UNLAWFUL REINSURANCE PAYMENTS: CMS DIVERTING $3.5 BILLION FROM TAXPAYERS TO PAY INSURANCE COMPANIES

HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON ENERGY AND COMMERCE

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C O N T E N T S

[1] Mr. Slavitt did not answer submitted questions for the record by the time of printing.

UNLAWFUL REINSURANCE PAYMENTS: CMS DIVERTING $3.5 BILLION FROM TAXPAYERS TO PAY INSURANCE COMPANIES

FRIDAY, APRIL 15, 2016

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 9:35 a.m., in room 2123 Rayburn House Office Building, Hon. Tim Murphy (chairman of the subcommittee) presiding.

Members present: Representatives Murphy, McKinley, Burgess, Blackburn, Flores, Brooks, Mullin, Hudson, Collins, Upton (ex officio), DeGette, Castor, Kennedy, Green, and Pallone (ex officio).

Staff present: Gary Andres, Staff Director; Rebecca Card, Assistant Press Secretary; Jessica Donlon, Counsel, Oversight and Investigations; Emily Felder, Counsel, Oversight and Investigations; Brittany Havens, Legislative Associate, Oversight and Investigations; Charles Ingebretson, Chief Counsel, Oversight and Investigations; Chris Santini, Policy Coordinator, Oversight and Investigations; Jeff Carroll, Democratic Staff Director; Ryan Gottschall, Democratic GAO Detailee; Tiffany Guarascio, Democratic Deputy Staff Director and Chief Health Advisor; Christopher Knauer, Democratic Oversight Staff Director; Una Lee, Democratic Chief Oversight Counsel; Elizabeth Letter, Democratic Professional Staff Member; Andrew Souvall, Democratic Director of Communications, Outreach, and Member Services; and Arielle Woronoff, Democratic Health Counsel.

OPENING STATEMENT OF HON. TIM MURPHY, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. MURPHY. Good morning. We are here today at the Oversights and Investigations hearing on unlawful reinsurance payments to examine the transitional reinsurance program established under the Patient Protection and Affordable Care Act.

The administration has inexplicably changed its position on a major component of this program and specifically how reinsurance payments are allocated. Despite issuing two final rules that allocated a portion of the reinsurance payments to the U.S. Treasury, CMS changed its position to prioritize payments to insurers. Essentially, CMS ruled that the Treasury doesn't get any money until the insurers get paid.

CMS' latest interpretation contradicts the plain language of the law. Repeatedly, this interpretation contradicts the plain language of the law. This is just the latest in a long line of examples of the administration breaking its own signature law in an attempt to prop it up.

The reinsurance program was created to provide financial assistance to insurance companies who offered plans through Obamacare. The program incentivizes insurance companies to continue selling plans through healthcare.gov and State exchanges because it compensates them for enrolling high risk individuals. Final payments for this 3-year program will end in 2017.

For each enrollee, insurance companies contribute a set dollar amount to the program, and then the funds collected are distributed to insurers who enroll the highest risk individuals. Built into this program was a deficit reduction measure, a proportion of each individual contribution is allocated to the Treasury. The statute estimates that approximately $5 billion would be designated to the Treasury through this program with $20 billion going to insurers.

On March 11th, 2014, CMS issued a rule that spelled out how to divide the fund between Treasury, insurance companies, and administrative costs. CMS wrote that Treasury would receive about 25 percent of the fund in 2015.

But while insurers have received billions of dollars from the program, the Treasury has still received nothing. That is because CMS changed its mind ten days later after issuing its final March 11th, 2014 rule. Ten days later, CMS published a rule completely reversing its policy position. In the new rule, CMS prioritized payments to insurers over payments to the Treasury and in short Treasury gets nothing until insurers are paid in full. CMS finalized this rule in May of 2014.

But why did CMS dramatically reverse its own policy to favor insurance companies? We look forward to getting a straight answer from CMS today. We do know there is a cozy relationship between insurance companies and this administration, and the administration has worked to incentivize insurers to stick with the exchanges. In fact, we know that insurers have even emailed top White House officials begging for more taxpayer money to lower premiums and keep insurers selling Affordable Care Act plans.

I expect Mr. Slavitt will attempt to justify why CMS changed its interpretation of the law, and he may argue that the statute is ambiguous or silent about what to do if the fund doesn't collect the full amount. However, the statute clearly states in this statement here that the portion of the contribution intended for the Treasury shall be deposited into the general fund of the Treasury of the United States and may not be used for a reinsurance program. This means that each contribution includes a portion intended just for the Treasury and CMS cannot divert those funds to pay insurance companies instead.

Now the nonpartisan Congressional Research Service agrees with us that the statute is not ambiguous and it is not silent on the issue. CRS analyzed the statute and CMS' interpretations. The CRS found that the statute, quote, unambiguously states that each issuer's contribution contain an amount that reflect its proportionate share of the U.S. Treasury contribution and that these

amounts should be deposited in the general fund of the U.S. Treasury, unquote.

Mr. Slavitt may also argue that neither the law nor CMS contemplated what to do if the reinsurance fund came up short of the target amounts. The law states, however, that a portion of what is collected must go to the Treasury. Moreover, CMS did contemplate what would happen if the fund did not collect enough money. In its final rule issued March 11th, 2014, CMS predicted there would be a variance between the statutory benchmark and actual amount received through the program.

When asked about the legal basis for diverting these funds at a February 24th, 2016, hearing before our Subcommittee on Health, Secretary Burwell provided no legal justification. The Secretary emphasized that this program is temporary, implying the committee's concerns are unimportant because the program will be over in 2017.

I disagree. I think this issue holds the utmost importance. CMS' actions exemplify a problem that goes beyond just this one Affordable Care Act program. When the executive branch decides to reprioritize the budget and divert money intended for the Treasury it is a concern for Congress. When CMS officials decide to ignore a clear mandate from Congress it is an affront to this legislative body.

The administration cannot rewrite its own law to make it more convenient for special interests. This sets a dangerous precedent and is an affront to the separation of powers. Moreover, this program funnels money to insurers, now with money intended for the Treasury, in an attempt to prop up the Affordable Care Act.

What will happen when this program runs out and there is no mechanism to underwrite high risk individuals who sign up on the exchanges? Will more insurers drop out? Will premiums raise even higher? The administration's actions appear to be trying to delay the inevitable, the collapse of the Affordable Care Act if it is not reformed.

I thank Mr. Slavitt for being here today. I know he and I have talked many times, and I appreciate his candor with me, and I hope that he will pledge to return CMS' first, lawful interpretation of the reinsurance program and allocate funds to Treasury as required by law.

[The prepared statement of Mr. Murphy follows:]

PREPARED STATEMENT OF HON. TIM MURPHY

We are here today to examine the "transitional reinsurance program" established under the Patient Protection and Affordable Care Act. The administration has inexplicably changed its position on a major component of this program-specifically, how reinsurance payments are allocated.

Despite issuing two final rules that allocated a portion of the reinsurance payments to the U.S. Treasury, CMS changed its position to prioritize payments to insurers. Essentially, CMS ruled that the Treasury doesn't get any money until the insurers get paid.

CMS' latest interpretation contradicts the plain language of the law. This is just the latest in a long line of examples of the administration breaking its own signature law in an attempt to prop it up.

The reinsurance program was created to provide financial assistance to insurance companies who offered plans through ObamaCare. The program incentivizes insurance companies to continue selling plans through healthcare.gov and State ex-

changes, because it compensates them for enrolling high risk individuals. Final payments for this 3-year program will end in 2017.

For each enrollee, insurance companies contribute a set dollar amount to the program, and then the funds collected are distributed to insurers who enroll the highest risk individuals. Built into this program was a deficit reduction measure-a proportion of each individual contribution is allocated to the Treasury. The statute estimates that approximately $5 billion would be designated to the Treasury through this program-with $20 billion going to insurers.

