Congress of the United States

Washington, D.C. 20515

June 10, 2014

The Honorable Sylvia Mathews Burwell
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Burwell:

We write to request information regarding your legal authority to adopt a provision from the President's FY 2015 budget to make risk corridor program payments from the Centers for Medicare & Medicaid Services (CMS) Program Management account. Under current law, payments made under the risk corridor program would constitute an unlawful transfer of potentially billions of taxpayer dollars to insurers offering qualified health plans under the President's health care law.

As you know, Section 1342 of the Patient Protection and Affordable Care Act (PPACA, P.L. 111-148) directs the Secretary of Health and Human Services (HHS) to operate a risk corridor program to limit the profits and losses of qualified health plans in the individual and small group markets. However, the provision does not specify a source of funding for the program.

On January 23, 2014, the Congressional Research Service's (CRS) American Law Division confirmed: "While the language of ACA § 1342(b)(1) establishes a directive to the Secretary to make such payments, it does not specify a source from which those payments are to be made. Therefore, § 1342 **would not appear to constitute an appropriation of funds for the purposes of risk corridor payments** under that section" (emphasis added).

CRS' analysis is consistent with GAO's longstanding interpretation of appropriations law. According to GAO's Principles of Appropriations Law (Red Book): "If the statute contains a specific direction to pay and a designation of funds to be used, such as a direction to make a specified payment or class of payments 'out of any money in the Treasury not otherwise appropriated,' then this amounts to an appropriation."[1] However, the GAO Red Book goes on to state: "Both elements of the test must be present. **Thus a direction to pay without a designation of the source of funds is not an appropriation**" (emphasis added). The risk corridor program in PPACA clearly fails to meet the second element of the test constituting an appropriation.

This interpretation also is consistent with the relevant legislative history. For instance, Section 3106 of the Affordable Health Choices Act (S. 1679), reported out of the Senate Committee on Health, Education, Labor, and Pensions as the President's health law was still taking shape, included a directive for the Secretary of HHS to administer a risk corridor program

[1] GAO, 1 PRINCIPLES OF FEDERAL APPROPRIATIONS LAW 2-16 (2004).

and created a "Health Benefit Plan Start-Up Fund" with an initial appropriation "out of any moneys in the Treasury not otherwise appropriated" from which the Secretary of HHS could collect and make payments. However, the language enacted in Section 1342 of PPACA originated in a different piece of legislation (Section 2214 of America's Healthy Future Act, S. 1796), which did not designate a source of funds to be used or provide an appropriation, signifying that Congress deliberately chose to review funding for the risk corridor program through the annual appropriations process.

Furthermore, although the text of Section 1342 of PPACA references the Medicare Prescription Drug risk corridor, there are critical differences between the two programs. The Medicare Prescription Drug, Improvement, and Modernization Act (P.L. 108-173) contained a provision establishing a risk corridor program. In addition to describing the direction of payments, the legislative text also explicitly stated that payments for the program would come from a newly created Medicare Prescription Drug Account within the Federal Supplementary Medical Insurance Trust Fund.[2] This language provided a permanent appropriation for the risk corridor program in Medicare Part D. Section 1342 of PPACA includes no such language.

Finally, Section 1342 does not specify that any amounts received by HHS from plans that have overestimated premiums must be deposited in a revolving account or specifically made available for outgoing payments under the program. Thus, CRS concludes: "In the absence of any specific directions, federal law requires such amounts to be deposited in the General Fund of the Treasury, from which they may be further appropriated by Congress."

Given these facts, HHS may not make payments under Section 1342 absent additional congressional action appropriating funds for such payments. Without an explicit appropriation, any money spent on the risk corridor program would be based on an illegal transfer of funds and your agency could be held in violation of the Antideficiency Act.

Despite the overwhelming factual record that should foreclose any such efforts, HHS has left open the possibility that it will make payments to health insurance companies under the risk corridor program without seeking additional funding from Congress. For example, HHS published a final rule on May 16, 2014, stating that "HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers. In [the event that the program operates at a deficit], HHS will use other sources of funding for the risk corridors payments, subject to the availability of appropriations."

