



Congressional Research Service

Informing the legislative debate since 1914

MEMORANDUM

February 23, 2016

To: House Committee on Ways and Means
[REDACTED]
House Committee on Energy and Commerce
[REDACTED]

From: Paulette C. Morgan, Specialist in Health Care Finance, [REDACTED]
Edward C. Liu, Legislative Attorney, [REDACTED]

Subject: Information on the ACA Transitional Reinsurance Program

You requested background information on the Transitional Reinsurance Program, one of three risk mitigation programs included in the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended). Specifically, you also requested answers to three questions:

1. What were the amounts required to be collected?
2. Does CMS have the authority to prioritize Reinsurance claimants over payments to the Treasury? If so what are the limits?
3. Does CMS have the authority to delay payments to the Treasury in one year and make it up in subsequent years?

This memorandum provides a brief description of the context for the three risk mitigation programs, and then provides a description of the transitional reinsurance program. It addresses each of your questions in order.

Because the issues addressed in this memorandum are of general interest to Congress, information included in this memorandum may be provided by the Congressional Research Service (CRS) to other congressional requesters or incorporated into a CRS report. Your identity as a requester would not be disclosed in either case.

ACA and Risk Mitigation Background

The private health insurance provisions in the ACA include market reforms that impose requirements on private health insurance plans.¹ Such reforms relate to the offer, issuance, generosity, and pricing of health plans, among other requirements, and are designed to increase the number of people who are able to purchase insurance. As part of a larger set of private health insurance market reforms,² the ACA requires

¹ For information, please see CRS Report R42069, *Private Health Insurance Market Reforms in the Patient Protection and Affordable Care Act (ACA)*.

² For more information, see CRS Report R43048, *Overview of Private Health Insurance Provisions in the Patient Protection and Affordable Care Act (ACA)*.

private health insurance issuers to provide coverage to individuals regardless of health status, medical history, and pre-existing conditions. Some individuals are eligible to receive premium tax credits and cost-sharing subsidies through a health insurance exchange (marketplace), which will increase the attractiveness of coverage by reducing its cost. Also, the individual mandate is in effect, which requires most individuals to maintain coverage or otherwise pay a penalty. All of the new health insurance market reforms and the expanded market of individuals seeking to purchase insurance, some of whom were previously uninsured and may have delayed receiving health care, contribute to the uncertainty insurers face in the early years of ACA implementation.

The transitional reinsurance program is one of three programs included in the ACA to mitigate the financial risk that insurers face. The three programs are designed to mitigate the effects of different types of risk as insurers respond to the new market rules.

- The first program is a *transitional reinsurance program* (2014-2016) which is designed to compensate insurers for a portion of the cost of particularly high-cost enrollees with individual insurance coverage inside and outside of the exchanges. Prior to ACA implementation, there was little information available on the health spending or demand of individuals who were previously uninsured, and the degree to which they had delayed health care due to their lack of insurance. Insurers in the early years of the ACA would likely raise premiums to the extent possible to protect themselves against the high cost of this delayed care. However, some of the new marketplace rules limit the degree to which insurers could vary premiums. The transitional reinsurance program is designed to mitigate the financial risk associated with individuals who had delayed needed health care while they were uninsured. If an enrollee's total claims exceed a specified level (referred to as the attachment point), the insurer is paid a proportion of claims costs (referred to as the coinsurance rate) beyond the attachment point until total claims costs reach the insurance cap. The attachment point, coinsurance rate, and reinsurance cap together are the payment parameters that the Secretary of Health and Human Services (Secretary) must specify each year. This is a temporary program under the assumption that any care that was delayed due to a lack of insurance would be provided in the early years of the program. This program is addressed below.
- The second program is a *permanent risk adjustment* program intended to mitigate the effects of adverse selection in the individual and small group markets, both inside and outside of the new exchanges. Adverse selection is a phenomenon wherein individuals who expect or plan for high use of health services tend to enroll in more generous (and consequently more expensive) plans, whereas individuals who do not expect to use many or any health services tend to enroll in less generous (and less expensive) plans. The relative generosity of the insurance plan will thus attract higher or lower spending enrollees. Risk adjustment more accurately compensates insurers for the higher cost of sicker enrollees who tend to enroll in more generous plans, as well as more accurately compensating insurers for the lower cost of healthier enrollees who tend to enroll in less generous plans. As adverse selection is a phenomenon that is always present, risk adjustment is a permanent mitigation program.
- The third program is the *temporary risk corridors program* (2014-2016). This program is designed to mitigate the effects of mistakes the insurers may make when trying to predict the appropriate amount of premium to charge for individual and small group Qualified Health Plans offered inside and outside exchanges.³ Insurers were faced with many

