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

## Subpart VV—Virginia

■ 2. In § 52.2420, the table in paragraph (c) is amended by revising the entries under Chapter 80 for Sections 5–80–1695 and 5–80–1715 to read as follows:

**§ 52.2420 Identification of plan.**

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(c) * * *

EPA-APPROVED VIRGINIA REGULATIONS AND STATUTES

| State citation | Title/Subject | State effective date | EPA Approval date | Explanation [former SIP citation] |
|---|---|---|---|---|
| * | * | * | * | * * * |
| **9 VAC 5, Chapter 80 Permits for Stationary Sources [Part VIII]** | | | | |
| * | * | * | * | * * * |
| **Article 8 Permits—Major Stationary Sources and Major Modifications Located in Prevention of Significant Deterioration Areas** | | | | |
| * | * | * | * | * * * |
| 5–80–1695 | Exemptions | 6/4/14 | 2/29/16 [Insert **Federal Register** Citation]. | Revised paragraph E(1) to add value for $PM_{2.5}$. Limited approval remains in effect. |
| * | * | * | * | * * * |
| 5–80–1715 | Source impact analysis | 6/4/14 | 2/29/16 [Insert **Federal Register** Citation]. | Revised paragraph A. Limited approval remains in effect. |
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[FR Doc. 2016–04245 Filed 2–26–16; 8:45 am]

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

## Centers for Medicare & Medicaid Services

## 42 CFR Part 600

**[CMS–2396–FN]**

**RIN 0938–ZB21**

## Basic Health Program; Federal Funding Methodology for Program Years 2017 and 2018

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

**ACTION:** Final methodology.

**SUMMARY:** This document provides the methodology and data sources necessary to determine Federal payment amounts made in program years 2017 and 2018 to states that elect to establish a Basic Health Program under the Affordable Care Act to offer health benefits coverage to low-income individuals otherwise eligible to purchase coverage through Affordable Insurance Exchanges (hereinafter referred to as the Exchanges).

**DATES:** These regulations are effective on January 1, 2017.

**FOR FURTHER INFORMATION CONTACT:** Christopher Truffer, (410) 786–1264; or Stephanie Kaminsky (410) 786–4653.

**SUPPLEMENTARY INFORMATION:**

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### Acronyms

To assist the reader, the following acronyms are used in this document.

ΔAV Change in Actuarial Value
APTC Advance payment of the premium tax credit
ARP Adjusted reference premium
AV Actuarial value
BHP Basic Health Program
CCIIO CMS' Center for Consumer Information and Insurance Oversight
CDC Centers for Disease Control and Prevention
CHIP Children's Health Insurance Program
CPI–U Consumer price index for all urban consumers
CSR Cost-sharing reduction
EHB Essential Health Benefit
FPL Federal poverty line
FRAC Factor for removing administrative costs
IRF Income reconciliation factor
IRS Internal Revenue Service
IUF Induced utilization factor
QHP Qualified health plan
OTA Office of Tax Analysis [of the U.S. Department of Treasury]
PHF Population health factor
PTC Premium tax credit
PTCF Premium tax credit formula
PTF Premium trend factor
RP Reference premium
SBE State Based Exchange

TRAF Tobacco rating adjustment factor

## I. Background

Section 1331 of the Patient Protection and Affordable Care Act (Pub. L. 111–148, enacted on March 23, 2010), as amended by 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) provides states with an option to establish a Basic Health Program (BHP). In the states that elect to operate 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 Federal poverty level (FPL) who are not otherwise eligible for Medicaid, the Children's Health Insurance Program (CHIP), or affordable employer-sponsored coverage, or for individuals whose income is below these levels but are lawfully present non-citizens ineligible for Medicaid. (For those states that have expanded Medicaid coverage under section 1902(a)(10)(A)(i)(VIII) of the Social Security Act (the Act), 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 (section 1902(e)(14)(I) of the Act)).

BHP provides another option for states in providing affordable health benefits to individuals with incomes in the ranges previously described. States may find BHP a useful option for several reasons, including the ability to potentially coordinate standard health plans in BHP with their Medicaid managed care plans, or to potentially reduce the costs to individuals by lowering premiums or cost-sharing requirements.

Federal funding will be available for BHP based on the amount of premium tax credit (PTC) and cost-sharing reductions (CSRs) that BHP enrollees would have received had they been enrolled in qualified health plans (QHPs) through Exchanges. These funds are paid to trust funds dedicated to BHP in each state, and the states then administer the payments to standard health plans within BHP.

In the March 12, 2014 **Federal Register** (79 FR 14112), we published a final 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'' (hereinafter referred to as the BHP final rule) implementing section 1331 of the Affordable Care Act), which directs the establishment of BHP. The BHP final rule establishes the standards for state and Federal administration of BHP, including provisions regarding eligibility and enrollment, benefits, cost-sharing requirements and oversight activities. While the BHP final rule codifies 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 final rule indicated that the development and publication of the funding methodology, including any data sources, would be addressed in a separate annual BHP Payment Notice.

In the BHP final rule, we specified 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 2016 would apply to BHP program year 2017, beginning in January 2017. As discussed in section III.C of this methodology, and as referenced in § 600.610(b)(2), state data needed to calculate the Federal BHP payment rates for the final BHP Payment Notice must be submitted to CMS.

As described in the BHP final rule, once the final methodology has been published, we will only make modifications to the BHP funding methodology on a prospective basis with limited exceptions. The BHP final rule provided that retrospective adjustments to the state's BHP payment amount may occur to the extent that the prevailing BHP funding methodology for a given program year permits adjustments to a state's Federal BHP payment amount due to insufficient data for prospective determination of the relevant factors specified in the payment notice. Additional adjustments could be made to the payment rates to correct errors in applying the methodology (such as mathematical errors).

Under section 1331(d)(3)(A)(ii) of the Affordable Care Act, the funding methodology and payment rates are expressed as an amount per eligible individual enrolled in a BHP standard health plan (BHP enrollee) for each month of enrollment. These payment rates may vary based on categories or classes of enrollees. Actual payment to a state would depend on the actual enrollment of individuals found eligible in accordance with a state's certified blueprint eligibility and verification methodologies in coverage through the state BHP. A state that is approved to implement BHP must provide data showing quarterly enrollment of eligible individuals in the various Federal BHP payment rate cells. Such data should include the following:

- Personal identifier;
- Date of birth;
- County of residence;
- Indian status;
- Family size;
- Household income;
- Number of person in household enrolled in BHP;
- Family identifier;
- Months of coverage;
- Plan information; and
- Any other data required by CMS to properly calculate the payment.

In the February 24, 2015 **Federal Register** (80 FR 9636), we published the final payment notice entitled ''Basic Health Program; Federal Funding Methodology for Program Year 2016'' (hereinafter referred to as the 2016 payment methodology) that sets forth the methodology that will be used to calculate the Federal BHP payments for the 2016 program year.

