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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-F]

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: Final rule.

SUMMARY: This final rule establishes the Basic Health Program (BHP), as required by section 1331 of the Affordable Care Act. The BHP 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 Affordable Insurance Exchange (Exchange, also called Health Insurance Marketplace). The BHP complements and coordinates with enrollment in a QHP through the Exchange, as well as with enrollment in Medicaid and the Children's Health Insurance Program (CHIP). This final rule also sets forth a framework for BHP eligibility and enrollment, benefits, delivery of health care services, transfer of funds to participating states, and federal oversight. Additionally, this final rule amends another rule issued by the Secretary of the Department of Health and Human Services (Secretary) in order to clarify the applicability of that rule to the BHP.

EFFECTIVE DATE: These regulations are effective on January 1, 2015.

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SUPPLEMENTARY INFORMATION:

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Regulation Text

Acronyms

Because of the many organizations and terms to which we refer by acronym in this final 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 line |
| 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 |
| MEC | Minimum Essential Coverage |
| 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 final rule implements 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 of the Affordable Care Act directs the Secretary to establish the Basic Health Program (BHP). In addition, this final rule amends certain other federal regulations, clarifying their applicability to the new program.

For coverage effective beginning on January 1, 2014, qualified individuals and small businesses will be able to purchase private health insurance coverage through competitive marketplaces, also termed “Exchanges” (or the Health Insurance Exchange). The premium tax credit and cost-sharing reductions are available to help lower income qualified individuals purchase and secure coverage and services through the plans operating on the Exchange. At the

same time, states provide coverage under Medicaid for low-income individuals and other individuals, including certain individuals with significant medical needs. New administrative procedures discussed in prior rulemaking establish a system for coordinating coverage across all insurance affordability programs (IAP) which includes coverage obtained through an Exchange with the associated premium tax credit and cost-sharing reductions, Medicaid, and the Children's Health Insurance Program. Beginning January 1, 2015, under this final rule, states will have an additional option to establish a BHP to provide coverage for certain individuals who are not eligible for Medicaid and would otherwise be eligible to obtain coverage through the Exchange.

This final rule establishes: (1) the requirements for certification of state submitted BHP Blueprints, and state administration of the BHP consistent with that Blueprint; (2) eligibility and enrollment requirements for standard health plan coverage offered through the BHP; (3) the minimum requirements for the benefits covered by such standard health plans; (4) the availability of federal funding of certified state BHPs; (5) the purposes for which states can use such federal funding; (6) the parameters for enrollee financial participation; and (7) the requirements for state and federal administration and oversight of BHP funds. The specific methods for calculating and providing payment to states, consistent with this rule, will be issued separately in a final payment notice.

II. Background

Section 1331 of the Affordable Care Act provides states with a new coverage option, the Basic Health Program (BHP), for specified individuals who do not qualify for Medicaid but whose income does not exceed 200 percent of the federal poverty level (FPL). This final rule also 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. 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 final rule describes standards for state administration and federal oversight of the BHP.

In the September 25, 2013 **Federal Register** (78 FR 59122), we published a proposed rule to provide states the opportunity to establish a BHP in coordination with other insurance affordability programs. Rather than establish new and different rules for the BHP, when possible, we 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. Where necessary to accommodate unique features of the BHP, we 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 offer states the choice, states must adopt all of the standards in the referenced Medicaid or Exchange regulations.

For a detailed description of the background of this rule, please refer to “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 published in the September 25, 2013 **Federal Register** (78 FR 59122).

III. Summary of Proposed Provisions and Analysis of the Responses to Public

Comments

For a complete and full description of the BHP proposed provisions as required by the statute, see the September 25, 2013 proposed rule (78 FR 59122).

We received a total of 132 timely comments from state agencies, groups advocating on behalf of consumers, health care providers, employers, health insurers, health care associations, Tribes, tribal organizations, and the general public. In addition, we held an all-state/advocate consultation session on November 6, 2013 as well as a tribal consultation session on November 7, 2013 to provide an overview of the BHP proposed rule where interested parties were afforded an opportunity to ask questions and make comments. We continued to meet during this time with interested states through the “learning collaborative” that was established prior to the publication of the proposed rule to solicit input related to program operations and coordination between all insurance affordability programs. At the consultation and learning collaborative sessions, participating parties were reminded to submit written comments before the close of the public comment period that was specified in the BHP proposed rule.

The following sections, arranged by subject area, include a summary of the public comments that we received, and our responses.

A. General Provisions and Definitions

In the September 25, 2013 proposed rule, we proposed in §600.1 the general authority for the BHP regulation as specified in section 1331 of the Affordable Care Act. The statute specifies that a state electing to implement a BHP must enter into contracts for the provision of standard health plan coverage, which must, at a minimum include the essential health benefits (EHB). A state implementing BHP will receive federal funding based on the amount of premium tax credit and cost-sharing reductions that would have otherwise been available to enrollees had

they obtained coverage in the Exchange. We did not receive specific comments on this section and are finalizing the provision as proposed.

In §600.5, we proposed the definitions and use of terms that apply to BHP. For specific definitions, please see the September 25, 2013 proposed rule (78 FR 59142).

We received several public comments for this section, which we discuss below. In addition to changes resulting from comments on this section, we have added a definition of “interim certification” in conformance with a change made to §600.110. Interim certification is an approval status for the initial design of a state’s BHP. It does not confer any permission to begin enrollment or authority to seek funding from the federal government for BHP expenditures.

Comment: Several commenters requested that the BHP use the Medicaid definition of Indian that is set forth in 42 CFR 447.51 for purposes of Medicaid premium and cost sharing reductions. The Affordable Care Act defines Indians for purposes of premium and cost sharing reductions in Exchange plans using the definition set out in section 4(d) of the Indian Self-Determination Act and Education Assistance Act, (25 U.S.C. 450b(d)). The referenced Medicaid regulatory definition of Indian is broader.

Response: We appreciate the commenters’ recommendation; however, because a BHP is required by statute only to provide that premium and cost sharing liability will not exceed such liability under Exchange coverage, the regulation adopts the Exchange definition.

Comment: One commenter recommended that HHS define the term “network of providers.”

Response: We have revised the list of definitions to include a definition of “network of healthcare providers.”

B. Establishment of the Basic Health Program

In §600.100 to §600.170, we proposed the administrative structure for BHP. Within this structure, we proposed that the BHP Blueprint would be the vehicle for BHP certification and specified the operational principles required to implement a BHP.

In §600.110(a), we proposed that the BHP Blueprint would be the comprehensive document submitted by states to the Secretary to receive certification of proposed BHP programs. For specific discussions on the proposed content of the Blueprint, refer to the September 25, 2013 proposed rule (78 FR 59142).

In §600.110(b), we proposed that the BHP Blueprint be accompanied by a funding plan that provides enrollment and cost projections for the first 12 months of operation as well as additional funding sources if the state expects to use any non-federal funding. The funding plan must demonstrate that the federal funds will only be used to reduce premiums or cost-sharing or to provide additional benefits. In §600.110(c), we proposed that HHS post the state's BHP Blueprint on-line.

The following sections, arranged by subject area, include a summary of the public comments that we received, and our responses.

1. General

Comment: We received a variety of supportive comments. One commenter supported the adoption of the Exchange approach of a Blueprint as opposed to utilizing a vehicle similar to a Medicaid state plan. A couple of commenters expressed support for the provision requiring Secretarial certification prior to implementation. We received several comments supporting the requirement that HHS post the Blueprint submitted by the state on-line.

Response: We are finalizing the proposed provisions with some modifications.

We are clarifying that HHS will post on line the Blueprint submitted by the state, and will update it to reflect subsequent amendments by the state (including amendments made to ensure certification by HHS).

Comment: Several commenters shared concerns related to the timing of the Blueprint requirements, and provided several suggestions in how to address this issue. One suggestion was to permit an abridged Blueprint in the first year of implementation, to permit greater flexibility in establishing contracts for standard health plans and making administrative arrangements. The abridged Blueprint would be required to include a few key areas in the Blueprint, such as its eligibility and enrollment processes as well as the standard health plan benefit package. Another suggestion included the use of an “interim certification” to outline basic program parameters until the contracting process concluded. One final suggestion was to permit a state to include contingencies in its Blueprint.

Response: We have carefully considered the commenters’ concern that we were requiring too much detail and certainty in the initial Blueprint submission, because that level of detail would not be operationally feasible. In response to these comments, we are modifying the certification process to include an interim certification level, which we have defined in the definitions section. We expect that states will be able to provide their basic program design choices and we will be able to approve the structure of the program through the interim certification process, which will involve the submission of a limited set of Blueprint elements. We anticipate that interim certification will give states more certainty as they seek legislative and budget authority for their programs, with the understanding that full certification would be granted only when the Blueprint was fleshed out with additional detail. Full certification would still be required before states enroll individuals in a BHP.

Comment: We received several comments expressing concern regarding the required content of the Blueprint. Several commenters, for example, requested that we make clear that we would not require exact premium amounts in the Blueprint (information that would not be available until later in implementation), but would only require a description of the process the state would use to establish premiums (information that would be available earlier.)

Response: In our proposed rule we created some inconsistency which has now been corrected, at §§600.110(a)(6) and 600.505. Now both are consistent, requiring that the Blueprint contain only assurances that the premiums would be calculated in such a way that BHP enrollees would not pay more than they would have been required to pay if they had been enrolled in the applicable benchmark plan, taking into account any premium tax credit that would have been available .

Comment: On later sections of the regulation, we received many comments suggesting that we need to allow greater flexibility for states around the start-up and establishment of the program. As with other aspects of program operations, this flexibility would need to be addressed in the Blueprint.

Response: We appreciate the commenters' interest in ensuring smooth and efficient BHP implementation, and as such, we have included a 15th content area for the Blueprint in §600.110(a). We will require a transition plan if a state requests to phase in enrollment, which would include information about coordination of such a transition with the Exchange operating in the state. This additional Blueprint requirement corresponds to modifications made to §600.145.

2. Development and Submission of the BHP Blueprint (§600.115)

In §600.115(a), we proposed that the Blueprint must be submitted by the Governor or the Governor's designee, and in §600.115(b) we proposed that the state must identify the agency and

officials, by position or title, responsible for program administration, operations, and financial oversight.

In §600.115(c), we proposed that the state must seek public comment on the BHP Blueprint content before submission to the Secretary for certification, and ensure the comment process included federally recognized tribes located in the state. Additionally, we proposed that the state must seek comment on significant revisions which are those that alter core program operations required by §600.145(e).

In §600.115(d), we proposed that states may not implement BHP prior to receiving full certification. The date of implementation for this purpose is proposed as the first day that enrollees would receive coverage under BHP.

Comment: We received many comments on the public comment process. One commenter supported the flexibility that is afforded to states by not having a federally prescribed list of required public notice participants in the public notice standard. Another commenter expressed the opposite view and would like HHS to require a specific list of stakeholders that must be included in the public comment process, including consumer, health care and safety net advocacy groups. Another commenter suggested that the prescribed list of stakeholders should be the same as the Exchange.

Response: We recognize that BHP will have a significant impact on consumers, providers, plans and other stakeholders, and we appreciate the commenters' interest in ensuring the public is afforded the opportunity to provide meaningful comment. While ensuring appropriate public participation in the comment process is important, we are not mandating the participation of certain stakeholders because the circumstances in different states in serving low income populations are not the same. Moreover, such a requirement could be viewed as giving particular weight to those stakeholders over others. But we do not preclude any state from

adopting such a procedure based on the circumstances in that state. Nor do we specify a calendar a state must use when soliciting public comment; the opportunity to comment, however, must be meaningful. We believe states will build on existing programs and approaches currently in place, and we want to provide the flexibility for them to do so.

Comment: Some commenters specifically recommended that we should borrow the section 1115 Medicaid demonstration transparency requirements under title XIX of the Act and apply those standards to BHP. The commenters expressed the sentiment that the level of rigor in the 1115 standards would be appropriate for BHP.

Response: Section 1115 transparency requirements are specified in statute in detail. Moreover, section 1115 demonstration authority is used when states are requesting permission to depart from otherwise applicable federal law but nevertheless achieving the objectives of federal law, and public input is essential to informing the federal decision whether to approve the demonstration request. In that circumstance, it is particularly important to have a full opportunity for public comment to determine if there would be any unforeseen or adverse impact. In contrast, there is no statutory public input requirement for the development of a BHP. Moreover, when developing a BHP Blueprint, the need and purpose for public comment is different. A state is not departing from federal law but rather engaging the public in the state's political process to assist in choices the state is making in establishing or modifying a program within a set of options. The opportunity for public input will help to ensure that the state has fully considered whether its BHP approach will meet all statutory requirements and has given due consideration to the required factors in its processes to contract with standard health plans. Interested parties typically are already involved in those processes, and do not need formal notice and comment periods to provide input to states on these choices. It may be appropriate for states to adjust public input processes to reflect these circumstances. For these reasons, we

are not accepting the commenters' recommendation to provide a rigid structure for the public input process for a BHP Blueprint and Blueprint amendments.

Comment: We received several comments recommending that HHS strengthen the definition of "significant revisions" in §600.115(c)(1) beyond the proposed reference to those that alter "core program operations required by §600.145(e)."

Response: We thank the commenters for their recommendation and we are modifying the regulatory text to reflect this definition change and clarify when an amendment to a BHP Blueprint is necessary.

Comment: Several commenters expressed concern that the timeline for BHP Blueprint submission and certification should be constructed to give sufficient notice to Qualified Health Plans (QHP) prior to the submission of Exchange premiums, QHP applications and the annual contract review process.

Response: We appreciate that there are many timing decisions to make with regard to the submission and certification of a BHP Blueprint that will impact, and be impacted, by many variables in any given state. States must synchronize legislative and funding authority with contracting timelines and federal approval. Given the legislative and contracting calendar differences between states, we do not believe it would be appropriate to mandate a specific timetable, or calendar for the public notice process. However, we expect states to take the QHP issuer bidding timeframe into account and to work with issuers to avoid unnecessary disruption and uncertainty in the individual market, particularly as issuers look to set rates for the next year.

With these considerations in mind, we are finalizing the provisions in this section as proposed except that in §600.115(c)(1). We are adding to the definition of "significant revisions" which will therefore, require an opportunity for public comment to "those that alter

core program operations required by §600.145(f), as well as changes that alter the BHP benefit package, enrollment, disenrollment and verification policies.”

3. Certification of a BHP Blueprint (§600.120)

In, §600.120(a), we proposed to establish the effective date of certification of the BHP Blueprint as the date of signature by the Secretary.

In §600.120(b), we proposed that the certification date is established as the first date for which any payments may be transmitted to the state for BHP operations.

Under §600.120(c), we proposed the period in which a certified Blueprint remains in effect. For specific discussions on this time period, refer to the September 25, 2013 proposed rule (78 FR 59143).

Under §600.120(d), we proposed Blueprint standards for certification. For specific discussions on the standards, refer to the September 25, 2013 proposed rule (78 FR 59143).

Comment: One commenter was concerned with our proposed Blueprint standard in §600.120(d)(3) specifying that the Blueprint be free of contingencies or reserved decisions on operational features. The commenter noted that, at times, contingencies are appropriate and contribute to operational success.

Response: We agree with the commenter regarding the need for contingencies and we will strive to develop a Blueprint template permissive of appropriate contingencies. We are deleting the word “contingencies” from paragraph (d). However, as the Blueprint will only collect information necessary for approval and oversight, we do not foresee being able to allow reserved decisions.

Comment: We received one comment requesting state flexibility in program development through 2016, particularly with respect to transitioning of populations.

Response: We have responded in other sections (§§600.110 and 600.145) regarding the need for flexibility around transitioning populations giving states with the shortest planning window, those that start in 2015, greater flexibility in planning for enrollment and service delivery needs.

4. Revisions to a certified BHP Blueprint (§600.125)

In §600.125(a), we proposed that a state seeking to make changes to its BHP Blueprint must submit those changes, if altering core program operations, to the Secretary for review and certification.

In §600.125(b), we proposed that the state must continue to operate under the existing certification unless and until a revised Blueprint is certified.

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

In §600.130, we proposed a process for a state deciding to terminate a BHP before enrolling participants. For specific discussions, refer to the September 25, 2013 proposed rule (78 FR 59143).

Comment: We received several comments expressing concern regarding the broad state authority to terminate its BHP at any time.

Response: We appreciate the commenters' concerns regarding this state authority; however, because BHP is an alternative health coverage program available at the state's option, we do not believe we can prohibit a state from electing to terminate its program.

Comment: Several commenters suggested that states be required to provide advance notification to standard health plan offerors and QHPs when they voluntarily withdraw Blueprints, to enable these entities the opportunity to adjust their offerings. Other commenters recommended Blueprint submission timelines to be specifically aligned with Exchange timeframes to enable the most accurate pricing of products.

Response: We agree that states should make decisions about BHP operations in a timely manner, to allow orderly transitions for beneficiaries and ensure proper coordination with the Exchange, including the ability of QHPs to price their products properly. However, the standard that the commenter is suggesting is very significant in that it would have to be lengthy notice in advance of the annual QHP pricing process. Given that BHP is a voluntary program, we do not believe we can force continued participation on the part of the state beyond that required for orderly shutdown.

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

In §600.135, we proposed that HHS respond to submissions in a timely manner and identify in writing impediments to certification if they exist.

Comment: We received comments recommending that Blueprints should be deemed certified and states should be able to proceed if they have not been acted upon within 60 days of state submission. Other commenters requested an expedited review process in the first year. A further request was that we institute a conditional approval and make retrospective payment available to states. We also received comments that we should have an administrative review process to resolve disputes over certification or potential decertification.

Response: We have carefully considered these comments and we are finalizing this section with the addition of a state option to request a reconsideration of an adverse certification decision. We believe this change, coupled with the addition of interim certification status discussed earlier and the requirement for HHS to respond timely to state submissions, will be sufficient to ensure responsiveness and opportunity for states to work effectively with HHS to secure necessary approvals to proceed with their programs. We have not included the request for a 60 day “clock” because we wish to allow for maximum flexibility in working with states to achieve certification of Blueprints for this new program.