On March 11, 2014, CMS issued a rule that spelled out how to divide the fund between Treasury, insurance companies and administrative costs. CMS wrote that Treasury would receive about 25% of the fund in 2015. But while insurers have received billions of dollars from the program, the Treasury has still received nothing.

This is because CMS changed its mind 10 days later after issuing its final March 11, 2014 rule. 10 days later, CMS published a proposed rule, completely reversing its policy position. In the new rule, CMS prioritized payments to insurers over payments to the Treasury. In short, Treasury gets nothing until insurers are paid in full. CMS finalized this rule in May 2014.

Why did CMS dramatically reverse its own policy to favor insurance companies? We look forward to getting a straight answer from CMS today. We do know there is a cozy relationship between insurance companies and this administration. And the administration has worked to incentivize insurers to stick with the exchanges. In fact, we know that insurers have even emailed top White House officials begging for more taxpayer money to lower premiums and keep insurers selling Obamacare plans.

I expect Mr. Slavitt will attempt to justify why CMS changed its interpretation of the law. He may argue that the statute is ambiguous or silent about what to do if the fund doesn't collect the full amount. However, the statute clearly states that the portion of the contribution intended for the Treasury "shall be deposited into the general fund of the Treasury of the United States and may not be used for the [reinsurance] program." This means that each contribution includes a portion intended just for the Treasury—and CMS cannot divert those funds to pay insurance companies instead.

The nonpartisan Congressional Research Service agrees with us—the statute is not ambiguous or silent on this issue. CRS analyzed the statute, and CMS' interpretations. CRS found that "the statute unambiguously states that 'each issuer's contribution' contain an amount that reflects 'its proportionate share' of the U.S. Treasury contribution, and that these amounts should be deposited in the General Fund of the U.S. Treasury." Mr. Slavitt may also argue that neither the law nor CMS contemplated what to do if the reinsurance fund came up short of the target amounts. The law states, however, that a portion of what is collected must go to the Treasury.

Moreover, CMS did contemplate what would happen if the fund did not collect enough money. In its final rule issued March 11, 2014, CMS predicted there could be a variance between the statutory benchmark and the actual amount received through the program. When asked about the legal basis for diverting these funds at a February 24, 2016 hearing before our Subcommittee on Health, Secretary Burwell provided no legal justification. The Secretary emphasized that this program is temporary, implying the committee's concerns are unimportant because the program will be over in 2017.

I disagree. I think this issue holds the utmost importance. CMS' actions exemplify a problem that goes beyond just this one ObamaCare program. When the executive branch decides to reprioritize the budget and divert money intended for the Treasury, it is a concern for Congress. When CMS officials decide to ignore a clear mandate from Congress, it is an affront to this legislative body. The administration cannot re-write its own law to make it more convenient for special interests. This sets a dangerous precedent and is an affront to the separation of powers.

Moreover, this program funnels money to insurers-now with money intended for the Treasury—in an attempt to prop up ObamaCare. What will happen when this program runs out, and there is no mechanism to underwrite high risk individuals who sign up on the exchanges? Will more insurers drop out? Will premiums rise even higher? The administration's actions appear to be trying to delay the inevitable—the collapse of Obamacare.

I thank Mr. Slavitt for being here today and hope that he will pledge to return to CMS' first, lawful interpretation of the reinsurance program -and allocate funds to Treasury as required by the law.

Mr. MURPHY. I now recognize the ranking member of the subcommittee, Ms. DeGette of Colorado, for 5 minutes.

OPENING STATEMENT OF HON. DIANA DEGETTE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO

Ms. DEGETTE. Thanks, Mr. Chairman. Well, I guess nobody here is surprised we are having yet another Oversight hearing on the Affordable Care Act. This subcommittee has had 16 oversight hearings on the act since it was passed, and also we have sent dozens of oversight letters to the Department of Health and Human Services, to CMS, and others, pertaining to the Affordable Care Act.

I know for a fact the agencies have spent countless staff hours and taxpayer dollars preparing testimony for hearings responding to these letters and providing documents, information and briefings to satisfy the committee's oversight interests.

Now I just want to ask one question. Has anything of value been achieved through these efforts? Have we actually changed or modified the Affordable Care Act to work better? No, we haven't. Now listen, I believe in Government oversight. In fact, I have urged the chairman of the full committee and you, Mr. Chairman, to have meaningful oversight hearings around the Affordable Care Act because I do believe there are some things that can be fixed.

But, you know, good Government illuminates the shortcomings and causes of institutional failures and thereby it informs any substantive changes in public policy. Unfortunately, our oversight over the act over the last 6 years has served neither to enlighten the committee, improve the law nor help millions of Americans. And I just use, for example, of what we are doing here today is the hashtag that the majority is using on social media, hashtag Great Obamacare Heist, or some of the inflammatory statements in the press release that the majority sent out about today's hearing and why we are having it.

Now you have heard over and over again for 6 years that the ACA is destroying the lives of Americans, and also you just heard that the administration has not followed the law. I mean, I think that there may be a matter of misinterpretation or different interpretation, but nobody can argue that 20 million new Americans have insurance because of the Affordable Care Act.

In this press release I just referenced, my colleagues describe the reinsurance program which is the topic of today's hearing as a, quote, "taxpayer-funded giveaway." Now this is a program, the reinsurance program, that the majority understood was necessary and in fact put in their own bill on Medicare Part D when they passed that in 2005.

The reason we have the ACA reinsurance program is because it helped us transition from an individual market that relied on medical underwriting to one in which insurers can no longer discriminate against individuals for preexisting conditions and cannot decline to offer coverage to somebody because they are sick. This temporary transitional program achieves this goal by collecting contributions from insurance companies which are then in turn used to make payments to insurance companies in the individual market which will offset the largest claims for the sickest individuals. I would hardly call that a taxpayer funded giveaway.

This self-same press release also described the administration's decision to prioritize reinsurance payments to insurers as, quote,

unlawful. You just heard that in the chairman's statement. Now this rhetoric is also unfair and inaccurate, because what we have here is a difference of opinion regarding a policy decision and a difference of views on how to interpret a provision of the ACA.

So I look forward to hearing about those differences today, but unlawful again seems to be a little bit extreme.

Now, I just want to put this in perspective, and I want to read an excerpt of a letter from Brent Brown to President Obama. Brent Brown is a lifelong Republican who recently introduced the President at a speech in Milwaukee, Wisconsin, and here is what he said.

Quote, I did not vote for you either time. I have voted Republican for the entirety of my life. I proudly wore pins and planted banners displaying my Republican loyalty. I was very vocal in my opposition to you, particularly the ACA. Before I briefly explain my story, allow me to say this. I am so very sorry. I was so very wrong. You saved my life, Mr. President. You saved my life and I am eternally grateful. I have a preexisting condition and so could never purchase health insurance. Only after the ACA came into being could I be covered. Put simply to take not too much of your time if you are in fact taking the time to read this, I would not be alive without access to the care I received due to your law.

Mr. Chairman, I would like unanimous consent to enter Mr. Brown's letter to the record.

Mr. MURPHY. Without objection.

[The information appears at the conclusion of the hearing.]

Ms. DEGETTE. And I think it is time to have a productive conversation about improving the ACA and the lives of all our constituents, and I yield back the balance of my time.

Mr. MURPHY. The gentlelady yields back. I now recognize the chairman of the full committee, Mr. Upton, for 5 minutes.

OPENING STATEMENT OF HON. FRED UPTON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. UPTON. Thank you, Mr. Chairman. This hearing does continue the subcommittee's thoughtful and necessary oversight of the President's healthcare law. Today, the three-and-half-billion-dollar question is why CMS is now diverting taxpayer dollars to insurance companies without any legal authority to do so.

