DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 600

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Basic Health Program; Federal Funding Methodology for Program Year 2015

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

ACTION: Final methodology.

SUMMARY: This document provides the methodology and data sources to determine the federal payment amounts made to states in program year 2015 that elect to establish a Basic Health Program certified by the Secretary under section 1331 of the Patient Protection and Affordable Care Act to offer health benefits coverage to low-income individuals otherwise eligible to purchase coverage through Affordable Insurance Exchanges.

EFFECTIVE DATE: January 1, 2015.

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SUPPLEMENTARY INFORMATION:

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D. Federalism

I. Background

The Patient Protection and Affordable Care Act (Pub. L. 111-148, enacted on March 23, 2010), together with the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), enacted on March 30, 2010 are collectively referred as the Affordable Care Act. The Affordable Care Act provides for the establishment of state Affordable Insurance Exchanges (Exchanges, also called the Health Insurance Marketplace) that provide access to affordable health insurance coverage offered by qualified health plans (QHPs) for most individuals under age 65 who are not eligible for health coverage under other federally supported health benefits programs or through affordable employer-sponsored insurance coverage, and who have incomes above 100 percent of the federal poverty line (FPL), or whose income is below that level but are lawfully present non-citizens ineligible for Medicaid because of immigration status. Individuals enrolled through Exchanges in coverage offered by QHPs with incomes below 400 percent of the FPL may qualify for the federal premium tax credit (PTC) and federally-funded cost-sharing reductions (CSRs) based on their household income, to ensure that such coverage meets certain standards for affordability.

In the states that elect to operate a Basic Health Program (BHP), BHP will make affordable health benefits coverage available for individuals under age 65 with household incomes between 133 percent and 200 percent of the FPL who are not otherwise eligible for Medicaid, the Children's Health Insurance Program (CHIP), or affordable employer sponsored coverage. (For those states that have expanded Medicaid coverage under section 1902(a)(10)(A)(i)(VIII) of 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.) Federal funding will be available for BHP based on the amount of PTC and CSRs that BHP enrollees would have received had they been enrolled in QHPs through Exchanges.

We are publishing, concurrently with this final methodology, a final rule entitled the "Basic Health Program: State Administration of Basic Health Programs; Eligibility and Enrollment in Standard Health Plans; Essential Health Benefits in Standard Health Plans; Performance Standards for Basic Health Programs; Premium and Cost Sharing for Basic Health Programs; Federal Funding Process; Trust Fund and Financial Integrity" (hereinafter referred to as the BHP final rule) implementing section 1331 of the Affordable Care Act, which requires the establishment of BHP. The BHP final rule establishes the requirements for state and federal administration of BHP, including provisions regarding eligibility and enrollment, benefits, cost-sharing requirements and oversight activities. While the BHP final rule codifies the overall statutory requirements and basic procedural framework for the funding methodology, it does not contain the specific information necessary to determine federal payments. We anticipated that the methodology would be based on data and assumptions that would reflect ongoing operations and experience of BHP programs as well as the operation of the Exchanges. For this reason, the BHP final rule specifies that the development and publication of the funding methodology, including any data sources, will be addressed in a separate annual Payment Notice process. The BHP final rule also specifies that the BHP Payment Notice process will include the annual publication of both a proposed and final BHP Payment Notice.

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

The following sections, arranged by subject area, include a summary of the public

comments that we received, and our responses. For a complete and full description of the BHP proposed funding methodology, see the "Basic Health Program; Proposed Federal Funding Methodology for Program Year 2015" proposed document published in the December 23, 2013 **Federal Register** (78 FR 77399).

We received a total of 32 timely comments from state agencies, groups advocating on behalf of consumers, health care providers, health insurers, health care associations, Tribes, and tribal organizations. The public comments received ranged from general support or opposition to the proposed methodology to very specific questions or comments regarding the proposed methodological factors. In addition, we held a consultation session on December 19, 2013 that was open to all interested parties, to provide an overview of the BHP proposed funding methodology where interested parties were afforded an opportunity to ask questions and make comments. At the consultation session, participating parties were reminded to submit written comments before the close of the public comment period that was specified in the BHP proposed methodology.

A. Background

In the December 23, 2013 (78 FR 77399) proposed methodology, as background and for contextual purposes, we discussed the proposed provisions from the September 25, 2013 BHP proposed rule (78 FR 77401). The proposed document also specified the methodology of how the federal BHP payments would be calculated. For specific discussions, please refer to the December 23, 2013 proposed methodology (78 FR 77401).

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

Comment: One commenter expressed support for publishing the final Payment Notice annually in February.

Response: We thank the commenter for their support.

Comment: Several commenters requested that CMS provide an option for states to have BHP payments retrospectively reconciled for the factors specified in statute. Specifically, commenters requested that such a reconciliation process use actual, state-specific data by taking into account the state's actual health insurance market experience for the program year, measure the data and payment factors in manner agreed upon by both CMS and the state, and perform the reconciliation using a methodology that is generally consistent with the methodology of the proposed payment document.

Response: We understand the commenters' concern regarding the market uncertainties in 2014 and appreciate the recommendations to refine the methodology to account for such uncertainties. However, based on initial feedback we received from interested states, we developed the BHP funding methodology on a prospective basis to provide states with a level of fiscal certainty as they consider implementing BHP in a given program year. Except for the population health factor, which is discussed further below in section III.G in this final methodology, we have determined not to retrospectively adjust or reconcile the various factors that comprise the methodology because we believe that states operating a BHP will need to have budget certainty in order to plan and operate their programs.

In addition, as also discussed below, we are revising our methodology to use actual 2015 premium amounts to calculate BHP funding for 2015. While this would be part of the prospective methodology and not a retrospective adjustment, it would further address some of the issues raised in these comments.

Comment: Many commenters noted that state-specific market conditions, such as in Minnesota where the state's high-risk pool will continue to operate in 2014, will not be reflected in the 2014 Exchange premiums but will affect the premium rates in 2015. As such, commenters recommended that CMS use actual 2015 Exchange premiums to improve the accuracy of the federal BHP payment rates for program year 2015.

Response: In response to these comments, and in particular because of the various issues in the first year of BHP implementation, we have adopted the commenters' recommendation and will use actual 2015 Exchange premiums to determine the final 2015 federal BHP payment rates in states. Given the fact that the Exchanges are new in 2014 and the potential for changes in 2015, we believe that it is appropriate to make this adjustment in the methodology for the first year of BHP implementation as it will improve the accuracy of the rates. For additional information on the process we will use to determine the final 2015 federal BHP payment rates, please see the additional discussion included in section III.D.1 (reference premium) of this final methodology.

While using actual 2015 Exchange premiums will improve the accuracy of the federal BHP payment rates by taking into account certain market conditions, we understand that, for decision making purposes, some states may need to establish budgets based on final 2015 federal BHP payment rates before actual 2015 premium information becomes available. In such an event, we will provide the state with the option to have us use 2014 premium data (projected forward to 2015) to calculate its final 2015 federal BHP payment rates. As specified in this payment notice, a state must notify CMS by May 15, 2014 that it is electing this option. Upon completing the calculation process, we will publish the final rates for such states in a subsequent **Federal Register** notice, and use these final rates to determine the state's aggregate 2015 BHP

federal payments, which will be deposited into the state's BHP trust fund on a quarterly basis. We have amended this final methodology by adding section III.F to discuss this process in further detail. If a state does not elect this option to use 2014 Exchange premiums for calculating final 2015 BHP federal payments, we will calculate the payments using the 2015 premiums and also publish those rates in the **Federal Register**. Before publication, we are available to provide technical assistance to help the state better estimate the potential range of 2015 BHP federal payments. Finally, as we gain more experience in the Exchanges, and as data becomes more readily available, we will continue to review the methodology, including the data elements and other factors to further refine future BHP funding methodologies and improve the accuracy of the overall result.

Comment: Several commenters requested that CMS consider adjusting the funding methodology during the annual program year to ensure the accuracy of the methodology in the event new data becomes available. The commenters also requested that CMS consider adjusting the methodology and recalculate the federal BHP payment rates in the event that the payment rates are determined to be inadequate and negatively affect the participation of standard health plan offerors.

Response: We appreciate the commenters' concern with respect to the accuracy of the funding methodology as well as their interest in ensuring robust standard health plan offeror participation. While the statute directs the Secretary to adjust the payment for any fiscal year to reflect any error in the determination of the payment amount in the preceding fiscal year, the statute generally does not contemplate retrospective adjustment to amounts properly calculated under the certified methodology. Instead, the statute provides that adjustments are only made prospectively, and only to reflect errors. We read that term "errors" to mean mathematical errors

or erroneous enrollment numbers (which are multiplied by the per enrollee amount determined by the certified methodology). While the statute does not expressly provide for retrospective adjustments to a certified methodology, as discussed below we are providing an optional process for states to propose to include in the certified methodology a state-specific retrospective adjustment to reflect any disparity in BHP population health status (a risk adjustment) in each rate cell in comparison to the Exchange population that would affect the federal payment for that population. Permitting retrospective adjustment on this one factor (the population health factor) given the difficulty in arriving at a national approach to accurately determine this factor prospectively, in particular due to the lack of data and experience from the exchanges available at the beginning of 2014.

With respect to other commenters' concern that the federal BHP payment rates could be so low that they would negatively affect standard health plan offeror participation, the federal BHP payment is not necessarily determinative of the contract costs for standard health plans. The statute provides states that elect to operate a BHP with considerable flexibility to control costs through a competitive contracting process and other measures, and to supplement federal funding with additional state or local funding. The state may negotiate with its standard health plan offerors on the amount of capitation payments, the benefits in excess of the required essential health benefits, and the premiums consistent with the BHP enrollee protections. A state does not need to structure its standard health plan offeror payments to align with the federal BHP payment rate cells. A state has the flexibility to use the same rate cell structure, mimic the same structure that is used in other insurance affordability programs, or develop a new structure specifically for BHP.

Comment: We received one comment requesting that CMS develop state-specific BHP funding methodologies to more accurately account for the health status of a state's BHP population relative to consumers in the state's Exchange.

Response: We appreciate the commenter's interest in ensuring the development of the most accurate population health factor, and as such, are revising our methodology from what was proposed to include in the certified methodology a temporary state-specific adjustment to retrospectively adjust this factor for 2015. This retrospective adjustment, which would be subject to CMS review and approval, would be conducted to determine whether the difference in health status between the state's BHP population and consumers in the Exchange in 2015 would affect PTC, CSRs, risk adjustment and reinsurance payments that would have been made had BHP enrollees been enrolled in coverage through the Exchange**.** For additional information on this option, please refer to section III.G.

Comment: One commenter requested that CMS clarify when the actual reconciliation of BHP payment amounts will occur, including the timeframes in each quarter.

