the policy subscriber fails to pay each of these amounts in a separate transaction as instructed by the issuer, the issuer may not terminate the policy subscriber's coverage on this basis, provided the amount due is otherwise paid.

(iii) Deposit all such separate payments into separate allocation accounts as provided in paragraph (e)(3) of this section. In the case of an enrollee whose premium for coverage under the QHP is paid through employee payroll deposit, the separate payments required under paragraph (e)(2)(i) of this section shall each be paid by a separate deposit.

* * * * *

Dated: October 11, 2018.

Seema Verma,

Administrator, Centers for Medicare & Medicaid Services.

Dated: October 18, 2018.

Alex M. Azar II,

Secretary, Department of Health and Human Services.

[FR Doc. 2018–24504 Filed 11–7–18; 4:15 pm]

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FEDERAL COMMUNICATIONS COMMISSION

47 CFR Parts 1 and 73

[AU Docket No. 17–329; DA 18–1038]

Auction of Cross-Service FM Translator Construction Permits; Comment Sought on Competitive Bidding Procedures for Auction 100

AGENCY: Federal Communications Commission.

ACTION: Proposed rule; proposed auction procedures.

SUMMARY: The Wireless Telecommunications and Media Bureaus (Bureaus) announce an auction of certain cross-service FM translator construction permits. This document also seeks comment on competitive bidding procedures and proposed minimum opening bids for Auction 100.

DATES: Comments are due on or before November 15, 2018, and reply comments are due on or before November 28, 2018.

ADDRESSES: Interested parties may submit comments in response to the Auction 100 Comment Public Notice by any of the following methods:

- *FCC's Website:* Federal Communications Commission's Electronic Comment Filing System (ECFS): *http://apps.fcc.gov/ecfs.* Follow the instructions for submitting comments.
- *Mail:* FCC Headquarters, 445 12th Street SW, Room TW–A325, Washington, DC 20554.
- *People with Disabilities:* To request materials in accessible formats for people with disabilities (braille, large print, electronic files, or audio format), send an email to *FCC504@fcc.gov* or call the Consumer & Governmental Affairs Bureau at 202–418–0530 (voice), 202–418–0432 (TTY). For detailed instructions for submitting comments, see the **SUPPLEMENTARY INFORMATION** section of this document.

FOR FURTHER INFORMATION CONTACT: For auction legal questions, Lynne Milne in the Wireless Telecommunications Bureau's Auctions and Spectrum Access Division at (202) 418–0660. For general auction questions, the Auctions Hotline at (717) 338–2868. For FM translator service questions, James Bradshaw, Lisa Scanlan or Tom Nessinger in the Media Bureau's Audio Division at (202) 418–2700.

SUPPLEMENTARY INFORMATION: This is a summary of the Auction 100 Comment Public Notice in AU Docket No.17–329, DA 18–1038, released on October 19, 2018. The complete text of this document, including its attachment, is available for public inspection and copying from 8:00 a.m. to 4:30 p.m. Eastern Time (ET) Monday through Thursday or from 8:00 a.m. to 11:30 a.m. ET on Fridays in the FCC Reference Information Center, 445 12th Street SW, Room CY–A257, Washington, DC 20554. The Auction 100 Comment Public Notice and related documents also are available on the internet at the Commission's website: *https://www.fcc.gov/auction/100/,* or by using the search function for AU Docket No. 17–329 on the Commission's ECFS web page at *https://www.fcc.gov/ecfs/.*

All filings in response to the Auction 100 Comment Public Notice must refer to AU Docket No. 17–329. The Bureaus strongly encourage interested parties to file comments electronically, and request that an additional copy of all comments and reply comments be submitted electronically to the following address: *auction100@fcc.gov.*

Electronic Filers: Comments may be filed electronically using the internet by accessing ECFS: *http://apps.fcc.gov/ecfs.* Follow the instructions for submitting comments.

Paper Filers: Parties who choose to file by paper must file an original and one copy of each filing. Filings can be sent by hand or messenger delivery, by commercial overnight courier or by first-class or overnight U.S. Postal Service mail. All filings must be addressed to the Commission's Secretary, Office of the Secretary, Federal Communications Commission (FCC). All hand-delivered or messenger-delivered paper filings for the Commission's Secretary must be delivered to the FCC Headquarters at 445 12th Street SW, Room TW–A325, Washington, DC 20554. The filing hours are 8:00 a.m. to 7:00 p.m. Eastern Time (ET). All hand deliveries must be held together with rubber bands or fasteners. Any envelope or box must be disposed of before entering the building. Commercial overnight mail (other than U.S. Postal Service Express Mail and Priority Mail) must be sent to 9050 Junction Drive, Annapolis Junction, MD 20701. U.S. Postal Service first-class, Express, and Priority mail must be addressed to 445 12th Street SW, Washington, DC 20554.

I. Introduction

1. On December 4, 2017, the Bureaus announced a second auction filing window for AM broadcasters seeking new cross-service FM translator station construction permits. By this Public Notice, the Bureaus seek comment on the procedures to be used for Auction 100. Auction 100 will be a closed auction: Only those entities listed in Attachment A of the Auction 100 Comment Public Notice will be eligible to participate further in Auction 100.

2. The Bureaus anticipate that the bidding for Auction 100 will commence in fiscal year 2019. The Bureaus will announce a schedule for bidding in Auction 100 by public notice, to provide applicants with sufficient time to submit upfront payments and prepare for bidding in the auction.

II. Construction Permits in Auction 100

3. Auction 100 will resolve by competitive bidding mutually exclusive (MX) engineering proposals for construction permits for up to 13 new cross-service FM translator stations. The locations and channels of these proposed stations are identified in Attachment A of the Auction 100 Comment Public Notice. Attachment A also specifies a proposed minimum opening bid and a proposed upfront payment amount for each construction permit listed.

4. An applicant listed in Attachment A may become qualified to bid only if it complies with the additional filing, qualification, and payment requirements, and otherwise complies with applicable rules, policies, and procedures. Each qualified bidder will be eligible to bid on only those construction permits specified for that qualified bidder in Attachment A of the