



DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 600

[CMS-2407-PN]

RIN 0938-ZB42

Basic Health Program; Federal Funding Methodology for Program Years 2019 and 2020

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

ACTION: Proposed methodology.

SUMMARY: This document proposes the methodology and data sources necessary to determine federal payment amounts to be made in program years 2019 and 2020 to states that elect to establish a Basic Health Program under the Patient Protection and Affordable Care Act to offer health benefits coverage to low-income individuals otherwise eligible to purchase coverage through Affordable Insurance Exchanges. Prior to the final notice being published, Basic Health Program (BHP) payments will be made using the methodology described in the Final Administrative Order published on August 24, 2018. Payments for 2019 will be conformed to the finalized 2019 payment methodology through reconciliation.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on [Insert date 30 days after date of publication in the **Federal Register**].

ADDRESSES: In commenting, refer to file code CMS-2407-PN. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

1. Electronically. You may submit electronic comments on this regulation to <http://www.regulations.gov>. Follow the "Submit a comment" instructions.
2. By regular mail. You may mail written comments to the following address ONLY:
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-2407-PN,
P.O. Box 8016,
Baltimore, MD 21244-8016.

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

3. By express or overnight mail. You may send written comments to the following address ONLY:

Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-2407-PN,
Mail Stop C4-26-05,
7500 Security Boulevard,
Baltimore, MD 21244-1850.

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

FOR FURTHER INFORMATION CONTACT:

Christopher Truffer, (410) 786-1264; or Cassandra Lagorio, (410) 786-4554.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period

are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following website as soon as possible after they have been received: <http://www.regulations.gov>. Follow the search instructions on that Web site to view public comments.

I. Background

A. Overview of the Basic Health Program

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 to as the Affordable Care Act) provides states with an option to establish a Basic Health Program (BHP). In the states that elect to operate a BHP, the 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)).

A BHP provides another option for states in providing affordable health benefits to individuals with incomes in the ranges described above. States may find a BHP a useful option for several reasons, including the ability to potentially coordinate standard health plans in the

BHP with their Medicaid managed care plans, or to potentially reduce the costs to individuals by lowering premiums or cost-sharing requirements.

Federal funding for a BHP under section 1331(d)(3)(A) of the Affordable Care Act is based on the amount of premium tax credit (PTC) and cost-sharing reductions (CSRs) that would have been provided for the fiscal year to eligible individuals enrolled in BHP standard health plans in the state if such eligible individuals were allowed to enroll in a qualified health plan (QHP) through Affordable Insurance Exchanges (“Exchanges”). These funds are paid to trusts established by the states and dedicated to the BHP, and the states then administer the payments to standard health plans within the 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 governs the establishment of BHPs. The BHP final rule establishes the standards for state and federal administration of BHPs, 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 BHPs, 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 funding methodology for the upcoming BHP program year,¹ 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 2019 would apply to BHP program year 2020, beginning in January 2020. As discussed in section II.C of this notice, and as referenced in 42 CFR 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)(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

¹ BHP program years span from January to December.

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 BHP Blueprint eligibility and verification methodologies in coverage through the state BHP. A state that is approved to implement a 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 persons in household enrolled in BHP;
- Family identifier;
- Months of coverage;
- Plan information; and
- Any other data required by CMS to properly calculate the payment.

B. 2018 Funding Methodology and Changes in Final Administrative Order

In the February 29, 2016 **Federal Register** (81 FR 10091), we published the final notice entitled "Basic Health Program; Federal Funding Methodology for Program Years 2017 and 2018" (hereinafter referred to as the February 2016 payment notice) that sets forth the methodology that would be used to calculate the federal BHP payments for the 2017 and 2018 program years. Updated factors for the program year 2018 federal BHP payments were provided

in the CMCS Informational Bulletin, “Basic Health Program; Federal Funding Methodology for Program Year 2018” on May 17, 2017.

On October 11, 2017, the Attorney General of the United States provided the Department of Health and Human Services and the Department of Treasury with a legal opinion indicating that the permanent appropriation at 31 U.S.C. 1324, from which the Departments had historically drawn funds to make CSR payments, cannot be used to fund CSR payments to insurers. In light of this opinion – and in the absence of any other appropriation that could be used to fund CSR payments – the Department of Health and Human Services directed us to discontinue CSR payments to issuers until Congress provides for an appropriation. In the absence of a Congressional appropriation for federal funding for CSRs, we cannot provide states with a federal payment attributable to CSRs that BHP enrollees would have received had they been enrolled in a QHP through an Exchange.

Starting with the payment for the first quarter (Q1) of 2018 (which began on January 1, 2018), we stopped paying the CSR component of the quarterly BHP payments to New York and Minnesota (the states), the only states operating a BHP in 2018. The states then sued the Secretary for declaratory and injunctive relief in the United States District Court for the Southern District of New York. *See State of New York, et al, v. U.S. Department of Health and Human Services*, 18-cv-00683 (S.D.N.Y. filed Jan. 26, 2018). On May 2, 2018, the parties filed a stipulation requesting a 60-day stay of the litigation so that HHS could issue an administrative order revising the 2018 BHP payment methodology. As a result of the stipulation, the court dismissed the BHP litigation, although it retained jurisdiction to enforce the stipulation and re-open the docket. On July 6, 2018, we issued a Draft Administrative Order on which New York and Minnesota had an opportunity to comment. The states each submitted comments on August 6, 2018. We considered the states’ comments and issued a Final Administrative Order

on August 24, 2018 setting forth the payment methodology that would only apply to the 2018 BHP benefit year. The payment methodology proposed in this notice would apply the methodology described in the Final Administrative Order with one additional adjustment to account for the impact of individuals selecting different metal-tier level plans in the Exchange. The payment methodology proposed in this notice would apply to program years 2019 and 2020.

We will be making future BHP payments for program year 2019 using the methodology described in the Final Administrative Order published on August 24, 2018 until a final methodology for 2019 and 2020 is published. If necessary, any payments for 2019 will be conformed to the finalized 2019 payment methodology through reconciliation.