Health law statute plainly states that a portion of the contributions to the reinsurance program must be given to the U.S. Treasury. Still, CMS has chosen to violate the law by prioritizing reinsurance contributions to health insurers rather than allocating the required portion to the U.S. Treasury.

Initially, CMS followed the letter of the law and according to its final rule issued on March 11th, 2014, and similar to its rule the prior year, CMS planned to allocate contributions to the reinsurance program between the health insurers, the Treasury, and administrative costs. Less than two weeks later, however, on March 31st, 2014, CMS switched gears and issued a different proposed rule completely reversing their previous position.

Rather than allocating a portion of the contribution to the Treasury as dictated by law, CMS instead prioritized reinsurance contributions to health insurers and finalized the rule two months

later. So why, the question is why the sudden reversal to redirect billions away from the taxpayer?

Legal memorandum released earlier this year by the nonpartisan CRS found that the statute does not permit CMS to prioritize reinsurance payments to insurers. In fact, the Congressional Research Service found that CMS' actions appear to contradict the plain language of the law.

I would like to think that you have come to provide us some answers to those questions today as we look to understand the who, what, when, where, and why of that decision. The American public deserves answers and we look forward to that discussion. I yield back.

[The prepared statement of Mr. Upton follows:]

PREPARED STATEMENT OF HON. FRED UPTON

This hearing continues the subcommittee's thoughtful and necessary oversight of the President's healthcare law.

Today, the 3.5-billion-dollar question is why CMS is now diverting taxpayer dollars to insurance companies without any legal authority to do so. The health law statute plainly states that a portion of the contributions to the reinsurance program must be given to the U.S. Treasury. Still, CMS has chosen to violate the law by prioritizing reinsurance contributions to health insurers rather than allocating the required portion to the U.S. Treasury.

Initially, CMS followed the letter of the law. According to its final rule issued March 11, 2014, and similar to its rule the prior year, CMS planned to allocate contributions to the reinsurance program between the health insurers, the U.S. Treasury, and administrative costs. Less than two weeks later, however, on March 21, 2014, CMS switched gears and issued a different proposed rule completely reversing CMS' prior position. Rather than allocating a portion of the contributions to the Treasury as dictated by law, CMS instead prioritized reinsurance contributions to health insurers and finalized this rule two months later. Why the sudden reversal to redirect billions away from taxpayers?

A legal memorandum released earlier this year by the nonpartisan Congressional Research Service found that the statute does not permit CMS to prioritize reinsurance payments to insurers. In fact, CRS found that CMS' actions appear to contradict the plain language of the law.

We hope Centers for Medicare and Medicaid Services' Acting Administrator Andy Slavitt has come with answers today as we look to understand the 'who, what, when, where, and why' of CMS' decision. The American public deserves answers.

I would note that on this date 104 years ago, the Titanic sank after striking an iceberg. The President's health law is taking on water, and the administration is doing everything in its power, including violating the law, to keep it afloat.

Regardless of one's view of the President's health law, the law and its implementation demand vigilant oversight. Congress cannot stand silent when its laws are not being faithfully executed.

Further, as we continue to see today, billions of taxpayer dollars are at stake.

Mr. MURPHY. The gentleman yields back. I now recognize the ranking member of the full committee, Mr. Pallone, for 5 minutes.

OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. Thank you, Mr. Chairman. When we passed the Affordable Care Act into law more than 6 years ago, we dramatically changed the healthcare landscape in this country and the law has been a historic success. It has achieved its goals and made access to comprehensive health care a reality for the American people. Thanks to the Affordable Care Act, 20 million more Americans now know the security of health insurance, and for the first time

ever the uninsured rate has fallen below ten percent. And these are remarkable achievements.

Before the Affordable Care Act was passed, the insurance system in this country was broken. Even my Republican colleagues who were obsessed with repealing the law acknowledge that this is the case.

Absolutely no one is advocating for returning to the old system of rapidly rising costs, gross inefficiencies, and painful inequalities. It was a system where upwards of 129 million Americans, nearly one in two people, could be discriminated against in the individual market for preexisting medical conditions ranging from diabetes to breast cancer to pregnancy. And these individuals could be charged more than a healthy person for the same coverage and were often denied coverage all together. Many insurance plans lacked important benefits and limited coverage.

Fortunately, thanks to the Affordable Care Act, these things are no longer true. People who were previously deemed uninsurable because of preexisting conditions are finally getting health insurance coverage and this has meant a big change in how insurance companies do business.

Under the old system, insurers sought to protect their bottom lines by avoiding the sickest and costliest patients in the individual market, a practice known as medical underwriting. Today, insurers must offer coverage to everyone and they cannot cancel someone's policy because he or she gets sick.

The law's temporary reinsurance program operates to smooth this transition from a medically underwritten individual insurance market to one in which everyone is guaranteed coverage. Simply put, the reinsurance program spreads the cost of large insurance claims for very sick individuals across all insurers, helping to stabilize premiums during the early years of the new marketplace. The program collects contributions from health insurance companies, which are then used to make payments to the insurance companies in the individual market to offset the costs of their sickest enrollees.

Now my Republican colleagues on this committee have called these payments, quote, handouts to insurance companies, and I quote, taxpayer funded giveaways. And neither of these things is true. The reinsurance program is a temporary program funded entirely by contributions from insurance companies to smooth the transition from a medically underwritten market to one where everyone is guaranteed coverage.

Unfortunately, this type of overblown rhetoric and blatant misinformation is typical when it comes to my Republican colleagues and the Affordable Care Act. In fact, this same framework is a permanent fixture of our Part D program, a law that Republicans support, defend and promote. And I just find it ironic and hypocritical that this framework is acceptable for Medicare Part D, which was signed into law by a Republican President, but it is supposedly a taxpayer funded giveaway under a healthcare law from a Democratic President. You can't have it both ways.

They have used similar rhetoric to describe the administration's decision to prioritize reinsurance payments to insurers over payments to the U.S. Treasury, the subject of today's hearing. For in-

stance, a March 22, 2016 press release from the majority describes, and I quote, CMS' decision to loot billions from the Treasury to pay off insurance companies and calls on the agency, and I quote again, to stop unlawful payments to insurers. And these characterizations by the GOP are simply absurd.

Let's be clear. What is at stake here is simply a policy disagreement about how to interpret statutory language in the Affordable Care Act. The administration has interpreted the law through a formal, transparent notice and comment rulemaking process. It determined that the statute is silent on what the agency should do in the event that collections are insufficient to fully fund both payments to insurance companies and payments to the U.S. Treasury. It then concluded that in the event of a shortfall, payments to insurers should be prioritized and that this prioritization furthers the statutory goals of the program.

I know my Republican colleagues clearly disagree with this interpretation and they are entitled to their view. But the hyperbole and the misinformation is counterproductive and does nothing to help a single person get health insurance.

So let me just conclude by expressing my disappointment in the direction this committee continues to take in conducting oversight of the Affordable Care Act. Hearings like this only serve to hurt Americans and reverse the progress that has been made for the millions who now benefit from the law. And I believe we should instead work to improve the law and ensure all of our constituents have access to the quality, affordable health care they deserve.

I yield back, Mr. Chairman.

[The prepared statement of Mr. Pallone follows:]

PREPARED STATEMENT OF HON. FRANK PALLONE, JR.

When we passed the Affordable Care Act into law more than 6 years ago, we dramatically changed the healthcare landscape in this country. The law has been a historic success. It has achieved its goals and made access to comprehensive healthcare a reality for the American people.

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Before the Affordable Care Act was passed, the insurance system in this country was broken. Even my Republican colleagues who are obsessed with repealing the law acknowledge that this is the case.

