and therefore would not have a significant economic impact on a substantial number of small entities.

Congressional Review Act

The Congressional Review Act, 5 U.S.C. 801 et seq., as amended by the Small Business Regulatory Enforcement Fairness Act of 1996, generally provides that before a rule may take effect, the agency promulgating the rule must submit a rule report, which includes a copy of the rule, to each House of the Congress and to the Comptroller General of the United States. We will submit a report containing this rule and other required information to the U.S. Senate, the U.S. House of Representatives, and the Comptroller General of the United States. A major rule cannot take effect until 60 days after it is published in the **Federal Register**. This rule is not a ''major rule'' as defined by 5 U.S.C. 804(2).

List of Subjects in 33 CFR Part 208

Dams, Flood control, Intergovernmental relations, Reservoirs.

For the reasons set out in the preamble, the Corps proposes to amend 33 CFR part 208 as follows:

PART 208—FLOOD CONTROL REGULATIONS

■ 1. The authority citation for 33 CFR part 208 continues to read as follows:

Authority: Sec. 7, 58 Stat. 890; 33 U.S.C. 709.

■ 2. Amend § 208.11(e) as follows:

■ a. Revise the entry for Marshall Ford Dam and Reservoir on the ''List of Projects'' table; and

■ b. Revise footnote 4.

§ 208.11 Regulations for use of storage allocated for flood control or navigation and/or project operation at reservoirs subject to prescription of rules and regulations by the Secretary of the Army in the interest of flood control and navigation.

* * * * *

(e) * * *

LIST OF PROJECTS

[Non-Corps projects with Corps regulation requirements]

Project name [1] (1)	State (2)	County (3)	Stream [1] (4)	Project purpose [2] (5)	Storage 1000 AF (6)	Elev limits feet M.S.L. Upper (7)	Elev limits feet M.S.L. Lower (8)	Area in acres Upper (9)	Area in acres Lower (10)	Authorizing legis. [3] (11)	Proj. owner [4] (12)
*	*	*	*	*	*	*	*	*		*	
Marshall Ford Dam & Res.	TX	Travis	Colorado R	F	779.8	714.0	681.0	29060	18955	PL 73–392	LCRA.
				NEIM	810.5	681.0	618.0	18955	8050	PL 78–534	
*	*	*	*	*	*	*	*	*		*	

[1] Cr—Creek; CS—Control Structure; Div—Diversion; DS—Drainage Structure; FG—Floodgate; Fk—Fork; GIWW—Gulf Intercoastal Waterway; Lk—Lake; L&D—Lock & Dam; PS—Pump Station; R—River; Res—Reservoir.

[2] F—Flood Control; N—Navigation; P—Corps Hydropower; E—Non Corps Hydropower; I—Irrigation; M—Municipal and/or Industrial Water Supply; C—Fish and Wildlife Conservation; A—Low Flow Augmentation or Pollution Abatement; R—Recreation; Q—Water Quality or Silt Control.

[3] FCA—Flood Control Act; FERC—Federal Energy Regulatory Comm; HD—House Document; PL—Public Law; PW—Public Works; RHA—River & Harbor Act; SD—Senate Document; WSA—Water Supply Act.

[4] Appl Pwr—Appalachian Power; Chln PUD—Chelan Cnty PUD 1; CLPC—CT Light & Power Co; Dgls PUD—Douglas Cnty PUD 1; DWR—Department of Water Resources; EB–MUD—East Bay Municipal Utility Dist; GRD—Grand River Dam Auth; Grnt PUD—Grant Cnty PUD 2; Hnbl—city of Hannibal; LCRA—Lower Colorado River Authority; M&T Irr—Modesto & Turlock Irr; Mrcd Irr—Merced Irr; NEPC—New England Power Co; Pgnt P&L—Pugent Sound Power & Light; Ptmc Comm—Upper Potomac R Comm; Rclm B—Reclamation Board; Rkfd—city of Rockford; Sttl—city of Seattle; Tac—City of Tacoma; Vale USBR—50% Vale Irr 50% USBR; WF&CWID—City of Wichita Falls and Wichita Cnty Water Improvement District No. 2; WMEC—Western MA Electric Co; YCWA—Yuba City Water Auth; Yolo FC&W—Yolo Flood Control & Water Conserv Dist.

* * * * *

■ 3. Revise § 208.19 to read as follows:

§ 208.19 Marshall Ford Dam and Reservoir (Mansfield Dam and Lake Travis), Colorado River, Texas.

In the interest of flood control, the Lower Colorado River Authority (LCRA) shall operate the Marshall Ford Dam and Reservoir in accordance with the water control plan of regulation most recently approved by the U.S. Army Corps of Engineers (USACE), effective on the date specified in the approval. Information regarding the most recently approved water control plan of regulation may be obtained by contacting the LCRA offices in Austin, Texas, or the offices of the U.S. Army Corps of Engineers, Fort Worth Engineer District, in Fort Worth, Texas.

Dated: December 13, 2013.

James C. Dalton,

Chief of Engineering and Construction, U.S. Army Corps of Engineers.

[FR Doc. 2013–30497 Filed 12–20–13; 8:45 am]

BILLING CODE 3720–58–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 600

[CMS–2380–PN]

Basic Health Program: Proposed Federal Funding Methodology for Program Year 2015

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

ACTION: Proposed methodology.

SUMMARY: This document provides the methodology and data sources necessary to determine federal payment amounts made to states that elect to establish a Basic Health Program certified by the Secretary under section 1331 of the Patient Protection and Affordable Care Act (the Affordable Care Act) to offer health benefits coverage to low-income individuals otherwise eligible to purchase coverage through Affordable Insurance Exchanges.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on January 22, 2014.

ADDRESSES: In commenting, refer to file code CMS–2380–PN. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four 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–2380–PN, 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–2380–PN, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* Alternatively, you may deliver (by hand or courier) your written ONLY to the following addresses: a. For delivery in Washington, DC—Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue SW., Washington, DC 20201.

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD—Centers for Medicare & Medicaid Services, Department of Health and Human Services, 7500 Security Boulevard, Baltimore, MD 21244–1850.

If you intend to deliver your comments to the Baltimore address, call telephone number (410) 786–7195 in advance to schedule your arrival with one of our staff members.

Comments erroneously mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

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

FOR FURTHER INFORMATION CONTACT: Christopher Truffer, (410) 786–1264; or Jessica Schubel, (410) 786–3032.

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 Web site as soon as possible after they have been received: *http://www.regulations.gov.* Follow the search instructions on that Web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1–800–743–3951.

Table of Contents

I. Background

The Affordable Care Act provides for the establishment of state Affordable Insurance Exchanges (Exchanges, also called the Health Insurance Marketplace) that provide access to affordable health insurance coverage offered by qualified health plans (QHPs) for most individuals under age 65 who are not eligible for health coverage under other federally supported health benefits programs or through affordable employer-sponsored insurance coverage, and who have incomes above 100 percent of the federal poverty line (FPL), or whose income is below that level but are lawfully present non-citizens ineligible for Medicaid because of immigration status. Individuals enrolled through Exchanges in coverage offered by QHPs with incomes below 400 percent of the FPL may qualify for the federal premium tax credit (PTC) and federally-funded cost-sharing reductions (CSRs) based on their household income, to ensure that such coverage meets certain standards for affordability.

In the states that elect to operate a Basic Health Program (BHP), BHP will make affordable health benefits coverage available for individuals under age 65 with household incomes between 133 percent and 200 percent of the FPL who are not otherwise eligible for Medicaid, the Children's Health Insurance Program (CHIP), or affordable employer sponsored coverage. (For many states, the lower income threshold for BHP eligibility is effectively 138 percent due to the application of a required 5 percent income disregard in determining the upper limits of Medicaid income eligibility.) Federal funding would be available for BHP based on the amount of PTC and CSRs that BHP enrollees would have received had they been enrolled in QHPs through Exchanges.

In the September 25, 2013 **Federal Register** (78 FR 59122), we published a proposed rule entitled the ''Basic Health Program: State Administration of Basic Health Programs; Eligibility and Enrollment in Standard Health Plans; Essential Health Benefits in Standard Health Plans; Performance Standards for Basic Health Programs; Premium and Cost Sharing for Basic Health Programs; Federal Funding Process; Trust Fund and Financial Integrity'' proposed rule (hereinafter referred to as the BHP proposed rule) implementing section 1331 of the Patient Protection and Affordable Care Act (Pub. L. 111–148, enacted on March 23, 2010), together with the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152), enacted on March 30, 2010 collectively referred as the Affordable Care Act, which requires the establishment of BHP. The BHP proposed rule proposes to establish the requirements for state and federal administration of BHP, including provisions regarding eligibility and enrollment, benefits, cost-sharing requirements and oversight activities. While the BHP proposed rule proposed to codify the overall statutory requirements and basic procedural framework for the funding methodology, it does not contain the specific information necessary to determine federal payments. We anticipated that the methodology would be based on

data and assumptions that would reflect ongoing operations and experience of BHP programs as well as the operation of the Exchanges. For this reason, the BHP proposed rule indicated that the development and publication of the funding methodology, including any data sources, would be addressed in a separate annual Payment Notice process.

In the BHP proposed rule, we proposed that the BHP Payment Notice process would include the annual publication of both a proposed and final BHP Payment Notice. The proposed BHP Payment Notice would be published in the **Federal Register** each October, and would describe the proposed methodology for the upcoming BHP program year, including how the Secretary considered the factors specified in section 1331(d)(3) of the Affordable Care Act, along with the proposed data sources used to determine the federal BHP payment rates. The final BHP Payment Notice would be published in the **Federal Register** in February, and would include the final BHP funding methodology, as well as the federal BHP payment rates for the next BHP program year. For example, payment rates published in February 2015 would apply to BHP program year 2016, beginning in January 2016. State data, as discussed further below, needed to calculate the federal BHP payment rates for the final BHP Payment Notice must be submitted to CMS.