## II. Summary of Proposed Provisions and Analysis of and Responses to Public Comments on the Proposed Methodology

The following sections, arranged by subject area, include a summary of the public comments that we received, and our responses. For a complete and full description of the BHP proposed funding methodology, see the ''Basic Health Program; Federal Funding Methodology for Program Years 2017 and 2018'' proposed rule published in the October 22, 2015 **Federal Register** (80 FR 63936).

We received a total of 5 timely comments from individuals and organizations. The public comments received ranged from general support or opposition to the BHP, but did not address the proposed methodology.

*A. Background*

In the October 22, 2015 (80 FR 63936) proposed rule, we specified the methodology of how the Federal BHP payments would be calculated. For specific discussions, please refer to the October 22, 2015 proposed rule (80 FR 63936).

We received the following comments on the background information included in the proposed methodology:

*Comment:* Some commenters expressed general opposition to or support for the BHP.

*Response:* The comments were outside of the scope of the BHP payment methodology.

*Comment:* Some commenters expressed general support for the BHP payment methodology.

*Response:* We appreciate the comments in support of the payment methodology.

*Final Decision:* We are finalizing our proposed methodology for how the Federal BHP payments will be calculated.

*B. Overview of the Funding Methodology and Calculation of the Payment Amount*

We proposed in the overview of the funding methodology to calculate the PTC and CSR as consistently as possible and in general alignment with the methodology used by Exchanges to calculate the advance payments of the PTC and CSR, and by the Internal Revenue Service (IRS) to calculate the allowable PTC. We proposed in this section 4 equations that compose the overall BHP funding methodology. For specific discussions, please refer to the October 22, 2015 proposed rule (80 FR 63936).

We received no comments regarding the overview of the funding methodology and calculation of the payment amount. We are finalizing the BHP overview of the funding methodology and the payment amount for 2017 and 2018 as proposed.

*C. Required Rate Cells*

In this section, we proposed that a state implementing BHP provide us with an estimate of the number of BHP enrollees it will enroll in the upcoming BHP program, by applicable rate cell, to determine the Federal BHP payment amounts. For each state, we proposed using rate cells that separate the BHP population into separate cells based on the following 5 factors: Age; geographic rating area; coverage status; household size; and income. For specific discussions, please refer to the October 22, 2015 proposed rule (80 FR 63936).

We received no comments regarding the rate cells used to calculate the Federal BHP payment amounts. We are finalizing the criteria and definitions of the rate cells to determine the Federal BHP payment amounts for 2017 and 2018.

*D. Sources and State Data Considerations*

We proposed in this section to use, to the extent possible, data submitted to the Federal government by QHP issuers seeking to offer coverage through an Exchange to determine the Federal BHP payment cell rates. However, in states operating a State Based Exchange (SBE), we proposed that such states submit required data for CMS to calculate the Federal BHP payment rates in those states. For specific discussions, please refer to the October 22, 2015 proposed rule (80 FR 63936).

We did not receive any comments on the ‘‘Sources and State Data Considerations’’ section and are finalizing the BHP methodology as proposed.

*E. Discussion of Specific Variables Used in Payment Equations*

In this section, we proposed 11 specific variables to use in the payment equations that compose the overall BHP funding methodology. (10 variables are described in section III.D of this document, and the premium trend factor is described in section III.F.) For each proposed variable, we included a discussion on the assumptions and data sources used in developing the variables. For specific discussions, please refer to the October 22, 2015 proposed rule (80 FR 63936).

We did not receive any comments on the ‘‘Specific Variables Used in Payment Equations’’ section and are finalizing the BHP methodology as proposed.

*F. Adjustments for American Indians and Alaska Natives*

We proposed to make several adjustments for American Indians and Alaska Natives when calculating the CSR portion of the Federal BHP payment rate to be consistent with the Exchange rules. For specific discussions, please refer to the October 22, 2015 proposed rule (80 FR 63936).

We did not receive any comments on the ‘‘Adjustments for American Indians and Alaska Natives’’ section and are finalizing the BHP methodology as proposed.

*G. State Option To Use 2016 or 2017 QHP Premiums for BHP Payments*

In this section, we proposed to provide states implementing BHP with the option to use the 2016 or 2017 QHP premiums multiplied by a premium trend factor to calculate the Federal BHP payment rates instead of using the 2017 or 2018 QHP premiums, for the 2017 and 2018 BHP program years, respectively. For specific discussions, please refer to the October 22, 2015 proposed rule (80 FR 63936).

We did not receive any comments on the ‘‘State Option to Use 2016 or 2017 QHP Premiums for BHP Payments’’ section and are finalizing the BHP methodology as proposed.

*H. State Option To Include Retrospective State-Specific Health Risk Adjustment in Certified Methodology*

In this section, we proposed to provide states implementing BHP the option to develop a methodology to account for the impact that including the BHP population in the Exchange would have had on QHP premiums based on any differences in health status between the BHP population and persons enrolled through the Exchange. For specific discussions, please refer to the October 22, 2015 proposed rule (80 FR 63936).

We did not receive any comments on the ‘‘State Option to Include Retrospective State-specific Health Risk Adjustment in Certified Methodology’’ section and are finalizing the BHP methodology as proposed.

## III. Provisions of the Final 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 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 PTC and CSR components of advance payments, and by the IRS to calculate final PTCs. In general, we rely on values for factors in the payment methodology specified in statute or other regulations as available, and we have developed 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 (OTA) 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 CSRs 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 PTC and CSR would have occurred if the enrollee had been so enrolled. This payment methodology takes each of these factors into account. This methodology is the same as the 2016 payment methodology, with minor changes to update the value of certain factors used to calculate the payments, but with no changes in methods. These updates are explained in later sections of this notice.

Through this notice, we are establishing a payment methodology for the 2017 and 2018 BHP program years. The same methodology will apply for both years, but the values of a number of factors will be updated for 2018, as noted throughout this notice. We reserve the right to specify a different methodology for 2018.

The methodology will be the same methodology as used for 2015 and 2016. We have developed a methodology 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 area and are in households of the same size and income range. We note that the development of the BHP payment rates will be consistent with those states' rules on age rating. Thus, in the case of a state that does not use age as a rating factor on the Marketplace, the BHP payment rates would not vary by age.

The rate for each rate cell would be calculated in 2 parts. The first part (as described in Equation (1)) will 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 (as described in Equation (2)) will 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 2 parts will be added together and the total rate for that rate cell would be equal to the sum of the PTC and CSR rates.