Response: We appreciate the commenter's interest in the payment reconciliation process, and anticipate providing future guidance on BHP payment operations.

Comment: We received one comment requesting clarification on when a state must submit both projected and actual enrollment data in order for CMS to determine the prospective quarterly federal BHP payment.

Response: For a state to receive a prospective federal BHP payment, the state must submit its projected BHP enrollment 60 days before the start of the fiscal quarter. Actual enrollment is required no later than 60 days after a fiscal quarter has ended. Once a state's BHP has been in operation for a few fiscal quarters, we anticipate using the state's actual enrollment

in the previous quarter to determine the upcoming quarter's federal BHP payment thereby eliminating the need for the state to submit projected enrollment data.

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 CSRs as consistently as possible and in general alignment with the methodology used by Exchanges to calculate the advance payments of the PTC and CSRs, and by the Internal Revenue Service (IRS) to calculate the final PTC. We proposed in this section four equations that comprise the overall BHP funding methodology. For specific discussions, please refer to the December 23, 2013 proposed methodology (78 FR 77401).

We received the following comments regarding the equations proposed to calculate the PTC and CSR components of the BHP funding methodology:

Comment: While we received support for the two-step process to calculate the federal BHP payment rate, one commenter requested that CMS release the data requirements states need to provide information related to the BHP risk profile so that rates are properly set to account for risk. The commenter also requested that CMS provide data alternatives in the event that states encounter difficulties in collecting the data needed to risk adjust.

Response: We appreciate the support for the two-step process and are finalizing this approach as proposed in this final methodology. As explained further in section III.D.2 of this final methodology, we are not requiring any data from the states on the risk of these populations unless a state elects to notify CMS that it will conduct a retrospective risk adjustment analysis in accordance with the process set forth in section III.G of this methodology. If the state decides to conduct such an analysis, it has discretion when determining the data requirements and any necessary alternatives; however, the state must submit to CMS such information as well as the

proposed methodology it intends to use during the reconciliation process for approval and certification. Regardless of whether or not states elect this option, we will continue to review this factor as we gain more experience in the Exchanges, and as data becomes more readily available, to refine future BHP funding methodologies.

Comment: One commenter requested clarification on Equation 1. Specifically, the commenter asked whether the average expected PTC that all persons in the rate cell would receive is an average for people within a certain region, or if this is a statewide average.

Response: The average expected PTC that all persons in the rate cell would receive is an average for persons within a state's geographic rating area, which in most instances would be a county or county-equivalent entity. These would not be statewide rates.

Comment: One commenter requested that CMS revise Equation 1 to account for the impact of induced utilization on the base premiums used to calculate the advanced payment of the premium tax credit (APTC). Such an adjustment would account for a greater APTC value due to the increase in health care service utilization. The commenter proposed such an adjustment to equal 1.12 divided by the average assumed induced utilization adjustment inherent in commercial premiums absent BHP.

Response: We do not believe that this adjustment is appropriate. This adjustment would be inconsistent with how the PTC is calculated and with the statute. In addition, we would note that only accounting for how the presence of the CSR may increase the average costs for enrollees would not be appropriate, as the CSR may also have an effect of lowering the average costs as well (for example, the provision of the CSR may encourage persons with lower expected health care costs to enroll).

Comment: Several commenters expressed support for the PTC calculation as it takes into account the CSRs that are particular to American Indians and Alaska Natives.

Response: We thank the commenters for their support and are finalizing the proposed provision.

Comment: Several commenters requested that CMS reconsider applying 100 percent of the CSR that would have been available in the Exchange to the BHP payment methodology, as opposed to 95 percent. Many commenters stated that the statute provides for this interpretation given the placement of the comma in section 1331(d)(3)(i) of the Affordable Care Act.

Response: We appreciate the commenters' concern regarding this issue, and we have carefully considered and reviewed the commenters' suggestions. We have interpreted the 95 percent specified in statute to refer to both the PTC and CSR components of the BHP payment methodology. We believe that applying the 95 percent to both components of the methodology represents the best reading of the statute and the intent of the drafters, and we are therefore finalizing the proposed provision.

Comment: We received one comment identifying a potential error in Equation 2. Specifically, the commenter believes that the equation should read "FRAC x AV" rather "FRAC + AV."

Response: We appreciate the identification of a potential error; however, the equation, as written in the proposed methodology, is correct. The symbol in the proposed methodology is the division symbol, not the addition symbol. We have revised the display of the formula for the sake of clarity, as shown below.

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

Comment: We received a comment with respect to the premium trend factor included in the equations. Specifically, the commenter expressed concern that it will not capture changes in premiums due to non-claim issues such as increases in premium taxes, assessment, and Exchange user fees. The commenter recommended that non-claim issues be included in the equations, and that the equations should be calculated using only individual membership and vary by state.

Response: The methodology does take into account non-claim issues, as the National Health Expenditure projections include all plan expenses (including administrative costs and plan taxes and fees). We recognize that the methodology does not use a factor specific to individual private health insurance premiums, but we believe this is a reasonable estimate of future growth of all private health insurance premiums. We believe that the equation reflects a consistent approach for calculating this portion of the federal BHP payment for all states, and note that it incorporates state-specific values for the adjusted reference premium and the tobacco rating factor adjustment.

We also note that the federal 2015 BHP payment will be calculated using the actual 2015 Exchange premiums instead of the projected 2015 Exchange premiums (unless a state elects to use its 2014 premium as the basis for the 2015 calculation). We believe that this addresses the concerns raised by the commenters that there may be differences in the premium growth rates across states because the calculation will use actual Exchange premiums in effect for the year.

C. Required Rate Cells

In this section, we proposed that a state implementing BHP provide us with an estimate of the number of BHP enrollees it will enroll in the upcoming BHP program, by applicable rate cell, to determine the federal BHP payment amounts. For each state, we proposed using rate

cells that separate the BHP population into separate cells based on the following five factors: age; geographic rating area; coverage status; household size; and income. For specific discussions, please refer to the December 23, 2013 proposed methodology (78 FR 77403).

We received the following comments on the proposed rate cells:

Comment: One commenter expressed support in using rate cells organized by income range to determine the aggregate federal BHP payment. The commenter believes that the variation in available PTC is minimal between the high and low points in each of the rates cells, and the proposed approach provides for an administratively simple way to calculate the federal BHP payment amount. The commenter believes that it was unclear in the proposed methodology how the averages in each rate cell will be calculated, and recommended that CMS provide states with the flexibility to determine the average PTC within each rate cell depending on the distribution of its BHP population.

Response: We thank the commenter for their support; however, we believe that applying a uniform distribution across income ranges within each rate cell to determine the average PTC is the most appropriate approach. This approach will allow for timely calculation of the rates, will eliminate the risk that rate cells with a small number of persons projected to enroll would see the BHP payment rates skewed, and will not require any estimation of BHP enrollment for each rate cell prospectively. Furthermore, we do not believe that determining the average PTC based on the distribution of the BHP population would materially change the final BHP payment.

Comment: Several commenters expressed concern that the age bands included in the proposed methodology were too broad, and recommended that CMS consider narrowing the age bands, particularly the 21 – 44 age band.

Response: We appreciate these comments, and the final BHP payment methodology will split the proposed age band into two separate age bands: 21-34 and 35-44.

Comment: One commenter requested that CMS offer as an option to states a smaller number of rate categories, actuarially rolled up from the population cells, to better align with the rate categories states already have established in their Medicaid information systems. The commenter believes that such an approach would reduce administrative burden on states implementing BHP.

Response: We appreciate and share the commenter's interest in reducing the administrative burden on states implementing BHP. The use of distinct rate cells is necessary to accurately reflect the different costs of the PTCs and CSRs for subcomponent population groups that would be paid if the individuals had been enrolled in coverage through the Exchange. This approach is necessary to ensure an accurate and precise determination of available federal funding in the absence of reliable data on the composition of the BHP population. At some future point in time, when reliable data is available about the BHP population, it might be possible to reduce the number of rate cells based on actuarial projections.

These rate cells will likely differ from the rate cells that the state uses to pay standard health plans (to the extent that a state uses rate cells at all), because they are based on a different underlying purpose. The BHP federal payment rate cells are to determine the PTCs and CSRs that would be paid in the absence of a BHP, while rate cells that a state may use for purpose of payment to standard health plans need to reflect the relative overall covered health care costs of each segment of the population. States have considerable flexibility in determining how to pay standard health plan offerors, and are not required to use rate cells at all. A state may elect to use

the BHP federal payment rate cells, may use a payment structure borrowed from other insurance affordability programs, or may use a payment structure specifically designed for BHP.

D. Sources and State Data Considerations

We proposed in this section to use, to the extent possible, data submitted to the federal government by QHP issuers seeking to offer coverage through an Exchange to determine the federal BHP payment cell rates. However, in states operating a State Based Exchange (SBE), we proposed that such states submit required data for CMS to calculate the federal BHP payment rates in those states. For specific discussions, please refer to the December 23, 2013 proposed methodology (78 FR 77404).

We received the following comments on the data needed from SBEs to determine the federal BHP payment rates:

Comment: One commenter requested that CMS permit states operating SBEs to submit data after the January 20, 2014 deadline on a technical assistance basis.

Response: We will review 2014 premium data that is submitted on a technical assistance basis after the January 20, 2014 deadline to help provide interested states determine preliminary 2015 federal BHP payment rates. Because final 2015 federal BHP payment rates will be determined using actual 2015 premium data, states do not need to submit 2014 premium data unless they are interested in working with CMS to develop preliminary estimates of the federal BHP payments using the 2014 data. Finally, we are also available to provide technical assistance to states as they collect the information needed to complete the premium collection tool.

E. Discussion of Specific Variables Used in Payment Equations

In this section, we proposed 11 specific variables to use in the payment equations that comprise the overall BHP funding methodology. For each proposed variable, we include a

discussion on the assumptions and data sources used in developing the variables. For specific discussions, please refer to the December 23, 2013 proposed methodology (78 FR 77404).

We received the following comments on the specific variables used in the payment equations:

1. Variable 1 – Reference Premium

Comment: Several commenters supported the assumptions used in developing the funding methodology, including the use of the second lowest cost silver plan premium and lowest cost bronze premium.

Response: We thank the commenters for their support and are finalizing the proposed assumptions.

Comment: While one commenter expressed support for using the second lowest cost silver plan as the methodology's reference premium, the commenter recommended that CMS permit the value of the second lowest cost silver plan change in the event that the QHP leaves the Exchange, or enrollment in the QHP closes.

Response: While we appreciate the commenter's interest in ensuring that the reference premium is reflective of the actual second lowest cost silver plan at a given point, we are not revising the final methodology to incorporate the commenter's recommendation. We believe that such a recommendation would prove inconsistent with the policy set forth in 26 CFR 1.36B-3(f)(6) to update the payment methodology, and subsequently the federal BHP payment rates, in the event that the second lowest cost silver plan used as the reference premium changes (that is terminates or closes enrollment during the year).