II. Provisions of the Proposed Notice

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 advance payments of the PTC and CSRs, and by the Internal Revenue Service (IRS) to calculate final PTCs. In general, we have relied on values for factors in the payment methodology specified in statute or other regulations as available, and 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 PTCs and CSRs that would have been provided to eligible individuals, including but not limited to, 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 QHP through an Exchange, and whether any reconciliation of PTC and CSR would have occurred if the enrollee had been so enrolled. Under the payment methodologies for 2015 (79 FR 13887, published on March 12, 2014), for 2016 (80 FR 9636, published on February 24, 2015), and for 2017 and 2018 (81 FR 10091, published on February 29, 2016), the total federal BHP payment amount has been calculated using multiple rate cells in each state. Each rate cell represents a unique combination of age range, geographic area, coverage category (for example, self-only or two-adult coverage through the BHP), household size, and income range as a percentage of FPL, and there is a distinct rate cell 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. The BHP payment rates developed also are consistent with the state's rules on age rating. Thus, in the case of a state that does not use age as a rating factor on an Exchange, the BHP payment rates would not vary by age.

Under the methodology in the Final Administrative Order, the rate for each rate cell is calculated in two parts. The first part is equal to 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 an Exchange.

The second part is equal to 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 an Exchange. These 2 parts are added together and the total rate for that rate cell would be equal to the sum of the PTC and CSR rates. As noted in the Final Administrative Order, we will assign a value of zero to the CSR portion of the BHP payment rate calculation, because there is presently no available appropriation from which we can make the CSR portion of any BHP Payment.

We propose that Equation (1) would be used to calculate the estimated PTC for eligible individuals enrolled in the BHP in each rate cell. We note that throughout this 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 would effectively take those factors into account in the calculation. In addition, the equations would reflect the estimated experience of individuals in each rate cell if enrolled in coverage through an 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 this payment notice. In addition, we describe how we propose to calculate the adjusted reference premium (ARP) (described later in this section of the payment notice) that is used in Equation (1). This is defined in Equation (2a) and Equation (2b).

Equation 1: Estimated PTC by rate cell

We propose that the estimated PTC, on a per enrollee basis, would continue to be calculated for each rate cell for each state based on age range, geographic area, coverage category, household size, and income range. The PTC portion of the rate would be calculated in a manner consistent with the methodology used to calculate the PTC for persons enrolled in a

QHP, with 5 adjustments. First, the PTC portion of the rate for each rate cell would represent the mean, or average, expected PTC that all persons in the rate cell would receive, rather than being calculated for each individual enrollee. Second, the reference premium (RP) (described in more detail later in the section) used to calculate the PTC would be adjusted for the BHP population health status, and in the case of a state that elects to use 2018 premiums for the basis of the BHP federal payment, for the projected change in the premium from 2018 to 2019, to which the rates announced in the final payment methodology would apply. These adjustments are described in Equation (2a) and Equation (2b). Third, the PTC would be adjusted prospectively to reflect the mean, or average, net expected impact of income reconciliation on the combination of all persons enrolled in the BHP; this adjustment, as described in section II.D.5 of this notice, would account for the impact on the PTC that would have occurred had such reconciliation been performed. Fourth, the PTC would be adjusted to account for the estimated impacts of plan selection; this adjustment, the metal tier selection factor (MTSF), would reflect the effect on the average PTC of individuals choosing different metal-tier levels of QHPs. 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.

We propose using Equation (1) to calculate the PTC rate, consistent with the methodology described above:

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

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

$MTSF$ = Metal-tier selection factor

Equation 2a and Equation 2b: Adjusted Reference Premium (ARP) Variable (used in Equation 1)

As part of the calculations for the PTC component, we propose to continue to calculate the value of the ARP is described below. Consistent with the existing approach, we are proposing to allow states to choose between using the actual current year premiums or the prior year's premiums multiplied by the premium trend factor (PTF) (as described in section II.F. of this notice). Below we describe how we would continue to calculate the ARP under each option.

In the case of a state that elected to use the RP based on the current program year (for example, 2019 premiums for the 2019 program year), we propose to calculate the value of the ARP as specified in Equation (2a). The ARP would be equal to the RP, which would be based on the second lowest cost silver plan premium in the applicable program year, multiplied by the BHP population health factor (PHF) (described in section II.D of this notice), which would reflect the projected impact that enrolling BHP-eligible individuals in QHPs through an Exchange would have had on the average QHP premium, and multiplied by the premium adjustment factor (PAF) (described in section II.D of this notice), which would account for the

change in silver-level premiums due to the discontinuance of CSR payments.

$$\textbf{Equation (2a): } ARP_{a,g,c} = RP_{a,g,c} \times PHF \times PAF$$

$ARP_{a,g,c}$ = 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

PAF = Premium adjustment factor

In the case of a state that elected to use the RP based on the prior program year (for example, 2018 premiums for the 2019 program year, as described in more detail in section II.F of this notice), we propose to calculate the value of the ARP as specified in Equation (2b). The ARP would be equal to the RP, which would be based on the second lowest cost silver plan premium in 2018, multiplied by the BHP PHF (described in section II.D of this notice), which would reflect the projected impact that enrolling BHP-eligible individuals in QHPs on an Exchange would have had on the average QHP premium, multiplied by the PAF (described in section II.D of this notice), which would account for the change in silver-level premiums due to the discontinuance of CSR payments, and multiplied by the PTF (described in section II.E of this notice), which would reflect the projected change in the premium level between 2018 and 2019.

$$\textbf{Equation (2b): } ARP_{a,g,c} = RP_{a,g,c} \times PHF \times PAF \times PTF$$

$ARP_{a,g,c}$ = 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

PAF = Premium adjustment factor

PTF = Premium trend factor

Equation 3: Determination of Total Monthly Payment for BHP Enrollees in Each Rate

Cell

In general, the rate for each rate cell would be multiplied by the number of BHP enrollees in that cell (that is, the number of enrollees that meet the criteria for each rate cell) to calculate the total monthly BHP payment. This calculation is shown in Equation (3).

$$\text{Equation (3): } PMT = \sum [(PTC_{a,g,c,h,i} + CSR_{a,g,c,h,i}) \times E_{a,g,c,h,i}]$$

(In this equation, we assign a value of zero to the CSR part of the BHP payment rate calculation ($CSR_{a,g,c,h,i}$) because there is presently no available appropriation from which we can make the CSR portion of any BHP payment. In the event that an appropriation for CSRs for 2019 or 2020 is made, we would determine whether to modify the CSR part of the BHP payment rate calculation ($CSR_{a,g,c,h,i}$) or include the PAF in the payment methodology.)

