

Testimony of Joshua D. Goldberg,
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to the

North Dakota Health Care Reform Review Interim Committee
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Good morning, Chairman Keiser, Senator Berry, and Members of the Committee. Thank you for the invitation to be with you today. My name is Joshua Goldberg, and I am a Health Policy and Legislative Advisor at the National Association of Insurance Commissioners (NAIC) in Washington, D.C, on whose behalf I am speaking. The NAIC is the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia and five U.S. territories. Through the NAIC, state insurance regulators establish standards and best practices, conduct peer review, and coordinate their regulatory oversight. NAIC staff supports these efforts and represents the collective views of state regulators domestically and internationally. NAIC members, together with the central resources of the NAIC, form the national system of state-based insurance regulation in the U.S.

Waivers for State Innovation

Overview

During Senate Finance Committee consideration of what would become the Affordable Care Act (ACA), Senator Ron Wyden (D-OR), who now chairs that panel, inserted an amendment that would have allowed states to seek a waiver of any of the health insurance market reforms and the bill's individual mandate, while meeting benchmarks regarding the scope and number of individuals receiving coverage.¹ As he later described it, the purpose of this amendment was "...to encourage additional innovative approaches in States, approaches that are tailored to the needs of States' own residents, that will help us, in my view, to promote choice and competition in the American health care system."² Given the belief held at that time by most Members of Congress that, if the bill became law, the majority of states would be implementing State-Based Exchanges (SBEs), this proposed flexibility for states to step outside the framework of the ACA, while achieving the same goals fit very nicely, and also

¹ America's Healthy Future Act of 2009, S. 1796, 111th Cong. (2009). Retrieved from <http://thomas.loc.gov/cgi-bin/query/z?c111:S.1796; section 2226>.

² Sen. Wyden (Ore.). "Empowering States to Innovate Act," *Congressional Record* Vol. 156, No. 151 (18 Nov. 2010) p. S8007.

provided a defense against charges that the legislation represented a federal takeover of the nation's health care sector.

When President Obama signed the legislation on March 23, 2010, this provision became law as section 1332 of the ACA, but with significant changes. Rather than permitting a state to waive any of the law's market reform provisions, the Waiver for State Innovation, as it is called in the final bill, will, beginning in 2017, allow states to waive only specified provisions of the law. Shortly after enactment of the ACA, Sen. Wyden proposed additional legislation, along with then-Sen. Scott Brown (R-MA), to accelerate implementation of the waiver program from 2017 to 2014, potentially freeing states from putting waived provisions into place in 2014 only to repeal them in 2017.³ While that legislation was endorsed by the Obama administration, it did not gain traction in Congress and was never brought to a vote in either chamber.

The Department of Health and Human Services issued proposed rules implementing this provision in March 2011,⁴ followed by final rules in February 2012.⁵

Scope of Waivers

As it stands today, the state innovation waiver program will allow states to apply for waivers from a specified set of provisions of Title I of the ACA:

- Part I of Subtitle D (Qualified Health Plan Standards)
- Part II of Subtitle D (Exchange Standards)
- Section 1402 (Cost-Sharing Reductions for Individuals Under 250% of FPL)
- Internal Revenue Code Section 36B (Premium Tax Credits)
- Internal Revenue Code Section 5000A (Requirement to Maintain Minimum Essential Coverage)
- Internal Revenue Code Section 4980H (Employer Shared Responsibility Requirements)

The list of provisions a state can waive under a state innovation waiver contains most of the legislation's major building blocks—Exchanges, mandates, and subsidies—and therefore creates an opportunity for states to radically reshape the ACA's structure. Within these portions of the ACA are a number of provisions that states may want to consider seeking a waiver from:

- Essential Health Benefits (EHBs) (ACA 1302(b))⁶
- Annual limitation on cost-sharing (ACA 1302(c))

³ Empowering States to Innovate Act, S. 3958, 111th Cong. (2010). Retrieved from <http://thomas.loc.gov/cgi-bin/query/z?c111:S.3958>.

⁴ "Application, Review, and Reporting Process for Waivers for State Innovation; Proposed rule," 76 Federal Register 49 (14 March 2011), pp. 13553-13567.

⁵ "Application, Review, and Reporting Process for Waivers for State Innovation; Final rule," 77 Federal Register 38 (27 February 2012), pp. 11700-11721.

