(d) Subject

Air Transport Association (ATA) of America Code 05, Time Limits/Maintenance Checks.

(e) Reason

This AD was prompted by a determination that new or more restrictive airworthiness limitations are necessary. The FAA is issuing this AD to address reduced structural integrity of the airplane.

(f) Compliance

Comply with this AD within the compliance times specified, unless already done.

(g) Retained Maintenance or Inspection Program Revision, With No Changes

This paragraph restates the requirements of paragraph (i) of AD 2020–04–22, with no changes. For airplanes an original airworthiness certificate or original export certificate of airworthiness issued on or before January 15, 2019: Within 90 days after May 4, 2020 (the effective date of AD 2020–04–22), revise the existing maintenance or inspection program, as applicable, to incorporate the information specified in Chapter 5–40, Airworthiness Limitations, DGT 113877, Revision 12, dated November 2018, of the Dassault Falcon 2000EX Maintenance Manual. The initial compliance times for doing the tasks are at the time specified in Chapter 5–40, Airworthiness Limitations, DGT 113877, Revision 12, dated November 2018, of the Dassault Falcon 2000EX Maintenance Manual, or within 90 days after May 4, 2020, whichever occurs later; except for task number 52–20–00–610–801–01, the initial compliance time is within 24 months after October 8, 2014 (the effective date of AD 2014–16–12, Amendment 39–17936 (79 FR 52187, September 3, 2014)). The term ''LDG'' in the ''First Inspection'' column of any table in the service information specified in this paragraph means total airplane landings. The term ''FH'' in the ''First Inspection'' column of any table in the service information specified in this paragraph means total flight hours. The term ''FC'' in the ''First Inspection'' column of any table in the service information specified in this paragraph means total flight cycles. Accomplishing the maintenance or inspection program revision required by paragraph (i) of this AD terminates the requirements of this paragraph.

(h) Retained Provision: No Alternative Actions or Intervals, With a New Exception

This paragraph restates the requirements of paragraph (j) of AD 2020–04–22, with a new exception. Except as required by paragraph (k) of this AD, after the existing maintenance or inspection program has been revised as required by paragraph (g) of this AD, no alternative actions (*e.g.,* inspections) or intervals may be used unless the actions or intervals are approved as an AMOC in accordance with the procedures specified in paragraph (m)(1) of this AD.

(i) New Maintenance or Inspection Program Revision

Except as specified in paragraph (j) of this AD: Comply with all required actions and compliance times specified in, and in accordance with, European Union Aviation Safety Agency (EASA) AD 2020–0114, dated May 20, 2020 (''EASA AD 2020–0114''). Accomplishing the maintenance or inspection program revision required by this paragraph terminates the requirements of paragraph (g) of this AD.

(j) Exceptions to EASA AD 2020–0114

(1) The requirements specified in paragraphs (1) and (2) of EASA AD 2020–0114 do not apply to this AD.

(2) Paragraph (3) of EASA AD 2020–0114 specifies revising ''the approved AMP'' within 12 months after its effective date, but this AD requires revising the existing maintenance or inspection program, as applicable, to incorporate the ''limitations, tasks and associated thresholds and intervals'' specified in paragraph (3) of EASA AD 2020–0114 within 90 days after the effective date of this AD.

(3) The initial compliance time for doing the tasks specified in paragraph (3) of EASA AD 2020–0114 is at the applicable ''associated thresholds'' specified in paragraph (3) of EASA AD 2020–0114, or within 90 days after the effective date of this AD, whichever occurs later.

(4) The provisions specified in paragraphs (4) and (5) of EASA AD 2020–0114 do not apply to this AD.

(5) The ''Remarks'' section of EASA AD 2020–0114 does not apply to this AD.

(k) New Provisions for Alternative Actions and Intervals

After the maintenance or inspection program has been revised as required by paragraph (i) of this AD, no alternative actions (*e.g.,* inspections), and intervals are allowed unless they are approved as specified in the provisions of the ''Ref. Publications'' section of EASA AD 2020–0114.

(l) Terminating Action for Certain Actions in AD 2010–26–05

Accomplishing the actions required by paragraph (g) or (i) of this AD terminates the requirements of paragraph (g)(1) of AD 2010–26–05, for Dassault Aviation Model FALCON 2000EX airplanes only.

(m) Other FAA AD Provisions

The following provisions also apply to this AD:

(1) *Alternative Methods of Compliance (AMOCs):* The Manager, Large Aircraft Section, International Validation Branch, FAA, has the authority to approve AMOCs for this AD, if requested using the procedures found in 14 CFR 39.19. In accordance with 14 CFR 39.19, send your request to your principal inspector or local Flight Standards District Office, as appropriate. If sending information directly to the Large Aircraft Section, International Validation Branch, send it to the attention of the person identified in paragraph (n)(4) of this AD. Information may be emailed to: *9-AVS-AIR-730-AMOC@faa.gov.* Before using any approved AMOC, notify your appropriate principal inspector, or lacking a principal inspector, the manager of the local flight standards district office/certificate holding district office.

(2) *Contacting the Manufacturer:* For any requirement in this AD to obtain instructions from a manufacturer, the instructions must be accomplished using a method approved by the Manager, Large Aircraft Section, International Validation Branch, FAA; or EASA; or Dassault Aviation's EASA Design Organization Approval (DOA). If approved by the DOA, the approval must include the DOA-authorized signature.

(n) Related Information

(1) For information about EASA AD 2020–0114, contact the EASA, Konrad-Adenauer-Ufer 3, 50668 Cologne, Germany; telephone +49 221 8999 000; email *ADs@easa.europa.eu;* Internet *www.easa.europa.eu.* You may find this EASA AD on the EASA website at *https://ad.easa.europa.eu.*

(2) For Dassault service information identified in this AD, contact Dassault Falcon Jet Corporation, Teterboro Airport, P.O. Box 2000, South Hackensack, NJ 07606; phone: 201–440–6700; internet: *https://www.dassaultfalcon.com.*

(3) You may view this material at the FAA, Airworthiness Products Section, Operational Safety Branch, 2200 South 216th St., Des Moines, WA. For information on the availability of this material at the FAA, call 206–231–3195. This material may be found in the AD docket on the internet at *https://www.regulations.gov* by searching for and locating Docket No. FAA–2020–0976.

(4) For more information about this AD, contact Tom Rodriguez, Aerospace Engineer, Large Aircraft Section, International Validation Branch, FAA, 2200 South 216th St., Des Moines, WA 98198; telephone and fax 206–231–3226; email *tom.rodriguez@faa.gov.*

Issued on October 26, 2020.

Lance T. Gant,

Director, Compliance & Airworthiness Division, Aircraft Certification Service.

[FR Doc. 2020–24041 Filed 11–2–20; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 600

[CMS–2438–PN]

RIN 0938–ZB64

Basic Health Program; Federal Funding Methodology for Program Year 2022

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

ACTION: Proposed methodology.

SUMMARY: This document proposes the methodology and data sources necessary

to determine Federal payment amounts to be made for program year 2022 to states that elect to establish a Basic Health Program under the Patient Protection and Affordable Care Act to offer health benefits coverage to low-income individuals otherwise eligible to purchase coverage through Affordable Insurance Exchanges.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on December 3, 2020.

ADDRESSES: In commenting, refer to file code CMS–2438–PN.

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

1. *Electronically.* You may submit electronic comments on this regulation to *http://www.regulations.gov.* Follow the ''Submit a comment'' instructions.

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–2438–PN, P.O. Box 8016, Baltimore, MD 21244–8016.

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

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–2438–PN, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

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

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

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

I. Background

A. Overview of the Basic Health Program

Section 1331 of the Patient Protection and Affordable Care Act (Pub. L. 111–148, enacted on March 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152, enacted on March 30, 2010) (collectively referred to as the Patient Protection and Affordable Care Act) provides states with an option to establish a Basic Health Program (BHP). In the states that elect to operate a BHP, the BHP will make affordable health benefits coverage available for individuals under age 65 with household incomes between 133 percent and 200 percent of the Federal poverty level (FPL) who are not otherwise eligible for Medicaid, the Children's Health Insurance Program (CHIP), or affordable employer-sponsored coverage, or for individuals whose income is below these levels but are lawfully present non-citizens ineligible for Medicaid. For those states that have expanded Medicaid coverage under section 1902(a)(10)(A)(i)(VIII) of the Social Security Act (the Act), the lower income threshold for BHP eligibility is effectively 138 percent due to the application of a required 5 percent income disregard in determining the upper limits of Medicaid income eligibility (section 1902(e)(14)(I) of the Act).

