



DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 600

[CMS-2438-FN]

RIN 0938-ZB64

Basic Health Program; Federal Funding Methodology for Program Year 2022

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 2022 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 Health Insurance Exchanges, and incorporates the effects on such payment amounts the American Rescue Plan Act of 2021 (ARP).

DATES: The methodology and data sources announced in this document are effective on January 1, 2022.

FOR FURTHER INFORMATION CONTACT: Christopher Truffer, (410) 786-1264; or Cassandra Lagorio, (410) 786-4554.

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 is another option for states to provide 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 Health 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 methodology. 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 of the Department of Health and Human Services (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 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 payment 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

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

this final methodology, 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, 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 methodology 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, 2020 Payment Methodology, and 2021 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 New York v. U.S. Dep't of Health & Human Servs.*, No. 18-cv-00683 (RJS) (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) (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 In the August 13, 2020 **Federal Register** (85 FR 49264 through 49280) (hereinafter referred to as the August 2020 final BHP Payment Notice), we finalized the payment methodology for BHP program year 2021. The 2021 payment methodology is the same methodology as the 2020 payment methodology, with one adjustment to the income reconciliation factor (IRF). The 2022 final payment methodology is the same as the 2021 payment methodology, except for the removal of the MTSF.

C. The American Rescue Plan Act and Impact on the Basic Health Program Final 2022 Payment Amounts

On March 11, 2021, President Biden signed the American Rescue Plan Act of 2021 (ARP) (Pub. L. 117-2). This action has a significant impact on state Medicaid, CHIP, and BHP programs and beneficiaries.³ ARP also impacts federal payments to states' BHPs.

Section 9661 of the ARP temporarily modifies for 2021 and 2022 the applicable

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.

³ <https://www.medicaid.gov/federal-policy-guidance/downloads/cib060321.pdf>.

percentages of household income used to calculate the amount of advance payments of the premium tax credit (APTC) that taxpayers are eligible to have paid on their behalf for coverage purchased through an Exchange under the Patient Protection and Affordable Care Act. The applicable percentages determine the maximum amount of an individual's household income that can be charged in premiums for purchasing the second lowest cost silver plan on the Exchange. The difference between the maximum amount of an individual's household income that can be charged in premiums and the cost of the second lowest cost silver plan is paid to the individual as a PTC. As discussed in section III.D.5. of this final notice, the applicable percentages are factored into the equation for calculating the amount of PTC provided for individuals enrolled in QHPs through the Exchange and, accordingly, the amount of the federal BHP payment owed to states. Lower applicable percentages result in higher PTCs provided for QHP enrollees and higher federal BHP payments for states. Therefore, this ARP provision has the effect under the BHP payment methodology of increasing the amount of the federal payments owed to states for their BHPs in 2022.

We published the BHP proposed funding methodology for program year 2022 in "Basic Health Program; Federal Funding Methodology for Program Year 2022" in the November 3, 2020 **Federal Register** (85 FR 69525) (hereinafter referred to as the 2022 proposed BHP Payment Notice). In the 2022 proposed BHP Payment Notice, we proposed that the applicable percentages, as then defined in 26 U.S.C. 36B(b)(3)(A) and 26 CFR 1.36B-3(g), for calendar year 2021 would be effective for BHP program year 2022. Because the applicable percentages have since been amended for 2022 by the ARP, we are revising the applicable percentages in the final BHP payment notice to comply with the ARP; we discuss this further in section III.D.5. of this final notice. We note that updating the applicable percentage amounts themselves does not alter the BHP payment methodology, but are inputs under that methodology that, when changed will impact the payment amounts paid by the federal government to the states that operate a BHP under the methodology. In previous payment methodologies, we have used the prior year's

applicable percentages to calculate BHP payments because those were the most recently published percentages at the time the methodologies were finalized. However, the 2022 applicable percentages are available now as a result of section 9661 of ARP, so we are updating the applicable percentages in this final notice.

In addition, in the 2022 proposed BHP Payment Notice, we proposed to include the IRF to account for potential differences between BHP enrollees' household income reported at the beginning of the year and the actual income over the year. This factor is needed because, unlike PTC recipients enrolled through Exchanges, BHP enrollees will not experience a reconciliation at the end of the tax year. This adjustment has been included in the methodology since 2015. In the 2022 proposed BHP Payment Notice, we proposed to set the value of the IRF equality to 99.01. However, due to changes made by the ARP, the Office of Tax Analysis (OTA) of the Department of the Treasury has revised its estimate for the IRF to be 100.63 percent. Therefore, we are updating the value of the IRF to be 100.63, as further discussed in section III.D.7 of this final notice.

