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From: C. Boyden Gray

Re: Allocation Of Funds Collected Under The Affordable Care Act's Transitional Reinsurance Program Between Treasury And Reinsurance-Eligible Issuers

QUESTION PRESENTED

Does the Affordable Care Act (ACA) permit the Department of Health and Human Services (HHS) to use funds collected under the Transitional Reinsurance Program (TRP) to fully finance payments to reinsurance-eligible issuers of health insurance plans before using them to make statutorily defined annual payments to the United States Treasury?

EXECUTIVE SUMMARY

TRP is a temporary ACA program that provides a form of risk protection to issuers of individual health insurance policies and offsets the $5 billion cost of another ACA program known as the Early Retiree Reinsurance Program (ERRP). Under TRP, HHS collects funds from health insurance policy issuers in both the group and individual markets and uses them to make payments to Treasury and to eligible issuers in the individual health insurance market. TRP is effective for the 2014 to 2016 benefit years.

TRP's operation depends upon, among other things, parameters for assessing and collecting contributions from issuers. The ACA states that HHS "shall" design the methodology for assessing and collecting contributions so that "aggregate contribution amounts . . . equal" $20 billion. HHS "shall" also design the collection methodology so that "in addition to the aggregate contribution amounts . . . each issuer's contribution amount . . . reflects its proportionate share of an additional" $5 billion for Treasury. The $5 billion collected for Treasury must be "deposited into the general fund of the Treasury of the United States and may not be used" for payments to reinsurance-eligible issuers.

HHS initially adopted regulations to implement TRP that allocated each issuer's contributions on a pro rata basis to payments to Treasury and payments to reinsurance-eligible issuers. Days later, however, HHS proposed to change course and eventually adopted regulations that allocate contributions to payments to Treasury only after fully financing payments to reinsurance-eligible issuers.

To justify its changed policy, HHS asserted that the ACA was silent regarding how collections should be allocated when they are insufficient to fully finance both payments to Treasury and to reinsurance-eligible issuers. It offered four justifications for resolving that purported ambiguity in favor of prioritizing payments to reinsurance-eligible issuers: (1) the

statute's alleged use of "mandatory language" with respect to reinsurance payments and "more permissive language" with respect to payments to Treasury; (2) the statute's alleged instruction that contributions for payments to Treasury "be collected 'in addition to'"—and therefore after—contributions for payments to reinsurance-eligible issuers; (3) the Secretary's supposed "general authority" to "design the method for determining contribution amounts toward reinsurance payments"; and (4) a belief that prioritizing payments to reinsurance-eligible issuers would further "the statutory goals for [TRP] by bringing more certainty to the individual market and helping moderate future premium increases."

TRP has failed to collect funds sufficient to fully finance both payments to reinsurance-eligible issuers and to Treasury. But because HHS has prioritized the former over the latter, by the time the books close on TRP for the 2014 and 2015 benefit years at the end of 2016, reinsurance-eligible issuers will likely have received 98% of expected payments ($15.6 billion out of an expected $16 billion), whereas Treasury will likely have received only 12% of expected payments ($495 million out of an expected $4 billion).

HHS's allocation scheme prioritizing payments to reinsurance-eligible issuers over payments to Treasury violates the ACA. Speaking in mandatory terms, the ACA unambiguously requires HHS to implement a collection methodology that collects defined amounts that fully finance TRP's required payments to both Treasury and reinsurance-eligible issuers.

This duty to collect statutorily defined amounts means TRP does not depend on any allocation or prioritization scheme for its implementation. The statute's command that HHS "shall" implement a methodology that produces defined amounts for payments to both reinsurance eligible issuers and Treasury stands in sharp contrast to its command that HHS "shall" implement a methodology that allows for the collection of undefined administrative expenses for TRP. Further, the statute provides for the correction of *cash-flow* deficits—allowing funds collected in any year to be allocated and used in any year—demonstrating Congress' intention to prohibit *persisting* deficits. And even if HHS may prioritize payments to temporarily address cash-flow deficits, *this* prioritization scheme—depriving Treasury of funds while transferring "surplus" reinsurance funds to future years—is still unlawful. Under such a regime, the statute's prohibition on reallocating certain funds to reinsurance-eligible issuers in future years would be mere surplusage.

Even if persisting deficits were permissible under the statute—and they are not—HHS's rationales for prioritizing payments to reinsurance-eligible issuers over payments to Treasury cannot withstand scrutiny.

First, the statute does not use "permissive language" with respect to collections for payments to Treasury. It requires in mandatory terms that each issuer's "contribution amount . . . reflect its proportionate share" of payments owed to Treasury. A contribution amount that does not comprise any funds for payment to Treasury does not "reflect" any share, and certainly not a proportionate share, of statutorily defined amounts.

Second, read in context, the ACA's "in addition to" language means only that collections for payments to Treasury should "also" occur, not that they should be secondary to collections for payments to reinsurance-eligible issuers.

Third, the statute does not confer any "general authority" on the Secretary to "design the method for determining the contribution amounts toward reinsurance payments." To the contrary, the Secretary's authority is limited to devising a method for assessing and collecting contributions to be used for both payments to reinsurance-eligible issuers and to Treasury. And notably, the statute specifies specific criteria the collection methodology must satisfy, including the production of "contribution amounts" that "reflect" each issuer's "proportionate share" of defined amounts owed to Treasury.

Fourth, however important the ACA's policy goals of market certainty and premium stabilization, HHS has no authority to implement a prioritization scheme that completely undermines the competing policy goal, explicitly set forth in the statute's text, of protecting the federal fisc.

BACKGROUND

A. Purpose Of The Transitional Reinsurance Program.

The TRP is part of the ACA, in effect from 2014 to 2016, designed to minimize the law's disruptive effects in the individual health insurance market. Under the ACA, TRP is a state program administered according to HHS regulations. State-established entities were to collect funds each year from *all* issuers of private health insurance—including employer-sponsored plans—within their jurisdictions. The contributions were to be deployed for two purposes: subsidizing claims attributable to high-risk individuals covered by individual insurance plans and bolstering the public fisc.

At its core, the ACA seeks to accomplish three sometimes-in-tension objectives with respect to the health insurance market: eliminate barriers to coverage, expand coverage, and hold down the cost of coverage. To eliminate barriers to coverage, the ACA prohibits issuers from denying or charging more for coverage on the basis of individuals' pre-existing conditions. 42 U.S.C. § 300gg. To expand coverage, the ACA assesses tax penalties against individuals who do not maintain qualifying coverage throughout the year and subsidizes coverage for people who satisfy certain criteria. 26 U.S.C. § 5000A. In conjunction, however, these provisions threaten to undermine the ACA's third objective of holding down the cost of coverage, particularly in the first years of the law's operation as issuers in the reorganized individual market cope with the obligation to cover the claims of new entrants likely to have high demand for healthcare services.