It is unclear from HHS' statement whether the Department asserts that an appropriation has been made available to make payments through risk corridors under current law. Given these facts, we respectfully request the following:

1) Please explain whether you agree with the legal analysis of GAO and CRS, which consistent with precedent, appears to limit HHS's ability to make payments. In this response include:

   A. All legal analysis prepared by HHS regarding its statutory authority to make payments to health insurance companies under the risk corridor program.

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[2] 42 U.S.C. § 1860d-16(b)(1)(B).

B. All legal analysis prepared by HHS regarding its ability to make payments under risk corridors absent additional congressional appropriation.

2) Please provide a list of all other funding sources HHS believes it has legally or otherwise available for funding the risk corridor program absent an appropriation.

When the Senate considered your nomination, you made a commitment to "transparency and accuracy in a timely fashion." We therefore look forward to receiving a response to our requests no later than June 24, 2014. If you have any questions regarding this request, please contact Paul Winfree with Senate Budget Committee at (202) 224-0642, or Paul Edattel with the Energy and Commerce Committee at (202) 225-2927.

Sincerely,

Fred Upton
Chairman
United States House of Representatives
Committee on Energy and Commerce

Jeff Sessions
Ranking Member
United States Senate
Committee on the Budget

Attachment

cc: The Honorable Henry Waxman, Ranking Member
United States House of Representatives
Committee on Energy and Commerce

The Honorable Patty Murray, Chairman
United States Senate
Committee on the Budget

New Memo Sounds Alarm On Legality of Health Law's Risk Corridor Payments

February 4, 2014

Nonpartisan CRS Memo Undercuts Administration's Claims of Authority

WASHINGTON, DC – A new memo prepared by the nonpartisan Congressional Research Service raises serious questions about the ability of the Obama administration to pay insurers through the health care law's risk corridor program. House Energy and Commerce Committee staff recently requested CRS address the appropriation of funds necessary to fulfill payments through the program. CRS explains, "While the language of ACA [Section] 1342 (B)(1) establishes a directive to the Secretary [of Health and Human Services] to make such payments, it does not specify a source from which those payments are to be made. **Therefore, [Section] 1342 would not appear to constitute an appropriation of funds for the purposes of risk corridor payments under that section."**

HHS Secretary Sebelius testified in December and CCIIO Director Gary Cohen repeated again in January that the administration did not know how much taxpayers will be on the hook for under the health care law's risk corridor program. The law's flawed design and botched rollout put taxpayers in jeopardy of being on the hook to bail out the president's health care law because of poor enrollment.

"The underlying question is, does the administration have the authority to make the payments to the insurance industry? This memo raises serious questions on the legality of the administration's plan, just the latest in a pattern of unilateral delays and actions outside the bounds of the law," commented Energy and Commerce Committee Chairman Fred Upton (R-MI). "We must protect taxpayer dollars even as the administration rushes to cover up its failures in implementing the health law."

Read the complete CRS memo online here.

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Committee on Energy and Commerce
2125 Rayburn House Office Building
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(202) 225-2927 tel
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law specifically states that an appropriation is made or that such a contract may be made."

Thus, the rule is that the making of an appropriation must be expressly stated. An appropriation cannot be inferred or made by implication. *E.g.*, 50 Comp. Gen. 863 (1971).

Regular annual and supplemental appropriation acts present no problems in this respect as they will be apparent on their face. They, as required by 1 U.S.C. § 105, bear the title "An Act making appropriations ... ." There are situations in which statutes other than regular appropriation acts may be construed as making appropriations, however. *See, e.g.*, 31 U.S.C. § 1304(a) ("necessary amounts are appropriated to pay final judgments, awards, compromise settlements"); 31 U.S.C. § 1324 ("necessary amounts are appropriated to the Secretary of Treasury for refunding internal revenue collections").

An appropriation is a form of budget authority that makes funds available to an agency to incur obligations and make expenditures.[29] 2 U.S.C. § 622(2)(A)(i). *See also* 31 U.S.C. § 701(2)(C) ("authority making amounts available for obligation or expenditure"). Consequently, while the authority must be expressly stated, it is not necessary that the statute actually use the word "appropriation." If the statute contains a specific direction to pay and a designation of the funds to be used, such as a direction to make a specified payment or class of payments "out of any money in the Treasury not otherwise appropriated," then this amounts to an appropriation. 63 Comp. Gen. 331 (1984); 13 Comp. Gen. 77 (1933). *See also* 34 Comp. Gen. 590 (1955).

