Flooding source(s)	Location of referenced elevation**	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground ∧ Elevation in meters (MSL)		Communities affected
		Effective	Modified	

City of Altoona
Maps are available for inspection at City Hall, 1301 12th Street, Suite 300, Altoona, PA 16601.

Township of Allegheny
Maps are available for inspection at the Allegheny Township Building, 3131 Colonial Drive, Duncansville, PA 16635.

Township of Freedom
Maps are available for inspection at the Freedom Township Building, 131 Municipal Street, East Freedom, PA 16637.

Township of Huston
Maps are available for inspection at the Huston Township Office, 1538 Sportsman Road, Martinsburg, PA 16662.

Township of Logan
Maps are available for inspection at the Logan Township Building, 100 Chief Logan Circle, Altoona, PA 16602.

Township of Snyder
Maps are available for inspection at the Snyder Township Building, 108 Baughman Hollow Road, Tyrone, PA 16686.

Township of Taylor
Maps are available for inspection at the Taylor Township Municipal Building, 1002 Route 36, Roaring Spring, PA 16673.

Township of Woodbury
Maps are available for inspection at the Woodbury Township Building, 6385 Clover Creek Road, Williamsburg, PA 16693.

(Catalog of Federal Domestic Assistance No. 97.022, "Flood Insurance.")

Dated: January 24, 2011.

Sandra K. Knight,

Deputy Federal Insurance and Mitigation Administrator, Mitigation, Department of Homeland Security, Federal Emergency Management Agency.

[FR Doc. 2011–2281 Filed 2–1–11; 8:45 am]

BILLING CODE 9110–12–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Part 170

[OCIIO–9983–NC; Docket No. THE SECRETARY–OS–2010–0034]

RIN 0950–AA19

Planning and Establishment of Consumer Operated and Oriented Plan Program; Request for Comments Regarding Provisions of Consumer Operated and Oriented Plan Program

AGENCY: Office of Consumer Information and Insurance Oversight, Department of Health and Human Services.

ACTION: Request for comments.

SUMMARY: This document is a request for comments regarding the provisions of section 1322 of the Patient Protection and Affordable Care Act (the Affordable Care Act), enacted on March 23, 2010, which requires the Secretary to establish the Consumer Operated and Oriented Plan program. The Secretary of Health and Human Services invites public comments in advance of future rulemaking and grant and loan solicitations.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on March 4, 2011.

ADDRESSES: All comments will be made available to the public. WARNING: Do not include any confidential business information that you do not want publicly disclosed. All comments are posted on the Internet exactly as received, and can be retrieved by most Internet search engines. No deletions, modifications, or redactions will be made to the comments received, as they are public records.

In commenting, please refer to file code OCIIO–9983–NC. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission. You may submit comments using any of the following methods (please choose only one of the ways listed):

- *Electronically.* You may submit electronic comments to *http://www.regulations.gov.* Follow the instructions under the "More Search Options" tab.
- *Mail.* You may mail written comments to the following address ONLY: Office of Consumer Information and Insurance Oversight, Department of Health and Human Services, Attention: OCIIO–9983–NC, Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201. Please allow sufficient time for mailed comments to be received before the close of the comment period.
- *Hand or Courier.* If you prefer, you may deliver (by hand or courier) your written comments before the close of the comment period to the following address: Office of Consumer Information and Insurance Oversight, Department of Health and Human Services, Attention: OCIIO–9983–NC, Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201.

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

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

FOR FURTHER INFORMATION CONTACT: Catherine Halverson, Office of Consumer Information and Insurance Oversight, Department of Health and Human Services, at (301) 492–4391. *Customer Service Information:* Individuals interested in obtaining information about the Patient Protection and Affordable Care Act may visit the Secretary of Health and Human Services' Web site (*http://www.HealthCare.gov*).

