

**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."<sup>1</sup> 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

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<sup>1</sup> 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.<sup>2</sup> 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.

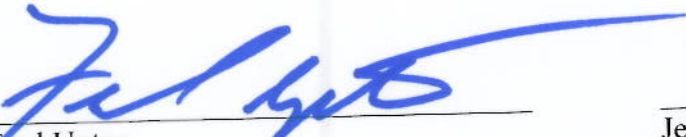
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<sup>2</sup> 42 U.S.C. § 1860d-16(b)(1)(B).

- 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.

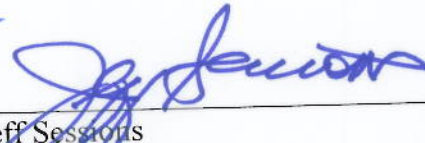
When the Senate considered your nomination, you made a commitment to “transparency and accuracy in a timely fashion.” We therefore look forward to receiving a response to our requests no later than June 24, 2014. If you have any questions regarding this request, please contact Paul Winfree with Senate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

Sincerely,



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



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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



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## 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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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.<sup>29</sup> 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,<sup>30</sup> which authorizes the Secretary of the Treasury to reimburse local fire departments or districts for costs incurred in fighting fires on federal

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<sup>29</sup> We discuss the concept of budget authority and define the term appropriation in section A (“Appropriations and Related Terminology”) of this chapter.

<sup>30</sup> Pub. L. No. 93-498, 88 Stat. 1535, 1543 (Oct. 29, 1974).

1           “(A) be a health insurance issuer; or

2           “(B) receive any consideration directly or  
3 indirectly from any health insurance issuer in  
4 connection with the participation of any em-  
5 ployer in the program under this title or the en-  
6 rollment of any qualified individual or qualified  
7 employer in a qualified health plan.

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

12 **“SEC. 3106. COMMUNITY HEALTH INSURANCE OPTION.**

13           “(a) VOLUNTARY NATURE.—

14           “(1) NO REQUIREMENT FOR HEALTH CARE  
15 PROVIDERS TO PARTICIPATE.—Nothing in this sec-  
16 tion shall be construed to require a health care pro-  
17 vider to participate in a community health insurance  
18 option, or to impose any penalty for non-participa-  
19 tion.

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

1       “(b) ESTABLISHMENT OF COMMUNITY HEALTH IN-  
2 SURANCE OPTION.—

3               “(1) ESTABLISHMENT.—The Secretary shall es-  
4 tablish a community health insurance option to  
5 offer, through each Gateway established under this  
6 title, health care coverage that provides value,  
7 choice, competition, and stability of affordable, high  
8 quality coverage throughout the United States.

9               “(2) COMMUNITY HEALTH INSURANCE OP-  
10 TION.—In this section, the term ‘community health  
11 insurance option’ means health insurance coverage  
12 that—

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

16                       “(B) provides high value for the premium  
17 charged;

18                       “(C) reduces administrative costs and pro-  
19 motes administrative simplification for bene-  
20 ficiaries;

21                       “(D) promotes high quality clinical care;

22                       “(E) provides high quality customer service  
23 to beneficiaries;

24                       “(F) offers a wide choice of providers; and

1           “(G) complies with State laws (if any), ex-  
2           cept as otherwise provided for in this title, re-  
3           lating to—

4                   “(i) guaranteed renewal;

5                   “(ii) rating;

6                   “(iii) preexisting conditions;

7                   “(iv) non-discrimination;

8                   “(v) quality improvement and report-  
9           ing;

10                  “(vi) fraud and abuse;

11                  “(vii) solvency and financial require-  
12           ments;

13                  “(viii) market conduct;

14                  “(ix) prompt payment;

15                  “(x) appeals and grievances;

16                  “(xi) privacy and confidentiality;

17                  “(xii) licensure; and

18                  “(xiii) benefit plan material or infor-  
19           mation.

20           “(3) ESSENTIAL HEALTH BENEFITS.—

21                   “(A) GENERAL RULE.—Except as provided  
22           in subparagraph (B), a community health in-  
23           surance option offered under this section shall  
24           provide coverage only for the essential health  
25           benefits described in section 3103.



1           “(B) STATES MAY OFFER ADDITIONAL  
2 BENEFITS.—A State may require that a com-  
3 munity health insurance option offered in such  
4 State offer benefits in addition to the essential  
5 health benefits required under subparagraph  
6 (A).

7           “(C) CREDITS.—

8           “(i) IN GENERAL.—An individual en-  
9 rolled in a community health insurance op-  
10 tion under this section shall be eligible for  
11 credits under section 3111 in the same  
12 manner as an individual who is enrolled in  
13 a qualified health plan.