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 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

Consistent with the previous payment methodologies, we propose that a state implementing a BHP provide us an estimate of the number of BHP enrollees it projects will enroll in the upcoming BHP program quarter, 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 would be used to calculate the prospective payment for the first and subsequent quarters of program operation until the state has provided us actual enrollment data. These data would be required to calculate the final BHP payment amount, and make any necessary reconciliation adjustments to the prior quarters' prospective payment amounts due to differences between projected and actual enrollment. Subsequent quarterly deposits to the state's trust fund would be based on the most recent actual enrollment data submitted to us. 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.

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

Factor 1--Age: We propose to continue separating enrollees into rate cells by age, using the following unchanged age ranges that capture the widest variations in premiums under HHS's

Default Age Curve:²

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

Factor 2--Geographic area: For each state, we propose separating enrollees into rate cells by geographic areas within which a single RP is charged by QHPs offered through the state's Exchange. Multiple, non-contiguous geographic areas would be incorporated within a single cell, so long as those areas share a common RP.³ This provision would also be unchanged from the current method.

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

² 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. The default age curve was updated for 2018 to include different age rating factors between children 0-14 and for persons at each age between 15 and 20. More information is available at <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Downloads/StateSpecAgeCrv053117.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>.

³ 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 QHPs, as described in 45 CFR 155.1055, except that service areas smaller than counties are addressed as explained below.

whether it involves children.

Factor 4--Household size: We propose to continue the current methods for separating enrollees into rate cells by household size that states use to determine BHP enrollees' household 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). We are proposing to require separate rate cells for several specific household sizes. For each additional member above the largest specified size, we propose to publish instructions for how we would develop additional rate cells and calculate an appropriate payment rate based on data for the rate cell with the closest specified household size. We propose to publish separate rate cells for household sizes of 1 through 10.

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

- 0 to 50 percent of the FPL.
- 51 to 100 percent of the FPL.
- 101 to 138 percent of the FPL.⁴
- 139 to 150 percent of the FPL.

⁴ The three lowest income ranges would be limited to lawfully present immigrants who are ineligible for Medicaid because of immigration status.

- 151 to 175 percent of the FPL.
- 176 to 200 percent of the FPL.

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

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

The number of factors contributing to rate cells, when combined, can result in over 350,000 rate cells which can increase the complexity when generating quarterly payment amounts. In future years, and in the interest of administrative simplification, we will consider whether to combine or eliminate certain rate cells, once we are certain that the effect on payment would be insignificant.

C. Sources and State Data Considerations

To the extent possible, we intend to continue to use data submitted to the federal government by QHP issuers seeking to offer coverage through the Exchange in the relevant BHP state to perform the calculations that determine federal BHP payment cell rates. We propose that the current methodology would not change, but we also propose clarifications regarding the

submission of state data in this section.

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. We propose that 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 30 days after the publication of the final notice for CMS to calculate the applicable rates for 2019, and by no later than October 15, 2019, for CMS to calculate the applicable rates for 2020. 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 us 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 enrollment data to us on a quarterly basis and should be technologically prepared to begin submitting data at the start of their BHP, starting with the beginning of the first program year. (This differs from the enrollment estimates used to calculate the initial BHP payment, which states would generally be submit to CMS 60 days before the start of the first quarter of the program start date.) This requirement is necessary for us to implement the payment methodology that is tied to a quarterly reconciliation based on actual enrollment data.

We propose to continue the policy adopted in the February 2016 payment notice that in 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 us at the time of their Blueprint submission to

determine the enrollees' household income and household size consistently with Marketplace requirements. We reserve the right to approve or disapprove the state's methodology to determine household income and household size for non-filers if the household composition and/or household income resulting from application of the methodology are different than what typically would be expected to result if the individual or head of household in the family were to file a tax return.

In addition, as the federal payments are determined quarterly and the enrollment data is required to be submitted by the states to us quarterly, we propose 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 the BHP in each quarter). Thus, if an enrollee were to experience a change in county of residence, household 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 would still be made only for months that the person is enrolled in and eligible for the BHP. We do not anticipate that this would have a significant effect on the federal BHP payment. The states must maintain data that are consistent with CMS' 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 a 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 BHP-eligible individuals enrolled in

QHPs through an 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 II.C.4 of this notice, regarding the Premium Tax Credit Formula (PTCF). The proposal is unchanged from the current method except to update the reference years, and to provide additional methodological details to simplify calculations and to deal with potential ambiguities. 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 that is offered through the same Exchange. We propose to use the adjusted monthly premium for an applicable second lowest cost silver plan in the applicable program year (2019 or 2020) as the RP (except in the case of a state that elects to use the prior plan year's premium as the basis for the federal BHP payment for 2019 or 2020, as described in section II.F of this notice).

The RP would be the premium applicable to non-tobacco users. This is consistent with the provision in 26 U.S.C. 36B(b)(3)(C) that bases the PTC on premiums that are adjusted for age alone, without regard to tobacco use, even for states that allow insurers to vary premiums based on tobacco use 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 an Exchange, we propose not to update the payment methodology, and subsequently the federal BHP payment rates, in the event that the second lowest cost silver plan used as the 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 the BHP.

We note that the choice of the second lowest cost silver plan for calculating BHP payments would rely on several simplifying assumptions in its selection. For the purposes of determining the second lowest cost silver plan for calculating PTC for a person enrolled in a QHP through an Exchange, the applicable plan may differ for various reasons. For example, a different second lowest cost silver plan may apply to a family consisting of 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 the aggregate, they would not result in a significant difference in the payment. Thus, we propose to use the second lowest cost silver plan available to any enrollee for a given age, geographic area, and coverage category.

This choice of RP relies on an assumption about enrollment in the Exchanges. In previous methodologies, we had assumed that all persons enrolled in the BHP would have elected to enroll in a silver level plan if they had instead enrolled in a QHP through an Exchange (and that the QHP premium would not be lower than the value of the PTC). While we propose to continue to use the second-lowest cost silver plan premium as the RP, we are proposing in this methodology to change the assumption about which metal-tier plans enrollees would choose (see the section on the metal-tier selection factor (MTSF) in this methodology).

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 QHP through an Exchange.

The applicable age bracket will be one dimension of each rate cell. We propose to assume a uniform distribution of ages and estimate the average premium amount within each rate cell. We believe that assuming a uniform distribution of ages within these ranges is a reasonable approach and would produce a reliable determination of the total monthly payment for BHP enrollees. We also believe this approach would avoid potential inaccuracies that could otherwise occur in relatively small payment cells if age distribution were measured by the number of persons eligible or enrolled.

