Basic Health Program Enrollment Data Requirements for Federal Payments

Centers for Medicare & Medicaid Services

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Introduction

Section 1331 of the Affordable Care Act provides for the establishment of the Basic Health Program (BHP), which is available to states to operate at their option. BHP provides affordable health benefits coverage for individuals who are citizens or lawfully present non-citizens under age 65 with household incomes between 133 percent and 200 percent of the Federal poverty level (FPL), who are not otherwise eligible for Medicaid, the Children's Health Insurance Program (CHIP), or affordable employer sponsored coverage. People who are lawfully present non-citizens who have income that does not exceed 133 percent of the FPL but who are unable to qualify for Medicaid due to such non-citizen status, are also eligible to enroll. Federal funding is available for BHP based on the amount of premium tax credit (PTC) and cost-sharing reductions (CSR) that BHP enrollees would have received had they been enrolled in Qualified Health Plans (QHPs) through the Exchange.

The Centers for Medicare & Medicaid Services (CMS) published an initial payment methodology, the "Basic Health Program; Federal Funding Methodology for Program Year 2015" on March 12, 2014 (CMS-2380-FN) that outlined the BHP program requirements and funding methods. The payment notice was updated annually until CMS published, "Basic Health Program; Federal Funding Methodology for Program Year 2023 and Changes to the Basic Health Program Payment Notice Process," on December 20, 2022 (CMS-2441-F) (2023 BHP final rule).

As described in the 2023 BHP final rule, beginning with the 2023 BHP payment methodology, CMS will publish payment notices that may be effective for only one or multiple program years, as determined by and subject to the discretion of the Secretary. The notices will contain the methodology and data sources CMS will use to determine the federal BHP payments. On January 15, 2025, the payment methodology established in the 2023 BHP final rule was modified for 2026 by the "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2026; and Basic Health Program" (2026 Payment Notice).[1] This modified methodology will remain in effect until revised by CMS through rulemaking. Until that time, CMS will CMS will publish annual sub-regulatory guidance that specifies the values of the factors to be used in the applicable year's payment methodology.

Based on the most recent payment methodologies, the federal BHP payment will be calculated by "rate cells." Each rate cell will represent a unique combination of the following factors:

- age range;
- geographic rating area;
- coverage category (for example, self-only, two-adult coverage or two-adults with one or more adult children);
- household size; and
- income range as a percentage of the federal poverty level (FPL).

[1] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2026; and Basic Health Program. https://www.govinfo.gov/content/pkg/FR-2025-01-15/pdf/2025-00640.pdf

The total federal BHP payment will be equal to the sum of the number of enrollees in each rate cell multiplied by the federal BHP payment rate for that rate cell.

CMS is requesting enrollment data from each state on a quarterly basis that contains the data elements that will be needed to calculate the federal BHP payment. In addition, a limited amount of other information to verify and to organize the data is also requested.

Instructions

1. States must report data for all individuals for whom the state has made a complete and accurate eligibility determination in accordance with BHP regulations at 42 C.F.R. § 600.320, 340 & 345 and who were enrolled in BHP in the previous quarter.
2. Recognizing that data elements can change for an enrollee over the course of a quarter (e.g., move to another county of residence, etc.), states should report data from the first calendar day of the quarter. For persons who become enrolled in the second or third month of the quarter, states should report data from the first calendar day of the first month of the quarter in which the person was enrolled.
3. States must retain records to support a claim that an individual is BHP-eligible and enrolled in a Standard Health Plan. This could include records of an eligibility determination or redetermination, using the standards described in the state's BHP Blueprint, and monthly BHP enrollment records that include the individual.
4. CMS will provide an Excel workbook that can be used to report enrollment data. This workbook will display all required data elements.
5. Please include a description of each Data Element on the Data Dictionary tab of the workbook.
6. States must comply with CMS Enterprise File Transfer (EFT) system requirements, including all privacy and security standards, as described in the Information Exchange Agreement Between The Centers for Medicare & Medicaid Services And Medicaid/CHIP Agencies For The Disclosure of Information for Administration of Insurance Affordability Programs or Information Exchange Agreement Between the Centers for Medicare & Medicaid Services and State-Based Exchanges For the Disclosure of Health Insurance Affordability Programs Information Under the Patient Protection Act, as applicable.
7. State reports are due to CMS no later than 60 days after the close of the quarter.
8. States must submit a signed and dated BHP Enrollment Data State Attestation Form, included here as Attachment A, with their data submissions.