14           “(ii) NO ADDITIONAL FEDERAL  
15 COST.—A requirement by a State under  
16 subparagraph (B) that a community health  
17 insurance option cover benefits in addition  
18 to the essential health benefits required  
19 under subparagraph (A) shall not affect  
20 the amount of a credit provided under sec-  
21 tion 3111 with respect to such plan.

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

1 additional benefits described in subparagraph  
2 (B).

3 “(E) ENSURING ACCESS TO ALL SERV-  
4 ICES.—Nothing in this Act shall prohibit an in-  
5 dividual enrolled in a community health insur-  
6 ance option from paying out-of-pocket the full  
7 cost of any item or service not included as an  
8 essential health benefit or otherwise covered as  
9 a benefit by a health plan. Nothing in this Act  
10 shall prohibit any type of medical provider from  
11 accepting an out-of-pocket payment from an in-  
12 dividual enrolled in a community health insur-  
13 ance option for a service otherwise not included  
14 as an essential health benefit.

15 “(F) PROTECTING ACCESS TO END OF  
16 LIFE CARE.—A community health insurance op-  
17 tion offered under this section shall be prohib-  
18 ited from limiting access to end of life care.

19 “(4) COST SHARING.—A community health in-  
20 surance option shall offer coverage at each of the  
21 cost sharing tiers described in section 3111(a).

22 “(5) PREMIUMS.—

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

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

4 “(B) APPLICABLE RULES.—The provisions  
5 of title XXVII relating to premiums shall apply  
6 to community health insurance options under  
7 this section, including modified community rat-  
8 ing provisions under section 2701.

9 “(C) COLLECTION OF DATA.—The Sec-  
10 retary shall collect data as necessary to set pre-  
11 mium rates under subparagraph (A).

12 “(D) CONTINGENCY MARGIN.—In estab-  
13 lishing premium rates under subparagraph (A),  
14 the Secretary shall include an appropriate  
15 amount for a contingency margin.

16 “(6) REIMBURSEMENT RATES.—

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

21 “(B) LIMITATION.—The rates described in  
22 subparagraph (A) shall not be higher, in aggre-  
23 gate, than the average reimbursement rates  
24 paid by health insurance issuers offering quali-  
25 fied health plans through the Gateway.

1           “(C) INNOVATION.—Subject to the limits  
2 contained in subparagraph (A), a State Advi-  
3 sory Council established or designated under  
4 subsection (d) may develop or encourage the  
5 use of innovative payment policies that promote  
6 quality, efficiency and savings to consumers.

7           “(D) PHYSICIAN NEGOTIATED RATES.—  
8 Nothing in this paragraph shall prohibit the ap-  
9 plication of a State law that permits physicians  
10 to jointly negotiate with health plans. In such  
11 State, physicians may jointly negotiate with a  
12 community health insurance option concerning  
13 rates paid by the option.

14           “(7) SOLVENCY AND CONSUMER PROTEC-  
15 TION.—

16           “(A) SOLVENCY.—The Secretary shall es-  
17 tablish a Federal solvency standard to be ap-  
18 plied with respect to a community health insur-  
19 ance option. A community health insurance op-  
20 tion shall also be subject to the solvency stand-  
21 ard of each State in which such community  
22 health insurance option is offered.

23           “(B) MINIMUM REQUIRED.—In estab-  
24 lishing the standard described under subpara-  
25 graph (A), the Secretary shall require a reserve

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

4 “(C) CONSUMER PROTECTIONS.—The con-  
5 sumer protection laws of a State shall apply to  
6 a community health insurance option.

7 “(8) REQUIREMENTS ESTABLISHED IN PART-  
8 NERSHIP WITH INSURANCE COMMISSIONERS.—

9 “(A) IN GENERAL.—The Secretary, in col-  
10 laboration with the National Association of In-  
11 surance Commissioners (in this paragraph re-  
12 ferred to as the ‘NAIC’), may promulgate regu-  
13 lations to establish additional requirements for  
14 a community health insurance option.

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

20 “(9) OMBUDSMAN.—In establishing community  
21 health insurance options, the Secretary shall estab-  
22 lish an ombudsman or similar mechanism to provide  
23 assistance to consumers with respect to disputes,  
24 grievances, or appeals.

25 “(c) START-UP FUND.—

1 “(1) ESTABLISHMENT OF FUND.—

2 “(A) IN GENERAL.—There is established in  
3 the Treasury of the United States a trust fund  
4 to be known as the ‘Health Benefit Plan Start-  
5 Up Fund’ (referred to in this section as the  
6 ‘Start-Up Fund’), that shall consist of such  
7 amounts as may be appropriated or credited to  
8 the Start-Up Fund as provided for in this sub-  
9 section to provide loans for the initial oper-  
10 ations of a community health insurance option.  
11 Such amounts shall remain available until ex-  
12 pended.

