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45 CFR Part 144

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; Proposed Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES**Centers for Medicare & Medicaid Services****42 CFR Part 600****Office of the Secretary****45 CFR Part 144**

[CMS–2380–P]

RIN 0938–AR93

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**AGENCY:** Centers for Medicare & Medicaid Services (CMS), HHS.**ACTION:** Proposed rule.

SUMMARY: This proposed rule would establish the Basic Health Program, as required by section 1331 of the Affordable Care Act. The Basic Health Program provides states the flexibility to establish a health benefits coverage program for low-income individuals who would otherwise be eligible to purchase coverage through the state's Affordable Insurance Exchange (Exchange, also called a Health Insurance Marketplace). The Basic Health Program would complement and coordinate with enrollment in a QHP through the Exchange, as well as with enrollment in Medicaid and the Children's Health Insurance Program (CHIP). This proposed rule sets forth a framework for Basic Health Program eligibility and enrollment, benefits, delivery of health care services, transfer of funds to participating states, and federal oversight. Additionally, this rule would amend other rules issued by the Secretary of the Department of Health and Human Services (Secretary) in order to clarify the applicability of those rules to the Basic Health Program.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on November 25, 2013.

ADDRESSES: In commenting, please refer to file code CMS–2380–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four 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–2380–P, 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–2380–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments before the close of the comment period to either of the following addresses:

a. For delivery in Washington, DC—Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue SW., Washington, DC 20201

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD—Centers for Medicare & Medicaid Services, Department of Health and Human Services, 7500 Security Boulevard, Baltimore, MD 21244–1850.

If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786–7195 in advance to schedule your arrival with one of our staff members.

Comments erroneously mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

Submission of comments on paperwork requirements. You may submit comments on this document's paperwork requirements by following the instructions at the end of the "Collection of Information

Requirements" section in this document.

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

FOR FURTHER INFORMATION CONTACT: Jessica Schubel (410) 786–3032 or Carey Appold (410) 786–2117.

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 Web site as soon as possible after they have been received: <http://www.regulations.gov>. Follow the search instructions on that Web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1–800–743–3951.

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Acronyms

Because of the many organizations and terms to which we refer by acronym in this proposed rule, we are listing

these acronyms and their corresponding terms in alphabetical order below:

[the] Act Social Security Act
 Affordable Care Act The collective term for the Patient Protection and Affordable Care Act (Pub. L. 111–148) and the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152))
 APTC Advance Payments of the Premium Tax Credit
 BHP Basic Health Program
 CHIP Children’s Health Insurance Program
 CMS Centers for Medicare & Medicaid Services
 [the] Code Internal Revenue Code of 1986
 EHBs Essential Health Benefits
 FEHBP Federal Employees Health Benefits Program (5 U.S.C 8901, et seq.)
 FPL Federal poverty level
 HCERA Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152, enacted March 30, 2010)
 HHS [U.S. Department of] Health and Human Services
 IHS Indian Health Service
 MAGI Modified adjusted gross income
 PHS Act Public Health Service Act
 PRA Paperwork Reduction Act of 1995
 QHP Qualified Health Plan
 SHOP Small Business Health Options Program

I. Executive Summary

This proposed rule would implement section 1331 of the Patient Protection and Affordable Care Act (Pub. L. 111–148, enacted on March 23, 2010) and the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111.152, enacted on March 30, 2010), which are collectively referred to as the Affordable Care Act. Section 1331 directs the Secretary to establish the Basic Health Program (BHP). In addition, this proposed rule would amend certain other federal regulations, clarifying their applicability to the new program.

Beginning in 2014, individuals and small businesses will be able to purchase private health insurance coverage through competitive marketplaces, also termed “Exchanges” (or the Health Insurance Marketplace). At the same time, states will have the opportunity to provide coverage under Medicaid for a broader range of low-income individuals. New administrative procedures discussed in prior rulemaking establishes a system for coordinating coverage across all insurance affordability programs. Beginning January 1, 2015, under this proposed rule, states will have an additional option to establish a Basic Health Program for certain low-income individuals who would otherwise be eligible to obtain coverage through the Exchange.

This proposed rule: (1) Establishes requirements for certification of state

submitted BHP Blueprints, and state administration of the BHP consistent with that Blueprint; (2) establishes eligibility and enrollment requirements for standard health plan coverage offered through the BHP; (3) establishes requirements for the benefits covered by such standard health plans; (4) provides for federal funding of certified state BHPs; (5) establishes the purposes for which states can use such federal funding; (6) sets forth parameters for enrollee financial participation; and (7) establishes requirements for state and federal administration and oversight of BHP funds. This issuance addresses everything that we believe to be essential to the establishment and operation of the BHP, with the specific exception of details on payment which will be issued separately. We continue to review existing regulations to identify areas for further development and coordination and we invite comment on additional areas that might be included.

II. Background

A. Introduction

Section 1331 of the Affordable Care Act provides states with a new coverage option, the Basic Health Program (BHP), for individuals who do not qualify for Medicaid but whose income does not exceed 200 percent of the federal poverty level (FPL). This proposed rule implements statutory provisions of the BHP and other provisions necessary to ensure coordination with the other coverage options that, along with BHP, are collectively referred to as “insurance affordability programs” (coverage obtained through an Exchange, Medicaid, and the Children’s Health Insurance Program, along with premium tax credits and cost sharing reductions). Coordination is necessary to ensure that consumers are determined eligible for the appropriate program through a streamlined and seamless process and are enrolled in appropriate coverage without unnecessary paperwork or delay. This proposed rule also describes standards for state administration and federal oversight of the BHP.

To maximize the coordination between BHP and other insurance affordability programs, rather than establish new and different rules for the BHP, we have proposed, when possible, to align BHP rules with existing rules governing coverage through the Exchange, Medicaid, or CHIP. This approach is supported by the statutory linkage between the minimum benefit coverage, maximum cost sharing, and overall funding for the BHP with the Exchange. It is also advisable in most instances to promote simplification and

coordination among programs. Where necessary to accommodate unique features of the BHP, we have adapted existing regulations or established specific rules for the new program. Recognizing that states may choose different ways to structure their BHP, when possible, we offer states flexibility in choosing to administer the program in accordance with Exchange rules or those governing Medicaid or CHIP. In those sections in which we propose to offer states the choice, states must adopt all of the standards in the referenced Medicaid or Exchange regulations.

B. Stakeholder Consultation and Input

HHS has consulted extensively with interested states and stakeholders on policies related to the BHP.

On September 14, 2011 (76 FR 56767), HHS published a Request for Information (RFI) inviting the public to provide input regarding the development of standards for the establishment and operation of a BHP. In particular, HHS asked states, tribal representatives, consumer advocates, and other interested stakeholders to comment on the general establishment of the BHP, standard health plan requirements and contracting process, the coordination between the BHP and other state programs, eligibility and enrollment, amount of payment, and Secretarial oversight. The comment period closed on October 31, 2011.

The public response to the RFI yielded comments from states, consumer advocacy organizations, health plans, and provider associations. The majority of the comments were related to the general administrative functions and standards for the BHP, the financial methodology used to determine a state's BHP payment amount, coordination between insurance affordability programs, benefit package, health plan selection and delivery systems, and the effect that the BHP may have on a state's Exchange.

The comments received are described, where applicable, in discussing specific regulatory proposals.

HHS also held a number of listening sessions with state representatives, consumer groups and health plans to gather input, and has directly engaged with interested states by establishing a "learning collaborative" to seek state input related to operations and coordination of the BHP with other insurance affordability programs. We considered input from these stakeholder meetings and responses to the RFI as we developed the policies in this proposed rule.

This proposed rule may be of interest to, and affect, American Indians/Alaska Natives. Therefore, we plan to consult with Tribes during the comment period and prior to publishing a final rule.

III. Provisions of the Proposed Rule

A. Scope and Definitions (§ 600.1 and § 600.5)

In § 600.1, we set forth the overall design of the BHP established under the authority of section 1331 of the Affordable Care Act. Generally, this provision authorizes federal funding for states that elect to operate an alternative program for eligible low-income individuals instead of offering such coverage through qualified health plans in the Exchange, if the Secretary certifies that the alternative program meets certain requirements. This proposed rule would implement that authority.

In proposed § 600.5, we set forth definitions for terms that are used throughout this part. Where a term used in this part has been defined in section 36B of the Internal Revenue Code (the Code) or in published regulations codifying the Affordable Care Act as related to operation of the Exchange, the Medicaid program and CHIP, we have adopted those definitions here consistent with the explicit statutory direction at section 1331(h) of the Affordable Care Act that terms used in section 36B of the Code shall have the same meaning under BHP. These definitions would incorporate interpretations, guidance and operating methodologies applicable under section 36B of the Code, to ensure a coordinated approach. Definitions for "Basic Health Program Blueprint," "program year," "certification," "enrollee," "standard health plan," and "standard health plan offeror" are created for the purpose of this proposed rule. We propose to define a regional compact to mean an agreement between two or more states to jointly procure and enter into contracts with standard health plans covering eligible individuals in those states.

We propose to adopt the definition of the "single streamlined application" used by both Medicaid and the Exchange, and found in 42 CFR 431.907(b)(1) of this chapter and 45 CFR 155.405(a) and (b).

We propose to adopt the Exchange definitions of "family and family size," "household income," "qualified health plan," "residency," and "modified adjusted gross income" in accordance with 26 CFR 1.36B-1. We are proposing to define "Minimum essential coverage" to have the meaning set forth in 26 CFR 1.5000A-2, including any coverage

recognized by the Secretary under 26 CFR 1.5000A-2(f). Under that authority, we are also proposing to recognize BHP coverage as minimum essential coverage, and would specifically include BHP coverage in our definition. It is our intention to clarify that BHP meets the requirements for the individual mandate, and, as such, we invite comment on the placement of this provision.

The proposed definition of "Indian" is the same as used in the Exchange for eligibility for cost-sharing reductions codified at 45CFR 155.300(a). This definition means any individual defined in section 4(d) of the Indian Self-Determination and Education Assistance Act (Pub. L. 93-638, 88 Stat. 2203), in accordance with section 1402(d)(1) of the Affordable Care Act. The definition of "lawfully present" found in 45 CFR 152.2 is also applied to BHP.

B. Establishment of a Basic Health Program

We propose adding subpart B consisting of § 600.100 through § 600.170 to specify the general requirements for certification of a state BHP. In this subpart, we propose required elements of the BHP Blueprint and procedures for development and submission of the BHP Blueprint. We would then require that states operate the BHP in accordance with a BHP Blueprint that has been certified by the Secretary. We also set forth certain overall principles for operation of the BHP. When possible, we have drawn on definitions and standards applied to other insurance affordability programs to promote state flexibility and reduce administrative burden.

1. Program description (§ 600.100)

Section 600.100 contains a general description of a state BHP that is operated in accordance with a BHP Blueprint certified by the Secretary to meet the requirements of this Part.

2. Basis, scope and applicability of subpart B (§ 600.105)

Proposed § 600.105 of subpart B specifies the general authority for and scope of standards proposed in part 600 that establish minimum requirements for the state option to operate a BHP.

3. Basic Health Program Blueprint (§ 600.110)

This section sets forth standards related to the content of a BHP Blueprint. We are proposing to adopt the construct of the Exchange blueprint for the BHP and are using the Blueprint as the mechanism by which the

Secretary will certify a state's proposed BHP and grant operational authority for the program. The Blueprint will include information necessary to establish compliance with many of the standards of the program. We further propose that the Blueprint be accompanied by a funding plan that identifies the funding sources, if any, beyond the BHP trust fund used to cover projected expenditures over a 12 month period. We recognize that it may be difficult to complete all sections of the Blueprint with certainty prior to finalizing contracts with standard health plan offerors or receiving notification of final funding amounts. Therefore, we intend to accept certain parts of the Blueprint in draft or proposed form, and provide states with a certification in principle, pending submission of final Blueprint provisions. We welcome comment on which aspects of the Blueprint will need to be submitted in draft or proposed form given the operational realities of program establishment.

Finally, we propose in this section that HHS will post submitted Blueprints on-line in the interest of public transparency.

4. Development and submission of a BHP Blueprint (§ 600.115)

We propose that the Governor or the Governor's designee must sign the state's Blueprint which must identify, by position or title, the agency and officials within that agency with responsibility for program operations, administration and finances.

In § 600.115 we propose to adopt the Exchange standard that a state must seek public comment on the BHP Blueprints, including significant revisions, before submission to the Secretary for certification. Unlike the Exchange process, which appears in statute, we have not proposed a specific list of stakeholders, with the exception of federally recognized tribes residing in the state, who must be addressed with public notification. We are extending flexibility to the state to contact stakeholders that may be affected. We welcome comment on any need to further require notification to particular interested parties.

5. Certification of a BHP Blueprint (§ 600.120)

We propose to have the date of signature by the Secretary be the effective date of certification, before which no payments may be made under this part. Once certified, we propose that Blueprints remain in effect unless revised by the state, terminated by the state, or the Secretary withdraws certification.

We propose standards for certification, which include sufficient information for the Secretary to establish compliance with the requirements of section 1331 of the Affordable Care Act and this Part, adequate planning for the integration of BHP with other insurance affordability programs, and sufficient planning to demonstrate operational readiness.

6. Revisions to a certified Blueprint (§ 600.125)

At § 600.125(a) we propose that a state wishing to make significant changes to the terms of its Blueprint must submit changes to the Secretary for review and certification. While not exhaustive, significant changes within this scope include changes that have a direct impact on the enrollee experience in BHP or the program financing.

7. Withdrawal of a BHP Blueprint prior to implementation (§ 600.130)

We propose in this section a process for withdrawing a BHP Blueprint, whether certified or not, as long as the state has not begun enrollment. If a state has begun enrollment, we consider the action a state would be taking as a program termination and the state would need to follow procedures as proposed in § 600.140.

8. Notice and timing of HHS action on a BHP Blueprint (§ 600.135)

We recognize that HHS has a responsibility to respond timely to a state requesting certification of a BHP Blueprint, or approval for revision of a certified Blueprint, to enable states to offer BHP as a part of the continuum of insurance affordability programs. We therefore propose at § 600.135(a) that HHS will act on all certification requests, including revisions, in a timely manner. We propose at § 600.135(b) that a state will receive a response from HHS to a complete certification request that includes information on impediments to approval.

9. State termination of a BHP (§ 600.140)

At § 600.140 we propose that for a certified program that is operational, or has begun enrollment, a state wishing to cease the operation of their BHP must follow specific termination procedures. We propose that a state must submit notification to the Secretary to terminate its BHP 120 days in advance of the planned termination date along with a transition plan. Proposed termination procedures also include written notice to participating standard health plan offerors and enrollees at least 90 days in advance, as well as other enrollee

protections to facilitate an orderly transition to other coverage without gaps in coverage. Section 600.140 further proposes that a state terminating its BHP will fulfill contractual obligations to standard health plans offerors, data reporting requirements to HHS, and the completion of any necessary financial reconciliation with the federal government. Notices to standard health plan offerors and enrollees must meet accessibility and readability standards set by the Exchange at § 155.230(b).

10. HHS Withdrawal of Certification and Termination of a BHP (§ 600.142)

We propose standards and conditions for a Secretarial finding that a BHP Blueprint no longer meets certification standards based on findings in an annual review, a program review conducted in accordance with proposed § 600.200, or from evidence of beneficiary harm, financial malfeasance or fraud. We propose that a state receive notice prior to withdrawal of certification and that all reasonable efforts are made to resolve the findings. Timing standards for notice to the state and eventual decertification are proposed. The effective date of an HHS determination withdrawing BHP certification is proposed as not earlier than 120 days following the finding of non-compliance.

11. State Program Administration and Program Operations (§ 600.145)

We propose at § 600.145(a) the requirements under which a state must operate its BHP.

At § 600.145(b) through (d), we propose certain principles to apply once a state has elected to implement a BHP. Specifically, the state must ensure that all persons have a right to apply, and if found eligible, to be enrolled into coverage that conforms to this part, and the state must operate the program statewide. The state would not be permitted to limit enrollment to a lower income level than prescribed in the statute, cap enrollment or impose waiting lists. These principles are set forth because individuals eligible for BHP in a state operating BHP are specifically excluded from receipt of the premium tax credit or cost-sharing reductions through the Exchange under section 1331(e)(2) of the Affordable Care Act and the establishment of a BHP must not leave individuals without an option for affordable coverage.

Additionally, at § 600.145(e) we propose a group of core operating functions that states must be able to perform to operate a BHP. These functions include making eligibility

determinations using the single streamlined application, processing appeals, contracting with standard health plan offerors, performing oversight and financial integrity functions, providing consumer assistance, extending essential protections to American Indians and Alaska Natives, ensuring civil rights protections, and collecting and reporting data necessary for program operations and oversight. Finally, terminating the program, if necessary, in accordance with proposed § 600.140 is also defined as a core operation. We solicit comment on whether these are, in fact, the core operating functions or whether there are other functions that should be recognized and considered essential to the successful establishment and operation of a BHP.

12. Enrollment Assistance and Information Requirements (§ 600.150)

Section 600.150(a)(1), (2), (3) and (4) set forth proposed requirements for the provision of information to consumers that is accessible and explanatory, aiding individuals' knowledge about the program, enrollment choices, and covered benefits, including additional benefits provided outside of standard health plan coverage, as well as other benefit options and limitations. This information should facilitate enrollment and participation in BHP. We are proposing that information provided to consumers by participating standard health plan offerors should be publically available, be clear and informative regarding premiums, covered services, and cost-sharing and should follow state specifications for format. We propose that such information be provided in a manner that complies with accessibility and readability standards of the Exchange. Further, we propose that states require participating standard health plan offerors to make current provider lists available.

13. Tribal Consultation (§ 600.155)

The BHP as proposed uses many Exchange concepts such as the development of a Blueprint to attain certification. Similarly, we extend in this rule many of the protections for American Indian/Alaska Native populations as are extended in the Exchange. To further this alignment, we propose in this section to use the tribal consultation agreements used by the state or federal Exchange for the BHP. We invite comment on this policy.

14. Basic Health Program Protections for American Indians and Alaska Natives (§ 600.160)

We propose that states adopt the same protections for American Indian and Alaska Native populations as they would receive in an Exchange. In § 600.160(a) we propose to apply the same special enrollment status for enrollment in standard health plans as established in 45 CFR 155.420, which permits Indians to enroll in Qualified Health Plans (QHPs) or change QHPs once per month. This status is independent of policies set by the state for open enrollment generally. We propose at § 600.160(b) that a state permit tribal organizations to pay premiums on behalf of enrolled individuals as is permitted in the Exchange at 45 CFR 155.240. At § 600.160(c) we propose that cost sharing may not be imposed on Indians to further align the Exchange's cost-sharing protections for Indians with household incomes at BHP levels. We also propose that BHP standard health plans must pay primary to Indian health programs for covered services; in other words, Indian health programs shall be the "payers of last resort" for services received through such programs that are covered by a standard health plan (with respect to the standard health plan).

