provided that they meet the criteria of the CAA. This action merely proposes to approve state law as meeting Federal requirements and does not impose additional requirements beyond those imposed by state law. For that reason, this proposed action:

- Is not a significant regulatory action subject to review by the Office of Management and Budget under Executive Orders 12866 (58 FR 51735, October 4, 1993) and 13563 (76 FR 3821, January 21, 2011);
- Is not an Executive Order 13771 (82 FR 9339, February 2, 2017) regulatory action because SIP approvals are exempted under Executive Order 12866;
- Does not impose an information collection burden under the provisions of the Paperwork Reduction Act (44 U.S.C. 3501 *et seq.*);
- Is certified as not having a significant economic impact on a substantial number of small entities under the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*);
- Does not contain any unfunded mandate or significantly or uniquely affect small governments, as described in the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4);
- Does not have Federalism implications as specified in Executive Order 13132 (64 FR 43255, August 10, 1999);
- Is not an economically significant regulatory action based on health or safety risks subject to Executive Order 13045 (62 FR 19885, April 23, 1997);
- Is not a significant regulatory action subject to Executive Order 13211 (66 FR 28355, May 22, 2001);
- Is not subject to requirements of section 12(d) of the National 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, Carbon monoxide, Incorporation by reference, Intergovernmental relations, Lead, Nitrogen dioxide, Ozone, Particulate matter, Reporting and recordkeeping requirements, Sulfur oxides, Volatile organic compounds.

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

Dated: February 25, 2019.

Mary S. Walker,

Acting Regional Administrator, Region 4.

[FR Doc. 2019–04383 Filed 3–8–19; 8:45 am]

BILLING CODE 6560–50–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Chapter IV

Office of the Secretary

45 CFR Subtitle A

[CMS–9921–NC]

RIN 0938–ZB45

Patient Protection and Affordable Care Act; Increasing Consumer Choice Through the Sale of Individual Health Insurance Coverage Across State Lines Through Health Care Choice Compacts

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

ACTION: Request for information.

SUMMARY: This request for information (RFI) solicits comment from interested parties on how to eliminate barriers to and enhance health insurance issuers' ability to sell individual health insurance coverage across state lines, primarily pursuant to Health Care Choice Compacts. This RFI was written in connection with Executive Order 13813, ''Promoting Healthcare Choice and Competition Across the United States,'' which directs the Administration, including the Department of Health and Human Services (HHS), to the extent consistent with law, to facilitate the purchase of health insurance coverage across state lines. HHS is committed to increasing health insurance coverage options under Title I of the Patient Protection and Affordable Care Act.

DATES: *Comment Date:* To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on May 6, 2019.

ADDRESSES: In commenting, please refer to file code CMS–9921–NC. 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–9921–NC, P.O. Box 8016, Baltimore, MD 21244–8016.

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

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–9921–NC, 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: Cam Moultrie Clemmons, (206) 615–2338.

SUPPLEMENTARY INFORMATION:

Submission of Comments: All submissions received must include the Agency file code CMS–9921–NC for this notice.

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. Background

On October 12, 2017, President Trump issued Executive Order 13813, ''Promoting Healthcare Choice and Competition Across the United States,'' which states the policy of the Administration will be ''to the extent consistent with law, to facilitate the purchase of insurance across State lines and the development and operation of a

healthcare system that provides high-quality care at affordable prices for the American people.'' [1] The Executive Order reflects the Administration's intention to put downward pressure on premiums by providing more meaningful choices for consumers and increasing competition. The Department of Health and Human Services (HHS) intends to work with states to innovate within the health insurance market by considering additional mechanisms for the purchase of individual health insurance coverage that are less burdened by regulatory requirements and will therefore simplify operations and lower costs for health insurance issuers, with the ultimate goal of lowering prices for coverage and increasing options for United States consumers.

