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The Patient Protection and Affordable Care Act's (ACA's) Transitional Reinsurance Program

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Summary

Section 1341 of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) establishes a transitional reinsurance program that is designed to provide payment to non-grandfathered, non-group market health plans (also known as *individual* market health plans) that enroll high-risk enrollees for 2014 through 2016. Under the program, the Secretary of the Department of Health and Human Services (HHS) collects reinsurance contributions from health insurers and from third-party administrators on behalf of group health plans. The Secretary then uses those contributions to make reinsurance payments to health insurers who enroll high-cost enrollees (statutes required the HHS Secretary to determine how high-risk enrollees are identified, and the Secretary in turn defined high-risk enrollees as high-cost enrollees) in their non-group market plans both inside and outside of the exchanges (also known as the *marketplaces*). That is, contributions are distributive in which they are collected from most non-group and group health insurers, but payments are made only to eligible non-group market health plans.

Reinsurance is an extension of insurance and further acts as a risk transfer and risk spreading mechanism. The availability of reinsurance allows insurers to reduce their risk exposure and can affect the availability and affordability of health insurance coverage. That is, the availability of reinsurance may be one of many factors an insurer considers in assessing potential exposure to loss in a certain market. This may impact whether or not to enter a market, what types of products to offer, and what premiums to set.

To mitigate the financial risk and uncertainty insurers may face in the early years of ACA implementation as a result of the ACA's private health insurance market reforms, the ACA establishes three risk-mitigation programs (the transitional reinsurance program, the permanent risk adjustment program, and the temporary risk corridors program).

Prior to ACA implementation, little information was available regarding health care usage and demand for the previously uninsured, as well as any pent-up demand due to the lack of health insurance coverage. Accordingly, to limit their risk exposure in offering plans on the non-group market, insurers would likely raise premiums to the extent possible to protect themselves against the potentially high cost associated with delayed care. However, some of the new ACA market reforms limit the degree to which insurers may 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.

Under the program, the HHS Secretary collects reinsurance contributions from most non-group and group health plans and then uses those contributions to make reinsurance payments only to non-group market health plans with high-cost enrollees. The programs cover a portion of the claims costs for these enrollees based on payment parameters set by the HHS Secretary.

This report provides an overview of one of the three risk-mitigation programs, the transitional reinsurance program. The program's aim is to offset the expenditures associated with high-cost individuals. The first section of the report provides background information on reinsurance and the ACA risk-mitigation programs. The second section describes the components of the transitional reinsurance program, as well as the amounts currently collected and remitted through the program. The third section discusses questions, including those raised by a recent Government Accountability Office report, regarding the scope of HHS's authority to administer the transitional reinsurance program. The last section briefly summarizes relevant legislation regarding the transitional reinsurance program. Finally, the report includes a table in the **Appendix** that summarizes key aspects of the transitional reinsurance program.

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Introduction

Section 1341 of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) establishes a transitional reinsurance program that is designed to provide payment to non-grandfathered, non-group market health plans (also known as *individual* market health plans) that enroll high-risk enrollees for 2014 through 2016.[1] Under the program, the Secretary of the Department of Health and Human Services (HHS) collects reinsurance contributions from health insurers and from third-party administrators on behalf of group health plans. The Secretary then uses those contributions to make reinsurance payments to health insurers who enroll high-cost enrollees (statutes required the HHS Secretary to determine how high-risk enrollees are identified, and the Secretary in turn defined high-risk enrollees as high-cost enrollees) in their non-group market plans both inside and outside of the exchanges (also known as *marketplaces,* where individuals can shop for and purchase private health insurance coverage).[2]

This report provides an overview of the ACA's transitional reinsurance program. The transitional reinsurance program's aim is to protect against the potential incentive to increase premiums by offsetting the expenditures associated with high-risk individuals. The first section of the report provides background information on reinsurance and the ACA risk-mitigation programs. The second section describes the components of the transitional reinsurance program, as well as the amounts currently collected and remitted through the program. The third section discusses questions, including those raised by a recent Government Accountability Office (GAO) report, regarding the scope of HHS's authority to administer the transitional reinsurance program. The last section briefly summarizes relevant legislation regarding the transitional reinsurance program. Finally, the report includes a table in the **Appendix** that summarizes key aspects of the transitional reinsurance program.

Background

Insurance Risk and Reinsurance

The concept underlying insurance is *risk* (i.e., the likelihood and magnitude of financial loss). In any type of insurance arrangement, all parties seek to minimize their own risk. In health insurance, consumers and insurers approach the management of insurance risk differently. From the consumer's point of view, a person (or family) buys health insurance to protect against financial losses resulting from the future use of medical care. From the insurer's point of view, it employs a variety of methods to manage the risk it takes on when providing health coverage to

[1] A grandfathered health plan refers to an existing plan in which at least one individual has been enrolled since enactment of the Patient Protection and Affordable Care Act (ACA, as amended) on March 23, 2010. A plan can maintain its grandfathered status as long as it meets certain requirements. Grandfathered health plans are exempt from the majority of ACA market reforms. The non-group (also known as the *individual*) market is where individual can purchase health coverage from an insurer. Health insurance can be provided to groups of people who are drawn together by an employer or other organization. When insurance is provided to a group, it is referred to as group coverage or group insurance. The group health insurance market is divided into two segments, small group and large group. Prior to the ACA, most states defined *small* as businesses having 50 or fewer employees. Under the ACA, the definition of *small* was set to expand to businesses having 100 or fewer employees beginning in 2016. However, President Obama signed into law the Protecting Affordable Coverage for Employees Act (PACE Act) to rescind the ACA's expanded definition of *small* subject to the rules of the small-group market in the state.

[2] For more information, see CRS Report R44065, *Overview of Health Insurance Exchanges*.

consumers, to assure that the insurer operates a profitable business (e.g., charging higher premiums for older individuals, because medical expenses tend to increase with age). The insurer uses these methods when pooling risk so that premiums collected from all enrollees generally are sufficient to fund claims (plus administrative expenses and profits).[3]

Sometimes, however, even with the variety of methods an insurer may employ to manage risk, the risk taken on by the insurer may be too large. For example, a single health insurance company may be unable to cover a catastrophic loss (i.e., individuals who experience illnesses that result in huge expenditures). To limit their risk exposure, insurers often transfer some of their liability or risk to another insurer, a reinsurance company.[4] That is, just as an insurer pools the risk of its covered consumers, a portion of that risk gets further spread to other insurance companies, known as reinsurers.

Reinsurance, thus, is an extension of insurance and further acts as a risk transfer and risk spreading mechanism. Insurers often purchase reinsurance for four reasons: (1) to limit liability on specific risks; (2) to stabilize loss experience; (3) to protect against catastrophes; and (4) to increase capacity.[5] The availability of reinsurance allows insurers to reduce their risk exposure and can affect the availability and affordability of health insurance coverage. That is, the availability of reinsurance may be one of many factors an insurer considers in assessing potential exposure to loss in a certain market. This may impact whether or not to enter a market, what types of products to offer, and what premiums to set.