³ Qualified health plans are plans that provide a comprehensive set of health benefits and comply with all applicable ACA market reforms. Plans offered on the health insurance exchanges, where individuals and small businesses can shop for and purchase (continued...)

questions at the start of health reform, such as whether young healthy individuals would sign up for insurance, or whether employers would choose to have their enrollees find insurance on the new marketplaces, or not. The insurers' assumptions about the answers to those questions can have an impact on the premiums they charge. But if their assumptions are wrong, they may end up underestimating or overestimating the premiums necessary to pay for their enrollees' claims. The risk corridors program is temporary under the assumption that insurers will be better able to estimate premiums under the new health reform rules after three years.

Description of the Transitional Reinsurance Program

The ACA⁴ requires that a transitional reinsurance program be established in each state for 2014 through 2016.⁵ Under the program, the Secretary collects reinsurance contributions from health insurance issuers and third party administrators on behalf of group health plans;⁶ the Secretary then uses those contributions to make reinsurance payments to health insurance issuers⁷ who enroll high-risk individuals in their individual market plans both inside and outside of the exchanges.

How much was required to be collected under the transitional reinsurance program?

The statutes specify that the aggregate collection for all states for the transitional reinsurance program equal \$10 billion for plan year beginning 2014, \$6 billion for plan year beginning in 2015, and \$4 billion for plan year beginning in 2016. The statutes also specify that an additional contribution be collected; this amount is not part of the transitional reinsurance program, but rather a contribution to the United States Treasury. In addition, the statutes allow for the collection of additional amounts for administration. Table 1 includes the amounts that are required to be collected, as well as the amounts estimated by the Secretary for administration of the program for 2014, 2015, and 2016.

Table 1. Contribution Amounts related to the Transitional Reinsurance Program

	2014	2015	2016
Aggregate contribution for reinsurance programs for all states	\$10 billion	\$6 billion	\$4 billion
Additional contribution to U.S. Treasury	\$2 billion	\$2 billion	\$1 billion

(...continued)

private health insurance coverage, must be QHPs, with limited exceptions; QHPs may also be offered in the private market outside of exchanges. The risk corridors program applies to QHPs, and plans that are the same as or substantially the same as QHPs, that are available both on the exchanges, as well as outside of the exchanges. For information on private health plans in general and qualified health plans specifically, please see CRS Report R43233, *Private Health Plans Under the ACA: In Brief*.

⁴ ACA, Section 1341.

⁵ Though states are allowed to establish their own transitional reinsurance programs, only Connecticut chose to do so. For all other states, the Secretary is implementing the transitional reinsurance programs. Under the regulations governing the establishment of the transitional reinsurance programs, states have discretion in certain aspects of program implementation. However, Connecticut has chosen to follow the federal benefit and payment parameters for 2014 and 2015. For more information, see [<http://ct.gov/hix/cvp/view.asp?a=4295&q=532146>].

⁶ A transitional reinsurance contributing entity is either (a) a health insurance issuer, or (b) for 2014 a self-insured group health plan regardless of whether it uses a third party administrator (TPA); for 2015 and 2016, a self-insured group health plan that uses a TPA for specified activities and specified degrees. See 45 CFR § 153.20. In 2015 and 2016, a self-insured group health plan that does not use a TPA is not considered a contributing entity.

⁷ A health insurance issuer is eligible to receive transitional reinsurance payments for enrollees in a plan (i.e., a reinsurance-eligible plan) if the health insurance plan is offered in the individual market, except for grandfathered plans and health insurance coverage not required to submit reinsurance contributions under 45 CFR § 153.400(a). See 45 CFR § 153.20.