In the final payment methodologies for program years 2020 and 2021 and proposed payment methodology for 2022, we included a factor to account for the impact of the discontinuation of CSR payments on individuals' selection of metal tier level plans in the Exchange, referred to as the Metal Tier Selection Factor. Specifically, the MTSF was included to account for the impact of QHP enrollees eligible for PTC choosing bronze-level plans (which have lower premiums than silver-level plans) and receiving less than the full value of the PTC, which was amplified after the discontinuation of the CSR payments. However, because section 9661 of the ARP reduces the maximum percentage of an individual's household income that can be charged in premiums for purchasing the second lowest cost silver plan on the Exchange, we believe consumer behavior around selecting different metal tier level plans likely will change significantly. In other words, we anticipate that, as a result of the ARP, more individuals with household income below 200 percent FPL will enroll in silver-level plans because these plans

can now be purchased for a lower premium amount, and for many individuals, there will be silver-level plans with \$0 premium. Therefore, we are removing the MTSF from the final payment methodology for program year 2022.

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 11 public comments from individuals and organizations, including, but not limited to, state government agencies, other government agencies, and private citizens. 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 2022, see the 2022 proposed BHP Payment Notice.

A. Background

In the 2022 proposed BHP Payment Notice, we proposed the methodology for how the federal BHP payments would be calculated for program year 2022.

We received the following comments on the background information included in the 2022 proposed BHP Payment Notice:

Comment: Several commenters were supportive of the 2022 BHP payment methodology described in the 2022 proposed BHP Payment Notice.

Response: We appreciate the support from these commenters. As described further in this final notice, we are finalizing the 2022 methodology as proposed in the 2022 proposed BHP Payment Notice, with the exception of the removal of the MTSF and updating the applicable percentages of household income used to calculate APTC amounts and the value of the IRF, as described in section I.C in this final notice.

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 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 2022 proposed BHP Payment Notice:

Comment: One commenter recommended CMS apply the proposed methodology only when a state initially establishes a BHP. This commenter recommended that after a BHP is established, states should be allowed to use prior program year premiums for payments. The commenter reasoned that simplifying the BHP payment methodology would provide administrative relief as well as greater certainty of expected funds for states.

Response: We did not propose and are not adopting the recommendation related to the proposed methodology applying only to a state's initial program year. We also note that current Federal BHP regulations in § 600.605 specify the BHP payment methodology. Specifically, § 600.605(c) provides that the Secretary will annually adjust the payment methodology on a prospective basis to adjust for any changes in the calculation of the PTC and CSR components to the extent that necessary data is available. Further, regulations at § 600.610 require that a proposed BHP payment methodology be published in the **Federal Register** each October, 2 years prior to the applicable program year, and describe the proposed funding methodology for the relevant BHP year. The final BHP payment methodology must be published in the **Federal Register** in February, and include the final BHP payment methodology, as well as the federal BHP payment rates for the applicable BHP program year. Changes to this process, like the one suggested by the commenter, would require amendments to existing BHP regulations.

Comment: One commenter recommended that for the purpose of calculating BHP payments, CMS assume that American Indian and Alaska Native (AI/AN) enrollees in BHPs would have enrolled in the second-lowest cost bronze-level plan instead of the second-lowest

cost silver-level plan on the Exchanges.

Response: While AI/AN enrollees may enroll in the second-lowest cost bronze-level plan and continue to receive CSRs, PTCs continue to be based on the second-lowest cost silver-level QHP. Therefore, BHP payments to states for AI/AN and all other enrollees need to continue to be based on the second-lowest cost silver QHP.

We did not propose and are not adopting this recommendation. The only portion of the rate affected by the use of the lowest-cost bronze-level plan is the CSR portion of the BHP payment; due to the discontinuance of CSR payments and the accompanying modification to the BHP payment methodology, the CSR portion of the payment is assigned a value of 0, and therefore, any change to the assumption about which bronze-level QHP is used would have no effect on the BHP payments.

Comment: One commenter recommended that AI/AN premiums in a BHP should not exceed the cost of the second-lowest cost bronze-level plan and suggested that CMS provide additional BHP funding to states in order to ensure that AI/AN populations do not experience a premium increase when enrolling in BHP from a bronze-level plan on the Exchange.

Response: We appreciate and understand the commenter's concern regarding the premium levels for the AI/AN population. However, section 1331(a)(2)(A)(i) of the Patient Protection and Affordable Care Act requires that states operating BHPs must ensure that individuals do not pay a higher monthly premium than they would have if they had been enrolled in the second lowest cost silver-level QHP in an Exchange, after reduction for any PTCs and CSRs allowable with respect to either plan. In addition, as specified in § 600.705(c)(1), BHP states are permitted to use BHP trust funds to reduce premiums and cost sharing for eligible individuals enrolled in standard health plans under BHP. For example, Minnesota does not charge premiums for the AI/AN population. This premium policy is required by state law and included in Minnesota's BHP Blueprint.⁴

⁴ Minnesota Statutes, Chapter 256L.15(c).

C. Federal BHP Payment Rate Cells

In this section of the 2022 proposed BHP Payment Notice, we proposed to continue to require 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 2022 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 2022 proposed BHP Payment Notice to continue 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), which do not use HealthCare.gov, we proposed to continue to require such states to submit required data for CMS to calculate the federal BHP payment rates in those states. For specific discussions, please refer to the 2022 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 2022 proposed BHP Payment Notice, we proposed to continue to use eight specific variables 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 2022 proposed BHP Payment Notice.