TRP aims to mitigate the law's adverse effects on both the cost of healthcare coverage and the federal fisc. TRP works by providing a form of reinsurance to issuers of policies in the individual health insurance market. It protects against some of the risks of covering individuals likely to have high demand for healthcare services. In addition, as HHS

has recognized, TRP also offsets the $5 billion taxpayer cost of another program, the ERRP, which was another ACA program designed to mitigate the law's adverse effects on healthcare costs. *See* 76 Fed. Reg. 41930, 41935 (July 15, 2011); 77 Fed. Reg. 73118, 73154 (Dec. 7, 2012); 42 U.S.C. § 18002(e). TRP does this by directing the collection of the exact same amount from issuers—$5 billion ($2 billion for each of the 2014 and 2015 plan years and $1 billion for the 2016 plan year).

B. Statutory Parameters Of The Transitional Reinsurance Program.

TRP's operation depends on parameters for collecting contributions from issuers of health insurance, identifying covered claims, and making payments to reinsurance-eligible issuers. The ACA establishes the outlines for these parameters.[1]

Collection: The ACA instructs HHS to develop a methodology for assessing TRP contributions. 42 U.S.C. § 18061(b)(3). HHS's methodology "shall be designed so that . . . the aggregate contribution amounts . . . equal" $10 billion for 2014, $6 billion for 2015, and $4 billion for 2016. *Id*. § 18061(b)(3)(B)(iii). It "shall" also "be designed so that . . . in addition to the aggregate contribution amounts . . . each issuer's contribution" for TRP "reflects its proportionate share of an additional" $2 billion for 2014 and 2015 and $1 billion for 2016, amounts owed to the Treasury. *Id.* § 18061(b)(3)(B)(iv). Finally, it "shall . . . be designed so that . . . contribution amount[s] can include an additional amount to fund [TRP's] administrative expenses." *Id.* § 18061(b)(3)(B)(ii).[2]

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[1] TRP, as contemplated by the ACA, was a state-operated program, authorizing the creation of state-based not-for-profit reinsurance entities and empowering them to assess and collect funds from issuers and to disburse payments to reinsurance-eligible issuers and to Treasury. 42 U.S.C. §§ 18061(a)(2), (c). Connecticut and Maryland, however, are the only states that established reinsurance entities. As a result, HHS authorized itself to operate TRP on the states' behalf. 78 Fed. Reg. at 15415 ("Section 1343 of the Affordable Care Act requires each State to operate a risk adjustment program. In states that have elected not to operate their own risk adjustment program, HHS will operate a program on their behalf.").

This memorandum takes no position on the legality of HHS's operation of TRP on behalf of states. It is noteworthy, however, that unlike other ACA programs, TRP does not make any explicit provision for federal control in the event states fail to act. *Compare* 42 U.S.C. § 18061, *with id.* §§ 18031, 18041; *see also* Seth Chandler, *How The Obama Administration Raided The Treasury To Pay Off Insurers*, Forbes.com (contending that nationalization of TRP "traded one constitutional problem — forcing states to impose assessments against their insurers . . . in favor of another . . . direc[t] assess[ment of] a tax/fee/levy/charge on insurers" without congressional authorization).

[2] At least one commentator has implied that TRP is constitutionally suspect because it imposes a "tax . . . without any effort to apportion liability among the states." Chandler, *supra* n.1. TRP's constitutional foundations are beyond the scope of this memorandum.

Identification of Reinsurance-Eligible Issuers: The ACA directs HHS either to develop a list of 50 to 100 medical conditions that would identify an individual as high-risk or to adopt a "comparable objective method of identification recommended by the American Academy of Actuaries [(AAA)]." *Id.* § 18061(b)(2)(A).

Payment to Reinsurance-Eligible Issuers: The ACA directs HHS either to develop a schedule of payments establishing an amount to be paid for each identified condition or to use a "comparable method . . . recommended by the [AAA]" that "encourages the use of care coordination and care management programs for high-risk conditions." *Id.* § 18061(b)(2)(B).

Congress authorized limited flexibility regarding how TRP payments could be financed. For example, it allowed that "contribution amounts collected for any calendar year" could 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." *Id.* § 18061(b)(4)(A). It further permitted "amounts remaining unexpended" as of the end of TRP in 2016 to be "used to make payments under any reinsurance program of a State in the individual market in effect in the 2-year period" thereafter. *Id.* § 18061(b)(4)(B). Notwithstanding this flexibility, however, the ACA requires that the $5 billion collected for Treasury must be "deposited into the general fund of the Treasury of the United States" and specifically "may not be used for" payments to reinsurance-eligible issuers. *Id.* § 18061(b)(4).

C. Regulatory Implementation Of The Transitional Reinsurance Program.

In a series of rulemakings, HHS adopted and amended regulations that purported to implement TRP's statutory parameters.

With respect to identifying reinsurance-eligible issuers, HHS declined to develop a list of medical conditions identifying individuals as high-risk. Instead, it determined that individuals would qualify as high-risk if their claims exceed a certain HHS-determined monetary threshold (the "attachment point"). Notably, HHS selected this methodology due to its "administrative[e] and operational[]" simplicity and despite AAA's warning that it was "likely to reward" issuers for "ineffective medical management." 77 Fed. Reg. 17220, 17228-29 (Mar. 23, 2012); 76 Fed. Reg. 41936.[3]

With respect to payment, HHS opted to pay a percentage of the total value of claims (the "coinsurance rate") in excess of the attachment point, up to a certain amount (the "insurance cap").

[3] *See* Letter from Mita Lodh, AAA, to Melinda Buntin, HHS, 9–10 (Sept. 22, 2010), *available at* http://bit.ly/1ZuxfbE.

With respect to collection, HHS determined that the ACA required and authorized the collection of different amounts, for different purposes, in different years. Those amounts are set forth in the following table:

	2014	**2015**	**2016**
Treasury (statutory)	$2 billion	$2 billion	$1 billion
Reinsurance (statutory)	$10 billion	$6 billion	$4 billion
Administration (regulatory)	$20.3 million	$25.4 million	$32 million

78 Fed. Reg. 15410, 15460 (Mar. 11, 2013); 79 Fed. Reg. 13744, 13777 (Mar. 11, 2014); 80 Fed. Reg. 10750, 10775-76 (Feb. 27, 2015).

HHS arrived at these amounts using projections of annual enrollees from its ACA Health Insurance Model (ACAHIM). 78 Fed. Reg. at 15461. Thus, for example, HHS's ACAHIM model determined that an annual assessment of $63 per enrollee for the 2014 benefit year would result in collections of $12.02 billion. 78 Fed. Reg. at 15460. Using the ACAHIM, HHS also determined that the annual assessments of $44 and $27 would produce $8.025 billion and $5.032 billion for plan years 2015 and 2016, respectively. 79 Fed. Reg. at 13775; 80 Fed. Reg. at 10775.

