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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 600

[CMS-2432-FN]

RIN 0938-ZB56

Basic Health Program; Federal Funding Methodology for Program Year 2021

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

ACTION: Final methodology.

SUMMARY: This document finalizes the methodology and data sources necessary to determine federal payment amounts to be made for program year 2021 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.

DATES: The methodology and data sources announced in this notice are effective on January 1, 2021.

FOR FURTHER INFORMATION CONTACT:

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SUPPLEMENTARY INFORMATION:

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 Patient Protection

and 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 Patient Protection and 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 Patient Protection and Affordable Care Act), which governs the establishment of BHPs. The BHP final rule established 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 codified 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, 2 years prior to the applicable program year, and would describe the proposed funding methodology for the relevant BHP year,[1] including how the Secretary considered the factors specified in section 1331(d)(3) of the Patient Protection and Affordable Care Act, along with the proposed data sources used to

[1] BHP program years span from January 1 through December 31.

determine the federal BHP payment rates for the applicable program year. 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 applicable BHP program year. For example, payment rates in the final BHP Payment Notice published in February 2015 applied to BHP program year 2016, beginning in January 2016. As discussed in section II.D. 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 for the applicable program year has been published, we will generally make modifications to the BHP funding methodology on a prospective basis, but 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 applicable final BHP Payment Notice. For example, the population health factor adjustment described in section III.D.3. of this final notice allows for a retrospective adjustment (at the state's option) to account for the impact that BHP may have had on the risk pool and QHP premiums in the Exchange. 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 Patient Protection and Affordable Care Act, the funding methodology and payment rates are expressed as an amount per eligible individual enrolled in a BHP standard health plan (BHP enrollee) for each month of enrollment. These payment rates may vary based on categories or classes of enrollees. Actual payment to a state

would depend on the actual enrollment of individuals found eligible in accordance with a state's certified 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 must 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. The 2018 Final Administrative Order, 2019 Payment Methodology, and 2020 Payment Methodology

On October 11, 2017, the Attorney General of the United States provided the Department of Health and Human Services and the Department of the 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 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. On July 6, 2018, we issued a Draft Administrative Order on which New York and Minnesota had an opportunity to comment. Each state submitted comments. We considered the states' comments and issued a Final Administrative Order on August 24, 2018 (Final Administrative Order) setting forth the payment methodology that would apply to the 2018 BHP program year.

In the November 5, 2019 **Federal Register** (84 FR 59529 through 59548) (hereinafter referred to as the November 2019 final BHP Payment Notice), we finalized the payment methodologies for BHP program years 2019 and 2020. The 2019 payment methodology is the same payment methodology described in the Final Administrative Order. The 2020 payment methodology is the same methodology as the 2019 payment methodology with one additional

adjustment to account for the impact of individuals selecting different metal tier level plans in the Exchange, referred to as the Metal Tier Selection Factor (MTSF).[2]

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

The following sections, arranged by subject area, include a summary of the public comments that we received, and our responses. We received 10 public comments from individuals and organizations, including, but not limited to, state Medicaid agencies, other government entities, and advocacy groups. In this section, we outline the proposed provisions and provide a summary of the public comments received and our responses. For a complete and full description of the BHP proposed funding methodology for program year 2021, see the "Basic Health Program; Federal Funding Methodology for Program Year 2021" proposed notice published in the February 10, 2020 **Federal Register** (85 FR 7500) (hereinafter referred to as the 2021 proposed BHP Payment Notice).

A. Background

In the 2021 proposed BHP Payment Notice, we proposed the methodology for how the federal BHP payments would be calculated for program year 2021.

We received the following comments on the background information included in the 2021 proposed BHP Payment Notice:

Comment: Several commenters were generally supportive of the BHP. Several commenters were generally supportive of the 2021 BHP payment methodology described in the 2021 proposed BHP Payment Notice.

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[2] "Metal tiers" refer to the different actuarial value plan levels offered on the Exchanges. Bronze-level plans generally must provide 60 percent actuarial value; silver-level 70 percent actuarial value; gold-level 80 percent actuarial value; and platinum-level 90 percent actuarial value. See 45 CFR 156.140.

Response: We appreciate the support from these commenters. As described further in this final notice, we have largely adopted the methodology as described in the 2021 proposed BHP Payment Notice.[3]

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

We proposed in the overview of the funding methodology to calculate the PTC and CSR as consistently as possible and in general alignment with the methodology used by Exchanges to calculate the advance payments of the PTC (APTC) and CSR, and by the Internal Revenue Service (IRS) to calculate the allowable PTC. We proposed four equations (1, 2a, 2b, and 3) that would, if finalized, compose the overall BHP payment methodology.

We received the following comments on the overview of the funding methodology included in the 2021 proposed BHP Payment Notice:

Comment: One commenter stated that CMS did not have the authority to exclude payment for the CSR portion of the BHP payment rate.

Response: As we explained in the November 2019 final BHP Payment Notice for 2019 and 2020 (84 FR 59530, 59534) and in the 2021 proposed BHP Payment Notice (85 FR 7502), in light of the Attorney General's opinion regarding the unavailability of the permanent appropriation at 31 U.S.C. 1324 to make CSR payments—and in the absence of any other appropriation that could be used to fund CSR payments—HHS directed CMS to discontinue CSR payments to issuers until the Congress provides for an appropriation. In the absence of a

[3] As explained in section II.F. of this final notice, we are finalizing that a state may notify CMS of its election for the 2021 program year to base federal BHP payment rates on actual 2021 premiums or the 2020 premiums trended forward within 60 days of publication of this final notice rather than by the proposed May 15, 2020 deadline. Additionally, as explained in section II.G. of this final notice, we are finalizing that a state may submit its optional health risk adjustment protocol to CMS within 30 days of publication of this final notice rather than by the proposed August 1, 2020 deadline.

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.

C. Federal BHP Payment Rate Cells

In this section of 2021 proposed BHP Payment Notice, we proposed that a state implementing BHP provide us with an estimate of the number of BHP enrollees it will enroll in the upcoming BHP program quarter, by applicable rate cell, to determine the federal BHP payment amounts. For each state, we proposed using rate cells that separate the BHP population into separate cells based on the following factors: age; geographic rating area; coverage status; household size; and income. For specific discussions of these proposals, please refer to the 2021 proposed BHP Payment Notice.

We received no comments on this aspect of the proposed methodology. Therefore, we are finalizing these policies as proposed.