Absolutely no one is advocating for returning to the old system of rapidly rising costs, gross inefficiencies, and painful inequalities. It was a system where upwards of 129 million Americans—nearly one in two people—could be discriminated against in the individual market for pre-existing medical conditions, ranging from diabetes to breast cancer to pregnancy.

These individuals could be charged more than a healthy person for the same coverage and were often denied coverage altogether. Many insurance plans lacked important benefits and limited coverage.

Fortunately, thanks to the Affordable Care Act, these things are no longer true. People who were previously deemed uninsurable because of pre-existing conditions are finally getting health insurance coverage.

This has meant a big change in how insurance companies do business. Under the old system, insurers sought to protect their bottom lines by avoiding the sickest and costliest patients in the individual market, a practice known as medical underwriting. Today, insurers must offer coverage to everyone, and they cannot cancel someone's policy just because he or she gets sick.

The law's temporary reinsurance program operates to smooth this transition from a medically underwritten individual insurance market to one in which everyone is guaranteed coverage. Simply put, the reinsurance program spreads the cost of large

insurance claims for very sick individuals across all insurers, helping to stabilize premiums during the early years of the new marketplace. The program collects contributions from health insurance companies, which are then used to make payments to insurance companies in the individual market to offset the costs of their sickest enrollees.

My Republican colleagues on this committee have called these payments "handouts to insurance companies" and a "taxpayer-funded giveaway." Neither of these things is true. The reinsurance program is a temporary program, funded entirely by contributions from insurance companies, to smooth the transition from a medically underwritten market to one where everyone is guaranteed coverage.

Unfortunately, this type of overblown rhetoric and blatant misinformation is typical when it comes to my Republican colleagues and the Affordable Care Act. In fact, this same framework is a permanent fixture of our Part D program—a law that Republicans support, defend and promote. I find it ironic and hypocritical that this framework is acceptable for Medicare Part D, which was signed into law by a Republican President, but it is a supposed "taxpayer-funded giveaway" under a healthcare law from a Democratic President. You can't have it both ways.

They have used similar rhetoric to describe the administration's decision to prioritize reinsurance payments to insurers over payments to the U.S. Treasury, the subject of today's hearing. For instance, a March 22, 2016 press release from the Majority describes "CMS' decision to loot billions from the Treasury to pay off insurance companies," and calls on the agency to "stop unlawful payments to insurers." These characterizations are absurd.

Let me be clear: what is at stake here is simply a policy disagreement about how to interpret statutory language in the Affordable Care Act.

The administration has interpreted the law through a formal, transparent, notice and comment rulemaking process. It determined that the statute is silent on what the agency should do in the event that collections are insufficient to fully fund both payments to insurance companies and payments to the U.S. Treasury. It then concluded that in the event of a shortfall, payments to insurers should be prioritized, and that this prioritization furthers the statutory goals of the program.

My Republican colleagues clearly disagree with this interpretation. They are entitled to their view. But the hyperbole and the misinformation is counterproductive and does nothing to help a single person get health insurance.

Let me conclude by expressing my disappointment in the direction this committee continues to take in conducting oversight of the Affordable Care Act. Hearings like this only serve to hurt Americans and reverse the progress that has been made for the millions who now benefit from the law.

We should instead work to improve the law and ensure all of our constituents have access to the quality, affordable health care they deserve.

Mr. MURPHY. The gentleman yields back. Now let me introduce our one witness here. Andy Slavitt is the Acting Administrator for the Centers for Medicare and Medicaid Services. As Acting Administrator, he oversees programs that provide access to quality health care for 140 million Americans including Medicaid and Medicare, the Children's Health Insurance Program, and Health Insurance Marketplace. You have been before us in this committee, so welcome back.

I ask unanimous consent also that the members' written opening statements be introduced in the record, and without objection, the documents will be entered into the record.

You are aware that this committee is holding an investigative hearing, Mr. Slavitt, and when doing so has the practice of taking testimony under oath. Do you have any objections to testifying under oath?

Mr. SLAVITT. I do not.

Mr. MURPHY. And the Chair then would advise you that under the rules of the House, under rules of committee, you are entitled to be advised by counsel. Do you desire to be advised by counsel during your testimony today?

Mr. SLAVITT. No, thank you.

Mr. MURPHY. In that case, would you please rise, raise your hand, and I will swear you in.

[Witness sworn.]

Mr. MURPHY. Thank you. You are now under oath and subject to the penalties set forth in Title 18, Section 1001, of the United States Code. You may now give a 5-minute summary of your witness statement.

STATEMENT OF ANDY SLAVITT, ACTING ADMINISTRATOR, CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH & HUMAN SERVICES

Mr. SLAVITT. Chairman Murphy, Ranking Member DeGette, and members of the subcommittee, I'm pleased to be here again and look forward to discussing the Affordable Care Act's transitional reinsurance program.

The transitional reinsurance program is a critical building block in the new health insurance market from which so many consumers are benefiting. By now you've heard the statistics, an estimated 20 million Americans have gained coverage and the Nation's uninsured rate is at its lowest recorded level.

When we talk about these numbers it's important to understand that it just doesn't happen by itself. Critical provisions of the ACA like reinsurance allow people with significant medical expenses to be covered affordably. Reducing the cost of health insurance is in everyone's interest, for individuals in small businesses who pay premiums, and because the Government gives Federal tax credits to people with modest incomes it is a much better deal for the Treasury. We all benefit. Covering people with significant medical expenses is a core policy objective of the ACA.

I will refer to an example of the Hubbard family who live in Dallas, Texas. Sean Hubbard is studying for a PhD, and his wife Jamie works in a hair salon. They signed up for health insurance through the marketplace. Sean described what happened when his son Navin was born a month early. Other than being small he appeared to be healthy, but doctors discovered that Navin had a heart defect that would require surgery, and transferred him to Medical City Children's Hospital.

In all, the bills have come to nearly $3 million, but we've been covered through it all. The little fellow has come home in mid-February, and though he's doing well he has more surgeries, speech and physical therapy and other procedures in his future, and it's comforting to know that because of the Affordable Care Act Navin can't be denied coverage in the future because of preexisting conditions.

My point isn't simply to remind us what's happening throughout the country as millions of families get coverage for the first time, but also to point to the importance of the details that matter, critical policy provisions like reinsurance.

We all know that the Hubbard situation could be visited on any of us. Sometimes we need expensive health care to get well. I spent more than two decades in the healthcare industry before joining the Government and I can tell you that until 2014, every day medical expenses like this haunted American families for the rest of their lives. The Affordable Care Act fundamentally changed that

and changed the entire insurance market. Insurance companies can no longer deny or put limits on a consumer's coverage because they have a serious illness.

This is precisely why reinsurance is so important. It spreads the risk across large populations. Every insurance company pays a smaller amount of money in the confidence that if they happen to enroll people like the Hubbards they'll receive money back to help cover the costs of the complex medical care. This is certainly not a concept unique to the Affordable Care Act, Congress also included the reinsurance program in Medicare Part D for similar reasons.

Let me directly address the implementation of this provision and in particular how the allocation of funds were determined. In the case of reinsurance the statute didn't contemplate what should occur if collections either fell above or below the mark indicated in the statute. While I've been in Government only a short time, I can tell you that occasionally across all of our programs including Medicare and Medicaid we do encounter instances in which the statute is silent as to the necessary details to implement the policy.

Given this, 2 years ago CMS proposed an approach of reimbursing high cost claims as a first priority and sought public comment on both the legal and policy reasoning of how to address the specific scenarios that weren't contemplated by the statute. CMS received universal public support for the policy of returning payments back to cover claims as a first priority, and no one, not one commenter questioned the legality or appropriateness of the approach.

In the brief time that I've been with the agency, I can tell you that we take concerns that we receive very seriously. We understand that differences of interpretation sometimes happen, and as the committee has more recently expressed. Our lawyers carefully reviewed and assessed the recent memo from the Congressional Research Service to confirm our approach is supported by the statute.