15. Nondiscrimination standards (§ 600.165)

We propose that the BHP and standard health plans must comply with all applicable non-discrimination statutes and the nondiscrimination requirements applicable to the Exchange and recipients of federal assistance.

16. Annual report content and timing (§ 600.170)

In compliance with section 1331(f) of the Affordable Care Act, which substantially conforms to Exchange functions codified at 45 CFR 155.200(c) through (f), we propose at § 600.170(a) requirements for an annual report on the state's BHP. This report is both a mechanism to report state knowledge of any program fraud, waste or abuse, and to ensure compliance with eligibility verification requirements, the use of federal funds, and quality and performance standards. We continue to work towards aligning quality and performance expectations across all insurance affordability programs. We intend to issue additional guidance with respect to quality and performance standards, harmonizing the BHP to the maximum extent possible with requirements of QHPs in the Exchange, including quality ratings assigned under

section 1311(c)(3) of the Affordable Care Act and consumer satisfaction surveys under section 1311(c)(4) of the Affordable Care Act, which will also align with our efforts for Medicaid and CHIP. We invite public comment on this approach.

Finally, at § 600.170(b) we propose a timing standard for annual reports, due 60 days prior to the end of each operational year. The annual report confirms the appropriate use of federal funds, as well as key operational features, confirming that the release of federal funding for the subsequent year is appropriate.

C. Federal Program Administration

We propose to add subpart C consisting of § 600.200 to specify the provisions for federal program administration of the BHP. In adding this proposed subpart, we have drawn from the administrative standards established for the other health insurance affordability programs to promote program efficiencies.

1. Federal program reviews and audits (§ 600.200)

The proposed BHP review standards at § 600.200(a) and (b) specify that HHS may review state administration of the BHP, as needed, but no less frequently than annually, to determine whether the state is complying with the federal requirements and provisions of its BHP Blueprint. We provide that the federal compliance review may either be based on the state's annual report, or on a separate direct federal review. We anticipate that separate federal reviews will generally be conducted only when there is a specific federal concern about program compliance. We then provide a protocol for identifying and resolving compliance concerns, providing opportunities for the state to substantiate compliance or develop corrective actions to address compliance. We also set forth a protocol for raising and resolving concerns about the improper use of BHP trust fund resources. Finally, the proposed audit standards in § 600.200(c) provide that the HHS Office of Inspector General (OIG) may periodically audit state operations and standard health plan practices consistent with the purpose and processes applied in Medicaid, as described in § 430.33(a).

D. Eligibility and Enrollment

As with other sections of this proposed rule, subpart D, which consists of § 600.300 through § 600.350, adopts eligibility and enrollment provisions from other insurance affordability programs wherever

possible. We have done this to prevent gaps in coverage, promote simplicity and continuity for consumers if they move from one insurance affordability program to another, or have family members eligible for different programs, to simplify program administration, promote reuse of administrative processes and infrastructure, and promote administrative simplification for states. In some instances we have adopted, with modification, standards from other insurance affordability programs or are proposing new rules to fit the eligibility and enrollment provisions of the BHP.

1. Basis, scope and applicability (§ 600.300)

Section 600.300 of subpart D specifies the general authority for and scope of standards proposed in this subpart that establishes eligibility requirements for the BHP.

2. Eligible individuals (§ 600.305)

We propose to implement the eligibility standards for the BHP in accordance with sections 1331(e)(1) and (e)(2) of the Affordable Care Act. Because BHP provides coverage in lieu of coverage through the Exchange that is supported by advanced payment of premium tax credits (APTC) and cost sharing reductions (CSR), we have adopted many of the eligibility rules used to determine eligibility for APTC and CSR in the Exchange and applied them to BHP. In some circumstances, particularly around eligibility processes, we propose to adopt Medicaid or CHIP rules, or to offer a state the option to apply either Exchange or Medicaid/CHIP rules. Where a state is given choice between applying Exchange standards or Medicaid standards, it is our intention that it chooses all the standards of Medicaid or the Exchange within one particular area.

At § 600.305(a) we propose to codify the eligibility requirements established in section 1331(e)(1) of the Affordable Care Act. With narrow exceptions, as reflected in the regulation text, individuals eligible for BHP would be eligible for premium tax credit support to enroll in a QHP in the Exchange if the state did not offer a BHP.

In situations in which an individual is enrolled in both limited-benefits Medicaid (because the Medicaid coverage does not meet the definition of minimum essential coverage (MEC) or because it does not include the 10 essential health benefits) and in the BHP, standard coordination of benefits rules set forth in § 433.139(b)(1) of the Medicaid regulations would apply, with

Medicaid serving as the secondary payer.

3. Application (§ 600.310)

The Affordable Care Act requires the use of a single, streamlined application, developed by the Secretary, for all insurance affordability programs. We propose to codify at § 600.310 this requirement for BHP by adopting by reference the regulations at § 431.907(b)(1) and 45 CFR 155.405(a) and (b). We further propose to adopt the Medicaid rule relating to an individual's opportunity to apply without delay (§ 435.906) and for assistance with an application at § 435.908. We note that call centers required of the Exchange (§ 155.205(a)) are encouraged to provide information on all insurance affordability programs.

The state may permit the use of authorized representatives to assist individuals with their applications or renewal of eligibility. If the state permits authorized representatives we propose that they follow the standards of either the Exchange (§ 155.227) or Medicaid (§ 435.923).

4. Certified Application Counselors (600.315)

Some individuals may need assistance with completing applications, enrolling in coverage, or with ongoing communications once determined eligible. State Medicaid and CHIP agencies have long allowed beneficiaries to use application counselors to promote enrollment and assist with application preparation, and current regulations at § 435.908 provides for states to certify Medicaid application counselors to ensure that they are properly trained in applicable rules and requirements. Similarly, 45 CFR 155.225 provides for Exchanges to certify application counselors to help individuals apply for enrollment in QHPs. We propose at § 600.315 to give a state the option to certify application counselors to assist individuals in applying for enrollment in BHP, and to adopt the standards for a certification program found in either § 155.225 (relating to the Exchange) or § 435.908 (relating to Medicaid/CHIP). We expect the state to adopt all of either the Exchange of Medicaid standards.

5. Determination of eligibility for and enrollment in a BHP (§ 600.320)

At § 600.320(a) we propose to allow BHPs to determine eligibility directly or to have eligibility determined by any governmental entity that determines eligibility for Medicaid, or the Exchange.

At § 600.320(b) we propose that the state adopt standards to conform with § 435.912, similar to both Medicaid and CHIP, regarding the timeliness of eligibility determinations.

At § 600.320(c) we propose that the state determine the effective date for eligibility using the method in place for either the Exchange or Medicaid.

Finally, at § 600.320(d), we propose that the state choose between the enrollment policies of the Exchange or the continuous enrollment of Medicaid. If choosing the Exchange enrollment policies, the state must adopt open and special enrollment periods equivalent to those specified for the Exchange at 45 CFR 155.410 and § 155.420 to minimize gaps in coverage for eligible individuals. Specifically, consistent with the Exchange provisions at 45 CFR 155.420(d), we propose to require the state to allow eligible individuals to enroll in BHP outside of the annual open enrollment period if, for example, they experience a triggering event including: the loss of minimum essential coverage; gaining a dependent or becoming a dependent; gaining status as a citizen, national or as lawfully present when previously he/she did not have such status; or making a permanent move. Additionally, Indians are provided one special enrollment per month.

6. Coordination with other Insurance Affordability Programs (§ 600.330)

We propose standards of coordination between insurance affordability programs in accordance with section 1331(c)(4) of the Affordable Care Act by adopting applicable provisions of 45 CFR 155.345(a) and incorporating § 435.1200 which pertain to coordination options and responsibilities for the Exchange and Medicaid respectively. Under existing regulations, Medicaid and CHIP agencies may make final Medicaid and CHIP eligibility determinations based on the BHP's assessment; or the state Medicaid or CHIP agency may accept a final eligibility determination made by a BHP that uses state Medicaid and CHIP eligibility rules and standards. Further, the Exchange may contract eligibility determinations to eligible entities. We propose to adapt the provisions of § 435.1200(c) through (e) to BHP to reflect this flexibility and to establish the standards and guidelines to ensure a simple, coordinated and timely eligibility determination process and accurate eligibility determinations regardless of the option elected by the state.

Specifically, we propose to require an agreement between the Medicaid/CHIP

agency, the Exchange, and the BHP, that includes the same elements as those required in § 155.345(a) and § 435.1200(b)(3), to include a delineation of the responsibilities of each agency to minimize burden on individuals, as well as to ensure timely determinations of eligibility and enrollment in the appropriate program.

Because all insurance affordability programs will be collecting the same information, the state will have the information necessary to evaluate MAGI based eligibility across programs. We propose to require that the state operate in full compliance with 45 CFR 155.345(a) and (h) regarding agreements with the Exchange, Medicaid and CHIP agencies, as well as the secure exchange of information including electronic account transfers.

Similarly, we propose to require the BHP agency to notify any referring agency of final eligibility determinations in accordance with § 600.330.

An effective notification process is important to ensure a high quality consumer experience and a coordinated eligibility and enrollment system as provided under section 1413 of the Affordable Care Act and section 1943 of the Act. We propose to adopt the standards for notices, in accordance with § 435.913 and § 155.230, and the requirement for electronic notices in § 435.918 for the BHP. Consistent with the provisions of the Affordable Care Act for a coordinated system across insurance affordability programs, we further propose to adopt the provisions for coordinated and combined notices at § 435.1200.

7. Appeals (§ 600.335)

Eligibility for BHP is largely based upon eligibility for participation in the Exchange, within applicable income limits. As such, many of the eligibility processes for BHP will be substantially the same as those for the Exchange. We propose that individuals will have an opportunity to appeal BHP eligibility determinations but that opportunity cannot be modeled on the Exchange appeal process because a core component of the Exchange appeals process is the federal level appeal. There is no independent authority for a federal level appeals process for BHP like the federal level appeal for the Exchange. Therefore, we propose that the state use the Medicaid appeals process for BHP, under an agreement with the Medicaid program. We appreciate that some state Medicaid programs may choose to delegate Medicaid appeals to the Exchange. In these states, there will not be complete alignment between appeals processes

for Medicaid and BHP, since BHP appeals will not be inclusive of the federal process. We invite comment on this proposal.

8. Periodic Renewal of BHP eligibility (§ 600.340)

Consistent with the Exchange, Medicaid and CHIP, we propose at § 600.340(b) that the state shall re-determine an individual's eligibility every 12 months. If a state has chosen to match the Exchange policies on enrollment at § 600.320(d), the redetermination process will occur as part of the annual open enrollment. If the state has chosen the 12 month renewal process of Medicaid, the redetermination process will occur 12 months from the initial determination. Consistent with the rules established for the Exchange, we propose to adopt the Exchange provisions at 45 CFR 155.330(b) that the state require enrollees to report changes that could affect eligibility within 30 days, and must redetermine eligibility based on verified information received, or updated information from data sources.

For purposes of encouraging continuity of care, we have also proposed that, if an enrollee remains eligible at annual redetermination, the state must maintain the individual's enrollment in the current standard health plan under BHP unless the individual affirmatively takes action to choose a different standard health plan.

9. Eligibility verification (§ 600.345)

We propose that the state establish verification plans that are practical for all agencies determining eligibility for BHP. We propose to give the state the option to apply to BHP the same eligibility verification processes used by either the Exchange at 45 CFR 155.315 and 320 or the Medicaid agency at § 435.945 through § 435.956.

Regardless of which approach is chosen, the verification process must include verification of citizenship and lawfully present status. Self-attestation is not an acceptable verification method for citizenship and immigration status. The state may choose to verify additional factors and adopt reasonable verification procedures, and specify those factors for which self-attestation will be accepted.

10. Privacy and security of information (§ 600.350)

The state must comply with all requirements on the use and disclosure of personally identifiable information in operating BHP that are applicable to the operation of an Exchange. We propose to apply to the BHP 45 CFR 155.260(b)

which sets limits on the use and disclosure of personally identifiable information. We also propose to apply § 155.260(c), which clarifies that data sharing agreements made between BHP and other agencies must comply with other applicable law including section 1942 of the Act.

E. Standard Health Plan

We propose to add subpart E consisting of § 600.400 through § 600.425 to specify the standard health plan coverage and the delivery of such coverage.

Section 1331(b) of the Affordable Care Act provides that a standard health plan is a benefits plan which, at a minimum, provides essential health benefits described in section 1302(b) of the Affordable Care Act to BHP enrollees and, if offered by a health insurance issuer, has a medical loss ratio of at least 85 percent. Standard health plan offerors, as provided for in section 1331(g) of the Affordable Care Act, may include a licensed health maintenance organization, a licensed health insurance insurer, or a network of health providers.

Section 1331(c) of the Affordable Care Act provides for the establishment of a competitive process for the state to contract with standard health plan offerors to provide standard health plan coverage. The statute requires that the competitive process include the selection of standard health plans, the negotiation of premiums, cost sharing and benefits, as well as the consideration of innovative features such as care coordination and incentives to encourage the use of preventive services and appropriate utilization of health care services. The competitive process must also take into account the health and resource differences of the BHP population and participating providers, techniques to manage service utilization, establishment of performance measures, enhancement of standard health plan availability to BHP enrollees and coordination with other insurance affordability programs.

While much that is proposed in this subpart is new, given the need to set forth parameters in the establishment of a new program, we have adopted, where appropriate, existing Exchange or Medicaid standards consistent with our goal to create coordination across all insurance affordability programs, promote efficiencies and reduce administrative costs. This includes adopting the Exchange's coverage standards and protections at proposed § 600.405. In light of the specific statutory requirement for a competitive

procurement process, we propose to require that the state adopt contracting processes consistent with the procurement standards and competition requirements set forth in 45 CFR 92.36(b) through (i). We have further adapted standards from the Exchange and Medicaid with respect to the contract requirements that apply when the state contracts for the provision of standard health plans.

1. Basis, scope and applicability (§ 600.400)

Proposed § 600.400(a) specifies the statutory basis, scope, and applicability for the provisions regarding the minimum coverage standards included in BHP's standard health plans as well as the delivery of such coverage, the competitive contracting process and contract requirements the state must use when contracting for the provision of standard health plans, and other applicable requirements to enhance the availability of standard health plan coverage.

2. Standard health plan coverage (§ 600.405)

We propose in this section to align the minimum benefit BHP standard with 45 CFR 156.110 and 45 CFR 156.122 regarding prescription drug coverage, which defines the EHBs for the Exchange and includes any subsequent changes resulting from periodic reviews by the Secretary specified in 1302(b)(4)(G) and (H) of the Affordable Care Act. As required by statute, the minimum benefit standard must include at least the ten general EHB categories: Ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services including oral and vision care. Provision of essential health benefits means that the standard health plan coverage provided by the BHP will not include any limitations on coverage that are not substantially equal to the EHB-benchmark or reference plan. Nothing in this proposed rule should be interpreted to preclude a state from offering additional benefits within the state's standard health plan or in addition to the state's standard health plan.

Additionally, section 1302(b)(4) of the Affordable Care Act requires that benefit design or implementation of benefit design cannot discriminate "on the basis of an individual's age, expected

length of life, or of an individual's present or predicted disability, degree of medical dependency, or quality of life or other health conditions." We further propose to implement this section by adopting the coverage protections set forth at 45 CFR 156.125, applicable to the Exchange.

Within the construct of the required coverage of essential health benefits, there is no requirement in BHP that all enrollees receive the same or comparable benefits (known in Medicaid as the comparability requirement). States may have reason to provide specialized standard health plans to targeted populations to the extent that the targeting criteria are not based on pre-existing conditions or health status-related factors, and the proposed regulation offers states that option. We are also proposing to adopt the Exchange's substitution and supplementation of coverage standards described at 45 CFR 156.115(b) and 45 CFR 156.110(b)(1) for the BHP. Additionally, we are proposing to adopt the Medicaid model permitting the selection of more than one option for establishing essential health benefits using a base benchmark or reference plan. We are proposing these policies, in combination, to provide states flexibility in benefit definition and configuration, while assuring that all standard health plans cover all ten essential health benefits, as well as other benefits based on the state's selected base benchmark plan.

The intent of the reference plan is to reflect both the scope of services and limits offered by a typical employer plan in the state and set a reference or benchmark by which to measure the provision of substantially equal benefits. The permitted reference, or base benchmark plans as defined in 45 CFR 156.100(a)(1) through (4) are: the largest plan by enrollment in any of the three largest small group insurance products in the state's small group insurance market as defined in 45 CFR 155.20; any of the largest three state employee health benefit plans by enrollment; any of the largest three national Federal Employees Health Benefits Program (FEHBP) plan options by enrollment that are open to federal employees; or the largest insured commercial non-Medicaid HMO operating in the state. By permitting states to choose more than one base benchmark or reference plan in combination with substitution of benefits we are proposing to provide states flexibility to achieve similar plan structures as under alternative benefit plan structures in Medicaid. Substitution of benefits does not preclude states from drawing benefits

from the Medicaid state plan to meet the EHB benchmark benefit package as long as they are actuarially equivalent and in the same EHB category, with the exception of prescription drugs for which substitution is not permitted.

Plans providing essential health benefits in BHP must meet all the requirements in 45 CFR 156.115(a) defining substantially equal, prohibiting the exclusion of individuals from coverage in any benefit category, and complying with all the specific requirements for the provision of prescription drugs, mental health, substance abuse, preventive health services, and habilitative services.

In addition to the essential health benefits described in detail previously, we propose to set forth conditions applicable when the standard health plan is subject to state insurance mandates requiring additional benefits. (This is not the same as a state choosing to add additional benefits only to its standard health plan(s).) We propose that the state adopt the determination of the Exchange at 45 CFR 155.170(a)(3) in deciding which benefits, enacted after December 31, 2011, are in addition to the EHBs and are, therefore, outside of the reference premium structure that will be used to determine the amount of the premium tax credit and cost sharing reductions forming the basis for federal payments to states. Payment for these benefits would come from either state funds or trust fund surplus.

Finally, section 1303 of the Affordable Care Act sets forth special rules relating to coverage of abortion services and the segregation of funding for those services. Abortion services are prohibited from inclusion as essential health benefits and federal funding for abortion services, except in the case of endangerment of the woman's life, rape or incest, is prohibited. If states provide abortion services for which public funding is prohibited, the state is not eligible for any federal contribution, and payments for those services must be kept in separate allocation accounts.

3. Competitive contracting process (§ 600.410)

The competitive contracting process is a unique feature to BHP, and while we have aligned, to the greatest extent possible, with existing standards for the Exchange, Medicaid, and CHIP, this section also proposes new standards specific to BHP consistent with the statute. To receive HHS certification, we propose that the state assure in its BHP Blueprint that it follows a competitive contracting process that includes a negotiation of the elements described in § 600.410(d) as well as consideration of

the elements described in § 600.410(e). We are interpreting the requirement for a competitive process to permit any state procedures that are consistent with the standards set out in section 45 CFR 92.36(b) through (i). These standards provide a state considerable flexibility in how they solicit bids, how bids are evaluated, and how contracts are awarded, while ensuring that the competition will be open and free of unnecessary restrictions. While we understand that a state may be interested in joint procurements for BHP and other programs (such as Medicaid or other state health programs), the state must ensure that such a joint procurement meets the highest standards for competition of any of the involved programs, involves negotiation of at least the elements required under the BHP statute, does not unnecessarily restrict competition, and ensures that there is no cross-subsidization of costs between programs. We invite comments on this approach as we are interested in ensuring both state flexibility and free and open competition for the provision of standard health plans.