	2014	2015	2016
Administration	\$20.3 million	\$25.4 million	\$32 million
Total Contribution Amounts	\$12.02 billion	\$8.03 billion	\$5.03 billion

Source: Table created by CRS based on information in Section 1341 of the ACA; Department of Health and Human Services, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014, Final Rule," 78 *Federal Register* 15460, March 11, 2013; Department of Health and Human Services, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2015, Final Rule," 79 *Federal Register* 13775, March 11, 2014; and Department of Health and Human Services, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, Final Rule," 80 *Federal Register* 10775, February 27, 2015.

Though the statutes specified certain aggregate amounts to be collected and allowed the collection of amounts for administration, the statutes require the Secretary to establish a methodology for determining how much each health insurance issuer or group health plan (i.e., contributing entity) must contribute. The Secretary established a methodology where contributing entities pay a per person amount based on their enrollment.⁸ The per person contribution (i.e., the per capita national contribution) was calculated as the sum of (a) the aggregate contribution for the reinsurance program, (b) the additional contribution to the U.S. Treasury, and (c) the cost of administration divided by the estimated number of enrollees in plans required to make reinsurance contributions. In other words:

National Per Capita Reinsurance Contribution =

(Reinsurance Contribution + Treasury Contribution + Administrative Cost)/HHS's estimate of enrollment in contributing entities.⁹

The national per capita reinsurance contribution was set at \$63 in 2014, \$44 for 2015, and \$27 for 2016. For example, for 2014, each reinsurance contributing entity must pay \$63 for each of their covered enrollees. For benefit year 2014, this resulted in collected contributions of approximately \$8.7 billion as of June 2015, and the Secretary was estimated to collect an additional \$1 billion on or before November 15, 2015.¹⁰

⁸ Enrollment is to be based on the contributing entity's fully insured commercial book of business for all major medical products. See 45 CFR § 153.400. Contributing entities must submit an annual enrollment count to the Secretary by November 15 of 2014, 2015, and 2016. The regulations specify acceptable methods for calculating the annual enrollment of reinsurance contribution enrollees. See 45 CFR § 153.405.

⁹ In order to estimate enrollment in entities required to make reinsurance contributions, as well as to estimate reinsurance payment parameters displayed in Table 2 of this memorandum, the Secretary developed a model, (the Affordable Care Act Health Insurance Model (ACAHiM)). This model is described in "Department of Health and Human Services, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters, Proposed Rule," 77 *Federal Register* 73160, December 7, 2012."

¹⁰ Department of Health and Human Services, *Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2014 Benefit Year*, September 17, 2015, p. 4, <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RI-RA-Report-REVISED-9-17-15.pdf>. This report was first published June 30, 2015, and then updated in September 2015. The Centers for Medicare & Medicaid Services confirmed in a January 8, 2016 phone conversation with CRS that, because the total contributions collected were less than \$10 billion for 2014, that entire amount was allocated to the reinsurance program and nothing was allocated for administrative expenses or the U.S. Treasury, consistent with regulations. For benefit year 2015, CMS has collected \$5.5 billion and expects to collect approximately \$1 billion more by November 15, 2016. Department of Health and Human Services, *The Transitional Reinsurance Program's Contribution Collections for the 2015 Benefit Year*, February 12, 2016, https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/RIC_2015ContributionsGuidance.pdf. CMS indicates that the \$5.5 billion already collected will be used entirely for reinsurance payments. Half of the projected \$1 billion collection will also be used for reinsurance payments; the other half allocated on a pro rata basis for administrative expenses and the contribution to the U.S. Treasury.