Originally, HHS appears to have contemplated that funds for Treasury, reinsurance, and administration would be assessed and collected separately. Its first proposed regulation on the subject suggested that "all contribution funds collected for reinsurance payments" would be "used for reinsurance," "all contribution funds collected for the U.S. Treasury" would be "paid to the U.S. Treasury," and that states would "cover the administrative costs" by "collect[ing] more than the amount collected" for reinsurance and Treasury. 76 Fed. Reg. at 41935. In the final regulation—perhaps upon realizing that states were not likely to participate in TRP—HHS changed course. There, HHS said it would announce the "proportion of the national contribution rate that will be allocated to reinsurance payments, payments to the U.S. Treasury, and administrative expenses" annually in a "notice of benefit and payment parameters." 77 Fed. Reg. at 17227.

On March 11, 2013, HHS finalized its notice of benefit and payment parameters for the 2014 benefit year. 78 Fed. Reg. at 15410. HHS determined to use a pro rata allocation to distribute collections between Treasury, reinsurance, and administration. *Id.* at 15459-60. Treasury would receive 16.6% of contributions ($2 billion/$12.02 billion) up to $2 billion, issuers eligible for reinsurance would receive 83.2% of contributions ($10 billion/$12.02 billion) up to $10 billion, and 0.2% of contributions ($0.02 billion/$12.02 billion) up to $20.3 million would be used for administrative expenses. *Id.* at 15460. Any surplus—whether because collections exceeded $12.2 billion or because reinsurance claims were less than $10 billion—would be rolled over to pay reinsurance claims for the 2014, 2015, or 2016 benefit years. *Id.* at 15460, 15462.

On March 11, 2014, HHS issued its notice of benefit and payment parameters for the 2015 year. 79 Fed. Reg. 13744. This regulation reaffirmed the allocation system HHS adopted for the 2014 benefit year. *Id.* at 13776-77. It also put in place the same pro rata allocation system for the 2015 benefit year, with any surplus going toward reinsurance claims for the 2015 or 2016 benefit years. *Id.*[4]

Ten days after issuing the notice of benefit and payment parameters for 2015, HHS proposed a dramatic shift in its contribution allocation policy that would cut Treasury out of the pro rata allocation. 79 Fed. Reg. 15808, 15808 (Mar. 21, 2014). Under this new scheme—which would apply to all benefit years covered by TRP—Treasury would receive 0% of contributions until reinsurance-eligible issuers had received the full amount set forth in the ACA and administrative expenses had been fully financed. *Id.* at 15820. Thereafter, Treasury would receive any surplus up to the amount provided for in the ACA, with anything left over going toward reinsurance claims. *Id.* at 15820-21.[5]

HHS offered two putative rationales for changing course: the "uncertainty in [its] estimates of reinsurance contributions to be collected" and its desire "to help assure that the reinsurance payment pool is sufficient to provide the premium stabilization benefits intended by the statue." 79 Fed. Reg. at 15820. HHS did not explain how concerns about "uncertainty" had changed in the ten days since finalizing the notice of benefit and payment parameters for the 2015 benefit year. Nor did it acknowledge that the ACA also intends TRP to collect $5 billion from issuers for Treasury, a sum HHS had earlier acknowledged would offset the cost of ERRP. *See* 76 Fed. Reg. at 41935; 77 Fed. Reg. at 73154; 42 U.S.C. § 18002(e).

On May 27, 2014, HHS finalized its new allocation scheme, with one modification. In addition to cutting only Treasury out of the pro rata allocation, the final regulation also cut out administrative expenses. Under the final rule, 0% of contributions are allocated to either Treasury or administrative expenses until 100% of the pool for payments to reinsurance-eligible issuers has been financed. Thereafter, 99% of contributions are allocated to payments to Treasury, up to the statutorily defined amount, and 1% of contributions are

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[4] In the same regulation, HHS decreased the likelihood that insufficient reinsurance claims would generate surpluses by allowing the coinsurance rate to adjust up to 100% and lowering the attachment point for the 2014 benefit year. 79 Fed. Reg. 13744, 13777, 13779. HHS also later lowered the attachment point for the 2015 benefit year and allowed the coinsurance rate to adjust up to 100% for the 2016 benefit year. 80 Fed. Reg. at 10776-77. These provisions make the reinsurance program more generous for eligible issuers by making more claims eligible for reinsurance and increasing reinsurance coverage of those claims, increasing the risk that it would reward "ineffective medical management" as the AAA had warned. *See supra* p.5 n.3.

[5] In the event collections were less than the combined allocations for reinsurance-eligible issuers and administrative expenses, HHS proposed to allocate them between the two on a pro rata basis. 79 Fed. Reg. at 15820.

allocated to administrative expenses, up to an amount determined by HHS annually. Any surplus goes to payments to reinsurance-eligible issuers.

In the final regulation, HHS asserted that it had discretion under the ACA to prioritize payments to reinsurance-eligible issuers over payments to Treasury. According to HHS, the ACA "does not . . . prescribe how [it] should approach the distribution of reinsurance contributions if insufficient amounts are collected to fully fund . . . reinsurance payments, administrative expenses, and payments to the U.S. Treasury." 79 Fed. Reg. 30240, 30258 (Mar. 27, 2014).

HHS offered at least four, and perhaps five, reasons for resolving the statute's purported ambiguity by prioritizing reinsurance payments over payments to Treasury:

A. The statute uses "mandatory language" with respect to collections for reinsurance payments, directing that they "shall" be collected, but "more permissive language" with respect to payments for Treasury, directing that they be "reflect[ed]" in contribution amounts collected. *Id*.

B. The statute directs that contributions to Treasury "be collected 'in addition to the aggregate contribution amounts'" for reinsurance payments. *Id.*

C. The Secretary has "general authority . . . to design the method for determining the contribution amounts toward reinsurance payments." *Id*.

D. Prioritizing the allocation of "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." *Id.*

E. HHS adopted its prioritization scheme through a notice-and-comment process, during which no party questioned the legality of its interpretation. Statement Of Andy Slavitt, Acting Administrator, CMS, *The Transitional Reinsurance Program* 5-6 (Apr. 15, 2016), *available at* http://1.usa.gov/23UPl7Q.

HHS has reaffirmed this new allocation scheme, prioritizing payments to reinsurance-eligible issuers over payments to Treasury and for administrative expenses, in its notice of benefit and payment parameters for 2016. 80 Fed. Reg. at 10775-76.

D. Operation Of The Transitional Reinsurance Program To Date.

To date, collections have consistently underfunded TRP. For the 2014 benefit year, contributions totaled roughly $9.6 billion, or 19% less than HHS's projection of $12.02 billion. HHS, *Summary Report On Transitional Reinsurance Payments And Permanent Risk Adjustment Transfers For The 2014 Benefit Year* 1, 3 (June 30, 2015). In accordance with its May 27, 2014 final rule, HHS allocated 100% of these contributions to reinsurance-eligible issuers. Claims for reinsurance payouts, however, totaled only $7.9 billion in claims, leaving $1.7 billion for reinsurance-eligible issuers in the 2015 benefit year. *Id*; HHS, *The Transitional*

Reinsurance Program's Contribution Collections For The 2015 Benefit Year 1-2 (Feb. 12, 2016). Treasury received $0.