Once the final methodology has been published, no modifications to the methodology will occur during the program year. As described in the BHP proposed rule, we will only make modifications to the BHP funding methodology on a prospective basis. Adjustments could be made to the payment rates to correct errors in applying the methodology (such as mathematical errors).

Under section 1331(d)(3)(ii) of the Affordable Care Act, the funding methodology and payment rates are expressed as an amount per BHP enrollee for each month of enrollment, and could vary based on categories or classes of enrollees. Actual payment to a state would depend on the actual enrollment in coverage through the state BHP. A state that is approved to implement BHP will be required to provide data showing quarterly enrollment corresponding to the federal BHP payment rate cells. The data submission requirements associated with this will be provided in a future CMS notice.

Given that BHP will be available for states to implement effective January 1, 2015, we intend to modify the publication dates of the BHP Payment Notices for the first year of BHP implementation. Specifically, we intend to publish the final BHP Payment Notice, which will contain the final 2015 BHP funding methodology and payment rates, concurrently with our intended schedule to publish the final BHP regulation in March 2014.

II. Provisions of the Proposed Methodology

A. Overview of the Funding Methodology and Calculation of the Payment Amount

Section 1331(d)(3) of the Affordable Care Act directs the Secretary to consider several factors when determining the federal BHP payment amount, which, as specified in the statute, must equal 95 percent of the value of the PTC and CSRs that BHP enrollees would have been provided had they enrolled in a QHP through an Exchange. Thus, the proposed BHP funding methodology is designed to calculate the PTC and CSRs as consistently as possible and in general alignment with the methodology used by Exchanges to calculate the advance payments of the PTC and CSRs, and by the Internal Revenue Service (IRS) to calculate final PTCs. In general, we propose to rely on values for factors in the payment methodology specified in statute or other regulations as available, and we propose to develop values for other factors not otherwise specified in statute, or previously calculated in other regulations, to simulate the values of the PTC and CSRs that BHP enrollees would have received if they had enrolled in QHPs offered through an Exchange. In accordance with section 1331(d)(3)(A)(iii) of the Affordable Care Act, the final funding methodology must be certified by the Chief Actuary of CMS, in consultation with the Office of Tax Analysis of the Department of the Treasury, as having met the requirements of section 1331(d)(3)(A)(ii) of the Affordable Care Act.

Section 1331(d)(3)(A)(ii) of the Affordable Care Act specifies that the payment determination ''shall take into account all relevant factors necessary to determine the value of the premium tax credits and cost-sharing reductions that would have been provided to eligible individuals . . . including the age and income of the enrollee, whether the enrollment is for self-only or family coverage, geographic differences in average spending for health care across rating areas, the health status of the enrollee for purposes of determining risk adjustment payments and reinsurance payments that would have been made if the enrollee had enrolled in a qualified health plan through an Exchange, and whether any reconciliation of the credit or cost-sharing reductions would have occurred if the enrollee had been so enrolled.'' The proposed payment methodology takes each of these factors into account.

We propose that the total federal BHP payment amount would be based on multiple ''rate cells'' in each state. Each ''rate cell'' would represent a unique combination of age range, geographic area, coverage category (for example, self-only or two-adult coverage through BHP), household size, and income range as a percentage of FPL. Thus, there would be distinct rate cells for individuals in each coverage category within a particular age range who reside in a specific geographic rating area and are in households of the same size and income range. We note that for states that do not use age as a rating factor on the Exchange, the BHP payment rates would be consistent with those states' Exchange rules. Thus, for a state that does not use age as a rating factor on the Exchange, the BHP payment rates would not vary by age.

The proposed rate for each rate cell would be calculated in two parts. The first part would equal 95 percent of the estimated PTC that would have been paid if a BHP enrollee in that rate cell had instead enrolled in a QHP in the Exchange. The second part would equal 95 percent of the estimated CSR payment that would have been made if a BHP enrollee in that rate cell had instead enrolled in a QHP in the Exchange. These two parts would be added together and the total rate for that rate cell would be equal to the sum of the PTC and CSR rates.

We propose that Equation (1) would be used to calculate the estimated PTC for individuals in each rate cell and Equation (2) would be used to calculate the estimated CSR payments for individuals in each rate cell. By applying the equations separately to rate cells based on age, income and other factors, we would effectively take those factors into account in the calculation. In addition, the equations would reflect the estimated experience of individuals in each rate cell if enrolled in coverage through the Exchange, taking into account additional relevant variables. Each of the variables in the equations is defined below, and further detail is provided later in this section of the payment notice.

In addition, we describe how we propose to calculate the adjusted reference premium (described later in this section of the payment notice) that

is used in Equations (1) and (2). This is defined below in Equation (3). This calculation would take into account a number of variables, including a premium trend factor to adjust currently available premium rates to estimate the rate for the applicable BHP program year.

1. Equation 1: Estimated PTC by Rate Cell

We propose that the estimated PTC, on a per enrollee basis, would be calculated for each rate cell for each state based on age range, geographic area, coverage category, household size, and income range. The PTC portion of the rate would be calculated in a manner consistent with the methodology used to calculate the PTC for persons enrolled in a QHP, with three adjustments. First, the PTC portion of the rate for each rate cell would represent the mean, or average, expected PTC that all persons in the rate cell would receive, rather than being calculated for each individual enrollee. Second, the reference premium used to calculate the PTC (described in more detail later in the section) would be adjusted for BHP population health status and for the projected change in the premium from the current year (that is, the year of the final payment notice) to the following year, to which the rates announced in the final payment notice would apply. These adjustments are described in Equation (3) below. Third, the PTC would be adjusted prospectively to reflect the mean, or average, net expected impact of income reconciliation on the combination of all persons enrolled in BHP; this adjustment, as described further below, would account for the impact on the PTC that would have occurred had such reconciliation been performed. Finally, the rate is multiplied by 95 percent, consistent with section 1331(d)(3)(A)(i) of the Affordable Care Act. We note that in the situation where the average income contribution of an enrollee would exceed the adjusted reference premium, we would calculate the PTC to be equal to 0 and not let the PTC be negative.

We are soliciting comments regarding the methodology that we are proposing to calculate the value of PTC rate, which is defined in Equation (1):

$$\textbf{Equation (1):}\ PTC_{a,g,c,h,i} = \left[ARP_{a,g,c} - \frac{\sum_j I_{h,i,j} \times PTCF_{h,i,j}}{n}\right] \times IRF \times 95\%$$

$PTC_{a,g,c,h,i}$ = Premium tax credit portion of BHP payment rate
a = Age range
g = Geographic area
c = Coverage status (self-only or applicable category of family coverage) obtained through BHP
h = Household size
i = Income range (as percentage of FPL)
$ARP_{a,g,c}$ = Adjusted reference premium
$I_{h,i,j}$ = Income (in dollars per month) at each 1 percentage-point increment of FPL
$j = j^{th}$ percentage-point increment FPL
n = Number of income increments used to calculate the mean PTC
$PTCF_{h,i,j}$ = Premium Tax Credit Formula percentage
IRF = Income reconciliation factor

2. Equation 2: Estimated CSR Payment by Rate Cell

We propose that the CSR portion of the rate would be calculated for each rate cell for each state based on age range, geographic area, coverage category, household size, and income range defined as a percentage of FPL. The CSR portion of the rate would be calculated in a manner consistent with the methodology used to calculate the prospective CSR advance payments for persons enrolled in a QHP, as described in the HHS Notice of Benefit and Payment Parameters for 2015 proposed rule, with three principal adjustments. (We further propose a separate calculation that includes different adjustments for American Indian/Alaska Native BHP enrollees, as described in section E.) For the first adjustment, the CSR rate, like the PTC rate, would represent the mean, or average, expected CSR subsidy that would be paid on behalf of all persons in the rate cell, instead of the CSR subsidy being calculated for each individual enrollee. Second, this calculation would be based on the adjusted reference premium, as described below. Third, as explained earlier, this equation uses an adjusted reference premium that reflects premiums charged to non-tobacco users, rather than the actual premium that is charged to tobacco users to calculate CSR advance payments for tobacco users enrolled in a QHP. Accordingly, we propose that the equation include a tobacco rating adjustment factor that would account for BHP enrollees' estimated tobacco-related health costs that are outside the premium charged to non-tobacco-users. As a practical matter, this would only affect states that allow tobacco use as a rating factor. Finally, the rate would be multiplied by 95 percent, as provided in section 1331(d)(3)(A)(i) of the Affordable Care Act. We propose using Equation (2) to calculate the CSR rate, consistent with the methodology described above.

$$\textbf{Equation (2):}\ CSR_{a,g,c,h,i} = ARP_{a,g,c} \times TRAF \times FRAC \div AV \times IUF_{h,i} \times \Delta AV_{h,i} \times 95\%$$

$CSR_{a,g,c,h,i}$ = Cost-sharing reduction subsidy portion of BHP payment rate
a = Age range
g = Geographic area
c = Coverage status (self-only or applicable category of family coverage) obtained through BHP
h = Household size
i = Income range (as percentage of FPL)
$ARP_{a,g,c}$ = Adjusted reference premium
$TRAF$ = Tobacco rating adjustment factor
$FRAC$ = Factor removing administrative costs
AV = Actuarial value of plan (as percentage of allowed benefits covered by the applicable QHP without a cost-sharing reduction subsidy)
$IUF_{h,i}$ = Induced utilization factor
$\Delta AV_{h,i}$ = Change in actuarial value (as percentage of allowed benefits)