D. Sources and State Data Considerations

We proposed in this section of the 2021 proposed BHP Payment Notice to use, to the extent possible, data submitted to the federal government by QHP issuers seeking to offer coverage through an Exchange that uses HealthCare.gov to determine the federal BHP payment cell rates. However, for states operating a State-based Exchange (SBE) that do not use HealthCare.gov, we proposed that such states submit required data for CMS to calculate the federal BHP payment rates in those states. For specific discussions, please refer to the 2021 proposed BHP Payment Notice.

We received no comments on this aspect of the proposed methodology. Therefore, we are finalizing these policies as proposed.

E. Discussion of Specific Variables Used in Payment Equations

In this section of the 2021 proposed BHP Payment Notice, we proposed eight specific variables to use in the payment equations that compose the overall BHP funding methodology. (seven variables are described in section III.D. of this final notice, and the premium trend factor is described in section III.E. of this final notice). For each proposed variable, we included a discussion on the assumptions and data sources used in developing the variables. For specific discussions, please refer to 2021 proposed BHP Payment Notice.

Below is a summary of the public comments we received regarding specific factors and our responses.

Comment: Two commenters recommended that CMS not apply the MTSF in the 2021 BHP payment methodology and offered rationales for CMS to not include the MTSF. One commenter stated that applying the MTSF would be inappropriate because the Essential Plan in New York provides coverage with actuarial value that is equivalent to a platinum plan, not a bronze plan.

One commenter stated that applying the MTSF is inappropriate because the experience in New York in 2015—before BHP was fully implemented—showed that a smaller percentage of enrollees with incomes below 200 percent of FPL chose bronze-level QHPs than the percentage of such enrollees nationwide who chose bronze-level QHPs nationwide in 2017. Two commenters cited New York's enrollment assistance efforts as the reason for a smaller percentage of enrollees choosing bronze-level QHPs in 2015. Further, one commenter noted that the amount of PTC reduction for these enrollees in New York in 2015 was about $12 per enrollee per month.

Response: As detailed in the 2021 proposed BHP Payment Notice and in section III.D.6.

of this final notice, we continue to believe that it is appropriate to take the MTSF into account due to several changes that occurred following the discontinuance of the CSR payments that increased the impact of enrollees' plan choices on the amount of PTC paid by the federal government. First, silver-level QHP premiums increased at a higher percentage in comparison to the increase in premiums of other metal-tier plans in many states starting in 2018 (on average, the national average benchmark silver-level QHP premium increased about 17 percentage points faster than the national average lowest-cost bronze-level QHP premium). Second, there was an increase in the percentage of enrollees with incomes below 200 percent of FPL choosing bronze-level QHPs. Third, the likelihood that a person choosing a bronze-level QHP would pay $0 premium also increased, as the difference between the bronze-level QHP premium and the full value of PTC widened. Finally, the average estimated reduction in PTC for enrollees with incomes below 200 percent of FPL that chose bronze-level QHPs increased substantially from 2017 to 2018. Our analysis of 2017 and 2018 data documents these effects.

In 2017, prior to the discontinuance of CSR payments, 11 percent of QHP enrollees with incomes below 200 percent of FPL elected to enroll in bronze-level QHPs, and on average the PTC paid on behalf of those enrollees was 11 percent less than the full value of PTC. In 2018, after the discontinuance of the CSR payments, 13 percent of QHP enrollees with incomes below 200 percent of FPL chose bronze-level QHPs, and on average, the PTC paid on behalf of those enrollees was 23 percent less than the full value of the PTC. In addition, the national average silver-level QHP premium was 17 percent higher than the national average bronze-level plan premium in 2017. In 2018, this ratio increased such that the national average silver-level QHP premium was 33 percent higher than the national average bronze-level plan premium. While the increase in the percentage of QHP enrollees with incomes below 200 percent of FPL who elected

to enroll in bronze-level QHPs between 2017 and 2018 is about 2 percentage points, the accompanying percentage reduction of the PTC paid by the federal government for QHP enrollees with incomes below 200 percent of FPL more than doubled between 2017 and 2018. Consistent with section 1331(d)(3) of the Patient Protection and Affordable Care Act, which requires that payments to states be based on what would have been provided if BHP eligible individuals were allowed to enroll in QHPs, we believe it is appropriate to consider how individuals would have chosen different plans—including across metal tiers—as part of the BHP payment methodology. As such, we are finalizing the application of the MTSF for program year 2021 as proposed.

Regarding comments that New York's experience has differed from the national averages, as we discussed in the November 2019 final BHP Payment Notice for 2019 and 2020 (84 FR 59533), we recognize there are certain unique state characteristics in the New York markets (for example, pure community rating); however, the BHP statute directs the Secretary to take into consideration the experience of other states when developing the payment methodology[4] and doing so is a reasonable basis for calculating the MTSF.

We also continue to believe that using 2015 data as the basis for the MTSF is not appropriate. Premiums and enrollment patterns have changed over time, including the above described changes in bronze-level and silver-level QHP premiums, changes in the ratio of the silver-level to bronze-level QHP premiums, and changes to the amount of PTC paid by the federal government. In addition, while the cited 2015 data provides some evidence of consumer plan selections prior to the full implementation of New York's BHP, we do not believe that the 2015 data should be relied upon for the development of the MTSF for the following reasons.

[4] See section 1331(d)(3)(A)(ii) of the Patient Protection and Affordable Care Act.

First, New York did not begin implementing its BHP until April 2015 (and did not fully implement BHP until 2016). Second, the 2015 data predates the discontinuance of the CSR payments in 2017 and the subsequent adjustments to premiums beginning in 2018 (particularly to silver-level QHP premiums). Therefore, relying on data from 2015 does not capture the more recent experience of New York and/or other states subsequent to the discontinuation of CSRs, which the MTSF is intended to reflect.