7. State termination of a BHP (§600.140)

In §600.140, we proposed a process for states to terminate a BHP program with active enrollees. The state must submit written notice to the Secretary 120 days in advance along with a transition plan to assist enrollees switching to other coverage, submit written notice to participating standard health plan offerors and enrollees 90 days in advance, and transmit all information provided as part of an application to other state agencies administering insurance affordability programs. Additionally, the state must fulfill contractual obligations to standard health plans, fulfill data reporting to HHS, complete the annual financial reconciliation process, and refund the remaining balance in the BHP trust fund.

Comment: We received several comments requesting that the notification requirement for standard health plans be the same as it is for the Secretary (120 days). We also received a comment recommending that we require notification be sent to providers contracting with standard health plans.

Response: We are finalizing this section as proposed, because we believe there is value in a Secretarial review of the state's transition plan before others are notified. We also anticipate that the state's transition plan will include specifications about plan and provider notification.

8. HHS withdrawal of certification and termination of a BHP (§600.142)

In §600.142, we proposed the process by which HHS would withdraw certification of a BHP Blueprint based on findings of non-compliance or significant beneficiary harm, financial malfeasance or fraud. This process is only invoked after notice to the state and a reasonable period (at least 120 days) for the state to address findings.

Comment: We received one comment requesting an appeal process for disagreement over findings of non-compliance or significant beneficiary harm, financial malfeasance or fraud.

Response: Similar to §600.135, we have decided to finalize this section as proposed with the addition of the right of the state to a reconsideration of the decision to withdraw certification if there is disagreement over findings that form the basis for that decision.

9. State program administration and operation (§600.145)

In §600.145, we proposed that a state must operate a BHP according to the certified Blueprint and all applicable law and regulations. This section also contains our proposed core operational features of a BHP beginning in paragraph (b) through (d). For additional discussions on the core operational features of a BHP, refer to the September 25, 2013 proposed rule (78 FR 59144).

Comment: We received many comments on this section in support of the establishment of BHP without the limitations characteristic of more limited programs such as waivers or demonstrations. Similarly, we received a comment commending the Department for including nondiscrimination provisions assuring equal access to services through BHP.

Response: We appreciate the support for the content of this section.

Comment: Several commenters questioned the operational reality of being able to implement a program for every eligible individual on day-one of operations.

Response: We understand the concern raised by the commenters regarding day-one operations, particularly in 2015, the first operational year, for which states have a limited amount of time to coordinate with their Exchange and Medicaid programs. To address this comment, we are adding paragraph (e) providing states implementing in 2015 the option to identify a transition period during initial implementation. These states will be required to submit a transition plan as part of their Blueprint describing their proposed alternative enrollment strategies.

10. Enrollment assistance and information requirements (§600.150)

In §600.150, we proposed that states make information available to potential applicants and enrollees about the BHP coverage option, including benefits and coverage, in a manner that is consistent with the requirements of the Exchange. Additionally, states must require standard health plans to provide information on premiums and covered services, including any limitations, cost-sharing, as well as other information conforming to the requirements of the Exchange. Finally, states must require participating standard health plans to provide current and complete information on the names and locations of participating providers.

Comment: One commenter suggested a requirement that we have application materials designed with individuals who have limited English proficiency in mind and that we should encourage marketing to younger individuals. Other commenters want states to be required to conduct outreach highlighting BHP availability to non-citizens or for individuals with limited English proficiency. Several of these commenters request applying Medicaid managed care requirements (42 CFR 438.10(c)) around enrollees with limited English proficiency to BHP.

Response: We agree with the commenters' request for application materials that serve individuals with limited English proficiency. We further clarify that states must satisfy rules concerning accessibility requirements for persons with disabilities. We also agree that Medicaid standards are appropriate to address these populations and have applied them in §600.310.

Comment: Other commenters supported the requirement to make provider lists available to enrollees. One commenter specifically requested the inclusion of facility providers such as clinics and health centers, another commenter wants the requirement to be strengthened by including a quarterly update standard because of churn between QHPs and Standard Health Plans.

Response: We also agree that information requirements are only valuable if kept current so we have added "at least quarterly" to the requirement in paragraph (a)(5) that states must

require participating plans to publicize and keep current their participating providers. Because this requirement is not limited to any classes or types of providers, we believe it is inclusive as written for all providers.

11. Tribal consultation (§600.155)

In §600.155, we proposed that states are required to 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 state or federal Exchange as applicable.

Comment: We received a comment recommending the removal of the word “federal” from the requirement to follow the approved state or federal tribal consultation policy. Also the commenter urges CMS to use the Washington State Exchange tribal consultation policy as the model.

Response: We agree that it is not necessary to identify in this rule whether the state exchange was established by the state or federal government, or whether the tribal consultation policy was based on a state or federal policy. It is only necessary to make clear that the BHP should comply with the state Exchange’s tribal consultation policy. Therefore we will remove “State or Federal” as descriptors of the tribal consultation policy. We appreciate the reference to Washington State’s Exchange tribal consultation policy but because each state has a different tribal makeup and relationship, it is important to maintain state flexibility in determining an appropriate consultation policy. Thus, we are not specifying adoption of any specific state’s policy.

12. Protections for American Indians and Alaska Natives (§600.160)

In §600.160, we proposed specific protections for American Indians and Alaska Natives. Specifically, we required the extension of the special enrollment status applicable in the Exchange, we require states to permit Indian tribes and tribal organizations to pay premiums on

behalf of BHP enrolled individuals, cost-sharing is prohibited, and we require standard health plans to pay primary to health programs operated by the Indian Health Service or tribal organizations for services covered under the standard health plan. Because we realized that the proposed policy with respect to premium payment should not be limited to tribes, tribal organizations and urban Indian organizations, we are broadening that requirement and moving it into §600.520 as discussed below.

Comment: We received a comment requesting that we further protect Indian health providers operating within standard health plans by prohibiting the offerors from reducing the payments to providers by the amount of any cost-sharing that would be due from Indians but for the prohibition on cost-sharing. This prohibition is equivalent to that extended to Indian health providers providing services to Indians enrolled in a QHP in the individual market through an Exchange at 45 CFR 156.430(g).

Response: We agree with the commenter that, if the cost of protecting Indians from cost sharing was placed on providers, it would have the result of reducing access to care and would frustrate the purpose of the cost sharing protection. Therefore, we have added this protection as paragraph (c).

13. Nondiscrimination standards (§600.165)

We proposed, in §600.165 that the state and standard health plans must comply with all applicable civil rights statutes which are delineated in the proposed rule (78 FR 59145) as well as the non-discrimination provision applicable to the Exchange.

Comment: One commenter specifically appreciated that the standards in this section clarify that BHP falls under protections of both Affordable Care Act and the Civil Rights Act bolstering the ability of the HHS Office for Civil Rights and individuals to hold states and contractors accountable.

Response: We are finalizing the language as proposed without change.

14. Annual report content and timing (§600.170)

In §600.170, we proposed specific requirements for the content and timing of the BHP annual report. The report must include content establishing compliance with statutory requirements including eligibility verification, limitations on the use of federal funds, and quality and performance measures from participating standard health plans. Additionally, states are required to submit any evidence of fraud, waste, or abuse known to the state and any follow up that had been specified in findings from a federal review or audit.

Comment: Several commenters made specific reference to the requirement to report quality and performance measures and requested the ability to align with reporting for other insurance affordability programs. A commenter further recommended the use of NCQA, HEDIS and CAHPs standards. Two commenters made specific suggestions for measures or offered assistance in the development of measures that would be appropriate for this purpose. Several commenters offered that 2 full years of data should be available before quality measures are collected. A commenter requested that we limit the use of measures based on patient surveys.

Response: We agree that this standard warrants attention and that the Department should take into account the desirability of aligning measures across insurance affordability programs. As indicated in the preamble of the proposed rule, we intend to issue future subregulatory guidance on the quality and performance standards taking into account these comments.

Comment: Several commenters questioned the timing of the annual report, pointing out that the data available to the state 60 days before the end of the operational year would be limited and perhaps of poor quality.

Response: We agree that the timing of the annual report as proposed will prove problematic for states in that it will not enable the submission of complete data. In response to this concern, we are changing the timing to 60 days following the end of the operational year. With this change, we are reserving the right to request information in advance specifically needed to substantiate the release of funds. Otherwise, the section is being finalized as proposed.

C. Federal Program Administration

1. Federal program reviews and audits (§600.200)

In §600.200(a), we proposed that HHS review each state BHP as needed, but no less frequently than annually, to determine state compliance with federal requirements and provisions of its BHP Blueprint. For additional discussions on specific reports and other documentation, refer to the September 25, 2013 proposed rule (78 FR 59126). We did not receive specific comments on this section and are finalizing the provision as proposed.

In §600.200(b), we proposed the types of action items that may result from such review. For specific discussions on the action items, see the September 25, 2013 proposed rule (78 FR 59126). We received specific comments on this section which are discussed below.

In §600.200(c), we proposed the HHS Office of Inspector General (OIG) may periodically audit state operations and standard health plan practices. For specific discussions on the periodically conducted OIG audit, see the September 25, 2013 proposed rule (78 FR 59126). We did not receive specific comments on this section and are finalizing the provision as proposed.

We received the following comments as they relate to federal program reviews and audits:

Comment: One commenter recommended that the section title be renamed to “Federal program compliance reviews and audits.” In addition, the commenter noted that §600.200(b)(3) may be missing an “and.”

Response: We appreciate the commenter’s recommended changes, which reflect the underlying intent of the provision. The final rule has been revised to include these changes.

Comment: One commenter expressed concern regarding the provision that permits HHS to withhold approval of Blueprint revisions in the event that the state has not resolved action items in which the state appears to be out of compliance. Specifically, the commenter expressed that withholding approval of Blueprint revisions that otherwise comply with federal requirements is inappropriate and potentially arbitrary given that the action to deny or disapprove a Blueprint revision should be directly related to the subject matter of that revision; therefore, the commenter recommended that we should delete paragraph (b)(3) under this section.

Response: We believe that maintaining this provision in the final rule is appropriate as it provides a compliance remedy that permits the state the opportunity and necessary time to resolve compliance issues while maintaining its BHP certification. Removing this provision would result in having only one compliance remedy – the withdrawal of a state’s BHP certification – in the event that identified action items were not immediately resolved. We believe that this alternative is not in the best interest of the state, or in the best interest of the BHP enrollees, as it would result in program termination as well as coverage disruptions for BHP enrollees.

Comment: We received a request to define the standard of review, especially as it relates to the use of BHP trust funds.

Response: The standard of review for federal program reviews and audits is defined in §600.200(a). Specifically, this standard of review includes all applicable laws, regulation, and interpretive guidance as it relates to federal BHP requirements as well as the provisions of the state's certified BHP Blueprint. The standard of review with respect to the use of BHP trust funds includes all applicable laws, regulation, and interpretive guidance as it relates to BHP trust funds, with a focus on the requirements specified in §600.705. We have modified the language in §600.200(b)(4) to clarify this standard.

D. Eligibility and Enrollment

The proposed content of Subpart D includes all eligibility and application, screening and enrollment standards and procedures.

1. Basis, scope and applicability (§600.300)

In proposed §600.300 we provided the citation for the statutory basis for subpart D of this rule as 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 for purposes of enrolling in QHPs through the Exchange. We did not receive specific comments on proposed §600.300 and are finalizing the provision as proposed.

2. Eligible individuals (§600.305)

In §600.305(a), we proposed that an individual is eligible for BHP if the individual:

- Resides in the state offering the BHP, and is not eligible for coverage under the state's Medicaid program that includes at least the essential health benefits (EHB) described in 45 CFR Part 156;
- Has household income that exceeds 133 percent of the federal poverty level (FPL) and does not exceed 200 percent of the FPL for the applicable family size, or for a lawfully present

non-citizen ineligible for Medicaid due to citizenship status, with household income not exceeding 200 percent of the FPL; and

- Is not eligible to enroll in minimum essential coverage (MEC), including Medicaid coverage that covers the EHBs described above (individuals enrolled in Medicaid or CHIP that does not constitute MEC, or individuals eligible only for unaffordable employer sponsored insurance as determined under section 5000A(e)(1) of the Internal Revenue Code would meet this criterion);

- Is under age 65;
- Is a citizen, or lawfully present non-citizen; and
- Is not incarcerated (other than during a period pending disposition of charges).

In §600.305(b), we proposed that a state may not impose limitations on eligibility through the imposition of waiting lists, caps on enrollment, restrictions based on geographic area or any other conditions.

We are finalizing the provisions of this section as proposed but have made some changes in response to the comments described below. In addition, we have made several revisions for clarity.

In §600.305(a)(1) we have modified the standard to read “are residents of the state.” In §600.305(a)(2), we changed the term “non-citizen” to “immigration” status clarifying that it is immigration status that is a determinant for eligibility. Additionally we clarified that this same immigration status may apply to CHIP as well as Medicaid. In the proposed §600.305(a)(1), the standard also referenced not being eligible for Medicaid consisting of at least the EHBs. Because this requirement is entirely subsumed under §600.305(a)(3) requiring ineligibility for MEC, we have deleted it from this section; this does not change the meaning of the regulations but rather makes the regulation more clear. Additionally, in §600.305(a)(3) we have removed

the word “affordable” to more closely reflect the underlying statutory language that connects affordability to employer sponsored insurance. In addition, we have also deleted the reference to CHIP in §600.305(a)(3)(i), and have limited the reference to “such other programs” only to Medicaid, because the Department of Treasury’s final rule on MEC (78 FR 53646) now clarifies that all CHIP coverage is MEC (in contrast to Medicaid, which for some individuals may be limited and therefore not MEC).

Comment: We received many comments supporting the proposed eligibility standards for BHP, including the provision permitting individuals in limited-benefit Medicaid programs to remain in such programs while also being determined eligible for BHP. Commenters expressed the importance of this provision as it relates to family planning, pregnancy related services, and HIV treatments.

Response: We are finalizing the proposed provisions.

Comment: We received one comment requesting that HHS provide an exception to the eligibility standards in states that do not expand Medicaid coverage citing the gap in coverage in those states that do not cover low income adults under 133 percent of the FPL.

Response: We share the commenter’s concern regarding the gap in coverage in states that have not elected to expand Medicaid to cover low income adults under 133 percent FPL; however, we have no authority to provide an exception as requested by the commenter given that the statute specifies the household income standard in BHP (that is, individuals with household income that exceeds 133 percent of the FPL and does not exceed 200 percent of the FPL).

Comment: Several commenters requested clarification that legally married same-sex couples will be recognized as married for purposes of BHP eligibility, in line with the Department’s policy in the Exchanges.

Response: Marriage recognition is not a policy subject to federal regulation under either

the Exchange or Medicaid, but it is necessary for the determination of household composition, which is a key element of calculating household income using the modified adjusted gross income (MAGI) methodology. Under section 1331(h) of the Affordable Care Act, BHP terms such as income, including the element of household composition, are required to have the same meaning as such terms have under section 36B of the Internal Revenue Code. Pursuant to September 2013 guidance on this issue from the IRS in Revenue Ruling 2013-17, a marriage of same-sex individuals validly entered into is recognized for purposes of the Internal Revenue Code even if the state in which the individuals are domiciled does not recognize the validity of same sex marriages. Because BHP is required to use the same definitions as are applicable under the Internal Revenue Code and because it would promote consistency across federal programs, we agree that this same policy is applicable to BHP. We intend to address this issue in subregulatory interpretive guidance similar to the guidance issued under the Exchange and Medicaid on BHP implications of *United States v. Windsor*, 570 U. S. ____ (2013). Using interpretive guidance will allow a more specific and nuanced consideration of the issues raised.

Comment: Several commenters requested flexibility in BHP to provide coverage for spouses affected by the affordability test for employer based insurance. Some spouses are not eligible for a premium tax credit because they would be considered eligible for affordable employer based insurance. Some commenters suggested that CMS provide a state option to cover such spouses but not to require such coverage, so as not to force states to cover individuals for whom there would be no federal reimbursement. The commenters urged CMS to revise the regulation to permit states the option for such spouses to enroll in BHP and for states to have as much flexibility in funding as possible.

Response: To explain the changes made to the regulation in response to these comments, it is necessary to point out that there is a statutory error in section 1331 of the

Affordable Care Act, which as part of the eligibility standards, sets the BHP standard of affordability of employer sponsored insurance by referencing section 5000A(e)(2) of the Internal Revenue Code. Section 5000A(e)(2) is not an affordability test. Compounding the error, we cited the affordability test in the proposed rule as section 5000A(e)(1) which is not the statutory reference, but is an affordability test. Resolving this double error, we are clarifying that the affordability test that should have been cited in BHP is to the premium tax credit standard at section 36B(c)(2)(C) of the Code. As the commenters correctly point out, including the affordability test at 5000A(e)(1) creates a difference in eligibility between BHP and the PTC which does not seem to be supported by other sections of the statute and amounts to an unfunded mandate.

These comments refer to statutory provisions concerning eligibility for the premium tax credit. Under current IRS rules, spouses are not eligible for the premium tax credit if the worker's offer of individual coverage requires a contribution less than a certain percentage of household income, because they would be considered eligible for affordable coverage. Since we are applying the same affordability test for BHP eligibility that applies for the premium tax credit, the same policies concerning spousal eligibility would apply. The statutory definition of an eligible individual for purposes of BHP expressly excludes individuals who are eligible for affordable coverage.

Comment: We received a comment recommending that HHS revise language regarding standards for non-citizens' BHP eligibility to be more clear about the applicable income standard.

Response: We have clarified the BHP eligibility standards for lawfully-present non-citizens ineligible for Medicaid by specifying the full income range (that is, lawfully present non-citizens who have household incomes from 0 to 200 percent of the FPL).

Comment: A few commenters supported, but wanted further clarity, regarding the provision in the proposed rule that a state must determine an individual eligible for BHP when they are enrolled in Medicaid or CHIP coverage that does not provide MEC. In particular, one commenter would like verification that pregnancy-related services provided through Medicaid, whether comprehensive or not, continue to be excluded under Department of Treasury rules regarding MEC and would not preclude eligibility for BHP.