A BHP provides another option for states in providing affordable health benefits to individuals with incomes in the ranges described above. States may find a BHP a useful option for several reasons, including the ability to potentially coordinate standard health plans in the BHP with their Medicaid managed care plans, or to potentially reduce the costs to individuals by lowering premiums or cost-sharing requirements.

Federal funding for a BHP under section 1331(d)(3)(A) of the Patient Protection and Affordable Care Act is based on the amount of premium tax credit (PTC) and cost-sharing reductions (CSRs) that would have been provided for the fiscal year to eligible individuals enrolled in BHP standard health plans in the state if such eligible individuals were allowed to enroll in a qualified health plan (QHP) through Affordable Insurance Exchanges (''Exchanges''). These funds are paid to trusts established by the states and dedicated to the BHP, and the states then administer the payments to standard health plans within the BHP.

In the March 12, 2014 **Federal Register** (79 FR 14112), we published a final rule entitled the ''Basic Health Program: State Administration of Basic Health Programs; Eligibility and Enrollment in Standard Health Plans; Essential Health Benefits in Standard Health Plans; Performance Standards for Basic Health Programs; Premium and Cost Sharing for Basic Health Programs; Federal Funding Process; Trust Fund and Financial Integrity'' (hereinafter referred to as the BHP final rule) implementing section 1331 of the Patient Protection and Affordable Care Act), which governs the establishment of BHPs. The BHP final rule established the standards for state and Federal administration of BHPs, including provisions regarding eligibility and enrollment, benefits, cost-sharing requirements and oversight activities. While the BHP final rule codified the overall statutory requirements and basic procedural framework for the funding methodology, it does not contain the specific information necessary to determine Federal payments. We anticipated that the methodology would be based on data and assumptions that would reflect ongoing operations and experience of BHPs, as well as the operation of the Exchanges. For this reason, the BHP final rule indicated that the development and publication of the funding methodology, including any data sources, would be addressed in a separate annual BHP Payment Notice.

In the BHP final rule, we specified that the BHP Payment Notice process would include the annual publication of both a proposed and final BHP Payment Notice. The proposed BHP Payment Notice would be published in the **Federal Register** each October, 2 years prior to the applicable program year, and would describe the proposed funding methodology for the relevant BHP year,[1] including how the Secretary considered the factors specified in section 1331(d)(3) of the Patient Protection and Affordable Care Act, along with the proposed data sources used to determine the Federal BHP payment rates for the applicable program year. The final BHP Payment Notice would be published in the **Federal Register** in February, and would include the final BHP funding methodology, as well as the Federal BHP payment rates for the applicable BHP program year. For example, payment rates in the final BHP Payment Notice published in February 2015 applied to BHP program year 2016, beginning in January 2016. As discussed in section II.D. of this proposed methodology, and as referenced in 42 CFR 600.610(b)(2), state data needed to calculate the Federal BHP payment rates for the final BHP Payment Notice must be submitted to CMS.

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

As described in the BHP final rule, once the final methodology for the applicable program year has been published, we will generally make modifications to the BHP funding methodology on a prospective basis, with limited exceptions. The BHP final rule provided that retrospective adjustments to the state's BHP payment amount may occur to the extent that the prevailing BHP funding methodology for a given program year permits adjustments to a state's Federal BHP payment amount due to insufficient data for prospective determination of the relevant factors specified in the applicable final BHP Payment Notice. For example, the population health factor adjustment described in section II.D.3. of this proposed methodology allows for a retrospective adjustment (at the state's option) to account for the impact that BHP may have had on the risk pool and QHP premiums in the Exchange. Additional adjustments could be made to the payment rates to correct errors in applying the methodology (such as mathematical errors).

Under section 1331(d)(3)(ii) of the Patient Protection and Affordable Care Act, the funding methodology and payment rates are expressed as an amount per eligible individual enrolled in a BHP standard health plan (BHP enrollee) for each month of enrollment. These payment rates may vary based on categories or classes of enrollees. Actual payment to a state would depend on the actual enrollment of individuals found eligible in accordance with a state's certified BHP Blueprint eligibility and verification methodologies in coverage through the state BHP. A state that is approved to implement a BHP must provide data showing quarterly enrollment of eligible individuals in the various Federal BHP payment rate cells. Such data must include the following:

- Personal identifier;
- Date of birth;
- County of residence;
- Indian status;
- Family size;
- Household income;
- Number of persons in household enrolled in BHP;
- Family identifier;
- Months of coverage;
- Plan information; and
- Any other data required by CMS to properly calculate the payment.

B. The 2018 Final Administrative Order, 2019 Payment Methodology, 2020 Payment Methodology, and 2021 Payment Methodology

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

Starting with the payment for the first quarter (Q1) of 2018 (which began on January 1, 2018), we stopped paying the CSR component of the quarterly BHP payments to New York and Minnesota (the states), the only states operating a BHP in 2018. The states then sued the Secretary for declaratory and injunctive relief in the United States District Court for the Southern District of New York. *See State of New York, et al.,* v. *U.S. Department of Health and Human Services,* 18–cv–00683 (S.D.N.Y. filed Jan. 26, 2018). On May 2, 2018, the parties filed a stipulation requesting a stay of the litigation so that HHS could issue an administrative order revising the 2018 BHP payment methodology. As a result of the stipulation, the court dismissed the BHP litigation. On July 6, 2018, we issued a Draft Administrative Order on which New York and Minnesota had an opportunity to comment. Each state submitted comments. We considered the states' comments and issued a Final Administrative Order on August 24, 2018 (Final Administrative Order) setting forth the payment methodology that would apply to the 2018 BHP program year.

In the November 5, 2019 **Federal Register** (84 FR 59529 through 59548) (hereinafter referred to as the November 2019 final BHP Payment Notice), we finalized the payment methodologies for BHP program years 2019 and 2020. The 2019 payment methodology is the same payment methodology described in the Final Administrative Order. The 2020 payment methodology is the same methodology as the 2019 payment methodology with one additional adjustment to account for the impact of individuals selecting different metal tier level plans in the Exchange, referred to as the Metal Tier Selection Factor (MTSF).[2] In the August 13, 2020 **Federal Register** (85 FR 49264 through 49280) (hereinafter referred to as the August 2020 final BHP Payment Notice), we finalized the payment methodology for BHP program year 2021. The 2021 payment methodology is the same methodology as the 2020 payment methodology, with one adjustment to the income reconciliation factor (IRF). The 2022 proposed payment methodology is the same as the 2021 payment methodology, except for using more recent data for developing the value of the Metal Tier Selection Factor (MTSF).

II. Provisions of the Proposed Methodology

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

Section 1331(d)(3) of the Patient Protection and Affordable Care Act directs the Secretary to consider several factors when determining the Federal BHP payment amount, which, as specified in the statute, must equal 95 percent of the value of the PTC and CSRs that BHP enrollees would have been provided had they enrolled in a QHP through an Exchange. Thus, the BHP funding methodology is designed to calculate the PTC and CSRs as consistently as possible and in general alignment with the methodology used by Exchanges to calculate the advance payments of the PTC (APTC) and CSRs, and by the Internal Revenue Service (IRS) to calculate final PTCs. In general, we have relied on values for factors in the payment methodology specified in statute or other regulations as available, and have developed values for other factors not otherwise specified in statute, or previously calculated in other regulations, to simulate the values of the PTC and CSRs that BHP enrollees would have received if they had enrolled in QHPs offered through an Exchange. In accordance with section 1331(d)(3)(A)(iii) of the Patient Protection and Affordable Care Act, the final funding methodology must be certified by the Chief Actuary of CMS, in consultation with the Office of Tax Analysis (OTA) of the Department of the Treasury, as having met the requirements of section 1331(d)(3)(A)(ii) of the Patient Protection and Affordable Care Act.