Executive Order 13813 further directs the Secretary of HHS, in consultation with the Secretaries of the Treasury, Labor, and the Federal Trade Commission, within 180 days from the date of the Executive Order, and every 2 years thereafter, to provide a report to the President that details the extent to which existing state and federal laws, regulations, guidance, requirements, and policies fail to conform to the policies set forth in section 1 of the Executive Order, including the facilitation of the purchase of insurance across state lines, and identifies actions that states or the federal government could take in furtherance of the policies set forth in section 1 of the Executive Order. Comments provided in response to this Request for Information (RFI) may help to inform future reports.

While there is no federal law that generally prohibits the sale of health insurance coverage across state lines, the McCarran-Ferguson Act of 1945 [2] establishes states as the primary regulators of insurance and declares that a federal law cannot preempt any state law that regulates the business of insurance, or that imposes a fee or tax upon such business, unless such federal law specifically relates to the business of insurance. While several mechanisms to facilitate the sale of individual health insurance coverage across state lines exist, such as Interstate Health Compacts enacted through state legislation and the allowance of the sale of insurance from out-of-state insurers by a state, this RFI primarily explores options related to Health Care Choice Compacts related to section 1333 of the Patient Protection and Affordable Care Act (PPACA) (Pub. L. 111–148) since section 1333 provides a specific role for the federal government.

Section 1333 of the PPACA provides for the establishment of a regulatory framework [3] that allows two or more states to enter into a Health Care Choice Compact. For plan years beginning on or after January 1, 2016, under a Health Care Choice Compact, a health insurance issuer could offer one or more qualified health plans (QHPs) [4] in the individual health insurance market in any state included in the compact. The QHP generally would only be subject to the laws and regulations of the state in which the health insurance coverage was written or issued.[5] Section 1333 of the PPACA does not address the sale of group health insurance coverage across state lines or the sale of individual market policies that are not QHPs. In order to enter into a Health Care Choice Compact, a state must pass legislation, after March 23, 2010, specifically authorizing it to do so. To date, no states have passed legislation authorizing the state to enter into a Health Care Choice Compact as contemplated by section 1333 of the PPACA or created a Health Care Choice Compact, and no issuer has offered health insurance coverage through a Health Care Choice Compact. However, four states (Georgia, Maine, Oklahoma, and Wyoming) have passed laws authorizing the sale of health insurance coverage across state lines. Under Georgia law,[6] insurers are authorized to offer individual accident and sickness insurance policies in Georgia that have been approved for issuance in other states, provided specified minimum criteria are met. Under Maine law,[7] domestic insurers or licensed health maintenance organizations that are authorized to transact individual health insurance in Maine are permitted to offer for sale in Maine an individual health insurance policy duly authorized for sale in Connecticut, Massachusetts, New Hampshire, Rhode Island, or Vermont by a parent or corporate affiliate, provided specified minimum criteria are met. Oklahoma law [8] allows issuers authorized to engage in the business of insurance in a state which has a legislatively approved compact with Oklahoma, and not so authorized in Oklahoma, to issue individual accident and health insurance policies in Oklahoma, provided specified minimum criteria are met. Wyoming law [9] allows insurers authorized to engage in the business of insurance in a state identified by the Commissioner as having insurance laws sufficiently consistent with Wyoming laws, and so authorized in Wyoming, to issue in Wyoming selected comprehensive individual medical and surgical insurance policies that have been approved in other such states, provided specified minimum criteria are met.

Three other states have passed laws to study the feasibility of selling insurance across state lines.[10] Since 2010, bills that would permit the purchase of health insurance coverage across state lines have been filed but not passed in an additional 11 states.[11]

Separately, ''Interstate Health Compacts,'' also known as ''Freedom

[1] *https://www.whitehouse.gov/the-press-office/2017/10/12/presidential-executive-order-promoting-healthcare-choice-and-competition.*

[2] 15 U.S.C. 1011–1015.

[3] Section 1333 of the PPACA requires that no later than July 1, 2013, the Secretary of HHS, in consultation with the National Association of Insurance Commissioners, issue regulations for the creation of Health Care Choice Compacts. To date, HHS has not promulgated rules implementing section 1333 of the PPACA.

[4] Qualified health plan, or QHP, means a health plan that has in effect a certification that it meets the standards described in subpart C of part 156 issued or recognized by each Exchange through which such plan is offered in accordance with the process described in subpart K of part 155. See 45 CFR 155.20.