Response: The definition of MEC is outside the scope of this rule. Section 1331(e) of the Affordable Care Act sets out two standards that are relevant to determining if individuals with household incomes from 133 up through 200 percent of the FPL, who are eligible for Medicaid, can enroll in BHP. First, such an individual may not be eligible for Medicaid benefits that consist of EHBs (as described in section 1302(b) of the Affordable Care Act). In addition, to be eligible for BHP, individuals may not be eligible for MEC. MEC is defined in the Internal Revenue Code and implementing regulations. In general, Medicaid coverage is considered to be MEC and Medicaid coverage consisting of the EHBs would be MEC. A recent rule issued by the Department of Treasury (78 FR 53646), however, now provides that some limited-benefits categories of coverage under title XIX are not MEC. Additionally, HHS has miscellaneous MEC authority to determine Medicaid programs to be MEC on an individual basis.

Comment: Another commenter wanted clarity that an individual may be eligible to enroll in a standard health plan through BHP if the individual has access to employer sponsored coverage that fails to meet the minimum value standards.

Response: As noted above, the standard for eligibility for BHP is based on statutory language in section 1331(e)(1) of the Affordable Care Act, which specifies that only individuals ineligible for MEC or individuals eligible for an employer-sponsored plan that is not affordable coverage are eligible for BHP. Minimum value is not a standard authorized by the statute.

Comment: We received two comments requesting greater flexibility in states that implement a BHP for individuals who wish to remain in QHPs. The commenters expressed interest in providing such individuals with the choice to enroll in BHP, or remain enrolled in the Exchange with their premium tax credit and cost-sharing reductions.

Response: We appreciate the commenters' interest in providing flexibility to individuals eligible for BHP who wish to continue to receive coverage through QHPs. Such individuals may continue to receive coverage through QHPs; however, the statute specifies that individuals eligible for BHP are not eligible to receive the premium tax credit or cost-sharing reductions. If an individual elects to remain enrolled in QHP coverage, and is determined to be eligible for the state's BHP, no federal subsidies will be available to purchase the QHP coverage.

Comment: One commenter expressed concern about Medicaid serving as a secondary payer to BHP, because the commenter believed Medicaid will likely be the better payer. The commenter recommended that HHS ensure that individuals have easy access to comparison information between Medicaid and BHP to help facilitate choice.

Response: If a person has eligibility for both Medicaid that is not MEC and for BHP, the Medicaid statute at section 1902(a)(25) of the Social Security Act and implementing Medicaid regulations require that Medicaid pay secondary to BHP. The provider is required to bill BHP primary to Medicaid; the individual is not given choice about who is the primary payer.

Comment: A commenter requested clarification on whether a state implementing a BHP between open enrollment periods in the Exchange can allow any QHP enrollees with the premium tax credit to be transitioned to the BHP at the next open enrollment with no impact on the enrollees' advance payments of the premium tax credits (APTCs).

Response: We are finalizing §600.305(b) as proposed except that we have added language to conform with a change made in subpart B of this rule permitting states implementing

BHP in 2015 to seek approval for a transition plan enabling the state to propose alternative initial enrollment strategies for eligible individuals. This would address the commenters concern if the state implements BHP in 2015. After 2015, we are requiring alignment of BHP with open enrollment in the Exchange at §600.115(d). Following the 2015 initial implementation year, a state implementing a BHP must coordinate implementation with open enrollment of the state's Exchange.

3. Application (§600.310)

In §600.310, we proposed that any state operating a BHP must use the single streamlined application or the state's approved alternative. Additionally, we proposed that application assistance be made available to individuals applying for BHP equal to that which is available in Medicaid. We also proposed that if a state uses authorized representatives, it would follow the standards of either Medicaid or the Exchange. We noted in the preamble that call centers required by the Exchange at 45 CFR 155.205(a) are encouraged under those regulations to provide information on all insurance affordability programs including BHP.

Comment: Several commenters requested that we require that application assistance be conducted in a manner accessible to those with limited English proficiency or individuals with disabilities. A commenter suggested requiring call center staff to refer consumers in real time to community resources if they are unable to answer questions about BHP. Another commenter wanted call centers to be required to provide information on BHP rather than encouraged to do so.

Response: After consideration of the comments received, we are finalizing this section as proposed. We have required application assistance for BHP equal to that provided in the Medicaid program, which requires accommodation for individuals with limited English proficiency and for persons with disabilities. Additionally, the call center requirements set forth

at 45 CFR 155.205(a) are outside of the scope of this rule-making; therefore, we cannot make the suggestions proposed by the commenters. While we are unable to include specific call center requirements in this final rule, we expect that, in accordance with §600.330, the state will enter into an agreement with the state Exchange to ensure coordination of BHP and Exchange application and enrollment mechanisms. Since call centers are part of those mechanisms, we expect that the agreement will require that coordination will include call center activities. We expect that call centers will support all insurance affordability programs, including BHP.

4. Certified Application Counselors (§600.315)

In §600.315, we proposed that if a state chooses to use certified application counselors (CACs), the state must apply either the certification standards and processes of Medicaid or the Exchange.

Comment: One commenter requested clarification on whether a state must use certified application counselors.

Response: We are not mandating the use of certified application counselors.

Comment: We received several comments requesting clarification on who can serve as certified application counselor. Specifically, commenters recommended that HHS permit health plans to serve as certified application counselors. The commenters noted that it would be desirable to have plans assist as “issuer customer service representatives.”

Response: Certified application counselors are individuals who meet certain qualifications, not entities. To the extent that employees of health plans or any other entities meet the applicable qualifications, they would not be precluded from serving as CACs. These qualifications would be based on the certification standards of either Medicaid at 42 CFR 435.908 or the Exchange at 45 CFR 155.225 (at state option). We note that employees of health plans acting as CACs would need to be able to maintain confidential records, and would need to

ensure that they will not operate with a conflict of interest (for example, they could not receive bonuses based on how many new enrollees sign up for the employing health plan).

Comment: We also received a comment that the certification process should include specific training components on how to provide accessible services to individuals with disabilities and culturally and linguistically appropriate services. Commenters suggested that training should include components on how to access and work with interpreters as well as how to access and use augmentative and assistive communication devices. The commenter recommended that application counselors have access to population level data to assist in determining the needs of the population being served. A commenter recommended the inclusion of language directing assistance in the form of pre-enrollment outreach and education.

Response: We share the commenter's interest in ensuring that certified application counselors have sufficient training to assist individuals seeking health insurance coverage; however, we believe that the content of such training is best determined at the state-level given the state-specific needs and unique market features within the state. We anticipate that states will use a variety of application assistance techniques relying heavily on the strength of current operations in each state. Such state training still must be in accordance with 45 CFR 155.225 (accessibility requirements for persons with disabilities), or 42 CFR 435.908 (accessibility requirements for persons with disabilities and for individuals with limited English proficiency.)

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

In §600.320, we proposed that determining eligibility for BHP is a governmental function that must be done by a state or local governmental entity, including at state choice, an Exchange that is a government entity. Further, we proposed that the timeliness standards for making modified adjusted gross income (MAGI) based eligibility determinations under Medicaid apply equally to BHP. Regarding establishment of the effective date of eligibility, we proposed that

states must establish a uniform method of determining the effective date for purposes of enrollment in standard health plans using either the Exchange standards or Medicaid rules. Likewise, we proposed that the state must offer either the enrollment and special enrollment periods of the Exchange or the state may choose to follow the continuous open enrollment standard of Medicaid.

We received several comments on this section, which we have carefully considered and we offer a variety of modifications, as described below.

Comment: One commenter offered endorsement of the policy of having eligibility determinations made by governmental agencies. With regard to enrollment, we also received general support for offering the choice between the enrollment policies of the Exchange or Medicaid; however, some commenters suggested we narrow the Medicaid option to be exclusive of §435.915(a), which establishes retroactive coverage.

Response: In §600.320(c) we have removed applicability of §435.915(a) to eliminate retroactive coverage from the Medicaid enrollment policies that would be required if the state elects the Medicaid model; states can still provide retroactive eligibility in BHP following the Medicaid rules if they so choose but it is not required.

Comment: A few commenters requested clarification on whether tax filing is required for enrollment.

Response: Tax filing is not an eligibility standard for BHP; the eligibility standards for BHP eligible individuals are set forth in §600.305. This section's focus is on the processes, not the standards, for determining eligibility and enrollment. These processes should be used to determine eligibility against the standards given in §600.305(a). In §600.305(b) we have made it clear that states may not add to the list of eligibility standards. Therefore, we have not altered the regulation text.

Comment: A commenter suggested that we permit presumptive eligibility in BHP and that we permit hospitals to delegate authority to another entity, such as an eligibility service vendor.

Response: There is no statutory provision that authorizes presumptive eligibility under BHP. As discussed above, states may elect to provide for retroactive effective dates for eligibility. This option may ensure that coverage is not delayed because of the eligibility and enrollment process.

Comment: We received a comment advising us to state the goal of real-time eligibility determinations.

Response: We agree with the commenters' position that insurance affordability programs, including BHP, should be moving towards real-time eligibility determinations. Achieving this goal is dependent on the development and maintenance of effective systems and procedures, which may take a substantial investment and time.

Comment: One commenter suggested that we not use the term "continuous eligibility", which the commenter noted could be confused with other eligibility policies. The commenter encouraged us to describe enrollment as continuing on a rolling basis throughout the year.

Response: In response to the comment we have added the phrase "continuous open enrollment throughout the year" to §600.320(d) to clarify the Medicaid choice of enrollment.

Comment: Several commenters raised concern that the Exchange standard does not include a special enrollment period for pregnancy and asked that we specifically address that in BHP.

Response: We have modified the text to clarify that states choosing the Exchange enrollment policy must establish enrollment periods no more restrictive than those permitted by

the Exchange, enabling states to add special enrollment periods based on pregnancy as suggested.

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

In §600.330, we proposed carrying over several of the coordination provisions from the Exchange and Medicaid regulations to BHP, including having agreements delineating lines of authority for making coordinated eligibility determinations. We have proposed that individuals applying to any insurance affordability program not be required to duplicate information already provided for purposes of applying for BHP, and that the state accomplish this through electronically transferring accounts between the BHP and other agencies as well as accepting determinations and assessments made by other insurance affordability programs and enrolling eligible individuals into coverage without delay. When accounts are transferred to the BHP from other agencies, we proposed a requirement that the BHP agency must notify the referring agency of any final determination. Also, we proposed that every application for BHP will result in a final determination of eligibility or ineligibility and that notices to applicants be coordinated with other insurance affordability programs.

Comment: We received many comments supporting coordination between IAPs, some of the comments particularly pointed out the importance of having agreements between IAPs. No comments requesting change were received on this section.

Response: We are finalizing this section as proposed.

7. Appeals (§600.335)

Section 1331 of the Affordable Care Act does not confer a federal level appeal for the BHP program. Therefore, we proposed in §600.335 that states follow the Medicaid appeals rules and processes. Under these processes, there would be no direct appeal to the Department of Health and Human Services. Further, we proposed that eligibility determinations must include

notice of the right to appeal and instructions for how to engage the appeals process. We proposed that this process must be conducted in a manner accessible to individuals with limited English proficiency and persons with disabilities.

Comment: While we received a few comments commending the decision to use the Medicaid appeals process, we received several comments expressing concern about this section. Commenters favored the ability to choose the Marketplace (Exchange) appeals process to decrease variability within a given state. One commenter acknowledged that notices would have to specify that there is no federal level appeal for BHP.

Response: We understand the commenters' desire to have the Exchange appeals rules and processes available to BHP, decreasing variability in states with state-based Exchanges. (We note the Federally Facilitated Exchange will only have a federal process, and we do not anticipate that this federal process will be available for BHP.) Therefore, as in many other areas of the regulation, we are changing this provision to give states the choice of using the appeals rules of Medicaid or the Exchange.

8. Periodic renewal of BHP eligibility (§600.340)

In §600.340(a), we proposed a 12-month period of eligibility unless redetermination is warranted based on new information. Additionally, we proposed that states require individuals to report changes in circumstances at least equivalent to that which is required by the Exchange. In §600.340(b), we proposed that enrollees who remain eligible be given notice of a reasonable opportunity to change plans. Further, we proposed that enrollees will remain in the plans selected for the previous year if they choose not to take action on such notices and such plans remain available. In paragraphs (c) and (d), we proposed that states apply the redetermination procedures of either the Exchange or Medicaid and that states are required to verify information in accordance with §600.345. Finally, in §600.340(e) we require states to provide an enrollee

with an annual notice of redetermination of eligibility which includes all current information used as the basis of the individual's eligibility. The enrollee is required to report changes within 30 days and the state must verify the information.

Comment: Many comments were received on this section, with the vast majority urging us to allow 12 month continuous eligibility. Commenters frequently cited that half the individuals in the eligible income bracket for BHP are expected to experience changes in income within a 12 month period that would cause them to shift from BHP to Medicaid or the Exchange. Many commenters were concerned with the administrative burden this would place on a state.

Response: We have carefully considered the comments received and we are sympathetic to the request for 12 month continuous eligibility because we share the concern of the commenters both with regard to the shifts between different insurance affordability programs that could be experienced by the BHP enrollees and the administrative burden on states. Therefore, we are extending to states the option of only redetermining eligibility every 12 months, regardless of any changes in income or other circumstances, as long as the enrollee is under age 65, is not otherwise enrolled in MEC, and remains a resident of the state. We have singled out those exceptions because they are situations in which BHP coverage would either be duplicative or outside its overall scope. However, enrollees must report changes impacting eligibility within 30 days regardless. Additionally, to clarify the relationship between this new provision and the 12 month periodic review of eligibility (provision (a)) we have replaced the language that an individual is "determined eligible for a period of" with "subject to periodic review of eligibility every" 12 months in provision (a). States will not receive additional funding to account for any higher BHP enrollment under this state option.

Comment: One comment requested clarification that enrollees must report all changes within 30 days.

Response: The 30 day standard specified in 45 CFR 155.330(b) is applied by reference.

9. Eligibility verification (§600.345) and Privacy and Security of Information (§600.350)

In §600.345, we proposed that states verify the eligibility of an applicant or enrollee in BHP using either the standards and procedures of Medicaid or the Exchange. In §600.350 we proposed that states are required to comply with standards and procedures protecting the privacy and security of eligibility information set forth by the Exchange. We did not receive specific comments on these sections and are finalizing the provisions as proposed.

E. Standard Health Plan

1. Basis, scope and applicability (§600.400)

Proposed §600.400 under subpart E specified the general statutory authority for, and the scope of, standards proposed in this subpart, which sets forth the minimum coverage standards under BHP and delivery of such coverage, including the competitive contracting process required for the provision of standard health plans. For specific discussions, see the September 25, 2013 proposed BHP rule (78 FR 59128 and 59129). We did not receive specific comments on this section and are finalizing the provision as proposed.

2. Standard health plan coverage (§600.405)

In §600.405(a), we proposed that standard health plan coverage must include, at a minimum, the EHBs as determined and specified under 45 CFR 156.110, and 45 CFR 156.122 regarding prescription drugs. We also proposed that states be able to select more than one base benchmark option from the reference plans specified at 45 CFR 156.100 when establishing EHBs for standard health plans. Additionally, we proposed that states comply with 45 CFR 156.122(a)(2) by requiring participating standard health plans to submit a list of covered prescription drugs under the plan to the state.

In proposed §600.405(b), the state is required to adopt the determination of the Exchange

at 45 CFR 155.170(a)(3) in determining which benefits subject to state insurance mandates enacted after December 31, 2011 are in addition to the EHBs.

In proposed §600.405(c) and (d), we required EHBs to include changes made through periodic review and prohibited discrimination in benefit design.

Proposed §600.405(e) is the prohibition on federal funding for abortion prescribed in section 1303 of the Affordable Care Act that applies in the same manner to BHP and standard health plans as it does to QHPs.

Comment: We received several comments in support of requiring coverage for preventive services without cost-sharing.

Response: We are finalizing the proposed provisions.

Comment: We received several commenters requesting that states have the ability to use the alternative benefit plan in Medicaid as the reference or base-benchmark plan for BHP in order to incorporate EPSDT and other child specific benefits in the event that CHIP does not continue beyond 2019. Another group of commenters request that we require the state to use the same base-benchmark or reference plan that the state uses for either the Exchange or the Medicaid benchmark.

Response: Sections 1331(a)(2)(B) and 1331(b)(2) of the Affordable Care Act provide that the benefits offered through BHP must contain at least EHBs, which is determined by a comparison to a base benchmark plan set forth at 45 CFR 156.100 using the processes set forth in 45 CFR 156.110 and 45 CFR 156.122. The statute does not require benefits equivalent to a Medicaid alternative benefit plan. That said, states have the ability to negotiate for additional benefits through the competitive procurement process required by section 1331(c)(1) of the Affordable Care Act and can also provide additional benefits for BHP enrollees in addition to the

standard health plan benefits, using BHP trust funds.

Comment: Other commenters recommend additional benefits outside of the EHBs in the standard health plan. They also expressed concern that requiring the state to offer at least the EHBs “at a minimum” is insufficient to mean the state, at its option, may provide additional benefits to the standard health plan.

Response: We have carefully considered the comments for this section and we are finalizing without change. We believe that this regulation is explicit in establishing that states must provide EHBs as a minimum level of benefits, can negotiate with standard health plans in the competitive procurement process for more benefits, and can supplement those benefits with additional benefits for BHP enrollees, using BHP trust fund dollars.

Comment: We received one comment requesting that HHS provide examples of additional benefits a state could provide. Another commenter requested clarification that a state must provide coverage of plasma protein therapies.

Response: We hesitate to provide examples in this area where states are extended complete latitude because examples are often viewed as recommendations. For benefits coverage policy, we are requiring the statutory floor of the EHBs, and each state is free to add to the benefits as the state decides is appropriate. We are leaving this provision unchanged.

Comment: Several commenters expressed concern that the preamble language concerning the abortion services standard appeared to be misleading in that it may be read to mean that states out of compliance with this requirement would not receive any federal funding for BHP, rather than just federal funding for abortion.

Response: The regulation text requires compliance with the rules on abortion coverage applicable to Exchanges at 45 CFR 156.280. The preamble explained that, consistent with that regulation, any abortion coverage for which public funding is prohibited could only be provided

using segregated non-federal funding. If a state or standard health plan does not segregate funding for such abortion coverage, the state would be out of compliance with BHP requirements, and could lose program certification. Or the state could face disallowance of improperly spent funds.

Comment: Another commenter requested the inclusion of additional guidance on substitution and supplementation of benefits.