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

Section 1331(d)(3)(A)(ii) of the Patient Protection and Affordable Care Act specifies that the payment determination shall take into account all relevant factors necessary to determine the value of the PTCs and CSRs that would have been provided to eligible individuals, including but not limited to, the age and income of the enrollee, whether the enrollment is for self-only or family coverage, geographic differences in average spending for health care across rating areas, the health status of the enrollee for purposes of determining risk adjustment payments and reinsurance payments that would have been made if the enrollee had enrolled in a QHP through an Exchange, and whether any reconciliation of PTC and CSR would have occurred if the enrollee had been so enrolled. Under the payment methodologies for 2015 (79 FR 13887 through 14151) (published on March 12, 2014), for 2016 (80 FR 9636 through 9648) (published on February 24, 2015), for 2017 and 2018 (81 FR 10091 through 10105) (published on February 29, 2016), for 2019 and 2020 (84 FR 59529 through) (published on November 5, 2019), and for 2021 (85 FR 49264 through 49280) (published on August 13, 2020) (hereinafter referred to as the August 2020 final BHP Payment Notice), the total Federal BHP payment amount has been calculated using multiple rate cells in each state. Each rate cell represents a unique combination of age range (if applicable), geographic area, coverage category (for example, self-only or two-adult coverage through the BHP), household size, and income range as a percentage of FPL, and there is a distinct rate cell for individuals in each coverage category within a particular age range who reside in a specific geographic area and are in households of the same size and income range. The BHP payment rates developed also are consistent with the state's rules on age rating. Thus, in the case of a state that does not use age as a rating factor on an Exchange, the BHP payment rates would not vary by age.

Under the methodology finalized in the August 2020 final BHP Payment Notice, the rate for each rate cell is calculated in two parts. The first part is equal to 95 percent of the estimated PTC that would have been paid if a BHP enrollee in that rate cell had instead enrolled in a QHP in an Exchange. The second part is equal to 95 percent of the estimated CSR payment that would have been made if a BHP enrollee in that rate cell had instead enrolled in a QHP in an Exchange. These two parts are added together and the total rate for that rate cell would be equal to the sum of the PTC and CSR rates. As noted in the November 2019 final BHP Payment Notice, we currently assign a value of zero to the CSR portion of the BHP payment rate calculation, because there is presently no available appropriation from which we can make the CSR portion of any BHP Payment.

We propose that Equation (1) would be used to calculate the estimated PTC for eligible individuals enrolled in the BHP in each rate cell. We note that throughout this proposed methodology, when we refer to enrollees and enrollment data, we mean data regarding individuals who are enrolled in the BHP who have been found eligible for the BHP using the eligibility and verification requirements that are applicable in the state's most recent certified Blueprint. By applying the equations separately to rate cells based on age (if applicable), income and other factors, we would effectively take those factors into account in the calculation. In addition, the equations would reflect the estimated experience of individuals in each rate cell if enrolled in coverage through an Exchange, taking into account additional relevant variables. Each of the variables in the equations is defined in this section, and further detail is provided later in this section of this proposed methodology. In addition, we describe in Equation (2a) and Equation (2b) (below) how we propose to calculate the adjusted reference premium (ARP) that is used in Equation (1).

Equation 1: Estimated PTC by Rate Cell

We propose that the estimated PTC, on a per enrollee basis, would continue to be calculated for each rate cell for each state based on age range (if applicable), geographic area, coverage category, household size, and income range. The PTC portion of the rate would be calculated in a manner consistent with the methodology used to calculate the PTC for persons enrolled in a QHP, with 5 adjustments. First, the PTC portion of the rate for each rate cell would represent the mean, or average, expected PTC that all persons in the rate cell would receive, rather than being calculated for each individual enrollee. Second, the reference premium (RP) (described in section II.D.1. of this proposed methodology) used to calculate the PTC would be adjusted for the BHP population health status, and in the case of a state that elects to use 2021 premiums for the basis of the BHP Federal payment, for the projected change in the premium from 2021 to 2022, to which the rates announced in the final payment methodology would apply. These adjustments are described in Equation (2a) and Equation (2b). Third, the PTC would be adjusted prospectively to reflect the mean, or average, net expected impact of income reconciliation on the combination of all persons enrolled in the BHP; this adjustment, the IRF, as described in section II.D.7. of this proposed methodology, would account for the impact on the PTC that would have occurred had such reconciliation been performed. Fourth, the PTC would be adjusted to account for the estimated impacts of plan selection; this adjustment, the MTSF, would reflect the effect on the average PTC of individuals choosing different metal tier levels of QHPs. Finally, the rate is multiplied by 95 percent, consistent with section 1331(d)(3)(A)(i) of the Patient Protection and Affordable Care Act. We note that in the situation where the average income contribution of an enrollee would exceed the ARP, we would calculate the PTC to be equal to 0 and would not allow the value of the PTC to be negative.

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

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

$PTC_{a,g,c,h,i}$ = Premium tax credit portion of BHP payment rate
a = Age range
g = Geographic area
c = Coverage status (self-only or applicable category of family coverage) obtained through BHP
h = Household size
i = Income range (as percentage of FPL)
$ARP_{a,g,c}$ = Adjusted reference premium
$I_{h,i,j}$ = Income (in dollars per month) at each 1 percentage-point increment of FPL
$j = j^{th}$ percentage-point increment FPL
n = Number of income increments used to calculate the mean PTC

$PTCF_{h,i,j}$ = Premium tax credit formula percentage
IRF = Income reconciliation factor
MTSF = Metal tier selection factor

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

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

In the case of a state that elected to use the reference premium (RP) based on the current program year (for example, 2022 premiums for the 2022 program year), we propose to calculate the value of the ARP as specified in Equation (2a). The ARP would be equal to the RP, which would be based on the second lowest cost silver plan premium in the applicable program year, multiplied by the BHP population health factor (PHF) (described in section II.D.3. of this proposed methodology), which would reflect the projected impact that enrolling BHP-eligible individuals in QHPs through an Exchange would have had on the average QHP premium, and multiplied by the premium adjustment factor (PAF) (described in section II.D of this proposed methodology), which would account for the change in silver-level premiums due to the discontinuance of CSR payments.

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

$ARP_{a,g,c}$ = Adjusted reference premium
a = Age range
g = Geographic area
c = Coverage status (self-only or applicable category of family coverage) obtained through BHP
$RP_{a,g,c}$ = Reference premium
PHF = Population health factor
PAF = Premium adjustment factor

In the case of a state that elected to use the RP based on the prior program year (for example, 2021 premiums for the 2022 program year, as described in more detail in section II.E. of this proposed methodology), we propose to calculate the value of the ARP as specified in Equation (2b). The ARP would be equal to the RP, which would be based on the second lowest cost silver plan premium in 2021, multiplied by the BHP PHF (described in section II.D of this proposed methodology), which would reflect the projected impact that enrolling BHP-eligible individuals in QHPs on an Exchange would have had on the average QHP premium, multiplied by the PAF (described in section II.D. of this proposed methodology), which would account for the change in silver-level premiums due to the discontinuance of CSR payments, and multiplied by the premium trend factor (PTF) (described in section II.E. of this proposed methodology), which would reflect the projected change in the premium level between 2021 and 2022.

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

$ARP_{a,g,c}$ = Adjusted reference premium
a = Age range
g = Geographic area
c = Coverage status (self-only or applicable category of family coverage) obtained through BHP
$RP_{a,g,c}$ = Reference premium
PHF = Population health factor
PAF = Premium adjustment factor
PTF = Premium trend factor

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

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

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

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 portion of BHP payment rate
$E_{a,g,c,h,i}$ = Number of BHP enrollees
a = Age range
g = Geographic area
c = Coverage status (self-only or applicable category of family coverage) obtained through BHP
h = Household size
i = Income range (as percentage of FPL)

In this equation, we would assign a value of zero to the CSR part of the BHP payment rate calculation ($CSR_{a,g,c,h,i}$) because there is presently no available appropriation from which we can make the CSR portion of any BHP payment. In the event that an appropriation for CSRs for 2022 is made, we would determine whether and how to modify the CSR part of the BHP payment rate calculation ($CSR_{a,g,c,h,i}$) or the PAF and the MTSF in the payment methodology.