For example, a private relief act that directs the Secretary of the Treasury to pay, out of any money in the Treasury not otherwise appropriated, a specified sum of money to a named individual constitutes an appropriation. 23 Comp. Dec. 167, 170 (1916). Another example is B-160998, Apr. 13, 1978, concerning section 11 of the Federal Fire Prevention and Control Act of 1974,[30] which authorizes the Secretary of the Treasury to reimburse local fire departments or districts for costs incurred in fighting fires on federal

[29] We discuss the concept of budget authority and define the term appropriation in section A ("Appropriations and Related Terminology") of this chapter.

[30] Pub. L. No. 93-498, 88 Stat. 1535, 1543 (Oct. 29, 1974).

"(A) be a health insurance issuer; or

"(B) receive any consideration directly or indirectly from any health insurance issuer in connection with the participation of any employer in the program under this title or the enrollment of any qualified individual or qualified employer in a qualified health plan.

"(2) FAIR AND IMPARTIAL INFORMATION AND SERVICES.—The Secretary, in collaboration with States, shall develop guidelines regarding the duties described in subsection (c).

"SEC. 3106. COMMUNITY HEALTH INSURANCE OPTION.

"(a) VOLUNTARY NATURE.—

"(1) NO REQUIREMENT FOR HEALTH CARE PROVIDERS TO PARTICIPATE.—Nothing in this section shall be construed to require a health care provider to participate in a community health insurance option, or to impose any penalty for non-participation.

"(2) NO REQUIREMENT FOR INDIVIDUALS TO JOIN.—Nothing in this section shall be construed to require an individual to participate in a community health insurance option, or to impose any penalty for non-participation.

"(b) ESTABLISHMENT OF COMMUNITY HEALTH INSURANCE OPTION.—

"(1) ESTABLISHMENT.—The Secretary shall establish a community health insurance option to offer, through each Gateway established under this title, health care coverage that provides value, choice, competition, and stability of affordable, high quality coverage throughout the United States.

"(2) COMMUNITY HEALTH INSURANCE OPTION.—In this section, the term 'community health insurance option' means health insurance coverage that—

"(A) except as specifically provided for in this section, complies with the requirements for being a qualified health plan;

"(B) provides high value for the premium charged;

"(C) reduces administrative costs and promotes administrative simplification for beneficiaries;

"(D) promotes high quality clinical care;

"(E) provides high quality customer service to beneficiaries;

"(F) offers a wide choice of providers; and

"(G) complies with State laws (if any), except as otherwise provided for in this title, relating to—

"(i) guaranteed renewal;

"(ii) rating;

"(iii) preexisting conditions;

"(iv) non-discrimination;

"(v) quality improvement and reporting;

"(vi) fraud and abuse;

"(vii) solvency and financial requirements;

"(viii) market conduct;

"(ix) prompt payment;

"(x) appeals and grievances;

"(xi) privacy and confidentiality;

"(xii) licensure; and

"(xiii) benefit plan material or information.

"(3) ESSENTIAL HEALTH BENEFITS.—

"(A) GENERAL RULE.—Except as provided in subparagraph (B), a community health insurance option offered under this section shall provide coverage only for the essential health benefits described in section 3103.

"(B) STATES MAY OFFER ADDITIONAL BENEFITS.—A State may require that a community health insurance option offered in such State offer benefits in addition to the essential health benefits required under subparagraph (A).

"(C) CREDITS.—

"(i) IN GENERAL.—An individual enrolled in a community health insurance option under this section shall be eligible for credits under section 3111 in the same manner as an individual who is enrolled in a qualified health plan.

"(ii) NO ADDITIONAL FEDERAL COST.—A requirement by a State under subparagraph (B) that a community health insurance option cover benefits in addition to the essential health benefits required under subparagraph (A) shall not affect the amount of a credit provided under section 3111 with respect to such plan.

