

**APR 13 2016**

The Honorable Ben Sasse
United States Senate
Washington, D.C. 20510

Dear Senator Sasse:

Thank you for your letter regarding the Affordable Care Act's transitional reinsurance program. The Department of Health and Human Services (HHS) has responsibility for the reinsurance program and has implemented it through the Centers for Medicare & Medicaid Services (CMS) in accordance with the statute to help provide stability in the health insurance market as the Affordable Care Act extends new benefits to consumers. As explained below, HHS promulgated the regulations governing the reinsurance program following an extensive notice-and-comment process, and the comments that HHS received regarding the reallocation procedures were supportive of both the rule and our legal authority.

The Affordable Care Act created three programs – reinsurance, risk adjustment, and risk corridors – to stabilize premiums and the health insurance market. These programs were designed to 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.

Section 1341 of the Affordable Care Act directs that a transitional reinsurance program be in effect in each state from 2014 through 2016. The reinsurance program is designed to partially reimburse insurers for the costs of high-cost enrollees in the individual market, helping to smooth risk as the 2014 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 issuers for enrollees in certain individual market plans with claims 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 it into their rates. CMS announced the 2014, 2015, and 2016 reinsurance contribution rates in the annual Notice of Benefit and Payment Parameters (Payment Notice) for 2014, 2015, and 2016, each of which was published in final form about one year before the applicable coverage year.¹ Reinsurance payments to issuers are based on a portion of the issuer's costs per enrollee (the coinsurance rate) paid once claims costs reach a certain level (attachment point) and up to a payment limit (cap). These reinsurance payments parameters were also proposed and finalized

¹ 2014 Payment Notice final rule (<https://www.gpo.gov/fdsys/pkg/FR-2013-03-11/pdf/2013-04902.pdf>); 2015 Payment Notice final rule (<https://www.gpo.gov/fdsys/pkg/FR-2014-03-11/pdf/2014-05052.pdf>); 2016 Payment Notice final rule (<https://www.gpo.gov/fdsys/pkg/FR-2015-02-27/pdf/2015-03751.pdf>).

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 HHS. Connecticut is the only state that elected to operate its own reinsurance program, and it is responsible for disbursing reinsurance payments to its issuers.

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 the Marketplace and related functions such as reinsurance and risk adjustment. In July 2011, CMS published the first proposed rule related to reinsurance, risk adjustment and risk corridors, in anticipation of these provisions taking effect in 2014, and to provide issuers and other stakeholders with adequate notice of our intended policies.² 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 Payment Notices for 2014, 2015 and 2016 benefit years. Consistent with Section 1341(b)(4)(A),³ 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 effectiveness of the transitional reinsurance program, 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 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 the rate setting timelines of issuers, group health plans, and states, 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.

Due to the uncertainty in our estimates of reinsurance contributions to be collected, and to help ensure that the reinsurance payment pool was sufficient to provide the premium stabilization benefits intended by the statute, CMS sought comment in the 2015 Exchange and Insurance Market Standards Proposed Rule on potential revisions to the allocation of reinsurance

² Standards Related to Reinsurance, Risks Corridors and Risk Adjustment proposed rule (<https://www.gpo.gov/fdsys/pkg/FR-2011-07-15/pdf/2011-17609.pdf>).

³ Section 1341(b)(4)(A) of the Affordable Care Act provides that “the contribution amounts collected for any calendar year may be allocated and used in any of the three calendar years for which amounts are collected based on the reinsurance needs of a particular period or to reflect experience in a prior period.”

contributions collected.⁴ Specifically, CMS proposed that, if collections fell short of our estimates (and therefore, short of the target collection amounts specified in the statute) for a particular year, CMS would allocate contributions that are collected first to the reinsurance payment pool and administrative expenses, until our statutory 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.