B. Federal BHP Payment Rate Cells

Consistent with the previous payment methodologies, we propose that a state implementing a BHP provide us an estimate of the number of BHP enrollees it projects will enroll in the upcoming BHP program quarter, by applicable rate cell, prior to the first quarter and each subsequent quarter of program operations until actual enrollment data is available. Upon our approval of such estimates as reasonable, we will use those estimates to calculate the prospective payment for the first and subsequent quarters of program operation until the state provides us with actual enrollment data for those periods. The actual enrollment data is required to calculate the final BHP payment amount and make any necessary reconciliation adjustments to the prior quarters' prospective payment amounts due to differences between projected and actual enrollment. Subsequent quarterly deposits to the state's trust fund would be based on the most recent actual enrollment data

submitted to us. Actual enrollment data must be based on individuals enrolled for the quarter who the state found eligible and whose eligibility was verified using eligibility and verification requirements as agreed to by the state in its applicable BHP Blueprint for the quarter that enrollment data is submitted. Procedures will ensure that Federal payments to a state reflect actual BHP enrollment during a year, within each applicable category, and prospectively determined Federal payment rates for each category of BHP enrollment, with such categories defined in terms of age range (if applicable), geographic area, coverage status, household size, and income range, as explained above.

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

Factor 1—Age: We propose to continue separating enrollees into rate cells by age (if applicable), using the following age ranges that capture the widest variations in premiums under HHS's Default Age Curve: [3]

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

This proposed provision is unchanged from the current methodology.[4]

Factor 2—Geographic area: For each state, we propose separating enrollees into rate cells by geographic areas within which a single RP is charged by QHPs offered through the state's Exchange. Multiple, non-contiguous geographic areas would be incorporated within a single cell, so long as those areas share a common RP.[5] This proposed provision is also unchanged from the current methodology.

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

Factor 4—Household size: We propose to continue the current methods for separating enrollees into rate cells by household size that states use to determine BHP enrollees' household income as a percentage of the FPL under 42 CFR 600.320 (Determination of eligibility for and enrollment in a standard health plan). We propose to require separate rate cells for several specific household sizes. For each additional member above the largest specified size, we propose to publish instructions for how we would develop additional rate cells and calculate an appropriate payment rate based on data for the rate cell with the closest specified household size. We propose to publish separate rate cells for household sizes of 1 through 10. This proposed provision is unchanged from the current methodology.

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

- 0 to 50 percent of the FPL.
- 51 to 100 percent of the FPL.
- 101 to 138 percent of the FPL.[6]
- 139 to 150 percent of the FPL.
- 151 to 175 percent of the FPL.
- 176 to 200 percent of the FPL.

This proposed provision is unchanged from the current methodology.

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

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

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

C. Sources and State Data Considerations

To the extent possible, unless otherwise provided, we intend to continue to use data submitted to the Federal Government by QHP issuers seeking to offer coverage through the

[3] This curve is used to implement the Patient Protection and Affordable Care Act's 3:1 limit on age-rating in states that do not create an alternative rate structure to comply with that limit. The curve applies to all individual market plans, both within and outside the Exchange. The age bands capture the principal allowed age-based variations in premiums as permitted by this curve. The default age curve was updated for plan or policy years beginning on or after January 1, 2018 to include different age rating factors between children 0–14 and for persons at each age between 15 and 20. More information is available at *https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Downloads/StateSpecAgeCrv053117.pdf.* Both children and adults under age 21 are charged the same premium. For adults age 21–64, the age bands in this 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 HHS-Developed Risk Adjustment Model Algorithm ''Do It Yourself (DIY)'' Software Instructions for the 2018 Benefit Year, April 4, 2019 Update, *https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Updated-CY2018-DIY-instructions.pdf.*

[4] In this document, references to the ''current methodology'' refer to the 2021 program year methodology as outlined in the August 2020 final BHP Payment Notice.

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

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

Exchange in the relevant BHP state 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 area, for CMS to calculate the Federal BHP payment rates in those states. We propose that a State-based Exchange interested in obtaining the applicable 2022 program year Federal BHP payment rates for its state must submit such data accurately, completely, and as specified by CMS, by no later than October 15, 2021. If additional state data (that is, in addition to the second lowest cost silver plan premium data) are needed to determine the Federal BHP payment rate, such data must be submitted in a timely manner, and in a format specified by us to support the development and timely release of annual BHP Payment Notices. The specifications for data collection to support the development of BHP payment rates are published in CMS guidance and are available in the Federal Policy Guidance section at *https://www.medicaid.gov/federal-policy-Guidance/index.html.*

States operating a BHP must submit enrollment data to us on a quarterly basis and should be technologically prepared to begin submitting data at the start of their BHP, starting with the beginning of the first program year. This differs from the enrollment estimates used to calculate the initial BHP payment, which states would generally submit to CMS 60 days before the start of the first quarter of the program start date. This requirement is necessary for us to implement the payment methodology that is tied to a quarterly reconciliation based on actual enrollment data.

We propose to continue the policy first adopted in the 2016 final BHP Payment Notice that in states that have BHP enrollees who do not file Federal tax returns (non-filers), the state must develop a methodology to determine the enrollees' household income and household size consistently with Marketplace requirements.[7] The state must submit this methodology to us at the time of their Blueprint submission. We reserve the right to approve or disapprove the state's methodology to determine household income and household size for non-filers if the household composition and/or household income resulting from application of the methodology are different than what typically would be expected to result if the individual or head of household in the family were to file a tax return. States currently operating a BHP that wish to change the methodology for non-filers must submit a revised Blueprint outlining the revisions to its methodology, consistent with § 600.125.

In addition, as the Federal payments are determined quarterly and the enrollment data is required to be submitted by the states to us quarterly, we propose that the quarterly payment would be based on the characteristics of the enrollee at the beginning of the quarter (or their first month of enrollment in the BHP in each quarter). Thus, if an enrollee were to experience a change in county of residence, household income, household size, or other factors related to the BHP payment determination during the quarter, the payment for the quarter would be based on the data as of the beginning of the quarter (or their first month of enrollment in the BHP in the applicable quarter). Payments would still be made only for months that the person is enrolled in and eligible for the BHP. We do not anticipate that this would have a significant effect on the Federal BHP payment. The states must maintain data that are consistent with CMS' verification requirements, including auditable records for each individual enrolled, indicating an eligibility determination and a determination of income and other criteria relevant to the payment methodology as of the beginning of each quarter.

Consistent with § 600.610 (Secretarial determination of BHP payment amount), the state is required to submit certain data in accordance with this methodology. We require that this data be collected and validated by states operating a BHP, and that this data be submitted to CMS.

D. Discussion of Specific Variables Used in Payment Equations

1. Reference Premium (RP)

To calculate the estimated PTC that would be paid if BHP-eligible individuals enrolled in QHPs through an Exchange, we must calculate a RP because the PTC is based, in part, on the premiums for the applicable second lowest cost silver plan as explained in section II.D.5. of this proposed methodology, regarding the premium tax credit formula (PTCF). The proposal is unchanged from the current methodology except to update the reference years, and to provide additional methodological details to simplify calculations and to deal with potential ambiguities. Accordingly, for the purposes of calculating the BHP payment rates, the RP, in accordance with 26 U.S.C. 36B(b)(3)(C), is defined as the adjusted monthly premium for an applicable second lowest cost silver plan. The applicable second lowest cost silver plan is defined in 26 U.S.C. 36B(b)(3)(B) as the second lowest cost silver plan of the individual market in the rating area in which the taxpayer resides that is offered through the same Exchange. We propose to use the adjusted monthly premium for an applicable second lowest cost silver plan in the applicable program year (2022) as the RP (except in the case of a state that elects to use the prior plan year's premium as the basis for the Federal BHP payment for 2022, as described in section II.E. of this proposed methodology).

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

Consistent with the policy set forth in 26 CFR 1.36B–3(f)(6), to calculate the PTC for those enrolled in a QHP through an Exchange, we propose not to update the payment methodology, and subsequently the Federal BHP payment rates, in the event that the second lowest cost silver plan used as the RP, or the lowest cost silver plan, changes (that is, terminates or closes enrollment during the year).

The applicable second lowest cost silver plan premium will be included in the BHP payment methodology by age range (if applicable), geographic area, and self-only or applicable category of family coverage obtained through the BHP.

We note that the choice of the second lowest cost silver plan for calculating BHP payments would rely on several simplifying assumptions in its selection. For the purposes of determining the second lowest cost silver plan for calculating PTC for a person enrolled in a QHP through an Exchange, the applicable plan may differ for various reasons. For example, a different second lowest cost silver plan may apply to a family consisting of two adults, their child, and their niece than to a family with two adults and their children, because one or more QHPs in the family's geographic area might not offer family coverage that includes the niece. We believe that it would not be possible to replicate such variations for calculating the BHP payment and

[7] See 81 FR at 10097.

believe that in the aggregate, they would not result in a significant difference in the payment. Thus, we propose to use the second lowest cost silver plan available to any enrollee for a given age, geographic area, and coverage category.