In the event that total reinsurance contributions collected fall short or exceed the amounts specified in Table 1, the regulations specify allocation of funding. For 2014, the May 27, 2014 final rule specified that if total contributions collected were less than \$10 billion, the entire amount of the collection would be allocated to the reinsurance program and none to the U.S. Treasury or administration;¹¹ if the collections were greater than or equal to \$10 billion, but less than \$12.02 billion, then \$10 billion would be allocated to the reinsurance program, and 99% of the remaining collections (\$2 billion/\$2.02 billion) would be allocated to the U.S. Treasury, and 1% (\$20.3 million/\$2.02 billion) would be allocated to administrative expenses. For 2014, if total reinsurance contributions were to exceed \$12.02 billion, \$2 billion would be allocated to the U.S. Treasury, \$20.3 million would be allocated to administrative expenses, and the balance would be allocated to the reinsurance program. A comparable allocation methodology would apply for 2015 and 2016.

Does CMS have the authority to prioritize reinsurance claimants over payments to the Treasury? If so what are the limits?

In the preamble to its May 27, 2014 final rule, CMS “sought comment on this proposal, including our legal authority to implement a prioritization of reinsurance contributions to reinsurance payments over payments to the U.S. Treasury.”¹² These comments and CMS’ responses to them noted that § 1341 “provides HHS with the discretion ... to determine the priority, method, and timing for the allocation of reinsurance contributions collected.”¹³

One commenter observed that § 1341 “imposes few requirements on the expenditure of reinsurance contributions, stating that the statute does not specify that payments must be made to issuers and to the U.S. Treasury simultaneously, or that the U.S. Treasury must receive its full funding before reinsurance pool payments are made.”¹⁴ While it appears correct that § 1341 does not speak to the timing of deposits to the General Fund of the Treasury, the “miscellaneous receipts statute” states that money received by the federal government must generally be deposited in the Treasury as miscellaneous receipts “as soon as practicable.”¹⁵ An agency is permitted to retain money as an exception to the “miscellaneous receipts statute” if it has statutory authority to do so.¹⁶ Section 1341 contains several such statements. First, § 1341(b)(1)(B) states that the reinsurance program shall collect payments from issuers and “use[] amounts so collected to make reinsurance payments.”¹⁷ Further, § 1341(b)(4) provides that:

(A) the contribution amounts collected for any calendar year may be *allocated and used* in any of the three calendar years for which amounts are collected based on the reinsurance needs of a particular period or to reflect experience in a prior period; and

¹¹ Department of Health and Human Services, “Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond,” 79 *Federal Register* 30258-30259, May 27, 2014.

¹² 79 Fed. Reg. 30240, 30257 (May 27, 2014).

¹³ *Id.* at 30258.

¹⁴ *Id.*

¹⁵ 31 U.S.C. § 3302(b). *See also* Government Accountability Office, 1 Principles of Federal Appropriations Law 6-167 (“This means deposited into the general fund (‘miscellaneous receipts’) of the Treasury, not into the agency’s own appropriations, even though the agency’s appropriations may be technically still ‘in the Treasury’ until the agency actually spends them.”); and 10 Comp. Gen. 382, 384 (1931) (“It is difficult to see how a legislative prohibition could be more clearly expressed.”).

¹⁶ *E.g.* 72 Comp. Gen. 164, 165-66 (1993).

¹⁷ 42 U.S.C. § 18061(b)(1)(B).

(B) amounts remaining unexpended as of December, 2016, *may be used* to make payments under any reinsurance program of a State in the individual market in effect in the 2-year period beginning on January 1, 2017.¹⁸

However, this authority to retain and use amounts collected under the reinsurance program is significantly qualified. Section 1341(b)(4) goes on to state that:

Notwithstanding the preceding sentence [subparagraphs (A) and (B) above], any contribution amounts described in paragraph (3)(B)(iv) [the U.S. Treasury contribution] *shall* be deposited into the general fund of the Treasury of the United States and *may not be used* for the program established under this section.¹⁹

This last statutory provision would appear to be a reaffirmation of the default rule under the “miscellaneous receipts statute,” requiring that amounts received pursuant to (3)(B)(iv) be deposited in the Treasury “as soon as practicable.”²⁰ Consequently, it appears that the agency is permitted to retain and use that part of each issuer’s contribution that is attributable to the reinsurance program and any administrative expenses, but not that portion of the issuer’s contribution that is attributable to the U.S. Treasury contribution.