To calculate the total Federal BHP payment, Equation (1) will be used to calculate the estimated PTC for eligible individuals enrolled in the BHP in each rate cell and Equation (2) will be used to calculate the estimated CSR payments for eligible individuals enrolled in the BHP in each rate cell. (Indeed, we note that throughout the payment notice, when we refer to enrollees and enrollment data, we mean data regarding individuals who are enrolled in the BHP who have been found eligible for the BHP using the eligibility and verification requirements that are applicable in the state's most recent certified Blueprint.) By applying the equations separately to rate cells based on age, income and other factors, we effectively take those factors into account in the calculation. In addition, the equations 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 in this section, and further detail is provided later in this section of the payment notice.

In addition, we describe how we will calculate the adjusted reference premium (ARP), which is the value of the premium accounting for specified adjustments (such as the relative health status of BHP enrollees or the projected annual increase in the premium) (described later in this section of the payment notice) that is used in Equations (1) and (2). This is defined in Equation (3a) and Equation (3b).

*Equation 1: Estimated PTC by Rate Cell*

The estimated PTC, on a per enrollee basis, will 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 will be calculated in a manner consistent with the methodology used to calculate the PTC for persons enrolled in a QHP, with 3 adjustments. First, the PTC portion of the rate for each rate cell will 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 (RP) used to calculate the PTC (described in more detail later in the section) will be adjusted for BHP population health status, and in the case of a state that elects to use 2016 premiums for the basis of the BHP Federal payment, for the projected change in the premium from the 2016 to 2017, to which the rates announced in the final payment methodology would apply. These adjustments are described in Equation (3a) and Equation (3b). Third, the PTC will 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 in section III.D.5. of this methodology, will 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 ARP, we would calculate the PTC to be equal to 0 and would not allow the value of the PTC to be negative.

Consistent with this description, Equation (1) is defined as:

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

$PTC_{a,g,c,h,i}$ = 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.

Equation 2: Estimated CSR Payment by Rate Cell

The CSR portion of the rate will 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 will be calculated in a manner consistent with the methodology used to calculate the CSR component of advance payments for persons enrolled in a QHP, as described in the ''HHS Notice of Benefit and Payment Parameters for 2016''final rule published in the February 27, 2015 **Federal Register** (80 FR 10749), with 3 principal adjustments. (We will make a separate calculation that includes different adjustments for American Indian/Alaska Native BHP enrollees, as described in section III.D.1 of this methodology.) For the first adjustment, the CSR rate, like the PTC rate, will represent the mean expected CSR subsidy that would be paid on behalf of all persons in the rate cell, rather than being calculated for each individual enrollee. Second, this calculation will be based on the ARP, as described in section III.A.3. of this methodology. Third, this equation uses an ARP that reflects premiums charged to non-tobacco users, rather than the actual premium that is charged to tobacco users to calculate the CSR component of advance payments for tobacco users enrolled in a QHP. Accordingly, the equation will 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. Finally, the rate will be multiplied by 95 percent, as provided in section 1331(d)(3)(A)(i) of the Affordable Care Act.

Consistent with the methodology previously described, Equation (2) is defined as:

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

$CSR_{a,g,c,h,i}$ = 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).

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

As part of these calculations for both the PTC and CSR components, we will calculate the value of the ARP as described below in this methodology. Consistent with the approach in previous years, we will allow states to choose between using the actual 2017 and 2018 QHP premiums or the 2016 and 2017 QHP premiums multiplied by the premium trend factor (for the 2017 and 2018 program years, respectively, and as described in section III.F). Therefore, we describe how we would calculate the ARP under each option.

In the case of a state that elected to use the RP based on the 2017 premiums for the 2017 program year, we will calculate the value of the ARP as specified in Equation (3a). The ARP will be equal to the RP, which will be based on the second lowest cost silver plan premium in 2017, multiplied by the BHP population health factor (described in section III.D of this methodology), which will reflect the projected impact that enrolling BHP-eligible individuals in QHPs on an Exchange would have had on the average QHP premium.

$$\boldsymbol{Equation\ (3a)\!:\ ARP_{a,g,c} = RP_{a,g,c} \times PHF}$$

$ARP_{a,g,c}$ = 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.
$PHF$ = Population health factor.

In the case of a state that elected to use the RP based on the 2016 premiums for the 2017 program year (as described in section III.F of this methodology), we will calculate the value of the ARP as specified in Equation (3b). The ARP will be equal to the RP, which will be based on the second lowest cost silver plan premium in 2016, multiplied by the BHP population health factor (described in section III.D of this methodology), which will reflect the projected impact that enrolling BHP-eligible individuals in QHPs on an Exchange would have had on the average QHP premium, and by the premium trend factor, which will reflect the projected change in the premium level between 2016 and 2017 (including the estimated impact of changes resulting from the transitional reinsurance program established in section 1341 of the Affordable Care Act).

$$\boldsymbol{Equation\ (3b)\!:\ ARP_{a,g,c} = RP_{a,g,c} \times PHF \times PTF}$$

$ARP_{a,g,c}$ = 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.
$PHF$ = Population health factor.
$PTF$ = Premium trend factor.

This methodology will also apply for the 2018 program year, using either actual 2018 QHP premiums or the 2017 QHP premiums multiplied by a premium trend factor.

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

In general, the rate for each rate cell will 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.

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

$PMT$ = 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. Federal BHP Payment Rate Cells*

The use of Federal BHP payment rate cells will be the same as in the 2015 and 2016 methodologies. We will require 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 and each subsequent quarter of program operations until actual enrollment data is available. Upon our approval of such estimates as reasonable, they will 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 will 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 will be based on the most recent actual enrollment data submitted to us. Actual enrollment data must be based on individuals enrolled for the quarter submitted who the state found eligible and whose eligibility was verified using eligibility and verification requirements as agreed to by the state in its applicable BHP Blueprint for the quarter that enrollment data is submitted. 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 in this section.

We will require the use of certain rate cells as part of the methodology. For each state, we will use rate cells that separate the BHP population into separate cells based on the 5 factors described as follows:

*Factor 1—Age:* We will separate enrollees into rate cells by age, using the following unchanged age ranges that capture the widest variations in premiums under Department of Health and Human Services' (HHS) Default Age Curve: [1]

- Ages 0–20.
- Ages 21–34.
- Ages 35–44.
- Ages 45–54.
- Ages 55–64.

*Factor 2—Geographic area:* For each state, we will separate enrollees into rate cells by geographic areas within which a single RP is charged by QHPs offered through the state's Exchange. Multiple, non-contiguous geographic areas will be incorporated within a single cell, so long as those areas share a common RP.[2] This provision would also be unchanged from the current method.

*Factor 3—Coverage status:* We will separate enrollees into rate cells by coverage status, reflecting whether an individual is enrolled in self-only coverage or persons are enrolled in other-than-self-only coverage (or "family coverage") through BHP, as provided in section 1331(d)(3)(A)(ii) of the Affordable Care Act, consistent with the current methodology. Among recipients of family coverage through BHP, separate rate cells, as explained below in this methodology, will apply based on whether such coverage involves 2 adults alone or whether it involves children.