HHS is currently collecting contributions for the 2015 benefit year and expects collections to total $6.5 billion, 19 percent less than the amount the ACA requires. *Id*. HHS will allocate the first $6 billion of these collections to reinsurance eligible issuers, leaving $495 million (99% of $500 million) for Treasury and $5 million for administrative expenses (1% of $500 million). *Id*. In addition, HHS will allocate the $1.7 billion "surplus" rolled over from 2014 to reinsurance-eligible issuers. *Id*.

Contributions for the 2016 benefit year will be assessed in late 2016 and collected throughout 2017. HHS has not, however, indicated that it will use any collections for 2016 to recompense Treasury for previous years' deficits. Thus, whatever HHS collects in 2017, Treasury will ultimately receive from TRP's full three-year operation, no more than $1.495 billion and perhaps as little as $495 million, between $4.505 and $3.505 billion less than provided for by the ACA.

STANDARD OF EVALUATION

In a judicial proceeding, a court would evaluate the lawfulness of HHS's prioritization scheme under the rubric of the Supreme Court's decision in *Chevron USA Inc. v. NRDC*, 467 U.S. 837, 842-45 (1984). Under *Chevron*, a court would first determine, using the standard tools of statutory construction, whether Congress had spoken directly to the issue of prioritization. *Id*. If not, the court would then evaluate whether HHS's prioritization scheme was permissible. *Id.*

Chevron is a judicial doctrine premised primarily on courts' relative lack of democratic accountability and expertise vis-à-vis federal bureaucracies. *See id.* at 865–66. As such, it need not guide legal evaluation of agency statutory interpretations by either Congress or the President. Both branches are, at all times, free to demand the best possible statutory interpretations, rather than those that are merely permissible. *See, e.g.*, *United States v. Mead Corp.*, 533 U.S. 218, 229 (2001).

This memorandum evaluates HHS's prioritization scheme using the *Chevron* framework, which affords the agency maximum leeway in interpreting the ACA. HHS's prioritization scheme fails even under *Chevron*'s deferential rubric. Part I concludes that the ACA unambiguously forecloses HHS's prioritization scheme because it does not permit HHS to implement a methodology for assessing and collecting contributions under TRP that produce persisting deficits. The statute's prohibition on persistent deficits obviates the need for a prioritization scheme of the type HHS has adopted. Part II demonstrates that, even assuming the ACA is ambiguous, HHS's prioritization scheme is not a permissible interpretation of the law. None of the rationales HHS has offered in support of its prioritization scheme withstand textual scrutiny.

ANALYSIS

I. The ACA Requires HHS To Implement A Collection Methodology That Fully Finances The Transitional Reinsurance Program, Rendering Irrelevant Its Silence With Regard To Allocation Of Insufficient Collections.

HHS's argument that it may prioritize payments to reinsurance-eligible issuers over payments to Treasury is flawed at its core. HHS's central premise is that it may collect amounts insufficient to "fully fund . . . reinsurance payments, administrative expenses, and payments to the U.S. Treasury." 79 Fed. Reg. at 30258. That foundational premise finds no support in the ACA's text or structure.

The absence of provisions detailing how funds should be permanently allocated in the event of a deficit or a surplus is a red herring because Congress did not grant HHS authority to implement a collection methodology that permanently underfinances TRP. Indeed, in its initial notice of benefit and payment parameters, HHS recognized that it could not implement a persisting-deficit-producing methodology, noting that the ACA sets forth "the total contribution amounts to be collected . . . is $12 billion plus administrative expenses" and declaring that it has "*no regulatory authority to change*" that "statutory amount." 78 Fed. Reg. at 15460 (emphasis added).

The ACA's text strongly supports HHS's initial conclusion that it must collect the statutorily defined amount for each benefit year. Under the statute, HHS's chosen collection methodology "shall be designed so that" each issuer's "contribution amounts . . . reflect its proportionate share of an additional" $2 billion, $2 billion, and $1 billion for payments to the Treasury for the 2014, 2015, and 2016 plan years, respectively. *Id.* § 18061(b)(3)(B)(iv). There is no flexibility in this provision, which uses the mandatory word "shall" to describe the criteria HHS's chosen collection methodology must satisfy. *See Fed. Exp. Corp. v. Holowecki*, 552 U.S. 389, 400 (2008) ("Congress' use of the term 'shall' indicates an intent to 'impose discretionless obligations.'" (quoting *Lopez v. Davis*, 531 U.S. 230, 241 (2001))). Whatever methodology HHS chooses, each issuer's annual contribution must "reflect its proportionate share" of a defined amount. A methodology that produces deficits does not satisfy that requirement.

Similarly, the methodology "shall be designed so that . . . aggregate contribution amounts . . . shall, based on the best estimates of the [National Association of Insurance Commissioners] . . . *equal*" $10 billion, $6 billion, and $4 billion for the 2014, 2015, and 2016 plan years, respectively. 42 U.S.C. § 18061(b)(3)(B)(iii). There is only limited flexibility in this provision. HHS must implement a methodology that, based on certain estimates, will produce annual aggregate contributions that "equal" defined amounts. A methodology that produces large, persisting deficits does not ensure that aggregate contributions "equal"—at least roughly—the statutorily required amounts.

A third feature of the methodology HHS "shall" develop bolsters the conclusion that the statute does not admit of deficit-producing methodologies. Under the ACA, HHS must

design a methodology so that each issuer's contribution amount "can include an additional amount to fund the administrative expenses of the applicable reinsurance entity." 42 U.S.C. § 18061(b)(3)(B)(ii). In other words, the methodology must be flexible enough so that amounts to finance administrative expenses "can" be recovered. Whereas the methodology need only only be *capable* of collecting funds to pay administrative expenses, it *must actually* collect funds to pay reinsurance-eligible issuers and Treasury. *See*, *e.g.*, *Russello v. United States*, 464 U.S. 16, 23 (1983) ("[W]here Congress includes particular language in one section of a statute but omits it in another section of the same Act, it is generally presumed that Congress acts intentionally and purposely in the disparate inclusion or exclusion" (alteration in original)).