"(D) STATE MUST ASSUME COST.—A State shall make payments to or on behalf of an eligible individual to defray the cost of any

additional benefits described in subparagraph (B).

"(E) ENSURING ACCESS TO ALL SERVICES.—Nothing in this Act shall prohibit an individual enrolled in a community health insurance option from paying out-of-pocket the full cost of any item or service not included as an essential health benefit or otherwise covered as a benefit by a health plan. Nothing in this Act shall prohibit any type of medical provider from accepting an out-of-pocket payment from an individual enrolled in a community health insurance option for a service otherwise not included as an essential health benefit.

"(F) PROTECTING ACCESS TO END OF LIFE CARE.—A community health insurance option offered under this section shall be prohibited from limiting access to end of life care.

"(4) COST SHARING.—A community health insurance option shall offer coverage at each of the cost sharing tiers described in section 3111(a).

"(5) PREMIUMS.—

"(A) PREMIUMS SUFFICIENT TO COVER COSTS.—The Secretary shall set premium rates in an amount sufficient to cover expected costs

(including claims and administrative costs) using methods in general use by qualified health plans.

"(B) APPLICABLE RULES.—The provisions of title XXVII relating to premiums shall apply to community health insurance options under this section, including modified community rating provisions under section 2701.

"(C) COLLECTION OF DATA.—The Secretary shall collect data as necessary to set premium rates under subparagraph (A).

"(D) CONTINGENCY MARGIN.—In establishing premium rates under subparagraph (A), the Secretary shall include an appropriate amount for a contingency margin.

"(6) REIMBURSEMENT RATES.—

"(A) NEGOTIATED RATES.—The Secretary shall negotiate rates for the reimbursement of health care providers for benefits covered under a community health insurance option.

"(B) LIMITATION.—The rates described in subparagraph (A) shall not be higher, in aggregate, than the average reimbursement rates paid by health insurance issuers offering qualified health plans through the Gateway.

"(C) INNOVATION.—Subject to the limits contained in subparagraph (A), a State Advisory Council established or designated under subsection (d) may develop or encourage the use of innovative payment policies that promote quality, efficiency and savings to consumers.

"(D) PHYSICIAN NEGOTIATED RATES.—Nothing in this paragraph shall prohibit the application of a State law that permits physicians to jointly negotiate with health plans. In such State, physicians may jointly negotiate with a community health insurance option concerning rates paid by the option.

"(7) SOLVENCY AND CONSUMER PROTECTION.—

"(A) SOLVENCY.—The Secretary shall establish a Federal solvency standard to be applied with respect to a community health insurance option. A community health insurance option shall also be subject to the solvency standard of each State in which such community health insurance option is offered.

"(B) MINIMUM REQUIRED.—In establishing the standard described under subparagraph (A), the Secretary shall require a reserve

fund that shall be equal to at least the dollar value of the incurred but not reported claims of a community health insurance option.

"(C) CONSUMER PROTECTIONS.—The consumer protection laws of a State shall apply to a community health insurance option.

"(8) REQUIREMENTS ESTABLISHED IN PARTNERSHIP WITH INSURANCE COMMISSIONERS.—

"(A) IN GENERAL.—The Secretary, in collaboration with the National Association of Insurance Commissioners (in this paragraph referred to as the 'NAIC'), may promulgate regulations to establish additional requirements for a community health insurance option.

"(B) APPLICABILITY.—Any requirement promulgated under subparagraph (A) shall be applicable to such option beginning 90 days after the date on which the regulation involved becomes final.

"(9) OMBUDSMAN.—In establishing community health insurance options, the Secretary shall establish an ombudsman or similar mechanism to provide assistance to consumers with respect to disputes, grievances, or appeals.

"(c) START-UP FUND.—

"(1) ESTABLISHMENT OF FUND.—

"(A) IN GENERAL.—There is established in the Treasury of the United States a trust fund to be known as the 'Health Benefit Plan Start-Up Fund' (referred to in this section as the 'Start-Up Fund'), that shall consist of such amounts as may be appropriated or credited to the Start-Up Fund as provided for in this subsection to provide loans for the initial operations of a community health insurance option. Such amounts shall remain available until expended.