In response to comments about New York's enrollment assistance efforts, we note that the statute does not require the Secretary to address every difference in Exchange operations among the states (including, but not limited to, enrollment assistance efforts by individual Exchanges). We also believe it is not practicable to address every potential difference in Exchange operations, and that not every potential difference in Exchange operations would be a relevant factor necessary to take into account. In response to the comment that the New York Essential Plan provides coverage with actuarial value that is equivalent to (or greater than) a platinum plan, not a bronze plan, we recognize that BHPs are prohibited from providing bronze-level coverage to enrollees. As we discussed in the November 2019 final BHP Payment Notice for 2019 and 2020 (84 FR 59533), regarding comments that BHPs are prohibited from providing bronze-level coverage to enrollees, and thus the BHP payment methodology should not assume enrollees would have chosen bronze-level QHPs in the Exchange, section 1331(d)(3)(A)(ii) of the Patient Protection and Affordable Care Act directs the Secretary to "take into account all relevant factors necessary to determine the value of the" PTCs and CSRs that would have been provided to eligible individuals if they would have enrolled in QHPs through an Exchange. We further note the statute does not set forth an exhaustive list of what those necessary relevant factors are, providing the Secretary with discretion and authority to identify and take into

consideration factors that are not specifically enumerated in the statute. In addition, section 1331(d)(3)(A)(ii) of the Patient Protection and Affordable Care Act requires the Secretary to "take into consideration the experience of other States with respect to participation on Exchanges and such credit and reductions provided to residents of the other States, with a special focus on enrollees with income below 200 percent of poverty." We recognize that applying the MTSF would reduce BHP funding, but we nonetheless believe that incorporating the MTSF into the BHP payment methodology for program year 2021 accurately reflects the changes in PTCs after the federal government stopped making CSR payments and is consistent with section 1331(d)(3)(A)(ii) of the Patient Protection and Affordable Care Act. Regarding the comments about the potential impact of reduced BHP funding on benefits available under BHPs, we note that the benefits requirements at § 600.405 are still applicable and therefore benefits available under BHPs should not be impacted.

Comment: Several commenters opposed or disagreed with our alternative options for calculating the MTSF, which included using partial 2019 data instead of 2018 data, and making a retrospective adjustment under § 600.610(c)(2)(ii) to update the MTSF using 2021 data once it becomes available. One commenter noted that calculating the MTSF retrospectively would introduce uncertainty into the program that would make planning difficult.

Response: After consideration of comments, we are finalizing the MTSF as proposed using 2018 data.[5] As detailed in the 2021 proposed BHP Payment Notice, we believe it is reasonable to use the same value for the MTSF as was used in the 2020 final payment methodology. Most notably, the MTSF reflects the percentage of enrollees choosing bronze-

[5] See section III.D.6. of this final notice for further details on the MTSF finalized as part of the 2021 final payment methodology.

level QHPs and the accompanying reduction in the PTCs paid and we do not expect significant year-to-year differences in these data points absent other significant changes to the operations of the Exchanges (for example, the discontinuance of CSR payments). Further, we believe that states and QHP issuers have not significantly changed their approaches to account for the discontinuation of CSR payments, and that most states and QHP issuers are using similar approaches as were used in 2018.[6] We also believe that consumers will continue to react to these adjustments and increases in silver-level QHP premiums in the same manner; meaning that consumers will continue to select bronze-level QHPs and the impact on PTCs paid by the government will generally remain the same.

We appreciate the comments on potential other sources of data beyond 2018 that could be used to calculate the MTSF for 2021. We recognize that making a retrospective adjustment to update the MTSF using 2021 data would introduce some uncertainty into the BHP payments because the necessary data would not be available until after the end of the 2021 program year and this could create planning challenges for states operating BHPs. We also remain concerned about using partial 2019 data to calculate the MTSF, and we believe that the final end-of-year data is more reliable than partial data and that the preliminary 2019 data does not suggest that there would be a substantial change in the MTSF value. We are therefore finalizing the MTSF as proposed using 2018 data, as we discuss in section III.D.6. of this final notice.

Comment: Several commenters opposed or disagreed with our alternative options for calculating the Premium Adjustment Factor (PAF), which included using other data sources to calculate the PAF, estimating the PAF rather than relying on the information from the QHP

[6] In fact, HHS may not take any action or prohibit or otherwise restrict silver loading practices with respect to plan year 2021. See Further Consolidated Appropriations Act, 2020, Division N, title I, subtitle F, section 609 (Pub. L. 116–94: December 20, 2019, enacting H.R. 1865).

issuers, and making a retrospective adjustment under § 600.610(c)(2)(ii) to the PAF for 2021 to reflect actual 2021 experience once the necessary data for 2021 becomes available. In addition, one commenter noted that calculating the PAF retrospectively would introduce uncertainty into the program that would make planning difficult.

Response: After consideration of comments received, we are finalizing the PAF value at 1.188 for program year 2021 using 2018 data, as proposed. As detailed in the 2021 proposed BHP Payment Notice, we believe this value for the PAF continues to reasonably account for the increase in silver-level premiums and the reduction in PTCs paid that took effect after the discontinuance of the CSR payments. As explained above, we believe that the impact of the increase in silver-level premiums in 2021 can reasonably be expected to be similar in 2018. In addition, we recognize that making a retrospective adjustment to update the PAF to reflect actual 2021 experience would create some additional uncertainty into the BHP payments because the necessary data would not be available until after the end of the 2021 program year, and that this could create planning challenges for states operating BHPs. We are not pursuing use of the other data sources for determining the value of the PAF, as we believe that QHP issuers may not be readily able to provide specific data. In addition, this information is not typically collected with the issuers' rate filings. We believe this may be burdensome on the QHP issuers to provide this information at this time (for example, through a survey specifically to request this information). We also are not calculating an estimate of the QHP premium adjustment. While we believe this could be a reasonable approach, we believe that the 2018 experience still provides an accurate reflection of the QHP premium adjustment and using 2018 data avoids the previously described concerns associated with the identified potential alternative data sources. We are finalizing the PAF as proposed, as discussed in section III.D.2. of this final notice.

Comment: Regarding the income reconciliation factor (IRF), several commenters supported our proposal to calculate the IRF using only the value for states that have expanded Medicaid eligibility to 138 percent of FPL. In past years, we calculated the IRF as the average of the values for states that have expanded Medicaid eligibility and for states that have not.

Response: We appreciate these comments and are finalizing the IRF as proposed.

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

In this section of the 2021 proposed payment notice, we proposed to provide states operating a BHP with the option to use the 2020 QHP premiums multiplied by a premium trend factor to calculate the federal BHP payment rates instead of using the 2021 QHP premiums. We proposed to require states to make their election for the 2021 program year by May 15, 2020. For specific discussions, please refer to the 2021 proposed BHP Payment Notice.

We received no comments on this aspect of the proposed methodology. We are finalizing these policies as proposed, with one exception.

Because we are finalizing the 2021 payment methodology after the proposed May 15, 2020 deadline for notifying us of the decision to base federal BHP payment rates on actual 2021 premiums or the 2020 premiums trended forward, we are finalizing that a state may notify CMS of its election within 60 days of publication of this final notice.