[5] Additionally, the issuer would be subject to the market conduct, unfair trade practices, network adequacy, and consumer protection standards (including standards relating to rating), including addressing disputes as to the performance of the contract, of the state in which the policyholder resides. The health insurance issuer must be licensed in or submit to the jurisdiction and be subject to the aforementioned standards of each state in which it offers health insurance coverage under the compact. In addition, the health insurance issuer must notify the policyholder that the coverage may not otherwise be subject to the laws of the state in which the policyholder resides. Under section 1333 of the PPACA, HHS has the authority to approve Health Care Choice Compacts if it determines that they would provide coverage that would be at least as comprehensive as health insurance coverage sold through the Exchanges that offer essential health benefits, provide coverage and cost-sharing protections against excessive out-of-pocket spending at least as affordable as coverage under Title I of the PPACA, provide coverage to at least a comparable number of residents as coverage under Title I of the PPACA, not increase the federal deficit, and not weaken the enforcement of the laws and regulations of any state that is included in the compact that would still apply to the issuer in states in which the purchaser of coverage resides that is not the state in which the coverage was issued or written under the Health Care Choice Compact requirements. To date, HHS has not received any requests for approval of a Health Care Choice Compact.

[6] Ga. Code Ann., sec. 33–29A–30, *et seq.*

[7] Me. Rev. Stat. tit. 24–A, sec. 405–B.

[8] Okla. Stat. Ann. tit. 36, sec. 4414.

[9] Wyo. Stat. Ann. sec. 26–18–201, et *seq.*

[10] Kentucky (2012 Ken. H.B. 265. Sec. 10), Rhode Island (RI General Law 27–67), and Washington (Chapter 303, Laws of the State of Washington 2008, section 8, (SSB 5261)).

[11] Arizona (SB 1593 of 2011), Indiana (HB 1063 of 2011 and HB 1013 of 2013), Minnesota (H 1859 and S 349 of 2015), Montana (H 280 of 2013), New Hampshire (H 327 and S 150 of 2011), New Jersey (A 1558, A 4364, and S 2806 of 2017), Pennsylvania (HB 47 of 2011–12 and SB 346 of 2013–14), South Carolina (S 185 of 2011 and S 886 of 2014), Texas (HCR 90 of 2017), Washington (S 5540 of 2013–14), and West Virginia (HB 2801 and SB 419 of 2011).

Health Compacts,'' are another type of compact, advocated by Competitive Governance Action and the American Legislative Exchange Council, which could provide broader interstate health markets than the Health Care Choice Compacts under section 1333 of the PPACA. Interstate Health Compacts include a provision allowing for the suspension of the operation of all federal laws, rules, regulations, and orders regarding health care that are inconsistent with the laws and regulations adopted by the member state pursuant to the compact and aim to secure federal funding that is not conditional on any action of the member states.[12] The creation of any such Interstate Health Compact requires formal Congressional approval pursuant to Article 1, Section 10, of the United States Constitution. As of January 2017, at least nine states [13] have enacted Interstate Health Compacts; however, no requests for Congressional approval of the Interstate Health Compacts have been submitted.

No health insurance issuers or consumers appear to have access to the increased flexibility that could be afforded by state laws related to the sale of health insurance coverage across state lines.

II. Solicitation of Public Comments

HHS solicits public comments about actions that could further facilitate selling individual health insurance coverage across state lines. Comments are requested in response to the questions below with respect to individual health insurance coverage. The Administration recognizes and strongly supports the fundamental role states play in regulating insurance. Providing states with flexibility to address the unique needs of their health insurance markets is a key component of achieving the goals stated in the Executive Order. This RFI is not intended to inform policy which will preempt state law or otherwise impede the role states play as the primary regulators of insurance.

A. Expanding Access to Health Insurance Coverage Across State Lines

1. What are the practical advantages and disadvantages of allowing health insurance issuers to sell individual health insurance coverage across state lines through Health Care Choice Compacts?

2. What actions could the federal government undertake to facilitate the state implementation of the sale of individual health insurance coverage across state lines pursuant to section 1333 of the PPACA?