Reinsurance also may be structured in different ways depending on the insurer's need and can range from simple to complex. Generally, however, reinsurance contracts either may be a broad agreement covering some portion of the business or may cover a specific risk.[6]

Occasionally, the government may act as the reinsurer in certain markets. Governmental involvement in insurance and reinsurance is not a new concept, and t the government covers risks in many markets (outside of health insurance). One example of the federal government acting as a reinsurer is through the Terrorism Risk Insurance Act of 2002 (TRIA; P.L. 107-297). Prior to the September 11, 2001, terrorist attacks, insurance covering terrorism losses was normally included in general insurance policies without additional cost to the policyholders. Following the attacks, both primary insurers and reinsurers pulled back from offering terrorism coverage. TRIA created a temporary, three-year terrorism insurance program to calm the insurance markets through a government reinsurance backstop sharing in terrorism losses.[7]

The ACA provides another example in which the federal government acts as the reinsurer in an insurance market.

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[3] For more information, see CRS Report RL32237, *Health Insurance: A Primer*.

[4] American Academy of Actuaries, "Catastrophe Exposures and Insurance Industry Catastrophe Management Practices," June 10, 2001. Department of Health and Human Services (HHS), "Establishing an Analytical Framework for Measuring the Role of Reinsurance in the Health Insurance Market," March 20, 1997, at https://aspe.hhs.gov/report/establishing-analytical-framework-measuring-role-reinsurance-health-insurance-market. R. R. Bovbjerg, "Reform of Financing for Health Coverage: What Can Reinsurance Accomplish?" *Inquiry*, vol. 29, no. 2(summer 1992), pp.158-175.

[5] Reinsurance Association of America (RAA), "Purposes of Reinsurance," at http://www.reinsurance.org/Fundamentals/Purposes_of_Reinsurance/.

[6] RAA, "The Reinsurance Contract," at http://www.reinsurance.org/Fundamentals/The_Reinsurance_Contract/.

[7] For more information, see CRS Report R43849, *Terrorism Risk Insurance Legislation in the 114th Congress: Issue Summary and Side-by-Side Analysis*.

The ACA and Risk Mitigation

The ACA includes provisions that restructure the private health insurance market by implementing market reforms that impose requirements on health insurance plans.[8] As part of a larger set of private health insurance market reforms, the ACA requires private health insurers to provide coverage to individuals regardless of health status, medical history, and preexisting conditions.[9] Under the ACA, insurers can adjust premiums based solely on certain ACA-specified factors (i.e., individual or family enrollment, geographic rating area, tobacco use, and age).[10] Further, some individuals may be eligible for financial assistance (i.e., premium tax credits and cost-sharing subsidies) through the health insurance exchanges (also known as the marketplaces).[11] In addition, the ACA requires that most individuals maintain health insurance coverage or pay a penalty for noncompliance (i.e., the individual mandate).[12]

As previously mentioned, the insurer often employs a variety of methods to manage the risk it takes on when providing health coverage to consumers. For instance, insurers often use projected enrollment, projected claims costs, and other policy-specific features (e.g., consumer cost sharing, provider networks) for a pool of individuals to set health insurance rates. Yet, prior to ACA implementation, little information was known regarding many of these factors in the newly created markets.

Accordingly, the new ACA market reforms and the expanded pool of individuals seeking to purchase health insurance coverage contribute to the uncertainty that insurers face in the early years of ACA implementation. Much of the uncertainty centers on the types of individuals who may or may not seek coverage. For example, would healthy individuals decide to seek coverage in addition to unhealthy individuals? Also, did the expanded pool extend to individuals who were previously uninsured and/or may have delayed receiving health care services? Furthermore, what was the demand for health care services for this expanded pool of individuals?

To mitigate the financial risk that insurers face and stabilize the price of health insurance in the non-group and small group markets, the ACA establishes three risk-mitigation programs: the transitional reinsurance program, the permanent risk adjustment program, and the temporary risk corridors program. **Table 1** summarizes the goals, objectives, and potential sources of uncertainty or risk that each of the ACA's three risk-mitigation programs aims to moderate. **Table 1** does not include information on program implementation.[13]

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[8] For more information, see CRS Report R42069, *Private Health Insurance Market Reforms in the Patient Protection and Affordable Care Act (ACA)*. See also 42 U.S.C. §300gg-300gg-95.

[9] For more information, see CRS Report R43854, *Overview of Private Health Insurance Provisions in the Patient Protection and Affordable Care Act (ACA)*. See also 42 U.S.C. §300gg-4.

[10] 42 U.S.C. §300gg.

[11] For more information, see CRS Report R44425, *Eligibility and Determination of Health Insurance Premium Tax Credits and Cost-Sharing Subsidies: In Brief*.

[12] For more information, see CRS Report R44438, *The Individual Mandate for Health Insurance Coverage: In Brief*.

[13] This report provides information on the transitional reinsurance program in further detail. For more information on the other two risk-mitigation programs, see CRS Report R43854, *Overview of Private Health Insurance Provisions in the Patient Protection and Affordable Care Act (ACA)*.

Table 1. Summary of the ACA's Risk-Mitigation Programs

Risk-Mitigation Program	Goal	Objective	Potential Uncertainty or Risk	Time Frame	Applicability
Transitional Reinsurance Program	Offset a plan's risk associated with high-cost enrollees.	Provide funding to plans that incur high costs for individual enrollees.	Uncertainty regarding health care usage and demand for the previously uninsured, as well as any pent-up demand due to the lack of health insurance.	Temporary; 2014-2016	Health insurers and third-party administrators on behalf of group health plans pay in; only non-group market plans (inside and outside of the exchanges) are eligible for payment.[a]
Permanent Risk Adjustment Program	Protect against adverse selection.[b]	Transfer funds from relatively low-risk plans to relatively high-risk plans.	Risk of adverse selection. That is, individuals who expect or plan for high use of health services tend to seek out coverage and enroll in more generous plans, whereas individuals who do not expect to use many or any health services may not obtain coverage and, if they do, they tend to enroll in less generous plans.	Permanent; beginning plan year 2014	All non-grandfathered, non-group, and small-group market plans (inside and outside the exchanges) are subject to the risk adjustment program.[c]
Temporary Risk Corridors Program	Protect against inaccurate rate setting.	Limit the insurer's gains and losses.	Uncertainty regarding individuals who may or may not seek coverage and their subsequent demand for health services. For example, would young people in addition to older people seek coverage? Would healthy individuals seek coverage in addition to unhealthy individuals?	Temporary; 2014-2016	All qualified health plans (QHPs) in the non-group and small-group market (inside and outside the exchanges) are subject to the risk corridors program.[d]

Source: Congressional Research Service (CRS) analysis of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) and its implementing regulations.

a. The non-group (also known as the *individual*) market is where an individual can purchase health coverage from an insurer. Health insurance can be provided to groups of people who are drawn together by an employer or other organization. When insurance is provided to a group, it is referred to as group coverage or group insurance. The group health insurance market is divided into two segments, small group and large group. Prior to the ACA, most states defined *small* as businesses having 50 or fewer employees. Under the ACA, the definition of *small* was set to expand to businesses having 100 or fewer employees beginning in 2016. However, President Obama signed into law the Protecting Affordable Coverage for Employees Act (PACE Act; P.L. 114-60) to rescind the ACA's expanded definition of *small* subject to the rules of the small-group market in the state.

b. Adverse selection occurs when individuals who expect or plan for high use of health services tend to enroll in more generous (and consequently more expensive) health plans.

c. A grandfathered health plan refers to an existing plan in which at least one individual has been enrolled since enactment of the ACA on March 23, 2010. A plan can maintain its grandfathered status as long as it meets certain requirements. Grandfathered health plans are exempt from the majority of ACA market reforms.

d. Qualified health plans (QHPs) are plans that are certified to be offered in the health insurance exchanges. Each exchange is responsible for certifying the plans it offers. QHPs can be offered both inside the health insurance exchanges and outside the exchanges on the private health insurance market.