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

Comment: One commenter supported maintaining the value of the premium adjustment factor (PAF) at 1.188 for program year 2022.

Response: We appreciate the support from this commenter. As described further in this final notice, we are finalizing the methodology as proposed in the 2022 proposed BHP Payment Notice, and will be maintaining the value of the PAF at 1.188 for program year 2022.

Comment: One commenter expressed their support of using 2019 data to calculate the MTSF as proposed in the 2022 proposed BHP Payment Notice. This commenter stated that using partial 2020 data to calculate the MTSF would likely not be a reasonable predictor of consumer behavior in 2022 due to the impact of the COVID-19 public health emergency (PHE).

Response: We appreciate the support from this commenter. However, since publication of the 2022 proposed Payment Notice, Congress passed the ARP, which, as discussed in section I.C. of this final notice, modifies the applicable percentages of household income used to calculate the amount of APTC taxpayers are eligible to have paid on their behalf for coverage purchased through an Exchange during taxable years 2021 and 2022. We believe that these changes are likely to significantly affect enrollees' plan choices starting in 2022. For this reason and the reasons discussed in sections I.C. and III.D.6. of this final notice, we are not finalizing inclusion of the MTSF in the 2022 final BHP Payment Notice.

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

In this section of the 2022 BHP proposed Payment Notice, we proposed to continue to provide states operating a BHP with the option to use the 2021 QHP premiums multiplied by a premium trend factor to calculate the federal BHP payment rates instead of using the 2022 QHP premiums. We proposed to require states to make their election for the 2022 program year by May 15, 2021, or within 60 days of publication of the final payment methodology, whichever is

later. For specific discussions, please refer to the 2022 BHP proposed Payment Notice.

Below is a summary of the public comments we received regarding this section and our responses.

Comment: One commenter expressed support for the proposed approach of using state-specific premiums and giving states the choice of applying actual current year premiums or the prior year's premiums multiplied by the premium trend factor (PTF). Due to the annual timing of this decision, this choice allows the state flexibility in making a determination that it believes is consistent with program goals for the upcoming year.

Response: We appreciate the support from this commenter. As described further in this final notice, we are finalizing the methodology as proposed in the 2022 proposed BHP Payment Notice.

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

In this section of the 2022 BHP proposed Payment Methodology, 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. We proposed that states would submit their optional protocol to CMS by the later of August 1, 2021 or 60 days after the publication of the final methodology. For specific discussions, please refer to the 2022 BHP proposed Payment Notice.

We received no comments on this aspect of the methodology. Therefore, we are finalizing this policy as proposed. Because we are finalizing the 2022 payment methodology within 60 days of August 1, 2021, a state electing this option must submit their protocol to CMS within 60 days of publication of this final notice.

III. Provisions of the 2022 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 APTC and CSRs, and by the IRS to calculate PTC for the tax year. 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 PTCs 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 APTC and CSR would have occurred if the enrollee had been so enrolled. Under the payment methodologies for 2015 (79 FR 13887 through 14151) (published on March 12, 2014), for 2016 (80 FR 9636 through 9648) (published on February 24, 2015), for 2017 and 2018 (81 FR 10091 through 10105) (published on February

29, 2016), for 2019 and 2020 (84 FR 59529 through) (published on November 5, 2019), and for 2021 (85 FR 49264 through 49280) (published on August 13, 2020) (hereinafter referred to as the 2021 final BHP Payment Notice), 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.

Under the methodology finalized in the August 2020 final BHP Payment Notice, 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. As noted in the August 2020 final BHP Payment Notice, we currently assign a value of zero to the CSR portion of the BHP payment rate calculation, because there is presently no available appropriation from which we can make the CSR portion of any BHP Payment.

We finalize that 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 methodology, when we refer to enrollees and enrollment data, we mean data regarding individuals who are enrolled in the BHP who have been found eligible for the BHP using the eligibility and verification requirements that are applicable in the state's most recent certified

Blueprint. By applying the equations separately to rate cells based on age (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 this final methodology. In addition, we describe in Equation (2a) and Equation (2b) (below) how we will calculate the adjusted reference premium that is used in Equation (1).

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 methodology) used to calculate the PTC would be adjusted for the BHP population health status, and in the case of a state that elects to use 2021 premiums for the basis of the BHP federal payment, for the projected change in the premium from 2021 to 2022, to which the rates announced in the final payment methodology would apply. These adjustments are described in Equation (2a) and Equation (2b). Third, the PTC 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 methodology, will account for the impact on the PTC that would have occurred had such reconciliation been performed. Finally, the rate is multiplied by 95 percent, consistent with section 1331(d)(3)(A)(i) of the Patient Protection and Affordable Care Act. We note that in the situation where the average income contribution of an enrollee would exceed the adjusted

reference premium, 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:

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

$PTC_{a,g,c,h,i}$ = Premium tax credit portion of BHP payment rate

a = Age range

g = Geographic area

c = Coverage status (self-only or applicable category of family coverage) obtained through BHP

h = Household size

i = Income range (as percentage of FPL)