Response: Supplementation and substitution are policies that were developed for use by plans in the individual and group markets, and were adopted with some minor variations by Medicaid, for alternative benefit plans. In general, these policies are part of the determination of the scope of EHBs. Section 1302 of the Affordable Care Act sets forth 10 required EHBs, and then indicates that the full scope of EHBs should be based on the scope of benefits provided by a typical employer plan. To implement this requirement, under applicable regulations at 45 CFR 156.100 et seq., states must select a base benchmark plan from among several options. While the state selects one base benchmark for individual and group plans, the state may select different and multiple base benchmarks for Medicaid. Supplementation allows a plan offeror to add to the base benchmark a required EHB that is missing, and substitution allows a plan offeror to substitute an actuarially equivalent essential health benefit into a reference plan. (In Medicaid, because the state acts as the plan offeror, it determines the supplementation and substitution procedures.) These flexibilities were created to make the definition of EHBs possible from existing commercial products. For BHP, we propose the same process to define EHBs, except that the state could select different and multiple base benchmarks for BHP. Any subregulatory guidance put forward by the Exchange will be made equally available under BHP.

Comment: One commenter requested that HHS ensure payment for out-of-network providers for emergency services and the extension of protections in section 1932(b)(2) of the

Act, the prudent laypersons standard for emergency care, to BHP.

Response: With respect to the provider rates, we do not believe that statute provides the authority to establish rate-setting standards in BHP. States are free to contract with standard health plan offerors to provide coverage which may take many forms including networks, fee-for-service or other models. States may impose additional requirements including mandatory benefits, rate structures, or delivery system limitations through law or contract.

Regarding the prudent layperson standard for emergency services, EHBs are required by statute to be offered in BHP. Emergency services is an EHB, to which the prudent layperson standard is applied at 45 CFR 147.138(b)(4). Therefore, any base benchmark plan will necessarily include emergency services based on the prudent layperson standard.

Comment: We received one comment expressing concern that the United States Pharmacopeia (USP) classification system as specified in 45 CFR 156.122 is not designed to be used with plans requiring EHBs, and are inadequate in providing for women's health care needs.

Response: This issue is not within the scope of this regulation.

3. Competitive contracting process (§600.410)

Under §600.410(a), we propose that a state must assure in its BHP Blueprint that it meets the requirements of this section.

We propose in §600.410(b) elements required in the competitive contracting process for the provision of standard health plans. For the specific elements, see the September 25, 2013 proposed rule (78 FR 59147).

In §600.410(c), we proposed an exception to the competitive contracting process for program year 2015. For specific requirements associated with this exception, see the September 25, 2013 proposed rule (78 FR 59130).

We proposed in §600.410(d) the specific negotiation criteria that the state must assure is included in its competitive contracting process. For the specific criteria, see the September 25, 2013 proposed rule (78 FR 59147).

In §600.410(e), we proposed additional considerations specified in statute that a state must include in its competitive contracting process for the provision of standard health plans. For specific discussions, see the September 25, 2013 proposed rule (78 FR 59147). We received the following comments on the competitive contracting process:

Comment: We received several comments supporting the proposed competitive contracting process.

Response: We are finalizing the competitive contracting process provisions with some modifications as discussed further below.

Comment: We received several comments requesting clarification on whether a state could use its Medicaid, or QHP, contracting process for BHP if that process was competitive in nature. Two commenters specifically asked whether Medicaid managed care organizations currently under contract could provide standard health plans to allow the alignment of BHP with existing benefits offered to Medicaid beneficiaries, or would the state need to begin a new procurement process for BHP. Another commenter requested that CMS waive the competitive contracting process if the state's Medicaid or Exchange-based contracting process aligns with the BHP requirements.

Response: With respect to how the state executes its procurements (that is, the manner in which the state solicits for bids and effectuates a contract award), a state may use an already established competitive contracting process, such as the Medicaid or QHP process, to enter into contracts with standard health plan offerors as long as the process provides for negotiation and consideration of each of the statutorily required factors for BHP procurement. This may require

some adjustment to those established processes, since, for example, a Medicaid managed care procurement would not necessarily include negotiation or consideration of those required elements. Although the procurement process might have many standard elements, the state would have to adjust its solicitation of bids to reflect the differing requirements of each separate program, and contractors would likely need to adjust their offerings to meet the requirements of each separate program. In addition, the procurement process would have to ensure that there was no cross-subsidization between programs. Except for program year 2015, in which a state may request an exception to the competitive contracting process, the procurement process used to contract for the provision of standard health plans, whether it is a joint or standalone procurement, must include and comply with all of the statutorily required elements of competitive bidding for BHP standard health plans codified in §600.410.

We understand the commenters' interest in ensuring rapid and efficient implementation of BHP and, as a result, we have provided a state implementing BHP in program year 2015 with the option to request an exception to the competitive process. As specified in §600.410(c), the state must include a justification as to why it cannot meet this requirement and describe the process it will use to enter into contracts for the provision of standard health plans in 2015. This process can include, but is not limited to, amending existing Medicaid or Exchange-based contracts for the purpose of promoting coordination and efficiency in procurements. After the exception period has expired (that is, beginning for coverage effective in program year 2016), simply amending an existing contract to include BHP, after the competition process is complete, is not permissible. The statute requires the use of a competitive contracting process, and we do not believe we have the authority to exempt states from the process beyond the startup year for the program.

Comment: Several commenters requested clarification regarding the procurement bidding process. Specifically, commenters asked if a state is required to open the bidding to all interested parties, or whether the state has the ability to impose criteria that limits the number of eligible bidders. Another commenter suggested that the bidding process ensure the participation of local health plans.

Response: The statute specifies that a state must establish a competitive contracting process for the provision of standard health plans. In order to meet this statutory requirement, we proposed that a state may establish such a process under state procedures that are consistent with the standards set out in section 45 CFR 92.36(b) through (i). These standards provide states considerable flexibility in the solicitation and evaluation of bids as well as in the awarding of contracts; therefore, to the extent that the state's solicitation complies with such standards as well as ensures that the qualified bidders can provide standard health plan coverage in all contexts, the state has the flexibility to determine the criteria for eligible standard health plan bidders, including the participation of local health plans.

Comment: We received many comments encouraging HHS to ensure the participation of Administrative Service Organizations (ASOs) in the competitive contracting process. They felt that permitting ASO participation would enable more states to implement BHP as it would allow interested states to build off of their existing Medicaid programs thereby reducing the administrative burden associated with implementing a new program.

Response: The statute requires states to contract for the provision of standard health plans under BHP. Neither the statute, nor our regulations, specifically prescribe or restrict the participation of certain kinds of entities as standard health plan offerors. Rather, standard health plan offerors must meet the requirements delineated out in §600.415(a). ASOs may participate in the competitive contracting process to the extent that they can meet the criteria of a standard

health plan offeror in §600.415(a). ASOs (who traditionally only offer administrative support) may expand their capabilities and practices to meet those requirements, or partner with other entities who do so.

Comment: While we received several comments supporting the competitive contracting process exception for program year 2015, many commenters recommended that HHS extend this exception through 2016, or alternatively, provide this exception to states during their first year of implementation even if that occurs after 2015.

Response: We are finalizing the proposed provisions providing an exception only for 2015. Given the short time period in which states have to establish a BHP in time for the January 1, 2015 effective date, we believe that the one year exception will not only help states quickly and efficiently implement BHP by leveraging existing contracts that may not have been procured consistent with the finalized regulation, but also promote coordination and continuity of care during the initial implementation of BHP in 2015. For states that elect to implement BHP after 2015, we believe that these states will have sufficient time between the issuance of these final rules and a post-2015 implementation to establish a competitive contracting process for the procurement of standard health plans. The statute requires such a process and we do not believe we have the authority to exempt states from the process beyond the startup year for the program.

Comment: We received many comments recommending that we allow states to utilize a primary care case management (PCCM) delivery of care model under BHP. Many commenters expressed that the PCCM model not only meets the statutory requirement to use a process with as many attributes of managed care as possible, but that it would also encourage BHP implementation as it would allow interested states to build off of their existing Medicaid programs.

Response: The statute requires states to contract for the provision of standard health plans under BHP. Neither the statute, nor our regulations, specifically prescribe or restrict the participation of certain kinds of entities as standard health offerors. Rather, standard health offerors must meet the requirements delineated in 600.415(a). Standard health plan offerors have the discretion to determine and utilize a delivery of care model, such as the PCCM model, of their choice. As such, standard health plan offerors electing to operate a PCCM delivery of care model may participate in the competitive contracting process to the extent that they can meet the criteria of a standard health plan offeror in §600.415(a). Entities that traditionally only provide some of the services delineated in section 600.410(c) and (d) may expand their capabilities and practices to meet those requirements, or partner with other entities who do so. While we appreciate commenters' suggested language changes throughout §600.410 to include the use of PCCM, we are not including those suggested language changes into the final regulation.

Comment: One commenter requested that CMS consider broadening the definition of what constitutes competitive contracting to permit fewer than two standard health plans to serve a local health care market. The commenter believes this would encourage the development of innovative models of care delivery that coordinates care throughout a locality, without a division between standard health plan offerors. Specifically, the commenter recommended that providing additional flexibility in competitive contracting would encourage states interested in establishing local community-based coordinated care models to pursue such models.

Response: We have considered the commenter's request, but we believe that, as proposed, the regulation already affords a state with considerable flexibility and opportunity for state innovation as it establishes its competitive contracting process. The standards set forth simply require the state to be consistent with those found in 45 CFR 92.36(b) which provide a

basic framework to the required procurement process. We believe that standard health plan offerors also have considerable flexibility in developing innovative models of care delivery, and encourage states to promote innovations in delivery system and payment reforms during the contracting process. Given that innovations in care coordination, utilization of preventive care services and patient-centered health decision making are specified in statute, we hope that states will make such innovations a high-ranking criterion in the solicitation process. A state interested in pursuing innovations that extend beyond the parameters of BHP and into other insurance affordability programs has the option, beginning in 2017, to request a waiver for state innovation as specified in section 1332 of the Affordable Care Act. Finally, as described below, we are clarifying the provision of the proposed regulation which requires availability of at least two standard health plan offerors; we do not believe that this provision will limit innovation. We view the choice of standard health plan offerors as an essential enrollee protection that is consistent with the requirement in section 1331(c) (3) to provide multiple plans to the maximum extent feasible.

Comment: We received many comments recommending that the final regulation strengthen the network adequacy requirements in the competitive contracting process. Specifically, many commenters suggested that the standard health plan offerors be required to demonstrate that their provider networks not only have a sufficient number of providers, especially specialty providers, but also have a sufficient geographic distribution such that enrollees in rural areas, for example, have sufficient access to providers. In addition, to strengthen the overall network adequacy requirements, many commenters also recommended that states ensure the standard health plan offerors include essential community providers; federally qualified health centers (FQHCs), pediatric primary care providers and other specialists in their networks.

Response: We appreciate and share the commenters' interest in ensuring that BHP enrollees have sufficient access to providers; therefore, we have revised the language in §600.410(e) (2) regarding access to providers. States will have some flexibility to determine the specific nature of the standards; however, we believe that at a minimum, the state should ensure that the standard health plan offerors maintain a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area to the same extent that would be required under the standards applicable either to managed care providers in Medicaid under 42 CFR Part 438, Subpart D or to coverage offered through the Exchange under 45 CFR 156.230 and 156.235. With respect to requiring states to ensure that standard health plan offerors contract with certain provider types, the strengthened language requiring that states ensure that standard health plans comply with either Medicaid or Exchange access standards should address this issue. While these access standards do not require that plans contract with any particular essential community providers, they address the inclusion of essential community providers in provider networks to ensure access to care. As a result of these stronger network adequacy standards, we anticipate that standard health plan offerors will need to include other providers, such as I/T/Us, FQHCs, OB/GYNs, pediatric primary care providers and other specialists in their networks to ensure that there is a sufficient number, mix and geographic distribution of providers for BHP enrollees to access. Finally, we would also like to note that the consideration of access concerns for states that have Indian populations should include consideration of access to providers that serve such populations.

Comment: Several commenters recommended that the final regulation require that as a condition of participating in BHP, a standard health plan offeror participate in either the state's Medicaid program or in the state's Exchange. Commenters offering this recommendation

believe that participating in BHP, Medicaid and/or the Exchange would help mitigate any disruptions in care in the event that a BHP enrollee transitions from BHP into Medicaid or the Exchange as the individual could potentially stay with the same health plan during the transition out of BHP.

Response: We share the commenters' interest in having strategies in place between states and standard health plan offerors to promote continuity of care for BHP enrollees transitioning into, or out of, the program. States have the discretion to include standards and criteria in their competitive procurement process to further the goals of continuity of care that the commenters are expressing. We do not believe, however, that limiting competition to plan offerors who participate in other IAPs is the only method to assure continuity of care, and in fact, could prevent BHP enrollees from having access to a range of qualified standard health plan offerors and their networks of providers. The commenters' concerns are addressed in part by the requirement specified in §600.425 that states must coordinate the continuity of care for enrollees across the insurance affordability programs, and describe in their Blueprints how they will do so. We anticipate that these descriptions will address how the state will ensure minimal disruptions in care for those who transition between insurance affordability programs.

Comment: Many commenters expressed concern that the provisions regarding the negotiation of benefits, premiums and cost sharing in the proposed rule precluded a state from developing a standard benefit package, premium amount, and/or cost-sharing amount and including such a standard in its solicitation. One commenter asked if it was permissible for a state to establish a standard benefit package as well as standard premium and cost-sharing amounts and accept any willing providers that agree to meet such standards issued in the solicitation. Many commenters felt that the final regulation should clarify that such an approach

(that is, establishing standard benefits, premiums and cost sharing) would satisfy the “negotiation of” requirement specified in statute.

Response: While the statute specifies that there must be a negotiation of benefits, premiums and cost sharing during the competitive contracting process, nothing precludes a state from establishing standards that will serve as the starting point for negotiations with standard health plans offerors. Such negotiations around benefits, premiums, cost sharing and other required elements specified in statute may include, but are not limited to price, the provision of benefits in addition to those specified in the state’s solicitation, lower premium and cost-sharing amounts than those specified in the state’s solicitation, or any other aspects of the state’s program that were included in its solicitation. While the state may propose a “standard” set of benefits, premiums and cost sharing, the state, at a minimum, must permit some level of negotiation, such as on price, or on additional benefits for enrollees, with the standard health plan offeror.

Comment: Many commenters requested that HHS include additional negotiation criteria in §600.410(d) and (e) that a state must include in its competitive contracting process. Recommendations included: (1) requiring states to consider similarities between BHP enrollees, Medicaid beneficiaries, and Exchange consumers; (2) requiring the inclusion of specific quality and performance measures; (3) specifying that standard health plan offerors provide documentation that they can bear risk and meet the state’s financial solvency requirements; (4) including the negotiation of provider reimbursement rates; and (5) require standard health plan offerors to provide proof that they meet all of the negotiation criteria and other considerations specified in §600.410(d) and (e) as well as all of the contract requirements specified in §600.415(b).

Response: We appreciate the commenters' recommendations; however, we believe that the statute specifies the minimum requirements that a state must assure are included in its competitive contracting and leaves considerable flexibility for states to include additional negotiation criteria. Therefore, the requirements specified in §600.410(d) and (e) are the minimum federal requirements that the state must assure are included in its competitive contracting process. A state can, at its option, include additional criteria, such as those recommended by the commenters, to establish sound negotiating standards and criteria to ensure the ability of offerors to provide standard health plans in such a manner that promotes affordable, high quality health care coverage to BHP enrollees.

4. Contracting qualifications and requirements (§600.415)

We proposed in §600.415(a) the entities that a state may contract with for the administration and provision of standard health plans. For specific discussions, see the September 25, 2013 proposed rule (78 FR 59130).

In §600.415(b), we proposed the general contract requirements that must be included in the state's standard health plan contracts. For specific discussions on these requirements as well as the proposed "safe harbor" approach, see the September 25, 2013 proposed rule (78 FR 59130 and 59131).

We proposed in §600.415(c) that a state must include in its BHP Blueprint the standard set of contract requirements it will include in its standard health plan contracts.

We received the following comments on contract qualifications requirements:

Comment: We received several comments in support of the proposed "safe harbor" approach enabling states to select either Medicaid or Exchange contracting provisions for their standard health plan contracts.

Response: We thank the commenters for their support and we are finalizing the

provisions as proposed.

Comment: We received several comments in support of our proposed rule permitting states to contract with non-licensed health maintenance organizations participating in Medicaid and/or CHIP.

Response: We thank the commenters for their support and we are finalizing the provisions as proposed.

Comment: Several commenters recommended that HHS apply a standard set of qualification standards, specifically the QHP certification and licensure standards, to standard health plan offerors.

Response: We appreciate the commenters' recommendations; however, we are not requiring such an approach, in part because it may undermine the state's efforts to encourage Medicaid managed care organizations and other health insurance issuers to participate in BHP. This, in turn, could undermine state efforts to promote coordination between all the insurance affordability programs. As commenters rightly pointed out, there are different standards applied to Medicaid managed care organizations relative to the standards applied to QHPs (for example, licensure and accreditation standards). In order to ensure that a state has the ability to contract with health maintenance organizations that operate in Medicaid and the Exchange, we believe that it is appropriate to impose a minimum standard at the federal level and permit state flexibility in determining whether the application of additional qualification standards are appropriate and in the best interest of the state's goals and objectives.

Comment: We received several comments requesting that HHS consider including safety net health plans, as defined in section 9010(c)(2)(C) of the Affordable Care Act, in the list of eligible standard health plan offerors.

Response: We appreciate the commenter's concern, and have modified the language in

§600.415(a) to clarify that states are not limited to contracting with the entities specified in this section for the provision of standard health plans. A state has the flexibility to establish the criteria included in its BHP solicitation, including specific qualifications of the standard health plan offeror. Assuming a safety net health plan, or another entity, meets both the federal requirements, as well as those specified in a state's BHP solicitation, the state may enter into contracts with such entities for the provision of standard health plans.

Comment: Several commenters requested that HHS require that a state include specific requirements in its standard health plan contracts. Specific recommendations include: (1) requiring that payment rates to standard health plan offerors are actuarially sound; (2) inclusion of specific providers; (3) specific provider reimbursements, such as the prospective payment system rate used for payment to FQHCs; (4) specific provider performance and quality measures; and (5) prohibition on the inclusion of "all-products" clauses in physician contracts.