The Transitional Reinsurance Program

Overview

Section 1341 of the ACA establishes the transitional reinsurance program.[14] The transitional reinsurance program is a temporary program (plan years 2014-2016) that provides payment to non-group market health plans that enroll high-cost (specified in statutes as high-risk) enrollees both inside and outside the exchanges.[15] Prior to ACA implementation, little information was available regarding health care usage and demand for the previously uninsured, as well as any pent-up demand due to the lack of health insurance coverage. Accordingly, to limit their risk exposure in offering plans on the non-group market, insurers would likely raise premiums to the extent possible to protect themselves against the potentially high cost associated with delayed care. However, some of the new ACA market reforms limit the degree to which insurers may vary premiums. For example, individuals who were previously uninsured may apply for coverage on a guaranteed-issue basis; insurers must accept these applicants and can only vary premiums based on the factors noted above.[16] The transitional reinsurance program is designed to mitigate the financial risk associated with individuals who had delayed needed health care while they were uninsured.

The ACA requires that a transitional reinsurance program be established in each state for 2014 through 2016.[17] The ACA establishes the transitional reinsurance program to be redistributive in nature in which the HHS Secretary collects reinsurance contributions from health insurers and from third-party administrators on behalf of group health plans;[18] the HHS Secretary then uses those contributions to make reinsurance payments only to health insurers offering plans in the non-group market both inside and outside of the exchanges.[19] Under the program, only non-group market health plans with high-cost enrollees are eligible for reinsurance payments; the programs

[14] ACA; §1341.

[15] The ACA requires the HHS Secretary to determine how high-risk enrollees are identified. HHS, in turn, determined that reinsurance payments would be made to plans with high-cost enrollees. Whether an eligible insurer receives a reinsurance payment is dependent on an enrollee's total claims and additional payment parameters specified by HHS.

[16] In general, guaranteed issue in health insurance is the requirement that a plan accept every applicant for health coverage, as long as the applicant agrees to the terms and conditions of the insurance offer (e.g., the premium). For more information on guaranteed issue, see CRS Report R42069, *Private Health Insurance Market Reforms in the Patient Protection and Affordable Care Act (ACA)*.

[17] Although states are allowed to establish their own transitional reinsurance programs, only Connecticut chose to do so. For all other states, the HHS 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, 2015, and 2016. For more information, see Access Health CT, "Transitional Reinsurance Program," at http://ct.gov/hix/cwp/view.asp?a=4295&q=532146.

[18] A transitional reinsurance contributing entity is either (1) a health insurer or (2) for 2014, a self-insured group health plan regardless of whether the plan 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 C.F.R. §153.20. In 2015 and 2016, a self-insured group health plan that does not use a TPA is not considered a contributing entity. TPAs typically handle the administrative duties of offering a health plan, such as member services, premium collection, and utilization review; however, third-party administrators do not underwrite risk.

[19] Centers for Medicare & Medicaid Services (CMS), "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, Exchange Standards for Employers (CMS-9989-FWP) and Standards Related to Reinsurance, Risk Corridors and Risk Adjustment (CMS-9975-F) Regulatory Impact Analysis," March 2012, at https://www.cms.gov/CCIIO/Resources/Files/Downloads/hie3r-ria-032012.pdf.

covers a portion of the claims costs for these enrollees based on payment parameters (see "Payment Parameters" section of this report) set by the HHS Secretary.[20] Overall, the transitional reinsurance program transfers a portion of the funds collected from most non-group and group health insurers to non-group market plans with high-cost enrollees.

Aggregate Collection Amounts

The statutes specify that the aggregate collection for all states for the transitional reinsurance program equals $10 billion for plan year 2014, $6 billion for plan year 2015, and $4 billion for plan year 2016.[21] The statutes also specify that an additional collection be deposited into the general fund of the U.S. Treasury.[22] The aggregate collection for the U.S. Treasury is to equal $2 billion for plan year 2014, $2 billion for plan year 2015, and $1 billion for plan year 2016.[23] In addition, the statutes allow for the collection of additional amounts for program administration.[24] The statutes do not specify the aggregate administration amounts; rather, the HHS Secretary provided estimates of these amounts in regulations.[25] The estimated amounts for program administration equal $20.3 million for plan year 2014, $25.4 million for plan year 2015, and $32.0 million for plan year 2016. **Table 2** includes the amounts to be collected for reinsurance payments and the U.S. Treasury, as specified in statutes; the amounts for program administration, as estimated by the Secretary, for 2014-2016; and a combined total.

Table 2. Transitional Reinsurance Program Contribution Amounts

Year	Total Collection for Reinsurance Payments[a]	Total Collection for U.S. Treasury[a]	Total Collection for Program Administration	Total
2014	$10 billion	$2 billion	$20.3 million[b]	$12.02 billion
2015	$6 billion	$2 billion	$25.4 million[c]	$8.03 billion
2016	$4 billion	$1 billion	$32.0 million[d]	$5.03 billion

Source: CRS analysis of statute and regulations.

a. Amounts are statutorily defined in §1341 of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended).

b. Department of Health and Human Services (HHS), "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014, Final Rule," 78 *Federal Register* 15410-15541, March 11, 2013.

c. HHS, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2015, Final Rule," 79 *Federal Register* 13744-13843, March 11, 2014.

d. HHS, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, Final Rule," 80 *Federal Register* 10750-10877, February 27, 2015.

[20] A health insurer 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 non-group market, except for grandfathered plans and health insurance coverage not required to submit reinsurance contributions under 45 C.F.R. §153.400(a). See 45 C.F.R. §153.20.

[21] 42 U.S.C. §18061(b)(3)(B)(iii).

[22] Ibid. §18061(b)(4).

[23] Ibid. §18061(b)(3)(B)(iv).

[24] Ibid. §18061(b)(3)(B)(ii).

[25] 45 C.F.R. §153.220(c)(3).

