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ONE HUNDRED FOURTEENTH CONGRESS

Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
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MEMORANDUM

April 13, 2016

To: Subcommittee on Oversight and Investigations Democratic Members and Staff

Fr: Committee on Energy and Commerce Democratic Staff

Re: Hearing on "Unlawful Reinsurance Payments: CMS Diverting $3.5 Billion from Taxpayers to Pay Insurance Companies"

On Friday, April 15, 2016, at 9:30 a.m. in room 2123 of the Rayburn House Office Building, the subcommittee will hold a hearing on the reinsurance program under the Affordable Care Act (ACA). The hearing will explore the Administration's legal basis for prioritizing reinsurance payments to insurers over payments to the U.S. Treasury.

I. BACKGROUND

A. ACA Third Open Enrollment Season

In the third open enrollment season, 12.7 million consumers selected plans or were automatically re-enrolled in affordable, quality health insurance through the state and federal exchanges.[1] Almost 10.5 million of these individuals qualify for the advance premium tax credit to make coverage more affordable.[2] Overall, the coverage provisions of the ACA have resulted

[1] Centers for Medicare & Medicaid Services, *Health Insurance Marketplace Open Enrollment Snapshot—Week 13* (Feb. 4, 2016).

[2] Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, *Health Insurance Marketplaces 2016 Open Enrollment Period: Final Enrollment Report* (Mar. 11, 2016).

in gains in health insurance coverage for an estimated 20 million uninsured adults through early 2016.[3] In addition, the uninsured rate has fallen to a historic low of 9 percent.[4]

B. Overview of Risk Mitigation Mechanisms

The ACA established three mechanisms to manage risk in the early years of the law's implementation.[5] Collectively, these three programs—risk adjustment, reinsurance, and risk corridors—are often referred as the "Three Rs." The ACA risk adjustment program is permanent, while the reinsurance and risk corridors programs are temporary (three years) and transitional.[6]

The "Three Rs" were established to address uncertainty in the initial years of the ACA marketplace, as insurance companies tried to establish premiums for a new group of people and implement a higher standard of coverage under the ACA. These three programs operate together to mitigate risks for insurance companies, stabilize premiums for consumers, and incentivize plans to compete on the basis of quality and efficiency:

- **The *risk adjustment* program** reduces incentives for insurers to insure only healthy individuals in order to protect consumers' access to a range of robust coverage options.[7] The program requires issuers with healthier consumers in a state to pay charges to offset some of the costs of insurance companies with sicker consumers in that state.[8]

- **The *reinsurance* program** keeps premiums affordable for consumers by spreading the cost of large insurance claims for very sick individuals across all insurers.[9] The program collects contributions from health insurance issuers and self-insured group health plans to fund reinsurance payments to ACA-compliant individual market

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[3] Department of Health and Human Services, *Health Insurance Coverage and the Affordable Care Act, 2010-2016* (Mar. 3, 2016).

[4] Centers for Disease Control and Prevention, *Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, January—September 2015* (Nov. 15, 2015).

[5] Centers for Medicare & Medicaid Services, *The Three R's: An Overview* (Oct. 1, 2015) (online at www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-10-1.html).

[6] The Commonwealth Fund Blog, *The Three R's of Health Insurance* (Mar. 5, 2014) (online at www.commonwealthfund.org/publications/blog/2014/mar/the-three-rs-of-health-insurance).

[7] Centers for Medicare & Medicaid Services, *The Three R's: An Overview* (Oct. 1, 2015) (online at www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-10-1.html).

[8] *Id.*

[9] *Id.*

plans, both on and off the exchanges. This program was put in place for the first three years of the marketplace (2014-2016).[10]

- **The *risk corridors* program** supports the marketplace by providing insurers with protection against uncertainty with regard to claims during the first three years of the marketplace. Risk corridors payments depend on how closely the premiums insurers charge cover their consumers' medical costs. Insurers whose premiums exceed claims and other costs by more than a certain amount pay into the program, and those whose claims and costs exceed premiums by a certain amount receive payments for their shortfall.[11] This program was put in place for the first three years of the marketplace (2014-2016).

The "Three Rs" are also an important feature of the Medicare Part D program, which have facilitated a functioning and robust market in Part D.[12] The programs discourage plans from avoiding individual enrollees with unusually high drug costs, and they lower premiums for consumers by stabilizing the insurance market.[13] Though reinsurance and risk corridors are temporary for the ACA plans, all "Three Rs" are permanent features of the Part D program.