Comment: Several commenters requested that CMS consider using a national average premium as the reference premium in the methodology in the event that CMS does not adjust the

methodology to use actual premiums rather than use a reference premium trended forward by the premium trend factor.

Response: While we appreciate the commenters' recommendation, we are not adopting the use of a national average premium as the methodology's reference premium as we believe this would be inconsistent with the requirements in statute. Unless otherwise notified by a state, we intend to use the actual 2015 second lowest cost silver plan premiums to determine the final 2015 federal BHP payment rates , which we believe addresses the commenters' concerns.

Comment: Several commenters requested that, when calculating the CSR component of the federal BHP payment, CMS account for the likelihood that American Indians and Alaska Natives will elect to enroll in a bronze-level QHP that would utilize the entire PTC that would have otherwise been available to the enrollees rather than assuming the enrollees will select the lowest cost bronze level QHP. The commenter noted that while American Indians and Alaska Natives purchasing coverage in the Exchange will likely select a bronze level QHP, they may not always select the lowest cost bronze plan.

Response: We appreciate the commenters' concerns about the level of funding related to American Indians and Alaska Natives enrolled in BHP. With regard to comments that the methodology assume that American Indians and Alaska Natives who enroll through the Exchange would choose a QHP with a premium that is at least equal to the value of the PTC, the payment methodology is consistent with this assumption.

With regard to the comments that American Indians and Alaska Natives who would enroll through the Exchange may select other bronze level QHPs than the lowest cost plan, we acknowledge the likelihood of the selection of different bronze level QHPs, but we believe it is not possible to project how these enrollees would select different plans for 2015 (similar to the

limitations regarding the assumption of how enrollees would select plans other than the second lowest cost silver plan). In addition, while there may be instances where the value of PTC would exceed the value of some bronze QHP premiums, this may vary by age, household size, household income, and other factors; we believe this further limits the ability to project how enrollees would select different plans. Thus, we have selected what we believe to be an assumption that is reasonable and results in the correct level of funding for BHP.

2. Variable 2 – Premium Trend Factor

Comment: Several commenters requested that CMS reconsider removing the premium trend factor from the methodology and simply reconcile the BHP federal payment rates using actual 2015 second lowest cost silver premiums. In the event that CMS will not use actual premiums, the commenters recommended, as an alternative, that CMS not use the proposed premium trend factor, but rather develop a factor that sufficiently offsets the artificially low 2014 Exchange premiums, or provide the state with the option to submit a state-specific trend factor that is based on other reliable cost and experience data. Commenters also expressed interest in using actual Exchange premium data to develop the premium trend factor in future program years.

Response: As noted in an earlier response, and discussed further in section III.D.1 of this final methodology, we will determine final 2015 federal BHP payment rates using actual 2015 premiums unless notified by a state to calculate its payment rates with 2014 premium data. We believe that this approach is appropriate in the first year of BHP implementation given the uncertainties in market conditions in the Exchanges.

Given that we are using actual 2015 premiums, we are not adopting the commenters' recommendation to apply a different premium trend factor other than the National Health

Expenditure projection with an adjustment for the impact of the reinsurance pool on QHP premiums between 2014 and 2015. With respect to commenters' interest in the premium trend factor that will be used in future BHP program years, we will use actual Exchange and BHP experience to develop this factor for future funding methodologies, which will follow the Payment document process specified in the BHP final regulation. Publishing an annual proposed and final Payment document will help refine the BHP funding methodology as we gain more experience from the Exchanges as well as better data that is based on actual market conditions.

Comment: One commenter requested that CMS provide additional clarification on the transitional reinsurance adjustment. The commenter believes that the adjustment would include a component that would be equal to the percentage of costs not covered by reinsurance recoveries in 2015 over the percentage of costs not covered by reinsurance recoveries in 2014.

Response: We provide additional clarification on the reinsurance adjustment in section III.F of this final methodology.

3. Variable 3 – Population Health Factor

Comment: Several commenters disagreed with our proposed value for the population health factor. Specifically, commenters believe that the 1.00 value did not accurately reflect the health status of potential BHP eligible individuals in certain states. As such, commenters requested that CMS retrospectively adjust this factor using either a state-specific methodology, or the same methodology that is used to risk adjust in the individual market.

Response: We understand the commenters' interest in ensuring that the population health factor accurately reflects the health status of BHP individuals relative to consumers in the Exchange. In light of the comments we received on this issue, and, in particular, because of the lack of currently available data, we are providing states with an option to propose a

methodology, as discussed further in section III.G of this final methodology, for CMS approval that would retrospectively adjust for risk. We understand that such an assessment may be necessary to determine whether the difference in health status between the state's BHP population and consumers in the Exchange would affect PTC, CSRs, risk adjustment and reinsurance payments that would have been made had BHP enrollees been enrolled in coverage through the Exchange.

While we are finalizing the proposed value of the population health factor, we would note that as additional experience is gained in the Exchange and more data becomes available, we believe that this factor will be reviewed to ensure it accurately reflects the health status of BHP enrollees relative to consumers in the Exchange.

Comment: While we received several comments in support of the proposed provision to exclude BHP from the individual market's risk pool, other commenters requested that CMS consider providing states with the option to include BHP in its individual market's risk pool. Commenters also requested that CMS permit states to have the ability to apply aspects of the reinsurance, risk adjustment, and risk corridor program to BHP. Several commenters noted that the existence of the reinsurance program has likely reduced individual market premiums, and further emphasized the importance of making a reinsurance payment in BHP using the same mechanism and conditions in the individual market.

Response: We have carefully considered this issue and have determined that BHP should be excluded from the individual market because the market reform rules under the Public Health Service Act that were added by Title I, Subtitles A and B of the Affordable Care Act, such as the requirements for guaranteed issue, and premium rating do not apply to standard health plans participating in BHP. Moreover, in accordance with 45 CFR 153.234 and 45 CFR 153.20,

standard health plans operating under a BHP are not eligible to participate in the reinsurance program and the federally-operated risk adjustment program. With respect to the risk corridor program, the statute, under section 1342 of the Affordable Care Act, precludes standard health plans from participation. To the extent that a state operating a BHP determines that, because of the risk-profile of its BHP population, standard health plans should be included in mechanisms that share risk, the state would need to use other methods for achieving this goal, such as electing to submit a proposed methodology to retrospectively risk adjust.

Comment: One commenter requested that CMS consider, when developing risk formulas, to adequately capture risk associated with chronic and behavioral health conditions.

Response: We appreciate the comment, but as we are not developing a risk adjustment between the BHP and individual market populations for 2015, the issue of risk associated with chronic and behavioral health conditions does not affect the federal BHP payment. In the event that a state elects to propose a risk adjustment reconciliation methodology, we encourage the commenter to engage with the state as it develops such a methodology.

Comment: One commenter requested clarification on whether the population health factor will be based on a certain region, or if it will be a statewide adjustment.

Response: The population health factor will be a state-wide adjustment unless a state utilizes a different approach approved by CMS in its risk adjustment reconciliation methodology.

4. Variable 6 – Income Reconciliation Factor

Comment: Several commenters recommended that CMS explicitly state that the PTC repayment caps specified in the Affordable Care Act will be applied to income reconciliation process in BHP.

Response: We appreciate the commenters' interest in ensuring that BHP enrollees are not subject to PTC repayments in excess of what would have otherwise occurred had they enrolled in the Exchange, but want to assure the commenters that BHP enrollees are not subject to PTC repayments. Repayments were considered as we developed the income reconciliation factor. While the repayment caps were included in the development of this factor, they do not apply to BHP enrollees as there is no individual income reconciliation process in BHP. BHP enrollees are not eligible to receive an advance payment of the PTC (APTC), and as such, they are not subject to the same income reconciliation process as Exchange consumers.

Comment: One commenter requested that CMS consider the differences in the income distribution of state BHP populations in estimating the reconciliation effect.

Response: We appreciate the comment, but we believe that a national factor is appropriate and we are maintaining it for this year's payment notice. We note that there is a relatively narrow range of incomes for BHP-eligible consumers, and thus state-specific income distributions are unlikely to have a significant impact on the BHP payment.

Comment: Several commenters recommended that CMS adjust the income reconciliation factor to account for certain eligibility and enrollment processes. For example, the commenters noted that if a state reviews databases and/or requires reporting of changes in enrollees' income and household composition, it would be unfair to apply a full reconciliation factor to this state since the income reconciliation factor assumes no income changes in the course of the payment year will affect eligibility. Commenters did note that a full reconciliation factor could be applied if a state elected to implement a 12-month continuous eligibility policy.

Response: The income reconciliation factor has been developed consistent with the assumption that states will adopt a continuous eligibility policy. We do not have a basis to

develop a prospective factor if a state does not do so, because state review and redetermination processes will vary. We will consider revisiting this assumption in future years for such states, based on available data on the effectiveness of state review and redetermination processes.

5. Variable 7 – Tobacco Rating Adjustment Factor

Comment: Based on available state data, one commenter expressed concern that the BHP population may have higher rates of smoking relative to the state average. As such, the commenter requested that CMS apply an adjustment based on state average smoking rates.

Response: We appreciate the comment, and intend to use state-specific tobacco usage rates by age, based on data available from the Center for Disease Control and Prevention, which is described in more detail in section III.D.6 of this final methodology. We do not intend to make an adjustment based on different rates of tobacco usage by income level.

Comment: One commenter requested that CMS provide additional detail on how it will calculate the estimated adjustment when calculating the CSR and whether the tobacco adjustment factor will be the same factor statewide, or vary by region.

Response: The tobacco usage rates that are a component of the tobacco rating adjustment factor are statewide. To the extent that the difference between the non-tobacco and tobacco premiums varies by geographic rating area within the state, the tobacco rating adjustment factor may also vary as well.

6. Variable 8 – Factor to Remove Administrative Costs

Comment: Several commenters requested that CMS either provide states the option to provide a state-specific factor, or to retrospectively reconcile using the actual medical loss ratio in the Exchange in a given BHP program year.

Response: We appreciate the comments, but we believe that using the factor that we proposed to remove administrative costs is the most appropriate and consistent methodology to calculate the federal BHP payment. We would clarify that the factor to remove administrative costs is not precisely the same as the medical loss ratio; the factor to remove administrative costs also excludes certain plan costs (such as taxes, fees, and quality improvement activities) that are not counted towards the total plan revenue when calculating the medical loss ratio. Thus, the factor to remove administrative costs would likely be less than the actual or target medical loss ratios.

Comment: Several commenters expressed concern that because states cannot expend BHP trust funds to cover administrative costs associated with BHP operations, including this factor in the methodology would only further reduce the state resources needed to support the operation of BHP.