As the CBO recently noted, the entire cost of the Treasury of the ACA's coverage provisions is projected to be 25 percent lower than originally estimated. The reinsurance program is reducing costs. It continues to help many, many families like the Hubbards and serves taxpayers well by lowering Federal tax credit obligations.

This year we will add approximately $500 million to the U.S. Treasury from the program as collections will exceed the targeted amount to reimburse high cost claims for 2015. We are committed to operating this program for American families and with focus on efficiency for taxpayers. I look forward to answering your questions now to the best of my abilities.

[The prepared statement of Mr. Slavitt follows:]

STATEMENT OF

ANDY SLAVITT
ACTING ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

THE TRANSITIONAL REINSURANCE PROGRAM

BEFORE THE

U. S. HOUSE ENERGY AND COMMERCE COMMITTEE,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

APRIL 15, 2016

U. S. House Energy and Commerce Committee,
Subcommittee on Oversight and Investigations
The Transitional Reinsurance Program
April 15, 2016

Chairman Murphy, Ranking Member DeGette, and members of the Subcommittee, thank you for the opportunity to discuss the Affordable Care Act's transitional reinsurance program. The Centers for Medicare & Medicaid Services (CMS) implemented the reinsurance program in accordance with the statute to help provide stability in the health insurance market as the Affordable Care Act extends new benefits to consumers.

CMS's priority is to provide Marketplace customers with access to quality, affordable coverage. In the years since the passage of the Affordable Care Act, we have seen increased competition among health plans and more choices for consumers.[1] During the third Marketplace Open Enrollment, nine out of ten returning customers were able to choose from three or more issuers for 2016 coverage, up from seven in ten in 2014.[2] Moving forward, CMS is eager to build on the progress in reducing the number of uninsured Americans – an estimated 20 million Americans gained coverage since the Affordable Care Act's coverage provisions have taken effect,[3] and the Nation's uninsured rate is at its lowest level since data collection began over five decades ago.[4,5] During the third open enrollment that concluded at the end of January, 12.7 million Americans selected affordable, quality health plans for 2016 coverage through the Marketplaces.[6]

The Affordable Care Act made many significant reforms in the individual and small group health insurance markets, including ending discrimination based on pre-existing conditions, establishing essential health benefits, and removing annual and lifetime dollar limits on these benefits. These reforms work in tandem with the medical loss ratio, also known as the 80/20 rule,

[1] www.hhs.gov/about/news/2015/07/30/competition-and-choice-in-the-health-insurance-marketplace-lowered-premiums-in-2015.html
[2] www.hhs.gov/about/news/2015/07/30/competition-and-choice-in-the-health-insurance-marketplace-lowered-premiums-in-2015.html
[3] https://aspe.hhs.gov/pdf-report/health-insurance-coverage-and-affordable-care-act-2010-2016
[4] http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201602.pdf
[5] http://www.cdc.gov/nchs/data/nhsr/nhsr017.pdf
[6] https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-02-04.html

and rate review, to result in significant benefits for consumers, providing many with access to high-quality, affordable health insurance.

The Affordable Care Act also includes programs based on similar, successful programs in the Medicare Part D prescription drug benefit – reinsurance, risk adjustment, and risk corridors – to stabilize premiums and the health insurance market. These programs mitigate the impact of potential adverse selection inside and outside the Marketplaces, while stabilizing premiums and encouraging plan participation in the individual and group markets, including in the Marketplaces.

Thanks in part to these programs, the Affordable Care Act will continue to provide consumers with affordable coverage options, encouraging issuers to participate in the Marketplaces and compete on price and quality. The reinsurance, risk adjustment, and risk corridors programs help ensure that the Affordable Care Act works as intended, with insurance plans competing on the basis of quality and service and not by seeking to attract the healthiest individuals. Better competition leads to improved coverage so that consumers — whether they are healthy or sick — can pick the best plan for their needs.

Transitional Reinsurance Program

Section 1341 of the Affordable Care Act directs that a transitional reinsurance program be established in each state from 2014 through 2016. The transitional reinsurance program is designed to partially reimburse the costs of high-cost enrollees in the individual market, helping to smooth risk, and thereby reduce premiums, in the individual health insurance market as the market reforms are implemented and the Marketplaces facilitate increased enrollment. In accordance with section 1341, health insurance issuers and certain group health plans make contributions. From these contributions, reinsurance payments are made to individual market issuers with claim costs within a pre-determined level as described below.

Reinsurance contributions are based on a uniform per capita contribution rate, which is calculated and announced each year in time for issuers and group health plans to incorporate into their rates. CMS announced the 2014, 2015, and 2016 reinsurance contribution rates in the

annual Payment Notices for 2014, 2015, and 2016, each of which was published in final form about one year before the applicable coverage year. Reinsurance payments to issuers are based on a portion (the coinsurance rate) of the issuer's costs per enrollee once paid claims costs reach a certain level (attachment point) and until a payment limit (cap) is reached.[7] CMS also proposed and finalized the 2014, 2015 and 2016 reinsurance payment parameters – that is, the coinsurance rate, attachment point and cap – in the annual Payment Notices for 2014, 2015 and 2016. States had the option to establish a reinsurance program and collect additional reinsurance contributions, or defer establishment and performance of all reinsurance functions to the Department of Health & Human Services (HHS).[8] Connecticut is the only state that elected to operate its own reinsurance program, and it is responsible for disbursing reinsurance payments to its issuers.

Operationalizing the Transitional Reinsurance Program

To implement the transitional reinsurance program, CMS followed the standard public rulemaking process, seeking public comment on all reinsurance policy proposals. Less than six months after enactment of the Affordable Care Act, CMS published a Request for Comment, inviting the public to provide input regarding the rules that would govern Marketplace and related functions such as reinsurance and risk adjustment.[9] In July 2011, CMS published the first proposed rule related to reinsurance, risk adjustment and risk corridors, in anticipation of the market reforms taking effect in 2014, and to provide issuers and other stakeholders with adequate notice of our intended policies.[10] Since that time, each rule implementing various aspects of the reinsurance program has been proposed and finalized according to our established rulemaking process. Annual per capita contribution rates and payment parameters for the reinsurance program were proposed and finalized in our Notice of Benefit and Payment Parameters (Payment Notice) for 2014, 2015 and 2016 benefit years. Consistent with the statutory flexibility to allocate and use contributions in any of the three years in which they are

[7] For 2014, the attachment point is $45,000 and the cap is $250,000.
[8] Connecticut is the only state to establish its own reinsurance program, and is operating the program for 2014-2016.
[9] *Planning and Establishment of State-Level Exchanges; Request for Comments Regarding Exchange-Related Provisions in Title I of the Patient Protection and Affordable Care Act (August 3, 2010); available at https://www.gpo.gov/fdsys/pkg/FR-2010-08-03/pdf/2010-18924.pdf*
[10] From preamble to CMS-9975-P, Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment; Proposed Rule; https://www.gpo.gov/fdsys/pkg/FR-2011-07-15/pdf/2011-17609.pdf

collected, CMS adopted a regulation to use remaining funds collected for reinsurance payments (if any) from one year to make payments in the subsequent years of the program.

In order to maximize the financial effect of the transitional reinsurance program and ensure that all of the contributions collected for a benefit year are expended for claims for that benefit year, CMS finalized a proposal in the Payment Notice for 2015 to increase the coinsurance rate on reinsurance payments for a benefit year, up to a maximum of 100 percent, if reinsurance contributions exceed the total requests for reinsurance payments for that benefit year. While the reinsurance contribution rate, program parameters and models were established prior to the start of the first open enrollment period in 2013, CMS continued to use the rulemaking process to help ensure that the program would function as intended.