"(B) FUNDING.—There is hereby appropriated to the Start-Up Fund, out of any moneys in the Treasury not otherwise appropriated an amount requested by the Secretary of Health and Human Services as necessary to—

"(i) pay the start-up costs associated with the initial operations of a community health insurance option;

"(ii) pay the costs of making payments on claims submitted during the period that is not more than 90 days from the date on which such option is offered; and

"(iii) make payments under paragraph (3).

"(2) USE OF START-UP FUND.—The Secretary shall use amounts contained in the Start-Up Fund to make payments (subject to the repayment requirements in paragraph (5)) for the purposes described in paragraph (1)(B).

"(3) RISK CORRIDOR PAYMENTS.—

"(A) IN GENERAL.—In any case in which the Secretary has entered into a contract with a contracting administrator, the Secretary shall use amounts contained in the Start-Up Fund to make risk corridor payments to such administrator during the 2-year period beginning on the date on which such administrator enters into a contract under subsection (e). Such payments shall be based on the risk corridors in effect during fiscal years 2006 and 2007 for making payments under section 1860D-15(e) of the Social Security Act.

"(B) SUBSEQUENT YEAR.—In years after the expiration of the period referred to in subparagraph (A), the Secretary may extend or increase the risk corridors and payments provided for under subparagraph (A).

"(C) AMOUNT USED TO REDUCE COSTS.—The Secretary shall deposit any payments received from a contracting administrator under subparagraph (A) into the Start-Up Fund.

"(4) PASS THROUGH OF REBATES.—The Secretary may establish procedures for reducing the amount of payments to a contracting administrator to take into account any rebates or price concessions.

"(5) REPAYMENT.—

"(A) IN GENERAL.—A community health insurance option shall be required to repay the Secretary of the Treasury (on such terms as the Secretary may require) for any payments made under paragraph (1)(B) by the date that is not later than 10 years after the date on which the payment is made. The Secretary may require the payment of interest with respect to such repayments at rates that do not exceed the market interest rate (as determined by the Secretary).

"(B) SANCTIONS IN CASE OF FOR-PROFIT CONVERSION.—In any case in which the Secretary enters into a contract with a qualified entity for the offering of a community health

insurance option and such entity is determined to be a for-profit entity by the Secretary, such entity shall be—

"(i) immediately liable to the Secretary for any payments received by such entity from the Start-Up Fund; and

"(ii) permanently ineligible to offer a qualified health plan.

"(d) STATE ADVISORY COUNCIL.—

"(1) ESTABLISHMENT.—A State shall establish or designate a public or non-profit private entity to serve as the State Advisory Council to provide recommendations to the Secretary on the operations and policies of a community health insurance option in the State. Such Council shall provide recommendations on at least the following:

"(A) policies and procedures to integrate quality improvement and cost containment mechanisms into the health care delivery system;

"(B) mechanisms to facilitate public awareness of the availability of a community health insurance option; and

"(C) alternative payment structures under a community health insurance option for health

care providers that encourage quality improvement and cost control.

"(2) MEMBERS.—The members of the State Advisory Council shall be representatives of the public and shall include educated health care consumers and providers.

"(3) APPLICABILITY OF RECOMMENDATIONS.—The Secretary may apply the recommendations of a State Advisory Council to a community health insurance option that State, in any other State, or in all States.

"(e) AUTHORITY TO CONTRACT; TERMS OF CONTRACT.—

"(1) AUTHORITY.—

"(A) IN GENERAL.—The Secretary may enter into a contract or contracts with one or more qualified entities for the purpose of performing administrative functions (including functions described in subsection (a)(4) of section 1874A of the Social Security Act) with respect to a community health insurance option in the same manner as the Secretary may enter into contracts under subsection (a)(1) of such section. The Secretary shall have the same authority with respect to a community health in-

surance option under this section as the Secretary has under subsections (a)(1) and (b) of section 1874A of the Social Security Act with respect to title XVIII of such Act.

"(B) REQUIREMENTS APPLY.—If the Secretary enters into a contract with a qualified entity to offer a community health insurance option, under such contract such entity—

"(i) shall meet the criteria established under paragraph (2); and

"(ii) shall receive an administrative fee under paragraph (7).