Response: While we understand the commenters' concerns regarding the availability of funding for administrative costs, the statute does not permit states to use BHP trust funds for any activity beyond the expenditures related to the provision of the standard health plan except for lowering premiums and cost sharing and/or providing additional benefits. We believe that it is appropriate to include this factor in the funding methodology as it is necessary to remove costs such as taxes, fees and administrative expenses from the reference premium in order to determine the costs associated with allowed health benefits.

7. Variable 10 – Induced Utilization Factor

Comment: Several commenters requested that CMS provide a state with the option to use a different induced utilization factor if it can demonstrate that utilization is more or less than 12 percent as a result of the CSRs.

Response: While we appreciate the commenters' interest in ensuring that the methodology is developed using the most accurate data available, we are not adopting the commenters' recommendation to permit such an option to states as we believe that using the factors developed for the 2015 HHS Payment Notice is the most appropriate methodology for calculating the federal BHP payment until more experience in BHP and the Exchange is gained and more data become available.

8. Variable 11 – Changes in Actuarial Value

Comment: One commenter requested that CMS allow states to adjust for the actuarial value difference based on empirical evidence of the utilization for a typical BHP eligible population in that state.

Response: While we appreciate the commenter's interest in ensuring that the methodology is developed using the most accurate data available that is based on market experience, we are not adopting the commenter's recommendation to permit such an option to states as it is not consistent with statute. The change in actuarial value, which determines the value of the CSR, is specified in statute. As such, there is no basis to make such an adjustment based on state experience.

F. Adjustments for American Indians and Alaska Natives

We proposed to make several adjustments for American Indians and Alaska Natives when calculating the CSR portion of the federal BHP payment rate to be consistent with the

Exchange rules. For specific discussions, please refer to the December 23, 2013 proposed methodology (78 FR 77409).

We received the following comments on the proposed adjustments when calculating the CSR component for American Indians and Alaska Natives:

Comment: Several commenters supported our proposal to make several adjustments for American Indians and Alaska Natives when calculating the CSR portion of the federal BHP payment rate.

Response: We thank the commenters for their support and are finalizing the proposed provision.

Comment: Consistent with their comments regarding the reference premium, many commenters requested that CMS provide states with the option to retrospectively reconcile their federal BHP payments using actual premiums for the lowest cost bronze plans in the CSR calculation for American Indians and Alaska Natives.

Response: As discussed further in section III.D.1 of this final methodology, and elsewhere, we believe that it is appropriate for the first year of BHP implementation to determine final 2015 federal BHP payments using actual 2015 premiums, unless otherwise notified by the state, given the market uncertainties and the infancy of the Exchanges. Given this, we will also use actual 2015 lowest cost bronze plan premiums to calculate the CSR component for American Indians and Alaska Natives.

G. Example Application of the BHP Funding Methodology

In this section, we included an example of the proposed approach described in the proposed methodology. For specific discussions, please refer to the December 23, 2013 proposed methodology (78 FR 77410).

We received the following comment on the example application of the BHP funding methodology:

Comment: One commenter requested clarification with respect to column 2 in Table 2 of the proposed methodology (78 FR 77411). Specifically, the commenter believes that the percentages included in the column were incorrect and requested that the correct values be included in the final methodology.

Response: We thank the commenter for identifying the incorrect percentages in Table 2 of the proposed methodology. Because the table was simply illustrative, we are not republishing the table in this final methodology. The incorrect percentages did not affect the illustrative purpose of the Table, but the correct values should have ranged from 3.29 to 4.00 percent, instead of 2.29 to 3.00 percent.

H. General/Miscellaneous Comments

We received the following general comments on the proposed federal BHP funding methodology, as well as comments related to the BHP proposed rule:

Comment: One commenter expressed support for the proposed methodology stating that CMS had struck the right balance without making the methodology unduly complex.

Response: We thank the commenter for their support.

Comment: Several commenters expressed concern that the proposed BHP funding methodology will not provide sufficient funding to sustain existing state coverage programs that provide affordable coverage to individuals enrolled in such programs.

Response: We appreciate the commenters' concerns with respect to ensuring the availability of affordable coverage and continuing existing programs to prevent disruptions in care; however, the statute specifies that the Secretary will determine the BHP funding amount

such that it equals 95 percent of the PTC and CSRs that would have otherwise been available had BHP enrollees received QHP coverage in an Exchange.

Comment: Several commenters requested that CMS consider offering states the option of implementing risk corridors as a means of sharing risk.

Response: We appreciate the commenters' interest in the implementation of risk corridors in BHP; to the extent that a state operating a BHP determines that, because of the risk-profile of its BHP population, standard health plans should be included in mechanisms that share risk, the state would need to establish state-specific methods for achieving this goal, such as proposing a risk adjustment reconciliation methodology. Because section 1342 of the Affordable Care Act specifically limits the risk corridor program to QHPs, standard health plans operating under BHP are not eligible to participate. As such, we are not revising the final methodology to adopt the commenters' recommendation as the document provides state flexibility in using other methods to implement mechanisms that share risk.

Comment: Several commenters urged CMS to permit states to use BHP trust funds to cover the administrative costs associated with implementing BHP.

Response: This comment is outside the scope of this final methodology; however, we received an identical comment on the BHP proposed rule. The statute only permits the expenditure of BHP trust funds to further reduce premiums and cost sharing and provide additional benefits to individuals eligible for BHP; more detail is provided in the BHP final rule.

Comment: One commenter requested that CMS clarify whether BHP trust funds can be used to provide benefits beyond Essential Health Benefits (EHBs) and to make supplemental payments to FQHCs if such payments are not equal to the PPS rate. The commenter also recommended that CMS require states to use excess funds to lower premiums and cost sharing.

Response: This comment is outside the scope of this final methodology; however, we received an identical comment on the BHP proposed rule. The statute does provide states with the flexibility to expend BHP trust funds to further reduce premiums and cost sharing and provide additional benefits to individuals eligible for BHP; more detail is provided in the BHP final rule.

Comment: One commenter requested that CMS require states to align their BHPs with existing Medicaid regulations and program requirements to prevent "churn" (that is, the temporary shifting of low-income individuals from one insurance affordability program to another).

Response: This comment is outside the scope of this final methodology; however, please refer to specific discussions in the BHP final rule regarding the insurance affordability program coordination requirements.

Comment: One commenter requested specific guidance on the premiums and cost sharing imposed on BHP enrollees, including whether these amounts can vary by income consistent with the premiums and cost sharing imposed in the Exchange.

Response: This comment is outside the scope of this final methodology; however, we received an identical comment on the BHP proposed rule, which is addressed further in the BHP final rule.

Comment: One commenter requested that CMS require states, as a condition of payment, assure that the BHP cost-sharing protections applicable to American Indians and Alaska Natives are equivalent to those these individuals would receive through the Exchange.

Response: This comment is outside the scope of this final methodology; however, we received an identical comment on the BHP proposed rule, which is addressed further in the BHP final rule.

Comment: One commenter expressed concern that the federal regulations and informal guidance implementing the Exchange's network adequacy standards do not sufficiently acknowledge FQHC's importance as safety-net providers, and recommended that CMS require the availability of FQHC services to each enrollee.

Response: This comment is outside the scope of this final methodology; however, we received an identical comment on the BHP proposed rule, which is addressed further in the BHP final rule.

Comment: Several commenters recommended that CMS require states to include FQHCs in their standard health plan contracts and ensure that FQHCs receive the PPS rate for services rendered.

Response: This comment is outside the scope of this final methodology; however, we received an identical comment on the BHP proposed rule, which is addressed further in the BHP final rule.

III. Provisions of the Final Methodology

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

Section 1331(d)(3) of the Affordable Care Act directs the Secretary to consider several factors when determining the federal BHP payment amount, which, as specified in the statute, must equal 95 percent of the value of the PTC and CSRs that BHP enrollees would have been provided had they enrolled in a QHP through an Exchange. Thus, the BHP funding methodology is designed to calculate the PTC and CSRs as consistently as possible and in

general alignment with the methodology used by Exchanges to calculate the advance payments of the PTC and CSRs, and by the IRS to calculate final PTCs. In general, we rely on values for factors in the payment methodology specified in statute or other regulations as available, and we have developed values for other factors not otherwise specified in statute, or previously calculated in other regulations, to simulate the values of the PTC and CSRs that BHP enrollees would have received if they had enrolled in QHPs offered through an Exchange. In accordance with section 1331(d)(3)(A)(iii) of the Affordable Care Act, the final funding methodology must be certified by the Chief Actuary of CMS, in consultation with the Office of Tax Analysis of the Department of the Treasury, as having met the requirements of section 1331(d)(3)(A)(ii) of the Affordable Care Act.

Section 1331(d)(3)(A)(ii) of the Affordable Care Act specifies that the payment determination "shall take into account all relevant factors necessary to determine the value of the premium tax credits and cost-sharing reductions that would have been provided to eligible individuals … including the age and income of the enrollee, whether the enrollment is for self-only or family coverage, geographic differences in average spending for health care across rating areas, the health status of the enrollee for purposes of determining risk adjustment payments and reinsurance payments that would have been made if the enrollee had enrolled in a qualified health plan through an Exchange, and whether any reconciliation of the credit or cost-sharing reductions would have occurred if the enrollee had been so enrolled." The payment methodology takes each of these factors into account.

We have developed a methodology such that the total federal BHP payment amount will be based on multiple "rate cells" in each state. Each "rate cell" represents a unique combination of age range, geographic rating area, coverage category (for example, self-only or two-adult

coverage through BHP), household size, and income range as a percentage of FPL. Thus, there are distinct rate cells for individuals in each coverage category within a particular age range who reside in a specific geographic rating area and are in households of the same size and income range. We note that for states that do not use age as a rating factor in the individual market, we will develop BHP payment rates to be consistent with those states' rating rules. Thus, in the case of a state that does not use age as a rating factor, the BHP payment rates would not vary by age.

The federal BHP payment rate for each rate cell will be calculated in two parts. The first part will equal 95 percent of the estimated PTC that would have been paid if a BHP enrollee in that rate cell had instead enrolled in a QHP in the Exchange. The second part will equal 95 percent of the estimated CSR payment that would have been made if a BHP enrollee in that rate cell had instead enrolled in a QHP in the Exchange. These two parts will be added together and the total rate for that rate cell will equal the sum of the PTC and CSR rates.

To calculate the total federal BHP payment, Equation (1) will be used to calculate the estimated PTC for individuals in each rate cell and Equation (2) will be used to calculate the estimated CSR payments for individuals in each rate cell. By applying the equations separately to rate cells based on age, income and other factors, we will have taken those factors into account in the calculation. In addition, the equations incorporate the estimated experience of individuals in each rate cell if enrolled in coverage through the Exchange, taking into account additional relevant variables. Each of the variables in the equations is defined in the following sections, and further detail is provided later in this section of the payment methodology.

