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CENTERS FOR MEDICARE & MEDICAID SERVICES
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CMCS Informational Bulletin

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SUBJECT: Basic Health Program; Federal Funding Methodology for Program Year 2027

This Center for Medicaid and CHIP Services (CMCS) Informational Bulletin (CIB) provides the annual update to values of the factors included in the funding methodology published in the Basic Health Program (BHP); Federal Funding Methodology for Program Year 2023 final rule (87 FR 77722) (hereinafter referred to as 2023 BHP Final Rule), as modified by the Notice of Benefit and Payment Parameters for 2026; and Basic Health Program final rule (90 FR 4424) (hereinafter referred to as the 2026 Payment Notice).[1] This CIB also reminds states operating a BHP for 2027 of the need to make two decisions: (1) whether to use the 2026 or 2027 QHP premiums in calculating the 2027 BHP federal payments; and (2) whether to use a retrospective state-specific health risk adjustment in calculating the 2027 BHP federal payments.

CMS has determined that updates to the overall funding methodology for 2027 are not needed and will continue to use the methodology published in the 2023 BHP Final Rule, as modified by the 2026 Payment Notice.[2] This methodology will continue to be in effect until CMS publishes a different methodology. *See* § 600.610(a)(1)(i), (b)(2).

Impact of the Working Families Tax Cut Legislation (Public Law 119-21) on BHP in 2027

On July 4, 2025, Public Law 119-21, which CMS refers to as the "Working Families Tax Cut" (WFTC) legislation, was signed into law. Section 71301 of the WFTC legislation amends

[1] Section 1331 of the Patient Protection and Affordable Care Act (Pub. L. 111-148, enacted March 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152, enacted March 30, 2010) (collectively referred to as the Affordable Care Act or ACA), provides states with an option to establish a BHP. Federal funding for a BHP under section 1331(d)(3)(A) of the ACA is based on the amount of the federal premium tax credit (PTC) allowed and payments to cover required cost-sharing reductions (CSRs) that would have been provided to eligible individuals enrolled in BHP standard health plans in the state if such eligible individuals were allowed to enroll in a qualified health plan (QHP) through an Exchange. The funding methodology and payment rates are expressed as an amount per eligible individual enrolled in a BHP standard health plan for each month of enrollment. These payment rates may vary based on categories or classes of enrollees.

[2] CMS published the 2023 BHP Final Rule on December 20, 2022. Previously, federal BHP regulations required CMS to publish the BHP funding methodology annually. The 2023 BHP Final Rule revised this requirement at 42 C.F.R. § 600.610 so that CMS only publishes a revised BHP funding methodology as needed. On January 15, 2025, CMS published the 2026 Payment Notice. In the 2026 Payment Notice, CMS revised the premium adjustment factor (PAF), which is used to calculate the adjusted reference premium (ARP) for BHP payment (90 FR 4424, 4433-4435). The 2026 Payment Notice also included a technical clarification for BHP payment rates in cases where there are multiple second lowest cost silver plan (SLCSP) premiums in an area (90 FR 4424, 4435). These changes are outlined in the BHP CIB for Program Year 2026, published on December 10, 2025.

§ 36B(e) of the Internal Revenue Code (the Code), effective for plan years beginning on or after January 1, 2027, to provide that a PTC is allowed for the QHP coverage of a lawfully present noncitizen only if he or she is an "eligible alien" and meets other applicable eligibility criteria.[3, 4] Under section 1331(d)(3)(A)(i) of the Affordable Care Act (ACA) and 42 C.F.R. § 600.605(a), federal BHP payments to states include 95 percent of both the PTC under 26 U.S.C. § 36B and the CSRs that would have been provided for the federal fiscal year to eligible individuals enrolled in BHP standard health plans in the state if such eligible individuals had been enrolled in QHPs through an Exchange. Currently, Congress does not fund CSR payments. Therefore, CMS assigns a value of zero to the CSR portion of the BHP payment rate calculation and States receive no BHP funding attributable to that portion.

Because federal BHP payments to states are based in part on the amount of PTC an individual enrolled in the BHP is eligible for and would have qualified for had he or she been enrolled in a QHP through an Exchange, only lawfully present noncitizens who are considered to be "eligible aliens" and who meet other applicable eligibility criteria will generate federal BHP payments to the state beginning on January 1, 2027. Section 71301 of the WFTC legislation defines "eligible alien" as: (1) a lawful permanent resident; (2) a Cuban and Haitian entrant; or (3) a Compact of Free Association (COFA) migrant.