3. Equation 3: Adjusted Reference Premium Variable (Used in Equations 1 and 2)

As part of these calculations for both the PTC and CSR components, we propose to calculate the value of the adjusted reference premium, described below, as specified in Equation (3). The adjusted reference premium would be equal to the reference premium, which would be based on the second lowest cost silver plan premium, multiplied by the premium trend factor, which would reflect the projected change in the premium level between the current year and the next year (including the estimated impact of changes resulting from the transitional reinsurance program established in section 1341 of the Affordable Care Act), and the BHP population health factor, described

below in section D, which would reflect the projected impact that enrolling BHP-eligible individuals in QHPs on an Exchange would have had on the average QHP premium.

$$\textbf{Equation (3):}\quad ARP_{a,g,c} = RP_{a,g,c} \times PTF \times PHF$$

$ARP_{a,g,c}$ = Adjusted reference premium
a = Age range
g = Geographic area
c = Coverage status (self-only or applicable category of family coverage) obtained through BHP
$RP_{a,g,c}$ = Reference premium
PTF = Premium trend factor
PHF = Population health factor

4. Equation 4: Determination of Total Monthly Payment for BHP Enrollees in Each Rate Cell

In general, the rate for each rate cell would be multiplied by the number of BHP enrollees in that cell (that is, the number of enrollees that meet the criteria for each rate cell) to calculate the total monthly BHP payment. This calculation is shown in Equation 4 below.

$$\textbf{Equation (4):}\quad PMT = \sum\left[\left(PTC_{a,g,c,h,i} + CSR_{a,g,c,h,i}\right) \times E_{a,g,c,h,i}\right]$$

PMT = Total monthly BHP payment
$PTC_{a,g,c,h,i}$ = Premium tax credit portion of BHP payment rate
$CSR_{a,g,c,h,i}$ = Cost-sharing reduction subsidy portion of BHP payment rate
$E_{a,g,c,h,i}$ = Number of BHP enrollees
a = Age range
g = Geographic area
c = Coverage status (self-only or applicable category of family coverage) obtained through BHP
h = Household size
i = Income range (as percentage of FPL)

B. Required Rate Cells

We propose that a state implementing BHP provide us an estimate of the number of BHP enrollees it projects will enroll in the upcoming BHP program year, by applicable rate cell, prior to the first quarter of program operations. Upon our approval of such estimates as reasonable, they would be used to calculate the prospective payment for the first and subsequent quarters of program operation until the state has provided us actual enrollment data. These data would be required to calculate the final BHP payment amount, and make any necessary reconciliation adjustments to the prior quarters' prospective payment amounts due to differences between projected and actual enrollment. Subsequent quarterly deposits to the state's trust fund would be based on the most recent actual enrollment data submitted to us. Procedures will ensure that federal payments to a state reflect actual BHP enrollment during a year, within each applicable category, and prospectively determined federal payment rates for each category of BHP enrollment, with such categories defined in terms of age range, geographic area, coverage status, household size, and income range, as explained above.

We propose requiring the use of certain rate cells as part of the proposed methodology. For each state, we propose using rate cells that separate the BHP population into separate cells based on the five factors described below.

Factor 1—Age: We propose separating enrollees into rate cells by age, using the following age ranges that capture the widest variations in premiums under HHS's Default Age Curve: [1]

- Ages 0–20.
- Ages 21–44.
- Ages 45–54.
- Ages 55–64.

Factor 2—Geographic area: For each state, we propose separating enrollees into rate cells by geographic areas within which a single reference premium is charged by QHPs offered through the state's Exchange. Multiple, non-contiguous geographic rating areas would be incorporated within a single cell, so long as those areas share a common reference premium.[2]

Factor 3—Coverage status: We propose separating enrollees into rate cells by coverage status, reflecting whether an individual is enrolled in self-only coverage or persons are enrolled in family coverage through BHP, as provided in section 1331(d)(3)(A)(ii) of the Affordable Care Act. Among recipients of family coverage through BHP, separate rate cells, as explained below, would apply based on whether such coverage involves two adults alone or whether it involves children.

Factor 4—Household size: We propose separating enrollees into rate cells by household size that states use to determine BHP enrollees' income as a percentage of the FPL under proposed 42 CFR 600.320. We are proposing to require separate rate cells for several specific household sizes. For each additional member above the largest specified size, we propose to publish instructions for how to develop additional rate cells and calculate an appropriate payment rate based on data for the rate cell with the closest specified household size. We are currently proposing to publish separate rate cells for household sizes 1, 2, 3, 4, and 5, as unpublished analyses of American Community Survey data conducted by the Urban Institute, which take into account unaccepted offers of employer-sponsored insurance as well as income, Medicaid and CHIP eligibility, citizenship and immigration status, and current health coverage status, find that less than 1 percent of

[1] This curve is used to implement the Affordable Care Act's 3:1 limit on age-rating in states that do not create an alternative rate structure to comply with that limit. The curve applies to all individual market plans, both within and outside the Exchange. The age bands capture the principal allowed age-based variations in premiums as permitted by this curve. More information can be found at *http://www.cms.gov/CCIIO/Resources/Files/Downloads/market-reforms-guidance-2-25-2013.pdf.* Both children and adults under age 21 are charged the same premium. For adults age 21–64, the age bands in this document divide the total age-based premium variation into the three most equally-sized ranges (defining size by the ratio between the highest and lowest premiums within the band) that are consistent with the age-bands used for risk-adjustment purposes in the HHS-Developed Risk Adjustment Model. For such age bands, see Table 5, ''Age-Sex Variables,'' in HHS-Developed Risk Adjustment Model Algorithm Software, May 7, 2013, *http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/ra_tables_04_16_2013xlsx.xlsx.*

[2] For example, a cell within a particular state might refer to ''County Group 1,'' ''County Group 2,'' etc., and a table for the state would list all the counties included in each such group. These geographic areas are consistent with the geographic rating areas established under the 2014 Market Reform Rules. They also reflect the service area requirements applicable to qualified health plans, as described in 45 CFR § 155.1055, except that service areas smaller than counties are addressed as explained below.

all BHP-eligible persons live in households of size 5 or greater.

Factor 5—Income: For households of each applicable size, we propose creating separate rate cells by income range, as a percentage of FPL. The PTC that a person would receive if enrolled in a QHP varies by income, both in level and as a ratio to the FPL, and the CSR varies by income as a percentage of FPL. Thus, we propose that separate rate cells would be used to calculate federal BHP payment rates to reflect different bands of income measured as a percentage of FPL. We propose using the following income ranges, measured as a ratio to the FPL:

- 0 To 50 percent of the FPL.
- 51 to 100 percent of the FPL.
- 101 to 138 percent of the FPL.[3]
- 139 to 150 percent of the FPL.
- 151 to 175 percent of the FPL.
- 176 to 200 percent of the FPL.

These rate cells would only be used to calculate the federal BHP payment amount. A state implementing BHP would not be required to use these rate cells or any of the factors in these rate cells as part of the state payment to the standard health plans participating in BHP or to help define BHP enrollees' covered benefits, premium costs, or out-of-pocket cost-sharing levels.

We propose using averages to define federal payment rates, both for income ranges and age ranges, rather than varying such rates to correspond to each individual BHP enrollee's age and income level. We believe that the proposed approach will increase the administrative feasibility of making federal BHP payments and reduce the likelihood of inadvertently erroneous payments resulting from highly complex methodologies. We believe that this approach should not significantly change federal payment amounts, as within applicable ranges, the BHP-eligible population is distributed relatively evenly.

We welcome comments on whether these are the appropriate factors for developing rate cells, whether there are other factors that should be considered as part of developing the rate cells, whether the ranges or categories specified above (including the width of the age bands) are appropriate, and whether (as proposed) we should assume even distributions, by age and income, in each cell or modify those distributions to reflect data about the precise distribution of BHP-eligible individuals. We also welcome comments on the form in which federal payment rates are displayed. Given the number of rating factors used to calculate the BHP payments, we would welcome comments if producing a smaller subset of tables would be more useful than a more complete set of tables; in no case would the choices about the list of rates to publish affect the actual calculation of the payment rate.

[3] The three lowest income ranges would be limited to lawfully present immigrants who are ineligible for Medicaid because of immigration status.

C. Sources and State Data Considerations

To the extent possible, we intend to use data submitted to the federal government by QHP issuers seeking to offer coverage through an Exchange to perform the calculations that determine federal BHP payment cell rates.

States operating a State Based Exchange (SBE) in the individual market, however, must provide certain data, including premiums for second lowest cost silver plans, by geographic area, in order for CMS to calculate the federal BHP payment rates in those states. An SBE state interested in obtaining the applicable federal BHP payment rates for its state must submit such data accurately, completely, and as specified by CMS, by no later than January 20, 2014, in order for CMS to calculate the applicable rates and include them in the intended publication of the final BHP Payment Notice for 2015. If additional state data (that is, in addition to the second lowest cost silver plan premium data) are needed to determine the federal BHP payment rate, such data must be submitted in a timely manner, and in a format specified by CMS to support the development and timely release of annual BHP payment notices. The specifications for data collection to support the development of BHP payment rates for 2015 will be published in a separate CMS notice.