Enrollment data elements

CMS is requesting that states submit quarterly enrollment data for each person covered by BHP, including the following specific data elements. Where possible, CMS is requesting data elements that are already collected and defined by the health insurance exchanges or state Medicaid programs. Sample specifications for these data elements have been provided below; however, states may suggest alternatives subject to CMS approval.

1. Personal identifier

A personal identifier would allow CMS to have a specific count of the number of enrollees and ensure that there are no duplicate enrollees in the BHP program. An appropriate personal identifier might include an enrollee's Social Security Number or a unique Exchange or Medicaid identification number. Please specify in the Data Dictionary whether the personal identifier is the same identifier as is used in the Exchange or Medicaid. A person should retain the same personal identifier throughout the duration of their BHP eligibility.

2. Family identifier

The family identifier for each person enrolled in BHP in the household will allow individuals to be matched to a specific household. The personal identifier of the head of the household may be used as the family identifier. This would be used to calculate the estimated premium tax credit the household would have received if enrolled in a QHP in the Exchange.

3. Date of birth

The date of birth of the enrollee is needed in order to determine the age of the enrollee. This is used to confirm eligibility and determine the appropriate rate cell for payment purposes. This may be reported as month, day, and year of birth (e.g., xx/xx/xxxx).

4. County of residence

The county of residence of the enrollee is required to determine the geographic rating area of the enrollee. States must report the name of the enrollee's county of residence and its National Bureau of Standards Federal Information Processing Standards (FIPS) numeric code.

5. American Indian/Alaska Native (AI/AN) Status

The AI/AN status of the enrollee is needed because AI/AN individuals receive different levels of cost-sharing reduction subsidies in the Exchange. The state should report whether an individual has AI/AN status consistent with the definition used for the Exchange at 45 C.F.R. § 155.300 and defined as follows:

- a member of any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or regional or village corporation as defined in or

established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688), which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians; and,

- would be eligible under the special eligibility standards and process for Indians as described in 45 C.F.R. §155.350(a) (with the exception that they are enrolled in a Standard Health Plan rather than a Qualified Health Plan).

This may be reported as "Y" for enrollees who indicate that they are members of a federally-recognized tribe or otherwise meet the criteria described above, and "N" for all other enrollees.

6. Family size

The state must report the size of the enrollee's family.

For tax filer households, family size should be consistent with the definition used for the Exchange at Section 36B(d)(1) of the Internal Revenue Code (42 C.F.R. § 600.5). That is, a tax filer's household must include the taxpayer, his or her spouse when filing jointly, and whoever the taxpayer expects to claim as a tax dependent in his or her federal income tax return in the coverage year. A tax dependent's household includes the enrollee who expects to be claimed as a tax dependent for the coverage year and whoever is claiming him or her as a tax dependent.

For non-filer households for this reporting period, household size definition should be consistent with that used in the Medicaid non-filer rules as defined at 42 C.F.R. § 435.603(f)(3). That is, for an adult enrolling in coverage, the household must include: the adult; the adult's married spouse if living with the individual; and the adult's natural, adopted, and stepchildren under age 19 (or at state option, age 19 or 20 if a full time student) if living with the adult. For a child enrolling coverage, the household must include: the child under age 19 (or at state option, age 19 or 20 if a full time student); any of the child's parents (biological, adoptive and step-parents), if living with the child; and any of the child's siblings (biological, adoptive and step-siblings), who are under age 19 (or at state option age 19 or 20 if a full-time student). CMS is further analyzing the impact of non-filer rules on payment and additional data and/or a payment adjustment may be required in the future.

For both filers and non-filers, this data element may be reported as a numeric value representing the household count (e.g., 1, 2, 3).

7. Household income

The annual MAGI household income of the enrollee's household is needed to determine premium tax credits and cost-sharing reduction subsidies in the exchanges. The state should submit verified household income from the enrollee's last eligibility determination.

For tax filer households, the MAGI household income definition should be consistent with that used for the Exchange in Section 36B(d)(2) of the Internal Revenue Code. That is, 'household income' means, with respect to any taxpayer, an amount equal to the sum of the MAGI income for all the members of the household.