$ARP_{a,g,c}$ = Adjusted reference premium

$I_{h,i,j}$ = Income (in dollars per month) at each 1 percentage-point increment of FPL

j = j^{th} percentage-point increment FPL

n = Number of income increments used to calculate the mean PTC

$PTCF_{h,i,j}$ = Premium tax credit formula percentage

IRF = Income reconciliation factor

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

As part of the calculations for the PTC component, we will calculate the value of the adjusted reference premium 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 PTF (as described in section III.E. of this final methodology). Below we describe how we will calculate the adjusted reference premium 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, 2022 premiums for the 2022 program year), we will calculate the

value of the adjusted reference premium as specified in Equation (2a). The adjusted reference premium 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 methodology), 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 PAF (described in section III.D.2. of this final methodology), 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, 2021 premiums for the 2022 program year, as described in more detail in section II.E. of this final methodology), we will calculate the value of the adjusted reference premium as specified in Equation (2b). The adjusted reference premium will be equal to the RP, which will be based on the second lowest cost silver plan premium in 2021, multiplied by the BHP PHF (described in section III.D.3. of this final methodology), which will reflect the projected impact that enrolling BHP-eligible individuals in QHPs on an Exchange would have had on the average QHP premium, multiplied by the PAF (described in section III.D.2. of this final methodology), which will account for the change in silver-level premiums due to the discontinuance of CSR payments, and multiplied by the PTF (described in section III.E. of this final methodology),

which would reflect the projected change in the premium level between 2021 and 2022.

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

$ARP_{a,g,c}$ = 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).

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

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)

In this equation, we will assign a value of zero to the CSR part of the BHP payment rate calculation ($CSR_{a,g,c,h,i}$) because there is presently no available appropriation from which we

can make the CSR portion of any BHP payment. In the event that an appropriation for CSRs for 2022 is made, we will determine whether and how to modify the CSR part of the BHP payment rate calculation ($CSR_{a,g,c,h,i}$) or the PAF in the payment methodology.

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, we will use those estimates to calculate the prospective payment for the first and subsequent quarters of program operation until the state provides us with actual enrollment data for those periods. The actual enrollment data is 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 are finalizing our proposal to require the use of certain rate cells as part of this final 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’s Default Age Curve:⁵

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

This provision is unchanged from the current methodology.⁶

Factor 2--Geographic area: For each state, we will separate enrollees into rate cells by geographic areas within which a single RP is charged by QHPs offered through the state’s Exchange. Multiple, non-contiguous geographic areas will be incorporated within a single cell, so long as those areas share a common RP.⁷ 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

⁵ 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 plan or policy years beginning on or after January 1, 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 HHS-Developed Risk Adjustment Model Algorithm “Do It Yourself (DIY)” Software Instructions for the 2018 Benefit Year, April 4, 2019 Update, <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Updated-CY2018-DIY-instructions.pdf>.

⁶ In this document, references to the “current methodology” refer to the 2021 program year methodology as outlined in the 2021 final BHP Payment Notice.

⁷ 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.

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 would develop additional rate cells and calculate an appropriate payment rate based on data for the rate cell with the closest specified household size. We will publish separate rate cells for household sizes of 1 through 10. This finalized 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.⁸
- 139 to 150 percent of the FPL.

⁸ The three lowest income ranges will be limited to lawfully present immigrants who are ineligible for Medicaid because of immigration status.

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

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.

Consistent with the current methodology, we are finalizing our proposal to 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 enrollee's age (if applicable) 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 an 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 BHPs interested in obtaining the applicable 2022 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, 2021. 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 Methodologies. 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> [under “State Report for Health Insurance Exchange Premiums.”](#)

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 2016 final BHP Payment Methodology 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.⁹ 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 from 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

⁹ See 81 FR at 10097.

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 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 will 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 will have a significant effect on the federal BHP payment. The states must maintain data that is 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 methodology, regarding the premium tax credit formula (PTCF). This method is unchanged from the current methodology except to update the reference years, and to provide additional methodological details to simplify calculations and to deal with potential ambiguities.

Accordingly, for the purposes of calculating the BHP payment rates, the RP, in accordance with 26 U.S.C. 36B(b)(3)(C), is defined as the adjusted monthly premium for an applicable second lowest cost silver plan. The applicable second lowest cost silver plan is defined in 26 U.S.C. 36B(b)(3)(B) as the second lowest cost silver plan of the individual market in the rating area in which the taxpayer resides that is offered through the same Exchange. We will use the adjusted monthly premium for an applicable second lowest cost silver plan in the applicable program year (2022) 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 2022, as described in section III.E. of this final methodology).

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

Consistent with the policy set forth in 26 CFR 1.36B-3(f)(6), to calculate the PTC for those enrolled in a QHP through 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 would not be 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 the payment 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 methodology). In the 2021 payment methodology, we continued to account for how enrollees may choose other metal tier plans by applying the MTSF. For the 2022 payment methodology, we will not continue to account for how enrollees may choose other metal tier plans by removing the MTSF as described in section III.D.6. of this final methodology.