If a state operating a SBE provides the necessary data accurately, completely, and as specified by CMS, but after the date specified above, we anticipate publishing federal payment rates for such a state in a subsequent Payment Notice. As noted in the BHP proposed rule, a state may elect to implement its BHP after a program year has begun. In such an instance, we propose that the state, if operating a SBE, submit its data no later than 30 days after the Blueprint submission for CMS to calculate the applicable federal payment rates. We further propose that the BHP Blueprint itself must be submitted for Secretarial certification with an effective date of no sooner than 120 days after submission of the BHP Blueprint. In addition, the state must ensure that its Blueprint include a detailed description of how the state will coordinate with other insurance affordability programs to transition and transfer BHP-eligible individuals out of their existing QHP coverage, consistent with the requirements set forth in proposed in 42 CFR 600.330 and § 600.425. We believe that this 120-day period is necessary to establish the requisite administrative structures and ensure that all statutory and regulatory requirements are satisfied.

D. Discussion of Specific Variables Used in Payment Equations

1. Reference Premium (RP)

In order to calculate the estimated PTC that would be paid if individuals enrolled in QHPs through the Exchange, we must calculate a reference premium (RP) because the PTC is based, in part, on the premiums for the second lowest cost silver plan as explained below in section II.C.5 regarding the Premium Tax Credit Formula (PTCF). Accordingly, for the purposes of calculating the BHP payment rates, the reference premium, in accordance with 26 U.S.C. 36B (b)(3)(C), is defined as the adjusted monthly premium for an applicable second lowest cost silver plan. The applicable second lowest cost silver plan is defined in 26 U.S.C. 36B (b)(3)(B) as the second lowest cost silver plan of the individual market in the rating area in which the taxpayer resides, which is offered through the same Exchange.

The reference premium would be the premium applicable to non-tobacco users. This is consistent with the provision in 26 U.S.C. 36B (b)(3)(C) that bases the PTC on premiums that are adjusted for age alone, without regard to tobacco use, even for states that allow insurers to vary premiums based on tobacco use pursuant to 42 U.S.C. 300gg (a)(1)(A)(iv).

Consistent with the policy set forth in 26 CFR 1.36B–3(f)(6) to calculate the PTC for those enrolled in a QHP through an Exchange, we propose not to update the payment methodology, and subsequently the federal BHP payment rates, in the event that the second lowest cost silver plan used as the reference premium changes (that is, terminates or closes enrollment during the year).

The applicable second lowest cost silver plan premium will be included in the BHP payment methodology by age range, geographic area, and self-only or applicable category of family coverage obtained through BHP.

We would note that the choice of the second lowest cost silver plan for

calculating BHP payments would rely on several simplifying assumptions in its selection. For the purposes of determining the second lowest cost silver plan for calculating PTC for a person enrolled in a QHP through an Exchange, the applicable plan may differ for various reasons. For example, a different second lowest cost silver plan may apply to a family consisting of two adults, their child, and their niece than to a family with two adults and their children, because one or more QHPs in the family's geographic area might not offer family coverage that includes the niece. We believe that it would not be possible to replicate such variations for calculating the BHP payment and believe that in aggregate they would not result in a significant difference in the payment. Thus, we propose to use the second lowest cost silver plan available to any enrollee for a given age, geographic area, and coverage category.

This choice of reference premium relies on two assumptions about enrollment in the Exchanges. First, we assume that all persons enrolled in BHP would have elected to enroll in a silver level plan if they had instead enrolled in a QHP through the Exchanges. It is possible that some persons would have chosen not to enroll at all or would have chosen to enroll in a different metal-level plan (in particular, a bronze level plan with a premium that is less than the PTC for which the person was eligible). We do not believe it is appropriate to adjust the payment for an assumption that some BHP enrollees would not have enrolled in QHPs for purposes of calculating the BHP payment rates, since Affordable Care Act section 1331(d)(3)(A)(ii) requires the calculation of such rates as ''if the enrollee had enrolled in a qualified health plan through an Exchange.''

Second, we assume that, among all available silver plans, all persons enrolled in BHP would have selected the second-lowest cost plan. Both this and the prior assumption allow an administratively feasible determination of federal payment levels. They also have some implications for the CSR portion of the rate. If persons were to have enrolled in a bronze level plan through the Exchange, they would not be eligible for the CSR, unless they were an eligible American Indian or Alaska Native; thus, assuming that all persons enroll in silver level plan, rather than a plan with a different metal level, would increase the BHP payment. Assuming that all persons enroll in the second lowest cost silver plan for the purposes of calculating the CSR portion of the rate may result in a different level of CSR payments than would have been paid if the persons were enrolled in different silver level plans on the Exchanges (with either lower or higher premiums). We believe it would not be reasonable at this point to estimate how BHP enrollees would have enrolled in different silver level QHPs, and thus propose to use the second lowest cost silver plan as the basis for the reference premium and calculating the CSR portion of the rate. For American Indian/Alaska Native BHP enrollees, we propose to use the lowest cost bronze plan as the basis for the reference premium as described further in section E.

The applicable age bracket will be one dimension of each rate cell. We propose to assume a uniform distribution of ages and estimate the average premium amount within each rate cell. We believe that assuming a uniform distribution of ages within these ranges is a reasonable approach and would produce a reliable determination of the PTC and CSR components. We also believe this approach would avoid potential inaccuracies that could otherwise occur in relatively small payment cells if age distribution were measured by the number of persons eligible or enrolled. We propose to use the same geographic areas as specified for the Exchanges in each state within which the same second lowest cost silver level premium is charged. Although plans are allowed to serve geographic areas smaller than counties after obtaining our approval, we propose that no geographic area, for purposes of defining BHP payment rate cells, will be smaller than a county. We do not believe that this assumption will have a significant impact on federal payment levels and it would likely simplify both the calculation of BHP payment rates and the operation of BHP.

Finally, in terms of the coverage category, we propose that federal payment rates only recognize self-only and two-adult coverage, with exceptions that account for children who are potentially eligible for BHP. First, in states that set the upper income threshold for children's Medicaid and CHIP eligibility below 200 percent of FPL (based on modified adjusted gross income), children in households with incomes between that threshold and 200 percent of FPL would be potentially eligible for BHP. Currently, the only states in this category are Arizona, Idaho, and North Dakota.[4] Second, BHP would include lawfully present immigrant children with incomes at or below 200 percent of FPL in states that have not exercised the option under the sections 1903(v)(4)(A)(ii) and 2107(e)(1)(E) of the Social Security Act (the Act) to qualify all otherwise eligible, lawfully present immigrant children for Medicaid and CHIP. States that fall within these exceptions would be identified based on their Medicaid and CHIP State Plans, and the rate cells would include appropriate categories of BHP family coverage for children. For example, Idaho's Medicaid and CHIP eligibility is limited to families with MAGI at or below 185 percent FPL. If Idaho implemented BHP, Idaho children with incomes between 185 and 200 percent could qualify. In other states, BHP eligibility will generally be restricted to adults, since children who are citizens or lawfully present immigrants and who live in households with incomes at or below 200 percent of FPL will qualify for Medicaid or CHIP and thus be ineligible for BHP under section 1331 (e)(1)(C) of the Affordable Care Act, which limits BHP to individuals who are ineligible for minimum essential coverage (as defined in section 5000A(f) of the Internal Revenue Code of 1986).

[4] CMCS. ''State Medicaid and CHIP Income Eligibility Standards Effective January 1, 2014.''

2. Premium Trend Factor (PTF)

In Equation 3, we calculate an adjusted reference premium (ARP) based on the application of certain relevant variables to the reference premium (RP), including a premium trend factor (PTF). At the time we issue the final federal payment notice, the adjusted monthly premium for the applicable second lowest cost silver plan will be known only for the year prior to the applicable BHP program year. For example, when federal payments are set for the 2015 BHP program year, the adjusted monthly premium for the applicable second lowest cost silver plan will be known only for 2014. It is appropriate to apply a factor that would account for the change in health care costs between the year of the premium data and the BHP plan year. We are defining this as the premium trend factor in the BHP payment methodology. This factor should approximate the change in health care costs per enrollee, which would include, but is not limited to, changes in the price of health care services and changes in the utilization of health care services. This would provide an estimate of the adjusted monthly premium for the applicable second lowest cost silver plan that would be more accurate and reflective of health care costs in the BHP program year, which will be the year following

issuance of the final federal payment notice.

There are several ways to develop this factor. One option would be to use a projection of national health care cost trends on a per capita or a per enrollee basis. Other options include using historical trends from Exchanges once available—for example, the average annual rate of growth of the applicable second lowest cost silver plans over the last 5 years, or the projected change in national health care cost trends, adjusted for observed differences between growth rates experienced by such silver plans and those for private health insurance expenditures overall.

In addition, we believe that it is appropriate to adjust the trend factor for the estimated impact of changes to the transitional reinsurance program on the average QHP premium. To the extent that changes in the operation of that program will affect QHP premiums in predictable ways that go beyond private insurance cost trends as a whole, such changes will be incorporated into the premium trend factor.

We believe that for the 2015 BHP program year the most reliable and appropriate approach would use projected national health care cost trends. Therefore, we propose to use the annual growth rate in private health insurance expenditures per enrollee from the National Health Expenditure projections. The National Health Expenditure Accounts and Projections are developed annually by the Office of the Actuary of CMS. Over the last 10 years, the average annual increase in private health insurance premiums per enrollee has been 6.55 percent per year, ranging from 3.22 percent to 11.55 percent.

Future changes in private health insurance premiums per enrollee may differ from historical experience for many reasons, including changes in use of health care services, provider reimbursement rates, net costs of insurance, the health status of the people with private health insurance, and the demographics of the U.S. population. Moreover, the change in the cost of the premium of the second lowest cost silver plan may differ from the increase in the average private health insurance premium; in particular, the second lowest cost silver plan in a region may be offered by different insurers year to year. There may also be some differences between the rate of premium increases in QHPs on the Exchanges and other forms of private health insurance (for example, employer-sponsored insurance). In addition, there may be regional differences in the change in health care premiums (that is, different regions of the country may see premium increases smaller or larger than the national average).