In the years leading up to the 2014 coverage year, when issuers and group health plans would begin offering coverage under the new market rules established by the Affordable Care Act, and consumers would begin purchasing coverage through the Marketplaces, CMS relied on models and projections to develop estimates related to a number of Affordable Care Act programs, including the premium stabilization programs. In order to meet issuers', group health plans' and states' rate-setting timelines, CMS needed to propose and finalize reinsurance collections rules more than a year before the beginning of the coverage year, so that issuers and group health plans could incorporate those expectations into their rates. Thus, in estimating a 2014 contribution rate that would target $12.02 billion in collections, CMS conducted modelling efforts through the summer and fall of 2012, using the latest available data on the insured and self-insured markets nationally, which was generally 2010 data.

CMS created the Affordable Care Act Health Insurance Model (ACAHIM) to estimate market enrollment and per enrollee expenditures, incorporating the effects of State and Federal policy choices, and accounting for the behavior of individuals and employers. We used the ACAHIM, which was developed with reference to existing models such as those of the Congressional Budget Office and the CMS Office of the Actuary, to characterize medical expenditures and health insurance enrollment choices nationally in 2014. The ACAHIM is made up of integrated modules that predict the number and characteristics of market entrants and medical spending.

The outputs of the ACAHIM, especially the estimated enrollment and expenditure distributions, were used to analyze estimated Marketplace enrollment in 2014.

The ACAHIM model was also used to establish the uniform contribution rate and reinsurance payment parameters for all three years – 2014, 2015, and 2016. These parameters and rates needed to be established for all three years, based on issuers', group health plans' and states' rate-setting timelines.

Due to the uncertainty in our estimates of reinsurance contributions to be collected, and to help ensure that the reinsurance payment pool is sufficient to provide the premium stabilization benefits intended by the statute, we sought comment in the 2015 Exchange and Insurance Market Standards Proposed Rule[11] on potential revisions to the allocation of reinsurance contributions collected. Specifically, we proposed that, if collections fell short of our estimates (and therefore, short of the target collection amounts) for a particular year, we would allocate contributions that are collected first to the reinsurance payment pool and administrative expenses, until our targets for reinsurance payments and administrative expenses were met. Once those targets were met, the remaining contributions collected for that benefit year would be allocated to the U.S. Treasury.

We sought comment on this proposal, including with respect to our legal authority to prioritize reinsurance contributions to reinsurance payments over payments to the U.S. Treasury. We also invited comments on alternative allocation approaches to maximize the premium stabilization benefits of the reinsurance program. All comments CMS received were supportive of the proposed policy. In the 2015 Exchange and Insurance Market Standards Final Rule, published on May 27, 2014,[12] CMS finalized our proposed reallocation approach with minor modifications.

Consistent with the policies finalized through rulemaking, CMS announced on June 17, 2015, that the national coinsurance rate for the 2014 benefit year for the transitional reinsurance program would be increased from 80 percent to 100 percent because reinsurance contributions

[11] https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/cms-9949-p.pdf
[12] https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/508-CMS-9949-F-OFR-Version-5-16-14.pdf

for the 2014 benefit year exceeded the requests for reinsurance payments.[13] As noted above, these changes were made in order to maximize the financial effect of the transitional reinsurance program and ensure that all of the contributions collected for a benefit year are expended for claims for that benefit year. This announcement also noted that since collections fell short of the estimates for the 2014 benefit year, the first $10 billion collected would be allocated for reinsurance payments, and any of the funds for reinsurance payments that remained would be used for such payments in the subsequent benefit year. For the 2014 benefit year, CMS received approximately $9.7 billion in reinsurance contributions, and made nearly $7.9 billion in reinsurance payments to 437 issuers nationwide. On February 12, 2016, CMS announced that we anticipate that we will collect approximately $6.5 billion in reinsurance contributions for the 2015 benefit year. This will provide $7.7 billion in reinsurance contributions for reinsurance payments for the 2015 benefit year (reflecting approximately $1.7 billion in contributions from the 2014 benefit year and approximately $6 billion in collection from the 2015 benefit year), while $500 million will be allocated on a pro rata basis for program administration and to the General Fund of the U.S. Treasury. Should we receive collections in excess of the amounts we have previously anticipated, this additional amount will be allocated between program administration and the General Fund of the U.S. Treasury pursuant to the reinsurance allocation process outlines in the Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond.

Conclusion

The Affordable Care Act created the reinsurance program to stabilize premiums and the insurance market in the first years of the new Marketplaces and implementation of the new federal reforms. Now in its final year, the reinsurance program continues to reduce uncertainty for issuers so the market can function more smoothly, encouraging issuers to offer high-quality, affordable plans, and stabilizing premiums for consumers. CMS believes that the reinsurance and other premium stabilization programs are an important part of our efforts to mitigate adverse selection and limit the consequences of uncertainty that could prevent Americans from accessing

[13] https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/The-Transitional-Reinsurance-Program/Downloads/RI-Payments-National-Proration-Memo-With-Numbers-6-17-15.pdf

health insurance. I appreciate the opportunity to discuss the regulatory framework outlined by CMS and look forward to answering your questions.

Mr. MURPHY. Thank you, Mr. Slavitt. Before I start I want unanimous consent to include the CRS memo in the record, so without objection, I will include that there.

[The information appears at the conclusion of the hearing.]

Mr. MURPHY. I recognize myself for 5 minutes. On March 11th, 2014, CMS did issue a final rule that it allocated a proportion of reinsurance contributions to Treasury in accordance with the law, and just ten days later CMS issued another rule reversing its position and prioritizing payments to insurers over the Treasury. Why did CMS change its mind?

Mr. SLAVITT. Thank you, Mr. Chairman. Well, this was before my time at CMS so I couldn't give you other than what I've seen in the regulation, which is first of all it's not uncommon for new regulations to supplant older regulations as people learn more, and I think it was laid out in the regulation that was proposed subsequently that they were concerned about the precision of the estimate and so they laid out the policy reasoning and legal reasoning subsequently as to why they felt like that was the right course.

Mr. MURPHY. In its prior rulemaking though CMS had already contemplated what would happen if the reinsurance fund did not collect enough money and CMS said the Treasury would still receive a portion of the funds, so this is out of CMS' interpretation at the time. So the rule did not change because CMS had to figure out what to do if the fund came up short, correct?

Mr. SLAVITT. I think the—I'm sorry. Can I ask you to repeat that question?

Mr. MURPHY. Sure. The rule did not change because CMS had to figure out what to do if the fund came up short. I mean, was that their motivation that it would come up short?

Mr. SLAVITT. I think they were—I think there was uncertainty as to how to handle situations if it did come up short, and so I believe they looked at the situation and determined that that was the best policy decision and sought public comment as to whether or not that indeed was the right policy decision, but also laid out the legal reasoning to get comment on whether or not that was appropriate.

Mr. MURPHY. But they had already contemplated that scenario that it might come up short and again then made this leap to change their interpretation, and this is what is so puzzling to us. One day they interpret it one way according to the law, and another day as you said some lawyers reviewed and changed their minds on that. I would think that we have responded in truth and the law instead of interpretations.

But let's go back to this nonpartisan Congressional Research Service statute which does speak to directly to the issue. I mean, CMS wrote that the law unambiguously states, and let me read the whole quote here, because the statute unambiguously states that each issuer's contribution contain an amount that reflects its proportionate share of the U.S. Treasury contribution and that these amounts should be deposited in the general fund of the U.S. Treasury, a contrary agency interpretation would not be entitled to deference under Chevron. Now you have read the CMS memo, I am assuming?

Mr. SLAVITT. Yes, I have, but more importantly so have our lawyers.