*Factor 4—Household size:* We will separate enrollees into rate cells by household size that states use to determine BHP enrollees' income as a percentage of the FPL under § 600.320 (Administration, eligibility, essential health benefits, performance standards, service delivery requirements, premium and cost sharing, allotments, and reconciliation; Determination of eligibility for and enrollment in a standard health plan), consistent with the current methodology. We will require separate rate cells for several specific household sizes. For each additional member above the largest specified size, we will publish instructions for how we will develop additional rate cells and calculate an appropriate payment rate based on data for the rate cell with the closest specified household size. We will

[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 notice 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, June 2, 2014, *http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/ra-tables-03-27-2014.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 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 in this methodology.

publish separate rate cells for household sizes of 1 through 10.

*Factor 5—Income:* For households of each applicable size, we will create separate rate cells by income range, as a percentage of FPL, consistent with the current methodology. 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, separate rate cells will be used to calculate Federal BHP payment rates to reflect different bands of income measured as a percentage of FPL. We will use 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 will only be used to calculate the Federal BHP payment amount. A state implementing BHP will 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 will use 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 this 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, since within applicable ranges, the BHP-eligible population is distributed relatively evenly.

*C. Sources and State Data Considerations*

To the extent possible, we will continue 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. In this methodology, we make some clarifications regarding the submission of state data in this section, and is otherwise consistent with the current methodology.

States operating a State Based Exchange in the individual market, however, must provide certain data, including premiums for second lowest cost silver plans, by geographic area, for CMS to calculate the Federal BHP payment rates in those states. A state operating a State Based Exchange 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 October 15, 2016, for CMS to calculate the applicable rates for 2017 and by October 15, 2017 for 2018. 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 will be published in CMS guidance and will be available at *http://www.medicaid.gov/Federal-Policy-Guidance/Federal-Policy-Guidance.html.*

States must submit to CMS enrollment data on a quarterly basis and should be technologically prepared to begin submitting data at the start of their BHP. This requirement is necessary for us to implement the payment methodology that is tied to a quarterly reconciliation based on actual enrollment data.

We make 2 additional clarifications regarding state-submitted data. First, for states that have BHP enrollees who do not file Federal tax returns (non-filers), the state must develop a methodology which they must submit to CMS at the time of their Blueprint submission to determine the enrollees' household income and household size consistently with Exchange requirements. We reserve the right to approve or disapprove the state's methodology to determine income and household size for non-filers.

Second, as the Federal payments are determined quarterly and the enrollment data is required to be submitted by the states to CMS quarterly, we clarify that the quarterly payment would be based on the characteristics of the enrollee at the beginning of the quarter (or their first month of enrollment in BHP in each quarter). Thus, if an enrollee were to experience a change in county of residence, income, household size, or other factors related to the BHP payment determination during the quarter, the payment for the quarter would be based on the data as of the beginning of the quarter. Payments will still be made only for months that the person is enrolled in and eligible for BHP. We do not anticipate that this will have a significant effect on the Federal BHP payment. The states must maintain data that are consistent with our verification requirements, including auditable records for each individual enrolled, indicating an eligibility determination and a determination of income and other criteria relevant to the payment methodology as of the beginning of each quarter.

As described in § 600.610 (Secretarial determination of BHP payment amount), the state is required to submit certain data in accordance with this Notice. We require that this data be collected and validated by states operating BHP and that this data be submitted to CMS.

*D. Discussion of Specific Variables Used in Payment Equations*

1. Reference Premium (RP)

To calculate the estimated PTC that would be paid if individuals enrolled in QHPs through the Exchange, we must calculate a RP because the PTC is based, in part, on the premiums for the applicable second lowest cost silver plan as explained in section III.C.4 of this methodology, regarding the Premium Tax Credit Formula (PTCF). Accordingly, for the purposes of calculating the BHP payment rates, the RP, 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. We will use the adjusted monthly premium for an applicable second lowest cost silver plan in 2017 and 2018 as the RP (except in the case of a state that elects to use the 2016 or 2017 premium, respectively, as the basis for the Federal BHP payment, as described in section III.F of this final notice). The use of the RP and the determination of the RP is consistent with the current methodology.

The RP will 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 in accordance with 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

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

an Exchange, we will not update the payment methodology, and subsequently the Federal BHP payment rates, in the event that the second lowest cost silver plan used as the RP, or the lowest cost silver plan, 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.

American Indians and Alaska Natives with household incomes between 100 percent and 300 percent of the FPL are eligible for a full cost sharing subsidy regardless of the plan they select (as described in sections 1402(d) and 2901(a) of the Affordable Care Act). We assume that American Indians and Alaska Natives would be more likely to enroll in bronze plans as a result, as it would reduce the amount of the premium they would pay compared to the costs of enrolling in a silver plan; thus, for American Indian/Alaska Native BHP enrollees, we will use the lowest cost bronze plan as the basis for the RP for the purposes of calculating the CSR portion of the Federal BHP payment as described further in section III.E of this methodology.

We note that the choice of the second lowest cost silver plan for calculating BHP payments relies 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 2 adults, their child, and their niece than to a family with 2 adults and their children, because 1 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 will use the second lowest cost silver plan available to any enrollee for a given age, geographic area, and coverage category.

This choice of RP relies on 2 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 section 1331(d)(3)(A)(ii) of the Affordable Care Act 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 enroll in a bronze level plan through the Exchange, they would not be eligible for CSRs, unless they were an eligible American Indian or Alaska Native; thus, assuming that all persons enroll in a 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 that it would be difficult to project how many BHP enrollees would have enrolled in different silver level QHPs, and thus will use the second lowest cost silver plan as the basis for the RP and calculating the CSR portion of the rate. While some data is available from the Exchanges, developing projections of how persons in different income ranges choose plans and extrapolating that to other states, with different numbers of plans and different premiums, would not be an improvement upon the current methodology. For American Indian/Alaska Native BHP enrollees, we will use the lowest cost bronze plan as the basis for the RP as described further in section III.E. of this methodology.

The applicable age bracket will be one dimension of each rate cell. We will 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 will produce a reliable determination of the PTC and CSR components. We also believe this approach will 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 will use geographic areas based on the rating areas used in the Exchanges. We will define each geographic area so that the RP is the same throughout the geographic area. When the RP varies within a rating area, we are defining geographic areas as aggregations of counties with the same RP. Although plans are allowed to serve geographic areas smaller than counties after obtaining our approval, 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, the Federal payment rates will 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 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

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

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).