In § 600.410(c), we propose exceptions to the initial implementation of a competitive contracting process in the event that the state is unable to implement such a process for program year 2015. The proposed exceptions are subject to HHS approval during the certification process as proposed in § 600.120. We are seeking comment on this provision as we anticipate that a state may be interested in leveraging existing Medicaid managed care contracts to ensure an efficient and quick implementation of BHP effective January 1, 2015. As these contracts may not have been procured consistent with the procedures proposed in this section, we have proposed this exception to help promote coordination and continuity of care during the initial implementation of BHP in 2015.

We have proposed in § 600.410(d) three elements specified in the statute that a state must negotiate during its competitive contracting process. In addition to proposing the negotiation of premiums, cost sharing and benefits, we propose that a state ensure the inclusion of innovative features in the negotiation process, such as care coordination, case management, the use of incentives to promote preventive services and encourage enrollee involvement in health care decision making, such as the ability for enrollees to select their providers. We further propose in paragraph (e) of this section that a state also include in its competitive process the consideration of health and resources differences of enrollees and

health care providers. We also proposed in paragraph (e) that a state also include in its competitive process the use of managed care, or a similar process to improve the quality, accessibility, appropriate utilization, and efficiency costs and prices of services provided to enrollees as well as measures to prevent, identify theft, and address fraud, waste and abuse and ensure consumer protections. We share the goal of states to focus on improving the quality of care and health outcomes, and as such, have proposed that the state consider specific measures and standards that focus on these important objectives as well as consider how to coordinate with other health insurance affordability programs. We seek comment on the specific measures to consider and include in the final rule. Specifically, we are considering the use of measures that ensure enrollee protection, such as tracking and monitoring grievance and claims appeals while, at the same time, balancing our goals of state flexibility and effective contracting. Finally, in paragraph (f) of this section, we propose that nothing in this competitive process shall permit or encourage discrimination in enrollment based on pre-existing conditions or other health status-related factors.

4. Contracting qualifications and requirements (§ 600.415)

In § 600.415(a), we propose the criteria by which an offeror is eligible to contract with a state for the administration and provision of one or more standard health plans under BHP. In addition to the criteria specified in statute, we propose that an eligible offeror also include a non-licensed health maintenance organization to the extent that the offeror participates in Medicaid or CHIP.

The proposed eligible offeror criteria include a network of health care providers with the capacity to administer and provide standard health plan coverage. We do not anticipate that individual providers would be eligible to administer and provide a standard health plan. A network of providers, such as an independent physician association, or a large health system that provides, for example, both inpatient and outpatient health care services, or an accountable care organization, is necessary to not only deliver the coverage specified under the program but also to provide care coordination and case management as required by statute.

Finally, we have proposed including a non-licensed health maintenance organization that participates in Medicaid or CHIP to provide the state

with the flexibility to contract with Medicaid or CHIP managed care organizations that may not meet the requirements of a qualified health plan on the Exchange. We believe providing such flexibility furthers the objective of the program by encouraging continuity of care for BHP enrollees, who may frequently enroll and disenroll between the state's Medicaid program and BHP. We believe that the proposed requirements assure that non-licensed standard health plan offerors have the capacity to deliver high quality care to enrollees in a manner that is consistent with Medicaid standards; however, we invite comments on this approach.

During the October 2011 RFI process, we received several comments regarding the use of managed care under BHP, and whether a state must contract with managed care organizations for the provision of standard health plans. While the statute directs that the state contract for the provision of a standard health plan under BHP, it does not restrict the state's option to contract with qualified health plans operating in the Exchange or with Medicaid managed care organizations. We believe the statute also provides a state with the flexibility to operate its BHP under an integrated care model as the state has the option to contract with a network of providers to provide a standard health plan to enrollees to the extent that the network of providers meet the elements specified in statute.

With respect to the specific contract requirements for a standard health plan, we propose requiring that the state establish specific contract provisions that are unique to its BHP and applicable state laws to the extent needed to address network adequacy, service provision and authorization, quality and performance, enrollment procedures, disenrollment procedures, noticing, provisions protecting the privacy and security of personally identifiable information, and other applicable contract requirements as determined by the Secretary. We anticipate providing future guidance that will further describe the minimum contract requirements needed for HHS certification of a state's BHP; however, at this time, we will apply a "safe harbor" approach to a state incorporating the contract requirements from either 45 CFR part 156 (the Exchange's qualified health plan requirements) or 42 CFR part 438 (Medicaid managed care requirements). This "safe harbor" approach means that a state modeling its contract requirements off of the Exchange or Medicaid will meet the contract requirements for purposes of HHS

certification unless and until the next contract cycle after HHS issues additional guidance. We believe that the contract requirements under the Exchange and Medicaid assure the provision of high quality care while maintaining sufficient consumer protections; however, we invite comments on this approach to determine whether it accomplishes the objectives of promoting program efficiencies and promoting administrative simplicity.

We further propose that a state include in its standard health plan contracts provisions that define a sound and complete procurement contract, as required by 45 CFR part 92(i), which is consistent with existing federal procurement guidance. Also under paragraph (b), we propose that contracts with standard health plans that provide health insurance coverage offered by a health insurance issuer must comply with the requirement at section 1331(b)(3) of the Affordable Care Act for a medical loss ratio of at least 85 percent. Finally, the state must, as proposed at § 600.415(c), include in its BHP Blueprint the standard set of contract requirements that will be incorporated into its standard health plan contracts in order to receive HHS certification.

5. Enhanced availability of Standard Health Plans (§ 600.420)

Section 1331(c)(3)(A) of the Affordable Care Act specifies that, to the maximum extent feasible, a state should seek to make multiple standard health plans available to individuals to ensure choice of standard health plans. While we recognize the number of standard health plans may not equal the number of QHPs offered in the Exchange, we believe that BHP applicants and enrollees should have not only choice of standard health plans, but also a similar experience to consumers purchasing coverage in the Exchange, including the ability to compare the benefits packages, premiums, cost-sharing charges, etc. between the available plans (this includes different standard health plans offered by the same standard health plan offeror). In order to ensure that BHP applicants and enrollees are afforded the opportunity to compare available standard health plans, we believe that a state must ensure that there are at least two standard health plans offered under the program. In addition to ensuring a similar coverage purchasing experience for BHP enrollees, we believe that offering at least two standard health plans will ensure there is always one standard health plan available in the event that

the availability of the second standard health plan is affected. We understand that while choice of health plan may not always occur in Medicaid, BHP, unlike Medicaid, does not have a fee-for-service program available in the event that a single standard health plan suddenly becomes unavailable. We invite comment on the proposal to assure that at least two standard health plans are offered under the program.

A state has the option, as defined in section 1331(c)(3)(B) of the Affordable Care Act, to enter into a regional compact with other states for the joint procurement of standard health plans. As this is a new option afforded to states operating a BHP, we propose in § 600.420 that a state may enter into a regional compact to provide standard health plans statewide, or in geographically specific areas within the states. If the state contracts for the provision of a geographically specific standard health plan, the state must assure in its BHP Blueprint that enrollees, regardless of residency within the State, continue to have choice of at least two standard health plans. The state must include in its BHP Blueprint which state(s) will participate in the regional compact; the specific areas within the participating states in which the standard health plans will operate, if applicable; an assurance that the competitive contracting process used in the joint procurement complies with proposed § 600.410; and any variations in benefits, premiums and/or cost sharing that may result due to regional differences within the participating states. A state operating a geographically specific standard health plan under a regional compact must still operate a BHP statewide.

6. Coordination with other Insurance Affordability Programs (§ 600.425)

Due to income or household composition changes that may occur, coverage for some individuals will shift from BHP to the Exchange, Medicaid or CHIP coverage during open enrollment or in special enrollment periods during the year as well as possible shifts of coverage for some individuals from those other programs to BHP. Section 1331(c)(4) of the Affordable Care Act requires that BHP coordinate with Medicaid, CHIP, the Exchange and any other state-administered health insurance program. This coordination is important not only for eligibility and enrollment, but also with respect to the provision of health care benefits as enrollees transition in or out of BHP. Our goal is to ensure that enrollees do not experience a disruption in care and that coordination exists between all

insurance affordability programs to promote continuity of care. As such, we are proposing in § 600.425 that a state describe such coordination to prevent disruptions in care for transitioning enrollees. Examples of how a state can ensure coordination across the insurance affordability programs include, but are not limited to, describing how the state will:

(1) Ensure that individuals who are undergoing an ongoing course of treatment can continue receiving such treatment and have access to their provider(s) through the duration of their prescribed treatment (or, as appropriate, until a transition can be made without disruption, inconvenience or burden for the enrollee);

(2) Promote the sharing of data through the use of health information technology;

(3) Promote access to the same providers and services through BHP available through other insurance affordability programs, through coordinated provider enrollment procedures, coordinated coverage procurement procedures, or similar coverage definitions and protocols; and

(4) Use auto-enrollment protocols in BHP, Medicaid and CHIP that seek to maximize continuity with a provider.

F. Enrollee Financial Responsibilities

We propose adding subpart F consisting of § 600.500 through 600.525 to specify the monthly premium and cost-sharing standards applicable to BHP.

1. Basis, scope and applicability (§ 600.500)

Section 1331(a)(2)(A)(i) of the Affordable Care Act permits a state operating a BHP to collect monthly premiums to the extent that they do not exceed the amount of the monthly premium that the enrollee would have been required to pay if he or she had enrolled in the applicable second lowest cost silver plan, as defined in section 36B(b)(3)(B) of the Code, offered to the individual through an Exchange. The amount of the required monthly premium, either under BHP or under the applicable second lowest cost silver plan, will be determined after accounting for any premium tax credit and cost-sharing reduction.

Section 1331(a)(2)(A)(ii) of the Affordable Care Act limits cost sharing for BHP enrollees with incomes at or below 150 percent of the FPL to the amount required under a platinum plan and for BHP enrollees with incomes above 150 percent of the FPL, the amount required under a gold plan.

At § 600.520, we propose to adopt three cost-sharing provisions that are directly based on Exchange requirements related to cost-sharing protections for preventive health services, Indians, and the cost-sharing standards in QHPs that enroll consumers with similar incomes as BHP enrollees. Finally, at § 600.525, we propose disenrollment procedures and consequences for nonpayment of premiums.

2. Premiums (§ 600.505)

As discussed previously, the statute requires that a BHP enrollee's monthly premium not exceed the monthly premium the individual would have paid had he or she enrolled in a plan with a premium equal to the premium of the applicable benchmark plan, as defined in 26 CFR 1.36B-3(f). In § 600.505(a), we propose that a state assure in its BHP Blueprint that the BHP monthly premium does not exceed what an otherwise qualified enrollee would receive through the Exchange. The state must also assure that when determining the amount of the enrollee's monthly premium, it took into account reductions for the premium tax credit that would otherwise be available to the enrollee. As currently proposed, we are not requiring that the state assure that it accounted for the cost-sharing reduction when determining the enrollee's monthly premium as it is already assumed in the actuarial values of the applicable standard health plan. We further propose in this section that the state include in its BHP Blueprint the proposed enrollee monthly premium amounts for each group or groups of enrollees subject to the applicable premiums, the collection method and procedure for an enrollee to make his or her premium payment, and the consequences for nonpayment of premium.

3. Cost sharing (§ 600.510)

We propose that the state include in its BHP Blueprint the group or groups of enrollees subject to cost sharing, and to assure that cost-sharing standards, including the establishment of an effective system to ensure compliance, are in accordance with § 600.520.

We propose to adopt at § 600.510(b) the Exchange's approach (which is also consistent with Medicaid's approach) to cost sharing for preventive health services as described at 45 CFR 147.130 and 45 CFR 155.115(a)(4). These provisions establish that preventive services without cost sharing are a required element of the provision of essential health benefits. By cross referencing to these provisions, we

propose to incorporate the same prohibition on the imposition of copayments, deductibles, coinsurance or other forms of cost sharing with respect to recommended preventive health services or items in BHP that applies to the provision of essential health benefits in other insurance affordability programs and in the overall marketplace. We believe that this approach is both required by the statutory provision that standard health plans offer essential health benefits, and also accomplishes the goal of not exceeding the cost sharing that would have otherwise occurred if the individual had been enrolled on the Exchange. Furthermore, this policy promotes consistent treatment and continuity of care for consumers who may move between BHP, the Exchange and Medicaid in a given coverage year.

4. Public schedule of enrollee premiums and cost sharing (§ 600.515)

Under § 600.515(a), we propose that the state must ensure that applicants and enrollees have access to information concerning premiums and cost-sharing amounts for a specific item or service under a standard health plan that would apply for individuals at different income levels. We propose to align with the Exchange's minimum standard of publishing such information through an Internet Web site as well as through other means for individuals who do not have Internet access. In addition to the publication of the premiums and cost-sharing amounts, we propose that the state make publicly available information regarding the nonpayment of premiums. Under paragraph (b), we propose that the premium and cost sharing information must be made available to applicants for standard health plan coverage and for enrollees in such coverage at time of enrollment, re-enrollment, determination of eligibility, when premium and/or cost-sharing amounts change, and upon request by the individual. We believe that applying similar transparency standards utilized in the Exchange (and consistent with Medicaid and CHIP) will ensure efficiencies between insurance affordability programs as well as provide a more seamless experience for consumers who may transition out of, or into, the BHP.

5. General cost-sharing protections (§ 600.520)

We propose at § 600.520(a) to adopt similar cost-sharing protections for lower income enrollees that currently apply in CHIP at § 457.530 and the Exchange at 45 CFR 156.420(e). In both insurance affordability programs,

premiums and cost sharing may vary to the extent that they do not favor enrollees with higher incomes over those with lower incomes. At proposed § 600.520(b), we have adopted the Exchange standards set forth at 45 CFR 156.420(b)(1) and (d) regarding the cost-sharing protections applied to Indians, which are also consistent with the rules in Medicaid and CHIP. Specifically, states will not be permitted to impose cost sharing on Indians enrolled in BHP for essential health benefits. We believe that these protections are legally required to ensure that this population does not experience higher cost sharing than what would otherwise have been required had they enrolled on the Exchange.

As noted previously, section 1331(a)(2)(A)(ii) of the Affordable Care Act provides that the cost sharing required for individuals under 150 percent of the FPL not exceed what is required under a platinum plan offered through the Exchange. Similarly, the statute specifies that the cost sharing required for individuals above 150 percent of the FPL not exceed what is required under a gold plan offered through the Exchange. We received many comments on this particular section of the statute during our October 2011 request for information. Specifically, we received questions regarding the actuarial value of the platinum and gold plans HHS would use to align BHP's on cost-sharing reduction standards. Actuarial value is a measure of the percentage of expected health care costs a health plan will cover, and can be considered a general summary measure of health plan generosity. Section 1302(d)(2) of the Affordable Care Act defines actuarial value relative to coverage of the EHB for a standard population, and is generally calculated by computing the ratio of the total expected payments by the plan for EHB over the total costs for the EHB the standard population is expected to incur. For example, a plan with an 80 percent actuarial value would be expected to pay, on average, 80 percent of a standard population's expected medical expenses for the EHB. The individuals covered by the plan would be expected to pay, on average, the remaining 20 percent of the expected expenses in the form of deductibles, copayments, and coinsurance.

We considered two options to ensure that BHP enrollees do not experience higher cost sharing when enrolled in BHP relative to what they would have experienced had they been enrolled through the Exchange. The first option we considered required BHP plans to meet the same actuarial value standards

applicable to Exchange plans for this population pursuant to the revisions made by section 1001(b)(1)(A) of HCERA to section 1402(c)(2)(B) of the Affordable Care Act. The second option would be based on a comparison of the BHP plan to a selected model gold or platinum plan available under the Exchange. Under the first option, required cost sharing, on average, would not be more than 6 percent of the cost of coverage for the lowest income BHP population, and not more than 13 percent of the cost of coverage for other BHP enrollees. Under the second option, required cost sharing could exceed such levels but could not exceed the levels that would be required under the model Exchange plans.

In our proposed rule, we have elected the first option as we have interpreted the revisions made by section 1001(b)(1)(A) of HCERA to the actuarial values described in section 1402(c)(2)(B) of the Affordable Care Act to apply to the applicable populations enrolled in BHP; therefore, proposed § 600.520(c) adopts the cost-sharing standards set forth at 45 CFR 156.420(a)(1) and (2), (c) and (e). As proposed at § 600.520(c), the cost-sharing standard for non-Indian enrollees with income below 150 percent of the FPL cannot exceed what is required under a platinum plan with an actuarial value of 94 percent. The cost-sharing standard for non-Indian enrollees with incomes above 150 percent of the FPL cannot exceed what is required under a gold plan with an actuarial value of 87 percent. By incorporating the Exchange cost-sharing standards at 45 CFR 156.420(a)(1) and (2), the out-of-pocket cost-sharing maximums also apply to individuals enrolled in BHP. We invite comment on our proposed approach.

6. Disenrollment Procedures and Consequences for Nonpayment of Premiums (§ 600.525)

We propose in paragraph (a)(1) of this section that a state assure compliance with the disenrollment procedures for nonpayment of premiums set forth at 45 CFR 155.430. At paragraph (a)(2), we propose that a state aligning its enrollment policy to 45 CFR 155.410 and § 155.420 comply with the premium grace period standards set forth at 45 CFR 156.270 for required premium payment prior to disenrollment. We believe aligning the Exchange standards will ensure consistency for a state electing to model its BHP enrollment policies after the Exchange's. Should a state elect to implement a continuous enrollment policy similar to Medicaid, we propose in paragraph (b)(3), a 30-day premium grace period, which is

consistent with the premium grace period standard that is applied in CHIP.

At § 600.525(b), we propose to again base consequences of nonpayment of premium to the state's enrollment policies. Specifically, in paragraph (b)(1), we propose that a state applying the Exchange enrollment policies to its BHP may not restrict reenrollment to BHP beyond the next open enrollment period, or if applicable, the next special enrollment period. At paragraph (b)(2), we propose that a state implementing a continuous enrollment policy apply the CHIP reenrollment standards set forth in § 457.570(c). Specifically, a state would be prohibited from imposing a lockout period of more than 90 days, from continuing to impose a lockout period after an enrollee has paid past due premiums, and could not require collection of past due premiums as a condition of eligibility for reenrollment upon the expiration of the lockout period. Nothing in this proposed rule would preclude a state from continuing to seek past due premiums from an individual. Should a state elect to implement a premium lockout period, it must define the length of such a period in its BHP Blueprint. As with the disenrollment requirements described in paragraph (a), we believe that aligning the consequences of nonpayment of premiums to the state's enrollment policies will ensure program continuity and consistency.