⁶ Waiver of EHB requirements is complicated by the comprehensive coverage requirement described on page 4 below.

- Actuarial Value (Bronze, Silver, Gold and Platinum Plans) (ACA 1302(d))
- Catastrophic Plans (ACA 1302(e))
- Child-only plans (ACA 1302(f))
- Definitions of large and small employers (ACA 1304(b))
- Rules for determining employer size (ACA 1304(b)(4))
- Employee choice of plans in the SHOP Exchange (ACA 1312(a)(2))
- Single risk pool requirements (ACA 1312(c))
- Preservation of market outside Exchanges (ACA 1312(d))

However, there are important limitations that must also be noted. None of the ACA's amendments to the Public Health Service Act (PHSA), which contain the vast majority of new standards that now apply to new health insurance coverage, may be waived under a State Innovations Waiver. Consequently, all newly sold health insurance coverage will still have to comply with these provisions, such as:

- Guaranteed issue (PHSA 2702) and guaranteed renewability (PHSA 2703);
- Prohibitions on annual and lifetime limits (PHSA 2711);
- Prohibitions on preexisting condition exclusions (PHSA 2704);
- Adjusted community rating rules (PHSA 2701);
- Medical loss ratio rules (PHSA 2718);
- Extended coverage of adult children up to age 26 (PHSA 2714); and
- Coverage of preventive services without cost-sharing (PHSA 2713).

Additionally, there are many other requirements outside of the Public Health Service Act that cannot be included in the State Innovations Waiver, such as risk adjustment (ACA 1343), CO-OP plans (ACA 1322), multi-state plans (ACA 1334), small business tax credits (ACA 1421), and nondiscrimination requirements (PHSA 2705, 2706; ACA 1557). Finally, it should be noted that the statute does not allow for a waiver of any provisions of the Employee Retirement Income Security Act of 1974 (ERISA). However, a State Innovation Waiver application may be coordinated in a single application with waivers available under Medicare, Medicaid, or the Children's Health Insurance Program (CHIP), or any other federal law dealing with the provision of health care items or services⁷.

Requirements

In order to qualify for the waiver a state must demonstrate that its proposal will meet four requirements:

- Coverage will be at least as comprehensive as the Essential Health Benefits (the "comprehensive coverage requirement");⁸

⁷ ACA 1332(a)(5)

⁸ ACA 1332(b)(1)(A)

- Coverage and cost-sharing protections against excessive out-of-pocket spending will be at least as affordable as the provisions of Title I of the ACA (the “affordability requirement”);⁹
- The plan will cover at least a comparable number of residents as Title I of the ACA (the “scope of coverage requirement”); and¹⁰
- The plan will not increase the federal deficit (the “federal deficit requirement”).¹¹

States will be required to submit extensive supporting documentation that waiver proposals will meet these requirements, including actuarial analyses and certifications, data, and assumptions that will allow the appropriate federal agencies to determine whether a state’s plan will meet these requirements. Additionally, state plans must be certified by the Office of the Actuary at the Centers for Medicare and Medicaid Services (CMS) as providing coverage that will be at least as comprehensive as the Essential Health Benefits defined in section 1302(b) of the ACA, based upon data from the state and other, comparable states. (Though EHB requirements are among those in Part I of Subtitle D that may be waived, the comprehensive coverage requirement limits a state’s ability to waive EHB requirements. A state could, however, conceivably use a waiver to require more comprehensive coverage than is specified under federal EHB regulations without being subject to the requirement to reimburse QHP enrollees for the cost of those additional mandated benefits.)

Application and Post-Approval Monitoring

A state wishing to apply for a State Innovation Waiver will be required to submit a detailed application to HHS sufficiently in advance of the requested effective date. If the state is requesting a waiver of any provisions of the Internal Revenue Code (the individual and employer mandates or premium tax credits), HHS will also send a copy of the application to the Department of Treasury for review. Within 45 days of receiving the application, the agencies will complete a preliminary review to determine if the application is complete and will notify the state in writing of their finding. If the application is deemed incomplete, the state will receive a notice of which elements are missing.¹²

A complete application must include the following¹³:

- A comprehensive description of the state legislation and program to implement the plan;
- A copy of enacted state legislation authorizing the waiver request (if a state already has a law in place allowing the plan to be implemented, new legislation is not necessary);
- A list of provisions of the ACA that the state seeks to waive, with the reason for each specific request
- Analyses, actuarial certifications, data, assumptions, analysis, targets and other supporting information:

⁹ ACA 1332(b)(1)(B)

¹⁰ ACA 1332(b)(1)(C)

¹¹ ACA 1332(b)(1)(D)

¹² 45 CFR 155.1308(c)

¹³ 45 CFR 155.1308(f)

- Actuarial analyses and certifications to demonstrate compliance with the comprehensive coverage, affordability and scope of coverage requirements;
- Economic analyses to demonstrate compliance with the four coverage requirements;
- A detailed 10-year budget plan that is deficit-neutral to the federal government, considering all costs, including administrative costs, to the federal government;
- A detailed analysis regarding the estimated impact of the waiver on health insurance coverage in the state
- Data and assumptions used to demonstrate compliance with requirements for State Innovation Waivers
- A detailed draft timeline for the state’s implementation of the proposed waiver;
- Explanations of:
 - Whether the waiver increases or decreases administrative burdens on individuals, insurers and employers;
 - How the waiver will affect implementation of other provisions of the ACA in the state;
 - How the waiver will affect residents seeking health care services out-of-state;
 - How the state will provide the federal government with all information necessary to administer the waiver at the federal level (if applicable);
 - How the proposal will address potential compliance, waste, fraud and abuse committed by individuals, employers, insurers, or health care providers
- Quarterly, annual and cumulative targets for the comprehensive coverage, affordability, scope of coverage, and federal deficit requirements; and
- Written evidence that the state has provided public notice and a meaningful opportunity to comment, including through public hearings convened by the state and separate consultations with federally recognized Indian tribes within the state’s borders, as well as a summary of major issues raised by commenters.

Once the agencies determine that an application is complete, they will notify the state of that determination and will have 180 days to approve or reject the waiver request. In the interim, the agencies will make the application and all supporting materials publicly available on the Internet and will solicit public comment.

The federal government will perform periodic reviews of the implementation of any approved waivers and states must hold a public forum within 6 months of the implementation date of a waiver, followed by annual forums thereafter. In addition, states will be required to submit quarterly reports detailing any ongoing operational challenges associated with waiver implementation, any plans to overcome those challenges, and the outcomes of those actions. Annual reports must be submitted to the federal agencies each year that document progress of the waiver implementation process, compliance with the comprehensive coverage, affordability, scope of coverage, and federal deficit requirements, a summary of the annual public forum and all comments received at that forum, and any other information required under the terms and conditions of the state’s approved waiver.¹⁴

¹⁴ 45 CFR 155.1324

Current State Efforts and Targeted Ideas for Waivers

Several states are currently exploring significant waiver applications. The most well-publicized of these states has been Vermont, which adopted legislation in 2011 to move the state towards a single-payer system using a State Innovation Waiver in combination with other existing waiver programs under Medicare and Medicaid. Green Mountain Health Care, the board that will be responsible for this transition, currently oversees the state's Exchange, which would be phased-out in 2017 under the potential waiver.

Hawaii is also in the process of exploring a waiver to better adapt the ACA to its Prepaid Health Care Act, a statute they have had on the books since 1974 that requires employers to provide health coverage to their employees. Because of this existing law, the state does not believe that the SHOP exchange makes sense as structured under the ACA, and has established an innovation waiver task force to explore alternatives.

In addition to these sweeping waiver proposals, states might also choose to pursue more targeted waiver proposals that would allow them greater flexibility in how one or more specific provisions are implemented.

Actuarial Value: Subsection 1302(d) of the ACA requires all non-grandfathered (and non-transitional) health plans in the individual and small group market to provide actuarial values of 60%, 70%, 80% or 90% (the so-called metal levels). Regulations implementing this requirement specify that coverage must be within 2% of these levels. States, however, might want to allow more, or different, actuarial value levels to be offered in their marketplaces, in order to make a wider variety of plans available to consumers.

Catastrophic plans: Subsection 1302(e) of the ACA allows individuals under the age of 30 and those who receive an affordability or hardship exemption to purchase a catastrophic plan through the Exchange. Through a waiver, states could potentially expand availability of these plans, which provide no benefits until an enrollee reaches the maximum out-of-pocket limit (other than a limited number of primary care visits and preventive services) to additional groups of individuals.