*2. Population Health Factor (PHF)*

The population health factor will be included in the methodology to account for the potential differences in the average health status between BHP enrollees and persons enrolled in the Exchange. To the extent that BHP enrollees would have been enrolled in the Exchange in the absence of BHP in a state, the exclusion of those BHP enrollees in the Exchange may affect the average health status of the overall population and the expected QHP premiums. The use and determination of the PHF as described below is consistent with the current methodology.

We currently do not believe that there is evidence that the BHP population would have better or poorer health status than the Exchange population. At this time, there is a lack of experience available in the Exchange that limits the ability to analyze the health differences between these groups of enrollees. Exchanges have been in operation since 2014, and 2 states have operated BHP in 2015, but we do not have the data available to do the analysis necessary to make this adjustment at this time. In addition, differences in population health may vary across states. Thus, at this time, we believe that it is not feasible to develop a methodology to make a prospective adjustment to the population health factor that is reliably accurate.

Given these analytic challenges and the limited data about Exchange coverage and the characteristics of BHP-eligible consumers that will be available by the time we establish Federal payment rates for 2017 and 2018, we believe that the most appropriate adjustment for 2017 and 2018 would be 1.00.

In the 2015 and 2016 payment methodologies, we included an option for states to include a retrospective population health status adjustment. Similarly, for the 2017 and 2018 payment methodology we will provide states with the same option, as described further in section III.G of this methodology, to include a retrospective population health status adjustment in the certified methodology, which is subject to our review and approval. (Regardless of whether a state elects to include a retrospective population health status adjustment, 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.)

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, we will not require that a BHP program's standard health plans receive such payments. As explained in the BHP final 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.

3. 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 BHP payment methodology incorporates income into the calculations of the payment rates through the use of income-based rate cells. The use and determination of income is consistent with the current methodology. We will define 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 will be measured relative to the FPL, which is updated periodically in the **Federal Register** by the Secretary 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 this methodology, household size and income as a percentage of FPL will be used as factors in developing the rate cells. We will use 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 will assume a uniform income distribution for each Federal BHP payment cell. We believe that assuming a uniform income distribution for the income ranges will 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 will calculate the value of the PTC at each 1 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 in section III.4 of this methodology.

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 will adjust the FPL by multiplying the FPL by a projected increase in the CPI–U between the time that the BHP payment rates are calculated and the QHP open enrollment period, if the FPL is expected to be updated during that time. The projected increase in the CPI–U will be based on the intermediate inflation forecasts from the most recent OASDI and Medicare Trustees Reports.[7]

4. Premium Tax Credit Formula (PTCF)

As is consistent with the current methodology, in Equation 1 described in section III.A.1 of this methodology, we will 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 contribution amount (the

[5] See 45 CFR 153.400(a)(2)(iv) (BHP standard health plans are not required to submit reinsurance contributions), 45 CFR 153.20 (definition of ''Reinsurance-eligible plan'' as not including ''health insurance coverage not required to submit reinsurance contributions''), and 45 CFR 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 in this methodology.

[7] See Table IV A1 from the 2015 reports in *http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2015.pdf.*

amount of premium that an individual or household theoretically would be required to pay for coverage in a QHP on an Exchange), which is based on (A) the household income; (B) the household income as a percentage of FPL for the family size; and (C) the schedule specified in 26 U.S.C. 36B(b)(3)(A) and shown below in this section. The difference between the contribution amount 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). The amount is equal to the lesser of the premium for the plan in which the person or household enrolls, or the adjusted premium for the applicable second lowest cost silver plan minus the contribution amount.

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 Table 1, increasing on a sliding scale in a linear manner from an initial premium percentage to a final premium percentage specified in Table 1. The methodology is unchanged, but we will update the percentages:

TABLE 1—APPLICABLE PERCENTAGE TABLE FOR CY 2016 [8]

| In the case of household income (expressed as percent of poverty line) within the following income tier: | The initial premium percentage is— | The final premium percentage is— |
|---|---|---|
| Up to 133% | 2.03% | 2.03% |
| 133% but less than 150% | 3.05 | 4.07 |
| 150% but less than 200% | 4.07 | 6.41 |
| 200% but less than 250% | 6.41 | 8.18 |
| 250% but less than 300% | 8.18 | 9.66 |
| 300% but not more than 400% | 9.66 | 9.66 |

These are the applicable percentages for calendar year (CY) 2016 and will be used for the 2017 payment methodology. We plan to use the CY 2017 percentages when they become available for the 2018 payment methodology, as the percentages are indexed annually and published by the IRS. The applicable percentages will be updated in future years in accordance with 26 U.S.C. 36B (b)(3)(A)(ii).

5. Income Reconciliation Factor (IRF)

For persons enrolled in a QHP through an Exchange who receive the benefit of advance payments of the premium tax credit (APTC), there will be an annual reconciliation following the end of the year to compare the advance payments 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 advance payments made during the year would either be refundable to the taxpayer (if too little APTC was paid) or charged to the taxpayer as additional tax (if too much APTC was made, 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 an individual eligible for BHP may not be treated as a qualified individual under section 1312 eligible for enrollment in a QHP offered through an Exchange. We are defining ''eligible'' to mean anyone for whom the state agency or the Exchange assesses or determines, based on the single streamlined application or renewal form, as eligible for enrollment in the BHP. Because enrollment in a QHP is a requirement for PTC for the enrolled individual's coverage, individuals determined or assessed as eligible for a BHP are not eligible to receive APTC assistance for coverage in the Exchange. Because they do not receive APTC assistance, BHP enrollees, on whom the 2017 and 2018 payment methodology is based, 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 APTC assistance.

Therefore, in accordance with current practice, we will include 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 § 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 will prospectively account for the average effect of income reconciliation aggregated across the BHP population had those BHP enrollees been subject to tax reconciliation after receiving APTC assistance for coverage provided through QHPs. For 2017 and 2018, we will estimate the reconciliation effects based on tax data for 2 years, reflecting income and tax unit composition changes over time among BHP-eligible individuals.

The OTA maintains a model that combines detailed tax and other data, including Marketplace enrollment and PTC claimed, to project Exchange premiums, enrollment, and tax credits. For each enrollee, this model compares the APTC based on household income

[8] IRS Revenue Procedure 2014–56, 2014–50 I.R.B. 948, Examination of returns and claims for refund, credit, or abatement; determination of correct tax liability. *http://www.irs.gov/pub/irs-drop/rp-14-62.pdf.*

and family size 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 and tax data furnished by the IRS. 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 PTC to the initial estimation of PTC will be used as the income reconciliation factor in Equation (1) for estimating the PTC portion of the BHP payment rate.

For 2017, OTA has estimated that the income reconciliation factor for states that have implemented the Medicaid eligibility expansion to cover adults up to 133 percent of the FPL will be 100.40 percent, and for states that have not implemented the Medicaid eligibility expansion and do not cover adults up to 133 percent of the FPL will be 100.35 percent. The value of the income reconciliation factor for 2017 will be 100.38 percent, which is the average of the factors, rounded to the nearest hundredth of one-percent.