This choice of RP relies on an assumption about enrollment in the Exchanges. In the payment methodologies for program years 2015 through 2019, we had assumed that all persons enrolled in the BHP would have elected to enroll in a silver level plan if they had instead enrolled in a QHP through an Exchange (and that the QHP premium would not be lower than the value of the PTC). In the November 2019 final BHP Payment Notice, we continued to use the second-lowest cost silver plan premium as the RP, but for the 2020 payments we changed the assumption about which metal tier plans enrollees would choose (see section II.D.6. on the MTSF in this proposed methodology). In the 2021 payment methodology, we continued to account for how enrollees may choose other metal tier plans by applying the MTSF. For the 2022 payment methodology, we propose to continue accounting for how enrollees may choose other metal tier plans by proposing the continued application of the MTSF as described in section II.D.6. of this proposed methodology.

We do not believe it is appropriate to adjust the payment for an assumption that some BHP enrollees would not have enrolled in QHPs for purposes of calculating the BHP payment rates, since section 1331(d)(3)(A)(ii) of the Patient Protection and Affordable Care Act requires the calculation of such rates as if the enrollee had enrolled in a QHP through an Exchange.

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

We propose to use geographic areas based on the rating areas used in the Exchanges. We propose to define each geographic area so that the RP is the same throughout the geographic area. When the RP varies within a rating area, we propose defining geographic areas as aggregations of counties with the same RP. Although plans are allowed to serve geographic areas smaller than counties after obtaining our approval, we propose that no geographic area, for purposes of defining BHP payment rate cells, will be smaller than a county. We do not believe that this assumption will have a significant impact on Federal payment levels and it would simplify both the calculation of BHP payment rates and the operation of the BHP.

Finally, in terms of the coverage category, we propose that Federal payment rates only recognize self-only and two-adult coverage, with exceptions that account for children who are potentially eligible for the BHP. First, in states that set the upper income threshold for children's Medicaid and CHIP eligibility below 200 percent of FPL (based on modified adjusted gross income (MAGI)), children in households with incomes between that threshold and 200 percent of FPL would be potentially eligible for the BHP. Currently, the only states in this category are Idaho and North Dakota.[8] Second, the BHP would include lawfully present immigrant children with household incomes at or below 200 percent of FPL in states that have not exercised the option under sections 1903(v)(4)(A)(ii) and 2107(e)(1)(E) of the Act to qualify all otherwise eligible, lawfully present immigrant children for Medicaid and CHIP. States that fall within these exceptions would be identified based on their Medicaid and CHIP State Plans, and the rate cells would include appropriate categories of BHP family coverage for children. For example, Idaho's Medicaid and CHIP eligibility is limited to families with MAGI at or below 185 percent FPL. If Idaho implemented a BHP, Idaho children with household incomes between 185 and 200 percent could qualify. In other states, BHP eligibility will generally be restricted to adults, since children who are citizens or lawfully present immigrants and live in households with incomes at or below 200 percent of FPL will qualify for Medicaid or CHIP, and thus be ineligible for a BHP under section 1331(e)(1)(C) of the Patient Protection and Affordable Care Act, which limits a BHP to individuals who are ineligible for minimum essential coverage (as defined in 26 U.S.C. 5000A(f)).

2. Premium Adjustment Factor (PAF)

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

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

Under the Final Administrative Order, we calculated the PAF by using information sought from QHP issuers in each state and the District of Columbia, and determined the premium adjustment that the responding QHP issuers made to each silver level plan in 2018 to account for the discontinuation of CSR payments to QHP issuers. Based on the data collected, we estimated the median adjustment for silver level QHPs nationwide (excluding those in the two BHP states). To the extent that QHP issuers made no adjustment (or the adjustment was zero), this would be counted as zero in determining the median adjustment made to all silver level QHPs nationwide. If the amount of the adjustment was unknown—or we determined that it should be excluded for methodological reasons (for example, the adjustment was negative, an outlier, or unreasonable)—then we did not count the adjustment towards determining the median adjustment.[9] The median adjustment for silver level

[8] CMCS. ''State Medicaid, CHIP and BHP Income Eligibility Standards Effective October 1, 2020.''

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

QHPs is the nationwide median adjustment.

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

PAF = (1 + Nationwide Median Adjustment) ÷ (1 + State Median Adjustment)

To determine the PAF described above, we sought to collect QHP information from QHP issuers in each state and the District of Columbia to determine the premium adjustment those issuers made to each silver level plan offered through the Exchange in 2018 to account for the end of CSR payments. Specifically, we sought information showing the percentage change that QHP issuers made to the premium for each of their silver level plans to cover benefit expenditures associated with the CSRs, given the lack of CSR payments in 2018. This percentage change was a portion of the overall premium increase from 2017 to 2018.

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

We propose that the PAF continue to be set to 1.188 for program year 2022. We believe that this value for the PAF continues to reasonably account for the increase in silver-level premiums experienced in non-BHP states that took effect after the discontinuance of the CSR payments. We believe that the impact of the increase in silver-level premiums in 2022 can reasonably be expected to be similar to that in 2018, because the discontinuation of CSR payments has not changed. Moreover, we believe that states and QHP issuers have not significantly changed the manner and degree to which they are increasing QHP silver-level premiums to account for the discontinuation of CSR payments since 2018, and we expect the same for 2022.

In addition, the percentage difference between the average second lowest-cost silver level QHP and the bronze-level QHP premiums has not changed significantly since 2018, and we do not expect a significant change for 2022. In 2018, the average second lowest-cost silver level QHP premium was 41.1 percent higher than the average lowest-cost bronze-level QHP premium ($481 and $341, respectively). In 2020 (the latest year for which premiums have been published), the difference is similar; the average second lowest-cost silver-level QHP premium is 39.6 percent higher than the average lowest-cost bronze-level QHP premium ($462 and $331, respectively).[10] In contrast, the average second lowest-cost silver-level QHP premium was only 23.8 percent higher than the average lowest-cost bronze-level QHP premium in 2017 ($359 and $290, respectively).[11] If there were a significant difference in the amounts that QHP issuers were increasing premiums for silver-level QHPs to account for the discontinuation of CSR payments over time, then we would expect the difference between the bronze-level and silver-level QHP premiums to change significantly over time, and that this would be apparent in comparing the lowest-cost bronze-level QHP premium to the second lowest-cost silver-level QHP premium.

We request comments on our proposal that the PAF continue to be set to 1.188 for program year 2022. We request comments on whether sources of data other than what we sought in 2018 are available to account for the adjustment to the silver-level QHP premiums to account for the discontinuation of CSRs beyond 2018.

We also generally seek comment on what impact (if any) the recent court decisions[12] regarding the government's obligation to make CSR payments may have on the observed trends regarding adjustments to the silver-level QHP premiums to account for the discontinuation of CSRs, as well as the potential continuation of these trends for the 2022 plan year. We also generally seek comment on whether, in the event an appropriation for CSRs for 2022 is made, we should determine if and how to modify the PAF in the payment methodology, including whether to eliminate it in light of the purpose for which it was initially included in the payment methodology.

3. Population Health Factor (PHF)

We propose that the PHF be included in the methodology to account for the potential differences in the average health status between BHP enrollees and persons enrolled through the Exchanges. To the extent that BHP enrollees would have been enrolled through an Exchange in the absence of a BHP in a state, the exclusion of those BHP enrollees in the Exchange may affect the average health status of the overall population and the expected QHP premiums.

We currently do not believe that there is evidence that the BHP population would have better or poorer health status than the Exchange population. At this time, there continues to be a lack of data on the experience in the Exchanges that limits the ability to analyze the potential health differences between these groups of enrollees. More specifically, Exchanges have been in operation since 2014, and 2 states have operated BHPs since 2015, but data is not available to do the analysis necessary to determine if there are differences in the average health status between BHP and Exchange enrollees. In addition, differences in population health may vary across states. We also do not believe that sufficient data would be available to permit us to make a prospective adjustment to the PHF under § 600.610(c)(2) for the 2022 program year.