G. State Option to Include Retrospective State-Specific Health Risk Adjustment in Certified Methodology

In this section of the 2021 proposed BHP Payment Notice, we proposed to provide states implementing BHP the option to develop a methodology to account for the impact that including the BHP population in the Exchange would have had on QHP premiums based on any differences in health status between the BHP population and persons enrolled through the

Exchange. For specific discussions, please refer to the 2021 proposed BHP Payment Notice.

We received no comments on this aspect of the methodology. Therefore, we are finalizing this policy as proposed, with one change. Because we are finalizing the 2021 payment methodology after the proposed August 1, 2020 deadline for states to submit their protocols to CMS, we are finalizing that a state electing this option must submit their protocol to CMS within 30 days of publication of this final notice.

III. Provisions of the 2021 BHP Final Methodology

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

Section 1331(d)(3) of the Patient Protection and 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 APTC and CSRs, and by the 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 Patient Protection and 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 Patient Protection and Affordable Care Act.

Section 1331(d)(3)(A)(ii) of the Patient Protection and 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 in March 2014), for 2016 (80 FR 9636) (published in February 2015), for 2017 and 2018 (81 FR 10091) (published in February 2016), and for 2019 and 2020 (84 FR 59529) (published in November 2019), 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 (if applicable), 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.

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 two parts are added together and the total rate for that rate cell would be equal to the sum of the PTC and CSR rates. 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.

Equation (1) will be used to calculate the estimated PTC for eligible individuals enrolled in the BHP in each rate cell. We note that throughout this final notice that when we refer to enrollees and enrollment data, we mean data regarding individuals who were enrolled in the BHP who had 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 (if applicable), income and other factors, we effectively take those factors into account in the calculation. In addition, the equations reflect the estimated experience of individuals in each rate cell if enrolled in coverage through 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 the final notice. In addition, we described how we will calculate the adjusted reference premium (ARP) that was used in Equation (1) and defined in Equation (2a) and Equation (2b).

Equation 1: Estimated PTC by rate cell

The estimated PTC, on a per enrollee basis, will be calculated for each rate cell for each state based on age range (if applicable), geographic area, coverage category, household size, and income range. The PTC portion of the rate will be calculated in a manner consistent with the methodology used to calculate the PTC for persons enrolled in a QHP, with 5 adjustments. First, the PTC portion of the rate for each rate cell will represent the mean, or average, expected PTC

that all persons in the rate cell would receive, rather than being calculated for each individual enrollee. Second, the reference premium (RP) (described in section III.D.1. of this final notice) used to calculate the PTC will be adjusted for the BHP population health status, and in the case of a state that elects to use 2020 premiums for the basis of the BHP federal payment, for the projected change in the premium from 2020 to 2021, to which the rates in this final payment methodology will apply. These adjustments are described in Equation (2a) and Equation (2b). Third, the PTC will be adjusted prospectively to reflect the mean, or average, net expected impact of income reconciliation on the combination of all persons enrolled in the BHP; this adjustment, the IRF, as described in section III.D.7. of this final notice, will account for the impact on the PTC that would have occurred had such reconciliation been performed. Fourth, the PTC will be adjusted to account for the estimated impacts of plan selection; this adjustment, the MTSF, would reflect the effect of individuals choosing different metal tier levels of QHPs on the average PTC. Finally, the rate is multiplied by 95 percent, consistent with section 1331(d)(3)(A)(i) of the Patient Protection and Affordable Care Act. We note that in the situation where the average income contribution of an enrollee would exceed the ARP, we will calculate the PTC to be equal to 0 and would not allow the value of the PTC to be negative.

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

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

$PTC_{a,g,c,h,i}$ = 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 will calculate the value of the ARP as described below. Consistent with the existing approach, we will 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 III.E. of this final notice). Below we describe how we will continue to calculate the ARP under each option.

In the case of a state that elected to use the reference premium (RP) based on the current program year (for example, 2021 premiums for the 2021 program year), we will calculate the value of the ARP as specified in Equation (2a). The ARP will be equal to the RP, which will 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 III.D.3. of this final notice), which will 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 III.D.2. of this final notice), which will 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, 2020 premiums for the 2021 program year, as described in more detail in section III.E. of this final notice), we will calculate the value of the ARP as specified in Equation (2b). The ARP will be equal to the RP, which will be based on the second lowest cost silver plan premium in 2020, multiplied by the BHP PHF (described in section III.D.3. of this final notice), which will 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 III.D.2. of this final notice), which will account for the change in silver-level premiums due to the discontinuance of CSR payments, and multiplied by the premium trend factor (PTF) (described in section III.E. of this final notice), which will reflect the projected change in the premium level between 2020 and 2021.

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

$ARP_{a,g,c}$ = 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 will be multiplied by the number of BHP enrollees in that cell (that is, the number of enrollees that meet the criteria for each rate cell) to calculate the total monthly BHP payment. This calculation is shown in Equation (3).

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

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

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, a state implementing a BHP will 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 will be used to calculate the prospective payment for the first and subsequent quarters of program operation until the state has provided us actual enrollment data. These data are required to calculate the final BHP payment amount, and make any necessary reconciliation adjustments to the prior quarters' prospective payment amounts due to differences between projected and actual enrollment. Subsequent quarterly deposits to the state's trust fund will be based on the most recent actual enrollment data submitted to us. Actual enrollment data must be based on individuals enrolled for the quarter 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 (if applicable), geographic area, coverage status, household size, and income range, as explained above.

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

Factor 1--Age: We will separate enrollees into rate cells by age (if applicable), using the following age ranges that capture the widest variations in premiums under HHS' Default Age Curve:[7]

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

[7] This curve is used to implement the Patient Protection and 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.

This provision is unchanged from the current methodology.

Factor 2--Geographic area: For each state, we will separate enrollees into rate cells by geographic areas within which a single RP is charged by QHPs offered through the state's Exchange. Multiple, non-contiguous geographic areas would be incorporated within a single cell, so long as those areas share a common RP.[8] This provision is also unchanged from the current methodology.

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

Factor 4--Household size: We will 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 (Determination of eligibility for and enrollment in a standard health plan). We will require separate rate cells for several specific household sizes. For each additional member above the largest specified size, we will publish instructions for how we will develop additional rate cells and calculate an appropriate payment rate based on data for the rate cell with the closest specified household size. We will publish separate rate cells for

[8] 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 in this notice.

household sizes of 1 through 10. This provision is unchanged from the current methodology.