G. Payments to States

We propose adding subpart G consisting of § 600.600 through § 600.615 to specify the BHP payment methodology and the procedures by which HHS will determine a state's BHP payment amount.

1. Basis, scope and applicability (§ 600.600)

Section 1331(d)(1) of the Affordable Care Act specifies that the Secretary must transfer each fiscal year federal funds to a state's BHP trust fund in the amount determined by the Secretary in accordance with the requirements set forth in section 1331(d)(3). Specifically, the statute requires the Secretary determine a per enrollee payment amount based on 95 percent of the premium tax credit under section 36B of the Code, and the cost-sharing reductions under section 1402 of the Affordable Care Act, that would have been provided to the enrollee in that fiscal year if he or she had been enrolled in a qualified health plan through an Exchange. When determining this payment amount, the statute further directs the Secretary to consider additional factors, such as age and

income of the enrollee as well as geographic rating differences.

Given the unique statutory requirements regarding the transfer and determination of a state's BHP payment amount, we propose, at § 600.605, the two components (the premium tax credit component and the cost-sharing reduction component) used in the general calculation of the state's federal payment. At § 600.610, we propose the process by which the Secretary will determine the state's BHP amount, and in § 600.615, we propose that HHS make quarterly federal deposits into the state's BHP trust fund.

2. BHP payment methodology (§ 600.605)

As described previously, section 1331(d)(3) of the Affordable Care Act directs the Secretary to determine the amount of payment to equal 95 percent of the premium tax credit and the cost-sharing reductions that the enrollee would have received had he or she enrolled in a qualified health plan through the Exchange. We received numerous comments during our October 2011 RFI process requesting clarity regarding the amount of the cost-sharing reductions that the Secretary will use when determining the BHP payment amount. Commenters expressed confusion by the placement of the comma in the statutory language and requested that HHS specify whether it would use 100 percent of the cost-sharing reductions, or 95 percent, which would coincide with the percentage of the premium tax credit. We have carefully considered this issue, and have interpreted the statute to read that the payment amount equals 95 percent of the cost-sharing reductions.

We are interpreting the statutory language directing the Secretary to make payments on a fiscal year to apply to a federal fiscal year. In addition, while payments to states will be made based on the federal fiscal year, the determination of payment rates will be made consistent with the calendar year operations utilized on the Exchange. Given that the determination of BHP payment rates requires data from the Exchange, we believe that utilizing calendar year based data will provide a more accurate determination of the payment rate.

We propose codifying in § 600.605(b) the seven factors specified in statute that must be considered when determining a state's BHP payment amount. We anticipate that these seven factors will be included in the funding formula which will be published on an annual basis in the proposed payment

notice process as described further in § 600.610.

We are also seeking specific comments on our proposed approach to address the statutory requirement that the federal payment take into account the health status of the enrollee for purposes of determining risk adjustment and reinsurance payments that would have been made had the individual enrolled in a QHP through the Exchange. As finalized in the March 11, 2013 **Federal Register** notice of benefit and payment parameters for 2014, 45 CFR 153.400(a)(2)(iv) excludes BHP participating plans from contributions to the reinsurance program. As such, BHP plans are not eligible to receive reinsurance payments since they are not contributing to the program; therefore, we are proposing to exclude reinsurance payments from consideration in the BHP funding formula.

With respect to risk adjustment, we have carefully considered this issue as we have received several comments from both states and stakeholders emphasizing the importance risk adjustment can have on not only a state's decision to elect BHP as an alternative source of coverage for low income adults, but also to the program's sustainability. Given the challenges associated with applying risk adjustment in the early years of both BHP and the individual market, we considered two possible approaches to recognize that BHP enrollees might differ from consumers in the individual market with respect to health status, associated health care service utilization, and program uptake. One possible approach we considered was to include BHP plans in risk adjustment as well as require that BHP enrollees and plans be included in the individual market risk pool. Under this approach, the funding mechanism would take into account the actual payments that would be made from that risk pool. The second approach was to account for the various differences between BHP enrollees and individual market enrollees in the BHP funding methodology only. We also considered under this approach the most appropriate time to include a risk adjustment factor in the BHP funding methodology; that is, whether we should address risk adjustment for year one or in the future, as well as the potential consequences of such timing.

We have carefully considered both approaches, and have decided that the most appropriate approach is to develop a risk adjustment factor to include in the BHP funding methodology rather than include BHP in the individual market risk pool. Our rationale for this approach is twofold. Specifically,

potential differences may exist between BHP and Exchange benefit packages and the market reform rules in the Affordable Care Act, such as the requirements for guaranteed issue, standard premium rating, and other such requirements may not apply to some standard health plan offerors. We believe that developing an appropriate factor in the BHP funding formula that accounts for the potential difference in health status between BHP enrollees and individual market enrollees would ensure that the BHP payment accurately reflects the statute's requirement to consider the impact of risk adjustment. In addition, we believe that this would provide a level of funding to BHP that more accurately reflects the expected health care costs for BHP enrollees.

Finally, the risk adjustment method being applied in the individual market is a concurrent model, which means that a current year's experience is applied retrospectively to premiums; however, we are proposing, as discussed further below, to limit the retrospective adjustments in calculating the federal payment amount for BHP to a small set, including enrollment, to improve predictability for states in the amount of federal funding they will receive in a given fiscal year. In so doing, we are not proposing to retrospectively apply risk adjustment to the federal payment amount.

While we seek comment on this approach, we will provide additional guidance that will further address this factor in our proposed Payment Notice which will be published in the fall of 2013 and will provide an additional opportunity for comment. Finally, we are not proposing to consider the issue of risk corridors in the BHP funding methodology as section 1342 of the Affordable Care Act specifically limits the program to QHPs.

Section 1331(d)(3)(B) of the Affordable Care Act directs the Secretary to adjust the payment for any fiscal year to reflect any error in the determination of the payment amount in the preceding fiscal year. We believe that the statutory language supports the idea that an adjustment that would trigger a repayment obligation is limited to "errors" in the determination of payment, and does not include adjustments to improve the underlying methodology for the per member per month payment rates. Specifically, the statute does not appear to contemplate adjustment to the certified methodology as an error; instead, it appears to contemplate that adjustments to the methodology are only made prospectively and do not include retroactive corrections/repayment.

Section 1331(d)(3)(A) of the Affordable Care Act specifies that the Secretary must determine the payment based on a certified methodology, and to the extent that the determination accurately reflects that methodology, there would be no error. Furthermore, we believe that the statute supports the idea that no retrospective adjustment would be necessary, subsequent to certification of the methodology, if the adjustment is an improvement in the methodology (for example, based on new data or analysis that would improve the accuracy of that methodology). The following list includes several examples of when a retrospective adjustment may or may not occur:

- Retrospective adjustment would be warranted for mathematical errors in applying the certified methodology.
- Retrospective adjustment in aggregate payments would be warranted if based on incorrect enrollment data.
- Retrospective adjustment would not appear to be warranted if the determination accurately reflected the certified methodology, and thus was consistent with the requirements of section 1331(d)(3)(A) of the Affordable Care Act, even if, based on new data or analysis, the same methodology would not be certified for subsequent fiscal years.

The interpretation of a prospective annual adjustment, except in the case of an error, means that the payment methodology published in accordance with the process set forth in § 600.610 will remain in effect for an entire fiscal year. The Secretary will only change the methodology for the following fiscal year in order to improve the accuracy of the methodology or to reflect more accurate data sources and assumptions. Should a change in methodology occur, the change will be applied on a prospective basis only. In addition to limiting retrospective adjustments to error, we also propose, as described further below, to adjust a state's preceding fiscal year payment amounts based on actual enrollment in that year. We believe that this process will ensure the financial stability of the program as well as provide fiscal certainty for states as they develop their budgets each year.

3. Secretarial determination of BHP payment amount (§ 600.610)

Section 1331(d)(3)(B) of the Affordable Care Act requires that the Chief Actuary of CMS, in consultation with the Department of Treasury's Office of Tax Analysis, certify the methodology to ensure that it meets the requirements set forth in the statute. The statute further provides that the certification must be based on sufficient

data from the state and from comparable states regarding their experiences with other insurance affordability programs.

We propose, at § 600.610(a), that beginning in fiscal year 2015, and upon receipt of certification, HHS will determine and publish in the **Federal Register** a proposed payment notice describing the BHP payment methodology utilized to calculate the payment factors and federal payment amount for the next fiscal year. This proposed payment notice will be published in October of each year. For example, in October 2014, HHS will publish the proposed BHP payment methodology that would be used to calculate the payment rates for fiscal year 2016. This approach is consistent with how payment parameters for Exchanges will be determined as well as how CHIP allotments were determined during the initial implementation of the program. In addition, we propose that the proposed payment notice may require states to submit data in order for the Secretary to determine and publish the BHP payment factors and to support the calculation of an estimated federal payment amount for the fiscal year in a subsequent **Federal Register** notice. We believe that publishing a proposed payment notice that includes the payment methodology would provide appropriate opportunity for public comment. We believe this timing would provide a state the information it needs to appropriately budget for BHP each year as well as provide fiscal assurance, a concern raised during our October 2011 RFI process from both states and other stakeholder groups.

We propose in § 600.610(b) that the Secretary determine and publish the final BHP payment methodology and payment factors that could be used to calculate an estimated federal payment amount based on a state's projected enrollment in a subsequent **Federal Register** notice. We propose publishing this notice in February of each year to provide states sufficient time to make any necessary adjustments to their BHP contracts well in advance of the new coverage year that begins in January. The final BHP payment amount will be calculated quarterly, as determined by using the final payment methodology and factors as well as actual enrollment and other data provided at regular intervals as specified in the notice. If needed, other applicable data will be used as determined by the Secretary in the final notice.

Given the timing of this proposed regulation and the January 1, 2015 implementation date, we intend to modify the publication dates of the payment notices for the first year of BHP

implementation. Specifically, because we will need to gather data from an interested state in order to model and calibrate the payment method and associated factors needed to determine preliminary payment amount, we intend to determine and publish in the **Federal Register** a proposed payment notice describing the BHP payment methodology for fiscal year 2015 in the fall of 2013. This notice will include requests for data to help the Secretary determine payment amounts. A subsequent **Federal Register** notice containing the final fiscal year 2015 BHP funding methodology and payment amounts (which will be calculated by inputting the appropriate data into the final BHP funding methodology) will be published concurrently with the final BHP regulation. We invite comment on our proposed approach to the use, and publication, of the proposed and final payment notices, especially with respect to the variation in fiscal year 2014, to determine whether this approach ensures administrative and financial stability for states interested in participating in BHP.

Under § 600.610(c)(1), we propose to determine, on a quarterly basis, state specific prospective aggregate payment amounts. This prospective amount will be calculated using the payment methodology and factors in the final payment notice. This prospective amount will be determined by multiplying the payment rates described in § 600.610(b) of this section by the projected number of BHP enrollees. This calculation may include different payment rates for enrollees related to the factors described in § 600.605(b). We are proposing this approach to quarterly prospective aggregate payments to provide the state with financial stability and assurance.

In § 600.610(c)(2), we propose retrospective adjustments to the aggregate amount described in § 600.610(c)(1) to account for any errors and to account for actual enrollment. The adjustment to account for actual enrollment would occur sixty days after the end of a quarter, and we would use the same method when determining a state's prospective aggregate payment amount; however, the enrollment numbers used in this calculation will be based on actual enrollment for the previous quarter rather than projected numbers. In the event that an adjustment to the payment amount is needed to account for differences in projected versus actual enrollment, we propose either depositing an additional payment in the state's BHP trust fund (to account for higher-than-projected enrollment), or a reduction in the state's

upcoming quarter's prospective aggregate payment amount (to account for lower-than-projected enrollment). We have proposed this process given that statute only authorizes payment on a per enrollee basis; therefore, we have determined that payments in excess of the per enrollee amount would not be permitted by statute. As with our proposed approach to determining proposed and final payment notices, we seek comment on this method of calculating and adjusting aggregate BHP payment amounts.

Finally, in § 600.615, we propose to make quarterly deposits to the state's BHP trust fund based on the aggregate quarterly payment amounts discussed in § 600.610(c).

H. BHP Trust Fund

We propose adding subpart H consisting of § 600.700 through 600.715 to specify the use of BHP trust funds, establishment of fiscal policies and accountability, and restitution and disallowance procedures.

1. Basis, scope and applicability (§ 600.700)

Section 1331(d)(2) of the Affordable Care Act specifies that a state implementing a BHP must establish a trust for the deposit of federal BHP payments. Because the trust fund is an integral feature of the BHP, we propose at § 600.705 to set new standards with respect to the establishment of the trust fund as well as the standards for allowable BHP trust fund expenditures. We propose at § 600.710 that a state establish appropriate fiscal and accountability standards to ensure that BHP trust funds are expended in accordance with the new standards set forth in § 600.705. At § 600.715, we propose restitution and disallowance procedures in the event that a determination is made that BHP trust funds have been improperly expended.

2. BHP Trust Fund (§ 600.705)

Section 1331(d)(2) of the Affordable Care Act specifies that the state establish a trust fund to receive federal deposits for the provision of the BHP. The statute also provides that the state may use unspent BHP trust funds to reduce premiums and cost sharing, or to provide additional benefits, for BHP enrollees. Under § 600.705(a), we propose that the state establish a trust fund at an independent entity, or as a subset account to the state's General Fund, and identify trustees responsible for oversight of the BHP trust fund along with individuals with the power to authorize withdrawal of funds. In addition to the federal deposits, we are

proposing in paragraph (b) that a state may deposit non-federal funds into its trust fund, which can include receipts from enrollees, providers or other third parties for standard health coverage. However, once non-federal funds have been deposited, such funds will be treated in the same manner as federal funds, must remain in the BHP trust fund and adhere to the same standards in accordance with paragraphs (c) and (d) in this section. We propose at § 600.705(c) to codify the statutory requirement which permits the use of BHP trust funds only to reduce premiums and cost sharing of standard health plan coverage, or to provide additional benefits for, eligible individuals enrolled in standard health plans within the state.

Finally, section 1331(d)(2) specifies particular limitations on the use of BHP trust funds. Specifically, states are not permitted to use BHP trust funds for purposes of meeting any matching or expenditure requirement of any federally-funded program, such as Medicaid or CHIP. We propose in § 600.705(d) to specify this as well additional situations in which the expenditure of BHP trust funds are not permitted, including the statutory prohibition of the use of funds to cover administrative costs. In § 600.705(e), we propose that a state may maintain in its trust fund a surplus or reserve of unexpended funds until such time as those funds are expended in accordance with the standards set forth in § 600.705(c) and (d).

3. State fiscal policies and accountability (§ 600.710)

We propose at § 600.710 to require the inclusion of fiscal policies and accountability requirements in the state's BHP Blueprint so that the state can document the use of BHP trust funds for authorized purposes. Specifically, under § 600.710(a), we propose that the state maintain an accounting and record system to ensure that BHP trust funds are properly maintained and expended. In accounting for such expenditures, the state must adhere to the cost principles applicable to governmental entities under Office of Management and Budget (OMB) Circulars A-87 and A-133.

We propose at § 600.710(b) that the state obtain an annual certification from the BHP trustees, the chief financial officer, or designee, certifying: (1) The program's financial statements for the fiscal year; (2) the separation of BHP trust funds from other state program funding to assure that BHP trust funds are not being used as the non-federal share to meet matching or expenditure

requirements of any federally-funded program, such as Medicaid or CHIP; and (3) compliance with all federal requirements consistent with those specified for the administration and provision of the program. In accounting for such expenditures, the state must adhere to the cost principles applicable to governmental entities under Office of Management and Budget (OMB) Circulars A-87 and A-133.

Under § 600.710(c), we propose that the state conduct an independent audit of BHP trust fund expenditures over a period of three years to determine whether the expenditures made during this time period were allowable and applied only to costs associated with reducing premiums and/or cost sharing, or provision of benefits. The independent audit may be conducted as a sub-audit of the single state audit conducted in accordance with OMB Circular A-133, and must follow the cost accounting principles in OMB Circular A-87. We propose that the state conduct the independent annual audit consistent with the standards set forth in chapter 3 of the Government Accountability Office's Government Auditing Standards (which are also consistent with those in Medicaid). As currently proposed, the state may elect to contract with a third party to conduct the audit, or may elect to use a state agency to the extent that the state can assure the audit was conducted in an independent manner.

We further propose in § 600.710(d) that the state publish annual reports on the use of funds, including a separate line item that tracks the use of funds described in § 600.705(e) to further reduce premiums and cost sharing, or for the provision of additional benefits, within 10 days of approval by the trustees. If applicable for the reporting year, the annual report must also contain the findings for the audit conducted in accordance with paragraph (c) of this section. At § 600.710(e), we propose that the BHP Blueprint establish and maintain BHP trust fund restitution procedures, in the event that the state or trustees must restore funds to the trust fund due to unallowable expenditures. We propose that the state maintain records for three years after the date of submission of a final expenditure report, or beyond, in instances where audit findings have not been resolved, consistent with the current standards in CHIP.

4. Resolution of questions about BHP transactions: Corrective action, restitution and disallowance of improper expenditures from the BHP Trust Fund (§ 600.715)

We propose at §§ 600.715(a) and (b) that when a question about the proper use of trust fund resources arises through the application of state fiscal policies, or through state or federal review and audit processes, the state and BHP trustees shall review those questions, and develop a written response to the questions raised no later than 60 days upon receipt of such a report, unless otherwise specified in the report, review or audit. In addition, based on that review, the state and BHP trustees shall take corrective action to ensure proper use of funds and restitution of questioned funds, as appropriate, to the state's trust fund. We further propose in paragraph (b) of this section, to the extent that the state and the BHP trustees determine that BHP trust funds may not have been properly spent, they shall ensure restitution to the BHP trust fund of amounts questioned by HHS, OIG or state auditors or reviewers. These policies are consistent with the normal business operations and proper management of a trust fund, with the possibility of ongoing reconciliation and correction of expenditures in the context of ongoing relationships with contractors and other business associates.

As proposed in § 600.715(b), to the extent that the state and BHP trustees determine that BHP trust funds may not have been properly spent, they must ensure restitution to the trust fund of the amounts in question. This is consistent with the nature of a trust fund, and the fiduciary relationship that trustees and other controlling entities have in the management of a trust fund. Restitution may be made directly, or by a liable third party (which could include the recipient of the improper expenditures, or an indemnifying insurer). Trustees may be the beneficiaries of indemnification agreements entered into by the state, the BHP trustees or an insurer.

We propose in § 600.715(c) to provide considerable flexibility in the timing of such restitution; restitutions may occur in a lump sum amount, or in equal installments. Restitution to the BHP trust fund cannot exceed a two year period from the date of the written response in accordance with paragraph (a) of this section. We propose providing a state with flexibility to determine the restitution option that best fits the circumstances so as to ensure the

viability and sustainability of its program.