In addition, we describe how we will calculate the adjusted reference premium (described later in this section of the payment methodology) that is used in Equations (1) and (2). This is defined in Equation (3a) and Equation (3b).

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, geographic rating 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 three 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 used to calculate the PTC (described in more detail later in the section) will be adjusted for BHP population health status (and, in the case of a state that elects to use 2014 premiums for the basis of the BHP federal payment, for the projected change in the premium from the current year (that is, the year of the final payment methodology) to the following year, to which the rates announced in the final payment methodology would apply.) These adjustments are described in Equation (3a) and Equation (3b). Third, the PTC will be adjusted prospectively to reflect the mean, or average, net expected impact of income reconciliation on the combination of all persons enrolled in BHP; this adjustment, as described further below, will account for the estimated impact on the PTC that would have occurred had such reconciliation been performed. Finally, the rate will be multiplied by 95 percent, consistent with section 1331(d)(3)(A)(i) of the Affordable Care Act. We note that in the situation where the average income contribution of an enrollee would exceed the adjusted reference premium, we will calculate the PTC to be equal to 0 and not let the PTC be negative. Equation (1) is defined as:

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

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

a = Age range

g = Geographic rating 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

2. Equation 2: Estimated CSR payment by Rate Cell

The CSR portion of the rate will be calculated for each rate cell for each state based on age range, geographic rating area, coverage category, household size, and income range defined as a percentage of FPL. The CSR portion of the rate will be calculated in a manner consistent with the methodology used to calculate the CSR advance payments for persons enrolled in a QHP, as described in the HHS Notice of Benefit and Payment Parameters for 2015 proposed rule, with three principal adjustments. (We will make separate calculations that include different adjustments for American Indian Alaska Native BHP enrollees, as described in section III.E of this final methodology.) For the first adjustment, the CSR rate, like the PTC rate, will represent the mean, or average, expected CSR subsidy that would be paid on behalf of all persons in the rate cell, instead of the CSR subsidy being calculated for each individual enrollee. Second, this

calculation will be based on the adjusted reference premium, as described below. Third, as explained earlier, this equation uses an adjusted reference premium that reflects premiums charged to non-tobacco users, rather than the actual premium that is charged to tobacco users to calculate CSR advance payments for tobacco users enrolled in a QHP. Accordingly, the equation includes a tobacco rating adjustment factor that will account for BHP enrollees' estimated tobacco-related health costs that are outside the premium charged to non-tobacco-users. Finally, the rate will be multiplied by 95 percent, as provided in section 1331(d)(3)(A)(i) of the Affordable Care Act.

Equation (2) is defined as:

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

$CSR_{a,g,c,h,i}$ = Cost-sharing reduction subsidy portion of BHP payment rate

a = Age range

g = Geographic rating area

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

h = Household size

i = Income range (as percentage of FPL)

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

$TRAF$ = Tobacco rating adjustment factor

$FRAC$ = Factor removing administrative costs

AV = Actuarial value of plan (as percentage of allowed benefits covered by the applicable QHP without a cost-sharing reduction subsidy)

$IUF_{h,i}$ = Induced utilization factor

$\Delta AV_{h,i}$ = Change in actuarial value (as percentage of allowed benefits)

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

As part of these calculations for both the PTC and CSR components, the value of the adjusted reference premium is described, as specified in Equation (3a) (except in the case of a state that elects to use the 2014 premiums as the basis for the federal BHP payment, as described in section III.F of this final methodology, and in which case Equation (3b) will be used). The adjusted reference premium will be equal to the reference premium, which will be based on the second lowest cost silver plan premium in 2015, multiplied by the BHP population health factor (described in section III.D 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.

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

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

a = Age range

g = Geographic rating area

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

$RP_{a,g,c}$ = Reference premium

PHF = Population health factor

In the case of a state that elects to use the reference premium based off of the 2014 premiums (as described in section III.F of this final methodology), the value of the adjusted reference premium will be calculated using Equation (3b). The adjusted reference premium will

be equal to the reference premium, which would be based on the second lowest cost silver plan premium in 2014, multiplied by the BHP population health factor (described in section III.D 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, and by the premium trend factor, which will reflect the projected change in the premium level between 2014 and 2015 (including the estimated impact of changes resulting from the transitional reinsurance program established in section 1341 of the Affordable Care Act).

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

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

a = Age range

g = Geographic rating area

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

$RP_{a,g,c}$ = Reference premium

PHF = Population health factor

PTF = Premium trend factor

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

In general, the rate for each rate cell will be multiplied by the number of BHP enrollees in that cell (that is, the number of enrollees that meet the criteria for each rate cell) to calculate the total monthly BHP payment. This calculation is shown in Equation 4.

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

PMT = Total monthly BHP payment

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

$CSR_{a,g,c,h,i}$ = Cost-sharing reduction subsidy portion of BHP payment rate

$E_{a,g,c,h,i}$ = Number of BHP enrollees

a = Age range

g = Geographic rating area

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

h = Household size

i = Income range (as percentage of FPL)

B. Federal BHP Payment Rate Cells

We will require that a state implementing BHP provide us an estimate of the number of BHP enrollees it projects will enroll in the upcoming BHP program year, by applicable rate cell, prior to the first quarter of program operations. Upon our approval of such estimates as reasonable, the estimates will be used to calculate the prospective payment for the first and subsequent quarters of program operation until the state has provided us actual enrollment data. These data will be required to calculate the final BHP payment amount, and make any necessary reconciliation adjustments to the prior quarters' prospective payment amounts due to differences between projected and actual enrollment. Subsequent quarterly deposits to the state's trust fund will be based on the most recent actual enrollment data submitted to us. Procedures will ensure that federal payments to a state reflect actual BHP enrollment during a year, within each applicable category, and prospectively determined federal payment rates for each category of BHP enrollment, with such categories defined in terms of age range, geographic rating area, coverage status, household size, and income range, as explained above.

We will require the use of certain rate cells as part of the federal BHP payment methodology. For each state, we will use rate cells that separate the BHP population into

separate cells based on the following five factors:

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

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

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

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 BHP, as provided in section 1331(d)(3)(A)(ii) of the Affordable Care

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[1] This curve is used to implement the Affordable Care Act's 3:1 limit on age-rating in states that do not create an alternative rate structure to comply with that limit. The curve applies to all individual market plans, both within and outside the Exchange. The age bands capture the principal allowed age-based variations in premiums as permitted by this curve. More information can be found at http://www.cms.gov/CCIIO/Resources/Files/Downloads/market-reforms-guidance-2-25-2013.pdf. Both children and adults under age 21 are charged the same premium. For adults age 21-64, the age bands in this methodology divide the total age-based premium variation into the three most equally-sized ranges (defining size by the ratio between the highest and lowest premiums within the band) that are consistent with the age-bands used for risk-adjustment purposes in the HHS-Developed Risk Adjustment Model. For such age bands, see Table 5, "Age-Sex Variables," in HHS-Developed Risk Adjustment Model Algorithm Software, May 7, 2013, http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/ra_tables_04_16_2013xlsx.xlsx.

[2] For example, a cell within a particular state might refer to "County Group 1," "County Group 2," etc., and a table for the state would list all the counties included in each such group. These geographic areas are consistent with the geographic rating areas established under the 2014 Market Reform Rules. They also reflect the service area requirements applicable to qualified health plans, as described in 45 CFR §155.1055, except that service areas smaller than counties are addressed as explained below.

Act. Among recipients of family coverage through BHP, separate rate cells, as explained below, will apply based on whether such coverage involves two adults alone or whether it involves children.

Factor 4--Household size: We will separate enrollees into rate cells by household size that states use to determine BHP enrollees' income as a percentage of the FPL under proposed 42 CFR 600.320. We will require separate rate cells for several specific household sizes. For each additional member above the largest specified size, we will publish instructions on how we will calculate the appropriate payment rate based on data for the rate cell with the closest specified household size. We will publish rates for separate rate cells for household sizes 1, 2, 3, 4, and 5, as unpublished analyses of American Community Survey data conducted by the Urban Institute (which take into account unaccepted offers of employer-sponsored insurance, as well as income, Medicaid and CHIP eligibility, citizenship and immigration status, and current health coverage status) find that less than 1 percent of all BHP-eligible persons live in households of size 5 or greater.

Factor 5--Income: For households of each applicable size, we will create separate rate cells by income range, as a percentage of FPL. The PTC that a person would receive if enrolled in a QHP varies by income, both in level and as a ratio to the FPL, and the CSR varies by income as a percentage of FPL. Thus, separate rate cells will be used to calculate federal BHP payment rates to reflect different bands of income measured as a percentage of FPL. We will use the following income ranges, measured as a ratio to the FPL:

- 0 to 50 percent of the FPL.
- 51 to 100 percent of the FPL.

- 101 to 138 percent of the FPL.[3]
- 139 to 150 percent of the FPL.
- 151 to 175 percent of the FPL.
- 176 to 200 percent of the FPL.

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

We will use the calculated rate for each rate cell to determine the federal BHP payment, rather than varying such rates to correspond to each individual BHP enrollee's age and income level. We believe that the proposed approach will increase the administrative feasibility of making federal BHP payments and provide an accurate and reasonable methodology for calculating the total federal BHP payment. We believe that this approach should not significantly change federal payment amounts, as within applicable ranges, the BHP-eligible population is distributed relatively evenly.

C. Sources and State Data Considerations

To the extent possible, we will use data submitted to the federal government by QHP issuers seeking to offer coverage through an Exchange to perform the calculations that determine federal BHP payment cell rates.

States operating a State Based Exchange (SBE) in the individual market, however, must provide certain data, including premiums for second lowest cost silver plans, by geographic

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

rating area, in order for CMS to calculate the federal BHP payment rates in those states. An SBE state interested in obtaining the applicable federal BHP payment rates for its state must submit such data accurately, completely, and as specified by CMS, by no later than November 1, 2014 , in order for CMS to calculate the applicable rates for 2015. If additional state data (that is, in addition to the second lowest cost silver plan premium data) are needed to determine the federal BHP payment rate, such data must be submitted in a timely manner, and in a format specified by CMS to support the development and timely release of annual BHP payment notices. The specifications for data collection to support the development of BHP payment rates for 2015 will be published in a separate CMS notice.

If a state operating a SBE provides the necessary data accurately, completely, and as specified by CMS, but after the date specified above, we anticipate publishing federal payment rates for such a state in a subsequent Payment Notice. As noted in the BHP proposed rule, a state may elect to implement its BHP after a program year has begun. In such an instance, we propose that the state, if operating a SBE, submit its data no later than 30 days after the Blueprint submission for CMS to calculate the applicable federal payment rates. We further propose that the BHP Blueprint itself must be submitted for Secretarial certification with an effective date of no sooner than 120 days after submission of the BHP Blueprint. In addition, the state must ensure that its Blueprint include a detailed description of how the state will coordinate with other insurance affordability programs to transition and transfer BHP-eligible individuals out of their existing QHP coverage, consistent with the requirements set forth in proposed in 42 CFR 600.330 and 600.425. We believe that this 120-day period is necessary to establish the requisite administrative structures and ensure that all statutory and regulatory requirements are satisfied.