National Per Capita Reinsurance Contribution

Although the statutes specify certain aggregate amounts to be collected (for reinsurance payments and U.S. Treasury) and allow collection for administration of the transitional reinsurance program, the statutes require the HHS Secretary to establish a methodology for determining how much each contributing entity (i.e., non-group health plan or group health plan) must contribute.[26] The Secretary established a methodology whereby contributing entities pay a per person amount based on their enrollment.[27] The per person contribution (i.e., the per capita national contribution) was calculated as the sum of (1) the aggregate contribution for the reinsurance program, (2) the additional contribution to the U.S. Treasury, and (3) the cost of administration divided by the estimated number of enrollees in plans required to make reinsurance contributions (see **Figure 1**).[28]

Figure 1. Calculation of the National Per Capita Reinsurance Contribution

$$National\ Per\ Capita\ Reinsurance\ Contribution = \frac{Reinsurance\ contribution + Treasury\ contribution + Administrative\ cost}{HHS's\ estimate\ of\ enrollment\ in\ conributing\ entities}$$

Source: HHS, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014, Proposed Rule," 77 *Federal Register* 73118-73218, December 7, 2012.

Accordingly, the national per capita reinsurance contribution equals $63 for plan year 2014, $44 for plan year 2015, and $27 for plan year 2016.

Insurers may pay national per capita reinsurance contribution amounts to the Centers for Medicare & Medicaid Services (CMS) in a single payment by mid-January of the following year or in two payments, the first payment due by mid-January of the following year and the second payment due by mid-November of the following year. For example, for plan year 2014, an insurer could have made a full payment of $63 per capita, due by January 1, 2015, or an insurer could have made the first payment of $52.50 per capita by January 15, 2015, and a second payment of $10.50 per capita by November 15, 2015.[29]

Payment Parameters

In addition to the national per capita reinsurance contribution, the statutes require the HHS Secretary to determine how high-risk enrollees are identified.[30] Accordingly, HHS determined that reinsurance payments would be made to plans with high-cost enrollees.[31] If an enrollee's total

[26] For more information on what qualifies as a contributing entity, see footnote 19.

[27] Enrollment is to be based on the contributing entity's fully insured commercial book of business for all major medical products. See 45 C.F.R. §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 C.F.R. §153.405.

[28] To estimate enrollment in entities required to make reinsurance contributions, as well as to estimate reinsurance payment parameters, the HHS Secretary developed a model (the Affordable Care Act Health Insurance Model, or ACAHIM). This model is described in HHS, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters, Proposed Rule," 77 *Federal Register* 73160, December 7, 2012.

[29] HHS, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2015 Final Rule," 79 *Federal Register* 13744-13843, March 11, 2014. For information on the payment deadlines for plan years 2015 and 2016, see **Table A-1**.

[30] 42 U.S.C. §18061(b)(2)(A).

[31] HHS, "Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment, Proposed Rule." 76 *Federal Register* 41930, July 15, 2012.

claims exceed a specified level (referred to as the *attachment point*), the insurer would be paid a proportion of claims costs (referred to as the *coinsurance rate*) beyond the attachment point until total claims costs reached a cap (referred to as the *reinsurance cap*).

The attachment point, coinsurance rate, and reinsurance cap together are the payment parameters that the Secretary proposes and publishes in the annual payment notice.[32] **Table 3** includes payment parameters (both proposed and final) for plan years 2014, 2015, and 2016.

Table 3. Transitional Reinsurance Program Payment Parameters

Year	Attachment Point	Coinsurance Rate	Reinsurance Cap
2014	Currently set at $45,000[a] Previously set at $60,000[b]	Currently set at 100.0%[a] Previously set at 80.0%[b]	$250,000[b]
2015	Currently set at $45,000[c] Previously set at $70,000[a]	Currently set at 55.1%[d] Previously set at 50.0%[a]	$250,000[a]
2016	Currently set at $90,000[c]	Currently set at 50.0%[c]	$250,000[c]

Source: CRS analysis of regulations published by HHS.

a. HHS, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2015 Final Rule," 79 *Federal Register* 13744-13843, March 11, 2014.

b. HHS, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014 Final Rule," 78 *Federal Register* 15410-15541, March 11, 2013.

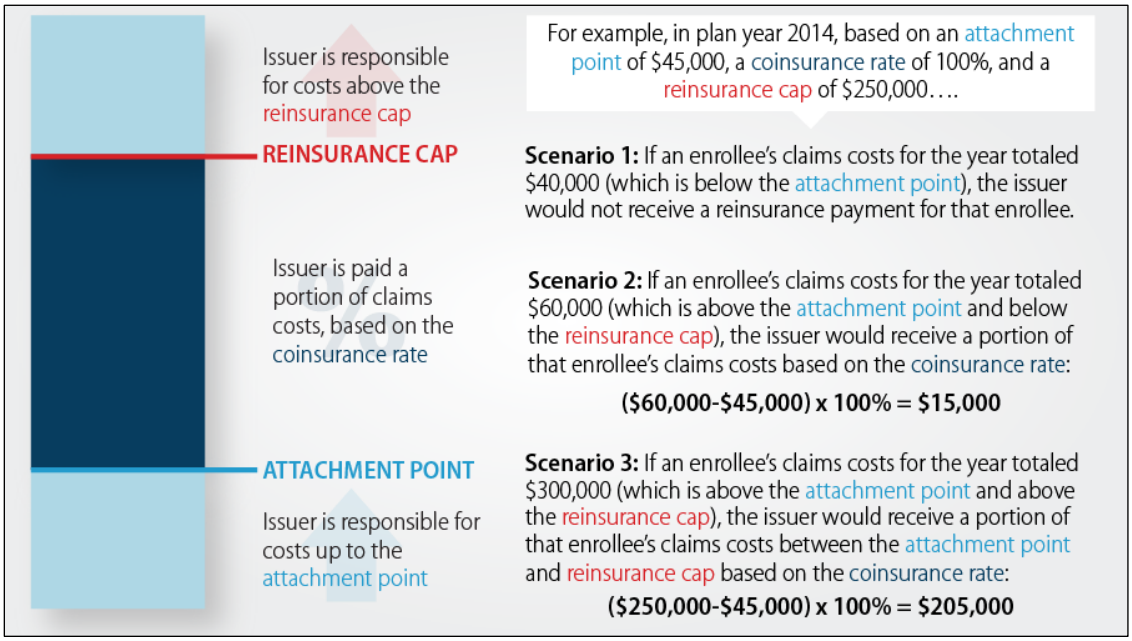
c. HHS, "Patient Protections and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016 Final Rule," 80 *Federal Register* 10750-10877, February 27, 2015.

d. Centers for Medicare & Medicaid Services, "Transitional Reinsurance Program: Pro Rata Adjustment to the National Coinsurance Rate for the 2015 Benefit Year," June 17, 2016.

An illustrative example of reinsurance payment eligibility and calculation, given the 2014 plan year's attachment point, coinsurance rate, and reinsurance cap can be seen in **Figure 2**.

[32] CMS, "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, Exchange Standards for Employers (CMS-9989-FWP) and Standards Related to Reinsurance, Risk Corridors and Risk Adjustment (CMS-9975-F) Regulatory Impact Analysis," March 2012, at https://www.cms.gov/CCIIO/Resources/Files/Downloads/hie3r-ria-032012.pdf.