6. Tobacco Rating Adjustment Factor (TRAF)

As described previously, the RP 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 described in 45 CFR 156.430, the CSR component of the advance payments is based on the total premium for a policy, including any adjustment for tobacco use. Accordingly, we will 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. The use and determination of this factor is consistent with the current methodology.

To estimate the average effect of tobacco use on health care costs (not reflected in the premium charged to non-users), we will 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 will use data from the Centers for Disease Control and Prevention (CDC) to estimate tobacco utilization rates by state and relevant population characteristic.[9] For each state, we will calculate the tobacco usage rate based on the percentage of persons by age who use cigarettes and the percentage of persons by age that use smokeless tobacco, and calculate the utilization rate by adding the 2 rates together. The data is available for 3 age intervals: 18–24; 25–44; and 45–64. For the BHP payment rate cell for persons ages 21–34, we will calculate the factor as (4/14 * the utilization rate of 18–24 year olds) plus (10/14 * the utilization rate of 25–44 year olds), which will be the weighted average of tobacco usage for persons 21–34 assuming a uniform distribution of ages; for all other age ranges used for the rate cells, we will use the age range in the CDC data in which the BHP payment rate cell age range is contained.

We will provide tobacco rating factors that may vary by age and by geographic area within each state. To the extent that the second lowest cost silver plans have a different ratio of tobacco user rates to non-tobacco user rates in different geographic areas, the tobacco rating adjustment factor may differ across geographic areas within a state. In addition, to the extent that the second lowest cost silver plan has a different ratio of tobacco user rates to non-tobacco user rates by age, or that there is a different prevalence of tobacco use by age, the tobacco rating adjustment factor may differ by age.

7. Factor for Removing Administrative Costs (FRAC)

The Factor for Removing Administrative Costs represents the average proportion of the total premium that covers allowed health benefits, and we will include this factor in our calculation of estimated CSRs in Equation 2. The product of the RP and the Factor for Removing Administrative Costs will approximate the estimated amount of Essential Health Benefit (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 will set this factor equal to 0.80, which is the same percentage for the factor to remove administrative costs for calculating the CSR component of advance payments for established in the 2016 HHS Notice of Benefit and Payment Parameters. This is consistent with the current methodology.

8. 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 § 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 x 0.70) for health care costs per enrollee.) By dividing such estimated costs by the actuarial value in the methodology, we will 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 will use the standard actuarial value of the silver level plans in the individual market, which is equal to 70 percent. This is consistent with the current methodology.

9. Induced Utilization Factor (IUF)

The induced utilization factor will be used 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. This is consistent with the current methodology.

The 2016 HHS Notice of Benefit and Payment Parameters provided induced utilization factors for the purposes of calculating the cost-sharing reduction component of advance payments for 2016. In that Notice, the induced utilization factors for silver plan variations ranged from 1.00 to 1.12, depending on income. Using those utilization factors, the induced utilization factor for all persons who would 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 American Indians and Alaska Natives with household income

[9] Centers for Disease Control and Prevention, *Tobacco Control State Highlights 2012: http://www.cdc.gov/tobacco/data_statistics/state_data/state_highlights/2012/index.htm.*

between 100 and 300 percent of FPL, not subject to any cost-sharing. Thus, consistent with last year, we will set the induced utilization factor equal to 1.12 for the BHP payment methodology.

We note that for CSRs for QHPs, there will be a final reconciliation at the end of the year and the actual level of induced utilization could differ from the factor used in the rule. This methodology for BHP funding does not include any reconciliation for utilization.

10. Change in Actuarial Value (ΔAV)

The increase in actuarial value will account for the impact of the CSR subsidies on the relative amount of EHB claims that would be covered for or paid by eligible persons, and it is included as a factor in calculating estimated CSRs in Equation 2. This is consistent with the current methodology.

The actuarial values of QHPs for persons eligible for CSR subsidies are defined in § 156.420(a), and eligibility for such subsidies is defined in § 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 will 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 will 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 will 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 will make adjustments to the payment methodology previously described to be consistent with the Exchange rules. These adjustments are consistent with the current methodology.

We will make the following adjustments:

- The ARP for use in the CSR portion of the rate will use the lowest cost bronze plan instead of the second lowest cost silver plan, with the same adjustment for the population health factor (and in the case of a state that elects to use the 2016 or 2017 premiums as the basis of the Federal BHP payment, the same adjustment for the premium trend 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 applicable second lowest cost silver plan.)
- The actuarial value for use in the CSR portion of the rate will be 0.60 instead of 0.70, which is consistent with the actuarial value of a bronze level plan.
- The induced utilization factor for use in the CSR portion of the rate would be 1.15 for 2017 and 2018, which is consistent with the 2016 HHS Notice of Benefit and Payment Parameters induced utilization factor for calculating the CSR component of advance payments for persons enrolled in bronze level plans and eligible for CSRs up to 100 percent of actuarial value.
- The change in the actuarial value for use in the CSR portion of the rate will 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 with household incomes between 100 and 300 percent FPL are eligible to receive CSRs up to 100 percent of actuarial value.

*F. State Option To Use 2016 or 2017 QHP Premiums for BHP Payments*

In the interest of allowing states greater certainty in the total BHP Federal payments for 2017 or 2018, we will provide states the option to have their final 2017 and 2018 Federal BHP payment rates, respectively, calculated using the projected 2017 and 2018 ARP (that is, using 2016 or 2017 premium data multiplied by the premium trend factor defined below in this methodology), as described in Equation (3b). This approach and the determination of the premium trend factor is consistent with the current methodology.

For a state that would elect to use the 2016 or 2017 premiums as the basis for the 2017 and 2018 BHP Federal payments, respectively, we will require that the state inform us no later than May 15, 2016 for the 2017 program year and May 15, 2017 for the 2018 program year. (Our experience to date has been that states have elected to use the premium data that correlates to the year of payment. If this trend continues, we will consider in future payment notices whether to eliminate the choice of the premium from the prior year moving forward.)

For Equation (3b), we define the premium trend factor, with minor changes in calculation sources and methods, as follows:

Premium Trend Factor (PTF): In Equation (3b), we calculate an ARP based on the application of certain relevant variables to the ARP, including a premium trend factor (PTF). In the case of a state that would elect to use the 2016 or 2017 premiums as the basis for determining the BHP payment, 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 define this as the premium trend factor in the BHP payment methodology. This factor will approximate the change in health care costs per enrollee, which would include, but not be limited to, changes in the price of health care services and changes in the utilization of health care services. This will provide an estimate of the adjusted monthly premium for the applicable second lowest cost silver plan that will be more accurate and reflective of health care costs in the BHP program year, which would be the year following issuance of the final Federal payment notice. In addition, we believe that it would be appropriate to adjust the trend factor for the estimated impact of changes to the transitional reinsurance program on the average QHP premium.