D. Discussion of Specific Variables Used in Payment Equations

1. Reference Premium (RP)

To calculate the estimated PTC that would be paid if individuals enrolled in QHPs through the Exchange, we must calculate a reference premium (RP) because the PTC is based, in part, on the premiums for the second lowest cost silver plan as explained in section II.C.5 of this final methodology regarding the Premium Tax Credit Formula (PTCF). Accordingly, for the purposes of calculating the BHP payment rates, the reference premium, in accordance with 26 U.S.C. 36B(b)(3)(C), is defined as the adjusted monthly premium for an applicable second lowest cost silver plan. The applicable second lowest cost silver plan is defined in 26 U.S.C. 36B(b)(3)(B) as the second lowest cost silver plan of the individual market in the rating area in which the taxpayer resides, which is offered through the same Exchange. We will use the adjusted monthly premium for an applicable second lowest cost silver plan in 2015 as the reference premium (except in the case of a state that elects to use the 2014 premium as the basis for the federal BHP payment, as described in section III.F of this final methodology).

The reference premium 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 pursuant to 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 reference premium changes (that is, terminates or closes enrollment during the year).

The applicable second lowest cost silver plan premium will be included in the BHP

payment methodology by age range, geographic area, and self-only or applicable category of family coverage obtained through BHP.

American Indians and Alaska Natives are eligible for a full cost sharing subsidy regardless of the plan they select. We assume that American Indians and Alaska Natives would be more likely to enroll in bronze plans as a result; thus, for American Indian/Alaska Native BHP enrollees, we will use the lowest cost bronze plan as the basis for the reference premium for the purposes of calculating the CSR portion of the federal BHP payment as described further in section III.E of this final methodology.

The applicable age bracket will be one dimension of each rate cell. We have assumed a uniform distribution of ages and will 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 PTC and CSR components. We also believe this approach would avoid potential inaccuracies that could otherwise occur in relatively small payment cells if age distribution were measured by the number of persons eligible or enrolled. We will also use the same geographic rating areas as specified for the Exchanges in each state within which the same second lowest cost silver level premium is charged. Although plans are allowed to serve geographic rating areas smaller than counties after obtaining our approval, for purposes of defining BHP payment rate cells, no geographic area will be smaller than a county. We do not believe that this assumption will have a significant impact on federal payment levels and it would likely simplify both the calculation of BHP payment rates and the operation of BHP.

Finally, in terms of the coverage category, federal payment rates will only recognize self-only and two-adult coverage, with exceptions that account for children who are potentially

eligible for BHP. First, in states that set the upper income threshold for children's Medicaid and CHIP eligibility below 200 percent of FPL (based on modified adjusted gross income), children in households with incomes between that threshold and 200 percent of FPL would be potentially eligible for BHP. Currently, the only states in this category are Arizona, Idaho, and North Dakota.[4] Second, BHP would include lawfully present immigrant children with incomes at or below 200 percent of FPL in states that have not exercised the option under the sections 1903(v)(4)(A)(ii) and 2107(e)(1)(E) of the Social Security Act (the Act) to qualify all otherwise eligible, lawfully present immigrant children for Medicaid and CHIP. States that fall within these exceptions would be identified based on their Medicaid and CHIP State Plans, and the rate cells would include appropriate categories of BHP family coverage for children. In other states, BHP eligibility will generally be restricted to adults, since children who are citizens or lawfully present immigrants and who live in households with incomes at or below 200 percent of FPL will qualify for Medicaid or CHIP and thus be ineligible for BHP under section 1331 (e)(1)(C) of the Affordable Care Act, which limits BHP to individuals who are ineligible for minimum essential coverage (as defined in section 5000A(f) of the Internal Revenue Code of 1986).

2. Population Health Factor (PHF)

We considered including an explicit population health factor in each rate cell that varies based on the characteristics of BHP enrollees within that cell, but we are not proposing such a variable, for several reasons. We believe that because BHP-eligible consumers' are eligible to enroll in QHPs in 2014, the 2014 QHP premiums already account for the health status of BHP-eligible consumers, as explained in further detail below. Also, the function of this factor is to

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

provide a reference premium amount that reflects the premiums that QHPs would have charged without the implementation of BHP, taking into account both the risk profile of BHP-eligible consumers in the state and the operation of risk-adjustment and reinsurance mechanisms in the Exchanges. Our proposed approach to the population health factor seeks to achieve this goal based on the characteristics of the state's BHP-eligible consumers as a whole.

In the BHP proposed rule, we described in preamble what we believe to be the most appropriate approach to account for potential differences in health status between BHP enrollees and consumers in the individual market, including those obtaining coverage through the Exchange—that is, including a risk adjustment factor in the BHP funding methodology. We believe that it is appropriate to consider whether or not to develop a population health adjustment to account for potential differences in health status between persons eligible for BHP and those enrolled in the individual market, as the two populations may not have the same average health status.

Accordingly, we have considered applying a population-wide adjustment for health status in the BHP payment calculation to account for the impact on a state's Exchange premiums, hence the PTC and the value of CSRs, of changes to average risk levels in the state's individual market that result from BHP implementation. Our proposed approach to the adjustment for population health status seeks to have the federal BHP payment reflect the premium that would have been charged if BHP-eligible consumers were allowed to purchase QHPs in their state's Exchange, rather than the premium that is being charged in the Exchange without the inclusion of BHP consumers. This factor would be greater than 1.00 if BHP enrollees in a state are, on average, in poorer health status than those covered through the state's individual market, and thus Exchange premiums would have been higher had the state not implemented BHP. This

factor would be less than 1.00 if BHP enrollees in a state are, on average, in better health status than those covered through the state's individual market, and thus Exchange premiums would have been lower if the state had not implemented BHP.

We proposed that the population health adjustment for the 2015 BHP program year would equal 1.00. Most BHP-eligible consumers will be able to purchase coverage in the individual market during 2014, or the "measurement year"—that is, the year that precedes implementation of BHP and that provides the basis for estimating unadjusted reference premiums; thus, making no adjustment to the premiums for differences in BHP-eligible enrollees' health would be appropriate. As a result, BHP-eligible consumers' health status is already included in the premiums that would be used to calculate the federal BHP payment rates.

In states where significant numbers of BHP-eligible persons are covered outside of the individual market in 2014, it may be possible to estimate differences in expected health status between persons who are eligible for BHP and persons otherwise eligible for coverage in the individual market. However, we believe that the different levels of federal subsidies based on household income for coverage for persons enrolled in a QHP through an Exchange may have a substantial influence on the participation rate of enrollees. This may result in relatively healthier persons with higher levels of subsidies enrolling in coverage, and this effect may partially or entirely offset some other differences in the health status between BHP-eligible persons and those otherwise covered in the individual market.

On the Exchanges, premiums in most states will vary based on age, which research has shown is directly correlated to average health cost. Because the reference premium used to calculate BHP federal payment rates will vary by age, some of the difference in average health costs would be addressed by this approach to calculating the BHP payment. However, this does

not further simplify the task of estimating the remaining adjustment needed to compensate for any impact of BHP implementation on average risk levels in the state's individual market. Given these analytic challenges, the existing role played by age-rated premiums in compensating for risk, and the limited data about Exchange coverage and the characteristics of BHP-eligible consumers that will available by the time we establish federal payment rates for 2015, we believe that the most appropriate adjustment for 2015 would be 1.00, including in states that cover BHP-eligible persons outside the individual market in 2014. In the event that states believe this adjustment is not reflective of the health status of their BHP populations, we are providing states with the option, as described further in section III.G, to include a retrospective population health status adjustment in the certified methodology, which is subject to CMS review and approval. Regardless of whether a state elects to include a retrospective population health status adjustment, we anticipate that, in future years, when additional data become available about Exchange coverage and the characteristics of BHP enrollees, we may estimate this factor differently.

Finally, while the statute requires consideration of risk adjustment payments and reinsurance payments insofar as they would have affected the PTC and CSRs that would have been provided to BHP-eligible individuals had they enrolled in QHPs, this does not mean that a BHP program's standard health plans receive such payments. As explained in the BHP final rule, BHP standard health plans are not included in the risk adjustment program operated by HHS on behalf of states. Further, standard health plans do not qualify for payments from the transitional reinsurance program established under section 1341 of the Affordable Care Act.[5] To

[5] See 45 CFR 153.400(a)(2)(iv) (BHP standard health plans are not required to submit reinsurance contributions),

the extent that a state operating a BHP determines that, because of the distinctive risk profile of BHP-eligible consumers, BHP standard health plans should be included in mechanisms that share risk with other plans in the state's individual market, the state would need to use other methods for achieving this goal.

3. Income (I)

Household income is a significant determinant of the amount of the PTC and CSRs that are provided for persons enrolled in a QHP through the Exchange. Accordingly, the BHP payment methodology incorporates income into the calculations of the payment rates through the use of income-based rate cells. We are defining 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 of Health and Human Services under the authority of 42 U.S.C. 9902(2), based on annual changes in the consumer price index for all urban consumers (CPI-U). In this methodology, household size and income as a percentage of FPL would be used as factors in developing the rate cells. We will use the following income ranges measured as a percentage of FPL:[6]

- 0–50 percent.
- 51–100 percent.
- 101–138 percent.
- 139–150 percent.

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").

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

- 151-175 percent.
- 176-200 percent.

We will assume a uniform income distribution for each federal BHP payment cell. We believe that assuming a uniform income distribution for the income ranges proposed would be reasonably accurate for the purposes of calculating the PTC and CSR components of the BHP payment and would avoid potential errors that could result if other sources of data were used to estimate the specific income distribution of persons who are eligible for or enrolled in BHP within rate cells that may be relatively small. Thus, when calculating the mean, or average, PTC for a rate cell, we will calculate the value of the PTC at each 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 will rely on the PTC formula described below.