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

[10] *See* Kaiser Family Foundation, ''Average Marketplace Premiums by Metal Tier, 2018–2020,'' *https://www.kff.org/health-reform/state-indicator/average-marketplace-premiums-by-metal-tier/.*

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

[12] See *Sanford Health Plan* v. *United States,* 969 F.3d 1370 (Fed. Cir. 2020) and *Community Health Choice, Inc.* v. *United States,* 970 F.3d 1364 (Fed. Cir. 2020).

In previous years BHP payment methodologies, we included an option for states to include a retrospective population health status adjustment. We propose that states be provided with the same option for 2022 to include a retrospective population health status adjustment in the certified methodology, which is subject to our review and approval. This option is described further in section II.F. of this proposed methodology. Regardless of whether a state elects to include a retrospective population health status adjustment, we anticipate that, in future years, when additional data becomes available about Exchange coverage and the characteristics of BHP enrollees, we may propose a different PHF.

While the statute requires consideration of risk adjustment payments and reinsurance payments insofar as they would have affected the PTC that would have been provided to BHP-eligible individuals had they enrolled in QHPs, we are not proposing to require that a BHP's standard health plans receive such payments. As explained in the BHP final rule, BHP standard health plans are not included in the federally-operated risk adjustment program.[13] Further, standard health plans did not qualify for payments under the transitional reinsurance program established under section 1341 of the Patient Protection and Affordable Care Act for the years the program was operational (2014 through 2016).[14] To the extent that a state operating a BHP determines that, because of the distinctive risk profile of BHP-eligible consumers, BHP standard health plans should be included in mechanisms that share risk with other plans in the state's individual market, the state would need to use other methods for achieving this goal.

4. Household Income (I)

Household income is a significant determinant of the amount of the PTC that is provided for persons enrolled in a QHP through an Exchange. Accordingly, both the current and proposed BHP payment methodologies incorporate household income into the calculations of the payment rates through the use of income-based rate cells. We propose defining household income in accordance with the definition of modified adjusted gross income in 26 U.S.C. 36B(d)(2)(B) and consistent with the definition in 45 CFR 155.300. Income would be measured relative to the FPL, which is updated periodically in the **Federal Register** by the Secretary under the authority of 42 U.S.C. 9902(2). In our proposed methodology, household size and income as a percentage of FPL would be used as factors in developing the rate cells. We propose using the following income ranges measured as a percentage of FPL: [15]

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

We further propose to assume a uniform income distribution for each Federal BHP payment cell. We believe that assuming a uniform income distribution for the income ranges proposed would be reasonably accurate for the purposes of calculating the BHP payment and would avoid potential errors that could result if other sources of data were used to estimate the specific income distribution of persons who are eligible for or enrolled in the BHP within rate cells that may be relatively small.

Thus, when calculating the mean, or average, PTC for a rate cell, we propose to calculate the value of the PTC at each 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 would rely on the PTC formula described in section II.D.5. of this proposed methodology.

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

5. Premium Tax Credit Formula (PTCF)

In Equation 1 described in section II.A.1. of this proposed methodology, we propose to use the formula described in 26 U.S.C. 36B(b) to calculate the estimated PTC that would be paid on behalf of a person enrolled in a QHP on an Exchange as part of the BHP payment methodology. This formula is used to determine the contribution amount (the amount of premium that an individual or household theoretically would be required to pay for coverage in a QHP on an Exchange), which is based on (A) the household income; (B) the household income as a percentage of FPL for the family size; and (C) the schedule specified in 26 U.S.C. 36B(b)(3)(A) and shown below.

The difference between the contribution amount and the adjusted monthly premium (that is, the monthly premium adjusted for the age of the enrollee) for the applicable second lowest cost silver plan is the estimated amount of the PTC that would be provided for the enrollee.

The PTC amount provided for a person enrolled in a QHP through an Exchange is calculated in accordance with the methodology described in 26 U.S.C. 36B(b)(2). The amount is equal to the lesser of the premium for the plan in which the person or household enrolls, or the adjusted premium for the applicable second lowest cost silver plan minus the contribution amount.

The applicable percentage is defined in 26 U.S.C. 36B(b)(3)(A) and 26 CFR 1.36B–3(g) as the percentage that applies to a taxpayer's household income that is within an income tier specified in Table 1, increasing on a sliding scale in a linear manner from an initial premium percentage to a final premium percentage specified in Table 1. We propose to continue to use applicable percentages to calculate the estimated PTC that would be paid on behalf of a person enrolled in a QHP on an Exchange as part of the BHP payment methodology as part of Equation 1. We propose that the applicable percentages in Table 1 for calendar year (CY) 2021 would be effective for BHP program year 2022. The applicable percentages will be updated in future years in accordance with 26 U.S.C. 36B(b)(3)(A)(ii).

[13] See 79 FR at 14131.

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

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

[16] *See* Table IV A1 from the 2020 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, available at *https://www.cms.gov/files/document/2020-medicare-trustees-report.pdf.*

TABLE 1—APPLICABLE PERCENTAGE TABLE FOR CY 2021 [a]

In the case of household income (expressed as a percent of poverty line) within the following income tier:	The initial premium percentage is—	The final premium percentage is—
Up to 133%	2.07	2.07
133% but less than 150%	3.10	4.14
150% but less than 200%	4.14	6.52
200% but less than 250%	6.52	8.33
250% but less than 300%	8.33	9.83
300% but not more than 400%	9.83	8.83

[a] IRS Revenue Procedure 2020–36. *https://www.irs.gov/pub/irs-drop/rp-20–36.pdf.*

6. Metal Tier Selection Factor (MTSF)

On the Exchange, if an enrollee chooses a QHP and the value of the APTC to which the enrollee is entitled is greater than the premium of the plan selected, then the APTC is reduced to be equal to the premium. This usually occurs when enrollees eligible for larger APTCs choose bronze-level QHPs, which typically have lower premiums on the Exchange than silver-level QHPs. Prior to 2018, we believed that the impact of these choices and plan selections on the amount of PTCs that the Federal Government paid was relatively small. During this time, most enrollees in income ranges up to 200 percent FPL chose silver-level QHPs, and in most cases where enrollees chose bronze-level QHPs, the premium was still more than the PTC. Based on our analysis of the percentage of persons with incomes below 200 percent FPL choosing bronze-level QHPs and the average reduction in the PTCs paid for those enrollees, we believe that the total PTCs paid for persons with incomes below 200 percent FPL were reduced by about 1 percent in 2017. Therefore, we did not seek to make an adjustment based on the effect of enrollees choosing non-silver-level QHPs in developing the BHP payment methodology applicable to program years prior to 2018. However, after the discontinuance of the CSR payments in October 2017, several changes occurred that increased the expected impact of enrollees' plan selection choices on the amount of PTC the government paid. These changes led to a larger percentage of individuals choosing bronze-level QHPs, and for those individuals who chose bronze-level QHPs, these changes also generally led to larger reductions in PTCs paid by the Federal Government per individual. The combination of more individuals with incomes below 200 percent of FPL choosing bronze-level QHPs and the reduction in PTCs had an impact on PTCs paid by the Federal Government for enrollees with incomes below 200 percent FPL.

Silver-level QHP premiums for the 2018 benefit year increased substantially relative to other metal tier plans in many states (on average, by about 20 percent). We believe this contributed to an increase in the percentage of enrollees with lower incomes choosing bronze-level QHPs, despite being eligible for CSRs in silver-level QHPs, because many were able to purchase bronze-level QHPs and pay $0 in premium; according to CMS data, the percentage of persons with incomes between 0 percent and 200 percent of FPL eligible for CSRs (those who would be eligible for the BHP if the state operated a BHP) selecting bronze-level QHPs increased from about 11 percent in 2017 to about 13 percent in 2018. In addition, the likelihood that a person choosing a bronze-level QHP would pay $0 premium increased, and the difference between the bronze-level QHP premium and the available PTC widened. Between 2017 and 2018, the ratio of the average silver-level QHP premium to the average bronze-level QHP premium increased: The average silver-level QHP premium was 17 percent higher than the average bronze-level QHP premium in 2017, whereas the average silver-level QHP premium was 33 percent higher than the average bronze-level QHP premium in 2018. Similarly, the average estimated reduction in APTC for enrollees with incomes between 0 percent and 200 percent FPL that chose bronze-level QHPs increased from about 11 percent in 2017 to about 23 percent in 2018 (after adjusting for the average age of bronze-level QHP and silver-level QHP enrollees); that is, in 2017, enrollees with incomes in this range who chose bronze-level QHPs received 11 percent less than the full value of the APTC, and in 2018, those enrollees who chose bronze-level QHPs received 23 percent less than the full value of the APTC.