Mr. MURPHY. Well, I don't give a darn what your lawyers say if they are wrong. I mean, what they are saying is, so this is a very unambiguous statement from CMS and Congress made a clear rule in this in the law. And just because some lawyer said, well, we don't agree with what the law says and we don't even agree with what CRS says, we are going to come up with our own interpretation, I don't see where the law grants any latitude to say, here is what the law says but this is open to the interpretation of any lawyer who wants to see otherwise.

So help me with this. I don't understand where the authority comes from to make that change.

Mr. SLAVITT. Sure. Well, we believe we have the statutory authority. And I think what is at root here is that the statute is very clear on what happens in the circumstance where $12 billion is collected and the statute is silent on what happens when different amounts are collected.

And I think as again because I wasn't here we'll piece this back based on what I've learned is that that meant either interpretations, there could be multiple interpretations of what to do in those situations.

Mr. MURPHY. I think the wording unambiguously is pretty clear. I don't think that says there is multiple interpretations. Have you seen the movie, The Big Short?

Mr. SLAVITT. I have.

Mr. MURPHY. So you know in there the whole issue was while they are taking all these mortgages, AAA, AB rated, that the banks were basically reselling these and repackaging these to keep these bond packages strong, and other people were saying it cannot be sustained, the banks at some point can't keep doing this.

This whole thing looks to me of the same ilk, and I worry here. Look, I like the story you told about people who have insurance. I agree with you. I am glad people have that kind of coverage now. What worries me is that when this whole thing ends in a few months and they are not going to have this kind of thing to prop it all up anymore, we are going to see some collapse here in the health insurance market like occurred there for the bond markets.

I am out of time. I now give 5 minutes to Ms. DeGette.

Ms. DEGETTE. Oh, OK. That was kind of an interesting question about a movie, about the big banks and everything. Mr. Slavitt, do you think—I haven't seen the movie, but I am going to—do you think that what is happening here with the reinsurance is the same thing that the big banks did in this movie depiction?

Mr. SLAVITT. No, Congresswoman.

Ms. DEGETTE. And why not?

Mr. SLAVITT. Well, this is reinsurance payments, which is—and I've been in the healthcare industry for quite some time.

Ms. DEGETTE. Right.

Mr. SLAVITT. The premiums are funded by the plans themselves in order to cover losses that they receive. So this is not in fact taxpayer funded, as you pointed out earlier, but it really is a very, very common technique to make sure that people with large claims can get covered, particularly in the early years of the market.

Ms. DEGETTE. It just smooths out the system, right?

Mr. SLAVITT. Exactly, smooths it out.

Ms. DEGETTE. And this is going to be phased out once the market is stabilized, right?

Mr. SLAVITT. Right, after 3 years. Yes.

Ms. DEGETTE. Now you said you weren't at the, we know you weren't at CMS at the time this policy was designed; is that right?

Mr. SLAVITT. That's correct.

Ms. DEGETTE. So when it was designed—but you say you have gone back and you have researched it——

Mr. SLAVITT. Yes.

Ms. DEGETTE [continuing]. And figured out what happened; is that right?

Mr. SLAVITT. That's correct.

Ms. DEGETTE. You also talked to your lawyers about it.

Mr. SLAVITT. That's correct.

Ms. DEGETTE. OK. Now, so when in 2015 CMS proposed prioritizing reinsurance payments to health insurance issuers over payments to the U.S. Treasury in the event that collections fell short of the amount needed to make both payments in full, do you know how that proposal came about?

Mr. SLAVITT. I don't know exactly how it came about, but I know that because they were unsure given that the statute didn't contemplate what to do, the approach they took was to file a notice of proposed rulemaking with the Federal Register for everybody to see so they could see comments both on the approach at the policy as well as the legal reasoning for that.

Ms. DEGETTE. And did they go through that process then?

Mr. SLAVITT. They did.

Ms. DEGETTE. And did they get any comments that this was illegal?

Mr. SLAVITT. No, they did not.

Ms. DEGETTE. Did they get any comments that it was a quote, taxpayer funded giveaway?

Mr. SLAVITT. No, they did not.

Ms. DEGETTE. OK. Do you know if the agency consulted with its lawyers when it put the proposal together?

Mr. SLAVITT. Yes. I can tell you that the lawyers scrupulously review every regulation that the agency proposes.

Ms. DEGETTE. And the lawyers felt I assume that it would be legal to do this kind of rulemaking; is that right?

Mr. SLAVITT. That's correct.

Ms. DEGETTE. Now you told Mr. Murphy that you have subsequently talked to the lawyers about whether this was legal despite the language that Mr. Murphy cited to from the statute. What was the advice that they gave you about why they thought it was legal?

Mr. SLAVITT. Well, so first of all it's not uncommon for there to be differences of opinion and for there to be memos that come in that don't agree. I think our practice, and I followed up specifically with the lawyers, was to make sure that upon reading that letter they still had the same interpretation that they had before.

Indeed, their comment was that they believed that the regulation's still very clearly supported by the statute and that there's statutory authority for it.

Ms. DEGETTE. Even now?

Mr. SLAVITT. Even now. And I would say, you know, I think we have a very good track record of responding. So, for example, the GAO over the last year, 2015, we have had 47 recommendations from the GAO and 43 times we've concurred with those recommendations. Four times we didn't concur. So sometimes, many times, we were in agreement. There are occasions when we seek comments that we don't think we agree with.

Ms. DEGETTE. And is this one of those four times?

Mr. SLAVITT. This is one of those times.

Ms. DEGETTE. OK. So do you still think that this is an appropriate rule?

Mr. SLAVITT. Yes. This is a highly successful program. It's benefiting many, many Americans and the taxpayers.

Ms. DEGETTE. And do you think that when it phases out that the bottom is going to fall out of the insurance industry?

Mr. SLAVITT. I don't think so.

Ms. DEGETTE. Why not?

Mr. SLAVITT. Because I think the market now has a better feel for the people that are being insured. And I think that wasn't the case 3 years ago, and it was a little more so last year and a little more so this year, but I think by the time we get to the third year people have a pretty good understanding of the illnesses that——

Ms. DEGETTE. And they will be able to smooth out the——

Mr. SLAVITT. I believe so.

Ms. DEGETTE [continuing]. Discrepancies. OK, thank you. I yield back.

Mr. MURPHY. The gentlewoman yields back. I now recognize the vice chairman of the committee, Mr. McKinley, for 5 minutes.

Mr. MCKINLEY. Thank you, Mr. Chairman. And I would like to follow up a little bit on the comments that were made when Chairman Murphy raised about the change of opinions and decisions that have been made under this administration.

Administrator, thank you for coming back. It is good to see you again. But small rural hospitals all across this country are in dire shape. We know that nearly 60 hospitals have closed over the last 5 years in these rural hospitals. In my State, over half the critical access hospitals are operating rural health clinics and they are being adversely impacted by CMS' decision to disallow the cost of operating these rural health clinics.

Now this is in contrary to a previous decision that approved it back in 2004, said that very specifically that you could include the cost. Now it has been a reversal. CMS apparently intends to enforce this new decision retroactively over 5 years, and the cumulative impact of this on rural health clinics and critical access hospitals in West Virginia is going to force a back payment of millions of dollars when they can barely afford to keep their doors open as they speak.

Now these hospitals as you well know are treating our poor and our most vulnerable citizens in rural communities. Just last week, West Virginia's Health and Human Resources wrote you all, CMS, a letter. Are you aware of that letter?

Mr. SLAVITT. Yes. I'm not familiar with it in detail.

Mr. MCKINLEY. I am sorry?

Mr. SLAVITT. I'm not familiar with it in detail.

Mr. MCKINLEY. OK. I am just simply asking you at this point since at stake is whether rural hospitals they simply can't afford to make this retroactive payment, they simply can't do it and it is almost a sixth of all the hospitals or 12 of the hospitals, and so nearly 20 percent of all the hospitals in West Virginia are threatened——

Mr. SLAVITT. Right.