Because the statute makes such a distinction, it raises the question of what portion of each issuer’s contribution is attributable to which category. Section 1341(b)(3)(B)(iv), which defines the U.S. Treasury contribution, states that the reinsurance program “shall be designed so that ... each issuer’s contribution for any calendar year ... reflects its proportionate share of” the U.S. Treasury contribution.²¹ One reading of this clause is that the amount required to be paid by an issuer under the reinsurance program includes some share attributable to the U.S. Treasury contribution. In contrast, CMS’ current position appears to be that no portion of an issuer’s contribution is attributable to the U.S. Treasury contribution until the aggregate amount collected meets the aggregate target for reinsurance payments.²²

Courts addressing the legitimacy of an agency’s interpretation of a statute typically look to the Supreme Court’s decision in *Chevron v. Natural Resources Defense Council*, which sets forth a widely accepted two-part test.²³ First, if Congress has spoken directly on the issue, then that statutory language or history must control. However, “if ... Congress has not directly addressed the precise question at issue,” the agency’s interpretation will stand so long as it is a reasonable one.²⁴ In other words, where a statutory provision is ambiguous and constitutes an implicit delegation to the agency to “elucidate” the provision, courts will generally give an agency significant discretion to fill in the gaps created by that ambiguity.²⁵

¹⁸ 42 U.S.C.A. § 18061(b)(4) (emphasis added).

¹⁹ *Id.* (emphasis added).

²⁰ 31 U.S.C. § 3302(b).

²¹ 42 U.S.C. § 18061(b)(3)(B)(iv). The amount described in (b)(3)(iv) is in addition to the amount collected for reinsurance payments. *Id.*

²² CMS has allowed contributing entities to make bifurcated payments in which an initial collection will occur on or around January 15, and a second collection on or around November 15 of a given year. At one point, the first collection was allocated towards reinsurance payments and administrative expenses, while the second collection was allocated only to the U.S. Treasury. 45 C.F.R. § 153.405(c); 78 Fed. Reg. 65046, 65051 (Oct. 30, 2013); 79 Fed. Reg. 13744, 13775-76 (Mar. 11, 2014). Subsequently, CMS issued a final rule revising this allocation formula such that the second collection would also be allocated to reinsurance payments to the extent that the first collection was insufficient to meet the statutory target amount. 79 Fed. Reg. at 30259.

²³ *Chevron v. Nat’l Resources Def. Council*, 467 U.S. 837, 842-845 (1984).

²⁴ *Id.*

²⁵ *Id.*

Under CMS' interpretation, some issuers' contributions for a given year would not include any amount allocated to the U.S. Treasury contribution. Specifically, all contributions would go towards reinsurance payments until the statutory target for reinsurance payments was reached. After that point, contributions would be allocated to the U.S. Treasury. However, the statute appears to speak directly to the question of whether the U.S. Treasury contribution must be taken from each issuer's contribution. Section 1341(b)(4) requires contribution amounts described in (3)(B)(iv) to be deposited in the U.S. Treasury, and (3)(B)(iv) describes a proportionate share of the aggregate U.S. Treasury contribution, reflected in "each issuer's contribution." Insofar as CMS' interpretation allows the entire contribution of an issuer to be used only for reinsurance payments, such that no part of it is used for the U.S. Treasury contribution, then that would appear to be in conflict with the plain text of § 1341(b)(4).

The statute explicitly provides CMS with some flexibility in how the payments of the contribution amounts will be implemented. Specifically, the statute permits the contribution amount to "be paid in advance or periodically throughout the plan year."²⁶ What is meant by a "periodic payment" is not defined in the statute, but Black's Law Dictionary defines it as "[o]ne of a series of payments made over time instead of a one-time payment for the full amount."²⁷ This would appear to give CMS the authority to spread payments of the contribution amount across a plan year. However, the combination of all periodic payments for an issuer ultimately comprises the "full amount." As discussed above, *each issuer's* contribution for any given year appears to be required to reflect the additional U.S. Treasury contribution. Therefore, even if the payments could be bifurcated in purpose *and* amount within a year, the total contribution for each issuer in a given year "shall" reflect "its proportionate share of" the U.S. Treasury contribution.