For the trend factor we will use the annual growth rate in private health insurance expenditures per enrollee from the National Health Expenditure projections, developed by the Office of the Actuary in CMS (*https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html,* Table 17). For 2017, the projected increase in private health insurance premiums per enrollee is 4.4 percent.

The adjustment for changes in the transitional reinsurance program is developed from analysis by CMS' Center for Consumer Information and Insurance Oversight (CCIIO). In unpublished analysis, CCIIO estimated that the end of the transitional reinsurance program in 2016 would contribute 4.0 percent to QHP premium increases between 2016 and 2017.

Combining these 2 factors together, we calculate that the premium trend factor for 2017 would be 8.6 percent $(1 + 0.044) \times (1 + 0.040) - 1 = 8.6$ percent.

States may want to consider that the increase in premiums for QHPs from 2016 to 2017 or from 2017 to 2018 may differ from the premium trend factor developed for the BHP funding methodology for several reasons. In particular, states may want to consider that the second lowest cost silver plan for 2016 or 2017 may not be the same as the second lowest cost silver plan in 2017 or 2018, respectively. This may lead to the premium trend factor being greater than or less than the actual change in the premium of the second lowest cost silver plan in 2016 compared to the premium of the second lowest cost silver plan in 2017 (or from 2017 to 2018).

### *G. State Option To Include Retrospective State-Specific Health Risk Adjustment in Certified Methodology*

To determine whether the potential difference in health status between BHP enrollees and consumers in the Exchange would affect the PTC, CSRs, risk adjustment and reinsurance payments that would have otherwise been made had BHP enrollees been enrolled in coverage on the Exchange, we will continue to provide states implementing the BHP the option to propose and to implement, as part of the certified methodology, a retrospective adjustment to the Federal BHP payments to reflect the actual value that would be assigned to the population health factor (or risk adjustment) based on data accumulated during program years 2017 and 2018 for each rate cell. This is consistent with the approach in the current methodology.

We acknowledge that there is uncertainty for this factor due to the lack of experience of QHPs on the Exchange and other payments related to the Exchange, which is why, absent a state election, we will use a value for the population health factor to determine a prospective payment rate which assumes no difference in the health status of BHP enrollees and QHP enrollees. There is considerable uncertainty regarding whether the BHP enrollees will pose a greater risk or a lesser risk compared to the QHP enrollees, how to best measure such risk, and the potential effect such risk would have had on PTC, CSRs, risk adjustment and reinsurance payments that would have otherwise been made had BHP enrollees been enrolled in coverage on the Exchange. To the extent, however, that a state would develop an approved protocol to collect data and effectively measure the relative risk and the effect on Federal payments, we will permit a retrospective adjustment that would measure the actual difference in risk between the 2 populations to be incorporated into the certified BHP payment methodology and used to adjust payments in the previous year.

For a state electing the option to implement a retrospective population health status adjustment, we will require the state to submit a proposed protocol to CMS, which would be subject to approval by us and would be required to be certified by the Chief Actuary of CMS, in consultation with the Office of Tax Analysis, as part of the BHP payment methodology. We describe the protocol for the population health status adjustment in guidance in *Considerations for Health Risk Adjustment in the Basic Health Program in Program Year 2015* (*http://www.medicaid.gov/Basic-Health-Program/Downloads/Risk-Adjustment-and-BHP-White-Paper.pdf*). We will require a state to submit its proposed protocol by August 1, 2016 for our approval for the 2017 program year, and by August 1, 2017 for the 2018 program year. This submission would also include descriptions of how the state would collect the necessary data to determine the adjustment, including any contracting contingences that may be in place with participating standard health plan issuers. We will provide technical assistance to states as they develop their protocols. To implement the population health status, we must approve the state's protocol no later than December 31, 2016 for the 2017 program year, and by December 31, 2017 for the 2018 program year. Finally, we will require that the state complete the population health status adjustment at the end of 2017 (or 2018) based on the approved protocol. After the end of the 2017 and 2018 program years, and once data is made available, we will review the state's findings, consistent with the approved protocol, and make any necessary adjustments to the state's Federal BHP payment amounts. If we determine that the Federal BHP payments were less than they would have been using the final adjustment factor, we would apply the difference to the state's next quarterly BHP trust fund deposit. If we determine that the Federal BHP payments were more than they would have been using the final reconciled factor, we would subtract the difference from the next quarterly BHP payment to the state.

## IV. Collection of Information Requirements

This 2017 and 2018 methodology is mostly unchanged from the 2016 final notice published on February 24, 2015 (80 FR 9636). For states that have BHP enrollees who do not file Federal tax returns (''non-filers''), this methodology notice clarifies that the state must develop a methodology to determine the enrollee's household income and household size consistent with Exchange requirements. Since the requirement applies to fewer than 10 states, and states would not reasonably be expected to transmit the methodology to any independent entities (5 CFR 1320.3(c)(4)) the 2017 and 2018 methodology does not require additional OMB review under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*). Otherwise, the methodology's information collection requirements and burden estimates are not affected by this action and are approved by OMB under control number 0938–1218 (CMS–10510). With regard to state elections, protocols, certifications, and status adjustments, this action would not revise or impose any additional reporting, recordkeeping, or third-party disclosure requirements or burden on qualified health plans or on states operating State Based Exchanges.

## V. Regulatory Impact Statement

### *A. Overall Impact*

We have examined the impacts of this methodology 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 Act, section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4, March 22, 1995) (UMRA), 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 final 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. Because we make no changes in methodology that would have a consequential effect on state participation incentives, or on the size of either the BHP program or offsetting PTC and CSR expenditures, the effects of the changes made in this methodology notice would not approach the $100 million threshold, and hence it is neither an economically significant rule under E.O. 12866 nor a major rule under the Congressional Review Act. The size of the BHP program depends on several factors, including the number of and which particular states choose to implement or continue BHP in 2017 or 2018, the level of QHP premiums in 2016 and 2017, the number of enrollees in BHP, and the other coverage options for persons who would be eligible for BHP. In particular, while we generally expect that many enrollees would have otherwise been enrolled in a QHP through the Exchange, some persons may have been eligible for Medicaid under a waiver or a state health coverage program. For those who would have enrolled in a QHP and thus would have received PTCs or CSRs, the Federal expenditures for BHP would be expected to be more than offset by a reduction in Federal expenditures for PTCs and CSRs. For those who would have been enrolled in Medicaid, there would likely be a smaller offset in Federal expenditures (to account for the Federal share of Medicaid expenditures), and for those who would have been covered in non-Federal programs or would have been uninsured, there likely would be an increase in Federal expenditures. None of these factors or incentives would be materially affected by the updates we have made here.