We believe that most questioned expenditures will be resolved through these steps based on preliminary findings prior to any final determination that there has been an improper or unauthorized expenditure. To the extent that the BHP trustees and the state assure restitution of questioned BHP expenditures, the result will be that there will be no net improper or unauthorized expenditure. But if questioned funding is not restored to the BHP trust fund, and the questions are not otherwise resolved, then there would be an improper expenditure of federal funds. The state is not entitled to retain federal grant funding expended for purposes not statutorily authorized, and would need to return any such amounts.

To provide for the return of federal funding not expended for statutory authorized purposes, we propose at § 600.715(d) a procedure for HHS to disallow federal BHP funding that the Secretary (or a designated hearing officer) determines to have been improperly expended, after taking into account provisions for restitution of funds (other than when the restitution schedule elected by the BHP trustees and state has not been maintained). While we believe such disallowances will be rare in light of the oversight that we expect will be exercised on a state level through the trustees and the state audit process, disallowances are a necessary part of the federal oversight process and ensure that the statutory conditions for BHP funding are met.

Because we believe that the issues underlying a federal disallowance will generally have been fully developed in these state level audit and reviews, or through federal audit and review processes that will provide ample opportunity for resolution by the BHP trustees and the state questions through corrective action and restitution, we provide for a simplified disallowance process. After notice of an initial finding that contains a written explanation of the basis for the determination, the state will have an opportunity to submit information and argument for administrative reconsideration. Upon receipt of such a submission, the Secretary (or designated hearing officer) will determine if further information or procedures are necessary. The Secretary will then issue a final decision within 90 days after the later of the date of receipt of the reconsideration request or the date of the last scheduled proceeding or submission.

In § 600.715(f), we set forth the timing of the return of disallowed federal BHP

funding. Disallowed federal BHP funding must be returned to HHS within 60 days after the later of the date of the disallowance notice or the final administrative reconsideration upholding the disallowance. Such repayment cannot be made from BHP trust funds, but must be made with other, non-federal, funds.

Finally, we propose to revise the definition of “individual market” as described in 45 CFR 144.103 to clarify that Medicaid, CHIP and BHP coverage is not considered health insurance coverage available on the individual market.

IV. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

To derive average costs, we used data from the U.S. Bureau of Labor Statistics for all salary estimates. The salary estimates include the cost of fringe benefits, calculated at 35 percent of salary, which is based on the March 2011 Employer Costs for Employee Compensation report by the Bureau.

We are soliciting public comment on each of the section 3506(c)(2)(A)-required issues for the following information collection requirements (ICRs):

A. ICRs Regarding the BHP Blueprint (§§ 600.110, 600.115, 600.125, 600.305, 600.320, 600.345, 600.405, 600.410, 600.415, 600.420, 600.425, 600.505, 600.510, 600.525, 600.530, and 600.710)

In § 600.110, states wishing to participate in the BHP would prepare and submit a “Blueprint” to the Secretary for certification of the state’s program. Although we intend to issue a template outlining the required components of a Blueprint, that

template will be made available at a later time. In the meantime, we are setting out the Blueprint’s burden estimates since its requirements are proposed in this proposed rule.

Section 600.115, specifies that the Blueprint must be signed by the state’s governor or signed by an official delegated by the governor. The Blueprint must identify the agency and officials, by position or title, who are responsible for program administration, operations, and financial oversight. The Blueprint would also be required to identify the required characteristics for all BHP Trust Fund trustees.

In § 600.305, the Blueprint would be required to be consistent with the standards used to determine BHP eligibility. The state may not impose conditions of eligibility other than those identified in this section.

In §§ 600.320 and 600.345, the Blueprint would be required to ensure that the state’s enrollment, disenrollment, and verification policies are consistent with these sections. It must also include a plan to ensure coordination with and eliminate gaps in coverage for individuals transitioning between other insurance affordability programs.

In § 600.405, the Blueprint would be required to ensure that standard health plan coverage include (at a minimum) EHBs including any changes resulting from periodic reviews. While states have the option to allow benefits in addition to the EHBs, standard health plan coverage must be in compliance with 45 CFR 156.280 regarding abortion services.

In § 600.410, states would be required to assure that they comply with competitive contracting provisions in § 600.410(b), (c), and (d). This includes but is not limited to a justification for states unable to implement a competitive contracting process for benefit year 2015 as well as a description of the process it will use to enter into contracts for standard health plans. The state must also include a proposed timeline for implementing a competitive contracting process and provide assurance that the process includes specific negotiation criteria.

In § 600.415, states would be required to enter into a contract (with an offeror) for the administration and provision of standard health plans. A standard set of contract requirements would be included in the Blueprint.

In § 600.420, the Blueprint would be required to include a description of how the state will ensure (to the greatest extent possible) enrollee choice of standard health plans. States may also enter into a joint procurement with

other states. States electing this option must address the Blueprint provisions in § 600.420(b)(2).

In § 600.425, the Blueprint would be required to demonstrate how the state will ensure coordination with other insurance affordability programs.

In § 600.505, the Blueprint would be required to describe: the amount of the premium imposed on enrollees; the group or groups that are subject to the applicable premium; the collection method and procedure for the payment of an enrollee's premium; the disenrollment procedures and consequences of nonpayment of premiums. The Blueprint must also ensure that the total premium liability for an enrollee does not exceed the monthly premium that the enrollee would have paid had he/she enrolled in the second lowest cost silver plan offered through an Exchange.

With regard to cost sharing imposed on enrollees, § 600.510 would require that the Blueprint identifies the group or groups of enrollees that may be subject to the cost sharing, and an assurance that the state has established a system to monitor and track the cost-sharing standards specified in § 600.520.

In § 600.525(a), the Blueprint would be required to assure that the state is in compliance with the disenrollment procedures described in 45 CFR 155.430.

If a state has elected to implement a continuous enrollment policy, the state may also impose a lockout period after an enrollee has been disenrolled from the program. The Blueprint must define the length of the state's lockout period and assure that it will not continue to impose a premium lockout period after an enrollee's past due premiums have been paid and will not require the collection of past due premiums as a condition of eligibility for reenrollment once the state-defined lockout period has expired.

In § 600.710, the Blueprint would be required to ensure that the state's fiscal policies and accountability standards are consistent with this section. In this regard, the Blueprint must ensure that the BHP administering agency will maintain an accounting system and support fiscal records to assure that the trust funds are maintained and expended in accordance with federal requirements. The Blueprint would also be required to assure that the administering agency will obtain an annual certification from the state's BHP trustees, or chief financial officer (or designee), certifying the state's trust fund financial statements for the fiscal year, that the trust funds are not being used as the non-federal share to meet

matching or expenditure requirements of any federally-funded program, and that the trust fund is used in accordance with federal requirements.

The Blueprint would include an assurance that the administering agency will conduct an audit of trust fund expenditures, publish annual reports on the use of funds and audit findings (if applicable), establish and maintain trust fund restitution procedures, and retain records. The Blueprint must also be accompanied by a funding plan that describes the enrollment and cost projections for the first 12 months of operation and funding sources beyond the trust fund (if any). The plan must demonstrate that federal funds will only be used to reduce premiums and cost-sharing or to provide additional benefits.

Finally, the Blueprint would be required to describe how the state will ensure program integrity, including how the state will address potential issues of fraud, waste, and abuse and ensure consumer protections.

While a few states have expressed interest in pursuing the Basic Health Program in their state, HHS does not have an estimate of how many states will pursue this option. As such, we provide the burden estimate for one state and seek comment on the number of likely states to pursue this option. We estimate that it will take a state approximately 100 hours to develop the Blueprint and submit to the Secretary.

For purposes of this estimate, we assume that meeting these requirements will take a health policy analyst 80 hours (at an average wage rate of \$43 an hour) and a senior manager 20 hours (at an average wage rate of \$77 an hour). The estimated cost burden for one state is \$4,980.

As described in § 600.125, a state must notify HHS of any significant changes to its Blueprint. We estimate that it will take one state 12 hours to revise its Blueprint and submit it to HHS. We presume that it will take a health policy analyst 10 hours at \$43 an hour and a senior manager 2 hours at \$77 an hour to submit the change. The estimated cost burden for one state is \$584.

Since we estimate less than 10 annual respondents, the requirements/burden are exempt from formal OMB review and approval under 5 CFR 1320.3(c). Consequently, a PRA package is not applicable.

B. ICRs Regarding the Operation of a Basic Health Program (§§ 600.145, 600.150, and 600.170, and Subpart E)

The ongoing burden associated with the requirements under § 600.145 is the

time and effort it would take each participating State Medicaid Program to perform the recordkeeping and reporting portions of the core operating functions of a BHP including eligibility determinations and appeals as well as enrollment and disenrollment, health plan contracting, oversight and financial integrity, consumer assistance, and if necessary program termination.

BHPs would function as part of a coordinated eligibility and enrollment structure over all insurance affordability programs. They need to maintain and transfer eligibility accounts with equal accuracy and efficiency as the Exchange, as well as maintain enrollment data reported monthly to HHS. As such, we are estimating equal burden to the Exchange for this function. We estimate that it will take 52 hours annually to ensure the collection of enrollment data. Additionally we estimate it will take 12 hours to submit monthly enrollment data and 12 hours to reconcile data monthly.

The BHP will issue notices to applicants and eligible individuals regarding eligibility status. These notices must be developed and processed in a coordinated fashion with other insurance affordability programs. The burden estimates here are only for added burden of customizing to the BHP. We estimate that it will take a state 16 hours annually to customize notices and processes for the BHP.

We estimate that it will take 356 hours ((24 × 12) + 52 + 16) for a BHP to meet these reporting requirements for eligibility and enrollment functions. We presume that it will take an operations analyst 220 hours (at \$55 an hour), a health policy analyst 80 hours (at \$43 and hour) and a senior manager 56 hours (at \$77 an hour). To carry out the requirements for this function, we estimate the total cost of the reporting burden to be \$19,852 per state.

Part 600, subpart E, describes reporting requirements associated with the core function of standard health plan contracting and operations. Each state BHP must contract with standard health plan offerors and require participating standard health plans to provide transparency in covered benefits, cost-sharing and participating providers by reporting and making public such information annually. We estimate that it will take a state 120 hours to create and evaluate the request for proposals for participating standard health plans. Using the same estimates as the Exchange, we presume that it will take an additional 24 hours to collect the information necessary to ensure that coverage and transparency requirements

are met for a total annual burden per state of 144 hours. We presume that it will take a health policy analyst 100 hours (at \$43 an hour), an operations analyst 20 hours (at \$55 an hour) and a senior manager 24 hours (at \$77 an hour). The cost burden per state is \$7,248.

Oversight and financial integrity are core functions of the BHP that include annual reporting requirements to HHS on the operation of the trust fund, providing annual data necessary to acquire and reconcile federal funding and complete financial sections of the annual report in § 600.170. We estimate that it will take a state operating a BHP 24 hours annually to complete these reporting requirements. We presume that it will take an operations analyst 10 hours (at \$55 an hour), a financial analyst 10 hours (at \$62 an hour) and a senior manager 4 hours (at \$77 an hour) for cost burden of \$1,478 for one state.

Finally, BHPs are required in § 600.150 to ensure that there is enrollment assistance and information readily available to understand the program and any choices a consumer would have. We estimate that it will take a state 48 hours annually to create and share its format for required information with participating health plan offerors and to provide the necessary oversight to ensure that each offeror has complied with the specifications. Additionally, the state must publish enrollment choices, covered services and any options and limitations in a manner that meets accessibility and readability standards.

The total burden estimate for program termination is 48 hours per state. We presume that it would take a health policy analyst 40 hours (at \$43 an hour) and an operations analyst 8 hours (at \$55 an hour) to fulfill the enrollment assistance and information requirements burden. The total cost burden to the state for this function is \$2,160.

Since we estimate less than 10 annual respondents, the requirements/burden are exempt from formal OMB review and approval under 5 CFR 1320.3(c). Consequently, a PRA package is not applicable.

C. ICRs Regarding the Termination of a Basic Health Program (§ 600.140)

Section 600.140 would direct a state electing to terminate its BHP to submit a notice and transition plan to the Secretary. We estimate that it would take a state 24 hours to create and submit such information. A state must submit written notice to all participating standard health plans and to all enrollees regarding their plans to

terminate. Consistent with other notice estimates in the Exchange and BHP, we estimate that it would take 16 hours to prepare and submit each notification for a total of 32 hours per state. Finally, the state would be required to perform eligibility account transfers on behalf of enrollees. Due to the requirement that a state use the single eligibility service for all insurance affordability programs, we do not believe this requirement to necessitate much effort. We estimate that a state can fulfill this requirement in 8 hours.

The total burden estimate for program termination is 64 hours (24 + 32 + 8) per state. We presume that it would take a health policy analyst 44 hours (at \$43 an hour), an operations analyst 10 hours (at \$55 an hour) and a senior manager 10 hours (at \$77 an hour) to fulfill the program termination reporting burden. The total cost burden to the state for this function is \$3,212.

Since we estimate less than 10 annual respondents, the requirements/burden are exempt from formal OMB review and approval under 5 CFR 1320.3(c). Consequently, a PRA package is not applicable.

D. Submission of PRA-Related Comments

We invite public comments on these potential information collection requirements. If you comment on these information collection and recordkeeping requirements, please do either of the following:

1. Submit your comments electronically as specified in the **ADDRESSES** section of this proposed rule; or

2. Submit your comments to the Office of Information and Regulatory Affairs, Office of Management and Budget, Attention: CMS Desk Officer, (CMS-2380-P) Fax: (202) 395-6974; or Email: OIRA_submission@omb.eop.gov.

Comments must be received on/by November 25, 2013.

V. 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.

VI. Regulatory Impact Statement (or Analysis)

A. Overall Impact

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

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

A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects (\$100 million or more in any 1 year). The Basic Health Program provides states the flexibility to establish an alternative coverage program for low-income individuals who would otherwise be eligible to purchase coverage through Exchange. We are uncertain as to whether the effects of this rulemaking will be “economically significant” as measured by the \$100 million threshold, and hence not a major rule under the Congressional Review Act. We seek comment on the analysis provided below to help inform this assessment by

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

1. Need for the Rule

Section 1331 of the Affordable Care Act (codified at 42 USC § 18051) requires the Secretary to establish a Basic Health Program. This proposed rule implements that section.

2. Benefits

We anticipate that the Basic Health Program will provide benefits to both consumers and states.

a. Benefits to Consumers

The Basic Health Program (BHP) targets low-income individuals who would be eligible for premium and cost-sharing reductions, if they purchased health insurance through an Exchange. These individuals often have variable income that causes them to move between insurance programs. For example, if their income drops, they may be eligible for Medicaid, and when their income rises, they would be eligible to purchase insurance (with premium and cost-sharing reductions) on an Exchange. This variability in income can result in individuals moving back and forth between Medicaid and an Exchange, a phenomenon known as “churning.” Because Medicaid health plans and health plans offered on Exchanges vary in terms of benefits, provider networks, cost-sharing, and administration, churn can be disruptive and lead to poorer health outcomes due to lack of continuity of care. Researchers have estimated that the Basic Health Program will significantly reduce the number of individuals that churn between Medicaid and Exchanges.¹

We request additional comments and data that would help us assess the benefits of a Basic Health Program to consumers.

b. Benefits to States

Several states currently operate health insurance programs for low-income adults with income above Medicaid eligibility levels. These states believe that the programs confer benefit to their residents beyond what those individuals

could obtain by purchasing health insurance on an Exchange. The Basic Health Program established by this rule would give states the option to maintain these programs rather than sending those individuals to purchase insurance on the Exchange. We request additional comments and data that would help us assess the benefits of a Basic Health Program to states.

3. Costs

The provisions of this rule were designed to minimize regulatory costs. Rarely did we create new administrative structures, both because the Basic Health Program does not include administrative funding and because of the need for states to coordinate with other insurance affordability programs. To the extent possible, we borrowed structures from existing programs. We request comments and data that would help us assess the costs of a Basic Health Program.

4. Transfers

The provisions of this rule are designed to transfer funds that would be available to individuals for premium and cost-sharing reductions for coverage purchased on an Exchange to states to offer coverage through a Basic Health Program. In states that choose to implement a Basic Health Program, eligible individuals will not be able to purchase health insurance through the Exchange. As a result, fewer individuals will use the Exchange to purchase health insurance. This choice may have economic impact, and we seek comments and data that would help us assess that impact.

5. Regulatory Alternatives

Many of the structures of the Basic Health Program are set out in statute, and therefore we were limited in the alternatives we could consider. When we had options, we attempted to limit the number of new regulatory structures we created. To make the program easier for states to implement, we adopt or adapt regulations from existing programs—Medicaid, the Children’s Health Insurance Program, and the Exchanges—whenever possible, rather than create new structures. Two areas in which we had choices are reporting compliance with federal rules and contracting with standard health plans.

a. Reporting compliance with federal rules to HHS

We followed the paradigm of adopting or adapting existing structures when creating a process for reporting state compliance with federal rules. Two existing structures we considered were

the Exchange model of Blueprints and the Medicaid model of state plans. We chose to use the Blueprint model, which we believe will be less burdensome to states than the state plan model. We seek comments, data, and suggestions for alternative methods for states to report to HHS.

b. Contracting requirements

Similarly when choosing how to regulate state contracts with standard health plans, we looked to models in the Exchange and Medicaid rather than creating new regulatory schemes. We have adopted, where possible, existing procurement requirements in order to minimize the burden on states. In addition, we have allowed states the option to seek an exemption from competitive contracting requirements for program year 2015 if they are unable to meet the requirements in the first year of the program. We seek comments, data, and suggestions for other alternatives to the contracting process we propose.

B. Unfunded Mandates Reform Act

Section 2 02 of the Unfunded Mandates Reform Act of 1995 (UMRA) requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of \$100 million in 1995 dollars, updated annually for inflation, by state, local, or tribal governments, in the aggregate, or by the private sector. In 2013, that threshold is approximately \$141 million. States have the option, but are not required, to establish a BHP. Thus, this proposed rule does not mandate expenditures by state governments, local governments, or tribal governments

C. Regulatory Flexibility Act

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

¹ Hwang, A., S. Rosenbaum, and B. D. Sommers. “Creation Of State Basic Health Programs Would Lead To 4 Percent Fewer People Churning Between Medicaid And Exchanges.” *Health Affairs* 31.6 (2012): 1314–1320.

Buettgens, M., A. Nichols, and S. Dorn. “Churning Under the ACA and State Policy Options for Mitigation: Timely Analysis of Immediate Health Policy Issues.” Urban Institute (2012). Available at <http://www.urban.org/UploadedPDF/412587-Churning-Under-the-ACA-and-State-Policy-Options-for-Mitigation.pdf>.

Because this proposed rule is focused on eligibility and enrollment in public programs, it does not contain provisions that would have a significant direct impact on hospitals, and other health care providers that are designated as small entities under the RFA. However, the provisions in this proposed rule may have a substantial, positive indirect effect on hospitals and other health care providers due to the substantial increase in the prevalence of health coverage among populations who are currently unable to pay for needed health care, leading to lower rates of uncompensated care at hospitals. The Department cannot determine whether this proposed rule would have a significant economic impact on a substantial number of small entities, and we request public comment on this issue.