SUPPLEMENTARY INFORMATION:

I. Background

Section 1322 of Patient Protection and Affordable Care Act (the Affordable Care Act) requires the Secretary to establish the Consumer Operated and Oriented Plan program (CO–OP program) to foster the creation of "qualified nonprofit health insurance issuers" (qualified nonprofit issuers) that will offer qualified health plans in the individual and small group markets. Such qualified nonprofit issuers must, as directed by the new law, operate with a strong consumer focus and use any profits to lower premiums, improve benefits, or improve the quality of health care delivered to plan members. For purposes of this document, "a CO–OP" refers to a qualified health plan offered by a qualified nonprofit issuer.

Under the CO–OP program, the Secretary will make loans to assist in funding start-up costs for qualified nonprofit issuers and will award grants (repayable in 15 years) to assist such issuers in meeting State solvency requirements. The Secretary must award the loans and grants and begin funding distribution no later than July 1, 2013. Loans must be repaid within 5 years and grants must be repaid within 15 years, taking into account State reserve requirements and solvency regulations.

The Affordable Care Act requires the Secretary to convene a Federal advisory board. This advisory board will offer recommendations to the Secretary on the awarding of loans and grants to emerging co-ops under Section 1322.

II. Solicitation of Comments

We are inviting public comment to aid in the development of regulations regarding this loan and grant program. To assist interested parties in responding, this request for comment describes various topics about which the Secretary is particularly interested in receiving public comments. Commenters should use the questions below to provide the Secretary with relevant information for the development of regulations regarding the CO–OP program. However, it is not necessary for commenters to address every question below, and commenters may also address additional issues related to the provisions for the CO–OP program in the Affordable Care Act. Individuals, groups, and organizations interested in providing comments may do so by following the instructions in the **ADDRESSES** section above.

Below, we summarize relevant statutory provisions and solicit public comment on the topics about which the Secretary is particularly interested.

A. Section 1322(a) of the Affordable Care Act

Section 1322(a) of the Affordable Care Act directs the Secretary to establish a program to foster, through grants and loans, the establishment of qualified nonprofit health insurance issuers. Substantially all of the activities of the qualified nonprofit issuers must be in the individual and small group markets. The issuers must be licensed in the State(s) in which they operate. The CO–OP program shall provide for the awarding of loans and grants to provide assistance for the establishment of qualified nonprofit issuers.

Section 1322(c) of the Affordable Care Act defines a "qualified nonprofit health insurance issuer" as one: (1) That is organized under State law as a nonprofit member corporation, (2) substantially all of the activities of which consist of the issuance of qualified health plans in the individual and small group markets, and (3) that meets other requirements of section 1322(c). To qualify for a loan or grant, the qualified nonprofit issuer (or a related entity or predecessor) must not have been a health insurance issuer on July 16, 2009 and must not be sponsored by a State or local government, any political subdivision thereof, or any instrumentality of such government or political subdivision. Section 1322(c)(4) provides that an organization cannot be a qualified nonprofit health insurance issuer unless any profits made by the organization are required to be used to lower premiums, to improve benefits, and for other programs intended to improve the quality of health care delivered to its members. Section 1322(e) provides that no representative of any Federal, State, or local government (or any political subdivision or instrumentality thereof), and no representative of a health insurance issuer or a related entity, may serve on the board of directors.

1. What is your assessment of the types of groups or organizations that would meet the criteria outlined above, and be successful in establishing durable qualified plans in the individual and small group markets? Do any organizations currently exist that would satisfy these statutory eligibility criteria for receiving a loan or grant under the CO–OP program? To what extent, and in what way, do funding needs of qualified nonprofit issuers that have already been established differ from the needs of those that have not been? How might funding needs differ for other groups or organizations that do not currently exist, but would be successful in establishing durable qualified plans in the individual and small group markets? How would such differences be considered in determining appropriate financing terms for Federal loans or grants?

2. What skills, background, and expertise should be required of the loan or grant applicant? What skills, background and expertise should be required of the management team of the qualified nonprofit issuer once the entity is operational (*e.g.*, experience in providing coverage)? What factors are most likely to lead to the successful operation and sustainability of a CO–OP?