Factor 5--Household Income: For households of each applicable size, we will 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, separate rate cells will be used to calculate federal BHP payment rates to reflect different bands of income measured as a percentage of FPL. We will use the following income ranges, measured as a percentage of the FPL:

- 0 to 50 percent of the FPL.
- 51 to 100 percent of the FPL.
- 101 to 138 percent of the FPL.[9]
- 139 to 150 percent of the FPL.
- 151 to 175 percent of the FPL.
- 176 to 200 percent of the FPL.

This provision is unchanged from the current methodology.

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

We will use averages to define federal payment rates, both for income ranges and age ranges (if applicable), rather than varying such rates to correspond to each individual BHP

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

enrollee's age and income level. This approach will increase the administrative feasibility of making federal BHP payments and reduce the likelihood of inadvertently erroneous payments resulting from highly complex methodologies. 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, unless otherwise provided, we will 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.

States operating a SBE 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. States operating a SBE interested in obtaining the applicable 2021 program year federal BHP payment rates for its state must submit such data accurately, completely, and as specified by CMS, by no later than October 15, 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 are published in CMS guidance and are available in the Federal Policy Guidance section at https://www.medicaid.gov/federal-policy-Guidance/index.html.

States operating a BHP 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 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 will continue the policy first 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 to determine the enrollees' household income and household size consistently with Marketplace requirements.[10] The state must submit this methodology to us at the time of their Blueprint submission. 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. States currently operating a BHP that wish to change the methodology for non-filers must submit a revised Blueprint outlining the revisions to its methodology, consistent with § 600.125.

In addition, as the federal payments are determined quarterly and the enrollment data is required to be submitted by the states to us quarterly, the quarterly payment will be based on the characteristics of the enrollee at the beginning of the quarter (or their first month of enrollment in

[10] See 81 FR at 10097.

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 (or their first month of enrollment in the BHP in the applicable quarter). Payments will 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.

Consistent with § 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 III.D.5. of this final notice, regarding the premium tax credit formula (PTCF). Accordingly, for the purposes of calculating the BHP payment rates, the RP, in accordance with 26 U.S.C. 36B(b)(3)(C), is defined as the adjusted monthly premium for an applicable second lowest cost silver plan. The applicable second lowest cost silver plan is defined in 26 U.S.C. 36B(b)(3)(B) as the second lowest cost silver plan of the individual market in the rating area in which the taxpayer resides

that is offered through the same Exchange. We will use the adjusted monthly premium for an applicable second lowest cost silver plan in the applicable program year (2021) 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 2021, as described in section III.E. of this final 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 will not update the payment methodology, and subsequently the federal BHP payment rates, in the event that the second lowest cost silver plan used as the RP, or the lowest cost silver plan, changes (that is, terminates or closes enrollment during the year).

The applicable second lowest cost silver plan premium will be included in the BHP payment methodology by age range (if applicable), 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 relies on several simplifying assumptions in its selection. For the purposes of determining the second lowest cost silver plan for calculating PTC for a person enrolled in a QHP through an Exchange, the applicable plan may differ for various reasons. For example, a different second lowest cost silver plan may apply to a family consisting of two adults, their child, and their niece than to a family with two adults and their children, because one or more QHPs in the family's geographic area might not offer family coverage that includes the niece.

We believe that it is not possible to replicate such variations for calculating the BHP payment and believe that in the aggregate, they will not result in a significant difference in the payment. Thus, we will use the second lowest cost silver plan available to any enrollee for a given age, geographic area, and coverage category.

This choice of RP relies on an assumption about enrollment in the Exchanges. In previous methodologies for program years 2015 through 2019, 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). In the November 2019 final BHP Payment Notice, we continued to use the second-lowest cost silver plan premium as the RP, but for the 2020 payments we changed the assumption about which metal-tier plans enrollees would choose (see section III.D.6. on the MTSF in this final notice). Therefore, for the 2021 payment methodology, we will continue to use the second-lowest cost silver plan premium as the RP, but account for how enrollees may choose other metal tier plans by applying the MTSF.

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 Patient Protection and 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 (if any) will be one dimension of each rate cell. We will assume a uniform distribution of ages and estimate the average premium amount within each rate cell. We believe that assuming a uniform distribution of ages within these ranges is a reasonable approach and 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 will use geographic areas based on the rating areas used in the Exchanges. We will define each geographic area so that the RP is the same throughout the geographic area. When the RP varies within a rating area, we will define geographic areas as aggregations of counties with the same RP. Although plans are allowed to serve geographic areas smaller than counties after obtaining our approval, no geographic areas, 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 simplify both the calculation of BHP payment rates and the operation of the BHP.

Finally, in terms of the coverage category, federal payment rates will 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.[11] Second, the BHP will include lawfully present immigrant children with household incomes at or below 200 percent of FPL in states that have not exercised the option under 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

[11] CMCS. "State Medicaid, CHIP and BHP Income Eligibility Standards Effective April 1, 2019."

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 Patient Protection and Affordable Care Act, which limits a BHP to individuals who are ineligible for minimum essential coverage (as defined in 26 U.S.C. 5000A(f)).

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, QHP issuers are required to provide CSRs to eligible enrollees. As a result, many QHP issuers 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 increases in premiums 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, and therefore issuers in BHP states did not significantly raise premiums to cover unpaid CSR costs.

In the Final Administrative Order and the November 2019 final BHP Payment Notice, we incorporated the PAF into the BHP payment. Similarly, we will include the PAF in the 2021

payment methodology and to calculate it in the same manner as in the Final Administrative Order.

Under the Final Administrative Order, we calculated the PAF 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.[12] The median adjustment for silver level QHPs is the nationwide median adjustment.

For each of the two BHP states, we determined the median premium adjustment for all silver level QHPs in that state, which we refer to as the state median adjustment. 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 + Nationwide Median Adjustment) ÷ (1 + State Median Adjustment).

To determine the PAF described above, we collected QHP information from QHP issuers in each state and the District of Columbia to determine the premium adjustment those issuers

[12] 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.

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 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 were 1,233 silver-level QHPs that submitted premiums to operate 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 SBEs (while we requested information only from QHP issuers in states serviced by an FFE, many of those issuers also had QHPs in states operating SBEs and submitted information for those states as well). 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 discontinuance of CSR payments (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%) ÷ (1 + 1%) (or 1.20/1.01), which results in a value of 1.188.

We will continue to set the PAF equal to 1.188 for program year 2021. 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 took effect after the discontinuance of the CSR payments. We believe that the impact of the increase in silver-level premiums in 2021 can reasonably be

expected to be similar to that in 2018, because the discontinuation of CSR payments has not changed.

3. Population Health Factor (PHF)

The PHF will 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.