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

We finalized the application of the MTSF for the first time in the 2020 payment methodology, and here we propose to calculate the MTSF using the same approach as finalized there (84 FR 59543). First, we would calculate the percentage of enrollees with incomes below 200 percent of the FPL (those who would be potentially eligible for the BHP) in non-BHP states who enrolled in bronze-level QHPs. Second, we would calculate the ratio of the average PTC paid for enrollees in this income range who selected bronze-level QHPs compared to the average PTC paid for enrollees in the same income range who selected silver-level QHPs. Both of these calculations would be done using CMS data on Exchange enrollment and payments. For 2022, we propose to use 2019 data, as it is the latest year of data available at this time. In the 2021 final BHP Payment Notice, we used 2018 data, as it was the latest year of data available at that time.

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

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

We have calculated that 16.14 percent of enrollees in households with incomes below 200 percent of the FPL selected bronze-level QHPs in 2019. We also have calculated that the ratio of the average PTC paid for those enrollees in bronze-level QHPs to the average PTCs paid for enrollees in silver-level QHPs was 79.41 percent after adjusting for the average age of bronze-level and silver-level QHP enrollees. The MTSF is equal to 1 minus the product of the percentage of enrollees in bronze-level QHPs (16.14 percent) and 1 minus the ratio of the average PTC paid for bronze-level QHP enrollees to the average PTC paid for silver-level QHP enrollees (79.41 percent). Thus, the MTSF would be calculated as:

MTSF = 1 − (16.14% × (1 − 79.41%))

Therefore, we propose that the value of the MTSF for 2022 would be 96.68 percent.

We believe it is reasonable to update the value for the MTSF from the value that was used in the 2021 payment methodology. In general, we believe it is appropriate to update the calculation of the MTSF (and other factors) as more recent data becomes available. At this time, we have complete data for 2019, and only for several months of 2020. Therefore, we propose to use 2019 data to calculate the 2022 MTSF. Therefore, we believe that our proposal to update the value of the MTSF to 96.68 percent is reasonable for program year 2022.

We request comments on this proposal. In particular, we welcome comments on whether other sources of data beyond 2019 are available and should be used to calculate the MTSF for 2022. One potential alternative would be to update the MTSF with partial 2020 data collected by CMS for Exchange plan selection and enrollment (by income and by metal tier selection) and for APTC paid for 2021 (based on the number of months available at the time the final payment methodology is published).

We also seek comment on what impact (if any) the recent court decisions [17] regarding the government's obligation to make CSR payments may have on the observed trends regarding adjustments to the silver-level QHP premiums to account for the discontinuation of CSRs and consumer plan selection behaviors, as well as the potential continuation of these trends for the 2022 plan year. We also seek comment on the potential for Congressional action on CSR appropriations.

7. Income Reconciliation Factor (IRF)

For persons enrolled in a QHP through an Exchange who receive APTC, there will be an annual reconciliation following the end of the year to compare the APTC to the correct amount of PTC based on household circumstances shown on the Federal income tax return. Any difference between the latter amounts and the APTC paid during the year would either be paid to the taxpayer (if too little APTC was paid) or charged to the taxpayer as additional tax (if too much APTC was paid, subject to any limitations in statute or regulation), as provided in 26 U.S.C. 36B(f).

Section 1331(e)(2) of the Patient Protection and Affordable Care Act specifies that an individual eligible for the BHP may not be treated as a ''qualified individual'' under section 1312 of the Patient Protection and Affordable Care Act who is eligible for enrollment in a QHP offered through an Exchange. We are defining ''eligible'' to mean anyone for whom the state agency or the Exchange assesses or determines, based on the single streamlined application or renewal form, as eligible for enrollment in the BHP. Because enrollment in a QHP is a requirement for individuals to receive APTC, individuals determined or assessed as eligible for a BHP are not eligible to receive APTC for coverage in the Exchange. Because they do not receive APTC, BHP enrollees, on whom the BHP payment methodology is generally based, are not subject to the same income reconciliation as Exchange consumers.

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

Therefore, in accordance with current practice, we propose including in Equation 1 an adjustment, the IRF, that would account for the difference between calculating estimated PTC using: (a) Household income relative to FPL as determined at initial application and potentially revised mid-year under § 600.320, for purposes of determining BHP eligibility and claiming Federal BHP payments; and (b) actual household income relative to FPL received during the plan year, as it would be reflected on individual Federal income tax returns. This adjustment would seek prospectively to capture the average effect of income reconciliation aggregated across the BHP population had those BHP enrollees been subject to tax reconciliation after receiving APTC for coverage provided through QHPs. Consistent with the methodology used in past years, we propose estimating reconciliation effects based on tax data for 2 years, reflecting income and tax unit composition changes over time among BHP-eligible individuals.

The OTA maintains a model that combines detailed tax and other data, including Exchange enrollment and PTC claimed, to project Exchange premiums, enrollment, and tax credits. For each enrollee, this model compares the APTC based on household income and family size estimated at the point of enrollment with the PTC based on household income and family size reported at the end of the tax year. The former reflects the determination using enrollee information furnished by the applicant and tax data furnished by the IRS. The latter would reflect the PTC eligibility based on information on the tax return, which would have been determined if the individual had not enrolled in the BHP. Consistent with prior years, we propose to use the ratio of the reconciled PTC to the initial estimation of PTC as the IRF in Equations (1a) and (1b) for estimating the PTC portion of the BHP payment rate.

For 2022, OTA has estimated that the IRF for states that have implemented the Medicaid eligibility expansion to cover adults up to 133 percent of the FPL will be 99.01 percent. We believe that it is appropriate to refine the calculation of the IRF and only use data regarding

[17] See *Sanford Health Plan* v. *United States,* 969 F.3d 1370 (Fed. Cir. 2020) and *Community Health Choice, Inc.* v. *United States,* 970 F.3d 1364 (Fed. Cir. 2020).

Exchange enrollees with incomes between 133 percent and 200 percent FPL, as in Medicaid expansion states, instead of an average that also includes data regarding Exchange enrollees with incomes between 100 percent and 200 percent FPL, as in non-Medicaid expansion states. This is the same approach that we finalized in the 2021 BHP Payment Notice. For other factors used in the BHP payment methodology, it may not always be possible to separate the experiences between different types of states and there may not be meaningful differences between the experiences of such states. Therefore, we propose to set the value of the IRF equal to the value of the IRF for states that have expanded Medicaid eligibility, which would be 99.01 percent for program year 2022.

We propose to use this value for the IRF in Equations (1a) and (1b) for calculating the PTC portion of the BHP payment rate.

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

In the interest of allowing states greater certainty in the total BHP Federal payments for a given plan year, we have given states the option to have their final Federal BHP payment rates calculated using a projected ARP (that is, using premium data from the prior program year multiplied by the premium trend factor (PTF), as described in Equation (2b). We propose to require states to make their election to have their final Federal BHP payment rates calculated using a projected ARP by the later of (1) May 15 of the year preceding the applicable program year or (2) 60 days after the publication of the final methodology. Therefore, we propose states inform CMS in writing of their election for the 2022 program year by the later of May 15, 2021 or 60 days after the publication of the final methodology.

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

PTF: In the case of a state that would elect to use the 2021 premiums as the basis for determining the 2022 BHP payment, it would be appropriate to apply a factor that would account for the change in health care costs between the year of the premium data and the BHP program year. This factor would approximate the change in health care costs per enrollee, which would include, but not be limited to, changes in the price of health care services and changes in the utilization of health care services. This would provide an estimate of the adjusted monthly premium for the applicable second lowest cost silver plan that would be more accurate and reflective of health care costs in the BHP program year.

For the PTF we propose to use the annual growth rate in private health insurance expenditures per enrollee from the National Health Expenditure (NHE) projections, developed by the Office of the Actuary in CMS (*https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html*). Based on these projections, for BHP program year 2022, we propose that the PTF would be 4.7 percent.