II. THE REINSURANCE PROGRAM

A. Reinsurance Collections and Payments

The transitional reinsurance program is funded by contributions from insurance companies and self-funded group health plans. The ACA specifies that aggregate collections for all states for the transitional reinsurance program equal $10 billion for the 2014 plan year, $6 billion for the 2015 plan year, and $4 billion for the 2016 plan year.[14] The statute directs the Secretary of Health and Human Services (HHS) to use the contributions "to make reinsurance payments to health insurance issuers…that cover high risk individuals in the individual market."[15]

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[10] Centers for Medicare & Medicaid Services, The Center for Consumer Information & Insurance Oversight, *The Transitional Reinsurance Program—Reinsurance Contributions* (online at www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/The-Transitional-Reinsurance-Program/Reinsurance-Contributions.html) (accessed Mar. 20, 2016).

[11] Centers for Medicare & Medicaid Services, *The Three R's: An Overview* (Oct. 1, 2015) (online at www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-10-1.html).

[12] Jack Hoadley, *How the Three "Rs" Contributed to the Success of Medicare Part D* (Jan. 28, 2014) (online at http://ccf.georgetown.edu/all/how-the-three-rs-contributed-to-the-success-of-medicare-part-d).

[13] *Id.*

[14] Patient Protection and Affordable Care Act, §1341(b)(3)(B)(iii), Pub. L. No 111-148 (2010).

[15] *Id.* at §1341(b)(1)(B).

Additionally, the ACA specifies that the following additional amounts be collected and deposited into the general fund of the Treasury: $2 billion in 2014, $2 billion in 2015, and $1 billion in 2016.[16] Finally, the ACA provides that HHS may also collect additional amounts to fund the administrative expenses of the program.[17]

The ACA requires the Secretary to establish a methodology for determining how much each health insurance issuer or group health plan must contribute to fund the reinsurance payments and the contributions to the U.S. Treasury. The per-enrollee contribution was set at $63 per enrollee in 2014, $44 per enrollee in 2015, and $27 per enrollee in 2016.[18]

Eligible insurance plans in the individual market receive reinsurance payments for each high cost enrollee's annual healthcare costs above a certain threshold, known as the "attachment point." Payments from the reinsurance fund cover a certain percentage of these costs, known as the "coinsurance" rate, up to the "reinsurance cap" of $250,000. The "attachment point" for enrollees' high cost claims was set at $45,000 in 2014, $45,000 for 2015, and $90,000 for 2016.[19] The "coinsurance rate" was set at 100 percent in 2014, 50 percent in 2015, and 50 percent in 2016.[20]

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[16] *Id.* at §1341(b)(3)(B)(iv), §1341(b)(4).

[17] *Id.* at §1341(b)(3)(B)(ii).

[18] Department of Health and Human Services, *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2015; Final Rule*, 79 Fed. Reg. 13744. (Mar. 11, 2014); Department of Health and Human Services, *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016; Final Rule*, 80 Fed. Reg. 10750 (Feb. 27, 2015).

[19] Department of Health and Human Services, *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2015; Final Rule*, 79 Fed. Reg. 13744. (Mar. 11, 2014); Department of Health and Human Services, *Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond; Final Rule*, 79 Fed. Reg. 30240 (May 27, 2014). In addition, for 2016, the Department has finalized a proposal to lower the attachment point of $90,000 and raise the coinsurance rate, in the event that contribution amounts remain after calculating reinsurance payments for the 2016 benefit year. *See* Department of Health and Human Services, *Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2017; Final Rule*, 81 Fed. Reg. 12204 (Mar. 8, 2016).

[20] In 2014, because collections exceeded requests for reinsurance payments, the coinsurance rate was raised from 80% to 100%. *See* Department of Health and Human Services, *Transitional Reinsurance Program: Pro Rata Adjustment to the National Coinsurance Rate for the 2014 Benefit Year* (June 17, 2015) (online at www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/The-Transitional-Reinsurance-Program/Downloads/RI-Payments-National-Proration-Memo-With-Numbers-6-17-15.pdf); Department of Health and Human Services, *Patient Protection and Affordable Care Act;*

In the 2015 Final Market Standards rule, the Center for Medicare and Medicaid Services (CMS) finalized a proposal to prioritize reinsurance payments to health insurance issuers over payments to the U.S. Treasury, in the event that collections fell short of the $12.02 billion needed to cover the reinsurance pool ($10 billion), administrative costs ($20.3 million), and contributions to the U.S. Treasury ($2 billion) in the 2014 benefit year.[21] Under the final rule, the first $10 billion collected goes to the reinsurance pool to fund reinsurance payments; any contributions in excess of $10 billion are allocated on a pro rata basis to the U.S. Treasury and to offset administrative expenses. Similarly, for the 2015 benefit year, CMS would prioritize the first $6 billion in contributions towards reinsurance payments; any contributions collected in excess of $6 billion would be allocated on a pro rata basis to the U.S. Treasury and to offset administrative expenses.[22]