In future years, we propose to evaluate whether historical data and projections related specifically to the QHPs offered on the Exchanges at a national level could produce a more reliable estimate of future changes to QHP reference premiums, compared to historical data and projections for private insurance in general.

We particularly invite comments concerning methods for addressing significant changes in the cost of the second lowest cost silver plan premium in a geographic rating area from one year to the next, due to changes in local Exchange structure rather than broader trends in health insurance costs. For example, if a certain second lowest cost silver plan offered on an Exchange serves a particular geographic rating area in one year but not the next, the identity of the second lowest cost plan in that area could change, with potentially significant effects on PTC amounts. Such changes would not be captured using the kind of premium trend factor discussed here.

3. Population Health Factor (PHF)

We considered including an explicit population health factor in each rate cell that varies based on the characteristics of BHP enrollees within that cell, but we are not proposing such a variable, for several reasons. We believe that because BHP-eligible consumers' are eligible to enroll in QHPs in 2014, the 2014 QHP premiums already account for the health status of BHP-eligible consumers, as explained in further detail below. Also, the function of this factor is to provide a reference premium amount that reflects the premiums that QHPs would have charged without the implementation of BHP, taking into account both the risk profile of BHP-eligible consumers in the state and the operation of risk-adjustment and reinsurance mechanisms in the Exchanges. Our proposed approach to the population health factor seeks to achieve this goal based on the characteristics of the state's BHP-eligible consumers as a whole.

In the BHP proposed rule, we described in preamble what we believed to be the most appropriate approach to account for potential differences in health status between BHP enrollees and consumers in the individual market, including those obtaining coverage through the Exchange—that is, including a risk adjustment factor in the BHP funding methodology. We believe that it is appropriate to consider whether or not to develop a population health adjustment to account for potential differences in health status between persons eligible for BHP and those enrolled in the individual market, as the two populations may not have the same average health status.

Accordingly, we have considered applying a population-wide adjustment for health status in the BHP payment calculation to account for the impact on a state's Exchange premiums, hence the PTC and the value of CSRs, of changes to average risk levels in the state's individual market that result from BHP implementation. Our proposed approach to the adjustment for population health status seeks to have the federal BHP payment reflect the premium that would have been charged if BHP-eligible consumers were allowed to purchase QHPs in their state's Exchange, rather than the premium that is being charged in the Exchange without the inclusion of BHP consumers. This factor would be greater than 1.00 if BHP enrollees in a state are, on average, in poorer health status than those covered through the state's individual market, and thus Exchange premiums would have been higher had the state not implemented BHP. This factor would be less than 1.00 if BHP enrollees in a state are, on average, in better health status than those covered through the state's individual market, and thus Exchange premiums would have been lower if the state had not implemented BHP.

We propose that the population health adjustment for the 2015 BHP program year would equal 1.00. Most BHP-eligible consumers will be able to purchase coverage in the individual market during 2014, or the ''measurement year''—that is, the year that precedes implementation of BHP and that provides the basis for estimating unadjusted reference premiums; thus, making no adjustment to the premiums for differences in BHP-eligible enrollees' health would be appropriate. As a result, BHP-eligible consumers' health status is already included in the premiums that would be used to calculate the federal BHP payment rates.

In states where significant numbers of BHP-eligible persons are covered outside of the individual market in 2014, it may be possible to estimate differences in expected health status between persons who are eligible for BHP and persons otherwise eligible for coverage in the individual market. However, we believe that the different levels of federal subsidies based on household income for coverage for persons enrolled in a QHP through an

Exchange may have a substantial influence on the participation rate of enrollees. This may result in relatively healthier persons with higher levels of subsidies enrolling in coverage, and this effect may partially or entirely offset some other differences in the health status between BHP-eligible persons and those otherwise covered in the individual market.

On the Exchanges, premiums in most states will vary based on age, which research has shown is directly correlated to average health cost. Because the reference premium used to calculate BHP federal payment rates will vary by age, some of the difference in average health costs would be addressed by this approach to calculating the BHP payment. However, this does not further simplify the task of estimating the remaining adjustment needed to compensate for any impact of BHP implementation on average risk levels in the state's individual market. Given these analytic challenges, the existing role played by age-rated premiums in compensating for risk, and the limited data about Exchange coverage and the characteristics of BHP-eligible consumers that will available by the time we establish federal payment rates for 2015, we believe that the most appropriate adjustment for 2015 would be 1.00, including in states that cover BHP-eligible persons outside the individual market in 2014. We anticipate that, in future years, when additional data become available about Exchange coverage and the characteristics of BHP enrollees, we may estimate this factor differently. We invite comment on whether methods are currently available to accurately and reliably estimate this factor for 2015, in general and in states that will cover BHP-eligible persons outside their individual markets in 2014.

Finally, while the statute requires consideration of risk adjustment payments and reinsurance payments insofar as they would have affected the PTC and CSRs that would have been provided to BHP-eligible individuals had they enrolled in QHPs, this does not mean that a BHP program's standard health plans receive such payments. As explained in the BHP proposed rule, BHP standard health plans are not included in the risk adjustment program operated by HHS on behalf of states. Further, standard health plans do not qualify for payments from the transitional reinsurance program established under section 1341 of the Affordable Care Act.[5] To the extent that a state operating a BHP determines that, because of the distinctive risk profile of BHP-eligible consumers, BHP standard health plans should be included in mechanisms that share risk with other plans in the state's individual market, the state would need to use other methods for achieving this goal.

4. Income (I)

Household income is a significant determinant of the amount of the PTC and CSRs that are provided for persons enrolled in a QHP through the Exchange. Accordingly, the proposed BHP payment methodology incorporates income into the calculations of the payment rates through the use of income-based rate cells. We propose defining income in accordance with the definition of modified adjusted gross income in 26 U.S.C. 36B(d)(2)(B) and consistent with the definition in 45 CFR 155.300. Income would be measured relative to the FPL, which is updated periodically in the **Federal Register** by the Secretary of Health and Human Services under the authority of 42 U.S.C. 9902(2), based on annual changes in the consumer price index for all urban consumers (CPI–U). In our proposed methodology, household size and income as a percentage of FPL would be used as factors in developing the rate cells. We propose using the following income ranges measured as a percentage of FPL:[6]

- 0–50 percent.
- 51–100 percent.
- 101–138 percent.
- 139–150 percent.
- 151–175 percent.
- 176–200 percent.

We further propose to assume a uniform income distribution for each federal BHP payment cell. We believe that assuming a uniform income distribution for the income ranges proposed would be reasonably accurate for the purposes of calculating the PTC and CSR components of the BHP payment and would avoid potential errors that could result if other sources of data were used to estimate the specific income distribution of persons who are eligible for or enrolled in BHP within rate cells that may be relatively small. Thus, when calculating the mean, or average, PTC for a rate cell, we propose to calculate the value of the PTC at each one percentage point interval of the income range for each federal BHP payment cell and then calculate the average of the PTC across all intervals. This calculation would rely on the PTC formula described below.

As the PTC for persons enrolled in QHPs would be calculated based on their income during the open enrollment period, and that income would be measured against the FPL at that time, we propose to adjust the FPL by multiplying the FPL by a projected increase in the CPI–U between the time that the BHP payment rates are published and the QHP open enrollment period, if the FPL is expected to be updated during that time. We propose that the projected increase in the CPI–U would be based on the intermediate inflation forecasts from the most recent OASDI and Medicare Trustees Reports.[7]

5. Premium Tax Credit Formula (PTCF)

In Equation 1, we propose to use the formula described in 26 U.S.C. 36B(b) to calculate the estimated PTC that would be paid on behalf of a person enrolled in a QHP on an Exchange as part of the BHP payment methodology. This formula is used to determine the amount of premium that an individual or household would be required to pay to enroll in a QHP on an Exchange, which is based on (A) the household income; (B) the household income measured as a percentage of FPL; and (C) the schedule specified in 26 U.S.C. 36B(b)(3)(A) and shown below. The difference between the amount of premium a person or a household is required to pay and the adjusted monthly premium for the applicable second lowest cost silver plan is the estimated amount of the PTC that would be provided for the enrollee.

The PTC amount provided for a person enrolled in a QHP through an Exchange is calculated in accordance with the methodology described in 26 U.S.C. 36B(b)(2) as the amount equal to the lesser of: (A) The monthly premiums for such month of one or more QHPs offered in the individual market within a state that cover the taxpayer, the taxpayer's spouse, or any dependent (as defined in section 26 U.S.C. 152) of the taxpayer and that the taxpayer and spouse or dependents were enrolled in through an Exchange; or (B) the excess (if any) of (i) the adjusted monthly premium for such month for the

[5] See 45 CFR 153.400(a)(2)(iv) (BHP standard health plans are not required to submit reinsurance contributions), 153.20 (definition of ''Reinsurance-eligible plan'' as not including ''health insurance coverage not required to submit reinsurance contributions''), § 153.230(a) (reinsurance payments under the national reinsurance parameters are available only for ''Reinsurance-eligible plans'').

[6] These income ranges and this analysis of income apply to the calculation of the PTC. Many fewer income ranges and a much simpler analysis apply in determining the value of CSRs, as specified below.

[7] See Table IV A1 from the 2013 reports in *http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2013.pdf.*

applicable second lowest cost silver plan for the taxpayer over (ii) an amount equal to 1/12 of the product of the applicable percentage (described below) and the taxpayer's household income for the taxable year.