We do not believe it is appropriate to adjust the payment for an assumption that some BHP enrollees would not have enrolled in QHPs for purposes of calculating the BHP payment rates, since section 1331(d)(3)(A)(ii) of the 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 propose to assume a uniform distribution of ages and estimate the average premium amount within each rate cell. We believe that assuming a uniform distribution of ages within these ranges is a reasonable approach and would produce a reliable determination of the total monthly payment for BHP enrollees. We also believe this approach will avoid potential inaccuracies that could

otherwise occur in relatively small payment cells if age distribution were measured by the number of persons eligible or enrolled.

We will use geographic areas based on the rating areas used in the Exchanges. We will define each geographic area so that the RP is the same throughout the geographic area. When the RP varies within a rating area, we 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 area, for purposes of defining BHP payment rate cells, will be smaller than a county. We do not believe that this assumption will have a significant impact on federal payment levels and it would simplify both the calculation of BHP payment rates and the operation of the BHP.

Finally, in terms of the coverage category, federal payment rates only recognize self-only and two-adult coverage, with exceptions that account for children who are potentially eligible for the BHP. First, in states that set the upper income threshold for children's Medicaid and CHIP eligibility below 200 percent of FPL (based on modified adjusted gross income (MAGI)), children in households with incomes between that threshold and 200 percent of FPL would be potentially eligible for the BHP. Currently, the only states in this category are Idaho and North Dakota.¹⁰ 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 will be identified based on their Medicaid and CHIP State Plans, and the rate cells will 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

¹⁰ CMCS. "State Medicaid, CHIP and BHP Income Eligibility Standards Effective October 1, 2020."

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, the 2019 final BHP Payment Notice, the 2020 final BHP Payment Notice, and the 2021 final BHP Payment Notice we incorporated the PAF into the BHP payment methodologies for 2018, 2019, 2020, and 2021 to capture the impact of how other states responded to us ceasing to pay CSRs. We will include the PAF in the 2022 payment methodology and to calculate it in the same manner as in the Final Administrative Order. In the event that an appropriation for CSRs for 2022 is made, we would determine whether and how to modify the PAF in the payment methodology.

Under the Final Administrative Order, we calculated the PAF by using information sought 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 zero), this would be counted as zero 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.¹¹ 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 one plus the nationwide median adjustment divided by one plus the state median adjustment for the BHP state. In other words,

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

To determine the PAF described above, we sought to collect QHP information from QHP issuers in each state and the District of Columbia to determine the premium adjustment those issuers made to each silver level plan offered through the Exchange in 2018 to account for the end of CSR payments. Specifically, we sought 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 operating on Exchanges in 2018. Of these 1,233 QHPs, 318 QHPs (25.8 percent) responded to our request for the percentage adjustment applied to silver-level QHP premiums in 2018 to account for the

¹¹ Some examples of outliers or unreasonable adjustments include (but are not limited to) values over 100 percent (implying the premiums doubled or more because of the adjustment), values more than double the otherwise highest adjustment, or non-numerical entries.

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 final PAF as $(1 + 20\%) \div (1 + 1\%)$ (or 1.20/1.01), which results in a value of 1.188.

We are finalizing our proposal to continue to set the PAF to 1.188 for program year 2022. 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 2022 can reasonably be expected to be similar to that in 2018, because the discontinuation of CSR payments has not changed. Moreover, we believe that states and QHP issuers have not significantly changed the manner and degree to which they are increasing QHP silver-level premiums to account for the discontinuation of CSR payments since 2018, and we expect the same for 2022.

In addition, the percentage difference between the average second lowest-cost silver level QHP and the bronze-level QHP premiums has not changed significantly since 2018, and we do not expect a significant change for 2022. In 2018, the average second lowest-cost silver level QHP premium was 41.1 percent higher than the average lowest-cost bronze-level QHP premium (\$481 and \$341, respectively). In 2021, (the latest year for which premiums have been published), the difference is similar; the average second lowest-cost silver-level QHP premium is

37.8 percent higher than the average lowest-cost bronze-level QHP premium (\$452 and \$328, respectively).¹² In contrast, the average second lowest-cost silver-level QHP premium was only 23.8 percent higher than the average lowest-cost bronze-level QHP premium in 2017 (\$359 and \$290, respectively).¹³ If there were a significant difference in the amounts that QHP issuers were increasing premiums for silver-level QHPs to account for the discontinuation of CSR payments over time, then we would expect the difference between the bronze-level and silver-level QHP premiums to change significantly over time, and that this would be apparent in comparing the lowest-cost bronze-level QHP premium to the second lowest-cost silver-level QHP premium.

3. Population Health Factor (PHF)

We are finalizing our proposal to include the PHF 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 that limits the ability to analyze the potential health differences between these groups of enrollees. More specifically, Exchanges have been in operation since 2014, and 2 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

¹² See Kaiser Family Foundation, “Average Marketplace Premiums by Metal Tier, 2018-2021,” <https://www.kff.org/health-reform/state-indicator/average-marketplace-premiums-by-metal-tier/>.