Subsidies: Under the ACA, an individual must purchase a QHP through the Exchange in order to be eligible for subsidies.¹⁵ QHPs, however, are subject to nearly all the same requirements as non-grandfathered health plans sold outside the Exchange. A state may decide that consumers would be better served by making subsidies available for the purchase of other non-grandfathered plans.

¹⁵ Internal Revenue Code 36B(b)(2)(A)

States considering these more targeted waivers should consider, however, whether the benefits of a waiver for their markets and consumers justify the administrative burden to the state of assembling and submitting a detailed waiver application and of the ongoing reporting required after implementation of the waiver. It is also not clear whether HHS will view these targeted waivers in a favorable light, particularly in states with a FFE whose IT systems may not be immediately compatible with the policy direction of some of the changes. For these reasons, I believe that the State Innovation Waiver Program is more feasible for states that are interested in exerting greater regulatory control over health plans or in moving their states towards a single-payer health care system than for states that might be interested in taking a more flexible regulatory approach.

State and Federal Exchanges

I was also asked to briefly discuss the comparative advantages and disadvantages of State-Based and Federally Facilitated Exchanges. States considering a transition in the type of Exchange serving their residents should consider these advantages and disadvantages, particularly those relating to flexibility, IT systems, and overhead costs.

Flexibility

The primary advantage to establishment of a SBE is the flexibility that it can potentially afford a state. Though HHS has provided states where it is operating an FFE with a significant amount of discretion in the oversight of qualified health plans, deferring to them on most plan certification reviews, there are a number of areas where states operating SBEs have been able to take different approaches than they would have been able to under an FFE in the areas of plan selection, consumer experience, employee choice, producer participation, and navigator selection and oversight.¹⁶

In the area of plan selection a number of states have placed additional requirements on insurers participating in the Exchange in order to promote either a wider choice of plans for consumers or to limit plan offerings in order to simplify choices for consumers. For example, concerned that consumers would face limited choices of plans outside of the Gold and Silver levels of coverage that Exchange-participating insurers are required to offer,¹⁷ California, New York and Massachusetts have required insurers in the Exchange to offer coverage in all four metal levels, as well as catastrophic plans. Five other states, plus the District of Columbia have put in place similar requirements, requiring insurers to offer coverage in more than the two federally required levels.

States making efforts to simplify plan choices have adopted a number of different tactics, including limiting the number of plans that an issuer may offer on the Exchange, requiring some or all plans to offer a standardized set of benefits and cost-sharing parameters, and applying meaningful difference

¹⁶ S. Dash, K. W. Lucia, K. Keith, and C. Monahan, Implementing the Affordable Care Act: Key Design Decisions for State-Based Exchanges, The Commonwealth Fund, July 2013.

¹⁷ ACA 1301(a)(1)(C)(ii)

standards similar to those used by HHS in FFEs. Alternatively, many SBEs have decided not to impose meaningful difference requirements at all.

The ACA requires SHOP Exchanges to allow employee choice of plans within a level designated by the employer. Applicability of this provision was delayed by HHS until the 2015 plan year, and in 2015 HHS has proposed allowing states to recommend an additional year of delay in implementation of employee choice. A number of SBEs did implement the provision in 2014, and have done so in ways that would not be possible in an FFE, allowing a broader choice of plans offered by one or more insurers in additional levels of coverage.

While HHS has this far mostly deferred to state network adequacy standards, they signaled in the 2015 Letter to Issuers in Federally Facilitated Exchanges that they are beginning to exert more federal control in this area. In 2015, they will be requiring all issuers to submit provider lists, and will be developing federal time and distance standards for use in states where the federal government will be conducting plan reviews, they have also signaled a desire to impose federal minimum standards across all states. Though the NAIC and others have been urging the federal government to continue to defer to state network adequacy determinations, as they did in 2014, States that have established SBEs will probably be better positioned to ensure that network adequacy standards in the Exchange are best suited to their unique market conditions if HHS moves ahead with federal standards.

Infrastructure Development

Many states where HHS has established an FFE have been frustrated by well-publicized technology failures early in the initial open enrollment period, by the fact that large portions of the FFE's critical back-end systems remain unbuilt, and by the policy and enforcement implications of these failures. These problems have been enormously frustrating for consumers as well, though many of the front-end enrollment and eligibility systems are now functioning as they should, even as challenges remain in transmitting those enrollments to insurers and reconciling membership rolls. Unfortunately, several SBEs have also suffered debilitating and costly infrastructure failures, so it is not clear that this is an area where either the SBE or FFE model has an advantage. For FFE states considering a transition to a SBE, however, there are several very successful SBE systems available for re-use, which should alleviate some of the risk of choosing a contractor who can successfully put these complicated systems in place.

