IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

UNITED STATES HOUSE OF REPRESENTATIVES, Plaintiff, v. SYLVIA MATHEWS BURWELL, in her official capacity as Secretary of the United States Department of Health and Human Services, et al., Defendants.	Case No. 14-cv-01967-RMC

EXHIBIT I

U.S. GOVERNMENT ACCOUNTABILITY OFFICE
441 G St. N.W.
Washington, DC 20548

B-325630

September 30, 2014

The Honorable Jeff Sessions
Ranking Member
Committee on the Budget
United States Senate

The Honorable Fred Upton
Chairman
Committee on Energy and Commerce
House of Representatives

Subject: *Department of Health and Human Services—Risk Corridors Program*

This responds to your February 7, 2014, request for our opinion regarding the availability of appropriations to make payments to qualified health plans pursuant to section 1342 of the Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111-148, title I, subtitle D, part V, § 1342, 124 Stat. 119, 211, 212 (Mar. 23, 2010), *classified at* 42 U.S.C. § 18062. Section 1342 directs the Department of Health and Human Services (HHS) to establish a temporary risk corridors program to limit the profits and losses of qualified health plans in the individual and small group markets.[1]

In accordance with our regular practice, we contacted HHS to obtain additional factual information and its legal views on this matter. GAO, *Procedures and Practices for Legal Decisions and Opinions*, GAO-06-1064SP (Washington, D.C.: Sept. 2006), *available at* www.gao.gov/legal/lawresources/resources.html. HHS provided us with information and its legal views. Letter from General Counsel, HHS, to Assistant General Counsel for Appropriations Law, GAO (May 20, 2014) (HHS Letter).

[1] The phrase "risk corridors," as used in section 1342, is generally understood to mean a mechanism for limiting an insurer's losses or gains because costs are higher or lower than expected.

BACKGROUND

PPACA required the establishment of American Health Benefit Exchanges (Exchanges) in each state for the purchase of insurance in the individual and small group markets. Pub. L. No. 111-148, §§ 1311(b), 1321(c). Insurers that choose to participate in the Exchanges must meet certain requirements to offer qualified health plans. *See* 45 C.F.R. § 155.1000. Qualified health plans offered through the Exchanges are subject to the risk corridors program. 42 U.S.C. § 1342(a).

The risk corridors program is part of what the Centers for Medicare and Medicaid Services (CMS) refers to as the "premium stabilization programs." CMS, *Premium Stabilization Programs*, *available at* www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/index.html (last visited Sept. 30, 2014). The premium stabilization programs "are designed to provide consumers with affordable health insurance coverage, to reduce incentives for health insurance issuers to avoid enrolling sicker people, and to stabilize premiums in the individual and small group health insurance markets inside and outside the Marketplaces."[2] *Id.*

Generally, insurers set premiums based upon their past experience and anticipated costs related to their pool of enrollees. However, individuals seeking coverage through the Exchanges may have potential health risks that are different than those historically handled by an insurer, resulting in a health plan having higher costs than anticipated. *See* 77 Fed. Reg. 17220, 17221 (Mar. 23, 2012). Because health insurance issuers may be uncertain about the proportion of high-cost enrollees under the new Exchanges, they may include a margin in their pricing to offset the potential expenses of these enrollees, especially during the first few years of the Exchanges. *Id.* at 17221. HHS expects that this uncertainty will decrease as the issuers gain actual claims experience with this new population. *Id*. In order to minimize the possible negative effects of this uncertainty during the initial years of operation of the Exchanges, section 1342 of PPACA directs the Secretary of HHS to operate a temporary risk corridors program. Pub. L. No. 111-148, § 1342(a). This program is intended to protect against uncertainty in rates for qualified health plans by limiting the extent of issuer losses and gains for calendar years 2014, 2015, and 2016. 77 Fed. Reg. at 17221.

Section 1342(a) provides that qualified health plans that choose to participate in the Exchanges "shall participate in a payment adjustment system based on the ratio of the allowable costs of the plan to the plan's aggregate premiums." Pub. L. No. 111-148, § 1342(a). Section 1342(b) sets forth the payment methodology. Under this system, HHS will make payments to qualified health plans experiencing losses above a set amount; conversely, plans realizing gains above a set amount will make payments to HHS. Section 1342(b)(1) provides that "the Secretary shall

[2] CMS uses the term "Marketplaces" to refer to the American Health Benefit Exchanges (Exchanges) required to be established by PPACA.

pay" to the qualified health plan a given amount to compensate for certain losses the plan incurs as a result of its allowable costs exceeding its premiums.[3] *Id.* § 1342(b)(1). Section 1342(b)(2), in contrast, provides that a qualified health plan "shall pay to the Secretary" a given amount to account for certain gains the plan recognizes because the amounts it collects in premiums exceed its allowable costs. *Id.* § 1342(b)(2).

The Secretary of HHS has delegated authority for section 1342 to the CMS Administrator.[4] 76 Fed. Reg. 53903 (Aug. 30, 2011). HHS informed us that as of May 20, 2014, it had not made or received any payments under section 1342. HHS Letter, at 3. HHS intends to begin collections and payments for this purpose in fiscal year (FY) 2015. *Id*.

DISCUSSION

At issue here is whether appropriations are available to the Secretary of HHS to make the payments specified in section 1342(b)(1). Agencies may incur obligations and make expenditures only as permitted by an appropriation. U.S. Const., art. I, § 9, cl. 7; 31 U.S.C. § 1341(a)(1); B-300192, Nov. 13, 2002, at 5. Appropriations may be provided through annual appropriations acts as well as through permanent legislation. *See, e.g.*, 63 Comp. Gen. 331 (1984). The making of an appropriation must be expressly stated in law. 31 U.S.C. § 1301(d). It is not enough for a statute to simply require an agency to make a payment. B-114808, Aug. 7, 1979. Section 1342, by its terms, did not enact an appropriation to make the payments specified in section 1342(b)(1). In such cases, we next determine whether there are other appropriations available to an agency for this purpose.

CMS Program Management Appropriation

We first examined the availability of the CMS Program Management (PM) appropriation for FY 2014, which provides:

> "For carrying out, except as otherwise provided, titles XI, XVIII, XIX, and XXI of the Social Security Act, titles XIII and XXVII of the PHS Act, the Clinical Laboratory Improvement Amendments of 1988, and *other*

[3] The payments required under section 1342(b) are calculated based upon the ratio of the allowable costs of the plan to the "target amount" of the plan. This target amount "is an amount equal to the total premiums (including any premium subsidies under any governmental program) reduced by the administrative costs of the plan." Pub. L. No. 111-148, § 1342(c)(2).

[4] In the same delegation of authority, the Secretary delegated several responsibilities established by PPACA to CMS, including authorities vested in the Secretary by certain provisions of titles I, II, and X of PPACA. 76 Fed. Reg. 53903.