While section 71301 of the WFTC legislation eliminates eligibility for PTC for the coverage of lawfully present noncitizens who are not "eligible aliens," such individuals remain eligible for enrollment in the BHP, provided they meet the eligibility requirements of section 1331(e) of the ACA and 42 C.F.R. § 600.305. Such individuals will no longer be included in the calculation of federal BHP payments beginning January 1, 2027. Recognizing the discrepancy between statutory provisions governing BHP eligibility and federal BHP funding for this cohort, CMS will exercise enforcement discretion for a period of three years; CMS will not take compliance action against any state that does not provide BHP coverage to this population between January 1, 2027, and December 31, 2029. CMS is available to provide technical assistance to states regarding this provision.

Updated Values for Factors Used in Payment Equations

This section briefly describes the 2027 values for the income reconciliation factor, the premium tax credit formula, and the premium trend factor used in the BHP payment equations. All other factors remain the same as previously published in the 2023 BHP Final Rule, as modified by the 2026 Payment Notice.

1. **Income Reconciliation Factor (IRF)**

[3] Section 71302 of the WFTC legislation also impacts, as of January 1, 2026, BHP payments to states attributable to lawfully present noncitizens who are ineligible for Medicaid due to their immigration status and have estimated household income below 100 percent of the FPL. This was discussed more fully in the CIB "Basic Health Program; Federal Funding Methodology for Program Year 2026," available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib12102025.pdf and in the Notice of Benefit and Payment Parameters for 2027; and Basic Health Program final rule in the Federal Register (91 FR 29526) (hereinafter referred to as the 2027 Payment Notice).

[4] In the 2027 Payment Notice, published May 20, 2026, CMS amended 42 C.F.R. § 600.5 to align the BHP regulations with section 71301 by adding a definition of 'eligible noncitizen' that cross-references 45 C.F.R. § 155.20.

As described in section III.D.6 of the 2023 BHP Final Rule, the IRF is used to estimate the reconciliation that otherwise would happen for individuals receiving advanced payments of the premium tax credit (APTC) for enrollment in a QHP through an Exchange. Because enrollment in a QHP is a requirement for individuals to receive APTC, individuals determined or assessed as eligible for a BHP are not eligible to receive APTC for coverage in the Exchange. Because they do not receive APTC, BHP enrollees are not subject to the same APTC reconciliation as Exchange enrollees.

The IRF accounts for (a) the difference between calculating estimated PTC (which is based on estimated income at initial application for enrollment) and (b) actual income, as reflected on individual federal income tax returns following the end of the plan year. States may not have access to BHP enrollees' actual income relative to the federal poverty level (FPL) during the plan year.

As previously described in the BHP CIB for Program Year 2026, section 71305 of the WFTC legislation eliminates the limitation on recapture of APTC by striking 26 U.S.C. § 36B(f)(2)(B). Households that receive APTC must reconcile APTC payments with the PTC for which they were eligible based on actual annual income when filing their federal income tax returns. Prior to this amendment, if the APTC exceeded the allowable PTC, taxpayers were required to repay the excess amount, but only up to capped amounts for households with incomes below 400 percent of the FPL. Section 71305 eliminates those caps and requires repayment of the full amount of any excess APTC, regardless of income level. While this statutory change does not directly affect federal BHP payments, it does impact the estimation of the IRF, which is derived from reconciliation outcomes among Exchange enrollees receiving APTC. We have incorporated this policy into our calculation of the IRF for 2027.

For 2027, the Office of Tax Analysis (OTA) in the Department of the Treasury has estimated that the IRF for states that have implemented the Medicaid expansion to cover adults up to 133 percent of the FPL will be 93.77 percent, and for states that have not implemented the Medicaid expansion and do not cover adults up to 133 percent of the FPL will be 94.73 percent.[5] The value of the IRF for 2027 is 93.77 percent, as all states currently operating a BHP are Medicaid expansion states.

2. Premium Tax Credit Formula (PTCF)

As described in section III.D.5 of the 2023 BHP Final Rule, we will use the formula described in 26 U.S.C. § 36B(b) to calculate the estimated PTC that would be paid on behalf of a person enrolled in a QHP on an Exchange as part of the BHP funding methodology. To calculate the PTC amount, this formula first determines the contribution amount (the amount that a household theoretically would be responsible for paying if they enrolled in the applicable SLCSP on an Exchange), which is based on (a) the household income; (b) the household income as a percentage of FPL for the family size; and (c) the schedule specified in 26 U.S.C. § 36B(b)(3)(A). The PTC amount is then calculated as the difference between that contribution amount and the SLCSP premium.

[5] States may cover adults under age 65 with income at or below 133 percent of the FPL under 42 C.F.R. § 435.119.

The applicable percentage is defined in 26 U.S.C. § 36B(b)(3)(A) and 26 C.F.R. § 1.36B-3(g) as the percentage that applies to a taxpayer's household income that is within an income tier, increasing on a sliding scale in a linear manner from an initial premium percentage to a final premium percentage, as specified in Table 1.