Overhead Costs

The cost to operate an Exchange is probably the one area in which a FFE has the biggest advantage over SBEs. A recent report¹⁸ compiled by Jay Angoff, the former director of HHS' Office of Consumer Information and Insurance Oversight, found that, on average, FFEs spent just 43% as much per enrollee as SBEs (\$647 versus \$1,503). It should be noted, however, that North Dakota was an outlier among FFE states, with HHS spending \$7,089 per enrollee in the state. This disparity reflects the ability of the federal government to spread its fixed costs across a much larger pool of enrollees, as well as the fact

¹⁸ Angoff, Jay. Memo to the Interested Parties re: Cost-per enrollee in state Exchanges. 7 May 2014, accessed at <http://capsules.kaiserhealthnews.org/wp-content/uploads/2014/05/5-7-14-Exchanges-report.pdf>.

that SBEs typically invested much larger amounts of money in marketing and outreach efforts than the federal government did. This cost-per enrollee disparity had less of an impact on state budgets in 2014 than it will going forward, as a large percentage of these costs were paid for using federal Exchange Establishment Grants. After November 15 of this year, no federal funds will be available and SBEs must become self-sufficient, bearing the full cost of establishment and operation. These costs will be of greatest concern to states with small populations, who must either spread their costs across a small pool of enrollees or find other revenue sources to fund Exchange operations, as the District of Columbia has recently had to do.¹⁹

Once again, thank you for the invitation to be with you today. I appreciate the opportunity to discuss these interesting and important issues and look forward to your questions.

¹⁹ Davis, Aaron C. "D.C. Council Approves Broad New Tax on Health Insurance to Cover City's Exchange." The Washington Post 6 May 2014. [washingtonpost.com](http://www.washingtonpost.com). Web. 12 May 2014.

Additional Resources:

Statutory Language regarding Waivers for State Innovation

SEC. 1332. WAIVER FOR STATE INNOVATION.

(a) APPLICATION.—

(1) IN GENERAL.—A State may apply to the Secretary for the waiver of all or any requirements described in paragraph (2) with respect to health insurance coverage within that State for plan years beginning on or after January 1, 2017. Such application shall—

(A) be filed at such time and in such manner as the Secretary may require;

(B) contain such information as the Secretary may require, including—

(i) a comprehensive description of the State legislation and program to implement a plan meeting the requirements for a waiver under this section; and

(ii) a 10-year budget plan for such plan that is budget neutral for the Federal Government;

and (C) provide an assurance that the State has enacted the law described in subsection

(b)(2).

(2) REQUIREMENTS.—The requirements described in this paragraph with respect to health insurance coverage within the State for plan years beginning on or after January 1, 2014, are as follows:

(A) Part I of subtitle D.

(B) Part II of subtitle D.

(C) Section 1402.

(D) Sections 36B, 4980H, and 5000A of the Internal Revenue Code of 1986.

(3) PASS THROUGH OF FUNDING.—With respect to a State waiver under paragraph (1), under which, due to the structure of the State plan, individuals and small employers in the State would not qualify for the premium tax credits, cost-sharing reductions, or small business credits under sections 36B of the Internal Revenue Code of 1986 or under part I of subtitle E for which they would otherwise be eligible, the Secretary shall provide for an alternative means by which the aggregate amount of such credits or reductions that would have been paid on behalf of participants in the Exchanges established under this title had the State not received such waiver, shall be paid to the State for purposes of implementing the State plan under the waiver. Such amount shall be determined annually by the Secretary, taking into consideration the experience of other States with respect to participation in an Exchange and credits and reductions provided under such provisions to residents of the other States.

(4) WAIVER CONSIDERATION AND TRANSPARENCY.—

(A) IN GENERAL.—An application for a waiver under this section shall be considered by the Secretary in accordance with the regulations described in subparagraph (B).