For non-filer households for this reporting period, CMS is permitting use of Medicaid non-filer rules. Household size and income definitions should be consistent with that used in the Medicaid non-filer rules as defined at 42 C.F.R. § 435.603(d) & (e).

For both filers and non-filers, this data element may be reported as a numeric value representing the annual MAGI income used to determine eligibility for BHP enrollees (e.g., dollar amount to two decimal points).

8. Number of persons in household enrolled in BHP (Coverage Family)

The number of persons in the household who are enrolled in BHP should be reported to determine the cost of the premium for the household. This must be reported as a numeric value representing the number of individuals in the household enrolled in BHP (e.g., 1, 2, 3).

9. Months of coverage

The enrollment status for each month of BHP-eligible coverage of the quarter should be reported. The state can report whether or not a person was enrolled in BHP for each month of the year.

Months of coverage means, any month where, as of the first day of the month, the individual or family is eligible, enrolled and covered by a BHP standard health plan described in Subpart E of Part 600 of 42 CFR and the premium for such coverage is paid by the state. This data must be provided as a sequential binary indicator showing the enrollment status in each month of the quarter (e.g., 1 = enrolled, 0 = not enrolled).

10. Plan information

Some information about the standard health plan in which the beneficiary is enrolled must be reported for the purposes of oversight/program integrity activities. This may include the issuer name, plan name, and, where available, a standard plan identification number (e.g., HIOS ID, NAIC-issued Payer ID). The state must describe which elements they are providing in the Data Dictionary tab of the workbook.

11. Eligibility for Federal BHP Funding

As described below, beginning on January 1, 2026, certain noncitizens continue to be eligible for BHP but are no longer eligible for Federal BHP funding. States should continue to include every BHP enrollee who is eligible, and the state should report whether the enrollee is 1.) eligible for BHP funding, or 2.) a noncitizen eligible to be enrolled in the BHP but not eligible for BHP funding. This should be coded as a numeric value, (1,2), with each number representing one of the two categories. This data point is necessary to determine which

individuals enrolled in the state's BHP are eligible to be included in the calculation of the state's BHP funding.

As of January 1, 2026, 26 U.S.C. 36B(c)(1) no longer provides that an individual could be considered eligible for PTC, and by extension inclusion in the calculation of BHP funding to states, if they have household income under 100 percent of the FPL and are a noncitizen lawfully present in the United States who is ineligible for Medicaid due to their immigration status. Therefore, beginning January 1, 2026, all BHP enrollees who meet this criteria should be coded as not eligible to be included in the calculation of the state's BHP funding.

In addition, for plan years beginning on or after January 1, 2027, 26 U.S.C. 36B(e) provides that a Premium Tax Credit, and by extension inclusion in the calculation of federal BHP funding to states, is allowed for the coverage of a lawfully present individual only if the individual is an "eligible alien." "Eligible aliens" are defined as 1.) Lawful permanent residents; 2.) Cuban and Haitian entrants; and 3.) Compact of Free Association (COFA) migrants. Therefore, beginning January 1, 2027, lawfully present noncitizen BHP enrollees should be coded as eligible for BHP funding if they meet the definition of "eligible alien" and should be coded as not eligible for BHP funding if they do not meet the definition.

Sample Spreadsheet

CMS has developed a sample spreadsheet for data submissions during the periods that the state reports estimated and actual enrollment. CMS will prepare a workbook that can be used to report this data and will work with states to consider other possible means to report this data.

Attachment A: BHP Enrollment Data State Attestation Form

I certify that:

1. I am the Governor of the state or his/her authorized designee to submit this BHP Enrollment Data File (hereinafter "File").
2. This File contains enrollment data only for individuals eligible for and enrolled in the Basic Health Program under Section 1331 of the Affordable Care Act. Individuals who are eligible for and enrolled in the BHP, but are ineligible for payment to the BHP Trust Fund for the quarter are indicated on the spreadsheet.
3. The data contained in this File are based on actual recorded BHP-enrolled individuals in the state and are not based on estimates.
4. The information in this File is correct to the best of my knowledge and belief.

_____

Signature/Date

_____

Name/Title