Response: We appreciate the commenters' recommendations; however, we believe that federal standard health plan contract requirements should reflect the competitive contracting requirements specified in statute rather than specific requirements that are not specified in the statute. We believe this approach promotes maximum flexibility for states that may wish to pursue different contracting approaches in BHP, or to blend elements from Medicaid and the Exchange. We are finalizing the proposed provision at §600.415(b), which sets forth the minimum contract requirements that must be included in a state's standard health plan contract. Because these are the minimum requirements and a state has the flexibility to include additional requirements based on its negotiation criteria, a state must assure and include in its BHP Blueprint the standard set of contract provisions that it intends to incorporate into its contracts. A state can, at its option, include additional contract requirements, such as those recommended by the commenters, to promote affordable, high quality health care coverage to BHP enrollees.

Comment: We received several comments recommending that HHS apply the 85 percent medical loss ratio requirement to all standard health plan offerors, and not just those that qualify as health insurance issuers.

Response: We appreciate the commenters' recommendation; however, we are finalizing the proposed provisions. The statute specifies the application of the medical loss ratio (MLR) requirement only to standard health plan offerors that are also health insurance issuers. As discussed above, this standard is the minimum standard that a state must adhere to. A state has the discretion to apply this MLR requirement to all standard health plan offerors if it determines that such a requirement furthers the objectives and goals of its program. However, we do not believe we have the authority to require the application of this standard to entities beyond those described by statute.

Comment: One commenter requested clarification about ongoing eligibility to offer a standard health plan in the event that a standard health plan offeror does not comply with the MLR requirement. The commenter also asked what standard, or calculation methodology, would be used in determining whether the standard health plan offeror met the MLR requirement.

Response: A standard health plan offeror that is also a health insurance issuer would not qualify for a contract award if that offeror was not able to comply with the MLR requirement. The statute as specified in section 1331(b)(3) of the Affordable Care requires that standard health plan offerors that are also health insurance issuers comply with the 85 percent MLR requirement. As described above, to the extent that the standard health plan offeror is, for example, a Medicaid managed care organization or a network of providers, the offeror would not need to meet the 85 percent MLR requirement as a condition for contract award unless a state chose to

impose that requirement. With respect to the MLR calculation, the same calculation used in the individual and small group market will be used in BHP.

5. Enhanced availability of standard health plans (§600.420)

We proposed in §600.420(a) that a state must assure that at least two standard health plans are offered under BHP.

In §600.420(b), we proposed standards for a state entering into a joint procurement, or regional compact, with another state for the provision of standard health plans. For specific discussions on the regional compact, see the September 25, 2013 proposed rule (78 FR 59131).

We received the following comments on enhancing the availability of standard health plans:

Comment: While we received several comments in support of ensuring choice of standard health plans, the majority of the comments we received on this provision requested that HHS clarify whether states must ensure the availability of at least two standard health plans, or the availability of at least two standard health plan offerors.

Response: After carefully considering this issue, we are adding clarifying language to require that states assure the availability of at least two standard health plan offerors. This standard is consistent with the Medicaid requirement set forth in 42 CFR 438.52(a), which requires states to give Medicaid managed care beneficiaries a choice of at least two “entities.” We believe that requiring a state to contract with at least two standard health plan offerors will afford BHP applicants and enrollees the opportunity to compare and select their health coverage in a manner comparable to selecting health coverage from different health insurance issuers in the Exchange. In addition, we believe that requiring at least two standard health plan offerors to participate in BHP will lead to more robust competition, which could lead to better offered standard health plans and lower costs. BHP enrollees will also have the assurance that standard

health plan coverage will always be available in the event that the participation of one of the two standard health plan offerors in the program is affected (that is, if one of the two offerors stopped participating in BHP).

We believe that, in certain circumstances, the availability of two standard health plan offerors may not be feasible. For example, after completing its competitive contracting process, a state may only have one eligible standard health plan offeror qualified to award a standard health plan contract, or there may be an area within a state that only one standard health plan offeror provides coverage. As such, we have added an exception to the choice of standard health plan offerors in §600.420(a)(2). In its exception request, the state must include a justification as to why it cannot assure choice of standard health plan offeror as well as demonstrate that it has reviewed all its contract requirements and qualifications to determine whether they are required under the federal framework for BHP, determined whether additional negotiating flexibility would be consistent with the minimum statutory requirements and available BHP funding, and reviewed the information provided to bidders was sufficient to encourage participation in the BHP competitive contracting process.

Comment: One commenter requested that states entering a regional compact ensure that certified registered nurse anesthetists (CRNAs) are used to their full scope of practice.

Response: We appreciate the commenter's interest in ensuring the issue of full scope of practice is addressed in regional compacts; however, we believe states entering into the regional compact have discretion in addressing this issue through the competitive contracting process. States entering into a regional compact must ensure that the standard health plans offered through the compact meet all of the required negotiation criteria set forth in §600.415(d) and (e), including ensuring the sufficient number, mix and geographic distribution of providers that is sufficient to ensure the proper provision of standard health plan coverage.

6. Coordination with other insurance affordability programs (§600.425)

In §600.425, we proposed that a state must ensure the coordination of health care services to promote continuity of care between Medicaid, CHIP, Exchange and other state-administered health insurance programs. The state must include in its BHP Blueprint a description of how it will assure such coordination. We received the following comments on insurance affordability program coordination:

Comment: We received several comments expressing support for the requirement that a state in its Blueprint describe how it will coordinate the provision of services to ensure continuity of care between insurance affordability programs.

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

Comment: Several commenters recommended that states submit detailed coordination plans to ensure continuity of care as well as require states to specifically include “churn” mitigation strategies for pregnant women and children.

Response: We appreciate the commenters’ concerns regarding the scope and level of detail of the coordination descriptions; however, we believe that the language as proposed sufficiently addresses and incorporates the commenters concern. These descriptions will be reviewed and considered during the certification approval process thereby permitting HHS to ask additional questions as needed to ensure the state has addressed this requirement and reflected it in its Blueprint.

Comment: One commenter recommended that HHS include stronger continuity of care requirements under this section.

Response: We share the commenter’s interest in ensuring continuity of care between the insurance affordability programs. We are not, however, revising the regulation because we

believe that states have several strategies available to them to promote continuity of care and reduce disruptions in care. As such, we believe that the state should have the discretion to select the strategies that best fit within the confines of its program. Examples of how states can ensure coordination across the insurance affordability programs were included in the September 25, 2013 proposed rule (78 FR 59131).

F. Enrollee Financial Responsibilities

1. Basis, scope and applicability (§600.500)

Proposed §600.500 under subpart F specified the general statutory authority for and scope of standards proposed in this subpart, which sets forth the calculation and imposition of monthly premiums and cost sharing for BHP enrollees. For specific discussions, see the September 25, 2013 proposed rule (78 FR 59131 and 59132). We did not receive specific comments on this section and are finalizing the provision as proposed.

2. Premiums (§600.505)

In §600.505(a), we proposed that a state must assure that the monthly premiums imposed on BHP enrollees do not exceed what they would have been required to pay had he or she enrolled in the Exchange. The state must include this assurance along with several other premium requirements in its BHP Blueprint. For specific discussions on monthly BHP premiums, see the September 25, 2013 proposed rule (78 FR 59132).

We received the following comment on BHP monthly premiums:

Comment: Several commenters recommended that HHS ensure that the American Indian and Alaska Native (AI/AN) population is not at a disadvantage with respect to premiums. In the Exchange, this population receives 100 percent of the cost-sharing reduction subsidy regardless of the metal level of the QHP that the individual enrolls in. Consequently, many commenters believe that premiums, and not cost sharing, will be the primary factor when selecting QHP

coverage, which may result in many individuals in this population selecting bronze-level QHP coverage as these QHPs will have the lowest premiums. As such, commenters recommended that HHS require that states set premium levels for this population in BHP such that they do not exceed the lowest cost bronze plan premium in the state. If HHS is not able to afford this protection to the American Indian and Alaska Native population, many of the commenters requested that this population have the ability to opt out of BHP.

Response: We appreciate and understand the commenters' point regarding the premium levels for the American Indian and Alaska Native population. However, the statute does not support requiring the bronze plan premiums as a minimum standard nor does such a premium protection exist in the Exchange. We have, however, applied the Exchange's cost-sharing protections afforded to this population to BHP. We would also note that states have the flexibility to use BHP trust funds (or state funds) to lower premiums for individuals eligible for BHP, and we encourage the commenters to work with their respective states on this issue.

With respect to the commenter's second recommendation that HHS permit this population to opt out of BHP, if individuals opt out of BHP, they would not be eligible to receive federal subsidies to purchase coverage in the Exchange. The statute specifies that individuals eligible for BHP are ineligible to receive the premium tax credit and cost-sharing reductions. As noted, states may lower premiums for BHP enrollees or decide not to charge premiums.

3. Cost Sharing (§600.510)

In §600.510(a), we proposed that a state must assure compliance with the cost-sharing standards specified in §600.520(c). The state must include this assurance, along with a description of several elements as they relate to cost sharing in BHP, in the state's BHP Blueprint. For specific discussions on BHP cost sharing, see the September 25, 2013 proposed rule (78 FR 59132).

We proposed in §600.510(b) that a state may not impose cost sharing on preventive health services or items as defined in 45 CFR 147.130. We received the following comments on cost sharing in BHP:

Comment: We received comments in support of the identification of BHP enrollees subject to cost sharing.

Response: We thank the commenters for their support, and are finalizing the provisions as proposed.

Comment: We received several comments recommending that HHS establish BHP cost-sharing amounts for specific services. In particular, one commenter suggested that cost sharing for dental services should not exceed levels imposed in CHIP for children and pregnant women. Another commenter opposed higher cost-sharing amounts for non-emergency use of the emergency department.

Response: We appreciate the commenters' interest in BHP cost-sharing amounts; however, we do not believe it is advisable to mandate the cost-sharing amounts for specific services in BHP. But we note that these regulations apply to BHP the Exchange's cost-sharing protections, including the prohibition of cost sharing for preventive health services, as specified in §§ 600.510(b) and 600.520. Furthermore, providing states with discretion subject to these protections when establishing the cost-sharing levels for particular services; may encourage competition and could ultimately lower costs for BHP enrollees.

Comment: One commenter expressed concern that permitting standard health plans to include varying cost-sharing amounts for prescription drugs (that is, through the use of drug tiers) would negatively affect access to such drugs.

Response: We appreciate the commenter's concern regarding the variation in cost-sharing amounts for prescription drugs and the potential effect this may have on their

availability; however, we believe that such variation in benefit design and cost sharing is consistent with the practices of QHPs offering coverage in the Exchange. Specifically, we believe that the Exchange's benefit and cost-sharing standards, which we apply to BHP as specified in §600.405(a) and §600.520(c), afford BHP enrollees the same protections that they would have otherwise received in the Exchange. These protections serve as the minimum benefit and cost-sharing standards for states when establishing their program. In addition, states have the option to set additional limits on cost sharing not included in the final regulation.

4. Public Schedule of Enrollee Premium and Cost Sharing (§600.515)

We proposed in §600.515(a) that the state must ensure that applicants and BHP enrollees have access to information related to premiums and cost sharing under BHP. For specific discussions, see the September 25, 2013 proposed rule (78 FR 59132). We did not receive specific comments on this section and are finalizing the provision as proposed.

5. General Cost-sharing Protections (§600.520)

In §600.520(a), we proposed that a state may vary premiums and cost sharing based on income only in a manner that does not favor enrollees with higher income over enrollees with lower income. We did not receive specific comments on this section and are finalizing the provision as proposed.

We proposed in §600.520(b) that the state must ensure standard health plans meet the cost-sharing standards applicable to Indians in accordance with 45 CFR 156.420(b)(1) and (d). We did not receive specific comments on this section and are finalizing the provision as proposed.

In §600.520(c), we proposed to apply the Exchange cost-sharing standards in BHP. For specific discussions, see the September 25, 2013 proposed rule (78 FR 59132 and 59133).

We also proposed in 600.160(b) that states must permit payment of premiums for Indians by Indian tribes, tribal organizations and urban Indian organizations. In our further consideration of that provision, we determined that this protection should be more broadly extended to all premiums and cost-sharing for all beneficiaries of state and federal programs. This will ensure coordination of benefits between these programs and BHP. As such, this protection is more logically located in the regulatory section governing general cost-sharing protections. Thus, in this final rule, we are including in 600.520(d) that states must permit payment of premiums and cost sharing by such programs for individuals by Indian tribes, tribal organizations, urban Indian organizations, Ryan White HIV/AIDS programs under title XXVI of the Public Health Service Act and other federal and state programs.

We received the following comments related to cost-sharing protections:

Comment: While we received many comments supporting our proposed provision to apply the Exchange's cost-sharing standards (which establish the maximum annual limitation on cost sharing, among other provisions) to BHP, we also received several comments expressing concern that the Exchange standards would result in high BHP cost-sharing amounts making BHP unaffordable to its enrollees.

Response: We thank the commenters that submitted comments in support of the proposed cost-sharing standards, and are finalizing the proposed provisions. With respect to the other commenters' concern that BHP cost-sharing amounts will be high, we believe that the application of the Exchange's cost-sharing standards, as specified in §600.520(c), to BHP will help prevent such an occurrence. These standards afford BHP enrollees the same cost-sharing protections that they would have otherwise received had they enrolled in QHP coverage in the Exchange. Furthermore, while these protections set the minimum standards for permissible cost-sharing amounts, states have the discretion to include additional standards when contracting with

standard health plan offerors and the negotiation process with standard health plan offerors may further reduce cost-sharing amounts for BHP enrollees.

Comment: We received one comment expressing opposition to the application of the Exchange's cost-sharing standards as the commenter felt that this should be left to the discretion of the state. Approval of the state's approach to its BHP design is already subject to Secretarial approval, and as such, the commenter believes that HHS does not need to impose minimum requirements

Response: We appreciate the commenter's concern; however, statute requires that, at a minimum, the same protections individuals would have otherwise received had they enrolled in a QHP in the Exchange apply to BHP.

Comment: Several commenters recommended that BHP enrollees should not be required to pre-pay the full amount of cost sharing, including the value of the cost-sharing reduction subsidy, and seek reimbursement for the subsidy at a later date. Commenters suggested that this process be "invisible" to the enrollee.

Response: The standard health plan offered to BHP enrollees will account for the value of the cost-sharing subsidy, which will be represented by the actuarial value of the standard health plan. Specifically, standard health plans offered to individuals with household income below 150 percent of the FPL must have an actuarial value of 94 percent, which, consistent with the Exchange's standard, is subject to a de minimis standard of 1 percent. For BHP enrollees with income above 150 percent of the FPL, the actuarial value must be 87 percent which, consistent with the Exchange's standard, is subject to a de minimis standard of 1 percent. In this manner, the application of the cost-sharing reduction subsidy will be "invisible" to the BHP enrollee as it will be accounted for in the design of the standard health plan that is offered to them. Any cost-sharing amounts that the enrollees would be required to pay would already

include the consideration of the subsidy and any further negotiation between the state and the standard health plan offeror.

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

In §600.525(a), we proposed the disenrollment procedures for nonpayment of premiums. For specific discussions, see the September 25, 2013 proposed rule (78 FR 59133).

In §600.525(b), we proposed the consequences of nonpayment of premiums and reenrollment into BHP. For specific discussions, see the September 25, 2013 proposed rule (78 FR 59133).

We received the following comments on the disenrollment procedures and consequences for nonpayment of premiums:

Comment: Several commenters expressed concern that providers will incur uncompensated care costs during the second and third months of the 3-month grace period as standard health plan offerors are not required to pay claims for services rendered during the last two months of the grace period.

Response: We understand that pended claims increase uncertainty for providers and can potentially increase the amount of uncompensated care, and we share the concerns of the commenters regarding claims incurred during the grace period that are not ultimately paid. In accordance with 45 CFR §156.270(d)(3), standard health plan offerors must notify providers of the possibility for denied claims for services incurred during months two and three of the grace period for enrollees who owe past due premiums. Similar to our expectation with issuers operating in the Exchange, we expect that standard health plan offerors will provide this notice within the first month of the grace period and throughout months two and three.

Comment: We received several comments expressing concern that individuals would be disenrolled from BHP who failed to pay a de minimis amount of their premium, and suggested that the final regulation protect individuals from being disenrolled in such an instance.

Response: We do not believe that the statute provides authority for CMS to require this type of protection in BHP. As with many other programmatic designs, states have the discretion to establish disenrollment policies that further the goals and objectives of their programs which may include not terminating individuals for failure to pay de minimis amounts.

Comment: Several commenters also offered an alternative to the 30-day premium grace period. Specifically, they recommended that HHS consider permitting a reinstatement period in which an individual is able to reinstate BHP coverage without a break in such coverage by paying the premium arrears by the 20th business day.

Response: We appreciate the commenters' alternative to the 30-day premium grace period; however, in keeping with our policy to adopt policies existing in other insurance affordability programs to ensure program consistencies, we are finalizing the proposed provision. As noted elsewhere, states have the discretion to establish additional standards that best fit the designs of their programs.

Comment: We received one comment recommending that HHS only permit a 90-day premium grace period rather than give states the option to select the grace period that most closely aligns with their enrollment policies.

Response: We believe that providing states with the option to select the grace period that most closely aligns with their enrollment policies ensures program consistency and can help consumers understand program rules.

G. Payment to States

1. Basis, scope and applicability (§600.600)

Proposed §600.600 under subpart G specified the general statutory authority for and scope of standards proposed in this subpart, which sets forth provisions relating to the methodology used to calculate the federal BHP payment to a state in a given fiscal year and the process and procedures by which the Secretary establishes such amount for each state operating a BHP. For specific discussions, see the September 25, 2013 proposed BHP rule (78 FR 59133). We did not receive specific comments on this section and are finalizing the provision as proposed.

2. BHP Payment Methodology (§600.605)

We proposed in §600.605(a) the two components that comprise the BHP payment methodology – the premium tax component and the cost-sharing reduction component. For specific discussions, see the September 25, 2013 proposed rule (78 FR 59133).

In §600.605(b), we proposed the factors specified in statute that the Secretary must consider when determining the federal BHP payment methodology. For specific discussions, see the September 25, 2013 proposed rule (78 FR 59133 and 59134).