¹³ See Basic Health Program: Federal Funding Methodology for Program Years 2019 and 2020; Final Methodology, 84 FR 59529 at 59532 (November 5, 2019).

prospective adjustment to the PHF under § 600.610(c)(2) for the 2022 program year.

Given these analytic challenges and the limited data about Exchange coverage and the characteristics of BHP-eligible consumers, the PHF will be 1.00 for program year 2022.

In previous years BHP payment methodologies, we included an option for states to include a retrospective population health status adjustment. States will have same option for 2022 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 methodology. 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 propose a different PHF.

While the statute requires consideration of risk adjustment payments and reinsurance payments insofar as they would have affected the PTC that would have been provided to BHP-eligible individuals had they enrolled in QHPs, we are not requiring 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.¹⁴ Further, standard health plans did 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).¹⁵ 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)

¹⁴ See 79 FR at 14131.

¹⁵ 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").

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, all BHP Payment Methodologies incorporate household income into the calculations of the payment rates through the use of income-based rate cells. We are finalizing our proposal to define household income in accordance with the definition of modified adjusted gross income in 26 U.S.C. 36B(d)(2)(B) and consistent with the definition in 45 CFR 155.300. Income will be measured relative to the FPL, which is updated periodically in the **Federal Register** by the Secretary under the authority of 42 U.S.C. 9902(2). Household size and income as a percentage of FPL will be used as factors in developing the rate cells. We are finalizing our proposal to use the following income ranges measured as a percentage of FPL:¹⁶

- 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 finalized will 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 one percentage point interval of the income range for each federal BHP payment cell and then calculate the average of the PTC across all intervals. This calculation

¹⁶ These income ranges and this analysis of income apply to the calculation of the PTC.

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

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 Old-Age, Survivors, and Disability Insurance (OASDI) and Medicare Trustees Reports.¹⁷

5. Premium Tax Credit Formula (PTCF)

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

¹⁷ See Table IV A1 from the 2020 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/files/document/2020-medicare-trustees-report.pdf>.

amount.

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

As discussed in section I.C. of this final notice, we note that the ARP updated the applicable percentages of household income used to calculate the PTC that would be paid to an individual enrolled in a QHP on an Exchange for calendar years (CY) 2021 and 2022. The applicable percentages in Table 1 for CY 2022 will be effective for BHP program year 2022. Absent future legislation addressing applicable percentages, 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 2022^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 150%	0.0%	0.0%
150.0% percent up to 200.0%	0.0%	2.0%
200.0% up to 250.0%	2.0%	4.0%
250.0% up to 300.0%	4.0%	6.0%
300.0 percent up to 400.0%	6.0%	8.5%
400.0% percent and higher	8.5%	8.5%

^a section 9661 of the American Rescue Plan Act of 2021.

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 did not seek to make an adjustment based on the effect of 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.

Therefore, in the 2020 and 2021 payment methodology, we included 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 believed that it was appropriate to consider how individuals would have chosen different plans—including across different metal tiers—as part of the BHP payment methodology.

In the 2022 proposed Payment Notice, we proposed to include the MTSF in the payment methodology and calculate its value using the same approach as finalized in the 2020 final Payment Notice (84 FR 59543). As discussed above, since publication of the 2022 proposed

Payment Notice, Congress passed the ARP, which, as discussed in section I.C. of this final notice, modifies the applicable percentages of household income used to calculate the amount of APTC taxpayers are eligible to have paid on their behalf for coverage purchased through an Exchange during taxable years 2021 and 2022. Also as discussed above, we believe that these changes are likely to significantly affect enrollees' plan choices starting in 2022. Most notably, individuals with incomes up to 150 percent of FPL will be able to purchase a silver-level plan with a \$0 premium, and individuals with incomes between 150 percent and 200 percent of FPL will be able to purchase a silver-level plan at a lower premium than previously. Therefore, we believe that significantly more enrollees likely will choose to enroll in silver-level plans (and fewer in bronze-level plans) and the amount of PTC foregone therefore will be less than it was in previous years. Accordingly, the impact of the MTSF likely will be significantly less. Therefore, we are not finalizing our proposal to include the MTSF in the 2022 payment methodology.

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 are finalizing our proposal to 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. Consistent with the methodology used in past years, we will estimate 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 will use the ratio of the reconciled PTC to the initial estimation of PTC as the IRF in Equation (1) for estimating the PTC portion of the BHP payment rate.

For 2022, OTA previously estimated that the IRF for states that have implemented the Medicaid eligibility expansion to cover adults up to 133 percent of the FPL would be 99.01 percent. However, due to changes made by the ARP, OTA has revised its estimate for the IRF to be 100.63 percent. Specifically, section 9661 of the ARP specifies new applicable percentages of household income for the purposes of calculating the PTC for 2021 and 2022. This would lead to an increase in PTC, by reducing the household premium contribution. It also is anticipated to have an effect on the income reconciliation for persons enrolled in QHPs in the Exchanges, as evidenced by the revised estimate.