13 “(B) FUNDING.—There is hereby appro-  
14 priated to the Start-Up Fund, out of any mon-  
15 eys in the Treasury not otherwise appropriated  
16 an amount requested by the Secretary of  
17 Health and Human Services as necessary to—

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

21 “(ii) pay the costs of making pay-  
22 ments on claims submitted during the pe-  
23 riod that is not more than 90 days from  
24 the date on which such option is offered;  
25 and

1                   “(iii) make payments under para-  
2                   graph (3).

3                   “(2) USE OF START-UP FUND.—The Secretary  
4                   shall use amounts contained in the Start-Up Fund  
5                   to make payments (subject to the repayment re-  
6                   quirements in paragraph (5)) for the purposes de-  
7                   scribed in paragraph (1)(B).

8                   “(3) RISK CORRIDOR PAYMENTS.—

9                   “(A) IN GENERAL.—In any case in which  
10                  the Secretary has entered into a contract with  
11                  a contracting administrator, the Secretary shall  
12                  use amounts contained in the Start-Up Fund to  
13                  make risk corridor payments to such adminis-  
14                  trator during the 2-year period beginning on  
15                  the date on which such administrator enters  
16                  into a contract under subsection (e). Such pay-  
17                  ments shall be based on the risk corridors in ef-  
18                  fect during fiscal years 2006 and 2007 for  
19                  making payments under section 1860D-15(e) of  
20                  the Social Security Act.

21                  “(B) SUBSEQUENT YEAR.—In years after  
22                  the expiration of the period referred to in sub-  
23                  paragraph (A), the Secretary may extend or in-  
24                  crease the risk corridors and payments provided  
25                  for under subparagraph (A).

1           “(C) AMOUNT USED TO REDUCE COSTS.—  
2           The Secretary shall deposit any payments re-  
3           ceived from a contracting administrator under  
4           subparagraph (A) into the Start-Up Fund.

5           “(4) PASS THROUGH OF REBATES.—The Sec-  
6           retary may establish procedures for reducing the  
7           amount of payments to a contracting administrator  
8           to take into account any rebates or price conces-  
9           sions.

10          “(5) REPAYMENT.—

11                 “(A) IN GENERAL.—A community health  
12                 insurance option shall be required to repay the  
13                 Secretary of the Treasury (on such terms as the  
14                 Secretary may require) for any payments made  
15                 under paragraph (1)(B) by the date that is not  
16                 later than 10 years after the date on which the  
17                 payment is made. The Secretary may require  
18                 the payment of interest with respect to such re-  
19                 payments at rates that do not exceed the mar-  
20                 ket interest rate (as determined by the Sec-  
21                 retary).

22                 “(B) SANCTIONS IN CASE OF FOR-PROFIT  
23                 CONVERSION.—In any case in which the Sec-  
24                 retary enters into a contract with a qualified  
25                 entity for the offering of a community health



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

4 “(i) immediately liable to the Sec-  
5 retary for any payments received by such  
6 entity from the Start-Up Fund; and

7 “(ii) permanently ineligible to offer a  
8 qualified health plan.

9 “(d) STATE ADVISORY COUNCIL.—

10 “(1) ESTABLISHMENT.—A State shall establish  
11 or designate a public or non-profit private entity to  
12 serve as the State Advisory Council to provide rec-  
13 ommendations to the Secretary on the operations  
14 and policies of a community health insurance option  
15 in the State. Such Council shall provide rec-  
16 ommendations on at least the following:

17 “(A) policies and procedures to integrate  
18 quality improvement and cost containment  
19 mechanisms into the health care delivery sys-  
20 tem;

21 “(B) mechanisms to facilitate public  
22 awareness of the availability of a community  
23 health insurance option; and

24 “(C) alternative payment structures under  
25 a community health insurance option for health

1 care providers that encourage quality improve-  
2 ment and cost control.

3 “(2) MEMBERS.—The members of the State  
4 Advisory Council shall be representatives of the pub-  
5 lic and shall include educated health care consumers  
6 and providers.

7 “(3) APPLICABILITY OF RECOMMENDATIONS.—  
8 The Secretary may apply the recommendations of a  
9 State Advisory Council to a community health insur-  
10 ance option that State, in any other State, or in all  
11 States.