Section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a proposed rule may have a significant economic impact on the operations of a substantial number of small rural hospitals. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a metropolitan statistical area and has fewer than 100 beds. As indicated in the preceding discussion, there may be indirect positive effects from reductions in uncompensated care. Again, the Department cannot determine whether this proposed rule would have a significant economic impact on a substantial number of small rural hospitals, and we request public comment on this issue.

D. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct effects on States, preempts State law, or otherwise has Federalism implications. The BHP is entirely optional for states, and if implemented in a state, provides access to a pool of funding that would not otherwise be available to the state.

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

We continue to engage in ongoing consultations with states that have expressed interest in implementing a BHP through the BHP Learning Collaborative, which serves as a staff level policy and technical exchange of information between CMS and the States. Through consultations with this Learning Collaborative, we have been

able to get input from States on many of the specific issues addressed in this rule.

List of Subjects

42 CFR Part 600

Administrative practice and procedure, Health care, Health insurance, Penalties, and Reporting and recordkeeping requirements, State and local governments.

45 CFR Part 144

Health care, Health insurance, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, under the authority at section 1331(a)(1) of the Affordable Care Act, the Centers for Medicare & Medicaid Services and the Office of the Secretary propose to amend 42 CFR chapter IV and 45 CFR subtitle A, respectively, as set forth below.

Title 42

■ 1. Subchapter I, consisting of part 600, is added to read as follows:

Subchapter I—Basic Health Program

PART 600—ADMINISTRATION, ELIGIBILITY, ESSENTIAL HEALTH BENEFITS, PERFORMANCE STANDARDS, SERVICE DELIVERY REQUIREMENTS, PREMIUM AND COST SHARING, ALLOTMENTS, AND RECONCILIATION

Subpart A—General Provisions and Definitions

- Sec.
600.1 Scope.
600.5 Definitions and use of terms.

Subpart B—Establishment and Certification of State Basic Health Programs

- 600.100 Program description.
600.105 Basis, scope, and applicability of subpart B.
600.110 BHP Blueprint.
600.115 Development and submission of the BHP Blueprint.
600.120 Certification of a BHP Blueprint.
600.125 Revisions to a certified BHP Blueprint.
600.130 Withdrawal of a BHP Blueprint prior to implementation.
600.135 Notice and timing of HHS action on a BHP Blueprint.
600.140 State termination of a BHP.
600.142 HHS withdrawal of certification and termination of a BHP.
600.145 State program administration and operation.
600.150 Enrollment assistance and information requirements.
600.155 Tribal consultation.
600.160 Protections for American Indian and Alaskan Natives.
600.165 Nondiscrimination standards.
600.170 Annual report content and timing.

Subpart C—Federal Program Administration

- 600.200 Federal program reviews and audits.

Subpart D—Eligibility and Enrollment

- 600.300 Basis, scope, and applicability.
600.305 Eligible individuals.
600.310 Application.
600.315 Certified application counselors.
600.320 Determination of eligibility for and enrollment in a standard health plan.
600.330 Coordination with other insurance affordability programs.
600.335 Appeals.
600.340 Periodic determination and renewal of BHP eligibility.
600.345 Eligibility verification.
600.350 Privacy and security of information.

Subpart E—Standard Health Plan

- 600.400 Basis, scope, and applicability.
600.405 Standard health plan coverage.
600.410 Competitive contracting process.
600.415 Contracting qualifications and requirements.
600.420 Enhanced availability of standard health plans.
600.425 Coordination with other insurance affordability programs.

Subpart F—Enrollee Financial Responsibilities

- 600.500 Basis, scope, and applicability.
600.505 Premiums.
600.510 Cost-sharing.
600.515 Public schedule of enrollee premium and cost sharing.
600.520 General cost-sharing protections.
600.525 Disenrollment procedures and consequences for nonpayment of premiums.

Subpart G—Payment to States

- 600.600 Basis, scope, and applicability.
600.605 BHP payment methodology.
600.610 Secretarial determination of BHP payment amount.
600.615 Deposit of Federal BHP payment.

Subpart H—BHP Trust Fund

- 600.700 Basis, scope, and applicability.
600.705 BHP trust fund.
600.710 Fiscal policies and accountability.
600.715 Corrective action, restitution, and disallowance of questioned BHP transactions

Authority: Section 1331 of the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111–148, 124 Stat. 119), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152, 124 Stat. 1029).

Subpart A—General Provisions and Definitions

§ 600.1 Scope.

Section 1331 of the Patient Protection and Affordable Care Act, provides for the establishment of the Basic Health Program (BHP) under which a State may enter into contracts to offer two or more standard health plans providing at least

essential health benefits to eligible individuals in lieu of offering such individuals the opportunity to enroll in coverage through an Affordable Insurance Exchange. States that elect to operate a BHP will receive federal funding based on the amount of premium tax credits and cost-sharing reductions that would have been available if enrollees had obtained coverage through the Exchange.

§ 600.5 Definitions and use of terms.

For purposes of this part, the following definitions apply:

Advance payments of the premium tax credit means payment of the tax credits authorized by 26 U.S.C. 36B and its implementing regulations, which are provided on an advance basis to an eligible individual enrolled in a QHP through an Exchange in accordance with sections 1402 and 1412 of the Affordable Care Act.

Affordable Care Act is the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152).

Basic Health Program (BHP) Blueprint is the operational plan that a State must submit to the Secretary of Health and Human Services (HHS) for certification to operate a BHP.

Certification means authority to operate the program which is required for program operations but it does not create an obligation on the part of the State to implement a BHP.

Code means the Internal Revenue Code of 1986.

Cost sharing means any expenditure required by or on behalf of an enrollee with respect to covered health benefits; such term includes deductibles, coinsurance, copayments, or similar charges, but excludes premiums, balance billing amounts for non-network providers and spending for non-covered services.

Enrollee means an eligible individual who is enrolled in a standard health plan contracted to operate as part of a BHP.

Essential health benefits means the benefits described under section 1302(b) of the Affordable Care Act.

Family and family size is as defined at 26 CFR 1.36B-1(d).

Federal fiscal year means the time period beginning October 1st and ending September 30th.

Federal poverty level or FPL means the most recently published Federal poverty level, updated periodically in the **Federal Register** by the secretary of Health and Human Services under the authority of 42 U.S.C. 9902(2).

Household income is as defined in 26 CFR 1.36B-1(e)(1).

Indian means any individual as defined in section 4 (d) of the Indian Self-Determination and Education Assistance Act (Pub. L. 93-638).

Lawfully present has the meaning given in 45 CFR 152.2

Minimum essential coverage has the meaning set forth at 26 CFR 1.5000A-2, including coverage recognized by the Secretary as minimum essential coverage pursuant to 26 CFR 1.5000A-2(f). Under that authority, the Secretary recognizes coverage through a BHP standard health plan as minimum essential coverage.

Modified adjusted gross income is as defined in 26 CFR 1-36B-1(e)(2).

Premium means any enrollment fee, premium, or other similar charge paid to the standard health plan offeror.

Preventive health services and items includes those services and items specified in 45 CFR 147.130(a).

Program year means a calendar year for which a standard health plan provides coverage for eligible BHP enrollees.

Qualified health plan or QHP means a health plan that has in effect a certification that it meets the standards described in subpart C of 45 CFR part 156 issued or recognized by each Exchange through which such plan is offered in accordance with the process described in subpart K of 45 CFR, except that such term must not include a qualified health plan which is a catastrophic plan described in 45 CFR 155.20

Reference plan is a synonym for the EHB benchmark plan and is defined at 45 CFR 156.100.

Regional compact means an agreement between two or more States to jointly procure and enter into contracts with standard health plan offeror(s) for the administration and provision of a standard health plan under the BHP to eligible individuals in such States.

Residency is determined in accordance with 45 CFR 155.305(a)(3).

Single streamlined application has the same meaning as application defined at 42 CFR 431.907(b)(1) of this chapter and 45 CFR 155.405(a) and (b)

Standard health plan means a health benefits package, or product, that is provided by the standard health plan offeror.

Standard health plan offeror means an entity that is eligible to enter into contracts with the State for the administration and provision of a standard health plan under the BHP.

State means each of the 50 states and the District of Columbia as defined by section 1304 of the Act.

Subpart B—Establishment and Certification of State Basic Health Programs

§ 600.100 Program description.

A State Basic Health Program (BHP) is operated consistent with a BHP Blueprint that has been certified by the Secretary to meet the requirements of this part. The BHP Blueprint is developed by the State for certification by the Secretary in accordance with the processes described in this subpart.

§ 600.105 Basis, scope, and applicability of subpart B.

(a) *Statutory basis.* This subpart implements the following sections of the Act:

(1) Section 1331(a)(1) which defines a Basic Health Program.

(2) Section 1331(a)(2) which requires the Secretary to certify a Basic Health Program before it may become operational.

(3) Section 1331(f) which requires Secretarial oversight through annual reviews.

(b) *Scope and applicability.* (1) This subpart sets forth provisions governing the administration of the BHP, the general requirements for development of a BHP Blueprint required for certification, for program operations and for voluntary program termination.

(2) This subpart applies to all States that submit a BHP Blueprint and request certification to operate a BHP.

§ 600.110 BHP Blueprint.

The BHP Blueprint is a comprehensive written document submitted by the State to the Secretary for certification of a BHP in the form and manner specified by HHS. The program must be administered in accordance with all aspects of section 1331 of the Affordable Care Act and other applicable law, this chapter, and the certified BHP Blueprint.

(a) *Content of a Blueprint.* The Blueprint will establish compliance with applicable requirements by including a description, or if applicable, an assurance of the following:

(1) The minimum benefits offered under a standard health plan that assures inclusion of essential health benefits as described in section 1302(b) of the Affordable Care Act, in accordance with § 600.405.

(2) The competitive process, consistent with § 600.410, that the State will undertake to contract for the provision of standard health plans.

(3) The standard contract requirements, consistent with § 600.415, that the State will incorporate in its standard health plan contracts.

(4) The methods by which the State will enhance the availability of standard health plan coverage as described in § 600.420.

(5) The methods by which the State will ensure and promote coordination with other insurance affordability programs as described in § 600.425.

(6) The premium imposed under the BHP, consistent with the standards set forth in § 600.505.

(7) The cost sharing imposed under the BHP, consistent with the standards described in § 600.510.

(8) The disenrollment procedures and consequences for nonpayment of premiums consistent with § 600.525, respectively.

(9) The standards, consistent with § 600.305 used to determine eligibility for the program.

(10) The State's policies regarding enrollment, disenrollment and verification consistent with §§ 600.320 and 600.345, along with a plan to ensure coordination with and eliminate gaps in coverage for individuals transitioning to other insurance affordability programs.

(11) The fiscal policies and accountability procedures, consistent with § 600.710.

(12) The process by which BHP trust fund trustees shall be appointed, the qualifications and responsibilities of such trustees, and any arrangements to insure or indemnify such trustees against claims for breaches of their fiduciary responsibilities.

(13) A description of how the State will ensure program integrity, including how it will address potential fraud, waste, and abuse and ensure consumer protections.

(14) An operational assessment establishing operating agency readiness.

(b) *Funding plan.* (1) The BHP Blueprint must be accompanied by a funding plan that describes the enrollment and cost projections for the first 12 months of operation and the funding sources, if any, beyond the BHP trust fund.

(2) The funding plan must demonstrate that Federal funds will only be used to reduce premiums and cost-sharing or to provide additional benefits.

(c) *Transparency.* HHS shall make a State's BHP Blueprint available on line.

§ 600.115 Development and submission of the BHP Blueprint.

(a) *State authority to submit the State Blueprint.* A State BHP Blueprint must be signed by the State's Governor or by

the official with delegated authority from the Governor to sign it.

(b) *State Basic Health Program officials.* The State must identify in the BHP Blueprint the agency and officials within that agency, by position or title, who are responsible for program administration, operations, and financial oversight.

(c) *Opportunity for public comment.* The State must provide an opportunity for public comment on the BHP Blueprint content described in § 600.110 before submission to the Secretary for certification.

(1) The State must seek public comment on any significant subsequent revisions prior to submission of those revisions to the Secretary for certification. Significant revisions are those that alter core program operations required by § 600.145(e).

(2) The process of seeking public comment must include Federally-recognized tribes as defined in the Federally Recognized Indian Tribe List Act of 1994, 25 U.S.C. 479a, located in the State.

(d) *Submission and timing.* The BHP Blueprint must be submitted in a manner and format specified by HHS. States may not implement the BHP prior to receiving certification. The date of implementation for this purpose is the first day enrollees would receive coverage under the BHP.

§ 600.120 Certification of a BHP Blueprint.

(a) *Effective date of certification.* The effective date of the certification is the date of signature by the Secretary.

(b) *Payments for periods prior to certification.* No payment may be made under this part for periods of BHP operation prior to the date of certification.

(c) *Period in which a certified Blueprint remains in effect.* The certified Blueprint remains in effect until:

(1) The Blueprint is replaced by Secretarial certification of an updated Blueprint containing revisions submitted by the State.

(2) The State terminates the program consistent with § 600.140.

(3) The Secretary makes a finding that the BHP Blueprint no longer meets the standards for certification based on findings in the annual review, or reports significant evidence of beneficiary harm, financial malfeasance, fraud, waste or abuse by the BHP agency or the State consistent with § 600.142.

(d) *Blueprint approval standards for certification.* The Secretary will certify a BHP Blueprint provided it meets all of the following standards:

(1) The Blueprint contains sufficient information for the Secretary to

determine that the BHP will comply with the requirements of section 1331 of the Affordable Care Act and this Part.

(2) The BHP Blueprint demonstrates adequate planning for the integration of BHP with other insurance affordability programs in a manner that will permit a seamless, coordinated experience for a potentially eligible individual.

(3) The Blueprint is a complete and comprehensive description of the BHP and its operations, demonstrating thorough planning and a concrete program design, without contingencies or reserved decisions on operational features.

§ 600.125 Revisions to a certified BHP Blueprint.

(a) *Submission of revisions.* In the event that a State seeks to make significant change(s) that alter program operations described in the certified BHP Blueprint, the State must submit a revised Blueprint to the Secretary for review and certification.

(b) *Continued operation.* The State is responsible for continuing to operate under the terms of the existing certified Blueprint until and unless a revised Blueprint is certified.

§ 600.130 Withdrawal of a BHP Blueprint prior to implementation.

To the extent that a State has not enrolled eligible individuals into the BHP:

(a) The State may submit a written request to stop any further consideration of a previously submitted BHP Blueprint, whether certified or not.

(b) The written request must be signed by the governor, or the State official delegated to sign the BHP Blueprint by the governor.

(c) HHS will respond with a written confirmation that the State has withdrawn the Blueprint.

§ 600.135 Notice and timing of HHS action on a BHP Blueprint.

(a) *Timely response.* HHS will act on all certification and revision requests in a timely manner.

(b) *Issues preventing certification.* HHS will notify the State in writing of any impediments to certification that arise in reviewing a proposed BHP Blueprint.

§ 600.140 State termination of a BHP.

(a) If a State decides to terminate its BHP, the State must complete all of the following prior to the effective date of the termination or the indicated dates:

(1) Submit written notice to the Secretary no later than 120 days prior to the proposed termination date accompanied by a proposed transition plan that describes procedures to assist

consumers with transitioning to other insurance affordability programs.

(2) Resolve concerns expressed by the Secretary and obtain approval by the Secretary of the transition plan.

(3) Submit written notice to all participating standard health plan offerors, and enrollees that it intends to terminate the program at least 90 days prior to the termination date. The notices to enrollees must include information regarding the State's assessment of their eligibility for all other insurance affordability programs in the State. Notices must meet the accessibility and readability standards at 45 CFR 155.230(b).

(4) Transmit all information provided as part of an application, and any information obtained or verified by the State or other agencies administering insurance affordability programs via secure electronic interface, promptly and without undue delay to the agency administering the Exchange and the Medicaid agency as appropriate.

(5) Fulfill its contractual obligations to participating standard health plan offerors including the payment of all negotiated rates for participants, as well as plan oversight ensuring that participating standard health plan offerors fulfill their obligation to cover benefits for each enrollee.

(6) Fulfill data reporting requirements to HHS.

(7) Complete the annual financial reconciliation process with HHS to ensure full compliance with Federal financial obligations.

(8) Refund any remaining balance in the BHP trust fund.

(b) [Reserved]

§ 600.142 HHS withdrawal of certification and termination of a BHP.

(a) The Secretary may withdraw certification for a BHP Blueprint based on a finding that the BHP Blueprint no longer meets the standards for certification based on findings in the annual review, findings from a program review conducted in accordance with § 600.200 or from significant evidence of beneficiary harm, financial malfeasance, fraud, waste or abuse.

(b) Withdrawal of certification for a BHP Blueprint shall occur only after the Secretary provides the State with notice of the proposed finding that the standards for certification are not met or evidence of harm or misconduct in program operations, a reasonable period for the State to address the finding (either by substantiating compliance with the standards for certification or submitting revisions to the Blueprint, or securing HHS approval of a corrective

action plan), and an opportunity for a hearing before issuing a final finding.

(c) The Secretary shall make every reasonable effort to resolve proposed findings without requiring withdrawal of BHP certification.

(d) The effective date of an HHS determination withdrawing BHP certification shall not be earlier than 120 days following a final finding of noncompliance with the standards for certification.

(e) Within 30 days following a final finding of noncompliance with the standards for certification, the State shall submit a transition plan that describes procedures to assist consumers with transitioning to other insurance affordability programs, and shall comply with the procedures described in § 600.140(a)(2) through (8).

§ 600.145 State program administration and operation.

(a) *Program operation.* The State must implement its BHP in accordance with the approved and certified State BHP Blueprint, any approved modifications to the State BHP Blueprint and the requirements of this chapter and applicable law.

(b) *Eligibility.* All persons have a right to apply for a determination of eligibility and, if eligible, to be enrolled into coverage that conforms to these regulations.

(c) *Statewide program operation.* A state choosing to operate a BHP must operate it statewide.

(d) *No caps on program enrollment.* A State implementing a BHP must not be permitted to limit enrollment by setting an income level below the income standard prescribed in section 1331 of the Affordable Care Act, having a fixed enrollment cap or imposing waiting lists.

(e) *Core operations.* A State operating a BHP must perform all of the following core operating functions:

(1) Eligibility determinations as specified in § 600.320.

(2) Eligibility appeals as specified in § 600.335.

(3) Contracting with standard health plan offerors as specified in § 600.410.

(4) Oversight and financial integrity including, but not limited to, operation of the Trust Fund specified at §§ 600.705 and 600.710, compliance with annual reporting at § 600.170, and providing data required by § 600.610 for Federal funding and reconciliation processes.

(5) Consumer assistance as required in § 600.150.