We propose to use geographic areas based on the rating areas used in the Exchanges. We propose to define each geographic area so that the RP is the same throughout the geographic area. When the RP varies within a rating area, we propose 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, we propose that no geographic area, for purposes of defining BHP payment rate cells, will be smaller than a county. We do not believe that this assumption will have a significant impact on federal payment levels and it would likely simplify both the calculation of BHP payment rates and the operation of the BHP.

Finally, in terms of the coverage category, we propose that federal payment rates only recognize self-only and two-adult coverage, with exceptions that account for children who are potentially eligible for the 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 (MAGI), children in households with incomes between that threshold and 200 percent of FPL would be potentially eligible for the BHP. Currently, the only states in this category are Idaho and North Dakota.⁵ Second, the BHP would include lawfully present immigrant children with household incomes at or below 200 percent of FPL in states that have not exercised the

⁵ CMCS. "State Medicaid, CHIP and BHP Income Eligibility Standards Effective April 1, 2018."

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 a BHP, Idaho children with household 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 live in households with incomes at or below 200 percent of FPL will qualify for Medicaid or CHIP, and thus be ineligible for a BHP under section 1331 (e)(1)(C) of the Affordable Care Act, which limits a BHP to individuals who are ineligible for minimum essential coverage (as defined in section 5000A(f) of the Internal Revenue Code of 1986).

2. Premium Adjustment Factor (PAF)

The PAF considers the premium increases in other states that took effect after we discontinued payments to issuers for CSRs provided to enrollees in QHPs offered through Exchanges. Despite the discontinuance of federal payments for CSRs, QHPs are required to provide CSRs to eligible enrollees. As a result, QHPs frequently increased the silver-level plan premiums to account for those additional costs; adjustments and how those were applied (for example, to only silver-level plans or to all metal-tier plans) varied across states. For the states operating BHPs in 2018, the adjustments were relatively minor, because the majority of enrollees eligible for CSRs (and all who were eligible for the largest CSRs) were enrolled in the BHP and not in QHPs on the Exchanges.

In the Final Administrative Order, we incorporated the PAF into the BHP payment methodology for 2018. We propose to include this factor in the 2019 and 2020 payment methodologies, and to use the same value for the factor as in the Final Administrative Order.

Under the Final Administrative Order, we calculated the PAF for each BHP state by using information requested from QHP issuers in each state and the District of Columbia, and determined the premium adjustment that the responding QHP issuers made to each silver level plan in 2018 to account for the discontinuation of CSR payments to QHP issuers. Based on the data collected, we estimated the median adjustment for silver level QHPs nationwide (excluding those in the two BHP states). To the extent that QHP issuers made no adjustment (or the adjustment was 0), this would be counted as 0 in determining the median adjustment made to all silver level QHPs nationwide. If the amount of the adjustment was unknown—or we determined that it should be excluded for methodological reasons (for example, the adjustment was negative, an outlier, or unreasonable)—then we did not count the adjustment towards determining the median adjustment.⁶

For each of the two BHP states, we determined the median adjustment for all silver level QHPs in that state. The PAF for each BHP state equaled 1 plus the nationwide median adjustment divided by 1 plus the state median adjustment for the BHP state. In other words,

$$PAF = (1 + \textit{Nationwide Median Adjustment}) \div (1 + \textit{State Median Adjustment}).$$

To determine the PAF described above, we requested information from QHP issuers in each state serviced by a Federally-facilitated Exchange (FFE) to determine the premium adjustment those issuers made to each silver level plan offered through the Exchange in 2018 to account for the end of CSR payments. Specifically, we requested information showing the

⁶ Some examples of outliers or unreasonable adjustments include (but are not limited to) values over 100 percent (implying the premiums doubled or more as a result of the adjustment), values more than double the otherwise highest adjustment, or non-numerical entries.

percentage change that QHP issuers made to the premium for each of their silver level plans to cover benefit expenditures associated with the CSRs, given the lack of CSR payments in 2018. This percentage change was a portion of the overall premium increase from 2017 to 2018.

According to our records, there are 1,233 silver-level QHPs operating on Exchanges in 2018. Of these 1,233 QHPs, 318 QHPs (25.8 percent) responded to our request for the percentage adjustment applied to silver-level QHP premiums in 2018 to account for the discontinuance of the CSRs. These 318 QHPs operated in 26 different states, with 10 of those states running State-based Exchanges (SBEs), working in partnership with us to implement the FFE in their state in 2018. Thirteen of these 318 QHPs were in New York (and none were in Minnesota). Excluding these 13 QHPs from the analysis, the nationwide median adjustment was 20.0 percent. Of the 13 QHPs in New York that responded, the state median adjustment was 1.0 percent. We believe that this is an appropriate adjustment for QHPs in Minnesota as well, based on the observed changes in New York's QHP premiums in response to the CSR adjustment (and the operation of the BHP in that state) and our analysis of expected QHP premium adjustments for states with BHPs. We calculated the proposed PAF as $(1 + 20\%) \div (1 + 1\%)$ (or 1.20/1.01), which results in a value of 1.188.

We propose that the PAF continue to be set to 1.188 for 2019 and 2020. We believe that this value for the PAF continues to reasonably account for the increase in silver-level premiums experienced in non-BHP states that is associated with the discontinuance of the CSR payments. The impact can reasonably be expected to be similar to that in 2018, because the unavailability of CSR payments has not changed. We welcome comments on this factor and its development.

3. Population Health Factor (PHF)

We propose that the PHF be included in the methodology to account for the potential differences in the average health status between BHP enrollees and persons enrolled through the

Exchanges. To the extent that BHP enrollees would have been enrolled through an Exchange in the absence of a 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. Our proposal continues the methodology currently in place, except to update reference years.

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 Exchanges 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 BHPs in 2015, 2016, 2017, and 2018, 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 PHF that is reliably accurate, consistent with the methodology described in previous notices. We will consider updating the methodology in future years when information becomes available.

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, we believe that the most appropriate adjustment for 2019 would be 1.00. We also propose that the adjustment for 2020 would remain at 1.00.

