STATEMENT OF

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ON

THE TRANSITIONAL REINSURANCE PROGRAM

BEFORE THE

U. S. HOUSE ENERGY AND COMMERCE COMMITTEE,
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The Transitional Reinsurance Program
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Chairman Murphy, Ranking Member DeGette, and members of the Subcommittee, thank you for the opportunity to discuss the Affordable Care Act's transitional reinsurance program. The Centers for Medicare & Medicaid Services (CMS) implemented the reinsurance program in accordance with the statute to help provide stability in the health insurance market as the Affordable Care Act extends new benefits to consumers.

CMS's priority is to provide Marketplace customers with access to quality, affordable coverage. In the years since the passage of the Affordable Care Act, we have seen increased competition among health plans and more choices for consumers.[1] During the third Marketplace Open Enrollment, nine out of ten returning customers were able to choose from three or more issuers for 2016 coverage, up from seven in ten in 2014.[2] Moving forward, CMS is eager to build on the progress in reducing the number of uninsured Americans – an estimated 20 million Americans gained coverage since the Affordable Care Act's coverage provisions have taken effect,[3] and the Nation's uninsured rate is at its lowest level since data collection began over five decades ago.[4,5] During the third open enrollment that concluded at the end of January, 12.7 million Americans selected affordable, quality health plans for 2016 coverage through the Marketplaces.[6]

The Affordable Care Act made many significant reforms in the individual and small group health insurance markets, including ending discrimination based on pre-existing conditions, establishing essential health benefits, and removing annual and lifetime dollar limits on these benefits. These reforms work in tandem with the medical loss ratio, also known as the 80/20 rule,

[1] www.hhs.gov/about/news/2015/07/30/competition-and-choice-in-the-health-insurance-marketplace-lowered-premiums-in-2015.html
[2] www.hhs.gov/about/news/2015/07/30/competition-and-choice-in-the-health-insurance-marketplace-lowered-premiums-in-2015.html
[3] https://aspe.hhs.gov/pdf-report/health-insurance-coverage-and-affordable-care-act-2010-2016
[4] http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201602.pdf
[5] http://www.cdc.gov/nchs/data/nhsr/nhsr017.pdf
[6] https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-02-04.html

and rate review, to result in significant benefits for consumers, providing many with access to high-quality, affordable health insurance.

The Affordable Care Act also includes programs based on similar, successful programs in the Medicare Part D prescription drug benefit – reinsurance, risk adjustment, and risk corridors – to stabilize premiums and the health insurance market. These programs mitigate the impact of potential adverse selection inside and outside the Marketplaces, while stabilizing premiums and encouraging plan participation in the individual and group markets, including in the Marketplaces.

Thanks in part to these programs, the Affordable Care Act will continue to provide consumers with affordable coverage options, encouraging issuers to participate in the Marketplaces and compete on price and quality. The reinsurance, risk adjustment, and risk corridors programs help ensure that the Affordable Care Act works as intended, with insurance plans competing on the basis of quality and service and not by seeking to attract the healthiest individuals. Better competition leads to improved coverage so that consumers — whether they are healthy or sick — can pick the best plan for their needs.

Transitional Reinsurance Program

Section 1341 of the Affordable Care Act directs that a transitional reinsurance program be established in each state from 2014 through 2016. The transitional reinsurance program is designed to partially reimburse the costs of high-cost enrollees in the individual market, helping to smooth risk, and thereby reduce premiums, in the individual health insurance market as the market reforms are implemented and the Marketplaces facilitate increased enrollment. In accordance with section 1341, health insurance issuers and certain group health plans make contributions. From these contributions, reinsurance payments are made to individual market issuers with claim costs within a pre-determined level as described below.