3. What relationship with CO–OP enrollees would promote initial and continued enrollment, *e.g.,* service to a geographic community, a strong provider network, its health care mission, etc.?

4. What issues might a qualified nonprofit issuer face in developing provider networks in rural or other medical shortage areas?

5. How much time would a new qualified non-profit issuer need to establish a plan, become operational, begin to accept enrollment and provide health insurance coverage? What factors may affect the timeline necessary to become operational, and how?

6. What specific details should be required in feasibility studies, business plans, and marketing plans provided by prospective applicants before any loan or grant award is made? What should be included in the scope and content of these studies and plans? What level of detail should be required at the time of application?

7. What level of investment would be required by a qualified nonprofit issuer to develop sufficient administrative and claims processing information technology (IT) systems? Is there a minimum level of investment that would be required regardless of the size of enrollment? Does it vary according to enrollment size, geographic location, or other factors, and by how much? Are funding needs for this purpose different for any qualified nonprofit issuers that may already be in existence, and if so, in what way?

8. What level of investment would be required by a qualified nonprofit issuer to develop sufficient health information technology systems necessary to operate a health plan in the health insurance Exchange market, including the use of electronic health records? Is there a minimum level of investment that would be required regardless of the size of enrollment? Does it vary according to enrollment size, enrollee characteristics, or other factors, and by how much? Are funding needs for this purpose different for any qualified nonprofit issuers that

may already be in existence, and if so, in what way?

9. What is the range of funding necessary to capitalize and fund the establishment of a new qualified nonprofit issuer? How much of that amount can be raised privately, or funded through non-Federal government support? What factors should be considered in determining the appropriate amount of Federal loans and/or grants that would be needed to support the establishment of a new nonprofit health insurance issuer? To what extent do the funds needed to capitalize a qualified nonprofit issuer, and the degree of Federal support necessary likely to vary across issuers?

10. What level of investment is needed to maintain appropriate fiduciary management and oversight, including setting actuarially sound premiums?

11. Are you aware of any State laws that could create opportunities for or barriers to the formation of qualified nonprofit issuers? Do you think States are likely to create or amend licensure laws to accommodate the formation of qualified nonprofit issuers? Under what circumstances could regional qualified nonprofit issuers serving multiple states be formed? Is there a role for a federation of qualified nonprofit issuers to serve more than one state or region, with risk shared among the issuers? Would this approach be desirable for specific types of communities (for example, agricultural/rural communities)? How would such a federation be organized? How would it be capitalized? What are the advantages and disadvantages of a regional qualified nonprofit issuer or a regional federation of issuers? What barriers would need to be overcome? What would be the advantages of, and barriers to, serving a metropolitan area that crosses State lines?

12. While "substantially all" of a qualified nonprofit issuer's activities must be in the individual and small group markets, in what other markets or product lines, if any, would it be desirable for qualified nonprofit issuers to participate? For instance, could they participate in Medicaid or the Children's Health Insurance Program (CHIP) and still satisfy the statutory criteria for being a qualified nonprofit issuer? How difficult would it be for a new qualified nonprofit issuer to successfully participate in the small group market? How difficult would it be for a new qualified nonprofit issuer to successfully participate in the individual market? To what extent would participation in other markets affect the viability of new qualified nonprofit issuers or their ability to satisfy the statutory criteria for being a qualified nonprofit issuer? What type of start-up costs are necessary and reasonable for establishing a qualifying CO–OP? What startup costs might be associated with establishing a private purchasing council?

13. Are there other considerations that should inform what costs would be eligible for a CO–OP loan? Should there be limited time periods for which Federal loans for start-up costs may be available? Are there any start-up costs that would be incurred after the qualified nonprofit issuer begins to provide coverage under one or more plans?

14. What market factors would most likely affect a qualified nonprofit issuer's durability in the market? What factors should be considered in determining which issuers are likely to be viable in the long-term?

15. In evaluating applications for loans and grants, what actuarial and minimum plan enrollment criteria should be considered? What is the effect, if any, if providers are anticipated to bear risk? How would such criteria affect the financial soundness of the qualified issuer?