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

1. Need for the Final Methodology Notice

Section 1331 of the Affordable Care Act (codified at 42 U.S.C. 18051) requires the Secretary to establish a BHP, and paragraph (d)(1) specifically provides that if the Secretary finds that a state meets the requirements of the program established under section (a) [of section 1331 of the Affordable Care Act], the Secretary shall transfer to the State Federal BHP payments described in paragraph (d)(3). This methodology provides for the funding methodology to determine the Federal BHP payment amounts required to implement these provisions in program years 2017 and 2018.

2. Alternative Approaches

Many of the factors used in this notice 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 methodology. Except for state-specific RPs and enrollment data, we are 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 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. In many cases, using state-specific data would necessitate additional requirements on the states to collect, validate, and report data to CMS. By using national data, we are able to collect data from other sources and limit the burden placed on the states. To RPs and enrollment data, we are using state-specific data rather than national data as we believe state-specific data will produce more accurate determinations than national averages.

In addition, we considered whether or not to provide states the option to develop a protocol for a retrospective adjustment to the population health factor in 2017 and 2018 as we did in the 2015 and 2016 payment methodologies. We believe that providing this option again in 2017 and 2018 is appropriate and likely to improve the accuracy of the final payments.

We also considered whether or not to require the use of 2017 and 2018 QHP premiums to develop the 2017 and 2018 Federal BHP payment rates. We believe that the payment rates can still be developed accurately using either the 2016 and 2017 QHP premiums (for the 2017 and 2018 program years, respectively) or the 2017 and 2018 program year premiums and that it is appropriate to provide the states the option, given the interests and specific considerations each state may have in operating the BHP.

3. Transfers

The provisions of this notice are designed to determine the amount of funds that will be transferred to states offering coverage through a BHP rather than to individuals eligible for Federal financial assistance 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 RP 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 methodology, like the methodology used in 2015 and 2016, accounts for these variations to ensure accurate BHP payment transfers are made to each state.

*B. Unfunded Mandates Reform Act*

Section 202 of the 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 2015, that threshold is approximately $144 million. States have the option, but are not required, to establish a BHP. Further, the 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, neither this payment methodology nor the methodologies used in 2015 and 2016 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 a final regulatory flexibility analysis to describe the impact of the final 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 methodology.

Because this methodology is focused solely on Federal BHP payment rates to states, it does not contain provisions that would have a direct impact on hospitals, physicians, and other health care providers that are designated as small entities under the RFA. Accordingly, we have determined that the methodology, like the previous methodology and the final rule that established the BHP program, will not have a significant economic impact on a substantial number of small entities.

Section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a methodology 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. For the preceding reasons, we have determined that the methodology will not have a significant impact on a substantial number of small rural hospitals.

*D. Federalism*

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a 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. Accordingly, the requirements of the Executive Order do not apply to this final methodology notice.

Dated: January 6, 2016.

**Andrew M. Slavitt,**

*Acting Administrator, Centers for Medicare & Medicaid Services.*

Dated: February 10, 2016.

**Sylvia Burwell,**

*Secretary, Department of Health and Human Services.*

[FR Doc. 2016–03902 Filed 2–25–16; 4:15 pm]

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## FEDERAL COMMUNICATIONS COMMISSION

### 47 CFR Parts 25, 73, and 76

**[MB Docket No. 14–127; FCC 16–4]**

### Expansion of Online Public File Obligations to Cable and Satellite TV Operators and Broadcast and Satellite Radio Licensees

**AGENCY:** Federal Communications Commission.

**ACTION:** Final rule.

**SUMMARY:** In this document, the Commission expand the list of entities that will be required to post their public inspection files to the FCC's online database. In 2012, the Commission adopted online public file rules that required broadcast television stations to post public file documents to a central, FCC-hosted online database rather than maintaining paper files locally at their main studios. Our goals were to modernize the procedures television broadcasters use to inform the public about how they are serving their communities, to make information concerning broadcast service more accessible to the public, and, over time, to reduce the cost of broadcasters' compliance. This final rule document continues our modernization effort by expanding the online file to other media entities to extend the benefits of improved public access to public inspection files and, ultimately, reduce the burden of maintaining these files.

**DATES:** Effective February 29, 2016, except for the amendments to 47 CFR 25.701, 25,702, 73.1943, 73.3526, 73.3527, 73.3580, 76.630, 76.1700, 76.1702, and 76.1709 which contain information collection requirements that have not been approved by OMB. The Commission will publish a document in the **Federal Register** announcing the effective date.

**FOR FURTHER INFORMATION CONTACT:** Kim Matthews, Media Bureau, Policy Division, 202–418–2154, or email at *kim.matthews@fcc.gov.*

**SUPPLEMENTARY INFORMATION:** This is a summary of the Commission's Report and Order, FCC 16–4, adopted on January 28, 2016 and released on January 29, 2016. The full text of this document is available for public inspection and copying during regular business hours in the FCC Reference Center, Federal Communications Commission, 445 12th Street SW., Room CY–A257, Washington, DC 20554. This document will also be available via ECFS at *http://fjallfoss.fcc.gov/ecfs/.* Documents will be available electronically in ASCII, Microsoft Word, and/or Adobe Acrobat. Alternative formats are available for people with disabilities (Braille, large print, electronic files, audio format), by sending an email to *fcc504@fcc.gov* or calling the Commission's Consumer and Governmental Affairs Bureau at (202) 418–0530 (voice), (202) 418–0432 (TTY).

**Paperwork Reduction Act of 1995 Analysis**

This *Report and Order* contains new or modified information collection requirements subject to the Paperwork Reduction Act of 1995 (PRA).[1] The requirements will be submitted to the Office of Management and Budget (OMB) for review under section 3507(d) of the PRA. OMB, the general public, and other Federal agencies will be invited to comment on the new or modified information collection requirements contained in this proceeding. In addition, we note that pursuant to the Small Business Paperwork Relief Act of 2002, we previously sought specific comment on how the Commission might further reduce the information collection burden for small business concerns with fewer than 25 employees.

**Summary of Report and Order**

**I. Introduction**

1. In this *Report and Order,* we expand the list of entities that will be required to post their public inspection files to the FCC's online database. In 2012, the Commission adopted online public file rules that required broadcast television stations to post public file documents to a central, FCC-hosted online database rather than maintaining paper files locally at their main studios. *Standardized and Enhanced Disclosure Requirements for Television Broadcast Licensee Public Interest Obligations, Second Report and Order,* 77 FR 27631, May 11, 2012 (''*Second Report and Order*''). Our goals were to modernize the procedures television broadcasters

[1] The Paperwork Reduction Act of 1995 (PRA), Public Law 104–13, 109 Stat. 163 (1995) (codified in Chapter 35 of title 44 U.S.C.).