We believe that it is appropriate to distinguish between the IRF for Medicaid expansion states and non-Expansion states to remove data for those with incomes under 138 percent of FPL for Medicaid expansion states. This is the same approach that we finalized in the 2021 final BHP Payment Notice. For other factors used in the BHP payment methodology, it may not always be possible to separate the experiences between different types of states and there may not be meaningful differences between the experiences of such states. Therefore, we will set the value of the IRF for states that have expanded Medicaid equal to the value of the IRF for

incomes between 138 and 200 percent of FPL and the value of the IRF for states that have not expanded Medicaid equal to the value of the IRF for incomes between 100 and 200 percent of FPL. This gives an IRF of 100.63 percent for states that have expanded Medicaid and 100.83 percent for states that have not expanded Medicaid for program year 2022.

We will use this value for the IRF in Equations (1) for calculating the PTC portion of the BHP payment rate.

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 adjusted reference premium (that is, using premium data from the prior program year multiplied by the premium trend factor (PTF), as described in Equation (2b). We will require states to make their election to have their final federal BHP payment rates calculated using a projected adjusted reference premium by the later of (1) May 15 of the year preceding the applicable program year or (2) 60 days after the publication of the final notice. Therefore, because we are finalizing the 2022 payment methodology after May 15, 2021, states must inform CMS in writing of their election for the 2022 program year by 60 days after the publication of the final notice.

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

PTF: In the case of a state that would elect to use the 2021 premiums as the basis for determining the 2022 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 are finalizing our proposal to use the annual growth rate in private health insurance expenditures per enrollee from the National Health Expenditure (NHE) projections, developed by the Office of the Actuary in CMS (<https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected>). Based on these projections, we are finalizing our proposal that the PTF be 4.7 percent for BHP program year 2022.

We note that the increase in premiums for QHPs from 1 year to the next may differ from the PTF developed for the BHP funding methodology for several reasons. In particular, we note that the second lowest cost silver plan may be different from one year to the next. This may lead to the PTF being greater than or less than the actual change in the premium of the second lowest cost silver plan.

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

To determine whether the potential difference in health status between BHP enrollees and consumers in 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 methodology) 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. However, to the extent 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 are finalizing our proposal to permit a retrospective adjustment that will 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 are finalizing our proposal to 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 will apply 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 for the 2022 program year by the later of August 1, 2021 or 60 days after the publication of this final notice. Because this final notice is being published within 60 days of August 1, 2021, we are finalizing that a state will be required to submit its proposed protocol for the 2022 program year by 60 days after the publication of this final notice. This submission will also need to include descriptions of how the state would collect the necessary data to determine the adjustment, including any contracting contingencies 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, 2021 for the 2022 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 the federal BHP payments were less than they would have been using the final adjustment factor, we will 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 will subtract the difference from the next quarterly BHP payment to the state.

IV. Collection of Information Requirements

Although the methodology's information collection requirements and burden had at one time been approved by the Office of Management and Budget (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 2022 methodology is not subject to the requirements of the PRA.

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 final methodology provides for the funding methodology to determine the federal BHP payment amounts required to implement these provisions for program year 2022.

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. 96354), 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), and Subtitle E of the Small Business Regulatory Enforcement Fairness Act of 1996 (the Congressional Review Act) (5 U.S.C. 801 *et seq.*).

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. To date, two states have established a BHP, and we expect state participation to remain static as a result of this

payment methodology. However, the final payment methodology for program year 2022 differs from the payment methodology for program year 2021 due to the removal of the MTSF, which would increase BHP payments, compared to the methodology for program year 2021. OMB Office of Information and Regulatory Affairs has determined this rulemaking is “economically significant” as measured by the \$100 million threshold under Executive Order 12866, and hence also a major rule under the Congressional Review Act, 5 U.S.C. 804(2). Accordingly, we have prepared a RIA that, to the best of our ability, presents the costs and benefits of the rulemaking.

C. Detailed Economic Analysis

The aggregate economic impact of this payment methodology is estimated to be \$1,114 million in transfers for CY 2022 (measured in real 2022 dollars), which would be an increase in federal payments to the state BHPs. For the purposes of this analysis, we have assumed that two states would implement BHPs in 2022. This assumption is based on the fact that two states have established a BHP to date, and we do not have any indication that additional states may implement the program. We also assumed there would be approximately 926,000 BHP enrollees in 2022. The size of the BHP depends on several factors, including the number of and which particular states choose to implement or continue a BHP, the level of QHP premiums, and the other coverage options for persons who would be eligible for the BHP. In particular, while we generally expect that many enrollees would have otherwise been enrolled in a QHP on the Exchange, some persons may have been eligible for Medicaid under a waiver or a state health coverage program. For those who would have enrolled in a QHP and thus would have received PTCs, the federal expenditures for the BHP would be expected to be more than offset by a reduction in federal expenditures for PTCs. For those who would have been enrolled in Medicaid, there would likely be a smaller offset in federal expenditures (to account for the federal share of Medicaid expenditures), and for those who would have been covered in non-federal programs or would have been uninsured, there likely would be an increase in federal expenditures.