(6) Extending protections to American Indian/Alaska Natives specified at § 600.160, as well as comply with the

Civil Rights and nondiscrimination provisions specified at § 600.165.

(7) Data collection and reporting as necessary for efficient and effective operation of the program and as specified by HHS to support program oversight.

(8) If necessary, program termination procedures at § 600.145.

§ 600.150 Enrollment assistance and information requirements.

(a) *Information disclosure.* (1) The State must make accurate, easily understood information available to potential applicants and enrollees about the BHP coverage option along with information about other insurance affordability programs.

(2) The State must provide accessible information on coverage, including additional benefits that may be provided outside of the standard health plan coverage, any tiers of coverage it has built into the BHP, including who is eligible for each tier.

(3) The State must require participating standard health plans to provide clear information on premiums; covered services including any limits on amount, duration and scope of those services; applicable cost-sharing using a standard format supplied by the State, and other data specified in, and in accordance with, 45 CFR 156.220.

(4) The State must provide information in a manner consistent with 45 CFR 155.205(c).

(5) The State must require participating standard health plans to make publicly available, and keep up to date, the names and locations of currently participating providers.

(b) [Reserved]

§ 600.155 Tribal consultation.

The State must consult with Indian tribes located in the State on the development and execution of the BHP Blueprint using the State or Federal tribal consultation policy approved by the applicable State or Federal Exchange.

§ 600.160 Protections for American Indian and Alaskan Natives.

(a) *Enrollment.* Indians must be extended the same special enrollment status in BHP standard health plans as applicable to enrollment in a QHP through the Exchange under 45 CFR 155.420(d)(8). Indians will be allowed to enroll in, or change enrollment in, standard health plans one time per month.

(b) *Premiums.* The State must permit Indian tribes, tribal organizations and urban Indian organizations to pay standard health plan premiums on

behalf of BHP eligible and enrolled individuals.

(c) *Cost sharing.* No cost sharing may be imposed on Indians under the standard health plan.

(d) *Requirement.* Standard health plans must pay primary to health programs operated by the Indian Health Service, Indian tribes, tribal organizations, and urban Indian organizations for services that are covered by a standard health plan.

§ 600.165 Nondiscrimination standards.

(a) The State and standard health plans, must comply with all applicable civil rights statutes and requirements, including Title VI of the Civil Rights Act of 1964, Title II of the Americans with Disabilities Act of 1990, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, Section 1557 of the Affordable Care Act, and 45 CFR part 80, part 84, and part 91 and 28 CFR part 35.

(b) The State must comply with the nondiscrimination provision at 45 CFR 155.120(c)(2).

§ 600.170 Annual report content and timing.

(a) *Content.* The State must submit an annual report that includes any evidence of fraud, waste, or abuse on the part of participating providers, plans, or the State BHP agency known to the State, and a detailed data-driven review of compliance with the following:

(1) Eligibility verification requirements for program participation as specified in § 600.345.

(2) Limitations on the use of Federal funds received by the BHP as specified in § 600.705.

(3) Requirements to collect quality and performance measures from all participating standard health plans focusing on quality of care and improved health outcomes as specified in sections 1311(c)(3) and (4) of the Affordable Care Act and as further described in § 600.415.

(4) Requirements specified by the Secretary at least 120 days prior to the date of the annual report as requiring further study to assess continued State compliance with Federal law, regulations and the terms of the State's certified Blueprint, based on a Federal review of the BHP pursuant to § 600.200, and/or a list of any outstanding recommendations from any audit or evaluation conducted by the HHS Office of Inspector General that have not been fully implemented, including a statement describing the status of implementation and why implementation is not complete,

(b) *Timing.* The annual reports, in the format specified by the Secretary, are due 60 days before the end of each operational year.

Subpart C—Federal Program Administration

§ 600.200 Federal program reviews and audits.

(a) *Federal compliance review of the State BHP.* To determine whether the State is complying with the Federal requirements and the provision of its BHP Blueprint, HHS may review, as needed, but no less frequently than annually, the compliance of the State BHP with applicable laws, regulations and interpretive guidance. This review may be based on the State's annual report submitted under § 600.170, or may be based on direct Federal review of State administration of the BHP Blueprint through analysis of the State's policies and procedures, reviews of agency operation, examination of samples of individual case records, and additional reports and/or data as determined by the Secretary.

(b) *Action on compliance review findings.* The compliance review will identify the following action items:

(1) Requirements that need further study or data to assess continued State compliance with Federal law, regulations and the terms of the State's certified Blueprint. Such findings must be addressed in the next State annual report due no more than 120 days after the date of the issuance of the Federal compliance review.

(2) Requirements with which the State BHP does not appear to be in compliance that could be the basis for withdrawal of BHP certification. Such findings must be resolved by the State (either by substantiating compliance with the standards for certification or submitting revisions to the Blueprint) If not resolved, such action items can be the basis for a proposed finding for withdrawal of BHP certification.

(3) Requirements with which the State BHP does not appear to be in compliance that are not a basis for withdrawal of BHP certification but require revision to the Blueprint must be resolved by the State. If not resolved, such action items can be the basis for denial of other Blueprint revisions.

(4) *Improper use of BHP trust fund resources.* The State and the BHP trustees shall be given an opportunity to review and resolve concerns regarding improper use of BHP trust funds as indicated in § 600.715(a) through (c): either by substantiating the proper use of trust fund resources or by taking corrective action which include changes

to procedures to ensure proper use of trust fund resources, and restitution of improperly used resources to the trust fund.

(c) The HHS Office of Inspector General (OIG) may periodically audit State operations and standard health plan practices as described in § 430.33(a) of this chapter. The State and the BHP trustees shall be given an opportunity to review and resolve concerns about improper use of BHP trust funds as indicated in § 600.715(a) through (c): either by substantiating the proper use of trust fund, or by taking corrective action that includes changes to procedures to ensure proper use of trust fund resources, and restitution of improperly used resources to the trust fund. Final reports on those audits shall be transmitted to both the State and the Secretary for actions on findings.

Subpart D—Eligibility and Enrollment

§ 600.300 Basis, scope, and applicability.

(a) *Statutory basis.* This subpart interprets and implements section 1331(e) of the Affordable Care Act which sets forth eligibility standards for the BHP and prohibits eligible individuals from being treated as qualified individuals and enrolling in qualified health plans offered through the Exchange.

(b) *Scope and applicability.* This subpart sets forth the requirements for all BHPs established under section 1331 of the Affordable Care Act regarding eligibility standards and application screening and enrollment procedures.

§ 600.305 Eligible individuals.

(a) *Eligibility standards* The State must determine individuals eligible to enroll in a standard health plan if they:

(1) Are residents of the State not eligible for the State's Medicaid program consisting of at least the essential health benefits codified in § 600.405.

(2) Have household income which exceeds 133 percent but does not exceed 200 percent of the FPL for the applicable family size, or, in the case of an individual who is a lawfully present non-citizen, ineligible for Medicaid due to such non-citizen status, whose household income does not exceed 200 percent of the FPL for the applicable family size.

(3) Are not eligible to enroll in affordable minimum essential coverage. If an individual meets all other eligibility standards, and—

(i) Is eligible for, or enrolled in, Medicaid or CHIP that does not meet the minimum essential coverage definition, the individual is eligible to enroll in a standard health plan without regard to

eligibility or enrollment in such other programs; or

(ii) Is eligible for Employer Sponsored Insurance (ESI) that is unaffordable (as determined under section 5000A of the Internal Revenue Code), the individual is eligible to enroll in a standard health plan.

(4) Are 64 years of age or younger.

(5) Are either a citizen or lawfully present non-citizen.

(6) Are not incarcerated, other than during a period pending disposition of charges.

(b) *Eligibility restrictions.* The State may not impose conditions of eligibility other than those identified in this section, including, but not limited to, restrictions on eligibility based on geographic location or imposition of an enrollment cap or waiting period for individuals previously eligible for or enrolled in other coverage.

§ 600.310 Application.

(a) *Single streamlined application.* The State must use the single streamlined application used by the State in accordance with § 435.907(b) of this chapter and 45 CFR 155.405(a) and (b).

(b) *Opportunity to apply and assistance with application.* The terms of §§ 435.906 and 435.908 of this chapter, requiring the State to provide individuals the opportunity to apply and receive assistance with an application in the Medicaid program, apply in the same manner to States in the administration of the BHP.

(c) *Authorized representatives.* The State may choose to permit the use of an authorized representative designated by an applicant or beneficiary to assist with the individual's application, eligibility renewal and other ongoing communication with the BHP. If the State chooses this option, the State must follow the standards set forth at either 45 CFR 155.227 or 42 CFR 435.923.

§ 600.315 Certified application counselors.

The State may have a program to certify application counselors to assist individuals to apply for enrollment in the BHP and other insurance affordability programs. If the State chooses this option, the State must follow the procedures and standards for such a program set forth in the regulations at either 45 CFR 155.225 or 42 CFR 435.908.

§ 600.320 Determination of eligibility for and enrollment in a standard health plan.

(a) Determining eligibility to enroll in a standard health plan may be performed by a State or local governmental entity, including a

governmental entity that determines eligibility for Medicaid or CHIP, and may be delegated by the state to an Exchange that is a government agency.

(b) *Timely determinations.* The terms of 42 CFR 435.912 (relating to timely determinations of eligibility under the Medicaid program) apply to eligibility determinations for enrollment in a standard health plan exclusive of § 435.912(c)(3)(i). The standards established by the State must be included in the BHP Blueprint.

(c) *Effective date of eligibility.* The State must establish a uniform method of determining the effective date of eligibility for enrollment in a standard health plan following either the Exchange standards at 45 CFR 155.420(b)(1) or the Medicaid process at 42 CFR 435.915.

(d) *Enrollment periods.* The State must offer enrollment and special enrollment periods equivalent to the Exchange at 45 CFR 155.410 and 155.420 or the State may follow the continuous eligibility standard of Medicaid.

§ 600.330 Coordination with other insurance affordability programs.

(a) *Coordination.* The State must establish eligibility and enrollment mechanisms and procedures to maximize coordination with the Exchange, Medicaid and CHIP. The terms of 45 CFR 155.345(a) regarding the agreements between insurance affordability programs apply to a BHP. The State BHP agency must fulfill the requirements of 42 CFR 435.1200(d) and (e) and, if applicable, paragraph (c) for BHP eligible individuals.

(b) *Coordinated determinations of eligibility.* The agency administering BHP must establish and maintain processes to make income eligibility determinations using modified adjusted gross income (MAGI), and to ensure that applications received by the agency, to the extent warranted and permitted under delegations from other agencies administering insurance affordability programs, also result in eligibility assessments or determinations for those other programs. The BHP must also accept applications transferred from other agencies administering insurance affordability programs, and ensure that individuals assessed or determined eligible for BHP by such other agencies are afforded the opportunity to enroll in a standard health plan without undue delay. Individuals submitting applications to any of the aforementioned agencies must not be required to duplicate the submission of information.

(c) *Account transfers.* The agency administering the BHP must participate in the secure exchange of information with agencies administering other insurance affordability programs, using the standards set forth under 45 CFR 155.345(h) regarding electronic account transfers.

(d) *Notification to referring agency.* The terms in § 435.1200(d)(5) regarding the notification to other programs of the final determination of eligibility apply equally to States administering a BHP.

(e) *Notice of decision concerning eligibility.* Every application for BHP shall result in a determination of eligibility or ineligibility, unless the application has been withdrawn, the applicant has died, or the applicant cannot be located. Notices of eligibility determinations shall be coordinated with other insurance affordability programs and Medicaid. Electronic notices shall be provided to the extent consistent with § 435.918(b).

§ 600.335 Appeals.

(a) *Notice of eligibility appeal rights.* Eligibility determinations must include a notice of the right to appeal the determination, and instructions regarding how to file an appeal.

(b) *Appeals process.* Individuals must be given the opportunity to appeal BHP eligibility determinations through the appeals process of the state's Medicaid program, as set forth in an agreement with the Medicaid agency, however, this process may not confer a second level appeal or an appeal to the federal Department of Health and Human Services.

(c) *Accessibility.* The appeals process must be conducted in a manner accessible to individuals with limited English proficiency and persons with disabilities.

§ 600.340 Periodic redetermination and renewal of BHP eligibility.

(a) *Period of eligibility.* An individual is determined eligible for a period of 12 months unless the eligibility is redetermined based on new information received and verified from enrollee reports or data sources. The State must require enrollees to report changes in circumstances, at least to the extent that they would be required to report such changes if enrolled in coverage through the Exchange, consistent with 45 CFR 155.330(b).

(b) *Renewal of coverage.* If an enrollee remains eligible for coverage in the BHP, the enrollee will be afforded notice of a reasonable opportunity to change plans to the extent the BHP offers a choice of plans, and shall remain in the plan selected for the

previous year unless such enrollee terminates coverage from the plan by selecting a new plan or withdrawing from a plan.

(c) *Procedures.* The State shall choose to apply equally all the redetermination procedures described in either 45 CFR 155.335 or 42 CFR 435.916(a) in administering a BHP.

(d) *Verification.* The State must verify information needed to redetermine and renew eligibility in accordance with § 600.345 and comply with the requirements set forth in § 600.330 relating to screening individuals for other insurance affordability programs and transmitting such individuals' electronic accounts and other relevant information to the other program, as appropriate.

(e) *Notice to enrollee.* The State must provide an enrollee with an annual notice of redetermination of eligibility. The annual notice should include all current information used for the most recent eligibility determination. The enrollee is required to report any changes with respect to information listed within the notice within 30 days of the date of the notice. The State must verify information in accordance with § 600.345.

§ 600.345 Eligibility verification.

(a) The State must verify the eligibility of an applicant or beneficiary for BHP consistent either with the standards and procedures set forth in—

- (1) Medicaid regulations at §§ 435.945 through 435.956 of this chapter; or
- (2) Exchange regulations at 45 CFR 155.315 and 155.320.

(b) [Reserved]

§ 600.350 Privacy and security of information.

The State must comply with the standards and procedures set forth in 45 CFR 155.260(b) and (c) as are applicable to the operation of the BHP.

Subpart E—Standard Health Plan

§ 600.400 Basis, scope, and applicability.

(a) *Statutory basis.* This subpart implements sections 1331(b), (c), and (g) of the Affordable Care Act, which set forth provisions regarding the minimum coverage standards under BHP, as well as the delivery of such coverage, including the contracting process for standard health plan offerors participating in the BHP.

(b) *Scope and applicability.* This subpart consists of provisions relating to all BHPs for the delivery of, at a minimum, the ten essential health benefits as described in section 1302(b) of the Affordable Care Act, the contracting process by which States

must contract for the provision of standard health plans, the minimum requirements States must include in their standard health plan contracts, the minimum coverage standards provided by the standard health plan offeror, and other applicable requirements to enhance the coordination of the provision of standard health plan coverage.

§ 600.405 Standard health plan coverage.

(a) *Essential Health Benefits (EHBs).* Standard health plan coverage must include, at a minimum, the essential health benefits as determined and specified under 45 CFR 156.110, and 45 CFR 156.122 regarding prescription drugs, except that States may select more than one base benchmark option from those codified at 45 CFR 156.100 for establishing essential health benefits for standard health plans. Additionally, States must comply with 45 CFR 156.122(a)(2) by requiring participating plans to submit their drug list to the State.

(b) *Additional required benefits.* Where the standard health plan for BHP is subject to State insurance mandates, the State shall adopt the determination of the Exchange at 45 CFR 155.170(a)(3) in determining which benefits enacted after December 31, 2011 are in addition to the EHBs.

(c) *Periodic review.* Essential health benefits must include any changes resulting from periodic reviews required by section 1302(b)(4)(G) of the Affordable Care Act. The provision of such essential health benefits must meet all the requirements of 45 CFR 156.115.

(d) *Non-discrimination in benefit design.* The terms of 45 CFR 156.125 apply to standard health plans offered under the BHP.

(e) *Compliance.* The State must comply with prohibitions on federal funding for abortion services equivalent to the Exchange at 45 CFR 156.280.

§ 600.410 Competitive contracting process.

(a) *General requirement.* In order to receive initial HHS certification as described in § 600.120, the State must assure in its BHP Blueprint that it complies with the requirements set forth in this section.

(b) *Contracting process.* The State must:

- (1) Conduct the contracting process in a manner providing full and open competition consistent with the standards of 45 CFR 92.36(b) through (i);
- (2) Include a negotiation of the elements described in paragraph (d) of this section on a fair and adequate basis; and

(3) Consider the additional elements described in paragraph (e) of this section.

(c) *Initial implementation exceptions.*

(1) If a State is not able to implement a competitive contracting process described in paragraph (b) of this section for program year 2015, the State must include a justification as to why it cannot meet the conditions in paragraph (b), as well as a description of the process it will use to enter into contracts for the provision of standard health plans under BHP.

(2) The State must include a proposed timeline that implements a competitive contracting process, as described in paragraph (b) of this section, for program year 2016.

(3) Initial implementation exceptions are subject to HHS approval consistent with the BHP Blueprint review process established in § 600.120, and may only be in effect for benefit year 2015.

(d) *Negotiation criteria.* The State must assure that its competitive contracting process includes the negotiation of:

(1) Premiums and cost sharing, consistent with the requirements at §§ 600.505(e) and 600.510(e);

(2) Benefits, consistent with the requirements at § 600.405;

(3) Inclusion of innovative features, such as:

(i) Care coordination and care management for enrollees, with a particular focus on enrollees with chronic health conditions;

(ii) Incentives for the use of preventive services; and

(iii) Establishment of provider-patient relationships that maximize patient involvement in their health care decision-making, including the use of incentives for appropriate health care utilization and patient choice of provider.

(e) *Other considerations:* The State shall also include in its competitive process criteria to ensure:

(1) Consideration of health care needs of enrollees;

(2) Local availability of, and access to, health care providers;

(3) Use of a managed care process, or a similar process to improve the quality, accessibility, appropriate utilization, and efficiency of services provided to enrollees;

(4) Performance measures and standards focused on quality of care and improved health outcomes as specified in § 600.415;

(5) Coordination between other health insurance affordability programs to ensure enrollee continuity of care as described in § 600.425; and

(6) Measures to prevent, identify, and address fraud, waste and abuse and ensure consumer protections.

(f) *Discrimination.* Nothing in the competitive process shall permit or encourage discrimination in enrollment based on pre-existing conditions or other health status-related factors.

§ 600.415 Contracting qualifications and requirements.

(a) *Eligible offerors for standard health plan contracts.* A State may enter into contracts for the administration and provision of two or more standard health plans under the BHP with a:

- (1) Licensed health maintenance organization.
- (2) Licensed health insurance insurer.
- (3) Network of health care providers demonstrating capacity to meet the criteria set forth in § 600.410(d).
- (4) Non-licensed health maintenance organization participating in Medicaid and/or CHIP.

(b) *General contract requirements.* (1) A State contracting with eligible standard health plan offerors described in paragraph (a) of this section must include contract provisions addressing network adequacy, service provision and authorization, quality and performance, enrollment procedures, disenrollment procedures, noticing and appeals, provisions protecting the privacy and security of personally identifiable information, and other applicable contract requirements as determined by the Secretary to the extent that the service delivery model furthers the objectives of the program.