Figure 2. Illustrative Example of Reinsurance Payment Eligibility and Calculation



Source: CRS's illustrative example of reinsurance payment eligibility is based on payment parameters set for plan year 2014. HHS, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014 Final Rule," 78 *Federal Register* 15410-15541, March 11, 2013.

Amounts Collected and Remitted

As previously mentioned, the statutes specify amounts to be collected for the transitional reinsurance program and for the U.S. Treasury, and they allow for the collection of amounts toward program administration (see **Table 2**). However, collection amounts fell short of the target for the 2014 and 2015 plan years (collection for the 2016 plan year has not yet begun), as outlined below. The following sections describe amounts collected by CMS, amounts requested by insurers, and amounts remitted to insurers in the 2014 and 2015 plan years, as well as due dates for payment in the 2016 plan year.

2014

For plan year 2014, the first or full reinsurance contribution was due to CMS by January 15, 2015, and the second reinsurance contribution was due by November 15, 2015. Eligible insurers also were required to submit reinsurance data by April 30, 2015. CMS remitted reinsurance payments to insurers between July 2015 and September 2015.[33]

CMS collected approximately $9.7 billion in reinsurance contributions, which was below the target amount of $12.0 billion for plan year 2014 ($10.0 billion for reinsurance payments and $2.0 billion for U.S. Treasury, see **Table 2**).[34] Nationwide, 437 insurers requested reinsurance-

[33] CMS, "Key Dates in 2015: QHP Certification in the Federally-Facilitated Marketplaces; Rate Review; Risk Adjustment, Reinsurance, and Risk Corridors."

[34] Approximately $8.7 billion was collected as of March 2015, and an additional approximately $1.0 billion was anticipated by November 2015. CMS, "Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2014 Benefit Year," September 17, 2015.

eligible claims of approximately $7.9 billion.[35] And, given the coinsurance rate of 100% for plan year 2014 (see **Table 3**), CMS remitted approximately $7.9 billion for reinsurance payments to insurers.[36] Moreover, approximately 18% of the reinsurance contributions for plan year 2014 (approximately $1.7 billion of the $9.7 billion) was reserved for reinsurance payments for the 2015 plan year.[37] No amount was deposited to the U.S. Treasury.

2015

For plan year 2015, the first or full reinsurance contribution was due to CMS by January 15, 2016, and the second reinsurance contribution was due by November 15, 2016. Eligible insurers also were required to submit final reinsurance data by May 2, 2016. CMS remitted early reinsurance payments to insurers between March 2016 and April 2016 and expects to remit the remaining reinsurance payments once November contributions are collected.[38]

CMS anticipates collecting approximately $6.5 billion in reinsurance contributions, which is below the target amount of $8.0 billion for plan year 2015 ($6.0 billion for reinsurance payments and $2.0 billion for U.S. Treasury, see **Table 2**).[39] Nationwide, 497 insurers requested reinsurance-eligible claims of approximately $14.3 billion. And, given the coinsurance rate of 55.1% for plan year 2015 (see **Table 3**); CMS expects to remit a total of $7.8 billion for reinsurance payments to insurers.[40] In March and April 2016, CMS remitted approximately $7.0 billion (of the $7.8 billion) in early reinsurance payments for the 2015 plan year to insurers.[41] This early payment represents a portion of the full reinsurance payment that insurers will receive for the 2015 plan year.[42] CMS will make a second reinsurance payment once the November 15, 2016, contributions have been collected.

Of the anticipated $6.5 billion collected for plan year 2015, CMS has indicated that $500 million will be allocated on a pro rata basis of 1% for program administration and 99% to the U.S.

[35] Ibid.

[36] Ibid. The Congressional Research Service (CRS) confirmed with CMS that plan year 2014 payments have all been remitted to the insurers.

[37] Numbers may not sum precisely due to rounding. CMS, "The Transitional Reinsurance Program's Contribution Collections for the 2015 Benefit Year," February 12, 2016.

[38] CMS, "Key Dates for Calendar Year 2016: QHP Certification in the Federally-Facilitated Marketplaces; Rate Review; Risk Adjustment and Reinsurance."

[39] Approximately $5.5 billion was collected as of February 2016, and an additional approximately $1.0 billion is anticipated to be collected by November 2016. CMS, "The Transitional Reinsurance Program's Contribution Collections for the 2015 Benefit Year," February 12, 2016.

[40] Of the approximately $6.5 billion expected from 2015 collection, approximately $0.5 billion is expected to be allocated for program administration and U.S. Treasury payment. Thus, approximately $6.0 billion (of the $6.5 billion) from the 2015 collection plus the approximately $1.7 billion from the 2014 rollover are to be used for reinsurance remittances for plan year 2015, totaling to approximately $7.8 billion. Numbers may not sum precisely due to rounding.

[41] CMS, *Summary Report on Transitional Reinsurance Payment and Permanent Risk Adjustment Transfers for the 2015 Benefit Year*, June 30, 2016.

[42] CMS, "The Transitional Reinsurance Program's Contribution Collections for the 2015 Benefit Year," February 12, 2016.

Treasury.[43] Accordingly, approximately $5 million and $495 million is anticipated to be allocated for program administration and to the U.S Treasury, respectively. [44]

2016

No contributions have been collected thus far for plan year 2016. The first or full payment for plan year 2016 is currently due on January 15, 2017, and the second payment is due on November 15, 2017.

Scope of HHS's Authority to Administer and Fund the Transitional Reinsurance Program[45]

Although states are directed to establish their own transitional reinsurance programs, only Connecticut has chosen to do so.[46] For all other states, the HHS Secretary is implementing the transitional reinsurance program, citing the authority under Section 1321(c)(1) of the ACA.[47] Under this authority, the Secretary may "take such actions as are necessary" to ensure that the requirements of the transitional reinsurance program are met.[48] In those states where the federal government is implementing the transitional reinsurance program, HHS (through CMS) acts as the reinsurance entity for purposes of Section 1341 of the ACA, collecting contributions from covered insurers and third-party administrators (i.e., contributing entities),[49] as well as making payments from those contributions to eligible insurers under the program.[50]

CMS currently allocates all collections in a given year to reinsurance payments for insurers until the statutory collection targets for those purposes have been met.[51] Once the statutory collection targets for a year are satisfied, any further collections in that year would be allocated to program administration expenses and to the U.S. Treasury. Prior to adopting this allocation formula, CMS had issued a final rule with a different allocation method, which has since been amended. In its 2015 Payment Notice issued on March 11, 2014, the first collection was allocated solely toward reinsurance payments and program administration expenses, whereas the second collection was allocated only to the U.S. Treasury.[52]

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[43] HHS, "Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond Final Rule," 79 *Federal Register* 30240-30353, May 27, 2014. Given that payment parameters are subject to change, the pro rata amount may be subject to change. CMS, "The Transitional Reinsurance Program's Contribution Collections for the 2015 Benefit Year," February 12, 2016.