The applicable percentage is defined in 26 U.S.C. 36B(b)(3)(A) and 26 CFR 1.36B–3(g) as the percentage that applies to a taxpayer's household income that is within an income tier specified in the table, increasing on a sliding scale in a linear manner from an initial premium percentage to a final premium percentage specified in the table (see Table 1):

TABLE 1:

In the case of household income (expressed as a percent of poverty line) within the following income tier:	The initial premium percentage is—(percent)	The final premium percentage is—(percent)
Up to 133%	2.0	2.0
133 but less than 150%	3.0	4.0
150 but less than 200%	4.0	6.3
200 but less than 250%	6.3	8.05
250 but less than 300%	8.05	9.5
300 but not more than 400%	9.5	9.5

These are the applicable percentages for CY 2014. The applicable percentages will be updated in future years in accordance with 26 U.S.C. 36B(b)(3)(A)(ii).

6. Income Reconciliation Factor (IRF)

For persons enrolled in a QHP through an Exchange who receive an advance payment of the PTC (APTC), there will be an annual reconciliation following the end of the year to compare such payment to the correct amount of PTC based on household circumstances shown on the federal income tax return. Any difference between the latter amounts and the credit received during the year would either be paid to the taxpayer (if the enrollee received less in APTC than they were entitled to receive) or charged to the taxpayer as additional tax (if the enrollee received more in APTC than they were entitled to receive, subject to any limitations in statute or regulation), as provided in 26 U.S.C. 36B(f).

Section 1331(e)(2) of the Affordable Care Act specifies that individuals enrolled in BHP may not be treated as a qualified individual under section 1312 eligible for enrollment in a QHP offered through an Exchange. Therefore, BHP enrollees are not eligible to receive an APTC to purchase coverage in the Exchange. Because they do not receive APTC, BHP enrollees are not subject to the same income reconciliation as Exchange consumers. Nonetheless, there may still be differences between a BHP enrollee's household income reported at the beginning of the year and the actual income over the year. These may include small changes (reflecting changes in hourly wage rates, hours worked per week, and other fluctuations in income during the year) and large changes (reflecting significant changes in employment status, hourly wage rates, or substantial fluctuations in income). There may also be changes in household composition. Thus, we believe that using unadjusted income as reported prior to the BHP program year may result in calculations of estimated PTC that are inconsistent with the actual incomes of BHP enrollees during the year. Even if the BHP program adjusts household income determinations and corresponding claims of federal payment amounts based on household reports during the year or data from third-party sources, such adjustments may not fully capture the effects of tax reconciliation that BHP enrollees would have experienced had they been enrolled in a QHP through an Exchange and received an APTC.

Therefore, we propose including in Equation 1 an income adjustment factor that would account for the difference between calculating estimated PTC using: (a) Income relative to FPL as determined at initial application and potentially revised mid-year, under proposed 42 CFR 600.320, for purposes of determining BHP eligibility and claiming federal BHP payments; and (b) actual income relative to FPL received during the plan year, as it would be reflected on individual federal income tax returns. This adjustment would seek prospectively to capture the average effect of income reconciliation aggregated across the BHP population had those BHP enrollees been subject to tax reconciliation after receiving APTC for coverage provided through QHPs. For 2015, we propose estimating reconciliation effects based on tax data for two years, reflecting income and tax unit composition changes over time among BHP-eligible individuals.

Specifically, the Office of Tax Analysis (OTA) at the Department of the Treasury maintains a model which combines detailed tax and other data, including Exchange enrollment and PTC claimed, to project Exchange premiums, enrollment, and tax credits. For each enrollee, this model compares the APTC estimated at the point of enrollment with the PTC based on household income and family size reported at the end of the tax year. The former reflects the determination using enrollee information furnished by the applicant. The latter would reflect the PTC eligibility based on information on the tax return, which would have been determined if the individual had not enrolled in BHP. The ratio of the reconciled premium tax credit to the initial determination of premium tax credit will be used as the income reconciliation factor in Equation (1) for estimating the PTC portion of the BHP payment rate. We invite comment on this approach.

7. Tobacco Rating Adjustment Factor (TRAF)

As described above, the reference premium is estimated, for purposes of determining both the PTC and related federal BHP payments, based on premiums charged for non-tobacco users, including in states that allow premium variations based on tobacco use, as provided in 42 U.S.C. 300gg (a)(1)(A)(iv). In contrast, as proposed in the HHS Notice of Benefit and Payment Parameters for 2015, the CSR advance payments are based on the total premium for a policy, including any adjustment for tobacco use. Accordingly, we propose to incorporate a tobacco rating adjustment factor into Equation 2 that reflects the average percentage increase in health care costs that results from tobacco use among the BHP-eligible population and that would not be reflected in the premium charged to non-users. This factor will also take into account the estimated proportion of

tobacco users among BHP-eligible consumers.

To estimate the average effect of tobacco use on health care costs (not reflected in the premium charged to non-users), we propose to calculate the ratio between premiums that silver level QHPs charge for tobacco users to the premiums they charge for non-tobacco users at selected ages. To calculate estimated proportions of tobacco users, we propose to use data from the Centers for Disease Control and Prevention to estimate tobacco utilization rates by state and relevant population characteristic.[8] For BHP program year 2015, we would compare these tobacco utilization rates to the characteristics of BHP-eligible consumers, as shown by national and state survey data. We invite comments on this approach.

We also propose to consider differentiating this factor by the rate cell factors, if there are significant variations in either (a) the difference in health care costs for tobacco users and non-tobacco users or (b) the prevalence of tobacco use along any of these dimensions (including age range, state, geographic area, and income range). For example, if the differences in the tobacco and non-tobacco user rates in a state vary by age group, we would consider applying different adjustments to different rate cells by age.

8. Factor for Removing Administrative Costs (FRAC)

The Factor for Removing Administrative Costs (FRAC) represents the average proportion of the total premium that covers allowed health benefits, and we propose including this factor in our calculation of estimated CSRs in Equation 2. The product of the reference premium and the FRAC would approximate the estimated amount of EHB claims that would be expected to be paid by the plan. This step is needed because the premium also covers such costs as taxes, fees, and QHP administrative expenses. We are proposing to set this factor equal to 0.80, which is proposed for calculating CSR advance payments for 2015 in the HHS Notice of Benefit and Payment Parameters for 2015.

9. Actuarial Value (AV)

The actuarial value is defined as the percentage paid by a health plan of the total allowed costs of benefits, as defined under 45 CFR 156.20. (For example, if the average health care costs for enrollees in a health insurance plan were $1,000 and that plan has an actuarial value of 70 percent, the plan would be expected to pay on average $700 ($1,000 × 0.70) for health care costs per enrollee, on average.) By dividing such estimated costs by the actuarial value in the proposed methodology, we would calculate the estimated amount of total EHB-allowed claims, including both the portion of such claims paid by the plan and the portion paid by the consumer for in-network care. (To continue with that same example, we would divide the plan's expected $700 payment of the person's EHB-allowed claims by the plan's 70 percent actuarial value to ascertain that the total amount of EHB-allowed claims, including amounts paid by the consumer, is $1,000.)

For the purposes of calculating the CSR rate in Equation 2, we propose to use the standard actuarial value of the silver level plans in the individual market, which is equal to 70 percent.

10. Induced Utilization Factor (IUF)

The induced utilization factor is proposed as a factor in calculating estimated CSRs in Equation 2 to account for the increase in health care service utilization associated with a reduction in the level of cost sharing a QHP enrollee would have to pay, based on the cost-sharing reduction subsidies provided to enrollees.

In the HHS Notice of Benefit and Payment Parameters for 2015 proposed rule, we proposed induced utilization factors for the purposes of calculating cost-sharing reduction advance payments for 2015. The induced utilization factor for all persons who would enroll in a silver plan and qualify for BHP based on their household income as a percentage of FPL is 1.12; this would include persons with household income between 100 percent and 200 percent of FPL, lawfully present non-citizens below 100 percent of FPL who are ineligible for Medicaid because of immigration status, and persons with household income under 300 percent of FPL, not subject to any cost-sharing. Thus, we propose to use the induced utilization factor equal to 1.12 for the BHP payment methodology.

We would note that for CSRs for QHP, there will be a final reconciliation at the end of the year and the actual level of induced utilization could differ from the factor proposed in the rule. Our proposed methodology for BHP funding would not include any reconciliation for utilization and thus may understate or overstate the impact of the effect of the subsidies on health care utilization.

11. Change in Actuarial Value (ΔAV)

The increase in actuarial value would account for the impact of the cost-sharing reduction subsidies on the relative amount of EHB claims that would be covered for or paid by eligible persons, and we propose including it as a factor in calculating estimated CSRs in Equation 2.

The actuarial values of QHPs for persons eligible for cost-sharing reduction subsidies are defined in 45 CFR 156.420(a), and eligibility for such subsidies is defined in 45 CFR 155.305(g)(2)(i) through (iii). For QHP enrollees with household incomes between 100 percent and 150 percent of FPL, and those below 100 percent of FPL who are ineligible for Medicaid because of their immigration status, CSRs increase the actuarial value of a QHP silver plan from 70 percent to 94 percent. For QHP enrollees with household incomes between 150 percent and 200 percent of FPL, CSRs increase the actuarial value of a QHP silver plan from 70 percent to 87 percent.

We propose to apply this factor by subtracting the standard AV from the higher AV allowed by the applicable cost-sharing reduction. For BHP enrollees with household incomes at or below 150 percent of FPL, this factor would be 0.24 (94 percent minus 70 percent); for BHP enrollees with household incomes more than 150 percent but not more than 200 percent of FPL, this factor would be 0.17 (87 percent minus 70 percent).