As the PTC for persons enrolled in QHPs would be calculated based on their income during the open enrollment period, and that income would be measured against the FPL at that time, we will adjust the FPL by multiplying the FPL by a projected increase in the CPI-U between the time that the BHP payment rates are published and the QHP open enrollment period, if the FPL is expected to be updated during that time. In that case, the projected increase in the CPI-U would be based on the intermediate inflation forecasts from the most recent OASDI and Medicare Trustees Reports.[7]

4. Premium Tax Credit Formula (PTCF)

In Equation 1, 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

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7 See Table IV A1 from the 2013 reports in http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2013.pdf.

part of the BHP payment methodology. This formula is used to determine the amount of premium that an individual or household would be required to pay if they had enrolled in the SLCSP on an Exchange, which is based on (A) the household income; (B) the household income measured as a percentage of FPL; and (C) the schedule specified in 26 U.S.C. 36B(b)(3)(A) and shown below. The difference between the amount of premium a person or a household is required to pay and the adjusted monthly premium for the applicable second lowest cost silver plan is the amount of the PTC that would be allowed to 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) as the amount equal to the lesser of: (A) the monthly premiums for such month of one or more QHPs offered in the individual market within a state that cover the taxpayer, the taxpayer's spouse, or any dependent (as defined in 26 U.S.C. 152) of the taxpayer and that the taxpayer and spouse or dependents were enrolled in through an Exchange; or (B) the excess (if any) of (i) the adjusted monthly premium for such month for the applicable second lowest cost silver plan for the taxpayer over (ii) an amount equal to 1/12 of the product of the applicable percentage (described below) and the taxpayer's household income for the taxable year.

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 the table, increasing on a sliding scale in a linear manner from an initial premium percentage to a final premium percentage specified in the table (see Table 1):

TABLE 1: Household's Contribution to Health Insurance Premium as a Percentage of Income

In the case of household income (expressed as a percent of poverty line) within the following income tier:	The initial premium percentage is–	The final premium percentage is–
Up to 133%	2.0%	2.0%
133% but less than 150%	3.0%	4.0%
150% but less than 200%	4.0%	6.3%
200% but less than 250%	6.3%	8.05%
250% but less than 300%	8.05%	9.5%
300% but not more than 400%	9.5%	9.5%

These are the applicable percentages for CY 2015. The applicable percentages will be updated in future years in accordance with 26 U.S.C. 36B(b)(3)(A)(ii).

5. Income Reconciliation Factor (IRF)

For persons enrolled in a QHP through an Exchange who receive APTC, there will be an annual reconciliation following the end of the year to compare such payment 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 credit received during the year would either be paid to the taxpayer (if the taxpayer received less in APTC than her or she was entitled to receive) or charged to the taxpayer as additional tax (if the taxpayer received more in APTC than he or she was entitled to receive, subject to any limitations in statute or regulation), as provided in 26 U.S.C. 36B(f).

Section 1331(e)(2) of the Affordable Care Act specifies that individuals enrolled in BHP may not be treated as a qualified individual under section 1312 eligible for enrollment in a QHP offered through an Exchange. Therefore, BHP enrollees are not eligible to receive an APTC to purchase coverage in the Exchange. Because they do not receive APTC, BHP enrollees are not

subject to the same income reconciliation as Exchange consumers. Nonetheless, there may still be differences between a BHP enrollee's household income reported at the beginning of the year and the actual income over the year. These may include small changes (reflecting changes in hourly wage rates, hours worked per week, and other fluctuations in income during the year) and large changes (reflecting significant changes in employment status, hourly wage rates, or substantial fluctuations in income). There may also be changes in household composition. Thus, we believe that using unadjusted income as reported prior to the BHP program year may result in calculations of estimated PTC that are inconsistent with the actual incomes of BHP enrollees during the year. Even if the BHP program adjusts household income determinations and corresponding claims of federal payment amounts based on household reports during the year or data from third-party sources, such adjustments may not fully capture the effects of tax reconciliation that BHP enrollees would have experienced had they been enrolled in a QHP through an Exchange and received APTC.

Therefore, we are including an income adjustment factor in Equation 1 that would account for the difference between calculating estimated PTC using: (a) income relative to FPL as determined at initial application and potentially revised mid-year, under proposed 42 CFR 600.320, for purposes of determining BHP eligibility and claiming federal BHP payments; and (b) actual income relative to FPL received during the plan year, as it would be reflected on individual federal income tax returns. This adjustment will prospectively estimate 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. For 2015, the reconciliation effects are based on tax data for 2 years, reflecting income and tax unit composition changes over time among BHP-eligible individuals. This estimate has

been developed by the Office of Tax Analysis (OTA) at the Department of the Treasury.

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 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. The latter would reflect the PTC eligibility based on information on the tax return, which would have been determined if the individual had not enrolled in BHP. The ratio of the reconciled PTC to the initial determination of PTC will be used as the income reconciliation factor in Equation (1) for estimating the PTC portion of the BHP payment rate.

For 2015, OTA has estimated that the income reconciliation factor for states that have implemented the Medicaid eligibility expansion to cover adults up to 133 percent of the FPL will be 94.52 percent, and for states that have not implemented the Medicaid eligibility expansion and do not cover adults up to 133 percent of the FPL will be 95.32 percent. Given that a state may implement the Medicaid eligibility expansion at any time during the year, and potentially after BHP payment rates have been developed, we will use the average of these two factors (94.92 percent) for 2015.

6. Tobacco Rating Adjustment Factor (TRAF)

As described above, the reference premium is estimated, for purposes of determining both the PTC and related federal BHP payments, based on premiums charged for non-tobacco users, including in states that allow premium variations based on tobacco use, as provided in 42 U.S.C. 300gg(a)(1)(A)(iv). In contrast, as proposed in the HHS Notice of Benefit and Payment Parameters for 2015, the CSR advance payments are based on the total premium for a

policy, including any adjustment for tobacco use. Accordingly, we will incorporate a tobacco rating adjustment factor into Equation 2 that reflects the average percentage increase in health care costs that results from tobacco use among the BHP-eligible population and that would not be reflected in the premium charged to non-users, subject to the tobacco rating factor adjustments allowed by each state. This factor will also take into account the estimated proportion of tobacco users among BHP-eligible consumers.

To estimate the average effect of tobacco use on health care costs (not reflected in the premium charged to non-users), we will calculate the ratio between premiums that silver level QHPs charge for tobacco users to the premiums they charge for non-tobacco users at selected ages. To calculate estimated proportions of tobacco users, we will use data from the Centers for Disease Control and Prevention (CDC) to estimate tobacco utilization rates by state and relevant population characteristic.[8] For BHP program year 2015, we will compare these tobacco utilization rates to the characteristics of BHP-eligible consumers, as shown by national and state survey data. Specifically, for each state, we will calculate the tobacco usage rate based on the percentage of persons by age who use cigarettes and the percentage of persons by age that use smokeless tobacco, and calculate the utilization rate by adding the two rates together. The data is available for 3 age intervals: 18-24; 25-44; and 45-64. For the BHP payment rate cell for persons ages 21-34, we would calculate the factor as (4/14 * the utilization rate of 18-24 year olds) plus (10/14 * the utilization rate of 25-44 year olds), which would be the weighted average of tobacco usage for persons 21-34 assuming a uniform distribution of ages; for all other age ranges used for the rate cells, we would use the age range in the CDC data in which the BHP

[8] See http://www.cdc.gov/nchs/nhis/tobacco.htm; http://apps.nccd.cdc.gov/statesystem/default/DataSource.aspx. .

payment rate cell age range is contained.

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

7. Factor for Removing Administrative Costs (FRAC)

The Factor for Removing Administrative Costs (FRAC) represents the average proportion of the total premium that covers allowed health benefits, and we include this factor in our calculation of estimated CSRs in Equation 2. The product of the reference premium and the FRAC would approximate the estimated amount of EHB claims that would be expected to be paid by the plan. This step is needed because the premium also covers such costs as taxes, fees, and QHP administrative expenses. We have set this factor equal to 0.80, which is proposed for calculating CSR advance payments for 2015 in the HHS Notice of Benefit and Payment Parameters for 2015.

8. Actuarial Value (AV)

The actuarial value is defined as the percentage paid by a health plan of the total allowed costs of benefits, as defined under 45 CFR §156.20. (For example, if the average health care costs for enrollees in a health insurance plan were $1,000 and that plan has an actuarial value of 70 percent, the plan would be expected to pay $700 ($1,000 x 0.70) for health care costs per enrollee, on average.) By dividing such estimated costs by the actuarial value in the proposed

methodology, we would calculate the estimated amount of total EHB-allowed claims, including both the portion of such claims paid by the plan and the portion paid by the consumer for in-network care. (To continue with that same example, we would divide the plan's expected $700 payment of the person's EHB-allowed claims by the plan's 70 percent actuarial value to ascertain that the total amount of EHB-allowed claims, including amounts paid by the consumer, is $1,000.)

For the purposes of calculating the CSR rate in Equation 2, we will use the standard actuarial value of the silver level plans in the individual market, which is equal to 70 percent.

9. Induced Utilization Factor (IUF)

The induced utilization factor is proposed as a factor in calculating estimated CSRs in Equation 2 to account for the increase in health care service utilization associated with a reduction in the level of cost sharing a QHP enrollee would have to pay, based on the cost-sharing reduction subsidies provided to enrollees.

In the HHS Notice of Benefit and Payment Parameters for 2015 proposed rule, we proposed induced utilization factors for the purposes of calculating cost-sharing reduction advance payments for 2015. The induced utilization factor for all persons who would enroll in a silver plan and qualify for BHP based on their household income as a percentage of FPL is 1.12; this would include persons with household income between 100 percent and 200 percent of FPL, lawfully present non-citizens below 100 percent of FPL who are ineligible for Medicaid because of immigration status, and persons with household income under 300 percent of FPL, not subject to any cost-sharing. Thus, we will use the induced utilization factor equal to 1.12 for the BHP payment methodology.

10. Change in Actuarial Value (ΔAV)

The increase in actuarial value would account for the impact of the cost-sharing reduction subsidies on the relative amount of EHB claims that would be covered for or paid by eligible persons, and we include it as a factor in calculating estimated CSRs in Equation 2.

The actuarial values of QHPs for persons eligible for cost-sharing reduction subsidies are defined in 45 CFR 156.420(a), and eligibility for such subsidies is defined in 45 CFR 155.305(g)(2)(i) through (iii). For QHP enrollees with household incomes between 100 percent and 150 percent of FPL, and those below 100 percent of FPL who are ineligible for Medicaid because of their immigration status, CSRs increase the actuarial value of a QHP silver plan from 70 percent to 94 percent. For QHP enrollees with household incomes between 150 percent and 200 percent of FPL, CSRs increase the actuarial value of a QHP silver plan from 70 percent to 87 percent.

We will apply this factor by subtracting the standard AV from the higher AV allowed by the applicable cost-sharing reduction. For BHP enrollees with household incomes at or below 150 percent of FPL, this factor is 0.24 (94 percent minus 70 percent); for BHP enrollees with household incomes more than 150 percent but not more than 200 percent of FPL, this factor is 0.17 (87 percent minus 70 percent).

E. Adjustments for American Indians and Alaska Natives

There are several exceptions made for American Indians and Alaska Natives enrolled in QHPs through an Exchange to calculate the PTC and CSRs. Thus, we will make adjustments to the payment methodology described above to be consistent with the Exchange rules.