At least two other statutory provisions lend further support to the conclusion that deficit-producing methodologies are unlawful. The first is the proviso that HHS's methodology for collecting *funds for the reinsurance pool* be based on the "best estimates of the NAIC." Whereas HHS might plausibly point to this provision as a reason for some reasonable underfunding of the reinsurance pool, no such statutory refuge exists with respect to funding for Treasury. Under the statute HHS must implement a collection methodology under which "each issuer's contribution amount . . . reflects its proportionate share" of statutorily defined amounts. The second is the statute's provision for how reinsurance funds in excess of the $25 billion (aggregate) may be collected. Under the ACA, such "additional amounts" may be collected from issuers "on a voluntary basis." *Id.* § 18061(b)(3)(B)(iv). This provision for excess collections "on a voluntary basis" demonstrates that excess collections may not be the result of HHS's forced collection methodology. *See Christensen v. Harris Cnty.*, 529 U.S. 576, 583 (2000) (noting the longstanding principle of statutory construction that "[w]hen a statute limits a thing to be done in a particular mode, it includes a negative of any other mode") (alteration in original). Since surplus-producing methodologies are foreclosed, the statute is naturally read to also foreclose deficit-producing methodologies. Such an interpretation would be "inconsistent with the administrative structure that Congress enacted into law." *FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 125 (2001).

Congress' provision for the obvious possibility that any collection methodology might possibly result in *cash-flow* deficits (and surpluses)—temporal mismatches between collections and disbursements—further demonstrates that persistent deficits are impermissible. Congress provided a statutory means to resolve cash-flow deficits, allowing that "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." 42 U.S.C. § 18061(b)(4)(A). Using this authority, HHS could have imposed a supplemental assessment for the 2015 benefit year and "used" the funds collected to eliminate the deficit its collection methodology generated for the 2014 benefit year. Such an assessment would have, as the statute permits, "reflect[ed] experience" from a "prior period."

While the possibility of cash-flow deficits may require some system for temporarily allocating funds until the deficit can be resolved, the scheme HHS has chosen unlawfully

converts important parts of the statute into meaningless surplusage. *See, e.g.*, *Williams v. Taylor*, 529 U.S. 362, 404 (2000) (It is a "cardinal principle of statutory construction that [courts] must give effect, if possible, to every clause and word of a statute."); *see also Whitman v. Am. Trucking Ass'ns*, 531 U.S. 457, 485 (2001) (An agency "may not construe the statute in a way that completely nullifies textually applicable provisions meant to limit its discretion."). The very provision that empowers HHS to address cash-flow deficits by shifting funds between years requires that "contribution amounts" for payments to Treasury "shall be deposited into the general fund" and specifies that they "*may not be used*" for reinsurance payments in any year. 42 U.S.C. § 18601(b)(4) (emphasis added). If this provision does not prevent HHS from eliminating Treasury from the allocation of funds collected for any program year—as it has done—then it serves no purpose.[6]

An example using the statutory amounts for the 2014 benefit year demonstrates why § 18061(b)(4) is superfluous under HHS's regulations. For the 2014 benefit year, collections were $9.6 billion and reinsurance claims were $7.9 billion, leaving a "surplus" of $1.7 billion. HHS paid out $7.9 billion in claims for 2014, and notwithstanding § 18061(b)(4), HHS paid $0 to Treasury. Instead, it rolled the $1.7 billion "surplus" over to pay reinsurance claims for 2015. According to HHS's regulations, the only funds that could never have been rolled over to pay reinsurance claims in future years would have been 99% of collections between $10 billion and $12.02 billion owed to Treasury. But even had such funds existed, §18061(b)(4) would have had nothing to do with those funds, which HHS concedes belong to the United States, going to Treasury. HHS would have had to send those funds to Treasury under the Miscellaneous Receipts Act, which requires agencies like HHS "receiving money for the Government" to "deposit [it] in the Treasury as soon as practicable." 31 U.S.C. § 3302(b). Thus, under HHS's allocation scheme, § 18061(b)(4) does no work. Its only conceivable function is to prevent HHS from rolling over funds collected in one benefit year and owed to Treasury to pay reinsurance claims attributable to other benefit years. But under HHS' regulations, it will *never* perform that—or any other—function.

II. In Any Event, None Of HHS's Rationales For Prioritizing Payments To Reinsurance-Eligible Issuers Over Payments To Treasury Withstand Scrutiny.

A. The Statute Does Not Use "Permissive Language" For Payments To Treasury.

After finding illusory ambiguity in the ACA, HHS seized on an illusory distinction to resolve it in favor of prioritizing payments to reinsurance-eligible issuers over payments to Treasury. According to HHS, the statute permits such prioritization because it uses

[6] The Supreme Court's caution against applying the surplusage canon to the ACA is inapposite here. *See King v. Burwell* 135 S. Ct. 2480, 2492 (2015). In *King*, the Court confronted a situation where "inartful drafting" generated surplusage. *Id.* Here, by contrast, 42 U.S.C. § 18061(b)(4) provides clear direction to HHS and surplusage results not from Congress's inartful drafting but from HHS's overly artful regulation.

"mandatory language" when directing the collection of funds for reinsurance payments and "more permissive language" when directing the collection of funds for Treasury.

No such distinction exists in the ACA's text. With respect to collections for payments to reinsurance-eligible issuers, the ACA *requires* the implementation of a collection methodology under which "aggregate contributions . . . shall equal" defined amounts for certain years. And with respect to collections for payments to Treasury, the ACA *requires* the implementation of a collection methodology under which "each issuer's contribution amount . . . reflects its proportionate share" of defined amounts for certain years. The mere fact that the statute uses different terms to provide for collections related to different payments is insufficient to support any prioritization scheme, least of all one that cuts Treasury out. The "shall" in section 18061(b)(3)(B) applies to collections for both payments.

Thus, the question that must be answered is whether a provision directing HHS to implement a collection method whereby "each issuer's contribution amounts . . . reflect its proportionate share" of defined amounts owed to Treasury authorizes it to instead implement a methodology whereby an issuer's contribution *very well may not reflect any* such payment. To ask the question is to answer it. *See* CRS, Memorandum to House Committee on Ways and Means & House Committee on Energy and Commerce, *Information on the ACA Transitional Reinsurance Program*, Feb. 23, 2016 (concluding interpretations of the ACA that do not require "'each issuer's contribution'" to "contain an amount that reflects 'its proportionate share'" of payments owed to Treasury "would not be entitled to deference under *Chevron*" (quoting 42 U.S.C. § 18061(b)(3)(B)(iv)).

HHS's effort to link collections for Treasury to discretionary collections for administrative costs also fails. According to HHS, the provision related to collections for payments to Treasury is akin to the provision related to collections for administrative expenses, which provides that the methodology "shall be designed so that" contributions "can include an additional amount" for such costs. 42 U.S.C. § 18061(b)(3)(B)(ii); 79 Fed. Reg. at 30258. HHS is correct that the word "can" permits but does not require, contributions to encompass administrative expenses. *See Rastelli v. Warden, Metro. Correctional Ctr.*, 782 F.2d 17, 23 (2d Cir. 1986) ("The use of a permissive verb . . . suggests a discretionary rather than mandatory review process."). The word "can," however, appears nowhere in the provision governing payments to Treasury, which requires that "each issuer's contribution amount . . . reflec[t] its proportionate share" of defined amounts. 42 U.S.C. § 18061(b)(3)(B)(iv).