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 continues to be a lack of data on the experience in the Exchanges, which limits the ability to analyze the potential health differences between these groups of enrollees. More specifically, Exchanges have been in operation since 2014, and two states have operated BHPs since 2015, but data is not available to do the analysis necessary to determine if there are differences in the average health status between BHP and Exchange enrollees. In addition, differences in population health may vary across states. We also do not believe that sufficient data would be available to permit us to make a prospective adjustment to the PHF under § 600.610(c)(2) for the 2021 program year.

Given these analytic challenges and the limited data about Exchange coverage and the characteristics of BHP-eligible consumers, the PHF will continue to be 1.00 for program year 2021.

In the previous BHP payment methodologies, we included an option for states to include a retrospective population health status adjustment. We will provide states with the same option for 2021 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 III.F. of this final 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 will not 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 federally-operated risk adjustment program.[13] Further, standard health plans do not qualify for payments under the transitional reinsurance program established under section 1341 of the Patient Protection and Affordable Care Act for the years the program was operational (2014 through 2016).[14] 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, the BHP payment methodology will incorporate household income into the calculations of the payment rates

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[13] See 79 FR at 14131.

[14] 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").

through the use of income-based rate cells. We will define 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). Household size and income as a percentage of FPL will be used as factors in developing the rate cells. We will use the following income ranges measured as a percentage of FPL:[15]

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

We will assume a uniform income distribution for each federal BHP payment cell. We believe that assuming a uniform income distribution for the income ranges 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 will calculate the value of the PTC at each 1 percentage point interval of the income range for each federal BHP payment cell and then calculate the average of the PTC across all intervals. This calculation will

[15] These income ranges and this analysis of income apply to the calculation of the PTC.

rely on the PTC formula described in section III.D.5. of this final notice.

As the APTC for persons enrolled in QHPs would be calculated based on their household income during the open enrollment period, and that income would be measured against the FPL at that time, we will adjust the FPL by multiplying the FPL by a projected increase in the CPI-U between the time that the BHP payment rates are calculated and the QHP open enrollment period, if the FPL is expected to be updated during that time. The projected increase in the CPI-U will be based on the intermediate inflation forecasts from the most recent OASDI and Medicare Trustees Reports.[16]

5. Premium Tax Credit Formula (PTCF)

In Equation 1 described in section III.A.1. of this final notice 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 (that is, the monthly premium adjusted for the age of the enrollee) 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

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[16] *See* Table IV A1 from the 2019 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2019.pdf.

equal to the lesser of the premium for the plan in which the person or household enrolls, or the adjusted premium for the applicable second lowest cost silver plan minus the contribution amount.

The applicable percentage is defined in 26 U.S.C. 36B (b)(3)(A) and 26 CFR 1.36B-3(g) as the percentage that applies to a taxpayer's household income that is within an income tier specified in Table 1 of the proposed notice, increasing on a sliding scale in a linear manner from an initial premium percentage to a final premium percentage specified in Table 1. We will continue to use applicable percentages 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 as part of Equation 1. The applicable percentages in Table 1 for calendar year (CY) 2020 will be effective for BHP program year 2021. The applicable percentages will be updated in future years in accordance with 26 U.S.C. 36B(b)(3)(A)(ii).

TABLE 1: Applicable Percentage Table for CY 2020[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%	2.06%	2.06%
133% but less than 150%	3.09%	4.12%
150% but less than 200%	4.12%	6.49%
200% but less than 250%	6.49%	8.29%
250% but less than 300%	8.29%	9.78%
300% but not more than 400%	9.78%	9.78%

[a] IRS Revenue Procedure 2019-29. https://www.irs.gov/pub/irs-drop/rp-19-29.pdf .

6. Metal Tier Selection Factor (MTSF)

On the Exchange, if an enrollee chooses a QHP and the value of the APTC to which the enrollee is entitled is greater than the premium of the plan selected, then the APTC is reduced to be equal to the premium. This usually occurs when enrollees eligible for larger APTCs choose bronze-level QHPs, which typically have lower premiums on the Exchange than silver-level QHPs. Prior to 2018, we believed that the impact of these choices and plan selections on the amount of PTCs that the federal government paid was relatively small. During this time, most

enrollees in income ranges up to 200 percent FPL chose silver-level QHPs, and in most cases where enrollees chose bronze-level QHPs, the premium was still more than the PTC. Based on our analysis of the percentage of persons with incomes below 200 percent FPL choosing bronze-level QHPs and the average reduction in the PTCs paid for those enrollees, we believe that the total PTCs paid for persons with incomes below 200 percent FPL were reduced by about 1 percent in 2017. Therefore, we made no adjustment based on the effect for enrollees choosing non-silver-level QHPs in developing the BHP payment methodology applicable to program years prior to 2018. However, after the discontinuance of the CSR payments in October 2017, several changes occurred that increased the expected impact of enrollees' plan selection choices on the amount of PTC the government paid. These changes led to a larger percentage of individuals choosing bronze-level QHPs, and for those individuals who chose bronze-level QHPs, these changes also generally led to larger reductions in PTCs paid by the federal government per individual. The combination of more individuals with incomes below 200 percent of FPL choosing bronze-level QHPs and the reduction in PTCs had an impact on PTCs paid by the federal government for enrollees with incomes below 200 percent FPL.

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 QHPs, despite being eligible for CSRs in silver-level QHPs, because many were able to purchase bronze-level QHPs 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 level QHPs increased from about 11 percent in 2017 to about 13 percent in 2018. In addition, the likelihood that a

person choosing a bronze-level QHP 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-level QHP premium to the average bronze-level QHP premium increased: the average silver level QHP premium was 17 percent higher than the average bronze-level QHP premium in 2017, whereas the average silver-level QHP premium was 33 percent higher than the average bronze-level QHP premium in 2018. Similarly, the average estimated reduction in APTC for enrollees with incomes between 0 percent and 200 percent FPL that chose bronze level QHPs increased from about 11 percent in 2017 to about 23 percent in 2018 (after adjusting for the average age of bronze-level QHP and silver-level QHP enrollees); that is, in 2017, enrollees with incomes in this range who chose bronze-level QHPs received 11 percent less than the full value of the APTC, and in 2018, those enrollees who chose bronze-level QHPs received 23 percent less than the full value of the APTC. The discontinuance of the CSR payments led to increases in silver-level QHP premiums (and thus in the total potential PTCs), but did not generally increase the bronze-level QHP premiums in most states; we believe this is the primary reason for the increase in the percentage reduction in PTCs paid by the government for those who enrolled in bronze-level QHPs between 2017 and 2018.