TABLE 1: Applicable Percentage Table for CY 2027[6]

In the case of household income (expressed as a percent of FPL) within the following income tier:	The initial premium percentage is:	The final premium percentage is:
Less than 133%	2.15%	2.15%
At least 133% but less than 150%	3.23%	4.3%
At least 150% but less than 200%	4.3%	6.78%
At least 200% but less than 250%	6.78%	8.66%

3. Premium Trend Factor (PTF)

As described in section III.E of the 2023 BHP Final Rule, states have the option to have their final 2027 federal BHP payment rates (based on actual enrollment data) calculated using (1) the projected 2027 ARP (that is, using 2026 premium data multiplied by the PTF defined below),[7] or (2) the 2027 QHP premiums. This approach and the determination of the PTF is consistent with the current methodology.

For the PTF, we use the annual growth rate in private health insurance expenditures per enrollee from the 2025-2034 National Health Expenditure (NHE) projections, developed by the Office of the Actuary (OACT) in CMS (*See* NHE projection tables, Table 17).[8] Based on these projections, the PTF will be 4.6 percent for BHP program year 2027 ($8,864 in 2026 and $9,274 in 2027).

State Options Regarding 2027 BHP Funding Methodology

This section briefly describes the state options to (1) use 2026 or 2027 QHP premiums for BHP payments, and (2) include a retrospective state-specific health risk adjustment in the certified methodology. Specific deadlines for electing each state option are outlined below.

1. State Option to Use 2026 or 2027 QHP Premiums for 2027 BHP Federal Payments

[6] For complete table, *see* IRS Revenue Procedure 2026-26. https://www.irs.gov/pub/irs-drop/rp-26-26.pdf
[7] See Equation (2b) of the 2023 BHP Final Rule, 87 FR 77722, 77727
[8] OACT projected NHE data is available at https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/projected.

As described above, states have the option to have their final 2027 federal BHP payment rates (based on actual enrollment data) calculated using (1) the projected 2027 ARP (that is, using 2026 premium data multiplied by the PTF, which is 4.6 percent as described above), or (2) the 2027 QHP premiums.

Deadline to elect option: States operating a BHP have **30 days from the release of this CIB** to notify CMS if they elect to use the projected 2027 ARP as the basis for the 2027 BHP federal payments. If the state does not notify CMS of its intent by **October 26, 2026**, the 2027 QHP premiums will be used.

2. State Option to Include Retrospective State-Specific Health Risk Adjustment in the Certified Methodology

To account for the potential differences in the average health status between BHP enrollees and Exchange enrollees, CMS included the population health factor (PHF) in the 2023 BHP Final Rule. To the extent that BHP enrollees would have been enrolled in a QHP through an Exchange in the absence of a BHP in a state, the exclusion of those BHP enrollees from QHPs sold on an Exchange may affect the average health status of the overall population and the expected QHP premiums of the SLCSP.

Currently, there is not evidence that the BHP population would have better or poorer health status than the Exchange population. There continues to be insufficient data that limits our ability to analyze the potential health differences between these groups of enrollees. More specifically, Exchanges have been in operation since 2014, and two states have operated BHPs since 2015,[9] but data are not available to perform the analysis necessary to determine if there are differences in the average health status between BHP and Exchange enrollees. In addition, differences in population health may vary across states.

Given these analytic challenges and the limited data about Exchange coverage and the characteristics of BHP-eligible consumers, the PHF will remain 1.00 for program year 2027, unless the state elects to use and CMS approves a retrospective state-specific health risk adjustment as described below.

Section III.F of the 2023 BHP Final Rule permits states operating a BHP to include, as part of the certified BHP funding methodology, a retrospective state-specific health risk adjustment to the PHF based on data accumulated during program year 2027 for each rate cell.

A state electing the option to implement a retrospective state-specific health risk adjustment to the PHF (a PHF adjustment protocol) must submit a proposed protocol to CMS as part of the BHP funding methodology, subject to CMS approval and certification by the Chief Actuary of CMS in consultation with the OTA.

Deadline to submit PHF adjustment protocol: The state must submit a proposed protocol to adjust the PHF based on a retrospective state-specific health risk adjustment for the 2027 program year **within 60 days of the release of this CIB.** If a state does not submit a PHF adjustment protocol by **November 24, 2026,** no adjustment to the PHF will be

[9] Four states currently have operational BHPs: the District of Columbia, Minnesota, New York, and Oregon.

made. For a state to implement a PHF adjustment protocol, CMS must approve it within 60 days of receipt.

For more information on the Basic Health Program or for questions related to the BHP funding methodology please contact Chris Truffer at Christopher.Truffer@cms.hhs.gov or Cassie Lagorio at Cassandra.Lagorio@cms.hhs.gov.