(2) All contracts under this part must include provisions that define a sound and complete procurement contract, as required by 45 CFR 92.36(i).

(3) To the extent that the standard health plan is health insurance coverage offered by a health insurance issuer, the contract must provide that the medical loss ratio is at least 85 percent.

(c) *Notification of State election.* To receive HHS certification, the State must include in its BHP Blueprint the standard set of contract requirements described in paragraph (b) of this section that will be incorporated into its standard health plan contracts.

§ 600.420 Enhanced availability of standard health plans.

(a) *Choice of standard health plans.* The State must include in its BHP Blueprint an assurance that at least two standard health plans are offered under BHP, and if applicable, a description of how it will further ensure enrollee choice of standard health plans.

(b) *Use of regional compacts.* (1) A State may enter into a joint procurement

with other States to negotiate and contract with standard health plan offerors to administer and provide standard health plans statewide, or in geographically specific areas within the States, to BHP enrollees residing in the participating regional compact States.

(2) A State electing the option described in paragraph (b)(1) of this section must include in its BHP Blueprint all of the following:

(i) The other State(s) entering into the regional compact.

(ii) The specific areas within the participating States that the standard health plans will operate, if applicable.

(A) If the State contracts for the provision of a geographically specific standard health plan, the State must assure that enrollees, regardless of residency within the State, continue to have choice of at least two standard health plans.

(B) [Reserved]

(iii) An assurance that the competitive contracting process used in the joint procurement of the standard health plans complies with the requirements set forth in § 600.410.

(iv) Any variations that may occur as a result of regional differences between the participating states with respect to benefit packages, premiums and cost sharing, contracting requirements and other applicable elements as determined by HHS.

§ 600.425 Coordination with other insurance affordability programs.

A State must describe in its BHP Blueprint how it will ensure coordination for the provision of health care services to promote enrollee continuity of care between Medicaid, CHIP, Exchange and any other state-administered health insurance programs.

Subpart F—Enrollee Financial Responsibilities

§ 600.500 Basis, scope, and applicability.

(a) *Statutory basis.* This subpart implements section 1331(a) of the Affordable Care Act, which sets forth provisions regarding the establishment of the BHP and requirements regarding monthly premiums and cost sharing for enrollees.

(b) *Scope and applicability.* This subpart consists of provisions relating to the imposition of monthly premiums and cost-sharing under all state BHPs.

§ 600.505 Premiums.

(a) *BHP Blueprint requirements.* For premiums imposed on enrollees, the State must include, or if applicable, assure in its BHP Blueprint:

(1) The monthly premium imposed on any enrollee does not exceed the monthly premium that the enrollee would have been required to pay had he or she enrolled in a plan with a premium equal to the premium of the applicable benchmark plan, as defined in 26 CFR 1.36B–3(f). The State must assure that when determining the amount of the enrollee's monthly premium, the State took into account reductions in the premium resulting from premium tax credit that the enrollee would have been paid on the enrollee's behalf.

(2) The group or groups of enrollees subject to premiums.

(3) The collection method and procedure for the payment of an enrollee's premium.

(4) The consequences for an enrollee or applicant who does not pay a premium.

(b) [Reserved]

§ 600.510 Cost-sharing.

(a) *BHP Blueprint requirements.* For cost sharing imposed on enrollees, the State must include, or if applicable, assure in its BHP Blueprint:

(1) The cost sharing imposed on enrollees meet the standards detailed in § 600.520(c).

(2) The group or groups of enrollees subject to the cost sharing.

(3) An assurance that the State has established an effective system to monitor and track the cost-sharing standards consistent with § 600.520(b) and (c) of this part.

(b) *Cost sharing for preventive health services.* A State may not impose cost sharing with respect to the preventive health services or items, as defined in, and in accordance with 45 CFR 147.130.

§ 600.515 Public schedule of enrollee premium and cost sharing.

(a) The State must ensure that applicants and enrollees have access to information about all of the following, either upon request or through an Internet Web site:

(1) The amount of and types of enrollee premiums and cost sharing for each standard health plan that would apply for individuals at different income levels.

(2) The consequences for an applicant or an enrollee who does not pay a premium.

(b) The information described in paragraph (a) of this section must be made available to applicants for standard health plan coverage and enrollees in such coverage, at the time of enrollment and reenrollment, after a redetermination of eligibility, when premiums, cost sharing, and annual

limitations on cost sharing are revised, and upon request by the individual.

§ 600.520 General cost-sharing protections.

(a) *Cost-sharing protections for lower income enrollees.* The State may vary premiums and cost sharing based on household income only in a manner that does not favor enrollees with higher income over enrollees with lower income.

(b) *Cost-sharing protections to ensure enrollment of Indians.* A State must ensure that standard health plans meet the standards in accordance with 45 CFR 156.420(b)(1) and (d).

(c) *Cost-sharing standards.* A State must ensure that standard health plans meet:

(1) The standards in accordance with 45 CFR 156.420(c) and (e); and

(2) The cost-sharing reduction standards in accordance with 45 CFR 156.420(a)(1) for an enrollee with household income at or below 150 percent of the FPL, and 45 CFR 156.420(a)(2) for an enrollee with household income above 150 percent of the FPL.

(3) The State must establish an effective system to monitor compliance with the cost-sharing reduction standards in paragraph (c) of this section, and the cost-sharing protections to ensure enrollment of Indians in paragraph (b) of this section to ensure that enrollees are not held responsible for such monitoring activity.

§ 600.525 Disenrollment procedures and consequences for nonpayment of premiums.

(a) *Disenrollment procedures due to nonpayment of premium.* (1) A State must assure in its BHP Blueprint that it is in compliance with the disenrollment procedures described in 45 CFR 155.430.

(2) A State electing to enroll eligible individuals in accordance with 45 CFR 155.410 and 420 must comply with the premium grace period standards set forth in 45 CFR 156.270 for required premium payment prior to disenrollment.

(3) A State electing to enroll eligible individuals throughout the year must provide an enrollee a 30-day grace period to pay any required premium prior to disenrollment.

(b) *Consequences of nonpayment of premium.* (1) A State electing to enroll eligible individuals in accordance with 45 CFR 155.410 and 420 may not restrict reenrollment to BHP beyond the next open enrollment period.

(2) A State electing to enroll eligible individuals throughout the year must

comply with the reenrollment standards set forth in § 457.570(c). If applicable, the State must define the length of its premium lockout period in its BHP Blueprint.

Subpart G—Payment to States

§ 600.600 Basis, scope, and applicability.

(a) *Statutory basis.* This subpart implements section 1331(d)(1) and (3) of the Affordable Care Act regarding the transfer of Federal funds to a State's BHP trust fund and the Federal payment amount to State for the provision of BHP.

(b) *Scope and applicability.* This subpart consists of provisions relating to the methodology used to calculate the amount of payment to a state in a given Federal fiscal year for the provision of BHP and the process and procedures by which the Secretary establishes a State's BHP payment amount.

§ 600.605 BHP payment methodology.

(a) *General calculation.* The Federal payment for an eligible individual in a given Federal fiscal year is the sum of the premium tax credit component, as described in paragraph (a)(1) of this section, and the cost-sharing reduction component, as described in paragraph (a)(2) of this section.

(1) *Premium tax credit component.* The premium tax credit component equals 95 percent of the premium tax credit for which the eligible individual would have qualified had he or she been enrolled in a qualified health plan through an Exchange in a given calendar year, adjusted by the relevant factors described in paragraph (b) of this section.

(2) *Cost-sharing reduction component.* The cost-sharing reduction component equals 95 percent of the cost of the cost-sharing reductions for which the eligible individual would have qualified had he or she been enrolled in a qualified health plan through an Exchange in a given calendar year adjusted by the relevant factors described in paragraph (b) of this section.

(b) *Relevant factors in the payment methodology.* In determining the premium tax credit and cost-sharing reduction components described in paragraph (a) of this section, the Secretary will consider the following factors to determine applicable adjustments:

(1) Age of the enrollee;

(2) Income of the enrollee;

(3) Self-only or family coverage;

(4) Geographic differences in average spending for health care across rating areas;

(5) Health status of the enrollee for purposes of determining risk adjustment

payments and reinsurance payments had the enrollee been enrolled in a qualified health plan through an Exchange;

(6) Reconciliation of the premium tax credit or cost-sharing reductions had such reconciliation occurred if an enrollee had been enrolled in a qualified health plan through an Exchange;

(7) Marketplace experience in other states with respect to Exchange participation and the effect of the premium tax credit and cost-sharing reductions provided to residents, particularly those residents with income below 200 percent of the FPL; and

(8) Other factors affecting the development of the methodology as determined by the Secretary.

(c) *Annual adjustments to payment methodology.* The Secretary will adjust the payment methodology on a prospective basis to adjust for any changes in the calculation of the premium tax credit and cost-sharing reduction components.

§ 600.610 Secretarial determination of BHP payment amount.

(a) *Proposed payment notice.* (1) Beginning in FY 2015 and each subsequent year thereafter, the Secretary will determine and publish in a **Federal Register** notice the next fiscal year's BHP payment methodology. The Secretary will publish this notice annually in October upon receiving certification from the Chief Actuary of CMS.

(2) A State may be required to submit data in accordance with the published proposed payment notice in order for the Secretary to determine the State's payment rate as described in paragraph (b) of this section.

(b) *Final payment notice.* (1) The Secretary will determine and publish the final BHP payment methodology and BHP payment amounts annually in February in a **Federal Register** notice.

(2) *Calculation of payment rates.* State payment rates are determined by the Secretary using the final BHP payment methodology, data requested in the proposed payment notice described in paragraph (a) of this section, and, if needed, other applicable data as determined by the Secretary.

(c) *State specific aggregate BHP payment amounts.* (1) *Prospective aggregate payment amount.* The Secretary will determine, on a quarterly basis, the prospective aggregate BHP payment amount by multiplying the payment rates described in paragraph (b) of this section by the projected number of enrollees. This calculation would be made for each category of enrollees based on enrollee

characteristics and the other relevant factors considered when determining the payment methodology. The prospective aggregate BHP payment amount would be the sum of the payments determined for each category of enrollees for a State.

(2) *Retrospective adjustment to state specific aggregate payment amount for enrollment and errors.* (i) Sixty days after the end of each fiscal year quarter, the Secretary will calculate a retrospective adjustment to the previous quarter's specific aggregate payment amount by multiplying the payment rates described in paragraph (b) of this section by actual enrollment for the respective quarter. This calculation would be made for each category of enrollees based on enrollee characteristics and the other relevant factors considered when determining the payment methodology. The adjusted BHP payment amount would be the sum of the payments determined for each category of enrollees for a State.

(ii) Upon determination that a mathematical error occurred during the application of the BHP funding methodology, the Secretary will recalculate the state's BHP payment amount and make any necessary adjustments in accordance with paragraph (c)(2)(iii) of this section.

(iii) Any difference in the adjusted payment and the prospective aggregate payment amount will result in either:

(A) A deposit of the difference amount into the State's BHP trust fund; or

(B) A reduction in the upcoming quarter's prospective aggregate payment as described in paragraph (c)(1) of this section by the difference amount.

§ 600.615 Deposit of Federal BHP payment.

HHS will make quarterly deposits into the state's BHP trust fund based on the aggregate quarterly payment amounts described in § 600.610(c).

Subpart H—BHP Trust Fund

§ 600.700 Basis, scope, and applicability.

(a) *Statutory basis.* This subpart implements section 1331(d)(2) of the Affordable Care Act, which set forth provisions regarding BHP trust fund expenditures, fiscal policies and accountability standards and restitution to the BHP trust fund for unallowable expenditures.

(b) *Scope and applicability.* This subpart sets forth a framework for BHP trust funds and accounting, establishing sound fiscal policies and accountability standards and procedures for the restitution of unallowable BHP trust fund expenditures.

§ 600.705 BHP trust fund.

(a) *Establishment of BHP trust fund.* (1) The State must establish a BHP trust fund with an independent entity, or as a subset account within its General Fund.

(2) The State must identify trustees responsible for oversight of the BHP trust fund.

(3) Trustees must specify individuals with the power to authorize withdrawal of funds for allowable trust fund expenditures.

(b) *Non-Federal deposits.* The State may deposit non-Federal funds, including such funds from enrollees, providers or other third parties for standard health plan coverage, into its BHP trust fund. Upon deposit, such funds will be considered BHP trust funds, must remain in the BHP trust fund and meet the standards described in paragraphs (c) and (d) of this section.

(c) *Allowable trust fund expenditures.* BHP trust funds may only be used to:

(1) Reduce premiums and cost sharing for eligible individuals enrolled in standard health plans under BHP; or

(2) Provide additional benefits for eligible individuals enrolled in standard health plans as determined by the State.

(d) *Limitations.* BHP trust funds may not be expended for any purpose other than those specified in paragraph (c) of this section. In addition, BHP trust funds may not be used for other purposes including but not limited to:

(1) Determining the amount of non-Federal funds for the purposes of meeting matching or expenditure requirements for Federal funding;

(2) Program administration of BHP or any other program;

(3) Payment to providers not associated with BHP services or requirements; or

(4) Coverage for individuals not eligible for BHP.

(e) *Year-to-year carryover of trust funds.* A State may maintain a surplus, or reserve, of funds in its trust through the carryover of unexpended funds from year-to-year. Expenditures from this surplus must be made in accordance with paragraphs (b) and (c) of this section.

§ 600.710 Fiscal policies and accountability.

A BHP Blueprint must provide that the BHP administering agency will:

(a) *Accounting records.* Maintain an accounting system and supporting fiscal records to assure that the BHP trust funds are maintained and expended in accord with applicable Federal requirements, such as OMB Circulars A-87 and A-133.

(b) *Annual certification.* Obtain an annual certification from the BHP

trustees, the State's chief financial officer, or designee, certifying all of the following:

(1) The State's BHP trust fund financial statements for the fiscal year.

(2) The BHP trust funds are not being used as the non-Federal share for purposes of meeting any matching or expenditure requirement of any Federally-funded program.

(3) The use of BHP trust funds is in accordance with Federal requirements consistent with those specified for the administration and provision of the program.

(c) *Independent audit.* Conduct an independent audit of BHP trust fund expenditures, consistent with the standards set forth in chapter 3 of the Government Accountability Office's Government Auditing Standards, over a 3-year period to determine that the expenditures made during the 3-year period were allowable as described in § 600.705(b) and in accord with other applicable Federal requirements. The independent audit may be conducted as a sub-audit of the single state audit conducted in accordance with OMB Circular A-133, and must follow the cost accounting principles in OMB Circular A-87.

(d) *Annual reports.* Publish annual reports on the use of funds, including a separate line item that tracks the use of funds described in § 600.705(e) to further reduce premiums and cost sharing, or for the provision of additional benefits within 10 days of approval by the trustees. If applicable for the reporting year, the annual report must also contain the findings for the audit conducted in accordance with paragraph (c) of this section.

(e) *Restitution.* Establish and maintain BHP trust fund restitution procedures.

(f) *Record retention.* Retain records for 3 years from date of submission of a final expenditure report.

(g) *Record retention related to audit findings.* If any litigation, claim, financial management review, or audit is started before the expiration of the 3-year period, the records shall be retained until all litigation, claims or audit findings involving the records have been resolved and final action taken.

§ 600.715 Corrective action, restitution, and disallowance of questioned BHP transactions.

(a) *Corrective action.* When a question has been raised concerning the authority for BHP trust fund expenditures in an OIG report, other HHS compliance review, State audit or otherwise, the BHP trustees and the State shall review the issues and develop a written

response no later than 60 days upon receipt of such a report, unless otherwise specified in the report, review or audit. To the extent determined necessary in that review, the BHP trustees and State shall implement changes to fiscal procedures to ensure proper use of trust fund resources.

(b) *Restitution.* To the extent that the State and BHP trustees determine that BHP trust funds may not have been properly spent, they must ensure restitution to the BHP trust fund of the funds in question. Restitution may be made directly by the BHP trustees, by the State, or by a liable third party. The State or the BHP trustees may enter into indemnification agreements assigning liability for restitution of funds to the BHP trust fund.

(c) *Timing of restitution.* Restitution to the BHP trust fund for any unallowable expenditure may occur in a lump sum amount, or in equal installment amounts. Restitution to the BHP trust fund cannot exceed a 2-year period from the date of the written response in accordance with paragraph (a) of this section.

(d) *HHS disallowance of improper BHP trust fund expenditures.* The State shall return to HHS the amount of federal BHP funding that HHS has determined was expended for unauthorized purposes, when no provision has been made to restore the funding to the BHP trust fund in accordance with paragraph (b) of this section (unless the restitution does not comply with the timing conditions described in paragraphs (c) of this section). When HHS determines that federal BHP funding is not allowable,

HHS will provide written notice to the state and BHP Trustees containing:

(1) The date or dates of the improper expenditures from the BHP trust fund;

(2) A brief written explanation of the basis for the determination that the expenditures were improper; and

(3) Procedures for administrative reconsideration of the disallowance based on a final determination.

(e) *Administrative reconsideration of BHP trust fund disallowances.* (1) BHP Trustees or the State may request reconsideration of a disallowance within 60 days after receipt of the disallowance notice described in paragraph (d)(1) of this section by submitting a written request for review, along with any relevant evidence, documentation, or explanation, to HHS.

(2) After receipt of a reconsideration request, if the Secretary (or a designated hearing officer) determines that further proceedings would be warranted, the Secretary may issue a request for further information by a specific date, or may schedule a hearing to obtain further evidence or argument.

(3) The Secretary, or designee, shall issue a final decision within 90 days after the later of the date of receipt of the reconsideration request or date of the last scheduled proceeding or submission.

(f) *Return of disallowed BHP funding.* Disallowed federal BHP funding must be returned to HHS within 60 days after the later of the date of the disallowance notice or the final administrative reconsideration upholding the disallowance. Such repayment cannot be made from BHP trust funds, but must be made with other, non-Federal funds.

Title 45

PART 144—REQUIREMENTS RELATING TO HEALTH INSURANCE COVERAGE

■ 2. The authority citation for part 144 continues to read as follows:

Authority: Secs. 2701 through 2763, 2791, and 2792 of the Public Health Service Act, 42 U.S.C. 300gg through 300gg-63, 300gg-91, and 300gg-92.

■ 3. Section 144.103 is amended by revising the definition of “individual market” to read as follows:

§ 144.103 Definitions.

* * * * *

Individual market means the market for health insurance coverage offered to individuals other than in connection with a group health plan, or other than coverage offered pursuant to a contract between the health insurance issuer with the Medicaid, Children’s Health Insurance Program, or Basic Health programs.

* * * * *

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program)

Dated: September 3, 2013.

Marilyn Tavenner,

Administrator, Centers for Medicare & Medicaid Services.

Approved: September 10, 2013.

Kathleen Sebelius,

Secretary, Department of Health and Human Services.

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