[44] $500 million × 1% = $5 million. $500 million × 99% = $495 million.

[45] This section was written by (name redacted), Legislative Attorney.

[46] Letter from Virginia Lamb, Access Health CT Gen. Counsel, to All Licensed Health Issuers in the State of Conn. April 11, 2013, at http://www.ct.gov/hix/lib/hix/April_10-2014_Notice_to_Carriers_re_Trans_Reinsurance_Final_%282%29.pdf.

[47] 45 C.F.R. §153.210(c).

[48] 42 U.S.C. §18041(c).

[49] See footnote 18.

[50] In states that have established their own reinsurance program, HHS still collects funds from insurers but does not make payments directly to insurers in that state. 45 C.F.R. §153.220.

[51] 79 *Federal Register* 30240, 30258-59, May 27, 2014.

[52] 45 C.F.R. §153.405(c); 78 *Federal Register* 65046, 65051, Oct. 30, 2013; 79 *Federal Register* 13744, 13775-76, March 11, 2014.

Subsequently, in a March 21, 2014, proposed rule, CMS sought comment on its "legal authority to implement a prioritization of reinsurance contributions to reinsurance payments over payments to the U.S. Treasury."[53] One commenter described Section 1341 of the ACA as "impos[ing] few requirements on the expenditure of reinsurance contributions, stating that the statute does not specify that payments must be made to insurers and to the U.S. Treasury simultaneously, or that the U.S. Treasury must receive its full funding before reinsurance pool payments are made."[54] CMS noted its agreement with this argument, stating that Section 1341 "provides [the agency] with the discretion ... to determine the priority, method, and timing for the allocation of reinsurance contributions collected."[55] Consistent with this conclusion, a final rule issued on May 27, 2014, revised the allocation formula. Under the current system, no funds collected from insurers are deposited in the Treasury until sufficient amounts have been received to fund the reinsurance program.[56]

The permissibility of CMS's final rule has been called into question by some observers. On September 29, 2016, GAO issued a legal opinion stating that the current method of allocating contributions from insurers is not authorized by Section 1341.[57] In its opinion, GAO focused on the language of Section 1341, noting that when Congress has enacted statutory language that speaks directly to an issue, such statutory language, viewed in the context of the overall statutory scheme, must control.[58] In particular, Section 1341 states that each insurer's contribution into the transitional reinsurance program "shall be designed so that each issuer's contribution amount for any calendar year ... reflects its proportionate share of an additional $2,000,000,000 for 2014, an additional $2,000,000,000 for 2015, and an additional $1,000,000,000 for 2016."[59]

GAO noted that this provision uses the mandatory term "shall" when directing HHS to collect amounts from insurers for the U.S. Treasury.[60] The use of this term led GAO to the conclusion that the plain language of Section 1341 "requires[s] HHS to collect amounts for the Treasury and do so without qualification."[61] In reaching this conclusion, GAO rejected CMS's argument that the use of the term "reflects" indicated that CMS retained a degree of flexibility in determining how to assess an insurer's U.S. Treasury contribution.[62] In GAO's view, the plain language and structure of the statutory provision counseled against a permissive reading of the statute's allocation requirements.[63]

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[53] 79 *Federal Register* 15808, 15821, Mar. 21, 2014.

[54] 79 *Federal Register* 30240, 30257-58, May 27, 2014.

[55] Ibid.

[56] Ibid. at 30258-59.

[57] GAO, *Department of Health and Human Services: Transitional Reinsurance Program*, B-328016 at 1 (Sept. 29, 2016).

[58] GAO, B-328016 at 4 (citing Chevron, U.S.A., Inc. v. Nat'l Res. Def. Council, 467 U.S. 837, 842 (1984) and King v. Burwell,—U.S.—, 135 S. Ct. 2480, 2489 (2015)).

[59] Ibid. at 5 (citing 42 U.S.C. §18061(b)(3)(B)(iv)).

[60] Ibid.

[61] Ibid.

[62] Ibid. at 9 ("HHS does not explain why it understands the term 'reflect' to be 'more permissive.' We are unable to identify a basis for interpreting the term in this manner, particularly in the context of a statutory provision framed in explicitly mandatory language."). GAO's reading of the term "reflect" is arguably supported by dictionary definitions of the term which state, for example, that it can mean to "mirror" or "make manifest or apparent." MERRIAM-WEBSTER'S COLLEGIATE DICTIONARY 982 (10th ed. 1999).

[63] GAO, B-328016 at 8.

Further, GAO concluded that the statute "explicitly prohibits" such amounts collected for the U.S. Treasury from being used for reinsurance payments to insurers.[64] Where overall collections were insufficient to meet the statutory targets, GAO stated that the proper course of action was to apportion the receipts between reinsurance payments and the U.S. Treasury on a pro rata basis instead of prioritizing one over the other.[65] In support of this pro rata allocation of collections, GAO cited federal court decisions that held that, in cases where programs of federal spending were underfunded, the agency should "preserve the allocation formula" provided in the statute rather than exercise "total discretion in the allocation of the funds."[66]

Following the issuance of GAO's opinion, CMS indicated that it disagreed with GAO's conclusions and would continue to prioritize collections toward reinsurance payments.[67] Past opinions by the Office of Legal Counsel (OLC) in the Department of Justice have taken the position that GAO legal opinions are not binding upon the executive branch, "[a]lthough the opinions and legal interpretations of the GAO and the Comptroller General often provide helpful guidance on appropriations matters and related issues.... "[68]

Other commentators have argued that the Supreme Court's recent decision in *King v. Burwell* counsels interpreting the ACA "[i]f at all possible ... in a way that is consistent" with "improving health insurance markets, not to destroy them."[69] In *King*, a majority of the court rejected a literal application of the statutory provision governing health insurance premium subsidies in part because such a reading would have resulted in significantly higher premiums and lower enrollment.[70] Arguably, CMS's prioritization of reinsurance contributions for reinsurance payments over U.S. Treasury contributions provides greater assistance to insurers by ensuring that more funding is available to make reinsurance payments to those insurers that enroll high-cost individuals. If the market consequences of not allowing such prioritization of reinsurance contributions would be similarly as significant, it could be argued that *King* suggests it might be permissible to depart from "the most natural reading of the statute."[71]

On the other hand, if allocating contributions to the U.S. Treasury would not result in the same degree of harm to the insurance market, it might be argued that the Court's opinion in *King* would not have any applicability to the interpretation of Section 1341 of the ACA. Moreover, the *King*

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[64] Ibid. at 6 (citing ACA §1341(b)(4), 42 U.S.C. §18061(b)(4) ("[A]ny contribution amounts described in paragraph (3)(B)(iv) [referring to 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.") (emphasis added)).

[65] Ibid. at 7.

[66] Ibid. at n.23 (quoting City of Los Angeles v. Adams, 556 F. 2d 40, 50 (D.C. Cir. 1977)) and ibid. at n.24 (citing Ramah Navajo Sch. Bd. v. Babbitt, 87 F.3d 1338, 1348-49 (D.C. Cir. 1996)).