CMS noted in the preamble to its May 27, 2014 final rule that § 1341 is silent on how the agency should approach the distribution of reinsurance contributions if insufficient amounts are collected to fully fund all three components of the program (that is, reinsurance payments, administrative expenses, and payments to the U.S. Treasury).²⁸ While that may be true, the statute is clear that amounts from "each issuer's contribution" must reflect the U.S. Treasury contribution, and that this reflected amount from "each issuer's contribution" must be deposited in the U.S. Treasury.

CMS also asserts that § 1341(b)(3)(B)(iii) uses "mandatory language with respect to the collection of amounts for the reinsurance payment pool" by stating that the aggregate issuer contributions "shall ... equal" specific, statutory amounts for plan years 2014, 2015, and 2016.²⁹ In contrast, CMS argues that "more permissive language" is used with respect to the contributions for administrative expenses or the U.S. Treasury.³⁰ Section 1341(b)(3)(B)(ii) states that the contribution amount "can" include an amount to fund administrative expenses.³¹ The use of the permissive "can" would appear to clearly establish that inclusion of administrative expenses in an issuer's contribution amount is optional. However, § 1341(b)(3)(B)(iv) states that the reinsurance program "shall be designed so that ... each issuer's contribution for any calendar year ... reflects its proportionate share of" the U.S. Treasury contribution.³² CMS argues that the term "reflects" indicates a similar degree of permissiveness regarding the U.S. Treasury contribution.³³ A dictionary definition of "reflect" states that it can mean "to make manifest or

²⁶ 42 U.S.C. § 18061(b)(3)(A).

²⁷ BLACK'S LAW DICTIONARY (10th ed. 2014).

²⁸ 79 Fed. Reg. at 30258.

²⁹ 42 U.S.C. § 18061(b)(3)(B)(iii).

³⁰ 79 Fed. Reg. at 30258.

³¹ 42 U.S.C. § 18061(b)(3)(B)(ii).

³² 42 U.S.C. § 18061(b)(3)(B)(iv).

³³ 79 Fed. Reg. at 30258.

apparent.”³⁴ It is not clear that the term admits of any significant discretion, particularly where the surrounding language of the clause includes aggregate statutory amounts of the same specificity as in clauses that CMS considers to be mandatory,³⁵ and further assigns to “each issuer’s contribution ... its *proportionate share*” of those aggregate amounts.³⁶

In conclusion, insofar as CMS’ interpretation allows the entire contribution of an issuer in any given year to be used only for reinsurance payments, such that no part of it is allocated for the U.S. Treasury contribution, then that would appear to be in conflict with a plain reading of § 1341(b)(4). Because the statute unambiguously states that “each issuer’s contribution” contain an amount that reflects “its proportionate share” of the U.S. Treasury contribution, and that these amounts should be deposited in the General Fund of the U.S. Treasury, a contrary agency interpretation would not be entitled to deference under *Chevron*.

Does CMS have the authority to delay payments to the U.S. Treasury in one year and make it up in subsequent years?

As described above, § 1341 requires the reinsurance program to be designed such that the contribution of an issuer for any given year reflects “its proportionate share” of the U.S. Treasury contribution. Additionally, these reflected amounts are required to be deposited in the General Fund of the Treasury, as soon as practicable.³⁷ If contributions to the U.S. Treasury were delayed for one year, that would appear to be inconsistent with this clear statutory mandate.

CMS has interpreted the statute in a similar manner. In its preamble to the May 27, 2014 final rule, it considered comments about deferring payments to the U.S. Treasury, but “concluded that we [CMS] have no authority to defer the collection of reinsurance contributions for those payments to the end of the program.”³⁸

³⁴ WEBSTER’S 9TH NEW COLLEGIATE DICTIONARY 989 (1983).

³⁵ 79 Fed. Reg. at 30258.

³⁶ 42 U.S.C. § 18061(b)(3)(B)(iv) (emphasis added).

³⁷ 31 U.S.C. § 3302(b).

³⁸ 79 Fed. Reg. at 30259.