We proposed in §600.605(c) that the Secretary will adjust the payment methodology on a prospective basis.

We received the following comments regarding the BHP payment methodology:

Comment: We received a comment supporting the relevant factors included in the BHP payment methodology as specified in §600.605(b).

Response: We thank the commenter for their support, and are finalizing the proposed provisions.

Comment: One commenter expressed concern that the information regarding the BHP payment methodology in the proposed rule did not address how a state's BHP could be

financially self-sustainable, such as the authority to assess an administrative charge on standard health plan offerors.

Response: We appreciate the commenter's concern; however, we believe that the state has considerable flexibility to ensure the sustainability of its program through program design and market competition. In addition to the federal BHP deposits, the state has the option to also supplement its program with non-federal funding sources.

Comment: We received many comments requesting that HHS reconsider applying 100 percent of the cost-sharing reduction that would have been available in the Exchange to the BHP payment methodology, as opposed to 95 percent. Many commenters argued that the statute provides for this interpretation given the placement of the comma in section 1331(d)(3)(i) of the Affordable Care Act.

Response: We appreciate the commenters' concern regarding this issue, and we have carefully considered and reviewed the commenters' arguments. We have interpreted the 95 percent specified in statute to refer to both the premium tax credit and the cost-sharing reduction component of the BHP payment methodology. We believe that applying the 95 percent to both components of the methodology represents the best reading of the statute and the intent of the drafters, and we are therefore finalizing the proposed provision.

Comment: We received a comment recommending that the premium tax credit component of the methodology use an overall average for the state so that all geographic variations are accounted for in the calculation rather than over-weighting geographic areas with fewer individuals receiving the premium tax credit.

Response: We appreciate the commenter's suggestion; however, geographic variations are accounted for in the proposed payment methodology as we are proposing to use the second lowest cost silver plan premium, which may vary in amount by county, as the basis for the

calculation of the premium tax credit component. Please refer to the final 2015 BHP Federal Funding Methodology for additional information on how we propose to calculate the premium tax credit component for program year 2015.

Comment: One commenter expressed concern that the BHP payment methodology will result in narrower provider networks as states will only receive 95 percent of both the premium tax credit and cost-sharing reduction that an individual would have otherwise received had he or she enrolled in a QHP in the Exchange.

Response: We appreciate the commenter's concern, although we do not agree that this is necessarily the result. States, for example, that combine their contracting for BHP with Medicaid and/or CHIP will have significant market power to drive efficiencies. In any event, network adequacy is essential, and we have required, as specified in §600.410(e)(2), that network adequacy must be considered during the state's competitive contracting process. States must ensure that standard health plan offerors have a network of providers sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area of the standard health plan, at least consistent with the access standards under Medicaid or the Exchange.

Comment: We received comments asserting that, to the extent that BHP eligibility exceeds the scope of eligibility for a PTC because the affordability test applied under BHP is less stringent than the affordability test for PTCs, there could be an unfunded mandate. These commenters explained that because federal BHP payment is limited to 95 percent of the amount of the PTCs and cost sharing reductions that would be paid if the individual was enrolled in coverage through the Exchange, there would be no federal BHP payment with respect to individuals eligible for BHP but not eligible for a PTC. One commenter suggested that, in light of the absence of funding, states should be given the option to restrict eligibility.

Response: We understand the possibility raised by the commenters; however, as discussed in the eligibility section above, we believe this possibility was created through a statutory error which we are correcting in this rule. We believe congressional intent was to align BHP eligibility seamlessly with premium tax credit eligibility, which eliminates the possibility of an unfunded mandate. The payment methodology has been aligned with this interpretation.

Comment: We received several comments requesting that HHS ensure that BHP payment methodology adequately address the issue of risk adjustment.

Response: Please refer to the final 2015 BHP Federal Funding Methodology for additional discussions related to the population health factor in the BHP payment methodology for program year 2015, as well as the optional risk adjustment reconciliation process as both sections in the Funding Methodology address the issue of risk adjustment.

Comment: One commenter requested that we include the relevant factors, their weight and applicability in the proposed payment notice.

Response: We have included additional detail on the relevant factors, including their values and data sources, in the final 2015 BHP Federal Funding Methodology.

Comment: Several commenters recommended that the BHP payment methodology include state-specific market factors to account for issues such as low premiums offered in the Exchange.

Response: Please refer to the final 2015 BHP Federal Funding Methodology for additional details on the option we are providing to states to use either 2014 premium data (trended forward) or actual 2015 premium data as the basis for calculating their 2015 federal BHP payment rates.

Comment: One commenter noted that the methodology specifies the use of factors much like those for adjusted community rating, but requested clarification whether that standard health plan offeror must also use adjusted community rating, or any other particular form of rating.

Response: We believe that this is an issue to be determined, and resolved, through the competitive contracting process between the state and the standard health plan offeror. There are minimum negotiation criteria and other considerations specified in statute that the state must include in its process; however, the state has the discretion to add additional qualifications and standards to its solicitation that would further the objectives of its program.

Comment: While we received several comments in support of the proposed provision to exclude BHP from the individual market's risk pool, other commenters requested that HHS consider providing states with the option to include BHP in its individual market's risk pool. Commenters also requested the HHS permit states to have the ability to apply aspects of the individual market's reinsurance and risk adjustment programs to BHP.

Response: We have carefully considered this issue and have determined that BHP should be excluded from the individual market because the market reform rules under the Public Health Service Act that were added by Title I, Subtitles A and B of the Affordable Care Act, such as the requirements for guaranteed issue, and premium rating do not apply to standard health plans participating in BHP. Moreover, in accordance with 45 CFR 153.234 and 45 CFR 153.20, standard health plans operating under a BHP are not eligible to participate in the reinsurance program and the federally-operated risk adjustment program. With respect to the risk corridor program, the statute, under section 1342 of the Affordable Care Act, precludes standard health plans from participation. To the extent that a state operating a BHP determines that, because of the risk-profile of its BHP population, standard health plans should be included in mechanisms that share risk, the state would need to use other methods for achieving this goal. But we are

providing an opportunity in 2015 for states to elect to include in the BHP federal payment methodology a retroactive adjustment to reflect the effect of the different health status of the BHP population on PTC and CSRs if the BHP population had been enrolled in coverage through the Exchange, and we will consider in future years whether data supports a prospective adjustment.

Comment: Several commenters requested clarification regarding a state's ability to implement a risk corridor-like mechanism in BHP.

Response: We appreciate the commenters' interest in the implementation of risk corridors in BHP; to the extent that a state operating a BHP determines that, because of the risk-profile of its BHP population, standard health plans should be included in mechanisms that share risk, the state would need to establish state-specific methods for achieving this goal. Because section 1342 of the Affordable Care Act specifically limits the risk corridor program to QHPs, standard health plans operating under BHP are not eligible to participate.

3. Secretarial Determination of BHP Payment Amount (§600.610)

We proposed in §600.610(a) that each year in October the Secretary will publish the BHP payment methodology for the upcoming program year in a proposed payment notice in the **Federal Register**. We did not receive specific comments on this section and are finalizing the provision as proposed.

In §600.610(b), we proposed that the Secretary will publish the final BHP payment methodology and BHP payment amounts annually in February in a **Federal Register** notice. We did not receive specific comments on this section and are finalizing the provision as proposed.

We proposed in §600.610(c) that states will receive a prospective aggregate BHP payment amount on a quarterly basis. For specific discussion, see the September 25, 2013 proposed rule (78 FR 59135).

We received the following questions related to the quarterly prospective BHP payment deposits:

Comment: We received several comments expressing support for the proposed provision to make quarterly prospective deposits into a state's BHP trust fund and for not making any retrospective adjustments that could cause a state to have to return federal BHP funding.

Response: We thank commenters for their support. We generally do not anticipate making any retrospective adjustments in the certified per enrollee payment methodology that would cause a state to return federal BHP funding. But we would provide for retrospective adjustments to ensure that this methodology is applied based on actual enrollment. To the extent that actual enrollment is lower than the state's projected enrollment, CMS will reduce the state's next quarterly BHP deposit by the difference amount. Another instance in which a retrospective adjustment may occur is if a mathematical "error" was made during the calculation process. For specific discussions on what constitutes a mathematical "error," please refer to the September 25, 2013 proposed notice (78 FR 59134). Finally, to the extent that the prevailing BHP funding methodology for a given program year permits adjustments to a state's BHP payment amount due to insufficient data that is necessary for the Secretary to prospectively determine the relevant factors specified in the payment notice, retrospective adjustments to the state's BHP payment amount may occur. For example, in light of the absence of any data in 2015 to prospectively take into account variance of the BHP population health status from the Exchange population, in the accompanying final payment methodology for 2015, we permit a state to elect to develop a protocol to support a retrospective adjustment for this factor.

Comment: We received several comments requesting clarification on the timing of the deposits, as well as when any necessary adjustments in payment are to be made based on differences between actual and projected enrollment numbers. Some commenters also expressed

concern that data used to determine some of the factors included in the payment methodology would negatively affect payment to states.

Response: We anticipate providing future guidance on the specific timeframes for deposits made to state BHP trust funds; however, we anticipate that deposits will be made at the beginning of each fiscal year quarter assuming the state has submitted its projected enrollment data at least 60 days prior to the beginning of each fiscal year quarter. For example, the deposit for fiscal year quarter one would occur on October 1st using enrollment data submitted by the state by July 31st. As stated in §600.620(c)(2)(i), a retrospective adjustment will be made 60 days after the end of each fiscal year quarter to account for any differences between projected and actual enrollment.

With respect to the commenters' concerns regarding the potential effect on the timing of payment and the release of data needed to calculate the factors included in the BHP payment methodology, we are generally not making any retrospective adjustment to the BHP payment methodology in a given year unless the payment notice specifies the availability of a retrospective adjustment due to the lack of sufficient data necessary for the Secretary to prospectively determine one or more relevant factors in the BHP funding methodology. We anticipate using new data, or adjustments to previously released data, to refine future prospective BHP funding methodologies, which will be published annually through a proposed notice process.

Comment: We received several comments recommending that after the first or second year of BHP implementation, HHS adjust the aggregate federal BHP payment amounts upward should actual experience support such an adjustment. Commenters felt that such an adjustment would be similar to a risk corridor approach.

Response: We appreciate the commenter's concern, and have addressed the issue raised by the commenters in further detail in the Final BHP Federal Funding Methodology for Program Year 2015. As described in greater depth in the final methodology, we are providing states with the option to propose, and implement, a retrospective adjustment protocol to the extent that such a protocol is approved as part of the certified payment methodology by the CMS Chief Actuary

Comment: We received several comments requesting clarification on the proposed retrospective adjustments. One commenter recommended that HHS revise language in the regulation text to clarify that HHS will not make retrospective adjustments to a state's quarterly deposit based on enrollee income changes.

Response: As explained elsewhere, HHS will not make any retrospective adjustments to a state's quarterly deposit except for in three instances. The first instance in which HHS will adjust the payment is in the event that a mathematical error occurred during the calculation of the payment amount. For example, if HHS multiplied the payment rate to the incorrect number of enrollees associated with that payment rate, HHS would then make a retrospective adjustment to correct the mathematical error. The second instance occurs when there is a difference in projected and actual enrollment for a given fiscal year quarter. For example, if the state projected that there would be 10,000 enrollees in payment rate cell A, but enrollment in payment rate cell A was actually 12,000, HHS would add the additional federal funds to the state's upcoming quarterly deposit to account for the difference between the projected and actual enrollment. Finally, the third instance occurs only when the prevailing payment notice in a given program year permits retrospective adjustment to a state's BHP federal payment amount to the extent that data necessary for the Secretary to prospectively determine the relevant factors included in the BHP funding methodology was not available. We believe that the regulation text at §600.605(c) and revised §600.610(c)(2) sufficiently describes this policy.

4. Deposit of Federal BHP Payment (§600.615)

In §600.615, we proposed that HHS will make a quarterly deposit into a state's trust fund based on the aggregate quarterly payment amount described in §600.610(c). We did not receive specific comments on this section and are finalizing the provision as proposed.

H. BHP Trust Fund

1. Basis, scope and applicability (§600.700)

Proposed §600.700 under subpart G specified the general statutory authority for and scope of standards proposed in this subpart, which sets forth a framework for BHP trust funds and accounting, establishing sound fiscal policies and accountability standard and procedures for the restitution of unallowable BHP trust fund expenditures. For specific discussions, see the September 25, 2013 proposed rule (78 FR 59135). We did not receive specific comments on this section and are finalizing the provision as proposed.

2. BHP Trust Fund (§600.705)

In §600.705(a), we proposed requirements for the BHP trust fund, including where to establish the trust fund and the identification of trustees and their authorities.

We proposed in §600.705(b) that states may deposit non-federal funds into its BHP trust fund; however, once deposited, those funds must meet the standards described in paragraphs (c) and (d) of this section.

In §600.705(c), we proposed that trust funds may only be used to reduce premiums and cost sharing and/or provide additional benefits to individuals eligible for BHP.

We proposed in §600.705(d) the limitations in expending BHP trust funds. For the specific limitations, see the September 25, 2013 proposed rule (78 FR 59150).

In §600.705(e), we proposed that a state may maintain a surplus of funds in its trust through the carryover of unexpended funds from year-to-year. We received a comment

supporting this provision, and are subsequently finalizing the provision as proposed. We received the following comments related to the BHP trust fund:

Comment: We received several comments in general support of using BHP trust funds, as specified in §600.705(c), to further reduce premiums and cost sharing and to provide additional benefits to individuals eligible for BHP.

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

Comment: One commenter requested clarification on the establishment of the state's BHP trust fund. Specifically, the commenter requested that the BHP trust fund be established at either an independent entity or in a segregated account within a state's fund structure rather than in a subset account to the state's general fund. The commenter indicated that there are sufficient legal boundaries through various state laws with respect to the integrity of federal funding streams.

Response: We appreciate the commenter's suggestion, and have clarified the language in the final rule to reflect the suggested language change.

Comment: We received a comment requesting that HHS further clarify the role of BHP trustees.

Response: There are two fundamental activities required of the BHP trustees. One is to provide trust fund oversight to ensure that trust fund expenditures are made in an allowable manner, and the second is to specify individuals with the authority to make withdrawals from the fund to make allowable expenditures. The state, as specified in §600.110(a)(12), must describe any additional responsibilities, outside of these two activities, that the trustees may have. Specifically, §600.110(a)(12) requires the state to describe the process by which the trustees will be appointed, the qualifications used to determine trustee appointment, and any arrangements

used to insure or indemnify such trustees against claims for breaches of their fiduciary responsibilities.

Comment: One commenter requested clarification that BHP trust funds are available to reduce premiums for American Indians and Alaska Natives.

Response: Yes. The state has the option to further reduce premiums for eligible BHP enrollees that are American Indian and Alaska Natives with its trust funds. This is a permissible expenditure.

Comment: Several commenters expressed support for the limitations on BHP trust fund expenditures; however, some emphasized that it was important to ensure that the limitations are applied consistently across functions and organizations.

Response: We appreciate the commenters' support, and are finalizing the proposed provisions.

Comment: We received many comments expressing concern regarding the limitations on the use of BHP trust funds. Specifically, commenters requested that HHS permit trust funds to pay for program implementation and start-up costs as well as for administrative costs. Commenters argued that without the authority to use trust funds to pay for implementation and administrative costs, states would not be able to implement BHP. We received one comment requesting that HHS provide states with options for paying administrative costs, including some of the user-fee assessments built into the Exchange carrier rates. Another commenter suggested that HHS develop a funding formula similar to Medicaid, or set a "flat fee" to pay for administrative costs.

In addition, several other commenters also expressed concern that these limitations do not permit states to finance consumer assistance programs with BHP trust funds, or promote

payment innovations, quality improvement activities or pay-for-performance incentives under BHP.

Response: We understand the concerns that the commenters have raised with respect to the use of trust funds to cover administrative costs; however, the statute prohibits the expenditure of BHP trust funds for any activities except for lowering premiums and cost sharing and providing additional benefits to individuals eligible for BHP. Through its competitive contracting process, a state can establish parameters for quality improvement projects and delivery system and payment reform innovations that it believes will further the objectives of its BHP. The state can then evaluate the innovation proposals submitted by standard health plan offerors in their BHP bids thereby including the negotiated projects into the contract awards.

While the statute has limited the use of federal trust funds to lowering premiums and cost sharing as well as for the provision of additional benefits, states have the option to establish sources of non-federal funding to help offset administrative costs associated with BHP. Non-federal resources can include assessments imposed on BHP participating plans. A state with a state-based Exchange has the ability to apply a portion of the fee assessed to QHPs in its Exchange to BHP; however, this ability does not extend to states in which the Federally-Facilitated Exchange is operating. In accordance with OMB Circular No. A-25 Revised (Circular No. A-25R), which establishes federal policy regarding user fees, the Federally-Facilitated Exchange user fee is collected from issuers to recover the cost to the federal government of providing special benefits to QHP issuers participating in a Federally-Facilitated Exchange; those funds are not available to fund BHP as it is not a special benefit provided to issuers by the federal government. Non-federal resources can either remain outside of the BHP trust fund, such as in a state's General Fund, or be deposited into the BHP trust fund. Should the state deposit these non-federal funds into the state's BHP trust fund, all standards applied to federal sources of

funding will also apply to the non-federal funds. While we are finalizing our proposed provision, we will continue to review this issue and publish additional guidance upon concluding our review.

Comment: One commenter requested that we clarify whether enrollee premiums collected outside of the trust fund are subject to the limitations in §600.705(d).

Response: If enrollee premiums are not deposited into the state's trust fund, then they are not considered to be BHP trust funds and are therefore not subject to the limitations specified in §600.705(d).

3. Fiscal Policies and Accountability (§600.710)

We proposed in §600.710(a) that the state maintain an accounting system and supporting fiscal records to assure the proper use of BHP trust funds. We did not receive specific comments on this section and are finalizing the provision as proposed.

In §600.710(b), we proposed that the state obtain an annual certification certifying the proper expenditure and maintenance of BHP trust funds. For the specific certification elements, see the September 25, 2013 proposed rule (78 FR 59150).

We proposed in §600.710(c) that the state conduct an independent audit of BHP trust funds over a 3-year period to determine whether the expenditures during this period were allowable. For specific standards of this audit, see the September 25, 2013 proposed rule (78 FR 59150). We did not receive specific comments on this section and are finalizing the provision as proposed.