E. Adjustments for American Indians and Alaska Natives

There are several exceptions made for American Indians and Alaska Natives enrolled in QHPs through an Exchange to calculate the PTC and CSRs. Thus, we propose adjustments to the payment methodology described above to be consistent with the Exchange rules.

We propose the following adjustments:

1. We propose that the adjusted reference premium for use in the CSR portion of the rate would use the lowest cost bronze plan instead of the second lowest cost silver plan, with the same adjustments for the premium trend factor and population health factor. American Indians and Alaska Natives are eligible for CSRs with any metal level plan, and thus we believe that eligible persons would be more likely to select a bronze level plan instead of a silver level plan. (It is important to note that this would not change the PTC, as that is the maximum possible PTC payment, which is always based on the

[8] See *http://www.cdc.gov/nchs/nhis/tobacco.htm; http://apps.nccd.cdc.gov/statesystem/default/DataSource.aspx.*

second lowest cost silver plan.) We invite comments as to whether other assumptions are warranted about the distribution, among bronze plans charging various premiums, of American Indian and Alaska Native BHP-eligible individuals.

2. We propose that the actuarial value for use in the CSR portion of the rate would be 0.60 instead of 0.70, which is consistent with the actuarial value of a bronze level plan.

3. We propose that the induced utilization factor for use in the CSR portion of the rate would be 1.15, which is consistent with the proposed HHS Notice of Benefit and Payment Parameters for 2015 induced utilization factor for calculating advance CSR payments for persons enrolled in bronze level plans and eligible for CSRs up to 100 percent of actuarial value.

4. We propose that the change in the actuarial value for use in the CSR portion of the rate would be 0.40. This reflects the increase from 60 percent actuarial value of the bronze plan to 100 percent actuarial value, as American Indians and Alaska Natives are eligible to receive CSRs up to 100 percent of actuarial value.

F. Example Application of the BHP Funding Methodology

This example of the proposed approach involves 1-person households with incomes between 138 and 150 percent FPL who obtain single coverage through BHP in a particular geographic rating area located in a state that permits insurers to increase premiums for tobacco users. To determine federal BHP payment rates, we begin by analyzing single-adult, silver-level coverage offered through the Exchange in that area. A particular QHP charges the ''reference premium''—that is, the second lowest cost premium among those charged by all silver-level plans offered in the area, for a specific age range, without premium increases for tobacco users. Within the following age ranges, the mean value of that reference premium for 2014, assuming every age in the range is equally represented, is as follows in our example:

- $132.34 for 0–20 year olds.
- $243.39 for 21–44 year olds.
- $385.37 for 45–54 year olds.
- $571.49 for 55–64 year olds.

We multiply these reference premiums by the premium trend factor—that is, by the expected increase in average private health insurance costs from 2014 to 2015. The most recent National Health Expenditure projections from the CMS Office of the Actuary estimate that, from 2014 to 2015, private health insurance costs per enrollee will rise by an average of 3.5 percent.[9] Accordingly, for purposes of calculating 2015 federal BHP payments, reference premium amounts will be adjusted to:

- $136.97 for 0–20 year olds.
- $251.91 for 21–44 year olds.
- $398.86 for 45–54 year olds.
- $591.50 for 55–64 year olds.

We then multiply these amounts by the population health factor, reflecting the amount by which premiums in the Exchange would have increased or decreased, relative to actual levels, if all BHP-eligible consumers had been allowed to obtain coverage through QHPs, rather than BHP. In this particular state, the amounts charged in the Exchange for 2014 assume the inclusion of BHP-eligible consumers, so no adjustment needs to be made for BHP program year 2015.[10] As a result, this factor is 1.00, so the final premiums listed above, by age, are the adjusted reference premiums.

We then factor in the effects of household size, FPL, and the PTC formula. We take current FPL guidelines (which are for 2013) [11] and trend them forwards to 2015, based on the intermediate inflation forecasts from the most recent Medicare Trustees Report.[12] Accordingly, for purposes of calculating federal BHP payments, we assume that 100 percent of FPL will be $12,024 a year ($1,002 a month) for a 1-person household in 2015.

With each household size and FPL range, we determine the average (mean) PTC amount. For purposes of this example, we calculate the amount that BHP-eligible consumers with incomes between 138 and 150 percent FPL in 1-person households would pay, after receiving a premium tax credit, for an adjusted-reference-premium plan at every FPL percentage point level included in that range—at 138 percent FPL, 139 percent FPL, 140 percent FPL, etc., up to and including 150 percent FPL. Household payments throughout this range average $38.28 (Table 2). Subtracting this payment level from the 2015 adjusted reference premium amounts shown above yields the following estimated premium tax credits, by age range, for 1-person households between 138 and 150 percent FPL:

- $98.69 for 0–20 year olds.
- $213.63 for 21–44 year olds.
- $360.58 for 45–54 year olds.
- $553.22 for 55–64 year olds.

If the best estimates from modeling show that, taking into account tax reconciliation effects across the entire BHP-eligible population, the net impact of reconciliation is to reduce tax credit amounts by an average (mean) of 2.00 percent, then the income reconciliation adjustment for 2015 would be 0.98. Between that adjustment and including 95 rather than 100 percent of the estimated premium tax credit within the federal BHP payment rate, the above amounts are multiplied by 0.931, resulting in the premium tax components of federal BHP payments as follows for 1-person households between 138 and 150 percent FPL receiving single coverage through BHP:

- $91.88 for 0–20 year olds.
- $198.89 for 21–44 year olds.
- $335.70 for 45–54 year olds.
- $515.05 for 55–64 year olds.

In calculating the cost-sharing reduction subsidy component of federal BHP payments, we begin with the above adjusted reference premiums for 2015, including the premium trend factor and the population health factor ($136.97 for 0–20 year olds, etc.). We then multiply those premiums by the following additional factors, with the results shown in Table 3:

- The Factor for Removing Administrative Costs, which is 0.80;
- A standard actuarial value (AV) factor, which is 1 over the standard actuarial value of 70 percent for silver-level plans, or 1.4286;
- The tobacco rating adjustment factor, which we assume, for purposes of this example, would be found to be 1.30, following a determination of: (a) Weighted-average premiums charged by silver level QHPs to tobacco users and non-users, by age; and (b) CDC estimates of tobacco usage within the state's BHP-eligible population, by age;
- An induced utilization factor of 1.12;
- The increase in actuarial value (by income), which is 0.24 for BHP enrollees in the applicable income range (138 to 150 percent FPL); and
- 0.95.

Table 4 concludes this example by showing both the premium tax credit

[9] *http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2012.pdf.*

[10] If the state implements BHP in 2015, this factor may change as early as BHP program year 2016 if state or national data demonstrate, based on differences between average risk scores for individual market participants below and above 200 percent FPL, that adding BHP-eligible consumers to the state's 2015 individual market would have changed the reference premiums charged in the state's Exchange.

[11] *https://www.federalregister.gov/articles/2013/01/24/2013–01422/annual-update-of-the-hhs-poverty-guidelines.*

[12] See Table IV A1 in *http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2013.pdf.* This forecast involves an increase in the Consumer Price Index of 2.2 percent in 2014 and 2.4 percent in 2015. Compounded, this results in a 4.65 percent increase from 2013 to 2015.

component and the cost-sharing reduction subsidy component of federal BHP payments for 1-person households between 138 and 150 percent FPL who obtain single coverage through BHP.

TABLE 2—HOUSEHOLD PREMIUM CHARGES, AFTER RECEIVING PREMIUM TAX CREDITS, FOR 1-PERSON HOUSEHOLDS BETWEEN 138–150 PERCENT FPL BUYING REFERENCE-PREMIUM SINGLE COVERAGE IN THE MARKETPLACE

FPL	Household premium charges	
	As a percentage of income	In dollars per month
138	2.29	31.72
139	2.35	32.77
140	2.41	33.83
141	2.47	34.91
142	2.53	35.99
143	2.59	37.09
144	2.65	38.19
145	2.71	39.31
146	2.76	40.45
147	2.82	41.59
148	2.88	42.75
149	2.94	43.91
150	3.00	45.09
Average	.....	38.28

Note: This table assumes a hypothesized geographic area that: (a) Is within a state that permits insurers to increase premiums for tobacco users; and (b) has mean premiums for the second-lowest-cost silver-level QHP, calculated for non-tobacco users assuming an even age distribution, as follows in 2014: $132.34 for 0–20 year olds; $243.39 for 21–44 year olds; $385.37 for 45–54 year olds; and $571.49 for ages 55–64 year olds.

TABLE 3—CALCULATING THE MONTHLY COST-SHARING REDUCTION SUBSIDY COMPONENT OF FEDERAL BHP PAYMENTS FOR 1-PERSON HOUSEHOLDS BETWEEN 138 AND 150 PERCENT FPL RECEIVING SINGLE COVERAGE THROUGH BHP

Age	Adjusted reference premium for 2015	After application of factor (by name and amount)					Final BHP CSR subsidy component
		Factor for removing administrative costs	Standard AV factor	Tobacco rating adjustment	Induced utilization	Increased AV	
		0.8	1.43	1.3	1.12	0.24	0.95
0–20	$136.97	$109.58	$156.69	$203.70	$228.15	$54.76	$52.02
21–44	251.91	201.53	288.19	374.64	419.60	100.70	95.67
45–54	398.86	319.09	456.30	593.18	664.37	159.45	151.48
55–64	591.50	473.20	676.68	879.68	985.24	236.46	224.63

Note: See note to Table 2.