Projected BHP enrollment and expenditures under the previous payment methodology were calculated using the most recent 2021 QHP premiums and state estimates for BHP enrollment. We projected enrollment for 2022 using the projected increase in the number of adults in the U.S. from 2021 to 2022 (0.4 percent), and we projected premiums using the NHE projection of premiums for private health insurance (4.7 percent). Prior to any changes made in the 2022 BHP payment methodology, federal BHP expenditures are projected to be \$6,738 million in 2022. This projection serves as our baseline scenario when estimating the net impact of the 2022 final methodology on federal BHP expenditures.

The change in the PTCF percentages is the most significant change in the methodology from the proposed notice, and is prescribed in the ARP. To calculate the changes that result from these changes in the payment methodology, we compared the results before and after these changes using the BHP payment model, we maintain to calculate payments to states, with projections used to calculate impacts in 2022. We recalculated the BHP payments using the new PTCF percentages to calculate the impact of this change, and we estimate that this would increase BHP payments by \$853 million in 2022 (as compared to using the previous PTCF percentages, as described in the proposed methodology). The new PTCF percentages can be found in Table 1 in section III.D.5 of this final notice. For the change in the methodology to remove the MTSF for benefit year 2022, the MTSF was calculated as having a value of 96.68 percent (as described previously). We recalculated the BHP payments excluding the MTSF from the formula, and we estimate this would increase BHP payments by \$261 million in 2022 (as compared to the payments using a methodology including the MTSF factor). The projected BHP expenditures after these changes are \$7,852 million, which is the sum of the prior estimate (\$6,738 million) and the impacts of the changes to the methodology (\$853 million and \$261 million).

TABLE 2: Estimated Federal Impacts for the Basic Health Program 2022 Payment Methodology (Millions of 2022 dollars)

Projected Federal BHP Payments under 2021 Final Methodology	\$6,738
Projected Federal BHP Payment under 2022 Final Methodology	\$7,852
Federal costs	\$1,114
<i>Totals may not add due to rounding</i>	

The provisions of this final methodology 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 2021, accounts for these variations to ensure accurate BHP payment transfers are made to each state.

D. Alternative Approaches

We considered several alternatives in developing the BHP payment methodology for 2022, and we discuss some of these alternatives below.

We considered alternatives as to how to calculate the PAF in the final methodology for 2022. The value for the PAF is 1.188, which is the same as was used for 2018, 2019, 2020, and 2021. We believe it would be difficult to obtain 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 2022. We are continuing to consider whether or not there are other methodologies or data sources we may be able to use to calculate the PAF.

We also considered alternatives as how to calculate the MTSF in the final methodology for 2022. Given the changes made to the determination of PTC for 2022 in the ARP, we are not including the MTSF in the 2022 payment methodology, as described in section III.D.6. of this final notice.

We also considered whether to continue to provide states the option to develop a protocol for a retrospective adjustment to the PHF as we did in previous payment methodologies. We believe that continuing to provide this option is appropriate and likely to improve the accuracy of the final payments.

We also considered whether 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 these options.

Many of the factors in this final methodology are specified in statute; therefore, for these factors we are limited in the alternative approaches we could consider. We do have some choices in selecting the data sources used to determine the factors included in the methodology. Except for state-specific RPs and enrollment data, we will use 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 will use state-specific data rather than national data, as we believe state-specific data will produce more accurate determinations than national averages. Our responses to public comments on these alternative approaches are in section II of this final notice.

E. Accounting Statement and Table

In accordance with OMB Circular A- 4, Table 3 depicts an accounting statement summarizing the assessment of the transfers associated with these payment methodologies.

TABLE 3: Accounting Statement Changes to Federal Payments for the Basic Health Program for 2022

Category	Estimates	Units		
		Year dollar	Discount rate (%)	Period Covered
Transfers: Annualized/Monetized (\$million/year)	\$1,114	2022	7	2022
	\$1,114	2022	3	2022
From Whom to Whom	From the Federal Government to States Operating BHPs			

F. Regulatory Flexibility Act (RFA)

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

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. Therefore, the Secretary has determined that this final rule will not

have a significant economic impact on a substantial number of small entities.

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

G. Unfunded Mandates Reform Act (UMRA)

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 2021, that threshold was approximately \$158 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.

H. Federalism

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 methodology.

I. Conclusion

Overall, federal BHP payments are expected to increase by \$1,114 million in 2022 as a result of the changes to the payment methodology. The analysis above, together with the remainder of this preamble, provides an RIA.

This final regulation is subject to the Congressional Review Act (5 U.S.C. 801 *et seq.*) and has been transmitted to the Congress and the Comptroller General for review.

Dated: June 30, 2021.

Xavier Becerra,

Secretary,

Department of Health and Human Services.

[FR Doc. 2021-14393 Filed: 7/2/2021 4:15 pm; Publication Date: 7/7/2021]