"(C) LIMITATION.—Contracts under this subsection shall not involve the transfer of insurance risk to the contracting administrator.

"(D) REFERENCE.—An entity with which the Secretary has entered into a contract under this paragraph shall be referred to as a 'contracting administrator'.

"(2) QUALIFIED ENTITY.—To be qualified to be selected by the Secretary to offer a community health insurance option, an entity shall—

"(A) meet the criteria established under section 1874A(a)(2) of the Social Security Act;

"(B) be a nonprofit entity for purposes of offering such option;

"(C) meet the solvency standards applicable under subsection (b)(7);

"(D) be eligible to offer health insurance or health benefits coverage;

"(E) meet quality standards specified by the Secretary;

"(F) have in place effective procedures to control fraud, abuse, and waste; and

"(G) meet such other requirements as the Secretary may impose.

"Procedures described under subparagraph (F) shall include the implementation of procedures to use beneficiary identifiers to identify individuals entitled to benefits so that such an individual's social security account number is not used, and shall also include procedures for the use of technology (including front-end, prepayment intelligent data-matching technology similar to that used by hedge funds, investment funds, and banks) to provide real-time data analysis of claims for payment under this title to identify and investigate unusual billing or order practices under this title that could indicate fraud or abuse.

"(3) TERM.—A contract provided for under paragraph (1) shall be for a term of at least 5 years but not more than 10 years, as determined by the Secretary. At the end of each such term, the Secretary shall conduct a competitive bidding process for the purposes of renewing existing contracts or selecting new qualified entities with which to enter into contracts under such paragraph.

"(4) LIMITATION.—A contract may not be renewed under this subsection unless the Secretary determines that the contracting administrator has met performance requirements established by the Secretary in the areas described in paragraph (7)(B).

"(5) AUDITS.—The Inspector General shall conduct periodic audits with respect to contracting administrators under this subsection to ensure that the administrator involved is in compliance with this section.

"(6) REVOCATION.—A contract awarded under this subsection shall be revoked by the Secretary or the Inspector General only after notice to the contracting administrator involved and an opportunity for a hearing. The Secretary may revoke such contract if the Secretary determines that such administrator has engaged in fraud, deception, waste, abuse

of power, negligence, mismanagement of taxpayer dollars, or gross mismanagement. An entity that has had a contract revoked under this paragraph shall not be qualified to enter into a subsequent contract under this subsection.

"(7) FEE FOR ADMINISTRATION.—

"(A) IN GENERAL.—The Secretary shall pay the contracting administrator a fee for the management, administration, and delivery of the benefits under this section.

"(B) REQUIREMENT FOR HIGH QUALITY ADMINISTRATION.—The Secretary may increase the fee described in subparagraph (A) by not more than 10 percent, or reduce the fee described in subparagraph (A) by not more than 50 percent, based on the extent to which the contracting administrator, in the determination of the Secretary, meets performance requirements established by the Secretary, in at least the following areas:

"(i) Maintaining low premium costs and low cost sharing requirements, provided that such requirements are consistent with section 3111(a).

"(ii) Reducing administrative costs and promoting administrative simplification for beneficiaries.

"(iii) Promoting high quality clinical care.

"(iv) Providing high quality customer service to beneficiaries.

"(C) NON-RENEWAL.—The Secretary may not renew a contract to offer a community health insurance option under this section with any contracting entity that has been assessed more than one reduction under subparagraph (B) during the contract period.

"(8) LIMITATION.—Notwithstanding the terms of a contract under this subsection, the Secretary shall negotiate the reimbursement rates for purposes of subsection (b)(6).

"(f) REPORT BY HHS AND INSOLVENCY WARNINGS.—

"(1) IN GENERAL.—On an annual basis, the Secretary shall conduct a study on the solvency of a community health insurance option and submit to Congress a report describing the results of such study.

"(2) RESULT.—If, in any year, the result of the study under paragraph (1) is that a community health insurance option is insolvent, such result shall be treated as a community health insurance option solvency warning.

