FACT SHEET

# THE TRANSITIONAL REINSURANCE PROGRAM

The Transitional Reinsurance Program is a state-based program created by the Affordable Care Act to level the playing field across the health insurance markets, moderate premium increases, and support the foundation of the Exchanges. States may opt to establish a reinsurance program regardless of whether they establish an Exchange. In the event a state does not establish a reinsurance program, the Department of Health and Human Services (HHS) will establish one on its behalf. The reinsurance program is effective beginning January 1, 2014, through December 31, 2016.

## REINSURANCE CONTRIBUTIONS

The Affordable Care Act defines the national aggregate contributions for reinsurance payments as $10 billion in 2014, $6 billion in 2015, and $4 billion in 2016.

**How much must an issuer or plan contribute?** Required reinsurance contributions are based on a national per capita contribution rate. This contribution rate funds reinsurance payments and program administrative costs. The contribution rate will be proposed in the annual draft HHS notice of benefit and payment parameters to be published in fall 2012 and finalized in January 2013.

**Who contributes?** All health insurance issuers, and self-insured health plans or third party administrators (on behalf of self-insured health plans or issuers) will contribute funds. The contributions will be attributed to the state in which the enrollee resides.

**Who collects the contributions**? This will vary depending on which market segment generates the contribution.

*Self-Insured Market* - For every state, all of the contributions from the self-insured market will be collected by HHS even if the state has a State-operated program. The contributions will be disbursed either to the State-operated program or to the HHS-operated program on behalf of the State.

*Fully Insured Market* - In a state-operated program, the state may collect fully insured market contributions within its state or request that HHS do so on its behalf. When HHS is operating the program on behalf of a state, HHS will collect the contributions from the fully insured market.

## REINSURANCE PAYMENTS

Reinsurance payments are based on a portion of an issuer's costs (coinsurance rate) paid per enrollee above a certain level (attachment point) and until a payment limit (reinsurance cap) is reached. Payments will be based on the total reinsurance payment funds available in each state's reinsurance fund at the time the payment is calculated.

**How much will reinsurance payments cover?** The reinsurance payment parameters such as the coinsurance rate are specific for each state. These parameters will be proposed in the annual draft HHS notice of benefit and payment parameters and finalized in January 2013. If a state-operated program would like to change its parameters, the state will publish its parameters in the state payment notice by no later than March 1, 2013.

**Who is eligible for reinsurance payments?** An issuer with enrollees in *non-grandfathered individual market plans* is eligible for reinsurance payments.

**How is a reinsurance payment determined?** Payments are determined based on the claims paid by the issuer on a per enrollee basis for the benefit year. The maximum reimbursement on behalf of each enrollee is the amount resulting when the coinsurance rate is applied to an issuer's costs above the attachment point and below the reinsurance cap.