In the previous BHP payment methodologies, we included an option for states to include a retrospective population health status adjustment. We propose that states be provided with the same option for 2019 and 2020 to include a retrospective population health status adjustment in the certified methodology, which is subject to our review and approval. This option is described further in section II.G of this notice. Regardless of whether a state elects to include a retrospective population health status adjustment, we anticipate that, in future years, when

additional data becomes available about Exchange coverage and the characteristics of BHP enrollees, we may estimate the PHF differently.

While the statute requires consideration of risk adjustment payments and reinsurance payments insofar as they would have affected the PTC that would have been provided to BHP-eligible individuals had they enrolled in QHPs, we are not proposing to require that a BHP'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.⁷ To the extent that a state operating a BHP determines that, because of the distinctive risk profile of BHP-eligible consumers, BHP standard health plans should be included in mechanisms that share risk with other plans in the state's individual market, the state would need to use other methods for achieving this goal.

4. Household Income (I)

Household income is a significant determinant of the amount of the PTC that is provided for persons enrolled in a QHP through an Exchange. Accordingly, both the current and proposed BHP payment methodologies incorporate household income into the calculations of the payment rates through the use of income-based rate cells. We propose defining household income in accordance with the definition of MAGI in 26 U.S.C. 36B(d)(2)(B) and consistent with the definition in 45 CFR 155.300. Income would be measured relative to the FPL, which is updated periodically in the **Federal Register** by the Secretary under the authority of 42 U.S.C. 9902(2),

⁷ See 45 CFR 153.400(a)(2)(iv) (BHP standard health plans are not required to submit reinsurance contributions), 153.20 (definition of "Reinsurance-eligible plan" as not including "health insurance coverage not required to submit reinsurance contributions"), 153.230(a) (reinsurance payments under the national reinsurance parameters are available only for "Reinsurance-eligible plans").

based on annual changes in the consumer price index for all urban consumers (CPI-U). In our proposed methodology, household size and income as a percentage of FPL would be used as factors in developing the rate cells. We propose using the following income ranges measured as a percentage of FPL:⁸

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

We further propose to assume a uniform income distribution for each federal BHP payment cell. We believe that assuming a uniform income distribution for the income ranges proposed would be reasonably accurate for the purposes of calculating the 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 the BHP within rate cells that may be relatively small.

Thus, when calculating the mean, or average, PTC for a rate cell, we propose to calculate the value of the PTC at each 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 II.D.4 of this notice.

As the advance payment of PTC (APTC) for persons enrolled in QHPs would be calculated based on their household income during the open enrollment period, and that income

⁸ These income ranges and this analysis of income apply to the calculation of the PTC. Many fewer income ranges and a much simpler analysis apply in determining the value of CSRs, as specified below.

would be measured against the FPL at that time, we propose to adjust the FPL by multiplying the FPL by a projected increase in the CPI-U between the time that the BHP payment rates are calculated and the QHP open enrollment period, if the FPL is expected to be updated during that time. We propose that the projected increase in the CPI-U would be based on the intermediate inflation forecasts from the most recent OASDI and Medicare Trustees Reports.⁹

5. Premium Tax Credit Formula (PTCF)

In Equation 1 described in section II.A.1 of this notice, we propose to use the formula described in 26 U.S.C. 36B(b) to calculate the estimated PTC that would be paid on behalf of a person enrolled in a QHP on an Exchange as part of the BHP payment methodology. This formula is used to determine the contribution amount (the 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. 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)

⁹ See Table IV A1 from the 2018 reports in <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2018.pdf>.

as the percentage that applies to a taxpayer’s household income that is within an income tier specified in Tables 1 and 2, increasing on a sliding scale in a linear manner from an initial premium percentage to a final premium percentage specified in Tables 1 and 2. We propose no changes to this methodology. The applicable percentages in Table 1 for calendar year (CY) 2018 would be effective for BHP program year 2019, and the applicable percentages in Table 2 for CY 2019 would be effective for BHP program year 2020.

TABLE 1: Applicable Percentage Table for CY 2018^a

In the case of household income (expressed as a percent of poverty line) within the following income tier:	The initial premium percentage is–	The final premium percentage is–
Up to 133%	2.01%	2.01%
133% but less than 150%	3.02%	4.03%
150% but less than 200%	4.03%	6.34%
200% but less than 250%	6.34%	8.10%
250% but less than 300%	8.10%	9.56%
300% but not more than 400%	9.56%	9.56%

^a IRS Revenue Procedure 2017-36. <https://www.irs.gov/pub/irs-drop/rp-17-36.pdf>.

TABLE 2: Applicable Percentage Table for CY 2019^b

In the case of household income (expressed as a percent of poverty line) within the following income tier:	The initial premium percentage is–	The final premium percentage is–
Up to 133%	2.08%	2.08%
133% but less than 150%	3.11%	4.15%
150% but less than 200%	4.15%	6.54%
200% but less than 250%	6.54%	8.36%
250% but less than 300%	8.36%	9.86%
300% but not more than 400%	9.86%	9.86%

^b IRS Revenue Procedure 2018-34. <https://www.irs.gov/pub/irs-drop/rp-18-34.pdf>.

The applicable percentages for CY 2018 (Table 1) would be used for the 2019 payment methodology, and the applicable percentages for CY 2019 (Table 2) would be used for the 2020 payment methodology. The applicable percentages will be updated in future years in accordance with 26 U.S.C. 36B (b)(3)(A)(ii).

6. Metal-Tier Selection Factor (MTSF)

On the Exchange, if an enrollee chooses a QHP and the value of the PTC is greater than the premium, then the PTC is reduced to be equal to the premium. This usually occurs when enrollees eligible for larger PTCs (generally those with lower household incomes or older

enrollees) choose bronze-level plans, which have the lowest premiums on the Exchange. Prior to 2018, we believed that the impact of these choices were relatively small on the amount of PTCs that the federal government paid. Most enrollees in income ranges up to 200 percent FPL chose silver-level plans, and in most cases where enrollees chose bronze-level plans, the premium was still more than the PTC. Therefore, we made no adjustment for enrollees choosing non-silver-level plans in developing the BHP payment methodology.