TABLE 4—TOTAL MONTHLY AND QUARTERLY FEDERAL BHP PAYMENTS FOR 1-PERSON HOUSEHOLDS BETWEEN 138 AND 150 PERCENT FPL RECEIVING SINGLE COVERAGE THROUGH BHP

Age	Monthly components		Total BHP payments per enrollee	Quarterly
	Premium tax credit	Cost-sharing reduction subsidy	Monthly	
0–20	$91.88	$52.02	$143.90	$431.69
21–44	198.89	95.67	294.56	883.67
45–54	335.70	151.48	487.18	1,461.53
55–64	515.05	224.63	739.68	2,219.05

Note: See note to Table 2.

III. Collection of Information Requirements

While this document contains collection of information requirements that are subject to the Paperwork Reduction Act, CMS is seeking emergency OMB review and approval of those requirements under 5 CFR 1320.13. The notice setting out the proposed requirements and burden estimates is publishing in today's **Federal Register** under CMS–10510 (OCN 0938—New). That notice also sets out instructions for submitting public comment, as well as the comment due date.

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, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

V. Regulatory Impact Statement

A. Overall Impact

We have examined the impacts of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 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) and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Section 3(f) of Executive Order 12866 defines a ''significant regulatory action'' as an action that is likely to result in a rule: (1) Having an annual effect on the economy of $100 million or more in any 1 year, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or state, local or tribal governments or communities (also referred to as ''economically significant''); (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order.

A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). As noted in the BHP proposed rule, BHP provides states the flexibility to establish an alternative coverage program for low-income individuals who would otherwise be eligible to purchase coverage through the Exchange. We are uncertain, as described further below, as to whether the effects of the proposed rulemaking, and subsequently, this document, will be ''economically significant'' as measured by the $100 million threshold, and hence not a major rule under the Congressional Review Act. We seek comment on the analysis provided below to help inform this assessment by the time of concurrent publication of the final BHP rule and final payment notice. In accordance with the provisions of Executive Order 12866, this document was reviewed by the Office of Management and Budget.

1. Need for the Notice

Section 1331 of the Affordable Care Act (codified at 42 U.S.C. 18051) requires the Secretary to establish a Basic Health Program, and subsection (d)(1) specifically provides that if the Secretary finds that a state ''meets the requirements of the program established under subsection (a) [of section 1331], the Secretary shall transfer to the State'' federal BHP payments described in subsection (d)(3). This document provides for the funding methodology to determine the federal BHP payment amounts required to implement these provisions.

2. Alternative Approaches

Many of the factors proposed in this document are specified in statute; therefore, we are limited in the alternative approaches we could consider. One area in which we had a choice was in selecting the data sources used to determine the factors included in the proposed methodology. Except for state-specific reference premiums and enrollment data, we propose using national rather than state-specific data. This is due to the lack of currently available state-specific data needed to develop the majority of the factors included in the proposed methodology. We believe the national data will produce sufficiently accurate determinations of payment rates. In addition, we believe that this approach will be less burdensome on states. With respect to reference premiums and enrollment data, we propose using state-specific data rather than national data as we believe state-specific data will produce more accurate determinations than national averages.

3. Transfers

The provisions of this document are designed to determine the amount of funds that will be transferred to states offering coverage through a Basic Health Program rather than to individuals eligible for premium and cost-sharing reductions for coverage purchased on the Exchange. We are uncertain what the total federal BHP payment amounts to states will be as these amounts will vary from state to state due to the varying nature of state composition. For example, total federal BHP payment amounts may be greater in more populous states simply by virtue of the fact that they have a larger BHP-eligible population and total payment amounts are based on actual enrollment. Alternatively, total federal BHP payment amounts may be lower in states with a younger BHP-eligible population as the reference premium used to calculate the federal BHP payment will be lower relative to older BHP enrollees. While state composition will cause total federal BHP payment amounts to vary from state to state, we believe that the proposed methodology accounts for these variations to ensure accurate BHP payment transfers are made to each state.

B. Unfunded Mandates Reform Act

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) 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, by state, local, or tribal governments, in the aggregate, or by the private sector. In 2013, that threshold is approximately $141 million. States have the option, but are not required, to establish a BHP. Further, the proposed methodology would establish federal payment rates without requiring states to provide the Secretary with any data not already required by other provisions of the Affordable Care Act or its implementing regulations. Thus, this proposed payment notice does not mandate expenditures by state governments, local governments, or tribal governments.

C. Regulatory Flexibility Act

The Regulatory Flexibility Act (5 U.S.C. 601 et seq.) (RFA) requires agencies to prepare an initial regulatory flexibility analysis to describe the impact of the proposed rule on small entities, unless the head of the agency can certify that the rule will not have a significant economic impact on a substantial number of small entities.

The Act generally defines a ''small entity'' as (1) a proprietary firm meeting the size standards of the Small Business Administration (SBA); (2) a not-for-profit organization that is not dominant in its field; or (3) a small government jurisdiction with a population of less than 50,000. Individuals and states are not included in the definition of a small entity. Few of the entities that meet the definition of a small entity as that term is used in the RFA would be impacted directly by this document.

Because this document is focused on the proposed funding methodology that will be used to determine federal BHP payment rates, it does not contain provisions that would have a significant direct impact on hospitals, and other health care providers that are designated as small entities under the RFA. However, the provisions in this document may have a substantial, positive indirect effect on hospitals and other health care providers due to the substantial increase in the prevalence of health coverage among populations who are currently unable to pay for needed health care, leading to lower rates of uncompensated care at hospitals. The Department cannot determine whether this document would have a significant economic impact on a substantial number of small entities, and we request public comment on this issue.

Section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a document may have a significant economic impact on the operations of a substantial number of small rural hospitals. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a metropolitan statistical area and has fewer than 100 beds. As indicated in the preceding discussion, there may be indirect positive effects from reductions in uncompensated care. Again, the Department cannot determine whether this document would have a significant economic impact on a substantial number of small rural hospitals, and we request public comment on this issue.

D. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct effects on states, preempts state law, or otherwise has federalism implications. The BHP is entirely optional for states, and if implemented in a state, provides access to a pool of funding that would not otherwise be available to the state.

We have consulted with states to receive input on how the Affordable Care Act provisions codified in this document would affect states. We have participated in a number of conference calls and in person meetings with state officials.

We continue to engage in ongoing consultations with states that have expressed interest in implementing a BHP through the BHP Learning Collaborative, which serves as a staff level policy and technical exchange of information between CMS and the states. Through consultations with this Learning Collaborative, we have been able to get input from states on many of the specific issues addressed in this document.

Authority: Section 1331(d)(3) of the Affordable Care Act.

Dated: November 20, 2013.

Marilyn Tavenner,

Administrator, Centers for Medicare & Medicaid Services.

Approved: November 22, 2013.

Kathleen Sebelius,

Secretary, Department of Health and Human Services.

[FR Doc. 2013–30435 Filed 12–18–13; 4:15 pm]

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DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 660

[Docket No. 130822744–3744–01]

RIN 0648–BD63

Fisheries Off West Coast States; Coastal Pelagic Species Fisheries; Change to Start of Pacific Sardine Fishing Year

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Proposed rule.

SUMMARY: Each year, NMFS implements regulations that set the annual quota and management measures for the Pacific sardine fishing year. NMFS proposes to change the starting date of the annual Pacific sardine fishery from January 1 to July 1. This would change the fishing season from one based on the calendar year to one based on a July 1 through the following June 30th schedule. No other changes to the annual allocation structure are being made and the existing seasonal allocation percentages will remain as specified in the FMP; as would the current quota roll-over provisions. The purpose of this change is to better align the timing of the research and science that is used in the annual stock assessments with the annual management schedule. To enable this transition in fishing years, this action also would establish a one-time interim harvest period for the 6 months from January 1, 2014, through June 30, 2014.

DATES: Comments must be received by January 22, 2014.

ADDRESSES: You may submit comments on this document identified by ''NOAA–NMFS–2013–0167'' by any of the following methods:

- *Electronic Submissions:* Submit all electronic public comments via the Federal e-Rulemaking Portal. Go to *www.regulations.gov/#!docketDetail;D=NOAA-NMFS-2013-0167,* click the ''Comment Now!'' icon, complete the required fields, and enter or attach your comments.
- *Mail:* Submit written comments to William W. Stelle, Jr., Regional Administrator, West Coast Region, NMFS, 7600 Sand Point Way NE., Seattle, WA 98115–0070; Attn: Joshua Lindsay.
- *Fax:* (562) 980–4047; Attn: Joshua Lindsay

Instructions: Comments sent by any other method, to any other address or individual, or received after the end of the comment period, may not be considered by NMFS. All comments received are a part of the public record and will generally be posted for public viewing on *www.regulations.gov* without change. All personal identifying information (e.g., name, address, etc.), confidential business information, or otherwise sensitive information submitted voluntarily by the sender will be publicly accessible. NMFS will accept anonymous comments (enter ''N/A'' in the required fields if you wish to remain anonymous). Attachments to electronic comments will be accepted in Microsoft Word, Excel, or Adobe PDF file formats only.

FOR FURTHER INFORMATION CONTACT: Joshua Lindsay, Southwest Region, NMFS, (562) 980–4034.

SUPPLEMENTARY INFORMATION: This proposed rule would change the start date of the 12-month Pacific sardine fishery from January 1 to July 1, thus changing the fishing season for Pacific sardine from one based on the calendar year to one beginning on July 1 and continuing through June 30th of the following year. The purpose of this change is to better align the timing of the research and science used in the annual stock assessments with the annual management schedule, as the present schedule imposes substantial