16. What types of technical assistance, if any, should the Secretary provide to grantees? How should such technical assistance be structured?

17. In what geographic areas are qualified nonprofit issuers most likely to be successful (*e.g.,* rural or metropolitan areas or certain regions of the country)?

18. How can qualified nonprofit issuers build provider networks? What strategies have proven effective?

19. What is the extent of interest in forming qualified nonprofit issuers under Section 1322 of the Affordable Care Act? In what State(s) or geographic region are these entities likely to be established?

B. Section 1322(b) of the Affordable Care Act

Section 1322(b) of the Affordable Care Act requires that the Secretary shall give priority to applicants that will offer qualified health plans on a statewide basis, utilize integrated care models, and have significant private support.

1. How should the term "integrated care model" be defined in the context of section 1322? How should the degree of integration and the degree to which integrated care is used be measured? Should qualified nonprofit issuers formed by primary care networks, even if they contract with secondary and tertiary providers, also be given priority for the award of a grant or loan? To what degree should priority be based on whether providers share risk?

2. How should "significant private support" be defined in this context?

3. What options for private support should qualified nonprofit issuers be able to pursue while maintaining nonprofit status? How can such support be structured to avoid inurnment to the benefit of non-members and protect the independence of consumer governance?

4. What types of organizations are most likely to be successful in meeting any or all of the statutory priority criteria?

C. Section 1322(b)(2)(a)(iii) of the Affordable Care Act

Section 1322(b)(2)(A)(iii) of the Affordable Care Act requires the Secretary to ensure that there is sufficient funding to establish at least one qualified nonprofit issuer in each State, except that nothing shall prevent the establishment of multiple issuers in a State if the funding is sufficient. Section 1322(b)(2)(B) provides that if no issuer applies to be a qualified nonprofit health insurance issuer in a State, the Secretary may use the amounts for the awarding of grants to encourage the establishment of an issuer or the expansion of another qualified nonprofit health insurance issuer from another State into the State where no issuer applied.

1. How can the Secretary best ensure sufficient funding to establish at least one qualified nonprofit issuer in each State?

2. How might the Secretary encourage the establishment of a CO–OP in a state without a qualified nonprofit issuer?

D. Section 1322(b)(C)(ii) of the Affordable Care Act

Section 1322(b)(C)(ii) of the Affordable Care Act restricts the use of loan and grant funds for (i) carrying out propaganda, or otherwise attempting to influence legislation, or (ii) for marketing.

1. How should the restriction on the use of federal funds for marketing be applied?

2. What other sources of financing for marketing would be available to qualified nonprofit issuers?

3. What accounting standards and metrics should be used to determine the sources of funding for marketing activities? If qualified nonprofit issuers did engage in these activities using non-federal funding, what rules should be in place to ensure federal funds are not used?

E. Section 1322(b)(2)(D) of the Affordable Care Act

Section 1322(b)(2)(D) of the Affordable Care Act requires the Secretary to award and begin the distribution of loans and grants not later than July 1, 2013.

1. To what extent is it necessary for new qualified nonprofit issuers to be operational by 2014 in order to be successful? How soon should grants or loans be distributed to establish qualified nonprofit issuers that can be operational in 2014?

2. How might funds be best allocated and, to what extent should distribution of loan funds be front-loaded to meet the statute's goal of establishing a CO–OP in each state?

3. Given the limited funding for this program, how long should draw down on grants and loans be permitted after the award date if loans and grants are not being utilized?

F. Section 1322(b)(3) of the Affordable Care Act

Section 1322(b)(3) of the Affordable Care Act requires that regulations regarding the repayment of loans and grants be "consistent with State solvency regulations and other similar State laws that may apply." Loans shall be repaid within 5 years and grants shall be repaid within 15 years, taking into consideration any appropriate State reserve requirements, solvency regulations, and requisite surplus note arrangements that must be constructed to provide for repayment prior to awarding loans/grants.