Unlike the word "can" the word "reflect" is not permissive. At its core, it means "to make apparent; express or manifest" and "to give evidence of . . . something." There is no meaning of "reflect" that means "may" or "can," and interpreting it to have such a meaning is unlawful. *See John Hancock Mut. Life Ins. Co. v. Harris Tr. & Sav. Bank*, 510 U.S. 86, 109 (Any ambiguity in a term is irrelevant if the agency's reading "exceed[s] the scope of available ambiguity."); *City of Chicago v. Envtl. Def. Fund*, 511 U.S. 328, 339 (1994) (If an interpretation "goes beyond the scope of whatever ambiguity [the statute] contains," then by definition Congress has spoken clearly to the issue, by foreclosing that interpretation.);

United States v. Home Concrete & Supply, LLC, 132 S. Ct. 1836, 1846 n.1 (2012) (Scalia, J., concurring in part and concurring in the judgment) ("It does not matter whether the word 'yellow' is ambiguous when the agency has interpreted it to mean 'purple.'").

Examples illustrate this point. A person searching a bank account for deposits that "can" be—but need not be—made into it, would not be surprised to find no such deposits. The same cannot be said for a person searching a bank account for funds that "reflect" a "proportionate share" of a deposited amount. A person looking into an imageless mirror could not say that the mirror "reflects" her face. For a reflection to exist, there must be an object being reflected. But somehow HHS contends that an issuer's "contribution amount" that contains no funds for payments to Treasury nonetheless "reflects" that issuer's "proportionate share" of a defined amount owed to Treasury. The law does not condone such Alice-in-Wonderland distortions. *See New York v. EPA*, 443 F.3d 880, 887 (D.C. Cir. 2006); *Sundance Associates, Inc. v. Reno*, 139 F.3d 804, 808 (10th Cir. 1998) ("The government's approach leads us down a path toward Alice's Wonderland, where up is down and down is up and words mean anything.").

Indeed, far from giving HHS discretion to prioritize payments to reinsurance-eligible issuers, the statute emphasizes the importance of payments to Treasury by speaking to the latter with more specificity than with regard to the former. *Cf. HCSC-Laundry v. United States,* 450 U.S. 1, 6 (1981) (A "basic principle of statutory construction" is "that a specific statute . . . controls over a general provision . . . particularly when the two are interrelated and closely positioned."). With respect to funds for payments to reinsurance-eligible issuers, the statute simply directs HHS to implement a methodology that collects defined amounts from a group of issuers. By contrast, with respect to funds for payments to Treasury, the statute is more specific, detailing what must be "reflect[ed]" in "each issuer's" annual "contribution amount," namely that issuer's "proportionate share" of defined amounts. Yet prioritizing payments to reinsurance-eligible issuers *ensures* that some issuers' contributions will not reflect any amounts for payments to Treasury—and certainly not their "proportionate share" of such payments. Such a result runs directly contrary to the ACA, which requires such a reflection to be in "each issuer's" annual "contribution amounts." *Util. Air Regulatory Grp. v. EPA*, 134 S. Ct. 2427, 2445 (2014) (holding that *Chevron* requires agencies to give effect to a statute's unambiguous language).

B. HHS Distorts The ACA's Text By Asserting That Collections For Payments To Treasury Are Secondary Because They Are To "Be Collected 'In Addition To'" Contributions For Payments To Reinsurance-Eligible Issuers.

HHS misleadingly implies that the ACA makes contributions destined for Treasury secondary by specifying that they are to "be collected 'in addition to'" contributions destined for reinsurance-eligible issuers. 79 Fed. Reg. at 30258. The phrase "be collected 'in addition to'" is an HHS invention, however, designed to convey the misleading impression that the statutory phrase "in addition to" means "inferior" or "secondary." But read in

context, it describes the two parts of the whole that must make up "each issuer's contribution amounts." 42 U.S.C. § 18061(b)(3)(B)(iv).

HHS's implication cannot withstand a close reading of the ACA's actual text. The relevant provision appears in a list specifying criteria that any assessment and collection methodology HHS implements to operationalize TRP must satisfy. Thus, the ACA instructs that any such methodology "shall be designed so that":

- collections "reflec[t] each issuer's fully insured commercial book of business . . . the total value of all fees charged . . . and the costs of coverage administered";
- collections "can include an additional amount to fund . . . administrative expenses";
- "aggregate contribution amounts . . . shall . . . equal" defined amounts; and
- "in addition to the aggregate contribution amounts [for payments to reinsurance-eligible issuers], each issuer's contribution amount . . . reflects" issuers' "proportionate share" of other defined amounts.

42 U.S.C. § 18061(b)(3)(B)(i)-(iv).

Read in context, Congress did not make contributions for payments to Treasury "secondary" to contributions for payments to reinsurance-eligible issuers through the phrase "in addition to." *See Brown & Williamson Tobacco Corp.*, 529 U.S. at 133 (requiring that statutory terms be understood "in their context"). The "in addition to" phrase instead describes the two parts that must comprise the whole of "each issuer's" annual "contribution amount": amounts for payments to reinsurance-eligible issuers and amounts for payments to Treasury. In effect, Congress has instructed HHS to generate "contributions" of (1) $20 billion for payments to reinsurance-eligible issuers and (2) "in addition to" to that $20 billion, to make sure the "contributions" "reflect" $5 billion for payments to Treasury. That command is akin to a customer instructing a carpenter to generate tables out of four cords of cherry and "in addition to the four cords of cherry" to ensure that each table "reflect a proportionate share of two cords of oak." After giving such an instruction, the customer would reasonably expect that the carpenter not to generate tables made entirely of cherry. So too here. After giving its instruction, Congress would reasonably expect HHS not to generate "contributions" made entirely of money for payments to reinsurance-eligible issuers.

C. The Secretary Does Not Have "General Authority" to "Design The Method For Determining The Contribution Amounts" That Go "Toward Reinsurance Payments."

HHS mistakenly asserts that the Secretary's "general authority" under section 18061(b)(3)(A) "to design the method for determining the contribution amounts toward reinsurance payments" supports its prioritization scheme. 79 Fed. Reg. 30258. This assertion distorts the ACA's text, implying and inserting words that are not there.

Section 18061(b)(3)(A) does not confer any "general authority" upon the Secretary. Indeed, the term "general authority" does not appear anywhere in the statute. Rather, section 10861(b)(3)(A) does nothing more than direct the Secretary to devise a "method for determining the amount each [covered issuer] is required to contribute" to TRP. In designing the collection methodology, the section confers discretion in two ways. First, it authorizes the Secretary to choose between assessment methodologies based on issuer revenue or number of enrollees. *Id*. Second, it gives the Secretary discretion to require contributions to be made "in advance" or "periodically throughout the plan year." The Secretary fully exercised her authority under section 18061(b)(3)(A) by, in both cases, choosing the second of the two options available.