After the discontinuance of the CSR payments in October 2017, several changes occurred that increased the expected impact of enrollees' plan choices on the amount of PTC paid. Silver-level QHP premiums for the 2018 benefit year increased substantially relative to other metal-tier plans in many states (on average, by about 20 percent). We believe this contributed to an increase in the percentage of enrollees with lower incomes choosing bronze-level plans, despite being eligible for CSRs in silver-level plans, because many were able to purchase plans and pay \$0 in premium; according to CMS data, the percentage of persons with incomes between 0 percent and 200 percent of FPL eligible for CSRs (those who would be eligible for the BHP if the state operated a BHP) selecting bronze plans increased from about 11 percent in 2017 to about 13 percent in 2018. In addition, the likelihood that a person choosing a bronze-level plan would pay \$0 premium increased (and the difference between the bronze-level QHP premium and the available PTC widened). Between 2017 and 2018, the ratio of the average silver plan premium to the average bronze plan premium increased from about 117 percent to 133 percent; that is, the average silver plan premium was 17 percent higher than the average bronze plan premium in 2017, and the average silver plan premium was 33 percent higher than the average bronze plan premium in 2018. Similarly, the average estimated reduction in APTC for enrollees with incomes between 0 percent and 200 percent FPL that chose bronze plan increased from about 11 percent in 2017 to about 23 percent in 2018 (after adjusting for the average age of

bronze plan and silver plan enrollees); that is, in 2017, enrollees with incomes in this range who chose bronze plans received 11 percent less than the full value of the APTC, and in 2018, those enrollees who chose bronze plans received 23 percent less than the full value of the APTC. The discontinuance of the CSR payments led to increases in silver plan premiums (and thus in the total potential PTCs), but did not generally increase the bronze plan premiums in most states; we believe this is the primary reason for the increase in the percentage reduction in PTCs paid for those who enrolled in bronze plans between 2017 and 2018. Therefore, we now believe that the impacts on the amount of PTC the government would pay due to enrollees' plan choices are larger and thus more significant, and we are proposing to include an adjustment in the BHP payment methodology to account for this (the MTSF). Section 1331(d)(3) of the Affordable Care Act requires that the BHP payments to states be based on what would have been provided if such eligible individuals were allowed to enroll in QHPs, and we believe that it is appropriate to consider how individuals would have chosen different plans—including across different metal tiers—as part of the BHP payment methodology.

We propose to calculate the MTSF using the following approach. First, we would calculate the percentage of enrollees with incomes below 200 percent of the FPL (those who would be potentially eligible for the BHP) in non-BHP states who enrolled in bronze-level plans in 2018. Second, we would calculate the ratio of the average PTC paid for enrollees in this income range who selected bronze-level plans compared to the average PTC paid for enrollees in the same income range who selected silver-level plans. Both of these calculations would be done using CMS data on Exchange enrollment and payments.

The MTSF would then be set to the value of 1 minus the product of the percentage of enrollees who chose bronze-level plans and 1 minus the ratio of the average PTC paid for enrollees in bronze-level plans to the average PTC paid for enrollees in silver-level plans:

MTSF = 1 – (percentage of enrollees in bronze-level plans x (1 – average PTC paid for bronze-level enrollees / average PTC paid for silver-level enrollees))

We have calculated that 12.68 percent of enrollees in households with incomes below 200 percent of the FPL selected bronze-level plans in 2018, and that those enrollees received average PTCs equal to 76.66 percent of the average PTCs paid for enrollees in silver-level plans (the average PTC was 27.04 lower for those who selected bronze plans, but after adjusting for the average age of bronze and silver plans enrollees, the difference was reduced to 23.34 percent). Therefore, we propose that the value of the MTSF for 2019 would be 97.04 percent. We also propose to update this with 2019 data for 2020.

We welcome comments on this factor and the determination of the value.

7. Income Reconciliation Factor (IRF)

For persons enrolled in a QHP through an Exchange who receive 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 paid 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 the BHP may not be treated as a qualified individual under section 1312 who is 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 individuals to receive PTC, 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 BHP 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 household 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 household incomes of BHP enrollees during the year. Even if the BHP 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 propose including in Equation 1 an income adjustment factor that would account for the difference between calculating estimated PTC using: (a) household income relative to FPL as determined at initial application and potentially revised mid-year under § 600.320, for purposes of determining BHP eligibility and claiming federal BHP payments; and (b) actual household income relative to FPL received during the plan year, as it would be reflected on individual federal income tax returns. This adjustment would seek prospectively to capture the average effect of income reconciliation aggregated across the BHP population had those BHP enrollees been subject to tax reconciliation

after receiving APTC assistance for coverage provided through QHPs. Consistent with the methodology used in past years, we propose estimating 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 Exchange enrollment and PTC claimed, to project Exchange premiums, enrollment, and tax credits. For each enrollee, this model compares the APTC based on household income 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 the BHP. We propose that the ratio of the reconciled PTC to the initial estimation of PTC would be used as the IRF in Equation (1) for estimating the PTC portion of the BHP payment rate.

For 2018, OTA estimated that the IRF for states that have implemented the Medicaid eligibility expansion to cover adults up to 133 percent of the FPL will be 97.37 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 97.45 percent. In the 2018 payment methodology, the IRF will be equal to 97.41 percent (this was previously published in the CMCS Informational Bulletin “Basic Health Program; Federal Funding Methodology for Program Year 2018” on May 17, 2017). We propose updating this calculation and the IRF for 2019 and for 2020.

E. State Option to Use Prior Program Year QHP Premiums for BHP Payments

In the interest of allowing states greater certainty in the total BHP federal payments for a given plan year, we have given states the option to have their final federal BHP payment rates

calculated using a projected ARP (that is, using premium data from the prior program year multiplied by the PTF defined below), as described in Equation (2b). Under the 2016 BHP payment notice, states were required to make their election for the 2017 program year by May 15, 2016 and to make their election for the 2018 program year by May 15, 2017. We propose that states generally continue to meet the deadline of making their election by May 15 of the year preceding the applicable program year. However, because we are proposing to revise the 2019 payment methodology after the May 15, 2018 deadline has passed, we are proposing that a state may change its election for the 2019 program year, provided that it does so within 30 days of the date of the notice announcing the final BHP payment methodology for 2019. A change in the state's election would be effective retroactive to January 1, 2019. For 2020, the state would need to inform us no later than May 15, 2019 of its decision for the 2020 program year. (If the final methodology is published after this deadline, we may extend this deadline to give states the opportunity to make this election.)