"(3) SUBMISSION OF PLAN AND PROCEDURE.—

"(A) IN GENERAL.—If there is a community health insurance option solvency warning under paragraph (2) made in a year, the President shall submit to Congress, within the 15-day period beginning on the date of the budget submission to Congress under section 1105(a) of title 31, United States Code, for the succeeding year, proposed legislation to respond to such warning.

"(B) PROCEDURE.—In the case of a legislative proposal submitted by the President pursuant to subparagraph (A), such proposal shall be considered by Congress using the same procedures described under sections 803 and 804 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 that shall be used for a medicare funding warning.

"(g) MARKETING PARITY.—In a facility controlled by the Federal Government, or by a State, where marketing

or promotional materials related to a community health insurance option are made available to the public, making available marketing or promotional materials relating to private health insurance plans shall not be prohibited. Such materials include informational pamphlets, guidebooks, enrollment forms, or other materials determined reasonable for display.

"(h) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated, such sums as may be necessary to carry out this section.

"SEC. 3107. APPLICATION OF SAME LAWS TO PRIVATE PLANS AND THE COMMUNITY HEALTH INSURANCE OPTION.

"(a) IN GENERAL.—Notwithstanding any other provision of law, any health insurance coverage offered by a private health insurance issuer shall not be subject to any Federal or State law described in subsection (b) if a community health insurance option under section 3106 is not subject to such law.

"(b) LAWS DESCRIBED.—The Federal and State laws described in this subsection are those Federal and State laws relating to—

"(1) guaranteed renewal;

"(2) rating;

"(3) preexisting conditions;

State may coordinate the State high-risk pool with such program to the extent not inconsistent with the provisions of this section.

"SEC. 2214. ESTABLISHMENT OF RISK CORRIDORS FOR PLANS IN INDIVIDUAL AND SMALL GROUP MARKETS.

"(a) IN GENERAL.—The Secretary shall establish and administer a program of risk corridors for plan years beginning during the 36-month period beginning on July 1, 2013, under which a qualified health benefits plan offered in the individual or small group market may elect (before the beginning of such 36-month period) to participate in a payment adjustment system based on the ratio of the allowable costs of the plan to the plan's aggregate premiums. Such program shall be based on the program for regional participating provider organizations under part D of title XVIII.

"(b) PAYMENT METHODOLOGY.—

"(1) PAYMENTS OUT.—The Secretary shall provide under the program established under subsection (a) that if—

"(A) a participating plan's allowable costs for any plan year are more than 103 percent but not more than 108 percent of the target amount, the Secretary shall pay to the plan an

amount equal to 50 percent of the target amount in excess of 103 percent of the target amount; and

"(B) a participating plan's allowable costs for any plan year are more than 108 percent of the target amount, the Secretary shall pay to the plan an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of allowable costs in excess of 108 percent of the target amount.

"(2) PAYMENTS IN.—The Secretary shall provide under the program established under subsection (a) that if—

"(A) a participating plan's allowable costs for any plan year are less than 97 percent but not less than 92 percent of the target amount, the plan shall pay to the Secretary an amount equal to 50 percent of the excess of 97 percent of the target amount over the allowable costs; and

"(B) a participating plan's allowable costs for any plan year are less than 92 percent of the target amount, the plan shall pay to the Secretary an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of

the excess of 92 percent of the target amount over the allowable costs.

"(c) DEFINITIONS.—In this section:

"(1) ALLOWABLE COSTS.—

"(A) IN GENERAL.—The amount of allowable costs of a plan for any year is an amount equal to the total costs (other than administrative costs) of the plan in providing benefits covered by the plan.

"(B) REDUCTION FOR RISK ADJUSTMENT AND REINSURANCE PAYMENTS.—Allowable costs shall be reduced by any risk adjustment and reinsurance payments received under section 2212 and 2213.

"(2) TARGET AMOUNT.—The target amount of a plan for any year is an amount equal to the total premiums (including any premium credits or subsidies under any governmental program) reduced by the administrative costs of the plan.

"SEC. 2215. TEMPORARY HIGH RISK POOLS FOR INDIVIDUALS WITH PREEXISTING CONDITIONS.