Therefore, we believe that the impacts on the amount of PTC the government would pay due to enrollees' plan selection choices are larger and thus more significant, and we will include an adjustment (the MTSF) in the BHP payment methodology to account for the effects of these choices. Section 1331(d)(3) of the Patient Protection and 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 finalized the application of the MTSF for the first time in the 2020 payment methodology, and we will calculate the MTSF using the same approach as finalized there (84 FR 59543). First, we will 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 QHPs in 2018. Second, we will calculate the ratio of the average PTC paid for enrollees in this income range who selected bronze-level QHPs compared to the average PTC paid for enrollees in the same income range who selected silver-level QHPs. Both of these calculations will be done using CMS data on Exchange enrollment and payments.

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

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

We have calculated that 12.68 percent of enrollees in households with incomes below 200 percent of the FPL selected bronze-level QHPs in 2018. We also calculated that the ratio of the average PTC paid for those enrollees in bronze-level QHPs to the average PTCs paid for enrollees in silver-level QHPs was 76.66 percent after adjusting for the average age of bronze level and silver-level QHP enrollees. The MTSF is equal to 1 minus the product of the percentage of enrollees in bronze-level QHPs (12.68 percent) and 1 minus the ratio of the average PTC paid for bronze-level QHP enrollees to the average PTC paid for silver-level QHP enrollees (76.66 percent). Thus, the MTSF would be calculated as:

$$MTSF = 1 – (12.68\% \times (1 – 76.66\%))$$

Therefore, the value of the MTSF for 2021 will be 97.04 percent.

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 APTC 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 APTC paid 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 paid, subject to any limitations in statute or regulation), as provided in 26 U.S.C. 36B(f).

Section 1331(e)(2) of the Patient Protection and Affordable Care Act specifies that an individual eligible for the BHP may not be treated as a "qualified individual" under section 1312 of the Patient Protection and Affordable Care Act 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 APTC, individuals determined or assessed as eligible for a BHP are not eligible to receive APTC for coverage in the Exchange. Because they do not receive APTC, BHP enrollees, on whom the BHP payment methodology is generally 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.

Therefore, in accordance with current practice, we will include in Equation 1 an adjustment, the IRF, that will 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 will seek prospectively to capture the average effect of income reconciliation aggregated across the BHP population had those BHP enrollees been subject to tax reconciliation after receiving APTC for coverage provided through QHPs offered on an Exchange. Consistent with the methodology used in past years, we estimated 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. Consistent with prior years, we proposed to use the ratio of the reconciled PTC to the initial estimation of PTC as the IRF in Equations (1a) and (1b) for estimating the PTC portion of the BHP payment rate.

OTA estimates the IRF separately for states that have implemented the Medicaid eligibility expansion and those that have not. In previous program years, we used the average of these two values to set the value for the IRF. To date, the only states that have operated a BHP are states that implemented the Medicaid eligibility expansion. Therefore, for 2021, we are using the value only for states that have implemented the Medicaid eligibility expansion. For 2021, OTA has 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 99.23 percent.

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 premium trend factor (PTF), as described in Equation (2b). For program years 2015 through 2018, we required states to make their election to have their final federal BHP payment rates calculated using a projected ARP by May 15 of the year preceding the applicable program year. Because this final notice is published after May 15, 2020, we are requiring states to inform CMS in writing of their election for the 2021 program year 60 days following the

publication of this final notice.

For Equation (2b), we will define the PTF as follows:

PTF: In the case of a state that would elect to use the 2020 premiums as the basis for determining the 2021 BHP payment, 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. 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 will 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 2021, the PTF will be 4.8 percent.

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 an Exchange would affect the PTC and risk adjustment payments that would have otherwise been made had BHP enrollees been enrolled in coverage through an Exchange, we will provide states implementing the BHP the option to propose and to implement, as part of the certified methodology, a retrospective adjustment to the federal BHP payments to reflect the actual value that would be assigned to the population health factor (or risk adjustment) based on

data accumulated during that program year for each rate cell.

We acknowledge that there is uncertainty with respect to this factor due to the lack of available data to analyze potential health differences between the BHP and QHP populations, which is why, absent a state election, we will use a value for the PHF (see section III.D.3. of this final notice) 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 of PTCs and CSRs, we will 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 as part of the BHP payment methodology applicable to the state, we will require the state to submit a proposed protocol to CMS, which would be subject to approval by us and would be required to be certified by the Chief Actuary of CMS, in consultation with the OTA. We applied the same protocol for the population health status adjustment as what is set forth in guidance in Considerations for Health Risk Adjustment in the Basic Health Program in Program Year 2015 (http://www.medicaid.gov/Basic-Health-Program/Downloads/Risk-Adjustment-and-BHP-White-Paper.pdf). We proposed to require a state to submit its proposed protocol by August 1, 2020. Given the publication date of this final notice, we will require a state to submit

its proposed protocol for the 2021 program year within 30 days after the publication of this final notice. This submission will need to include descriptions of how the state would collect the necessary data to determine the adjustment, including any contracting contingences that may be in place with participating standard health plan issuers. We will provide technical assistance to states as they develop their protocols, as requested. To implement the population health status adjustment, we must approve the state's protocol by December 31, 2020 for the 2021 program year. Finally, the state will 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 will review the state's findings, consistent with the approved protocol, and make any necessary adjustments to the state's federal BHP payment amounts. If we determine that the federal BHP payments were less than they would have been using the final adjustment factor, we would apply the difference to the state's next quarterly BHP trust fund deposit. If we determine that the federal BHP payments were more than they would have been using the final reconciled factor, we would subtract the difference from the next quarterly BHP payment to the state.

IV. Collection of Information Requirements

This final methodology for program year 2021 is similar to the methodology finalized for program year 2020 in the November 2019 final BHP Payment Notice. While we are finalizing one change related to the calculation of the Income Reconciliation Factor, the change will not revise or impose any new reporting, recordkeeping, or third-party disclosure requirements or burden on states operating a BHP, as it pertains to any of our active collections of information Although the methodology's information collection requirements and burden had at one time been approved by OMB under control number 0938-1218 (CMS-10510), the approval was

discontinued on August 31, 2017, since we adjusted our estimated number of respondents below the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3501 et seq.) threshold of ten or more respondents (only New York and Minnesota operate a BHP at this time). Since we continue to estimate fewer than ten respondents, the final 2021 methodology is not subject to the requirements of the PRA.