We will make the following adjustments:

1. The adjusted reference premium for use in the CSR portion of the rate will be the lowest cost bronze plan instead of the second lowest cost silver plan, with the same adjustment

for the population health factor (and in the case of a state that elects to use the 2014 premiums as the basis of the federal BHP payment, the same adjustment for the premium trend factor). American Indians and Alaska Natives are eligible for CSRs with any metal level plan, and thus we believe that eligible persons would be more likely to select a bronze level plan instead of a silver level plan. (It is important to note that this would not change the PTC, as that is the maximum possible PTC payment, which is always based on the second lowest cost silver plan.)

2. The actuarial value for use in the CSR portion of the rate is 0.60 instead of 0.70, which is consistent with the actuarial value of a bronze level plan.

3. The induced utilization factor for use in the CSR portion of the rate is 1.15, which is consistent with the proposed HHS Notice of Benefit and Payment Parameters for 2015 induced utilization factor for calculating advance CSR payments for persons enrolled in bronze level plans and eligible for CSRs up to 100 percent of actuarial value.

4. The change in the actuarial value for use in the CSR portion of the rate is 0.40. This reflects the increase from 60 percent actuarial value of the bronze plan to 100 percent actuarial value, as American Indians and Alaska Natives are eligible to receive CSRs up to 100 percent of actuarial value.

F. State Option to Use 2014 QHP Premiums for BHP Payments

In the interest of allowing states greater certainty in the total BHP federal payments for 2015, we will provide states the option to have their final 2015 federal BHP payment rates to be calculated using the projected 2015 adjusted reference premium (that is, using 2014 premium data multiplied by the premium trend factor defined below), as described in Equation (3b).

For a state that elects to use the 2014 premium as the basis for the 2015 BHP federal payment, the state must inform CMS no later than May 15, 2014.

For Equation (3b), we define the premium trend factor as follows:

Premium Trend Factor (PTF)

In Equation (3b), we calculate an adjusted reference premium (ARP) based on the application of certain relevant variables to the reference premium (RP), including a premium trend factor (PTF). In the case of a state that elects to use the 2014 premiums as the basis for determining the BHP payment, it is appropriate to apply a factor that would account for the change in health care costs between the year of the premium data and the BHP plan year. We are defining this as the premium trend factor in the BHP payment methodology. This factor approximates the change in health care costs per enrollee, which would include, but is not limited to, changes in the price of health care services and changes in the utilization of health care services. This provides 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, which will be the year following issuance of the final federal payment notice. In addition, we believe that it is appropriate to adjust the trend factor for the estimated impact of changes to the transitional reinsurance program on the average QHP premium.

We will use the annual growth rate in private health insurance expenditures per enrollee from the National Health Expenditure projections, developed by the Office of the Actuary in CMS (citation, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2012.pdf). For 2015, the projected increase in private health insurance premiums per enrollee is 3.55 percent.

The adjustment for changes in the transitional reinsurance program is developed from analysis by CMS' Center for Consumer Information and Insurance Oversight (CCIIO). In the 2014 notice (78 FR 15519), CCIIO estimated that the transitional reinsurance program reduced

QHP premiums on average by 10 to 15 percent. In unpublished analysis, CCIIO estimated that the transitional reinsurance program would reduce QHP premiums in 2015 on average by 6 percent, as the amount of funding in the reinsurance program decreases. Based on these analyses, we estimate that the changes in the transitional reinsurance program would lead to an increase of 4.44 percent in average QHP premiums between 2014 and 2015; assuming that the 2014 QHP premiums are reduced by 10 percent due to the reinsurance program, we calculate the adjustment as $(1 – 0.06)/(1 – 0.10) – 1 = 0.0444$.

Combining these two factors together, we calculate that the premium trend factor for 2015 would be 8.15 percent: $(1+0.0355) * (1+0.0444) – 1 = 0.0815$.

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

In order to determine whether the potential difference in health status between BHP enrollees and consumers in the Exchange would affect the PTC, CSRs, risk adjustment and reinsurance payments that would have otherwise been made had BHP enrollees been enrolled in coverage on the Exchange, we will provide states implementing the BHP the option to propose and to implement, as part of the certified methodology, a retrospective adjustment to the federal BHP payments to reflect the actual value that would be assigned to the population health factor (or risk adjustment) based on data accumulated during program year 2015 for each rate cell.

We acknowledge that there is notable uncertainty with respect to this factor due to the lack of experience of QHPs on the Exchange and other payments related to the Exchange, which is why, absent a state election, we will use a value for the population health factor to determine a prospective payment rate which assumes no difference in the health status of BHP enrollees and QHP enrollees. There is considerable uncertainty regarding whether the BHP enrollees will pose

a greater risk or a lesser risk compared to the QHP enrollees, how to best measure such risk, and the potential effect such risk would have had on PTC, CSRs, risk adjustment and reinsurance payments that would have otherwise been made had BHP enrollees been enrolled in coverage on the Exchange. To the extent, however, that a state develops an approved protocol to collect data and effectively measure the relative risk and the effect on federal payments, we would permit a retrospective adjustment that measured 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.

In order for a state electing the option to implement a retrospective population health status adjustment, the state would be required to submit a proposed protocol to CMS, which would be subject to approval by CMS and would be required to be certified by the Chief Actuary of CMS, in consultation with the Office of Tax Analysis, as part of the BHP payment methodology. We anticipate issuing future guidance shortly that will provide the basic framework in which a state must include in its proposed protocol and instructions for submission to CMS for approval; a state must submit its proposed protocol by August 1, 2014 for CMS approval. This submission must also include how the state will collect the necessary data to determine the adjustment, including any contracting contingences that may be in place with participating standard health plan offerors. CMS will provide technical assistance to states as they develop their protocol. In order to implement the population health status, CMS must approve the state's protocol no later than December 31, 2014. Finally, the state must complete the population health status adjustment at the end of 2015 based on the approved protocol. After the end of the 2015 program year, and once data is made available, CMS will review the state's findings, consistent with the approved protocol, and make any necessary adjustments to the

state's federal BHP payment amount. If CMS determines that the federal BHP payments were less than they would have been using the final adjustment factor, CMS would apply the difference to the state's quarterly BHP trust fund deposit. If CMS determines that the federal BHP payments were more than they would have been using the final reconciled factor, CMS would subtract the difference from the next quarterly BHP payment to the state.

IV. Collection of Information Requirements

The information collection requirements and burden estimates associated with this final methodology have been approved by OMB through July 31, 2014 under OCN 0938-1218 (CMS-10510). CMS will be seeking to extend OMB's approval period at a later time.

This final methodology would not impose any new or revised reporting or recordkeeping requirements and, therefore, does not require additional OMB review under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 et seq.).

V. Regulatory Impact Statement

A. Overall Impact

We have examined the impacts of this final methodology as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96-354), section 1102(b) of the Social Security 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 the Congressional Review Act (5 U.S.C. 804(2)).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches

that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Section 3(f) of Executive Order 12866 defines a "significant regulatory action" as an action that is likely to result in a rule: (1) having an annual effect on the economy of $100 million or more in any 1 year, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or state, local or tribal governments or communities (also referred to as "economically significant"); (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order.

A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). As noted in the BHP rule, BHP provides states the flexibility to establish an alternative coverage program for low-income individuals who would otherwise be eligible to purchase coverage through the Exchange. We are uncertain, as described further below, as to whether the effects of the rulemaking, and subsequently, this final methodology, will be "economically significant" as measured by the $100 million threshold, and hence a major rule under the Congressional Review Act. In accordance with the provisions of Executive Order 12866, this final methodology was reviewed by the Office of Management and Budget.

1. Need for the Notice

Section 1331 of the Affordable Care Act (codified at 42 U.S.C. 18051) requires the Secretary to establish a BHP, and subsection (d)(1) specifically provides that if the Secretary

finds that a state "meets the requirements of the program established under subsection (a) [of section 1331], the Secretary shall transfer to the State" federal BHP payments described in subsection (d)(3). This final methodology provides for the funding methodology to determine the federal BHP payment amounts required to implement these provisions.

2. Alternative Approaches

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

3. Transfers

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 premium and cost-sharing reductions for coverage purchased on the Exchange. We are uncertain what the total federal BHP payment amounts to states will be as these amounts will vary from state to state due to the varying nature of state composition. For example, total federal BHP payment amounts may be greater in more populous states simply by virtue of the fact that they have a larger BHP-eligible population and total payment amounts are based on actual

enrollment. Alternatively, total federal BHP payment amounts may be lower in states with a younger BHP-eligible population as the reference premium 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, the methodology accounts for these variations to ensure accurate BHP payment transfers are made to each state.

B. Unfunded Mandates Reform Act

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation, by state, local, or tribal governments, in the aggregate, or by the private sector. In 2014, that threshold is approximately $141 million. States have the option, but are not required, to establish a BHP. Further, the methodology will establish federal payment rates without requiring states to provide the Secretary with any data not already required by other provisions of the Affordable Care Act or its implementing regulations. Thus, this final methodology does not mandate expenditures by state governments, local governments, or tribal governments.

C. Regulatory Flexibility Act

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

definition of a small entity. Few of the entities that meet the definition of a small entity as that term is used in the RFA would be impacted directly by this final methodology.

Because this final document is focused on the funding methodology that will be used to determine federal BHP payment rates, it does not contain provisions that would have a significant direct impact on hospitals and other health care providers that are designated as small entities under the RFA. However, the provisions in this final methodology may have a substantial, positive indirect effect on hospitals and other health care providers due to the substantial increase in the prevalence of health coverage among populations who are currently unable to pay for needed health care, leading to lower rates of uncompensated care at hospitals. As such, the Department cannot determine whether this final methodology would 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 proposed notice 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. As indicated in the preceding discussion, there may be indirect positive effects from reductions in uncompensated care. Again, the Department cannot determine whether this final methodology would have a significant economic impact on a substantial number of small rural hospitals.

D. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent 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.

We have consulted with states to receive input on how the Affordable Care Act provisions codified in this final methodology would affect states. We have participated in a number of conference calls and in person meetings with state officials.

We continue to engage in ongoing consultations with states that have expressed interest in implementing a BHP through the BHP Learning Collaborative, which serves as a staff level policy and technical exchange of information between CMS and the states. Through consultations with this Learning Collaborative, we have been able to get input from states on many of the specific issues addressed in this methodology.

CMS-2380-FN

Authority: Section 1331(d)(3) of the Affordable Care Act.

Dated: February 19, 2014.

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Marilyn Tavenner,

Administrator,

Centers for Medicare & Medicaid Services.

Approved: February 21, 2014.

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Kathleen Sebelius,

Secretary,

Department of Health and Human Services.

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