In §600.710(d), we proposed that the state publish an annual report on the use of funds. We did not receive specific comments on this section and are finalizing the provision as proposed.

We proposed in §600.710(e) that the state establish and maintain BHP trust fund restitution procedures. We did not receive specific comments on this section and are finalizing the provision as proposed.

In §600.710(f) we proposed that the state maintain records for 3 years from the date of submitting its final expenditure report. We did not receive specific comments on this section and are finalizing the provision as proposed.

We proposed in §600.710(g) that the state retain all records beyond the 3-year retention period in the event litigation begins prior to the expiration of the retention period. We did not receive specific comments on this section and are finalizing the provision as proposed.

We received the following comment regarding the annual certification process in §600.710(b):

Comment: We received several comments requesting that HHS require that the annual certification include a certification that the payment rates made to the standard health plan offerors are actuarially sound.

Response: As noted in the contract requirements section, the statutory actuarial soundness requirement found in Medicaid does not apply in BHP; therefore, we are not requiring that a state certify that its standard health plan offeror rates are actuarially sound. We anticipate that the competitive contracting process will help to ensure that the rates paid to the standard health plan offerors are reflective of the costs associated in the provision of standard health plans.

4. Corrective Action, Restitution, and Disallowance of Questioned BHP Transactions (§600.715)

In §600.715(a), we proposed that a state review and develop written responses to questions identified concerning the authority for BHP trust fund expenditures. To the extent

necessary, the state shall implement changes to fiscal procedures to ensure proper use of BHP trust funds. We did not receive specific comments on this section and are finalizing the provision as proposed.

We proposed in §600.715(b) that state must ensure restitution to its BHP trust fund such funds that have not been properly spent. We did not receive specific comments on this section and are finalizing the provision as proposed.

In §600.715(c), we proposed that the restitution period may not exceed a 2-year period, and that restitution may occur in a lump sum amount, or in equal installment amounts. We did not receive specific comments on this section and are finalizing the provision as proposed.

We proposed in §600.715(d) that HHS may disallow the improper BHP trust fund expenditures in the event that no restitution has been made back to the state's trust fund. For specific discussions on the disallowance procedures, see the September 25, 2013 proposed rule (78 FR 59151). We did not receive specific comments on this section and are finalizing the provision as proposed.

In §600.715(e), we proposed the administrative reconsideration procedures in the event of a disallowance. For specific discussions on such procedures, see the September 25, 2013 proposed rule (78 FR 59151).

We proposed in §600.715(f) that disallowed federal BHP funding must be returned to HHS within 60 days after the disallowance notice, or the final administrative reconsideration upholding the disallowance. Such repayment cannot be made from BHP trust funds. We did not receive specific comments on this section and are finalizing the provision as proposed.

We received the following comments on the administrative procedures in the event of a disallowance of questioned BHP transactions:

Comment: We received a comment requesting clarification on the administrative process for reconsideration. The commenter suggested that HHS consider using either the Medicaid procedures found in 42 CFR 430.42(f) for disallowances, or the procedures at 42 CFR 430.38 which provides for judicial review without further administrative process.

Response: We appreciate the commenter's suggestions; however, given the numerous processes available to the state prior to the corrective action stage, we believe that requiring the additional administrative reconsideration procedures found in 42 CFR 430.42(f) or in 42 CFR 430.38 is unnecessary. Therefore, we are finalizing the proposed provisions.

Comment: We received several comments in general support of the proposed provisions as they relate to benefits, premiums, cost sharing and expanding coverage to low-income individuals.

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

Comment: Several commenters expressed support for the various market reforms authorized under the Affordable Care Act, such as the ability to remain on a parent's health insurance policy and the expansion of health insurance coverage to all those that are uninsured.

Response: While we appreciate the support for these important reforms, this comment is beyond the scope of this rulemaking.

Comment: We received one comment requesting more information on BHP in order for states to decide whether to implement the program.

Response: We hope that the clarifications provided in this rulemaking as well as the BHP Final Federal Funding Methodology for program year 2015 have provided sufficient information for states during their decision making process. We also anticipate continuing to

work closely with states as they contemplate their options and responding in writing to questions posed about implementation.

Comment: We received several comments on how, and when, individuals can enroll in BHP.

Response: States that elect to implement a BHP will determine the effective date for their programs, which will be no earlier than January 1, 2015. As indicated in §600.145, initial implementation in 2015 may involve an alternate enrollment strategy as a transition to BHP operation. In order to enroll, individuals must complete the single streamlined application and be determined eligible for a state BHP. As discussed elsewhere in these regulations, states have the option to use a limited open enrollment period approach or to allow applications to be submitted throughout the year.

Comment: One commenter requested that HHS delay the implementation of BHP until January 1, 2017 in order to provide the Exchange sufficient time to ensure efficient and effective operability before additional coverage programs are launched.

Response: We appreciate the commenter's interest in ensuring the operability of the Exchange. We are committed to ensuring the availability of this insurance affordability coverage option to states effective January 1, 2015. To comply with BHP requirements, however, states will need to coordinate the BHP with Exchange, Medicaid and CHIP. As the commenter noted, in determining an implementation date, states need to consider the time and resources needed to achieve such coordination by January 1, 2015.

Comment: Several commenters expressed interest in how BHP will affect costs associated with emergency department care. Specifically, commenters hoped that BHP would reduce such costs.

Response: We share the commenters' interest in lowering the costs associated with emergency department care. Although this comment is beyond the scope of this rulemaking, we will be interested to observe the impact of BHP over time.

Comment: One commenter recommended that HHS design BHP in such a fashion as to ensure appropriate coverage for children who may lose CHIP coverage in the event that CHIP is not authorized in 2019.

Response: We appreciate the commenter's recommendation. We believe that the BHP statute provides states with a vehicle to provide such coverage without any change in design or administrative requirements.

Comment: We received several comments expressing concern that the implementation of BHP will increase the temporary shifting of low-income individuals from one insurance affordability program to another ("churn").

Response: While BHP does introduce an additional insurance affordability program, the amount of churn is not clear at this time. It is our understanding that many states and other observers believe that BHP will reduce churn between BHP and Medicaid. Regardless of how a state might establish its BHP, as specified in §600.425, states are required describe how they will ensure coordination for the provision of health care services to promote enrollee continuity of care among the insurance affordability programs. In addition, and as described further above, another feature in BHP that can promote continuity of coverage and care is the provision specified in §600.340 permitting states to adopt a policy of limited redeterminations during a 12 month period, reducing churn based on fluctuations in income..

Comment: Several commenters expressed concern regarding the effect of BHP on Exchange enrollment as well as the risk profile of those enrolled in Exchange coverage.

Response: Because the BHP population is the lower income range of the population that would otherwise be enrolled in coverage through the Exchange, states that elect to implement BHP will experience somewhat lower enrollment in coverage through the Exchange. We do not believe the reduction will impair the Exchange's ability to operate effectively. With respect to the commenters' concerns on the Exchange's risk profile, it is unclear at this time the effect BHP will have (that is, whether healthier, or sicker, individuals will enroll in BHP relative to those enrolled in the Exchange). We anticipate that this will be the subject of research once all of the programs are operational.

Comment: We received one comment requesting that standard health plan offerors be subject to the annual insurer fee.

Response: The annual insurer fee is administered by the Department of the Treasury and its applicability is beyond the scope of this rulemaking.

IV. Provisions of the Final Regulations

For the most part, this final rule incorporates the provisions of the proposed rule. Those provisions of this final rule that differ from the proposed rule are as follows:

A. General Provisions and Definitions

We have amended §600.5 to add two new definitions: interim certification and network of providers to reflect clarifications made in subsequent sections of this final rule.

We have clarified, in this section, the definition of Essential Health Benefits to include the citation to the implementing regulations.

We have clarified in the reference plan definition that "reference" is synonymous to "base" benchmark by adding the word "base."

B. Establishment and Certification of State Basic Health Programs

We are amending §600.110(a)(6) to clarify the BHP Blueprint content to align with the premium standards specified in §600.505.

We are adding §600.110(a)(15) to conform with a later change to §600.145. The change adds a requirement for the inclusion of a transition plan as a required element of the Blueprint if a state participating in 2015 plans to propose an alternative enrollment strategy. Additionally, the transition plan must include a plan for the coordination of any proposed implementation strategies with the Exchange operating in the state.

We amended § 600.110(c) to include the requirement that HHS post revisions to Blueprints on line.

We amended §§600.115(c)(1) and 600.125(a) clarifying that significant change includes changes that alter the BHP benefit package, enrollment, disenrollment and verification policies.

To conform the addition of an interim certification level, we amended §600.115(a) and (d) as well as §600.120(a) and (b). To §600.115(a) we added the sentence, “A State may choose to submit its BHP Blueprint in two parts: the first limited submission to secure interim certification and the second full submission to secure full certification.” To §600.115(d) we added the word “full” to indicate that states must receive full certification to implement a program. To §600.120(a) we clarified that the effective date of interim certification is also the date of signature of the Secretary, and to §600.120(b) we clarified that full certification is needed before payments may be made.

We further amended §600.115(d) to require states implementing after 2015 to coordinate with open enrollment of the state’s Exchange.

We amended §600.120(d) by deleting the word “contingencies”.

We added §600.135(c) to require HHS to accept a state request for reconsideration and to provide an impartial review against the certification standards if requested. We also extended

the state's ability to request reconsideration for termination decisions made by the Secretary in §600.142.

We added §600.145(e) providing states implementing BHP in 2015 the opportunity to create a transition plan for approval delineating any proposed alternative enrollment strategies.

We amended §600.150(a)(5) to include a minimum timeliness standard of at least quarterly regarding standard health plans provision of updated provider lists.

We amended §600.155 to remove the qualifying language "State or Federal" describing the tribal consultation policy.

We amended §600.160 to include a new paragraph (c) prohibiting BHP offerors from reducing the payments to providers by the amount of cost-sharing that would be due from Indians if it was not prohibited. Additionally, we are amending §600.520 to add paragraph (d) incorporating and broadening the protection set forth in the proposed rule at §600.160(b), to require that states permit payment of premiums and cost-sharing for individuals in Indian tribes, tribal organizations, urban Indian organizations, Ryan White HIV/AIDS programs, and other federal and states programs. We have renamed the proposed paragraphs to reflect these changes.

We have amended the timeliness standard in §600.170(b) to be 60 days after the end of each operational year for the submission of the state's required annual report.

C. Federal Program Administration

We amended the section title to "Federal program compliance review and audits" to better represent the nature of this section.

In §600.200(b)(3) we made an editorial revision to add the word "add" to the paragraph.

We amended §600.200(b)(4) by clarifying that the standards of review during federal program reviews and audits for the improper use of BHP trust funds are the provisions specified in §600.705.

We amended §600.200(c) to clarify that all paragraphs, and not only paragraph (a), under §430.33 apply. We have also clarified the language in this paragraph to clarify the timing of the final report and state opportunity for correction.

D. Eligibility and Enrollment

We amended §600.305(a)(1) to limit it to requiring residency.

We amended §600.305(a)(2) to clarify that lawfully present non-citizens, ineligible for Medicaid, must have household income between zero and 200 percent of the FPL. We further clarified this standard by changing “non-citizen” status to “immigration” status to increase technical accuracy and we clarified that a person may also be ineligible for CHIP due to immigration status.

We amended §600.305(a)(3) by removing the word “affordable” to more closely reflect the underlying statutory language connecting affordability to employer sponsored insurance. We also added a parenthetical to conform to our definition of MEC, clarifying that an individual may not have access to MEC other than a standard health plan.

We deleted the reference to CHIP in §600.305(a)(3)(i) and have limited the proposed reference to “such other programs” only to Medicaid to conform with Department of Treasury rules on MEC.

We changed the parenthetical in §600.305(a)(3)(ii) to tie the definition of affordable employer sponsored insurance to section 36B(c)(2)(C) of the Internal Revenue Code.

We amended §600.305(b) to provide a conforming exception for a change made in §600.145 permitting states to submit a transition plan in certain circumstances.

We amended §600.310(b) to include the requirements of §435.907(g) of this chapter regarding accessibility of written applications in addition to the other standards of accessibility for individuals with limited English proficiency and individuals with disabilities.

We amended §600.320(a) to clarify that states permitting local government entities to make eligibility determinations do so through delegation.

We amended §600.320(c) to be exclusive of §435.915(a).

We amended §600.320(d) to clarify the Medicaid choice of enrollment as being “continuous open enrollment throughout a year” and the Exchange choice of enrollment policy as being no “more” restrictive than that used by the Exchange.

We have amended §600.335(b) to give the states the choice of following the appeals process or either Medicaid or the Exchange.

We amended §600.340(a) to remove the reporting requirement exception clause “Except as provided in paragraph (d)” because paragraph (d) did not include reporting requirements.

We added language to §600.340(b) to clarify that the opportunity to change plans must be offered “at least annually,” and that enrollees in plans that are no longer available will be given a reasonable opportunity to select a new plan.

Finally, we have added §600.340(f) to offer states the option of not redetermining eligibility for a 12-month period as long as enrollees are under age 65, are not otherwise enrolled in MEC and remain residents of the state. Additionally, we have further amended §600.340(a) to draw the distinction between it and the new paragraph (f). We have replaced the proposed language that an individual is “determined eligible for a period of” with “subject to periodic review of eligibility every” 12 months.

E. Standard Health Plan

We are amending §600.415(a) to clarify that a state can contract with an entity for one standard health plan rather than contracting with at least two or more standard health plans. This clarification is needed to conform to the changes made in §600.420 regarding choice of standard

health plan offeror. Ensuring choice of standard health plan offeror is a beneficiary protection not a contracting issue, and not related to the eligibility of the offeror; therefore, we have removed the reference to choice in this paragraph.

We are amending §600.415(e)(2) to clarify that a state must consider the local availability and access to providers to ensure a sufficient number, mix and geographic distribution to meet the needs of enrollees in a service area, including but not limited to services provided by essential community providers as defined in 45 CFR 156.235 so that access to services is least be sufficient to meet the access standards applicable under 42 CFR Part 438, Subpart D, or 45 CFR 156.230 and 156.235.

We are amending §600.420(a)(1) to clarify that a state must ensure choice of at least two standard health plan offerors. We are also amending this section to clarify that the state must assure to choice of standard health plan offeror and that this assurance be reflected in the state's BHP Blueprint along with a description of how it will further enrollee choice of standard health plans.

We are also adding a new paragraph to §600.420(a) to provide an exception to the choice of standard health plan offeror requirement set forth in paragraph (a)(1). This new paragraph provides the procedural steps for a state to submit a request for such an exception.

We are adding a new paragraph to §600.420(b) to clarify that a state entering into a regional compact with another state for the provision of a geographically specific standard health plan must assure that enrollees, regardless of residency within the state, continue to have choice of at least two standard health plans. This new requirement is specified in §600.420(b)(2).

We are amending §600.420(b)(3)(ii)(A) to clarify that a state entering into a regional compact for the provision of a geographically specific standard health plan, must continue to

assure that enrollees, regardless of location, continue to have choice of at least two standard health plan offerors.

In §600.425, we have revised the regulatory text to clarify that the state must ensure coordination between all other insurance affordability programs. We are also clarifying that the state's BHP Blueprint must describe how it will ensure such coordination.

F. Enrollee Financial Responsibilities

We are amending §600.505(a) to clarify the premium requirements that the state must assure to and that such an assurance must be included in the state's BHP Blueprint along with the other requirements specified in §600.505(a)(2).

In §600.510(a), we are clarifying the cost-sharing requirements that the state must assure to and that such an assurance must be included in the state's BHP Blueprint along with the other requirements specified in §600.510(a)(2).

We have added §600.520(d) to broaden the protection in the proposed rule under §600.160(b) as described above and we have modified §600.510(a)(ii) to reflect the inclusion of the new paragraph (d).

We are amending §600.525(a) to clarify that the state must assure that it is in compliance with the disenrollment procedures described in 45 CFR 155.430. We are also clarifying that this assurance is reflected in the state's BHP Blueprint.

G. Payments to States

We are amending §600.605(c) to clarify 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 that to the extent that necessary data is available for the Secretary to prospectively determine all relevant factors, as specified in paragraph (b) of this section.

We are adding new paragraph §600.610(c)(2)(iii) to reflect that to the extent that the final payment notice permits retrospective adjustments to the state's BHP payment amount (due to the lack of necessary data for the Secretary to prospectively determine the relevant factors comprising the premium tax credit and cost-sharing reductions components 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)(iv) of this section, which was previously (c)(2)(iii).

H. BHP Trust Fund

In §600.705(a), we have amended this provision by deleting the option for the state to establish its BHP trust fund in a subset account within its General Fund and replaced it with the option to establish it in a segregated account within the state's fund structure to provide states with the opportunity to utilize state financial management services while maintaining accountability. The option to establish the trust fund at an independent entity remains. We believe this change will provide states with more flexibility given the unique features each state may have in its accounting and fiscal structures.

We are amending §600.710 to clarify that the state must assure to the fiscal policies and accountability standards set forth in that section. We are also clarifying that this assurance must be reflected in the state's BHP Blueprint.

V. Collection of Information Requirements

The information collection requirements/burden that were set out in the September 25, 2013, proposed rule estimated one respondent per year. Based on comments received, we continue to estimate one respondent in this final rule. Since we estimate fewer than the Paperwork Reduction Act's 10 respondent per year threshold, the information collection

requirements/burden that are associated with this final rule are not subject to the requirements of the Paperwork Reduction Act (5 CFR 1320.3(c)).

VI. Regulatory Impact Statement

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. The effects of this rulemaking will be “economically significant” as measured by the \$100 million threshold, and hence a major rule under the Congressional Review Act. We did not receive any public comments on the impact analysis section of the proposed rule. We received a variety of comments from six states on other sections of the rule. These comments did not provide further information that would contribute to the assessment of economic impact. We have received a solid commitment of participation from one state and we expect that a mid-range participation estimate over the first 5 years would be 3 states. In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

The aggregate economic impact of this rule of this final rule is estimated to be -\$900 million from CY 2015 to 2019 (measured in real 2015 dollars). The federal government is expected to reduce its overall expenditures, as the payments to the states for BHP are anticipated to be less than the payments that would have been made to qualified health plans (QHPs) for PTCs and CSR, if persons had been enrolled in those plans instead of in BHP. In general, we expect that federal payments to states for BHP would be 5 percent less than the federal payments for PTCs and CSR to QHPs if persons had been enrolled in those plans through the exchange.