3. While four states have passed laws specifically authorizing the sale of individual health insurance across state lines, we understand that no action to implement these laws has been taken. Additionally, nine states have enacted laws authorizing the creation of Interstate Health Compacts, yet we understand that no such Compact has been created. Why have states not taken advantage of these opportunities? Are there federal or state statutory and/or regulatory barriers that prevent states from doing so?

4. Should HHS promote the sale of QHPs through Health Care Choice Compacts across state lines and why?

5. How would the sale of individual health insurance coverage across state lines through Health Care Choice Compacts impact access to QHPs? We are particularly interested in the impact on counties that do not have many options for QHP coverage in their current markets and whether the sale of health insurance coverage across state lines would increase or decrease the number of issuers offering QHPs in these counties.

6. Are there mechanisms, such as memoranda of understanding or other contractual arrangements, other than Health Care Choice Compacts established pursuant to section 1333 of the PPACA, that states could utilize to facilitate the sale of individual health insurance coverage across state lines? Would selling health insurance coverage such as short-term, limited-duration insurance; state-regulated farm bureau coverage; or insurance licensed by a state as defined under section 2791(d)(14) of the Public Health Service Act (PHS Act) (to include each of the several states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands) [14] to individuals pursuant to such state agreements help facilitate the sale of individual health insurance coverage across state lines? Consider whether the type of coverage is relevant to, or would impact, the form or nature of the agreements utilized by states.

B. Operationalizing the Sale of Health Insurance Coverage Across State Lines

1. Is the structure of Health Care Choice Compacts contemplated by section 1333 of the PPACA effective in facilitating the sale of individual health insurance coverage across state lines? To date, no states have passed laws specifically authorizing the state to enter into a Health Care Choice Compact under section 1333 of the PPACA. Why have states not enacted such laws? Are there any necessary revisions to section to 1333 of the PPACA that would facilitate the sale of health insurance coverage across state lines?

2. How difficult is it for small and/or regional health insurance issuers to develop provider networks in multiple states that could be used for health insurance coverage sold pursuant to Health Care Choice Compacts, and what are the causes of any such difficulties? For individual market health insurance issuers that already have a national provider network, what are the challenges for selling individual health insurance coverage across state lines through Health Care Choice Compacts? In what ways could the federal government facilitate expanding and strengthening provider networks?

3. How would states allowing health insurance issuers to sell individual health insurance coverage across state lines through Health Care Choice Compacts (if the health insurance coverage only covers health benefits in accordance with federal law and the laws of the state where the coverage is written) impact access to and the utilization of medical services?

4. What new and existing consumer protections are needed to protect policyholders that reside in one state but purchase individual health insurance coverage from a health insurance issuer in another state

[12] *See e.g.,* Ala. Code sec. 22–21A; Ga. Code Ann. sec. 31–48–1; Ind. Code sec. 12–16.5–1–1, *et seq.*; Kan. Stat. Ann. 65–6230; Mo. Rev. Stat. sec. 191.025; Okla. St. Ann. tit. 63, sec. 7300; S.C. Code Ann. sec. 44–10–10, *et seq.;* and Tex. Ins. Code Ann. sec. 5002.001. The legality of suspending the operation of federal law is not addressed herein, but this type of provision likely will face legal challenges.

[13] Alabama, Georgia, Indiana, Kansas, Missouri, Oklahoma, South Carolina, Texas, and Utah (expired July 2014).

[14] On July 14, 2016, the CMS Administrator sent letters to the territories stating the new market reforms in the PHS Act enacted in title I of the PPACA are governed by the definition of ''state'' set forth in that title, and therefore do not apply to issuers of health insurance coverage in the territories. The letter states the definition of ''state'' set forth in the PHS Act will apply only to PHS Act requirements in place prior to the enactment of the PPACA, or subsequently enacted in legislation that does not include a separate definition of ''state'' (as the PPACA does). This analysis applies only to health insurance that is governed by the PHS Act. The PHS Act, the Employee Retirement Income Security Act (ERISA), and the Internal Revenue Code (Code) requirements applicable to group health plans continue to apply to such coverage. The letters are available at *https://www.cms.gov/CCIIO/Resources/Letters/index.html#HealthMarketReforms.*

pursuant to a Health Care Choice Compact? How would allowing health insurance issuers to sell individual health insurance coverage across state lines impact the ability of state regulators to assist consumers or impact the ability of state courts to resolve legal disputes when the policyholder resides in a state other than that in which the policy was written, pursuant to a Health Care Choice Compact?