We sought comment on whether or not to solicit information from QHP issuers on the amount of the adjustment to premiums to account for the discontinuance of CSR payments. We noted that we believe that soliciting such information would likely impose some additional reporting requirements on QHP issuers and sought comments on the amount of burden this would create.

We received no comments on the Collection of Information Requirements section of the 2021 proposed BHP Payment Notice, including whether or not to solicit information from QHP issuers on the amount of the adjustment to premiums to account for the discontinuance of CSR payments.

V. Regulatory Impact Analysis

A. Statement of Need

Section 1331 of the Patient Protection and Affordable Care Act (42 U.S.C. 18051) requires the Secretary to establish a BHP, and section 1331(d)(1) specifically provides that if the Secretary finds that a state meets the requirements of the program established under section 1331(a) of the Patient Protection and Affordable Care Act, the Secretary shall transfer to the state federal BHP payments described in section 1331(d)(3). This methodology provides for the funding methodology to determine the federal BHP payment amounts required to implement these provisions for program year 2021.

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 on an Exchange. Because we make no changes in methodology that would have a consequential effect on state participation incentives, or on the size of either the BHP program or offsetting PTC and CSR expenditures, the effects of the changes made in this payment notice would not approach the $100 million threshold, and hence it is neither an economically significant rule under E.O. 12866 nor a major rule under the Congressional Review Act. Moreover, the regulation is not economically significant within the meaning of section 3(f)(1) of the Executive Order.

C. Anticipated Effects

The provisions of this final notice are designed to determine the amount of funds that will be transferred to states offering coverage through a BHP rather than to individuals eligible for federal financial assistance for coverage purchased on the Exchange. We are uncertain what the total federal BHP payment amounts to states will be as these amounts will vary from state to state due to the state-specific factors and conditions. For example, total federal BHP payment amounts may be greater in more populous states simply by virtue of the fact that they have a larger BHP-eligible population and total payment amounts are based on actual enrollment. Alternatively, total federal BHP payment amounts may be lower in states with a younger BHP-eligible population as the RP used to calculate the federal BHP payment will be lower relative to older BHP enrollees. While state composition will cause total federal BHP payment amounts to vary from state to state, we believe that the methodology, like the methodology used in 2020, accounts for these variations to ensure accurate BHP payment transfers are made to each state.

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

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

Section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a methodology may have a significant economic impact on the operations of a substantial number of small rural hospitals. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a metropolitan statistical area and has fewer than 100 beds. For the preceding reasons, we have determined that this methodology will not have a significant impact on a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act (UMRA) of 2005 requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation, by state, local, or tribal governments, in the aggregate, or by the private sector. In 2020, that threshold is

approximately $156 million. States have the option, but are not required, to establish a BHP. Further, the methodology would establish federal payment rates without requiring states to provide the Secretary with any data not already required by other provisions of the Patient Protection and Affordable Care Act or its implementing regulations. Thus, the final payment methodology does not mandate expenditures by state governments, local governments, or tribal governments.

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

D. Alternative Approaches

We considered several alternatives in developing the proposed BHP payment methodology for 2021, and we discuss some of these alternatives below.

We considered alternatives as to how to calculate the PAF in the proposed methodology for 2021. The proposed value for the PAF is 1.188, which is the same as was used for 2018, 2019, and 2020. We believe it would be difficult to get the updated information from QHP issuers comparable to what was used to develop the 2018 factor, because QHP issuers may not distinctly consider the impact of the discontinuance of CSR payments on the QHP premiums any longer. We do not have reason to believe that the value of the PAF would change significantly between program years 2018 and 2021. We continued to consider whether or not there are other methodologies or data sources we may be able to use to develop the PAF. We also considered

whether or not to update the value of the PAF for 2021 after the end of the 2021 BHP program year.

We also considered alternatives as how to calculate the MTSF in the proposed methodology for 2021. The proposed value for the MTSF is 97.04 percent, which is the same as was finalized for 2020. We believe that we would use the latest data available each year; for example, we anticipate data from 2019 being available next year in developing the subsequent BHP payment methodology. We considered whether or not there are other methodologies or data sources we may be able to use to develop the MTSF. We also considered whether or not to update the value of the MTSF for 2021 after the end of the 2021 BHP program year.

We considered alternatives as how to calculate the IRF in the proposed methodology for 2021. We proposed to calculate the value of this factor based on modeling by OTA, as we have done for prior years. For the 2021 BHP payment methodology, we considered calculating the IRF from the latest available year of Exchange data. We do not anticipate this will lead to a significant change in the value of the IRF. In addition, we also considered whether to set the IRF as the average of the expected values for states that have expanded Medicaid eligibility and for states that have not, or to set the IRF as the value for only states that have expanded Medicaid eligibility, because only states that have expanded eligibility have operated a BHP to date.

We also considered whether or not to continue to provide states the option to develop a protocol for a retrospective adjustment to the population health factor (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 considered 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 in this final notice are specified in statute; therefore, for these factors 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 methodology. Except for state-specific RPs and enrollment data, we are using national rather than state-specific data. This is due to the lack of currently available state-specific data needed to develop the majority of the factors included in the methodology. We believe the national data will produce sufficiently accurate determinations of payment rates. In addition, we believe that this approach will be less burdensome on states. In many cases, using state-specific data would necessitate additional requirements on the states to collect, validate, and report data to CMS. By using national data, we are able to collect data from other sources and limit the burden placed on the states. For RPs and enrollment data, we are using state-specific data rather than national data as we believe state-specific data will produce more accurate determinations than national averages.

We requested public comment on these alternative approaches.

Our responses to public comments on these alternative approaches are in section II.E. of this final notice.

E. Regulatory Reform Analysis under EO 13771

Executive Order 13771, titled Reducing Regulation and Controlling Regulatory Costs, was issued on January 30, 2017 and requires that the costs associated with significant new regulations "shall, to the extent permitted by law, be offset by the elimination of existing costs

associated with at least two prior regulations." This final rule, if finalized as proposed, is expected to be neither an EO 13771 regulatory action nor an EO 13771 deregulatory action.

F. Conclusion

We believe that this final BHP payment methodology is effectively the same methodology as finalized for 2020. BHP payment rates may change as the values of the factors change, most notably the QHP premiums for 2020 or 2021. We do not anticipate this final methodology to have any significant effect on BHP enrollment in 2021.

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

Dated: August 6, 2020.

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Seema Verma,

Administrator,

Centers for Medicare & Medicaid Services.

Dated: August 6, 2020.

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Alex M. Azar II,

Secretary,

Department of Health and Human Services.

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