For the 2014 benefit year, HHS collected $9.7 billion in reinsurance contributions, or $2.3 billion less than the $12 billion expected. The Department paid out approximately $8 billion in reinsurance payments.[23] The approximately $1.7 billion in excess reinsurance contributions were carried over to the 2015 benefit year.[24] For the 2015 benefit year, the Department expects to collect $6.5 billion in reinsurance contributions, and expects to pay out $7.7 billion in reinsurance payments. Additionally, the Administration plans to allocate $500 million to the U.S. Treasury for the 2015 benefit year.[25]

B. CMS Authority to Prioritize Payments to Insurers

Congressional Republicans have questioned the Administration's legal authority to prioritize payments to health insurers over the U.S. Treasury, citing a Congressional Research Service (CRS) memorandum.[26] The CRS memorandum relies on an interpretation of Section 1341(b)(3) and Section 1341(b)(4) of the ACA.

Exchange and Insurance Market Standards for 2017; Final Rule, 81 Fed. Reg. 12204 (Mar. 8, 2016).

[21] Department of Health and Human Services, *Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond; Final Rule*, 79 Fed. Reg. 30240 (May 27, 2014).

[22] *Id.*

[23] Center for Medicare & Medicaid Services, *The Transitional Reinsurance Program's Contribution Collections for the 2015 Benefit Year* (Feb. 12, 2016).

[24] *Id.*

[25] *Id.*

[26] *See, e.g.*, Letter from House Energy and Commerce Chairman Fred Upton et al, to Sylvia Mathews Burwell, Secretary, U.S. Department of Health and Human Services (Mar. 23, 2016); Congressional Research Service, Memorandum to House Committee on Ways and Means and House Committee on Energy and Commerce (Feb. 23, 2016) (available online at energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/documents/114/analysis/20160223CRS.pdf).

Section 1341(b)(3)(B)(iii) states that the aggregate reinsurance contribution amounts to be collected should cover the cost of the reinsurance program ($10 billion for 2014, $6 billion for 2015, and $4 billion for 2016). Under 1341(b)(3)(B)(iv), the amount collected should also "reflect [each insurer's] proportionate share" of the amount to be contributed to the Treasury ($2 billion for 2014 and 2015 and $1 billion for 2016).

Section 1341(b)(4)(A) provides that the amounts collected for reinsurance over the three years can be allocated to cover the costs of reinsurance for any of the three years, and funds left over can be used to make payments for reinsurance programs for two additional years beyond 2017. Section 1341(b)(4)(B) then says:

> Notwithstanding the preceding sentence, any contribution amounts described in paragraph (3)(B)(iv) [referring to collections for the U.S. Treasury] 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.

CRS reads these provisions to conclude that each insurer's contribution to the reinsurance program in any given year must contain an amount that reflects the Treasury's proportionate share and that those shares must be deposited with the U.S. Treasury. Therefore, CRS concludes the agency's decision to prioritize payments to insurers over the U.S. Treasury conflicts with a plain reading of the statute.[27]

CMS, however, notes that the statute is silent on how it should approach the distribution of reinsurance contributions if insufficient amounts are collected to fully fund all three components of the program (reinsurance payments, administrative expenses, and payments to the U.S. Treasury). In general, when a statutory provision is ambiguous, courts defer to an agency's interpretation of the statute as long as it is a reasonable one.[28] CMS conducted notice and comment rulemaking, and concluded that it has discretion to prioritize payments for the reinsurance program, and that this prioritization furthers the statutory goals for this program by bringing more certainty to the individual market and helping moderate future premium increases. Since less than $10 billion was collected for the reinsurance fund in 2014, no funds were available to repay the U.S. Treasury; thus, this provision did not apply for 2014. In 2015, contributions are expected to exceed the $6 billion allocated under the statute to reinsurance, and the excess will be used to reimburse the U.S. Treasury and cover administrative costs.[29]

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[27] Congressional Research Service, Memorandum to House Committee on Ways and Means and House Committee on Energy and Commerce (Feb. 23, 2016) (available online at energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/documents/114/analysis/20160223CRS.pdf).

[28] *Id.*

[29] *Id.*

III. WITNESSES

The following witnesses have been invited to testify:

Andy Slavitt
Administrator
Centers for Medicare & Medicaid Services