CMS sought public comment on all aspects of its proposal to implement a prioritization of reinsurance contributions to reinsurance payments over payments to the U.S. Treasury. CMS also invited comments on alternative allocation approaches to maximize the premium stabilization benefits of the reinsurance program. All public comments CMS received were supportive of the proposed policy. These comments included support for CMS's legal authority regarding prioritization of reinsurance contributions. In the 2015 Exchange and Insurance Market Standards Final Rule, published on May 27, 2014, CMS finalized our proposed reallocation approach with minor modifications.⁵ As we explained in the final rule,

Section 1341 of the Affordable Care Act directs that a transitional reinsurance program be established in each State for a three-year period to reduce premiums and to ensure market stability for enrollees in the individual market as the new consumer protections and market reforms are implemented in 2014. The statute does not, however, prescribe how HHS should approach the distribution of reinsurance contributions if insufficient amounts are collected to fully fund all three components of the program (that is, reinsurance payments, administrative expenses, and payments to the U.S. Treasury). We agree that HHS has discretion to implement the program to determine the priority, method, and timing for the allocation of reinsurance contributions collected. Section 1341(b)(3)(B)(iii) uses mandatory language with respect to the collection of amounts for the reinsurance payment pool and states that the total contribution amounts "shall . . . equal \$10,000,000,000" for 2014 and specific, lesser amounts for 2015 and 2016. Thus, the statute explicitly directs the Secretary to collect these amounts for the reinsurance payment pool (based on the best estimates of the NAIC). On the other hand, the statute uses more permissive language in sections 1341(b)(3)(B)(ii) and (iv) with respect to the collection of amounts for administrative expenses and payments for the U.S. Treasury (that is, "can" and "reflects", respectively). We believe that this language, as well as language directing that amounts collected pursuant to section 1341(b)(3)(B)(iv) be collected "in addition to the aggregate contribution amounts under clause (iii)," as well as the general authority granted to the Secretary under section 1341(b)(3)(A) to design the method for determining the contribution amount toward reinsurance payments, gives the Secretary discretion to prioritize the collections for the reinsurance program. We also believe that it is significant that prioritizing the allocation of reinsurance contributions to the reinsurance payment pool furthers the statutory goals for this program by bringing more certainty to the individual market and helping moderate future premium increases.

We are therefore finalizing our proposal, with one modification—we will not allocate reinsurance collections to administrative expenses or the U.S. Treasury until the reinsurance payment pool for a benefit year is funded. Thus, if our reinsurance collections fall short of our estimates for a particular benefit year, we will allocate reinsurance contributions collected first to the reinsurance payment pool, with any remaining amounts being then

⁴ CMS-9949-P: Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond (<https://www.gpo.gov/fdsys/pkg/FR-2014-03-21/pdf/2014-06134.pdf>).

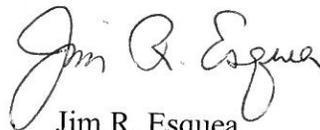
⁵ CMS-9949-F: Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond (<http://www.gpo.gov/fdsys/pkg/FR-2014-05-27/pdf/2014-11657.pdf>).

allocated to administrative expenses and the U.S. Treasury, on a pro rata basis. For example, as described in Table 1, for the 2014 benefit year, reinsurance contributions will go first to the reinsurance payment pool, up to \$10 billion, and any additional contributions collected will be allocated to administrative expenses and the U.S. Treasury, on a pro rata basis, up to the total \$12.02 billion.

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 for the 2014 benefit year exceeded the requests for reinsurance payments.⁶ As noted above, these changes were made in order to maximize the effect of the transitional reinsurance program. 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. Since less than \$10 billion was collected for the 2014 benefit year, the contributions were allocated to reinsurance payments and remaining funds for reinsurance payments will be used for such payments in the subsequent benefit year. On February 12, 2016, CMS announced that we anticipate that we will have \$7.7 billion in reinsurance contributions to be used for reinsurance payments for the 2015 benefit year (reflecting approximately \$1.7 billion in contributions carried over from the 2014 benefit year and approximately \$6 billion in contributions from the 2015 benefit year), while approximately \$500 million of the 2015 benefit year contributions will be allocated to the General Fund of the U.S. Treasury.⁷ Should we receive collections in excess of the amounts we have previously anticipated for the 2015 benefit year this additional amount will be allocated principally to the General Fund of the U.S. Treasury, pursuant to the reinsurance allocation process outlined in the Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond final rule.

Please contact my staff further should you have additional questions.

Sincerely,



Jim R. Esquea

Assistant Secretary for Legislation

⁶ <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>.

⁷ https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/RIC_2015ContributionsGuidance.pdf.