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

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

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

We acknowledge that there is uncertainty with respect to this factor due to the lack of available data to analyze potential health differences between the BHP and QHP populations, which is why, absent a state election, we propose to use a value for the PHF (see section II.D.3. of this proposed methodology) to determine a prospective payment rate which assumes no difference in the health status of BHP enrollees and QHP enrollees. There is considerable uncertainty regarding whether the BHP enrollees will pose a greater risk or a lesser risk compared to the QHP enrollees, how to best measure such risk, the potential effect such risk would have had on PTC, and risk adjustment that would have otherwise been made had BHP enrollees been enrolled in coverage through an Exchange. To the extent, however, that a state would develop an approved protocol to collect data and effectively measure the relative risk and the effect on Federal payments of PTCs and CSRs, we propose to continue to permit a retrospective adjustment that would measure the actual difference in risk between the two populations to be incorporated into the certified BHP payment methodology and used to adjust payments in the previous year.

For a state electing the option to implement a retrospective population health status adjustment as part of the BHP payment methodology applicable to the state, we propose requiring the state to submit a proposed protocol to CMS, which would be subject to approval by us and would be required to be certified by the Chief Actuary of CMS, in consultation with the OTA. We propose to apply the same protocol for the population health status adjustment as what is set forth in guidance in *Considerations for Health Risk Adjustment in the Basic Health Program in Program Year 2015* (*http://www.medicaid.gov/Basic-Health-Program/Downloads/Risk-Adjustment-and-BHP-White-Paper.pdf*). We propose requiring a state to submit its proposed protocol for the 2022 program year by August 1, 2021 or 60 days after the publication of the final methodology. We propose that this submission would also need to include descriptions of how the state would collect the necessary data to determine the adjustment, including any contracting contingences that may be in place with participating standard health plan issuers. We would provide technical assistance to states as they develop their protocols, as requested. To implement the population health status adjustment, we propose that we must approve the state's protocol by December 31, 2021 for the 2022 program year. Finally, we propose that the state be required to complete the population health status adjustment at the end of the program year based on the approved protocol. After the end of the program year, and once data is made available, we propose to review the state's findings, consistent with the approved protocol, and make any necessary adjustments to the state's Federal BHP payment amounts. If we determine that the Federal BHP payments were less than they would have been using the final adjustment factor, we would apply the difference to the state's next quarterly BHP trust fund

deposit. If we determine that the Federal BHP payments were more than they would have been using the final reconciled factor, we would subtract the difference from the next quarterly BHP payment to the state.

III. Collection of Information Requirements

Although our Federal funding methodology's information collection requirements and burden had at one time been approved by OMB under control number 0938–1218 (CMS–10510), the approval was discontinued on August 31, 2017, since we adjusted our estimated number of respondents to be below the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3501 *et seq.*) threshold of ten or more respondents. Since we continue to estimate fewer than ten respondents (only New York and Minnesota operate a BHP at this time), the proposed program year 2022 methodology is not subject to the requirements of the PRA.

IV. Response to Comments

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

V. Regulatory Impact Analysis

A. Statement of Need

Section 1331 of the Patient Protection and Affordable Care Act (42 U.S.C. 18051) requires the Secretary to establish a BHP, and section 1331(d)(1) specifically provides that if the Secretary finds that a state meets the requirements of the program established under section 1331(a) of the Patient Protection and Affordable Care Act, the Secretary shall transfer to the state Federal BHP payments described in section 1331(d)(3). This proposed methodology provides for the funding methodology to determine the Federal BHP payment amounts required to implement these provisions for program year 2022.

B. Overall Impact

We have examined the impacts of this 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 Act, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995; Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999), the Congressional Review Act (5 U.S.C. 804(2) and Executive Order 13771 on Reducing Regulation and Controlling Regulatory Costs (January 30, 2017).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Section 3(f) of Executive Order 12866 defines a ''significant regulatory action'' as an action that is likely to result in a rule: (1) (Having an annual effect on the economy of $100 million or more in any 1 year, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or state, local or tribal governments or communities (also referred to as ''economically significant''); (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order.

A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). As noted in the BHP final rule, the BHP provides states the flexibility to establish an alternative coverage program for low-income individuals who would otherwise be eligible to purchase coverage on an Exchange. Because we make no changes in methodology that would have a consequential effect on state participation incentives, or on the size of either the BHP program or offsetting PTC and CSR expenditures, the effects of the changes made in this Payment Notice would not approach the $100 million threshold, and hence it is neither an economically significant rule under E.O. 12866 nor a major rule under the Congressional Review Act. Moreover, the proposed regulation is not economically significant within the meaning of section 3(f)(1) of the Executive Order.

C. Anticipated Effects

The provisions of this proposed methodology are designed to determine the amount of funds that will be transferred to states offering coverage through a BHP rather than to individuals eligible for Federal financial assistance for coverage purchased on the Exchange. We are uncertain what the total Federal BHP payment amounts to states will be as these amounts will vary from state to state due to the state-specific factors and conditions. For example, total Federal BHP payment amounts may be greater in more populous states simply by virtue of the fact that they have a larger BHP-eligible population and total payment amounts are based on actual enrollment. Alternatively, total Federal BHP payment amounts may be lower in states with a younger BHP-eligible population as the RP used to calculate the Federal BHP payment will be lower relative to older BHP enrollees. While state composition will cause total Federal BHP payment amounts to vary from state to state, we believe that the methodology, like the methodology used in 2021, accounts for these variations to ensure accurate BHP payment transfers are made to each state.

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

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

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

Section 202 of the Unfunded Mandates Reform Act (UMRA) of 2005 requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation, by state, local, or tribal governments, in the aggregate, or by the private sector. In 2020, that threshold is approximately $156 million. States have the option, but are not required, to establish a BHP. Further, the methodology would establish Federal payment rates without requiring states to provide the Secretary with any data not already required by other provisions of the Patient Protection and Affordable Care Act or its implementing regulations. Thus, neither the current nor the proposed payment methodologies mandate expenditures by state governments, local governments, or tribal governments.

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

D. Alternative Approaches

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

We considered alternatives as to how to calculate the PAF in the proposed methodology for 2022. The proposed value for the PAF is 1.188, which is the same as was used for 2018, 2019, 2020, and 2021. We believe it would be difficult to obtain the updated information from QHP issuers comparable to what was used to develop the 2018 factor, because QHP issuers may not distinctly consider the impact of the discontinuance of CSR payments on the QHP premiums any longer. We do not have reason to believe that the value of the PAF would change significantly between program years 2018 and 2022. We are continuing to consider whether or not there are other methodologies or data sources we may be able to use to calculate the PAF.

We also considered alternatives as how to calculate the MTSF in the proposed methodology for 2022. The proposed value for the MTSF for program year 2022 is 96.68 percent. We considered whether other sources of data that include data after 2019 should be used to calculate the MTSF for 2022, including calculating the MTSF with partial 2020 data collected by CMS for Exchange plan selection and enrollment (by income and by metal tier selection) and for APTC paid for 2021 (based on the number of months available at the time the final payment methodology is published).

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

We also considered whether to require the use of the program year premiums to develop the Federal BHP payment rates, rather than allow the choice between the program year premiums and the prior year premiums trended forward. We believe that the payment rates can still be developed accurately using either the prior year QHP premiums or the current program year premiums and that it is appropriate to continue to provide the states these options.

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

We request public comment on these alternative approaches.

E. Regulatory Reform Analysis Under E.O. 13771

Executive Order 13771, titled Reducing Regulation and Controlling Regulatory Costs, was issued on January 30, 2017 and requires that the costs associated with significant new regulations ''shall, to the extent permitted by law, be offset by the elimination of existing costs associated with at least two prior regulations.'' This proposed methodology, if finalized as proposed, is expected to be neither an E.O. 13771 regulatory action nor an E.O. 13771 deregulatory action.

F. Conclusion

We believe that this proposed BHP payment methodology is effectively the same methodology as finalized for 2021. BHP payment rates may change as the values of the factors change, most notably the QHP premiums for 2021 or 2022. We do not anticipate this proposed methodology to have any significant effect on BHP enrollment in 2022.

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

Dated: October 8, 2020.

Seema Verma,

Administrator, Centers for Medicare & Medicaid Services.

Dated: October 15, 2020.

Alex M. Azar II,

Secretary, Department of Health and Human Services.

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