



Insight

HHS Violating the Law, Once Again, Stealing from Taxpayers

TARA O'NEILL HAYES | FEBRUARY 25, 2016

Introduction

Once again, the Obama Administration is unilaterally, and without legal authority, making changes to the [Affordable Care Act](#) (ACA). This particular change is resulting in a loss of \$3.5 billion from the general fund of the U.S. Treasury to date, and if the pattern continues next year, taxpayers stand to lose a total of \$5 billion.

A temporary reinsurance program, established by the ACA, requires insurers to make payments to cover the costs of the program, as well as additional payments to the general fund of the U.S. Treasury. The administration failed to adequately set payment rates causing the amount of funds raised to be less than the statutorily required totals in both 2014 and 2015. HHS decided through rulemaking that in the event of a funding shortfall payments would be made to insurers before any payments are made to the Treasury, despite the law specifically stating that the share of funds collected for payment to the Treasury *must* be paid to the Treasury and *may not* be made to plan issuers. The administration has clearly acted in violation of the law, and the taxpayers are the ones paying the price.

Background

One of the [many mechanisms](#) included in the ACA to try to ensure the law's success was the creation of a temporary “reinsurance” program. Reinsurance programs are designed to help mitigate risk and guard insurers against individuals with unexpectedly high costs by setting a limit (in this case, to be determined by the Secretary of HHS) for their liability for an individual’s medical claims, beyond which a third party (the federal government) would cover the remaining costs. All eligible entities are required to pay a fee (again, an amount determined by HHS) to cover their share of the total amount to be collected; these funds would then be redistributed to insurers to assist in covering individuals whose medical costs exceeded the predetermined limit. Such a program was deemed critical to the overall success of the reformed health care landscape given that the ACA dramatically restricted an insurer’s ability to mitigate their risk, particularly given the extreme uncertainty of the health status and needs of the individuals who would be enrolling in insurance plans for the first time in a long time, or possibly ever.

Under the provision of the ACA creating the reinsurance program, insurers are required to pay reinsurance fees in 2014, 2015, and 2016 to cover the costs of the program, and also to make payments to the U.S. Treasury’s general fund. The amount each insurer must pay is to be reflective of their share of the insured population; the law calls for the Secretary of HHS to determine the method and formula to be used to calculate each insurer’s share such that all necessary funds are raised. As laid out in [§1341\(b\)\(3\)\(B\)](#), the amounts to be collected for reinsurance payments were \$10 billion in 2014, \$6 billion in 2015, and \$4 billion in 2016. Additional contributions of \$2 billion for 2014, \$2 billion for 2015, and \$1 billion for 2016 were also required to be collected through these fees and paid to the Treasury. Specifically, §1341(b)(4) stipulates that those additional

contributions “*shall* be deposited into the general fund of the Treasury of the United States and *may not* be used for the [reinsurance] program...” *[emphasis added]*.

However, an insufficient amount of funds has been raised the last two years to meet these requirements. In 2014, an estimated \$9.7 billion was collected, roughly \$2 billion short of the \$12 billion total that was required by law to be collected. For the 2015 benefit year, HHS only expects to collect \$6.5 billion or \$1.5 billion short of the total that was to be collected. The law does not stipulate how to divvy up the payments in the event of a shortfall. In May 2014, HHS published a rule declaring how such a situation would be handled. HHS decided that payments to the insurers should be made first, and any remaining funds (above the amount to be collected specifically for reinsurance payments) should be divided up between payments to the Treasury and payments to cover the costs of administering the reinsurance program. Due to the shortcomings and HHS’s decision, deposits to the Treasury will now be \$3.5 billion short after the first two years of the program.

At question is what share of the payments should have been made to the Treasury given the shortfalls which have occurred, and the timing of when such payments must be made.

This rule is in clear violation of the language of the statute. The law (§1341(b)(4) quoted above) explicitly states that each insurer’s share of the funds raised by this fee must include its share of the amount to be paid to the Treasury each year, and those funds must be paid to the Treasury and may not be used for the reinsurance program. In a memorandum issued by the Congressional Research Service (CRS) on February 23, 2016, CRS explains that HHS’s interpretation of the law, that only funds raised in excess of the amounts to be raised specifically for the reinsurance payments are to be used to make payments to the Treasury, “would appear to be in conflict with the plain text of §1341(b)(4).” The memo goes on to state that HHS’s claim that the language surrounding the amounts to be collected and deposited to the Treasury (specifically, the word “reflects”) is “permissive” and thus gives HHS discretion as to when and in what amount these payments should be made, as opposed to the “mandatory” language regarding the reinsurance payments, is inconsistent with the definition of the word “reflects”, “particularly where the surrounding language of the clause includes... the same specificity as in the clauses that CMS considers to be mandatory.”

Secondly, some may try to argue that a violation has not yet been made because of claims of ambiguity regarding the timing of the payments to the Treasury. While the law clearly allows funds raised by the fee for reinsurance payments in any year to be used for reinsurance payments in any of the years the program exists (2014, 2015, or 2016) or for an additional two years (2017 or 2018), §1341(b)(4) does not allow similar flexibility for the funds raised which are to be deposited in the Treasury’s general fund. CRS explains that the “miscellaneous receipts statute” requires that “money received by the federal government must generally be deposited in the Treasury as miscellaneous receipts ‘as soon as practicable.’” HHS came to the same conclusion, writing in the preamble to the rulemaking that “we have no authority to defer the collection of reinsurance contributions for the payments to the end of the program.”

Adding insult to injury, the problem doesn’t stop there. Despite the \$2 billion that was supposed to be deposited into the general fund in 2014, HHS announced that \$1.7 billion is being carried over from the 2014 benefit year to make reinsurance payments for the 2015 benefit year. Thus, even if HHS’s decision that payments to the Treasury should be made only after all reinsurance payments were made was not in violation of the law, the transfer of funds from 2014 to 2015 implies that there was a surplus of funds beyond what was necessary to make adequate reinsurance payments. Even under HHS’s incorrect interpretation of the law, this surplus of \$1.7 billion should have been paid to the Treasury. The administration’s priority is clearly with propping up the president’s signature legislative achievement, rather than its obligation to the taxpayers.

Finally, in 2014, HHS issued a [rule](#) to exempt “self-insured, self-administered” plans from the definition of a “contributing entity”. This had the effect of exempting [union plans](#) from having to make payments for this reinsurance program, and is likely part of the reason why an insufficient amount of funds has been collected so far.

Conclusion

This is yet another example of the Obama Administration unilaterally deciding how to implement the ACA, even in cases where they have no legal authority to do so. The administration’s decision to not make payments to the Treasury, and to instead prioritize payments to the insurers, is a clear violation of the law.