[67] Inside Health Policy, *HHS Rejects GAO Finding It Ignored Law By Prioritizing Insurers Over Treasury For Reinsurance Funds* (Sept. 29, 2016), http://insidehealthpolicy.com/daily-news/hhs-rejects-gao-finding-it-ignored-law-prioritizing-insurers-over-treasury-reinsurance.

[68] Permissibility of Small Business Administration Regulations Implementing the Historically Underutilized Business Zone, 8(A) Business Development, and Service-Disabled Veteran-Owned Small Business Concern Programs, 33 Op. O.L.C. 1, 35-38 (2009) (collecting citations to past opinions of OLC opinions standing for same proposition). See also GAO, 1 PRINCIPLES OF FEDERAL APPROPRIATIONS LAW 1-13 (4th ed. 2016) (stating that "[t]he Comptroller General has no power to enforce decisions.").

[69] See Timothy Jost, *Section 1341 And Financing The Reinsurance Program (Update)*, HEALTH AFFAIRS BLOG (Mar. 15, 2016), http://healthaffairs.org/blog/2016/03/15/section-1341-and-financing-the-reinsurance-program/ (citing King v. Burwell,—U.S.—, 135 S. Ct. 2480, 2496 (2015)).

[70] *King*, 135 S. Ct. at 2493-94 (citing reports estimating that premiums would increase by 35%-47% and enrollment would fall by more than 2/3's).

[71] Ibid. at 2496.

Court's interpretation of the ACA provision was not simply based upon the potential policy consequences of a literal reading of the provision; rather, the Court's interpretation of the ACA provision was guided in part by the "broader structure" of ACA.[72] Relying upon "the fundamental canon of statutory construction that the words of a statute must be read in their context and with a view to their place in the overall statutory scheme,"[73] the *King* Court determined that support existed to interpret the ACA provision in a manner different than a plain reading of the text might initially suggest. It is not clear that a reviewing court would necessarily believe that the *King* ruling supports construing Section 1341 in a manner contrary to the reading suggested by its plain text, unless evidence could be found elsewhere in the ACA that favored a different interpretation. To date, it does not appear that any suits have been filed challenging CMS's prioritization of reinsurance contributions for reinsurance payments over U.S. Treasury contributions. At least one bill has been introduced in the 114th Congress, S. 2803, which addresses the allocation of reinsurance funds to the U.S. Treasury, as discussed in the following section ("Current Legislation Addressing the Transitional Reinsurance Program").

Current Legislation Addressing the Transitional Reinsurance Program

As of the publication date of this report, three bills regarding the transitional reinsurance program have been introduced in the 114th Congress.

S. 2803, Taxpayers Before Insurers Act

S. 2803 was introduced in the Senate on April 14, 2016, and has been referred to the House Committee on Health, Education, Labor, and Pension. The bill would require the HHS Secretary to make deposits to the U.S. Treasury or otherwise would rescind amounts appropriated to HHS.

Currently, the statutes specify amounts to be collected for the transitional reinsurance program and for the U.S. Treasury and allow for the collection of amounts toward program administration (see **Table 2**). However, reinsurance program collection amounts for plan years 2014 and 2015 fell short of target amounts (see "Amounts Collected and Remitted") and CMS has not deposited the complete amounts, specified by statutes, to the U.S. Treasury. CMS's current position appears to be that no portion of an insurer's contribution is attributable to the U.S. Treasury contribution until the aggregate amount collected meets the aggregate target for reinsurance payments.

S. 2803 would require the HHS Secretary to make reinsurance-related deposits into the general fund of the U.S. Treasury as follows:

- $2 billion each for calendar years 2014 and 2015, within 45 days of the date of enactment of the bill, and
- $1 billion for calendar year 2016, by March 1, 2017.

If the Secretary failed to make the deposits as specified above, S. 2803 would rescind amounts appropriated for the general departmental management of the Office of the Secretary of HHS as follows:

[72] Ibid. at 2492.

[73] Ibid. (quoting Util. Air Regulatory Grp. v. Envtl. Prot. Agency, 134 S. Ct. 2427, 2441 (2014)).

- For calendar years 2014 and 2015 deposits, 50% of the general departmental management of the Office of the Secretary of HHS's unexpended balance for FY2016, and
- For calendar year 2016 deposit, 50% of the general departmental management of the Office of the Secretary of HHS's unexpended balance for FY2017.

S. 2803 also specifies that the sources of the deposited funds must be derived from contributions collected under the transitional reinsurance program.

H.R. 1886

H.R. 1886 was introduced in the House on April 16, 2015, and has been referred to the Energy and Commerce's Subcommittee on Health. The bill would amend the ACA to repeal the funding mechanism for the transitional reinsurance program.

Under the reinsurance program, the HHS Secretary collects reinsurance contributions from health insurers and from third-party administrators on behalf of group health plans;[74] the Secretary then uses those contributions to make reinsurance payments to health insurers who enroll high-risk enrollees in their non-group market plans both inside and outside of the exchanges.[75] That is, contributions are collected from most non-group and group health insurers but payments are made to eligible non-group health insurance plans.

H.R. 1886 addresses the redistributive nature of the transitional reinsurance program in which most non-group and group health insurers contribute to the program but only non-group market plans with high-cost enrollees receive payments. The bill would eliminate collecting the national per capita reinsurance contribution for plan years 2015 and 2016 and would authorize appropriations for reinsurance payments as follows:[76]

- $6 billion for plan year 2015 and
- $4 billion for plan year 2016.

These amounts are equivalent to the total collection for reinsurance payment amounts as specified by statutes (see **Table 2**). The suggested appropriated amounts do not, however, include total collection amounts for the U.S. Treasury. H.R. 1886 specifies that amounts remaining unexpended as of December 31 of the following year shall be deposited into the general fund of the U.S. Treasury.

H.R. 1886 also would require GAO to audit expenditures under the transitional reinsurance program for plan years beginning 2014.

H.R. 5904, Taxpayers Before Insurers Act

H.R. 5904 was introduced in the House on July 14, 2016, and has been referred to the House Committee on Appropriations and the House Committee on Energy and Commerce. The bill is the House version of "S. 2803, Taxpayers Before Insurers Act." The bill would require the HHS Secretary to make deposits to the U.S. Treasury or otherwise would rescind amounts appropriated to HHS.

[74] For more information on contributing entities under the reinsurance program, see footnote 18.

[75] For more information on insurers eligible for payment under the reinsurance program, see footnote 19.

[76] For more information, see "National Per Capita Reinsurance Contribution."

Currently, the statutes specify amounts to be collected for the transitional reinsurance program and for the U.S. Treasury and allow for the collection of amounts toward program administration (see **Table 2**). However, reinsurance program collection amounts for plan years 2014 and 2015 fell short of target amounts (see "Amounts Collected and Remitted") and CMS has not deposited the complete amounts, specified by statutes, to the U.S. Treasury. CMS's current position appears to be that no portion of an insurer's contribution is attributable to the U.S. Treasury contribution until the aggregate amount collected meets the aggregate target for reinsurance payments.