Reinsurance contributions are based on a uniform per capita contribution rate, which is calculated and announced each year in time for issuers and group health plans to incorporate into their rates. CMS announced the 2014, 2015, and 2016 reinsurance contribution rates in the

annual Payment Notices for 2014, 2015, and 2016, each of which was published in final form about one year before the applicable coverage year. Reinsurance payments to issuers are based on a portion (the coinsurance rate) of the issuer's costs per enrollee once paid claims costs reach a certain level (attachment point) and until a payment limit (cap) is reached.[7] CMS also proposed and finalized the 2014, 2015 and 2016 reinsurance payment parameters – that is, the coinsurance rate, attachment point and cap – in the annual Payment Notices for 2014, 2015 and 2016. States had the option to establish a reinsurance program and collect additional reinsurance contributions, or defer establishment and performance of all reinsurance functions to the Department of Health & Human Services (HHS).[8] Connecticut is the only state that elected to operate its own reinsurance program, and it is responsible for disbursing reinsurance payments to its issuers.

Operationalizing the Transitional Reinsurance Program

To implement the transitional reinsurance program, CMS followed the standard public rulemaking process, seeking public comment on all reinsurance policy proposals. Less than six months after enactment of the Affordable Care Act, CMS published a Request for Comment, inviting the public to provide input regarding the rules that would govern Marketplace and related functions such as reinsurance and risk adjustment.[9] In July 2011, CMS published the first proposed rule related to reinsurance, risk adjustment and risk corridors, in anticipation of the market reforms taking effect in 2014, and to provide issuers and other stakeholders with adequate notice of our intended policies.[10] Since that time, each rule implementing various aspects of the reinsurance program has been proposed and finalized according to our established rulemaking process. Annual per capita contribution rates and payment parameters for the reinsurance program were proposed and finalized in our Notice of Benefit and Payment Parameters (Payment Notice) for 2014, 2015 and 2016 benefit years. Consistent with the statutory flexibility to allocate and use contributions in any of the three years in which they are

[7] For 2014, the attachment point is $45,000 and the cap is $250,000.
[8] Connecticut is the only state to establish its own reinsurance program, and is operating the program for 2014-2016.
[9] *Planning and Establishment of State-Level Exchanges; Request for Comments Regarding Exchange-Related Provisions in Title I of the Patient Protection and Affordable Care Act (August 3, 2010); available at https://www.gpo.gov/fdsys/pkg/FR-2010-08-03/pdf/2010-18924.pdf*
[10] From preamble to CMS-9975-P, Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment; Proposed Rule; https://www.gpo.gov/fdsys/pkg/FR-2011-07-15/pdf/2011-17609.pdf

collected, CMS adopted a regulation to use remaining funds collected for reinsurance payments (if any) from one year to make payments in the subsequent years of the program.

In order to maximize the financial effect of the transitional reinsurance program and ensure that all of the contributions collected for a benefit year are expended for claims for that benefit year, CMS finalized a proposal in the Payment Notice for 2015 to increase the coinsurance rate on reinsurance payments for a benefit year, up to a maximum of 100 percent, if reinsurance contributions exceed the total requests for reinsurance payments for that benefit year. While the reinsurance contribution rate, program parameters and models were established prior to the start of the first open enrollment period in 2013, CMS continued to use the rulemaking process to help ensure that the program would function as intended.

In the years leading up to the 2014 coverage year, when issuers and group health plans would begin offering coverage under the new market rules established by the Affordable Care Act, and consumers would begin purchasing coverage through the Marketplaces, CMS relied on models and projections to develop estimates related to a number of Affordable Care Act programs, including the premium stabilization programs. In order to meet issuers', group health plans' and states' rate-setting timelines, CMS needed to propose and finalize reinsurance collections rules more than a year before the beginning of the coverage year, so that issuers and group health plans could incorporate those expectations into their rates. Thus, in estimating a 2014 contribution rate that would target $12.02 billion in collections, CMS conducted modelling efforts through the summer and fall of 2012, using the latest available data on the insured and self-insured markets nationally, which was generally 2010 data.

CMS created the Affordable Care Act Health Insurance Model (ACAHIM) to estimate market enrollment and per enrollee expenditures, incorporating the effects of State and Federal policy choices, and accounting for the behavior of individuals and employers. We used the ACAHIM, which was developed with reference to existing models such as those of the Congressional Budget Office and the CMS Office of the Actuary, to characterize medical expenditures and health insurance enrollment choices nationally in 2014. The ACAHIM is made up of integrated modules that predict the number and characteristics of market entrants and medical spending.