CMS’ Office of the Actuary (OACT) developed estimates for the impact of this section of the Affordable Care Act, which were initially published in April 2010, (https://www.cms.gov/ActuarialStudies/downloads/PPACA_2010-04-22.pdf). These estimates are consistent with the assumptions and projections in the President’s FY 2014 Budget. In particular, these estimates rely on many of the same data and assumptions used to project the federal costs related to the health insurance Exchanges. (The original estimates that appeared in

the April 2010 estimates were based off of the President's Fiscal Year 2010 Budget Mid-Session Review.)

To determine the impact of BHP on federal expenditures, OACT developed estimates of the number of persons who would enroll in BHP if the program were implemented in all states. In general, this estimate was based on projections of the number of people who would be eligible for BHP based on their household income and other eligibility criteria, and the number of people who would enroll in BHP. The percentage of people who would enroll in BHP among those eligible is affected by estimates of the likelihood of persons having other forms of health insurance (in particular, for persons who have employer sponsored insurance) and the estimated participation rate of those without other forms of coverage. The participation rate may be affected by a number of factors, which include the health status and expected health care costs of eligible persons (in general, persons with higher expected health care costs are assumed to be more likely to enroll), the cost to the enrollee for participating (in general, lower premiums and fewer cost sharing requirements are assumed to lead to greater participation), and the effectiveness of enrollment systems and outreach efforts. These assumptions are consistent with those used to estimate the number of people that would enroll in QHPs through the Exchanges.

OACT also developed estimates of health care costs and the amounts of PTCs and CSR that the federal government would pay for persons who would enroll in BHP. These estimates relied on historical health care cost expenditure data for eligible persons, adjusted for the effect that having health insurance would have on health care costs. (For persons who were previously uninsured, their costs were adjusted to reflect that having health insurance is expected to lead to greater utilization of health care services than compared to not having insurance. In addition, for persons who were previously uninsured or had different forms of health insurance, their costs

were adjusted to reflect differences in cost sharing requirements on health care expenditures, and differences in provider payment rates between types of insurance.

To determine the impact of BHP, OACT has developed estimates compared to those of the impacts of the Exchanges (CMS-9989-F). As the implementation of BHP would result in a decrease in the number of persons enrolled through the Exchange, and thus the amount of PTCs and CSR that would be paid by the federal government, we believe it is appropriate to develop the impact analysis using the net effects of BHP relative to the previously estimated impacts of the Exchanges.

For the purpose of this analysis, OACT has assumed that 3 states would implement BHP between 2015 and 2019. This assumption is based off of information on states' preliminary interest in BHP; however, in actuality more or fewer states may decide to implement BHP, and may decide to implement BHP after 2015. Accordingly, more or fewer states implementing BHP would increase or decrease the impact of the program, and the particular number of enrollees and the costs of the BHP may vary state to state. These estimates are not specific to any 3 particular states.

OACT has also assumed that persons would be enrolled in BHP plans at the same participation rate as they would have been expected to enroll in QHPs through the Exchanges. The participation rate may depend on a number of factors (including the amount of premium and cost sharing a person would be required to pay in BHP, the choice of BHP plans, and the benefits offered in BHP), and in actuality could vary from the participation rate of persons eligible for QHPs. OACT has assumed that BHP plans would have similar premium and cost-sharing requirements as QHPs on the Exchange (net of the effects of PTCs and CSR) and would offer similar benefits to QHPs. Thus, the effects of implementing BHP on enrollees would be no different than the effects of the Exchanges; however, to the extent that BHP plans offer

additional benefits or further reduce the amount of costs enrollees would pay for their health care, enrollees may experience some additional benefit. Lastly, OACT has assumed that states would not contribute any other state funds to BHP and that federal BHP payments and enrollees' premiums and cost sharing would be sufficient to pay for the required benefits under BHP. To the extent that a state contributes additional funds (possibly to provide additional benefits or reduce enrollees' premiums or cost sharing), the state would experience an increase in expenditures.

The estimated effects of BHP on federal government are shown in Table 1.

**TABLE 1: Estimated Federal Impacts for the Basic Health Program
(Millions of 2015 dollars)**

| | 2015 | 2016 | 2017 | 2018 | 2019 | Total |
|---------------------------------|----------|----------|----------|----------|----------|-----------|
| BHP Expenditures | \$2,610 | \$3,000 | \$3,410 | \$4,000 | \$4,170 | \$17,190 |
| PTC and CSR Expenditures | -\$2,750 | -\$3,160 | -\$3,590 | -\$4,210 | -\$4,390 | -\$18,100 |
| Net Federal Impact | -\$140 | -\$160 | -\$180 | -\$210 | -\$220 | -\$900 |

The estimated number of BHP enrollees is shown in Table 2.

TABLE 2: Estimated Number of Basic Health Program Enrollees

| | 2015 | 2016 | 2017 | 2018 | 2019 |
|-----------------------|---------|---------|---------|---------|-----------|
| BHP Enrollment | 460,000 | 550,000 | 710,000 | 970,000 | 1,020,000 |

B. Accounting Statement and Table

As required by OMB's Circular A-4 (available at http://www.whitehouse.gov/omb/circulars_a004_a-4/), in Table 3 we have prepared an accounting statement illustrating the classification of the federal and state expenditures associated with this final rule.

TABLE 3: Accounting Statement: Classification of Estimated Expenditures for Basic Health Program during Calendar Years 2015 through 2019 (Millions of 2015 Dollars)

| Category | Transfers | | |
|---------------------------------------|--|---------|----------------|
| Annualized Monetized Transfers | Discount Rate | | Period Covered |
| | 7% | 3% | CYs 2015-2019 |
| Primary Estimate | \$3,561 | \$3,594 | |
| From/To | Qualified Health Plans to Federal Government | | |
| Category | Transfers | | |
| Annualized Monetized Transfers | Discount Rate | | Period Covered |
| | 7% | 3% | CYs 2015-2019 |
| Primary Estimate | \$3,382 | \$3,414 | |
| From/To | Federal Government to State Governments | | |

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 final 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 may 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 phenomenon is 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. Researchers have estimated that the Basic Health Program will significantly reduce the number of individuals that churn between Medicaid and Exchanges¹. We have modified the rule to include the option of 12 month continuous eligibility. This option will further reduce churn in states that adopt it, by enabling those enrolled to remain eligible for a full 12 months regardless of income fluctuation. However, we are not adjusting the payment methodology and have clarified in the response to comment that states will bear the associated financial burden to the extent there is one.

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 will give states the option to maintain these programs rather than having those individuals purchase insurance through the Exchange.

3. Costs

The provisions of this rule were designed to minimize regulatory costs. It minimizes new administrative structures, 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. In finalizing

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>.

the rule, we further extended the use of existing administrative infrastructure by permitting the use of the Exchange appeals process for BHP. Additionally, we created an interim certification level to mitigate the risk associated with state expenditure of start-up funding prior to receiving any conceptual approval for the program.

4. Transfers

The provisions of this rule are designed to transfer funds that will 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. Depending on the profile of the people in BHP, this may result in adjustments to the risk profile of the Exchange.

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. Additionally, we indicated in the final rule that we would be accepting a limited set of data elements from the Blueprint to establish an interim level of certification giving states design approval before further investment.

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.

C. Unfunded Mandates Reform Act

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of \$100 million in 1995 dollars, updated annually for inflation, by state, local, or tribal governments, in the aggregate, or by the private sector. In 2014, that threshold is approximately \$141 million. States have the option, but are not required, to establish a BHP. Thus, this final rule does not mandate expenditures by state governments, local governments, or tribal governments

D. Regulatory Flexibility Act

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

(1) a proprietary firm meeting the size standards of the Small Business Administration (SBA); (2) a not-for-profit organization that is not dominant in its field; or (3) a small government jurisdiction with a population of less than 50,000. Individuals and states are not included in the definition of a small entity.

We have clarified in the final rule that we do not have statutory authority to mandate the inclusion or exclusion of particular providers. This final rule is focused on eligibility and enrollment in public programs, and it sets out broad contracting standards but it does not contain provisions that would have a significant direct impact on hospitals, and other health care providers that are designated as small entities under the RFA. However, the provisions in this final 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 determines that this final rule will not have a significant economic impact on a substantial number of small entities.

Section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a 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, but we have concluded that there is not a direct economic impact of these facilities.

E. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a final rule that imposes substantial direct effects on States, preempts State law, or

otherwise has Federalism implications. The BHP is entirely optional for states, and if implemented in a state, provides access to a pool of funding that would not otherwise be available to the state.

We conclude that there is not an impact on Federalism by this voluntary state program.

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 amends 42 CFR chapter IV and 45 CFR subtitle A, respectively, as set forth below:

Title 42 – Public Health

1. Subchapter I, consisting of part 600, is added to chapter IV 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

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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 Affordable Care Act, provides for the establishment of the Basic Health Program (BHP) under which a State may enter into contracts for 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 the premium tax credit 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 credit 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, as determined in accordance with implementing regulations at 45 CFR 156.100 through 156.110 and 156.122 regarding prescription drugs.

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) and is determined in the same way as it is for purposes of eligibility for coverage through the Exchange.

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

Interim certification is an approval status for the initial design of a state's Basic Health Program. It does not confer any permission to begin enrollment or seek federal funding.

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).

Network of health care providers means an entity capable of meeting the provision and administration of standard health plan coverage, including but not limited to, the provision of benefits, administration of premiums and applicable cost sharing and execution of innovative features, such as care coordination and care management, and other requirements as specified under the Basic Health Program. Such entities may include but are not limited to: Accountable Care Organizations, Independent Physician Associations, or a large health system.

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 part 156, 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 base 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 which will include an opportunity for states to submit a limited set of elements necessary for interim certification at the state option. 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 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.
- (15) A transition plan if a state participating in 2015 plans to propose an alternative enrollment strategy for initial implementation consistent with §600.145. Such a transition plan must include a plan for coordination of this initial implementation strategy with the Exchange operating in the state, and if beneficiaries will be transitioning from Medicaid, with the Medicaid agency.

(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 after it is submitted for certification, and will update the posted Blueprint to the extent that it is later revised by the state.

§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. A State may choose to submit its BHP Blueprint in two parts: the first limited submission to secure interim certification and the second full submission to secure full certification.

(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(f), as well as changes that alter the BHP standard health plan benefit package, or enrollment, disenrollment and verification policies.

(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 full certification. The date of implementation for this purpose is the first day enrollees would receive coverage under the BHP. Following the 2015 initial implementation year, a state implementing a BHP must coordinate implementation with open enrollment of the state's exchange.

§600.120 Certification of a BHP Blueprint.

(a) Effective date of certification. The effective date of either interim or full 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 full 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 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 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 the BHP benefit package, enrollment, disenrollment and verification policies 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.

(c) Reconsideration of decision. HHS will accept a State request for reconsideration of a certification decision and provide an impartial review against the standards for certification if requested.

§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 and in the event of a decision to withdraw certification, will accept a request from the State for reconsideration.

(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 fully 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 the regulations in this part.

(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) Transition plan. States implementing in 2015 may identify a transition period following initial implementation during which the state may propose alternative enrollment strategies for approval. The transition plan is required to be submitted as part of the state's BHP Blueprint consistent with § 600.110.

(f) 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 (at least quarterly), 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 tribal consultation policy approved by the State Exchange.

§600.160 Protections for American Indian and Alaska 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) Cost sharing. No cost sharing may be imposed on Indians under the standard health plan.

(c) Payments to providers. Equal to the protection extended to Indian health providers providing services to Indians enrolled in a QHP in the individual market through an Exchange at 45 CFR 156.430(g), BHP offerors may not reduce the payment for services to Indian health providers by the amount of any cost-sharing that would be due from the Indian but for the prohibition in paragraph (b) of this section.

(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 after the end of each operational year. Information that may be required to secure the release of funding for the subsequent year may be requested in advance.

Subpart C--Federal Program Administration

§600.200 Federal program compliance reviews and audits.

(a) Federal compliance review of the State BHP. To determine whether the State is complying with the Federal requirements and the provisions 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 and 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, including failure to use these funds as specified in §600.705. As indicated in § 600.715(a) through (c), the state may do this either by substantiating the proper use of trust fund resources as specified in §600.705(c) 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 of this chapter. Final reports on those audits shall be transmitted to both the State and the Secretary for actions on findings. The State and the BHP trustees shall be given an opportunity to 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.

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 under section 1312 of the Affordable Care Act 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.

(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 or CHIP due to such immigration status, whose household income is between zero and 200 percent of the FPL for the applicable family size.

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

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

(ii) Is eligible for Employer Sponsored Insurance (ESI) that is unaffordable (as determined under section 36B(c)(2)(C) 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. With the exception of during an approved implementation period specified in a transition plan in accordance with §600.145, 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 a 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, 435.907(g) 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 through delegation to a 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 exclusive of § 435.915(a).

(d) Enrollment periods. The State must either offer enrollment and special enrollment periods no more restrictive than those required for an Exchange at 45 CFR 155.410 and 155.420 or follow the Medicaid process permitting continuous open enrollment throughout the year.

§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, 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. Written notices of eligibility determinations shall be provided and 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 rules of the state's Medicaid program or the Exchange.

However, this process may not include an appeal to the federal Department of Health and Human Services.

(c) Accessibility. Notices must be provided and 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) Periodic review of eligibility. An individual is subject to periodic review of eligibility every 12 months unless the eligibility is redetermined sooner 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 at least annually 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, or the plan is no longer available as a standard health plan in BHP. Enrollees in plans that are no longer available will be given a reasonable opportunity to select a new plan, and if they do not select a new plan will be enrolled in another plan pursuant to a methodology set forth in the State's Blueprint.

(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.

(f) Continuous eligibility. The state is not required to redetermine eligibility of BHP enrollees more frequently than every 12 months, regardless of changes of circumstances, as long as the enrollees are under age 65, are not otherwise enrolled in minimum essential coverage and remain residents of the State.

§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 (EHB). 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 EHB.

(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 applies to

standard health plans offered under the BHP.

(e) Compliance. The State and standard health plans must comply with prohibitions on federal funding for abortion services 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 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 to ensure the appropriate number, mix and geographic distribution to meet the needs of the anticipated number of enrollees in the service area (including but not limited to services provided by essential community providers, as defined in 45 CFR 156.235) so that access to services is at least sufficient to meet the access standards applicable under 42 CFR Part 438, Subpart D, or 45 CFR 156.230 and 156.235;
 - (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 standard health plans under the BHP with, but not limited to, the following entities:

(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 organizations 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 offerors. (1) The State must assure that standard health plans from at least two offerors are available to enrollees under BHP. This assurance shall be reflected in the BHP Blueprint, which if applicable, shall also include a description of how it will further ensure enrollee choice of standard health plans.

(2) If a State is not able to assure choice of standard health plan offerors, the State may request an exception to the requirement set forth in paragraph (a)(1) of this section, which must include a justification as to why it cannot assure choice of standard health plan offeror as well as demonstrate that the State has reviewed its competitive contracting process to determine the following:

(i) Whether all contract requirements and qualifications are required under the federal framework for BHP;

(ii) Whether additional negotiating flexibility would be consistent with the minimum statutory requirements and available BHP funding; and

(iii) Whether potential bidders have received sufficient information to encourage participation in the BHP competitive contracting process.

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

(3) 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 describe in its BHP Blueprint how it will assure that enrollees, regardless of location within the State, continue to have choice of at least two standard health plan offerors.

(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 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. The State's BHP Blueprint must describe how it will ensure such coordination.

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) Premium requirements. (1) For premiums imposed on enrollees, the State must assure that 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 the premium tax credit that would have been paid on the enrollee's behalf.

(2) This assurance must be reflected in the BHP Blueprint, which shall also include:

- (i) The group or groups of enrollees subject to premiums.
- (ii) The collection method and procedure for the payment of an enrollee's premium.
- (iii) The consequences for an enrollee or applicant who does not pay a premium.

(b) [Reserved]

§600.510 Cost-sharing.

(a) Cost-sharing requirements. (1) For cost sharing imposed on enrollees, the State must assure the following:

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

(ii) The establishment of an effective system to monitor and track the cost-sharing standards consistent with §600.520(b) through (d).

(2) This assurance must be reflected in the BHP Blueprint, which shall also include the group or groups of enrollees subject to the cost sharing.

(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.

(d) Acceptance of certain third party payments. States must ensure that standard health plans must accept premium and cost-sharing payments from the following third party entities on behalf of plan enrollees:

(1) Ryan White HIV/AIDS Programs under title XXVI of the Public Health Service Act;

(2) Indian tribes, tribal organizations or urban Indian organizations; and

(3) State and federal government programs.

§600.525 Disenrollment procedures and consequences for nonpayment of premiums.

(a) Disenrollment procedures due to nonpayment of premium. (1) A State must assure that it is in compliance with the disenrollment procedures described in 45 CFR 155.430. This assurance must be reflected in the state's BHP Blueprint.

(2) A State electing to enroll eligible individuals in accordance with 45 CFR 155.410 and 155.420 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 155.420 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) of this chapter. 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 a 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 to the extent that necessary data is available for the Secretary to prospectively determine all relevant factors, as specified in paragraph (b) of this section ..

§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** document the next fiscal year's BHP payment methodology. The Secretary will publish this document 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 document 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** document.

(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)(iv) of this section.

(iii) To the extent that the final payment notice described in paragraph (b) of this section permits retrospective adjustments to the state's BHP payment amount (due to the lack of necessary data for the Secretary to prospectively determine the relevant factors comprising the premium tax credit and cost-sharing reductions components 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)(iv) of this section.

(iv) 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 in a segregated account within the State's fund structure.

(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.

The BHP administering agency must assure the fiscal policies and accountability set forth in paragraphs (a) through (g) of this section. This assurance must be reflected in the BHP Blueprint.

(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 – Public Welfare

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: February 19, 2014.

Marilyn Tavenner,

Administrator,

Centers for Medicare & Medicaid Services.

Approved: February 21, 2014.

Kathleen Sebelius,

Secretary,

Department of Health and Human Services.

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