1. When developing a repayment schedule, how should HHS take into consideration state reserve requirements?

2. What factors will determine the ability of qualified nonprofit issuers to generate sufficient revenues to repay the loans and grants? How and when will such issuers likely develop sufficient revenues to start the repayment of grants provided to fund reserves?

3. What interim benchmarks after initial funding should the Secretary use to determine an issuer's ongoing likelihood of success and whether corrective actions, or other protective measures might be necessary with respect to loan and grant funds?

4. What data are available about the potential success and failure rate of nonprofit health plans who may apply for grants and loans? If data are not available, what proxy data would be useful to inform benchmarks, or other performance standards?

G. Section 1322(c)(2) of the Affordable Care Act

Section 1322(c)(2) of the Affordable Care Act provides that an organization shall not be treated as a qualified nonprofit issuer (and therefore shall not be qualified to apply for loans and grants under the CO–OP program) if the organization or a related entity (or a predecessor of either) was a health insurance issuer on July 16, 2009. Section 1322(c)(2) of the Affordable Care Act also provides that an organization shall not be treated as a qualified nonprofit issuer if it is sponsored by a State or local government, political subdivision thereof, or an instrumentality of such government or political subdivision.

1. What should and should not constitute a "related entity" or "predecessor" of a health insurance issuer for purposes of Section 1322 of the Affordable Care Act?

H. Section 1322(c)(3) of the Affordable Care Act

Section 1322(c)(3) of the Affordable Care Act requires that a qualified nonprofit issuer must be a nonprofit, member corporation and meet a number of governance requirements including the following:

- The governance of the organization must be subject to a majority vote of its members;
- Its governing documents must incorporate ethics and conflict of interest standards against insurance industry involvement and interference; and
- The organization is required to operate with a strong consumer focus, including timeliness, responsiveness, and accountability to members.

1. How can prospective applicants demonstrate a commitment to operating with a strong consumer focus, including responsiveness and accountability to members? How can prospective applicants demonstrate a commitment to responsiveness and accountability to members from diverse populations?

2. What type(s) of governance structure(s) should be required? What criteria should be used in determining who is eligible to be members of the organization and of the governing body? What type of characteristics should the governing body have to ensure consumer representation and involvement? What are the options for consumer governance, beyond electing the board of directors, that would most promote ongoing consumer engagement and responsiveness of the qualified nonprofit issuer to consumer needs?

I. Section 1322(c)(4) of the Affordable Care Act

Section 1322(c)(4) of the Affordable Care Act provides that an organization cannot be a qualified nonprofit health insurance issuer unless any profits made by the organization are required to be used to lower premiums, to improve benefits, and for other programs intended to improve the quality of health care delivered to its members.

1. How could the governance structure and type of organization help ensure that excess revenues are used for the benefit of members? What accounting standards and metrics should be used to determine how such funds are applied? Should such funds in one year be used to lower premiums in a subsequent year? What types of benefits might be considered? Should excess funds be used to prepay loans or grants, to allow for greater revenues/benefits to the members over time? Is this preferable to giving refunds to members for the year in which the profit was earned?

2. How should programs intended to improve the quality of care be defined and measured in this context?

J. Section 1322(c)(5) of the Affordable Care Act

Section 1322(c)(5) of the Affordable Care Act requires qualified nonprofit issuers to meet all the requirements that other issuers of qualified health plans are required to meet, including solvency and licensure requirements, rules on payments to providers, network adequacy rules, rate and form filing rules, any applicable State premium assessments and any other State laws described in section 1324(b).

1. Do any States permit newly-formed issuers (or plans) to meet these requirements incrementally over a period of time after enrollment and provision of health insurance coverage?

K. What other considerations should be addressed relating to the CO–OP program?

Please include in your comment letter any additional questions or comments you have about the CO–OP program.

Dated: January 26, 2011.

Marilyn Tavevnner,

Principal Deputy Administrator and Chief Operating Officer.

[FR Doc. 2011–2254 Filed 1–28–11; 4:15 pm]

BILLING CODE 4150–03–P