12 “(e) AUTHORITY TO CONTRACT; TERMS OF CON-  
13 TRACT.—

14 “(1) AUTHORITY.—

15 “(A) IN GENERAL.—The Secretary may  
16 enter into a contract or contracts with one or  
17 more qualified entities for the purpose of per-  
18 forming administrative functions (including  
19 functions described in subsection (a)(4) of sec-  
20 tion 1874A of the Social Security Act) with re-  
21 spect to a community health insurance option in  
22 the same manner as the Secretary may enter  
23 into contracts under subsection (a)(1) of such  
24 section. The Secretary shall have the same au-  
25 thority with respect to a community health in-

1 insurance option under this section as the Sec-  
2 retary has under subsections (a)(1) and (b) of  
3 section 1874A of the Social Security Act with  
4 respect to title XVIII of such Act.

5 “(B) REQUIREMENTS APPLY.—If the Sec-  
6 retary enters into a contract with a qualified  
7 entity to offer a community health insurance  
8 option, under such contract such entity—

9 “(i) shall meet the criteria established  
10 under paragraph (2); and

11 “(ii) shall receive an administrative  
12 fee under paragraph (7).

13 “(C) LIMITATION.—Contracts under this  
14 subsection shall not involve the transfer of in-  
15 surance risk to the contracting administrator.

16 “(D) REFERENCE.—An entity with which  
17 the Secretary has entered into a contract under  
18 this paragraph shall be referred to as a ‘con-  
19 tracting administrator’.

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

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

1           “(B) be a nonprofit entity for purposes of  
2 offering such option;

3           “(C) meet the solvency standards applica-  
4 ble under subsection (b)(7);

5           “(D) be eligible to offer health insurance  
6 or health benefits coverage;

7           “(E) meet quality standards specified by  
8 the Secretary;

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

11           “(G) meet such other requirements as the  
12 Secretary may impose.

13           “Procedures described under subparagraph (F) shall  
14 include the implementation of procedures to use ben-  
15 efitary identifiers to identify individuals entitled to  
16 benefits so that such an individual’s social security  
17 account number is not used, and shall also include  
18 procedures for the use of technology (including  
19 front-end, prepayment intelligent data-matching  
20 technology similar to that used by hedge funds, in-  
21 vestment funds, and banks) to provide real-time  
22 data analysis of claims for payment under this title  
23 to identify and investigate unusual billing or order  
24 practices under this title that could indicate fraud or  
25 abuse.

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

9           “(4) LIMITATION.—A contract may not be re-  
10 newed under this subsection unless the Secretary de-  
11 termines that the contracting administrator has met  
12 performance requirements established by the Sec-  
13 retary in the areas described in paragraph (7)(B).

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

19           “(6) REVOCATION.—A contract awarded under  
20 this subsection shall be revoked by the Secretary or  
21 the Inspector General only after notice to the con-  
22 tracting administrator involved and an opportunity  
23 for a hearing. The Secretary may revoke such con-  
24 tract if the Secretary determines that such adminis-  
25 trator has engaged in fraud, deception, waste, abuse

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

6 “(7) FEE FOR ADMINISTRATION.—

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

11 “(B) REQUIREMENT FOR HIGH QUALITY  
12 ADMINISTRATION.—The Secretary may increase  
13 the fee described in subparagraph (A) by not  
14 more than 10 percent, or reduce the fee de-  
15 scribed in subparagraph (A) by not more than  
16 50 percent, based on the extent to which the  
17 contracting administrator, in the determination  
18 of the Secretary, meets performance require-  
19 ments established by the Secretary, in at least  
20 the following areas:

21 “(i) Maintaining low premium costs  
22 and low cost sharing requirements, pro-  
23 vided that such requirements are con-  
24 sistent with section 3111(a).

1           “(ii) Reducing administrative costs  
2           and promoting administrative simplifica-  
3           tion for beneficiaries.

4           “(iii) Promoting high quality clinical  
5           care.

6           “(iv) Providing high quality customer  
7           service to beneficiaries.

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

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

18          “(f) REPORT BY HHS AND INSOLVENCY WARN-  
19          INGS.—

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

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

6           “(3) SUBMISSION OF PLAN AND PROCEDURE.—

7           “(A) IN GENERAL.—If there is a commu-  
8 nity health insurance option solvency warning  
9 under paragraph (2) made in a year, the Presi-  
10 dent shall submit to Congress, within the 15-  
11 day period beginning on the date of the budget  
12 submission to Congress under section 1105(a)  
13 of title 31, United States Code, for the suc-  
14 ceeding year, proposed legislation to respond to  
15 such warning.