"(a) ESTABLISHMENT OF HIGH RISK POOLS.—

"(1) IN GENERAL.—Not later than 1 year after the date of enactment of this title, the Secretary shall establish 1 or more high risk pools that—

(c) APPLICABLE REINSURANCE ENTITY.—For purposes of this section—

(1) IN GENERAL.—The term "applicable reinsurance entity" means a not-for-profit organization— Definition.

(A) the purpose of which is to help stabilize premiums for coverage in the individual and small group markets 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 the Internal Revenue Code of 1986. The preceding sentence shall not apply to the tax imposed by section 511 such Code (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.

SEC. 1342. ESTABLISHMENT OF RISK CORRIDORS FOR PLANS IN INDIVIDUAL AND SMALL GROUP MARKETS. 42 USC 18062.

(a) IN GENERAL.—The Secretary shall establish and administer a program of risk corridors for calendar years 2014, 2015, and 2016 under which a qualified health plan offered in the individual or small group market shall participate in a payment adjustment system based on the ratio of the allowable costs of the plan to the plan's aggregate premiums. Such program shall be based on the program for regional participating provider organizations under part D of title XVIII of the Social Security Act.

(b) PAYMENT METHODOLOGY.—

(1) PAYMENTS OUT.—The Secretary shall provide under the program established under subsection (a) that if—

(A) a participating plan's allowable costs for any plan year are more than 103 percent but not more than 108 percent of the target amount, the Secretary shall pay to the plan an amount equal to 50 percent of the target amount in excess of 103 percent of the target amount; and

(B) a participating plan's allowable costs for any plan year are more than 108 percent of the target amount, the Secretary shall pay to the plan an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of allowable costs in excess of 108 percent of the target amount.

(2) PAYMENTS IN.—The Secretary shall provide under the program established under subsection (a) that if—

(A) a participating plan's allowable costs for any plan year are less than 97 percent but not less than 92 percent of the target amount, the plan shall pay to the Secretary an amount equal to 50 percent of the excess of 97 percent of the target amount over the allowable costs; and

(B) a participating plan's allowable costs for any plan year are less than 92 percent of the target amount, the plan shall pay to the Secretary an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of the excess of 92 percent of the target amount over the allowable costs.

(c) DEFINITIONS.—In this section:

(1) ALLOWABLE COSTS.—

(A) IN GENERAL.—The amount of allowable costs of a plan for any year is an amount equal to the total costs (other than administrative costs) of the plan in providing benefits covered by the plan.

(B) REDUCTION FOR RISK ADJUSTMENT AND REINSURANCE PAYMENTS.—Allowable costs shall reduced by any risk adjustment and reinsurance payments received under section 1341 and 1343.

(2) TARGET AMOUNT.—The target amount of a plan for any year is an amount equal to the total premiums (including any premium subsidies under any governmental program), reduced by the administrative costs of the plan.

42 USC 18063.

SEC. 1343. RISK ADJUSTMENT.

(a) IN GENERAL.—

(1) LOW ACTUARIAL RISK PLANS.—Using the criteria and methods developed under subsection (b), each State shall assess a charge on health plans and health insurance issuers (with respect to health insurance coverage) described in subsection (c) if the actuarial risk of the enrollees of such plans or coverage for a year is less than the average actuarial risk of all enrollees in all plans or coverage in such State for such year that are not self-insured group health plans (which are subject to the provisions of the Employee Retirement Income Security Act of 1974).

(2) HIGH ACTUARIAL RISK PLANS.—Using the criteria and methods developed under subsection (b), each State shall provide a payment to health plans and health insurance issuers (with respect to health insurance coverage) described in subsection (c) if the actuarial risk of the enrollees of such plans or coverage for a year is greater than the average actuarial risk of all enrollees in all plans and coverage in such State for such year that are not self-insured group health plans (which are subject to the provisions of the Employee Retirement Income Security Act of 1974).

(b) CRITERIA AND METHODS.—The Secretary, in consultation with States, shall establish criteria and methods to be used in carrying out the risk adjustment activities under this section. The Secretary may utilize criteria and methods similar to the criteria and methods utilized under part C or D of title XVIII of the Social Security Act. Such criteria and methods shall be included