In any event, HHS incorrectly contends that the "general authority" that section 18061(b)(3)(A) confers on the Secretary authorizes her to determine "contribution amounts toward reinsurance payments [sic]." 79 Fed. Reg. at 30258. Even if section 18061(b)(3)(A) conferred some type of "general authority"—which it does not—it could not overcome the plain text of section 18061(b)(3)(B), which details the requirements of the contribution assessment "method" the Secretary is to develop under 18061(b)(3)(A). *See Am. Petroleum Inst. v. EPA*, 706 F.3d 474, 479 (D.C. Cir. 2013) (An agency may not "rely on its general authority . . . when a specific statutory directive defines the relevant functions of [the agency] in a particular area."); *Law v. Siegel*, 134 S. Ct. 1188, 1194 n.1 (2014) (noting that any "general authority [is] limited by more specific [statutory] provisions"). Under section 18061(b)(3)(B), the method developed by the Secretary "shall" generate contributions that go toward payments to the Treasury, and not only contributions that go "toward reinsurance payments," as HHS mistakenly implies.

In short, HHS has no "general authority" to determine "contribution amounts" that go "toward reinsurance payments." Whatever authority HHS has to devise a methodology for assessing and collecting contributions, the methodology as implemented must generate contributions that go toward both Treasury and reinsurance-eligible issuers.

D. HHS's Reliance On The ACA's Policy Goals Of Market Certainty And Premium Stabilization To Justify Its Prioritization Scheme Impermissibly Ignores The Act's Competing Policy Goal Of Protecting The Federal Fisc.

Ultimately, HHS purports to ground its prioritization scheme on the theory that it "furthers the statutory goals for this program by bringing more certainty to the individual

market and helping moderate future premium increases." 79 Fed. Reg. at 30258. Specifically, HHS concluded that prioritization of payments to reinsurance-eligible issuers over payments to Treasury would "help assure that the reinsurance payment pool is sufficient to provide the premium stabilization benefits intended by the statute." *Id.* at 30257.

Section 18061's text, however, reflects at least two purposes. First, it aims to collect $5 billion for deposit "into the general fund of the Treasury of the United States." 42 U.S.C. § 18061(b)(3)(B)(iv); *id* at § 18061(b)(4). Such deposits offset the enormous costs the ACA imposes on taxpayers, including—as HHS recognized—exactly the $5 billion cost of the ERRP. *See* 76 Fed. Reg. at 41935; 77 Fed. Reg. at 73154; 42 U.S.C. § 18002(e). Second, it aims to collect $20 billion to "make reinsurance payments to health insurance issuers . . . that cover high risk individuals in the individual market" during the ACA's first three years of operation. 42 U.S.C. 18061(b)(1). Such payments could, in theory, discourage issuers from implementing market-destabilizing premium hikes, which they might do if they had to bear the full cost of covering the high risk individuals entering the individual health insurance market as a result of the ACA.

In light of these dual purposes, HHS's prioritization scheme "frustrates rather than effectuates" Congress' purposes by "simplistically" assuming that whatever furthers a statutory goal "must be the law." *Rodriguez v. United States,* 480 U.S. 522, 525-26 (1987); *see also MetroPCS Cal., LLC v. FCC*, 644 F.3d 410, 414 (D.C. Cir. 2011) (quoting *Babbitt v. Sweet Home Chapter of Cmtys. for a Great Or.,* 515 U.S. 687, 726 (1995) (Scalia J., dissenting) ("'The Act must do everything necessary to achieve its broad purpose' is the slogan of the enthusiast, not the analytical tool of the arbiter."))). Congress' intent to create a pool of funds for reinsurance-eligible issuers to mitigate ACA-induced market destabilization is, on its own, insufficient to justify a prioritization scheme that frustrates Congress' express intention to also create a pool of funds for Treasury. HHS's "approach here manifests an interpretative error of long standing, one that apparently will never die: to treat a statute's primary or precipitating object as its sole object." *Albany Eng'g Corp. v. FERC*, 548 F.3d 1071, 1076 (D.C. Cir. 2008). *Cf. Nat'l Pub. Radio, Inc. v. FCC*, 254 F.3d 226, 230 (D.C. Cir. 2001) (holding that agencies cannot pursue congressional purposes in ways that undermine statutory provisions.)

Notably, HHS has not identified (and could not identify) any statutory justification for prioritizing the purpose of reinsurance payments over the purpose of making deposits into the Treasury. Indeed, textual indications are to the contrary, that payments to Treasury should be prioritized. First, as explained above, the requirement that each issuer's annual contribution amount "reflect" its "proportionate share" of $5 billion suggests that Treasury's share of each contribution is at least as important as the share for reinsurance-eligible issuers. *See supra* p.14. Second, Congress specifically protected Treasury's share of each contribution, declaring that it "may not be used" for payments to reinsurance-eligible issuers. No analogous statutory protection exists for reinsurance-eligible issuers' share of each contribution. And third, TRP is just one of several programs designed to address ACA-induced destabilizing influxes of high-risk individuals into the individual insurance market.

See generally, HHS, *Reinsurance, Risk Corridors, and Risk Adjustment Final Rule* (2012). These programs would mitigate the ACA's market-destabilizing effects even if fulfilling section 18061's purpose of providing $5 billion to the Treasury hindered its ability to also remedy those effects. But the converse is not true. TRP is the only program capable of generating the $5 billion necessary to offset the costs of ERRP.

In sum, HHS lacks authority to subordinate TRP's objective of creating a pool of funds for Treasury to TRP's objective of of creating a pool of funds for reinsurance-eligible issuers. HHS's prioritization of reinsurance-eligible issuers is particularly troubling in light of multiple statutory indications that Congress intended Treasury's interests to prevail in the event of a conflict. At the very least, lacking any statutory basis for prioritizing reinsurance-eligible issuers over Treasury, HHS was obligated to pursue all statutory objectives simultaneously. Its prioritization scheme is unlawful.

E. HHS's Use Of Notice-And-Comment Procedures Does Not Render Its Prioritization Scheme Lawful.

In recent testimony before the Subcommittee on Oversight of the United States House of Representatives Committee on Energy and Commerce, Andy Slavitt, Acting Administrator of the Centers for Medicare and Medicaid (CMS), appeared to argue that the prioritization scheme is lawful because HHS adopted it through a notice-and-comment process, during which no party questioned its legality. Statement Of Andy Slavitt, Acting Administrator, CMS, *supra* p.8. HHS should find no comfort in these arguments.

First, procedural and substantive regularity are not correlated. Procedural invalidity can doom a rule. Thus, regulations that implement statutes, like HHS' prioritization scheme, are substantive and, therefore, must satisfy at least the notice- and-comment requirements of the Administrative Procedure Act. *Mendoza v. Perez*, 754 F.3d 1002, 1023 (D.C. Cir. 2014); C*hamber of Commerce v. OSHA*, 636 F.2d 464, 469 (D.C. Cir. 1980). But procedural validity is only the first step. Procedurally valid regulations must still conform to the substance of the underlying statute. *See, e.g.*, *Chevron USA Inc.*, 467 U.S. at 842-45.