16           “(B) PROCEDURE.—In the case of a legis-  
17 lative proposal submitted by the President pur-  
18 suant to subparagraph (A), such proposal shall  
19 be considered by Congress using the same pro-  
20 cedures described under sections 803 and 804  
21 of the Medicare Prescription Drug, Improve-  
22 ment, and Modernization Act of 2003 that shall  
23 be used for a medicare funding warning.

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



1 or promotional materials related to a community health  
 2 insurance option are made available to the public, making  
 3 available marketing or promotional materials relating to  
 4 private health insurance plans shall not be prohibited.  
 5 Such materials include informational pamphlets, guide-  
 6 books, enrollment forms, or other materials determined  
 7 reasonable for display.

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

11 **“SEC. 3107. APPLICATION OF SAME LAWS TO PRIVATE**  
 12                               **PLANS AND THE COMMUNITY HEALTH INSUR-**  
 13                               **ANCE OPTION.**

14       “(a) IN GENERAL.—Notwithstanding any other pro-  
 15 vision of law, any health insurance coverage offered by a  
 16 private health insurance issuer shall not be subject to any  
 17 Federal or State law described in subsection (b) if a com-  
 18 munity health insurance option under section 3106 is not  
 19 subject to such law.

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

23               “(1) guaranteed renewal;

24               “(2) rating;

25               “(3) preexisting conditions;

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

4 **“SEC. 2214. ESTABLISHMENT OF RISK CORRIDORS FOR**  
 5 **PLANS IN INDIVIDUAL AND SMALL GROUP**  
 6 **MARKETS.**

7 “(a) IN GENERAL.—The Secretary shall establish  
 8 and administer a program of risk corridors for plan years  
 9 beginning during the 36-month period beginning on July  
 10 1, 2013, under which a qualified health benefits plan of-  
 11 fered in the individual or small group market may elect  
 12 (before the beginning of such 36-month period) to partici-  
 13 pate in a payment adjustment system based on the ratio  
 14 of the allowable costs of the plan to the plan’s aggregate  
 15 premiums. Such program shall be based on the program  
 16 for regional participating provider organizations under  
 17 part D of title XVIII.

18 “(b) PAYMENT METHODOLOGY.—

19 “(1) PAYMENTS OUT.—The Secretary shall pro-  
 20 vide under the program established under subsection  
 21 (a) that if—

22 “(A) a participating plan’s allowable costs  
 23 for any plan year are more than 103 percent  
 24 but not more than 108 percent of the target  
 25 amount, the Secretary shall pay to the plan an

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

4 “(B) a participating plan’s allowable costs  
5 for any plan year are more than 108 percent of  
6 the target amount, the Secretary shall pay to  
7 the plan an amount equal to the sum of 2.5  
8 percent of the target amount plus 80 percent of  
9 allowable costs in excess of 108 percent of the  
10 target amount.

11 “(2) PAYMENTS IN.—The Secretary shall pro-  
12 vide under the program established under subsection  
13 (a) that if—

14 “(A) a participating plan’s allowable costs  
15 for any plan year are less than 97 percent but  
16 not less than 92 percent of the target amount,  
17 the plan shall pay to the Secretary an amount  
18 equal to 50 percent of the excess of 97 percent  
19 of the target amount over the allowable costs;  
20 and

21 “(B) a participating plan’s allowable costs  
22 for any plan year are less than 92 percent of  
23 the target amount, the plan shall pay to the  
24 Secretary an amount equal to the sum of 2.5  
25 percent of the target amount plus 80 percent of

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

3 “(c) DEFINITIONS.—In this section:

4 “(1) ALLOWABLE COSTS.—

5 “(A) IN GENERAL.—The amount of allow-  
6 able costs of a plan for any year is an amount  
7 equal to the total costs (other than administra-  
8 tive costs) of the plan in providing benefits cov-  
9 ered by the plan.

10 “(B) REDUCTION FOR RISK ADJUSTMENT  
11 AND REINSURANCE PAYMENTS.—Allowable  
12 costs shall be reduced by any risk adjustment  
13 and reinsurance payments received under sec-  
14 tion 2212 and 2213.

15 “(2) TARGET AMOUNT.—The target amount of  
16 a plan for any year is an amount equal to the total  
17 premiums (including any premium credits or sub-  
18 sidies under any governmental program) reduced by  
19 the administrative costs of the plan.

20 **“SEC. 2215. TEMPORARY HIGH RISK POOLS FOR INDIVID-**  
21 **UALS WITH PREEXISTING CONDITIONS.**

22 “(a) ESTABLISHMENT OF HIGH RISK POOLS.—

23 “(1) IN GENERAL.—Not later than 1 year after  
24 the date of enactment of this title, the Secretary  
25 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—

(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 be 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