The outputs of the ACAHIM, especially the estimated enrollment and expenditure distributions, were used to analyze estimated Marketplace enrollment in 2014.

The ACAHIM model was also used to establish the uniform contribution rate and reinsurance payment parameters for all three years – 2014, 2015, and 2016. These parameters and rates needed to be established for all three years, based on issuers', group health plans' and states' rate-setting timelines.

Due to the uncertainty in our estimates of reinsurance contributions to be collected, and to help ensure that the reinsurance payment pool is sufficient to provide the premium stabilization benefits intended by the statute, we sought comment in the 2015 Exchange and Insurance Market Standards Proposed Rule[11] on potential revisions to the allocation of reinsurance contributions collected. Specifically, we proposed that, if collections fell short of our estimates (and therefore, short of the target collection amounts) for a particular year, we would allocate contributions that are collected first to the reinsurance payment pool and administrative expenses, until our targets for reinsurance payments and administrative expenses were met. Once those targets were met, the remaining contributions collected for that benefit year would be allocated to the U.S. Treasury.

We sought comment on this proposal, including with respect to our legal authority to prioritize reinsurance contributions to reinsurance payments over payments to the U.S. Treasury. We also invited comments on alternative allocation approaches to maximize the premium stabilization benefits of the reinsurance program. All comments CMS received were supportive of the proposed policy. In the 2015 Exchange and Insurance Market Standards Final Rule, published on May 27, 2014,[12] CMS finalized our proposed reallocation approach with minor modifications.

Consistent with the policies finalized through rulemaking, CMS announced on June 17, 2015, that the national coinsurance rate for the 2014 benefit year for the transitional reinsurance program would be increased from 80 percent to 100 percent because reinsurance contributions

[11] https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/cms-9949-p.pdf
[12] https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/508-CMS-9949-F-OFR-Version-5-16-14.pdf

for the 2014 benefit year exceeded the requests for reinsurance payments.[13] As noted above, these changes were made in order to maximize the financial effect of the transitional reinsurance program and ensure that all of the contributions collected for a benefit year are expended for claims for that benefit year. This announcement also noted that since collections fell short of the estimates for the 2014 benefit year, the first $10 billion collected would be allocated for reinsurance payments, and any of the funds for reinsurance payments that remained would be used for such payments in the subsequent benefit year. For the 2014 benefit year, CMS received approximately $9.7 billion in reinsurance contributions, and made nearly $7.9 billion in reinsurance payments to 437 issuers nationwide. On February 12, 2016, CMS announced that we anticipate that we will collect approximately $6.5 billion in reinsurance contributions for the 2015 benefit year. This will provide $7.7 billion in reinsurance contributions for reinsurance payments for the 2015 benefit year (reflecting approximately $1.7 billion in contributions from the 2014 benefit year and approximately $6 billion in collection from the 2015 benefit year), while $500 million will be allocated on a pro rata basis for program administration and to the General Fund of the U.S. Treasury. Should we receive collections in excess of the amounts we have previously anticipated, this additional amount will be allocated between program administration and the General Fund of the U.S. Treasury pursuant to the reinsurance allocation process outlines in the Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond.

Conclusion

The Affordable Care Act created the reinsurance program to stabilize premiums and the insurance market in the first years of the new Marketplaces and implementation of the new federal reforms. Now in its final year, the reinsurance program continues to reduce uncertainty for issuers so the market can function more smoothly, encouraging issuers to offer high-quality, affordable plans, and stabilizing premiums for consumers. CMS believes that the reinsurance and other premium stabilization programs are an important part of our efforts to mitigate adverse selection and limit the consequences of uncertainty that could prevent Americans from accessing

[13] https://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

health insurance. I appreciate the opportunity to discuss the regulatory framework outlined by CMS and look forward to answering your questions.