H.R. 5904 would require the HHS Secretary to make reinsurance-related deposits into the general fund of the U.S. Treasury as follows:

- $2 billion each for calendar years 2014 and 2015, within 45 days of the date of enactment of the bill, and
- $1 billion for calendar year 2016, by March 1, 2017.

If the Secretary failed to make the deposits as specified above, H.R. 5904 would rescind amounts appropriated for the general departmental management of the Office of the Secretary of HHS as follows:

- For calendar years 2014 and 2015 deposits, 50% of the general departmental management of the Office of the Secretary of HHS's unexpended balance for FY2016, and
- For calendar year 2016 deposit, 50% of the general departmental management of the Office of the Secretary of HHS's unexpended balance for FY2017.

H.R. 5904 also specifies that the sources of the deposited funds must be derived from contributions collected under the transitional reinsurance program.

Appendix. Transitional Reinsurance Program Summary Table

Table A-1. Selected Summary Information for the Affordable Care Act's Transitional Reinsurance Program

Year	Contribution Parameters				Payment Parameters[a]			Amounts Collected/ Anticipated	Amounts Remitted
	Total Collection for Reinsurance Payments[b]	Total Collection for U.S. Treasury[b]	National Per Capita Reinsurance Contribution[c]	Deadlines	Attachment Point[d]	Coinsurance Rate[e]	Reinsurance Cap[f]		
2014	$10B	$2B	$63[g]	Full payment by 01/15/15 or first payment of $52.50 by 01/15/15 and second payment of $10.50 by 11/15/15[h]	Currently set at $45,000[h] Previously set at $60,000[g]	Currently set at 100.0%[h] Previously set at 80.0%[g]	$250,000[g]	**Total ≈ $9.7B**[i] ≈$8.7B collected as of Mar. 2015 ≈$1.0B more anticipated by Nov. 2015	≈$7.9B remitted for reinsurance payments[j] ≈$1.7B reserved for reinsurance payments for the 2015 plan year[k] No amount deposited to the U.S. Treasury
2015	$6B	$2B	$44[h]	Full payment by 01/15/16 or first payment of $33.00 by 01/15/16 and second payment of $11.00 by 11/15/16[h]	Currently set at $45,000[l] Previously set at $70,000[h]	Currently set at 55.1%[m] Previously set at 50.0%[h]	$250,000[h]	**Total ≈ $6.5B**[k] ≈$5.5B collected as of Feb. 2016 ≈$1.0B more anticipated by Nov. 2016	≈$7.8B anticipated for reinsurance payments[n] ≈$7.0B remitted for initial partial payments to insurers in Mar. and Apr. 2016[o] ≈$495M anticipated for U.S. Treasury deposit[p]

Year	Contribution Parameters				Payment Parameters[a]			Amounts Collected/ Anticipated	Amounts Remitted
	Total Collection for Reinsurance Payments[b]	Total Collection for U.S. Treasury[b]	National Per Capita Reinsurance Contribution[c]	Deadlines	Attachment Point[d]	Coinsurance Rate[e]	Reinsurance Cap[f]		
2016	$4B	$1B	$27[i]	Full payment by 01/15/17 or first payment of $21.60 by 01/15/17 and second payment of $5.40 by 11/15/17[h]	Currently set at $90,000[i]	Currently set at 50.0%[i]	$250,000[i]	Payments have not yet been collected.	Payments have not yet been collected.

Source: Congressional Research Service (CRS) analysis of statutes, regulations, and guidance related to the Patient Protection and Affordable Care Act's (ACA's; P.L. 111-148, as amended) transitional reinsurance program as of October 31, 2016.

Notes:

a. The statutes require the Secretary of the Department of Health and Human Services (HHS) to determine how high-risk enrollees are identified. Accordingly, HHS determined that reinsurance payments would be made to plans with high-cost enrollees using the following payment parameters: attachment point, coinsurance rate, and reinsurance cap. The Secretary proposes and publishes the payment parameters in the annual payment notices. The payment parameters are subject to change.

b. Amounts are statutorily defined in ACA §1341.

c. The statutes specify certain aggregate amounts to be collected and allow the collection of amounts for program administration; the statutes require the HHS Secretary to establish a methodology for determining how much each contributing entity must contribute. The national per capita reinsurance contribution was calculated as the sum of the aggregate contribution for the reinsurance program, the additional contribution to the U.S. Treasury, and the cost of administration divided by the estimated number of enrollees in plans required to make reinsurance contributions.

d. The threshold dollar amount for claims costs incurred by a health insurer for an enrolled individual's covered benefits in a plan year, after which threshold the claims costs for such benefits are eligible for reinsurance payments. 45 C.F.R. §153.20.

e. The rate at which the applicable reinsurance entity will reimburse the health insurer for claims costs incurred for an enrolled individual's covered benefits in a plan year after the attachment point and before the reinsurance cap. 45 C.F.R. §153.20.

f. The threshold dollar amount for claims costs incurred by a health insurer for an enrolled individual's covered benefits, after which threshold the claims costs for such benefits are no longer eligible for reinsurance payments. 45 C.F.R. §153.20.

g. HHS, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014 Final Rule," 78 *Federal Register* 15410-15541, March 11, 2013.

h. HHS, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2015 Final Rule," 79 *Federal Register* 13744-13843, March 11, 2014.

i. Centers for Medicare & Medicaid Services (CMS), "Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2014 Benefit Year," September 17, 2015.

j. CMS, "Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2014 Benefit Year," September 17, 2015. CRS confirmed with CMS that plan year 2014 payments have all been remitted to the insurers.

k. CMS, "The Transitional Reinsurance Program's Contribution Collections for the 2015 Benefit Year," February 12, 2016.

l. HHS, "Patient Protections and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016 Final Rule," 80 *Federal Register* 10750-10877, February 27, 2015.

m. CMS, "Transitional Reinsurance Program: Pro Rata Adjustment to the National Coinsurance Rate for the 2015 Benefit Year," June 17, 2016.

n. CMS, "Summary Report on Transitional Reinsurance Payment and Permanent Risk Adjustment Transfers for the 2015 Benefit Year," June 30, 2016. $6.5B (from 2015 collections) + $1.7B (from 2014 rollover) – $0.5B (for program administration and U.S. Treasury payment) ≈ $7.8B. Numbers may not sum precisely due to rounding.

o. CMS, "Summary Report on Transitional Reinsurance Payment and Permanent Risk Adjustment Transfers for the 2015 Benefit Year," June 30, 2016.

p. CMS, "The Transitional Reinsurance Program's Contribution Collections for the 2015 Benefit Year," February 12, 2016. $0.5B (for program administration and U.S. Treasury payment) × 99% (pro rata amount to U.S. Treasury) ≈ $495M. The pro rata amount is based on regulations from HHS, "Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond Final Rule," 79 *Federal Register* 30240-30353, May 27, 2014. Given that payment parameters are subject to change, the pro rata amount may be subject to change.

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