5. To what extent, if any, would the sale of individual health insurance coverage across state lines pursuant to a Health Care Choice Compact positively or negatively impact the following populations: Persons with pre-existing conditions; persons with disabilities; persons with chronic physical health conditions; expectant mothers; newborns; American Indians and Alaska Natives and tribal entities; veterans; and persons with behavioral health conditions, including both mental health and substance use disorder conditions?

6. In general, which statutes or regulations of the issuing state should apply to an individual market policy sold in another state pursuant to a Health Care Choice Compact, and which statutes or regulations, if any, of the state in which the policy is sold should apply? To what extent should policies being sold in another state pursuant to a Health Care Choice Compact be required to cover the state-required benefits of that state, and to what extent should such policies be required to cover the state-required benefits of the issuing state?

C. Financial Impact of Selling Health Insurance Coverage Across State Lines

1. What policies, including how premiums and rates are established and reviewed, and how risk is pooled, should be in place with respect to rating and pricing of health insurance coverage sold across state lines pursuant to Health Care Choice Compacts?

2. What impact would the sale of health insurance coverage across state lines pursuant to Health Care Choice Compacts have on health insurance coverage premiums for purchasers of insurance across state lines and for policyholders purchasing in-state insurance in the state where the across-state-lines purchasers live or in the state in which the issuer is located? Would the impact be different for policyholders in different states?

3. What impact would the sale of health insurance coverage across state lines pursuant to Health Care Choice Compacts have on policyholders' out-of-pocket expenses? Would the impact be different for different policyholders?

4. What impact would the sale of health insurance coverage across state lines pursuant to Health Care Choice Compact have on a health insurance issuer's operating costs?

5. What impact would the sale of health insurance coverage across state lines pursuant to Health Care Choice Compacts have on market participation in each state?

6. What impact would the sale of health insurance coverage across state lines pursuant to Health Care Choice Compacts have on competition and the viability of health insurance issuers that elect not to sell health insurance coverage across state lines?

7. What impact would the sale of health insurance coverage across state lines pursuant to Health Care Choice Compacts have on health care cost growth and medical inflation?

8. What impact would the sale of health insurance coverage across state lines pursuant to Health Care Choice Compacts have on consolidation of health insurance issuers?

9. What impact would the sale of health insurance coverage across state lines pursuant to Health Care Choice Compacts have on the market risk pools of the states where the health insurance issuer is domiciled and where the policyholder resides?

10. What impact would the sale of health insurance coverage across state lines pursuant to Health Care Choice Compacts have on the size and composition of the uninsured population?

III. Collection of Information Requirements

This document does not impose information collection requirements, that is, reporting, recordkeeping or third-party disclosure requirements. This RFI constitutes a general solicitation of comments. In accordance with the implementing regulations of the Paperwork Reduction Act (PRA) at 5 CFR 1320.3(h)(4), information subject to the PRA does not generally include ''facts or opinions submitted in response to general solicitations of comments from the public, published in the **Federal Register** or other publications, regardless of the form or format thereof, provided that no person is required to supply specific information pertaining to the commenter, other than that necessary for self-identification, as a condition of the agency's full consideration of the comment.'' Consequently, there is no need for review by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501, *et seq.*).

IV. 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, in the event we issue a subsequent document, we will respond to the comments in the preamble to that document.

Dated: January 28, 2019.

Seema Verma,

Administrator, Centers for Medicare & Medicaid Services.

Dated: February 14, 2019.

Alex M. Azar II,

Secretary, Department of Health and Human Services.

[FR Doc. 2019–04270 Filed 3–6–19; 4:15 pm]

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