Second, the prioritization regulations remain open to challenge to any petitioner with standing. Such a challenge would be timely. *See* 28 U.S.C. § 2401(a) ("[E]very civil action commenced against the United States shall be barred unless the complaint is filed within six years after the right of action first accrues."). Further, HHS could not raise any waiver or exhaustion defense against a legal challenge because it undoubtedly "understood" that its "statutory authority" to prioritize payments to reinsurance-eligible issuers was in question and "expressly addressed" the issue. *NRDC v. EPA*, 755 F.3d 1010, 1023 (D.C. Cir. 2014).

CONCLUSION

HHS allocation scheme prioritizing payments to reinsurance-eligible issuers over payments to Treasury is unlawful. The ACA unambiguously prohibits HHS from implementing a collection methodology that produces persistent deficits. Accordingly,

TRP's implementation does not require any prioritization scheme to address the allocation of contributions in the event of a deficit. Even if the statute admitted of persistent deficits—and it does not—HHS's rationales for prioritizing payments to reinsurance-eligible issuers over payments to Treasury cannot withstand scrutiny. The statute does not use "permissive language" with respect to collections for payments to Treasury. Its direction to collect contributions for payments to Treasury "in addition to" contributions for payments to reinsurance-eligible issuers does not govern the priority of such payments. The Secretary does not have any "general authority" to "design the method for determining the contribution amounts toward reinsurance payments." And pursuit of the ACA's policy goals of market certainty and premium stabilization is an insufficient justification for implementing policies that turn a blind eye to the competing policy goal, explicitly set forth in the statute's text, of protecting the federal fisc.

APPENDIX

42 U.S.C. § 18061. Transitional reinsurance program for individual market in each State

(a) In general

Each State shall, not later than January 1, 2014--

(1) include in the Federal standards or State law or regulation the State adopts and has in effect under section 18041(b) of this title the provisions described in subsection (b); and

(2) establish (or enter into a contract with) 1 or more applicable reinsurance entities to carry out the reinsurance program under this section.

(b) Model regulation

(1) In general

In establishing the Federal standards under section 18041(a) of this title, the Secretary, in consultation with the National Association of Insurance Commissioners (the "NAIC"), shall include provisions that enable States to establish and maintain a program under which--

(A) health insurance issuers, and third party administrators on behalf of group health plans, are required to make payments to an applicable reinsurance entity for any plan year beginning in the 3-year period beginning January 1, 2014 (as specified in paragraph (3); and

(B) the applicable reinsurance entity collects payments under subparagraph (A) and uses amounts so collected to make reinsurance payments to health insurance issuers described in subparagraph (A) that cover high risk individuals in the individual market (excluding grandfathered health plans) for any plan year beginning in such 3-year period.

(2) High-risk individual; payment amounts

The Secretary shall include the following in the provisions under paragraph (1):

(A) Determination of high-risk individuals

The method by which individuals will be identified as high risk individuals for purposes of the reinsurance program established under this section. Such method shall provide for identification of individuals as high-risk individuals on the basis of--

(i) a list of at least 50 but not more than 100 medical conditions that are identified as high-risk conditions and that may be based on the identification of diagnostic and procedure codes that are indicative of individuals with pre-existing, high-risk conditions; or

(ii) any other comparable objective method of identification recommended by the American Academy of Actuaries.

(B) Payment amount

The formula for determining the amount of payments that will be paid to health insurance issuers described in paragraph (1)(B) that insure high-risk individuals. Such formula shall provide for the equitable allocation of available funds through reconciliation and may be designed--

(i) to provide a schedule of payments that specifies the amount that will be paid for each of the conditions identified under subparagraph (A); or

(ii) to use any other comparable method for determining payment amounts that is recommended by the American Academy of Actuaries and that encourages the use of care coordination and care management programs for high risk conditions.

(3) Determination of required contributions

(A) In general

The Secretary shall include in the provisions under paragraph (1) the method for determining the amount each health insurance issuer and group health plan described in paragraph (1)(A) contributing to the reinsurance program under this section is required to contribute under such paragraph for each plan year beginning in the 36-month period beginning January 1, 2014. The contribution amount for any plan year may be based on the percentage of revenue of each issuer and the total costs of providing benefits to enrollees in self-insured plans or on a specified amount per enrollee and may be required to be paid in advance or periodically throughout the plan year.

(B) Specific requirements

The method under this paragraph shall be designed so that--

(i) the contribution amount for each issuer proportionally reflects each issuer's fully insured commercial book of business for all major medical products and the total value of all fees charged by the issuer and the costs of coverage administered by the issuer as a third party administrator;

(ii) the contribution amount can include an additional amount to fund the administrative expenses of the applicable reinsurance entity;

(iii) the aggregate contribution amounts for all States shall, based on the best estimates of the NAIC and without regard to amounts described in clause (ii), equal $10,000,000,000 for plan years beginning in 2014, $6,000,000,000 for plan years beginning 2015, and $4,000,000,000 for plan years beginning in 2016; and

(iv) in addition to the aggregate contribution amounts under clause (iii), each issuer's contribution amount for any calendar year under clause (iii) 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.

Nothing in this subparagraph shall be construed to preclude a State from collecting additional amounts from issuers on a voluntary basis.

(4) Expenditure of funds

The provisions under paragraph (1) shall provide that--

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

(B) amounts remaining unexpended as of December, 2016, may be used to make payments under any reinsurance program of a State in the individual market in effect in the 2-year period beginning on January 1, 2017.

Notwithstanding the preceding sentence, any contribution amounts described in paragraph (3)(B)(iv) 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.

(c) Applicable reinsurance entity

For purposes of this section--

(1) In general

The term "applicable reinsurance entity" means a not-for-profit organization --

(A) the purpose of which is to help stabilize premiums for coverage in the individual market in a State during the first 3 years of operation of an Exchange for such markets within the State when the risk of adverse selection related to new rating rules and market changes is greatest; and

(B) the duties of which shall be to carry out the reinsurance program under this section by coordinating the funding and operation of the risk-spreading mechanisms designed to implement the reinsurance program.

(2) State discretion

A State may have more than 1 applicable reinsurance entity to carry out the reinsurance program under this section within the State and 2 or more States may enter into agreements to provide for an applicable reinsurance entity to carry out such program in all such States.

(3) Entities are tax-exempt

An applicable reinsurance entity established under this section shall be exempt from taxation under chapter 1 of Title 26. The preceding sentence shall not apply to the tax imposed by section 511 such Title (relating to tax on unrelated business taxable income of an exempt organization).

(d) Coordination with State high-risk pools

The State shall eliminate or modify any State high-risk pool to the extent necessary to carry out the reinsurance program established under this section. The State may coordinate the State high-risk pool with such program to the extent not inconsistent with the provisions of this section.