For Equation (2b), we propose to continue to define the PTF, with minor changes in calculation sources and methods, as follows:

PTF: In Equation (2b), we propose to calculate an ARP based on the application of certain relevant variables to the RP, including a PTF. In the case of a state that would elect to use the 2018 premiums as the basis for determining the 2019 BHP payment, for example, it would be 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 program year. We are proposing to define this as the PTF in the BHP payment methodology. This factor would 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 would provide an estimate of the adjusted monthly premium for the applicable second lowest cost silver plan that

would be more accurate and reflective of health care costs in the BHP program year.

For the PTF, we propose to use the annual growth rate in private health insurance expenditures per enrollee from the National Health Expenditure (NHE) 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>). For BHP program year 2019, we propose that the PTF would be 3.8 percent.

States may want to consider that the increase in premiums for QHPs from one year to the next may differ from the PTF developed for the BHP funding methodology for several reasons. In particular, states may want to consider that the second lowest cost silver plan may be different from one year to the next. This may lead to the PTF being greater than or less than the actual change in the premium of the second lowest cost silver plan.

F. 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, risk adjustment payments that would have otherwise been made had BHP enrollees been enrolled in coverage through an Exchange, we propose to 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 PHF (or risk adjustment) based on data accumulated during that program year for each rate cell.

We acknowledge that there is uncertainty with respect to this factor due to the lack of experience of QHPs through an Exchange and other payments related to the Exchange, which is why, absent a state election, we propose to use a value for the PHF 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, the potential effect such risk would have had on PTC, and risk adjustment that would have otherwise been made had BHP enrollees been enrolled in coverage through an 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 propose to permit a retrospective adjustment that would measure the actual difference in risk between the two 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 propose requiring 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 OTA, 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>). Under the February 2016 BHP payment notice, states were required to submit a proposed protocol by August 1, 2017 for the 2018 program year. We propose requiring a state to submit its proposed protocol within 60 days of the publication of the final payment methodology for our approval for the 2019 program year, and by August 1, 2019 for the 2020 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 would provide technical assistance to states

as they develop their protocols. To implement the population health status, we propose that we must approve the state's protocol no later than 90 days after the submission of the PHF methodology for the 2019 program year, and by December 31, 2019 for the 2020 program year. Finally, we propose that the state be required to complete the population health status adjustment at the end of the program year based on the approved protocol. After the end of the program year, and once data is made available, we propose to 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.

III. Collection of Information Requirements

This notice's proposed methodology is similar to the methodology originally published in the February 2016 payment notice and modified by the Final Administrative Order. The proposed methodology changes would not revise or impose any additional reporting, recordkeeping, or third-party disclosure requirements or burden on QHPs or on states operating State-based Exchanges. The methodology's information collection requirements and burden estimates are approved by OMB under control number 0938-1218 (CMS-10510). The proposed methodology would not necessitate the need to make any changes under that control number.

IV. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the "DATES" section of this

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

V. Regulatory Impact Analysis

A. Statement of Need

Section 1331 of the Affordable Care Act (codified at 42 U.S.C. 18051) requires the Secretary to establish a BHP, and section (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 section (d)(3). This proposed methodology provides for the funding methodology to determine the federal BHP payment amounts required to implement these provisions in program years 2019 and 2020.

B. Overall Impact

We have examined the impacts of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96-354), section 1102(b) of the Act, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995; Pub. L. 104-4), Executive Order 13132 on Federalism (August 4, 1999), the Congressional Review Act (5 U.S.C. 804(2) and Executive Order 13771 on Reducing Regulation and Controlling Regulatory Costs (January 30, 2017).

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, the 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 Marketplace. To date, two states have established a BHP, and we expect state participation to remain static as a result of this payment methodology. However, the proposed payment methodology differs from prior years’ methodologies as the MTSF is incorporated and would reduce BHP payments compared to using the previous year’s methodology. We estimate that this rulemaking is “economically significant” as measured by the \$100 million threshold, and hence also a major rule under the Congressional Review Act. Accordingly, we have prepared a RIA that, to the best of our ability, presents the costs and benefits of the rulemaking.

The aggregate economic impact of this proposed payment methodology is estimated to be \$300 million from CY 2019 through 2020 (measured in real 2019 dollars). For the purposes of this analysis, we have assumed that 2 states would implement BHP in 2019 and 2020. This assumption is based on the fact that two states have established a BHP to date, and we do not have any indication that additional states may implement the program. We also assumed there

would be about 802,000 BHP enrollees in 2019 (based on the most recent state estimates of enrollment as of October 2018) and about 806,000 in 2020. The size of the BHP depends on several factors, including the number of and which particular states choose to implement or continue a BHP, the level of QHP premiums, and the other coverage options for persons who would be eligible for the BHP. In particular, while we generally expect that many enrollees would have otherwise been enrolled in a QHP through the Marketplace, 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, the federal expenditures for the BHP would be expected to be more than offset by a reduction in federal expenditures for PTCs. 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.

Projected BHP enrollment and expenditures under the previous payment methodology were calculated using the most recent 2018 QHP premiums and state estimates for BHP enrollment. Enrollment was projected to 2019 using the projected increase in the number of adults in the U.S. from 2018 to 2019 (0.5 percent), and premiums were projected using the NHE projection of premiums for private health insurance. Expenditures are in real 2019 dollars and are deflated using the projected change in the medical component of the consumer price index (CPI-M). Expenditures are projected to be \$4.890 billion in 2019 and \$4.944 billion in 2020.

For the change in the methodology to incorporate the MTSF, the MTSF was calculated as having a value of 97.04 percent (as described previously). This reduced projected expenditures by \$149 million in 2019 and \$151 million in 2020, compared to projected expenditures using the methodology in the 2018 Final Administrative Order.

**TABLE 3: Estimated Federal Impacts for the Basic Health Program 2019 and 2020
Payment Methodology [Millions of 2019 dollars]**

	2019	2020
Projected Federal BHP payments under 2018 Final Administrative Order	\$5,040	\$5,094
Projected Federal BHP payments under proposed methodology	\$4,890	\$4,944
Federal savings under proposed methodology	\$149	\$151

C. Anticipated Effects

The proposed change in the BHP methodology is expected to shift a portion of BHP costs from the Federal government to the state operating a BHP. Currently, we understand that states pay a portion of the BHP costs each year. This increase in costs may lead the states to consider a combination of the following changes: increasing state payments to the BHP; increasing beneficiary premiums and cost-sharing to the BHP; and reducing payment rates to standard health plans. Beneficiary premiums and cost-sharing are limited under the BHP, so it is unlikely states could make up much of the difference through increased beneficiary contributions. We expect that most of the difference in federal payments would be made up through increases in state funding.

The Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*) (RFA) requires agencies to prepare an initial regulatory flexibility analysis to describe the impact of the proposed rule on small entities, unless the head of the agency can certify that the rule will not have a significant economic impact on a substantial number of small entities. The Act generally defines a “small entity” as (1) a proprietary firm meeting the size standards of the Small Business Administration (SBA); (2) a not-for-profit organization that is not dominant in its field; or (3) a small government jurisdiction with a population of less than 50,000. Individuals and states are not included in the definition of a small entity.

Because this proposed 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 proposed methodology, like the current methodology and the final rule that established the BHP, will not have a significant economic impact on a substantial number of small entities.

In addition, section 1102(b) of the Act requires us to prepare a RIA if a rule may have a significant 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, the Secretary has determined that this proposed methodology will not have a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also 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. In 2019, that threshold is approximately \$154 million. States have the option, but are not required, to establish a BHP. Further, the proposed methodology would establish federal payment rates without requiring states to provide the Secretary with any data not already required by other provisions of the Affordable Care Act or its implementing regulations. Thus, neither the current nor the proposed payment methodologies mandate expenditures by state governments, local governments, or tribal governments.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, 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. This requirement unlike the preceding requirement excludes the impact on the private sectors.

D. Alternatives Approaches

Given the absence of an appropriation for federal CSR payments, we considered several alternatives of how to consider this in the BHP payment methodology for 2019 and 2020, following the Final Administrative Order. In States without BHPs, there were increases in the silver plan premiums due to the lack of federal funding for CSRs in 2018, and those are expected to remain in the rates in 2019 and 2020 (absent federal funding for CSRs). QHP issuers are still responsible for CSRs on behalf of eligible enrollees, regardless of federal funding; therefore, in many States QHP issuers have increased premiums significantly to account for the costs of the CSRs in 2018 and are expected to continue to do so in subsequent years. In states operating BHPs, the majority of the individuals eligible for CSRs (and the vast majority eligible for the largest CSRs) are enrolled in the BHP and not in the Exchange. As a result, in those states, QHP issuers made much smaller adjustments to premiums to account for CSR costs in 2018. We considered whether or not to make an adjustment in the BHP payment methodology for how much QHP premiums would have increased if BHP enrollees had been enrolled through the Exchange instead as part of the Final Administrative Order. We are also considering other methodologies for calculating the adjustment, including using program data to estimate the expected adjustment and to request information from QHPs and/or states for 2019 and 2020 QHP premiums. We are proposing to use the same methodology, data, and adjustment to the premiums as was used in the 2018 payment methodology described in the Final Administrative Order. (See section II.D.2 for more information.)

We are also considering whether or not to make an adjustment to account for the number of enrollees who would select other metal-tier plans on the Exchange (if not for the existence of the BHP) and the impact that this would have on the average PTC paid. In previous methodologies, we have not made such an adjustment; however, there are two results from the

discontinuance of CSR payments that we considered in adding this adjustment for the 2019 and 2020 payment methodology. First, there are a significant percentage of enrollees with incomes below 200 percent of the FPL in states without BHPs that have chosen to enroll in bronze-level QHPs, despite the availability of CSRs if they had chosen to enroll in a silver-level QHP (about 13 percent in 2018). Second, the discontinuance of the CSR payments and the subsequent increases to silver-level QHP premiums in 2018 led to a larger difference between the bronze-level and silver-level QHP premiums in many states (from a difference of about 17 percent in 2017 to about 33 percent in 2018). As a result, the likelihood that enrollees eligible for CSRs who enrolled in bronze-level plans would pay \$0 in premium increased (and thus the full value of the PTC they were eligible for would not be paid), and the average difference between the bronze-level premium and the full value of the PTC likely increased. In addition, the percentage of enrollees eligible for CSRs enrolled in bronze-level QHPs also increased from 2017 to 2018 (from 11 percent to 13 percent), and we believe this is likely due to the availability of QHPs that effectively had \$0 in premium due to the PTC for which individuals qualified. Therefore, we are proposing to make an adjustment for enrollees selecting bronze-level QHPs in this methodology.

In addition, we are also considering whether or not to continue to provide states the option to develop a protocol for a retrospective adjustment to the PHF as we did in previous payment methodologies. We believe that continuing to provide this option is appropriate and likely to improve the accuracy of the final payments.

We also are considering whether or not to require the use of the program year premiums to develop the federal BHP payment rates, rather than allow the choice between the program year premiums and the prior year premiums trended forward. We believe that the payment rates can still be developed accurately using either the prior year QHP premiums or the current program year premiums and that it is appropriate to continue to provide the states the option.

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

We request public comment on these alternative approaches.

E. Accounting Statement and Table

In accordance with OMB Circular A– 4, Table 4 depicts an accounting statement summarizing the assessment of the benefits, costs, and transfers associated with this proposed payment methodology.

TABLE 4: Account Statement Changes to Federal Payments for the Basic Health Program for 2019 and 2020

Category	Estimates	Units		
		Year dollar	Discount rate (%)	Period covered
Transfers: Annualized/Monetized (\$million/year)...	150.0	2019	7	2019-2020
	150.0	2019	3	2019-2020
From Whom to Whom.....	From the States Operating BHPs to the Federal Government			

F. Reducing Regulation and Controlling Regulatory Costs

Executive Order 13771, titled “Reducing Regulation and Controlling Regulatory Costs,”

was issued on January 30, 2017 (82 FR 9339, February 3, 2017). It has been determined that this notice is a transfer notice that does not impose more than *de minimis* costs, and thus is not a regulatory action for the purposes of E.O. 13771.

G. Conclusion

Overall, federal BHP payments are expected to decrease by \$300 million from 2019 through 2020 as a result of the changes to the methodology. The decrease in federal BHP payments is expected to be made up in increased state BHP expenditures, with a potential increase in beneficiary contributions and potential decreases in provider payment rates (including rates to standard health plans in the BHP) as a result of these changes. The analysis above, together with the remainder of this preamble, provides an RIA.

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

CMS-2407-PN

Dated: February 19, 2019.

Seema Verma,

Administrator,

Centers for Medicare & Medicaid Services.

Dated: March 5, 2019.

Alex M. Azar,

Secretary,

Department of Health and Human Services.

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