(B) REGULATIONS.—Not later than 180 days after the date of enactment of this Act, the Secretary shall promulgate regulations relating to waivers under this section that provide—

(i) a process for public notice and comment at the State level, including public hearings, sufficient to ensure a meaningful level of public input;

(ii) a process for the submission of an application that ensures the disclosure of—

(I) the provisions of law that the State involved seeks to waive; and

(II) the specific plans of the State to ensure that the waiver will be in compliance with subsection (b);

(iii) a process for providing public notice and comment after the application is received by the Secretary, that is sufficient to ensure a meaningful level of public input and that does not impose requirements that are in addition to, or duplicative of, requirements imposed under the Administrative Procedures Act, or requirements that are unreasonable or unnecessarily burdensome with respect to State compliance;

(iv) a process for the submission to the Secretary of periodic reports by the State concerning

- the implementation of the program under the waiver; and
- (v) a process for the periodic evaluation by the Secretary of the program under the waiver.
- (C) REPORT.—The Secretary shall annually report to Congress concerning actions taken by the Secretary with respect to applications for waivers under this section.
- (5) COORDINATED WAIVER PROCESS.—The Secretary shall develop a process for coordinating and consolidating the State waiver processes applicable under the provisions of this section, and the existing waiver processes applicable under titles XVIII, XIX, and XXI of the Social Security Act, and any other Federal law relating to the provision of health care items or services. Such process shall permit a State to submit a single application for a waiver under any or all of such provisions.
- (6) DEFINITION.—In this section, the term “Secretary” means—
 - (A) the Secretary of Health and Human Services with respect to waivers relating to the provisions described in subparagraph (A) through (C) of paragraph (2); and
 - (B) the Secretary of the Treasury with respect to waivers relating to the provisions described in paragraph (2)(D).
- (b) GRANTING OF WAIVERS.—
 - (1) IN GENERAL.—The Secretary may grant a request for a waiver under subsection (a)(1) only if the Secretary determines that the State plan—
 - (A) will provide coverage that is at least as comprehensive as the coverage defined in section 1302(b) and offered through Exchanges established under this title as certified by Office of the Actuary of the Centers for Medicare & Medicaid Services based on sufficient data from the State and from comparable States about their experience with programs created by this Act and the provisions of this Act that would be waived;
 - (B) will provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable as the provisions of this title would provide;
 - (C) will provide coverage to at least a comparable number of its residents as the provisions of this title would provide; and
 - (D) will not increase the Federal deficit.
 - (2) REQUIREMENT TO ENACT A LAW.—
 - (A) IN GENERAL.—A law described in this paragraph is a State law that provides for State actions under a waiver under this section, including the implementation of the State plan under subsection (a)(1)(B).
 - (B) TERMINATION OF OPT OUT.—A State may repeal a law described in subparagraph (A) and terminate the authority provided under the waiver with respect to the State.
- (c) SCOPE OF WAIVER.—
 - (1) IN GENERAL.—The Secretary shall determine the scope of a waiver of a requirement described in subsection (a)(2) granted to a State under subsection (a)(1).
 - (2) LIMITATION.—The Secretary may not waive under this section any Federal law or requirement that is not within the authority of the Secretary.
- (d) DETERMINATIONS BY SECRETARY.—
 - (1) TIME FOR DETERMINATION.—The Secretary shall make a determination under subsection (a)(1) not later than 180 days after the receipt of an application from a State under such subsection.
 - (2) EFFECT OF DETERMINATION.— (A) GRANTING OF WAIVERS.—If the Secretary determines to grant a waiver under subsection (a)(1), the Secretary shall notify the State involved of such determination and the terms and effectiveness of such waiver.
 - (B) DENIAL OF WAIVER.—If the Secretary determines a waiver should not be granted under subsection (a)(1), the Secretary shall notify the State involved, and the appropriate committees of Congress of such determination and the reasons therefore.
- (e) TERM OF WAIVER.—No waiver under this section may extend over a period of longer than 5 years unless the State requests continuation of such waiver, and such request shall be deemed granted unless the Secretary, within 90 days after the date of its submission to the Secretary, either denies such request in

writing or informs the State in writing with respect to any additional information which is needed in order to make a final determination with respect to the request.

Regulations:

Proposed Regulation:

Application, Review, and Reporting Process for Waivers for State Innovation: Proposed Rule, published in the Federal Register on 3/14/2011, may be found at <https://federalregister.gov/a/2011-5583>.

Final Regulation:

Application, Review, and Reporting Process for Waivers for State Innovation: Final Rule, published in the Federal Register on 2/27/2012, may be found at <https://federalregister.gov/a/2012-4395>.