Mr. MCKINLEY [continuing]. Whether or not they can make this payment or not. So I am asking, please, they have reached up this far up. They have been trying, and I know you all have dug your heels in and I understand that. But this is a time not, to maybe rethink that please, and see if there isn't some kind of solution if we could work through this. Because they were based on a previous decision and you have made another decision, your department's made another decision that is contrary to that.

We are just trying to prevent a retroactive payment. If it has to go forward I think they can make the adjustment, but going backwards I have got to appeal to your sensitivity. Will you take a look at that? Will you try to take a good look at that letter?

Mr. SLAVITT. Yes, we will. And I know we've been working with your staff on this issue, we'll continue to, and health care in rural America is a foremost issue for us. We have recently appointed a rural health task force and we will ask this task force to look specifically into this for you.

Mr. MCKINLEY. If you would, please. And would you also agree to work with the State of West Virginia to provide some technical assistance in drafting a Medicaid State plan amendment that would recognize the important role that these critical access hospitals serve in providing rural healthcare services and consequently clarify their eligibility for continued Medicaid DSH payments? Would you do that, please?

Mr. SLAVITT. Yes. Yes.

Mr. MCKINLEY. Just in closing, the last three questions. Does CMS provide any grants or other forms of financial assistance to rural hospitals so they can better cope and address these situations that are occurring? Again with the backdrop, all across America these small hospitals are closing.

Mr. SLAVITT. Right, yes.

Mr. MCKINLEY. We can't afford to have that as you well know, but do you have anything like that of funding sources?

Mr. SLAVITT. We have a number of initiatives that apply in many specific situations that support the economics and the long term economics in rural health. We have to look and see what's appropriate in the case of West Virginia, but there are a number of programs that I think are across the department.

Mr. MCKINLEY. I am going to say you are agreeing, and can you work with our office and also the State hospital association to ensure they have the resource, if that is what I am hearing you say that you may have some sources that they may not be aware of?

Mr. SLAVITT. Yes, we will absolutely do that.

Mr. MCKINLEY. Thank you. Most importantly, just please, don't make it retroactive. They can't do it. Thank you. I yield back my time.

Mr. SLAVITT. Thank you.

Mr. MURPHY. Thank you. I now recognize Ms. Castor of Florida for 5 minutes.

Ms. CASTOR. Thank you, Mr. Chairman. Good morning, Mr. Slavitt.

Mr. SLAVITT. Good morning.

Ms. CASTOR. Despite countless attempts by my Republican colleagues in Congress to repeal, undermine, defund the Affordable Care Act, the law is making affordable health insurance a reality for so many American families and especially in my State of Florida. Since passage of the ACA 5 years ago, an estimated 20 million Americans have gained coverage through the ACA's various coverage provisions.

And I would like to think of the Affordable Care Act in a couple of different categories. You have the improvements to Medicare, the fact that so many of our older neighbors are paying much less for their prescription drugs, billions of dollars back into the pockets of our older neighbors. And then lengthening the life of the Medicare trust fund is vitally important, all of the preventive care that our older neighbors on Medicare receive.

And I think about the consumer protections, ending discrimination against people who had cancer, diabetes that health insurance companies can no longer discriminate and keep them out, they have gained coverage. And now after a few years we can finally take a true measure on coverage for so many of our neighbors.

According to a recent Gallup poll, the uninsured rate has dropped to a historic low. As of the first quarter of 2016, the rate has dropped 6.1 percentage points since the mandate provision of the ACA took effect in 2014. And our African American and Hispanic neighbors have experienced the greatest decrease in uninsured rates by approximately ten percent. So now we are at this overall historic low in America for the uninsured rate.

And let me tell you the story of the State of Florida, my home State, where we had one of the highest rates of uninsured in the country. In Florida, 1.7 million Floridians selected or were automatically re-enrolled in quality, affordable health coverage through the marketplace. That is ten percent of the entire country, because nationwide nearly 11.7 million consumers selected a plan or automatically re-enrolled.

The tax credits have really helped. Seventy two percent of Florida marketplace enrollees obtained coverage for $100 or less after the tax credits in 2015. And in Florida, consumers, we are fortunate to have a competitive market. We have consumers could choose from 14 issuers in the marketplace last year. That was up from 11 in 2014.

Florida consumers could choose from an average of 42 health plans in their county for 2015 coverage. This was the goal, to have a competitive marketplace so Americans can do what they do best, go shopping and compare. And having the navigators kind of help them through a lot of these decisions has been a godsend.

And then there was the question would young adults, we need healthy folks to enroll and that plays right into this transitional reinsurance. And the good news is that in Florida over a half million consumers under the age of 35 signed up for marketplace coverage,

and about half a million consumers 18 to 34, which was 28 percent of all plan selections, were signed up.

So this continuing to harp on this has been a disaster. It is just not true and now the facts bear it out. But I was wondering if you could put this historic low of the uninsured rate into perspective. What does this mean for our country to have such a low uninsured rate?

Mr. SLAVITT. Well, thank you, Congresswoman. Having been in health care my entire career and never seeing the uninsured rate decline, it certainly has been rewarding to see that happen and to feel it. At least in my job you can see it in the actual people as you can in your constituents.

Florida, I believe, as you said, has a lot to be proud of. The uninsured rate, I believe, has declined by a third in Florida, and if the State chooses to expand Medicaid at some point, that will——

Ms. CASTOR. It will be even lower.

Mr. SLAVITT [continuing]. Be even greater. So I think there's a lot of good things that have happened and good things to come.

Ms. CASTOR. Well, thank you to you and your team for everything that you have done to help make health insurance more affordable for so many of our neighbors across America.

Mr. SLAVITT. Thank you.

Ms. CASTOR. Thank you.

Mr. MURPHY. The gentlewoman yields back, and now Dr. Burgess is recognized for 5 minutes.

Mr. BURGESS. Thank you, Mr. Chairman. Thank you, Administrator Slavitt, for joining us here in our committee again. I think it is important that we continue to have these types of discussions.

Certainly in the very early days of President Obama's administration the statement was made repeatedly that transparency would abound in this healthcare law. In many ways it was meant as a criticism to Republicans that boy, if your member is not on board with this everybody will know it; if your member is standing with the insurance companies and not with the administration everybody is going to know it because it is all going to be transparent. It is all going to be on C–SPAN, and then we found that it wasn't.

And in fact, even going back to 2009 when Henry Waxman was chairman of this committee, I submitted a resolution of inquiry asking for who was involved in crafting the things that eventually became known as the Affordable Care Act. And to my surprise, Mr. Waxman agreed about halfway with me and agreed that I should have seven of the 11 things that I asked for. I never got them, but it was a minor moral victory for me that I got Mr. Waxman's concurrence during that. And as we have gone on through this, time after time we bump up against things where it just doesn't seem like it all adds up.

So at this point can you tell me which person, official, office within CMS is responsible for interacting with HHS leadership with the White House on these reinsurance payments? Is there a single individual or office?

Mr. SLAVITT. Thank you for the question. I think the best way for me to answer that question—given that I wasn't here, I couldn't name any specific individuals—is everybody. This was a public,

transparent rule put out that had to be reviewed and cleared across the Government and so everybody had the concurrence and the review, and then as it went into the Federal Register that was also true for the general public and everybody else.

Mr. BURGESS. Yes.

Mr. SLAVITT. So there was no attempt for someone to do something without a broad review within the department and then even broader review with the public.

Mr. BURGESS. You know the old saying, too many people in charge; no one in charge. Someone has to be in charge, so who would have been the person who picked up the phone and called the White House when it was seen that there were problems meeting your obligations?

Mr. SLAVITT. This is before my time so I don't know the answer to that question.

Mr. BURGESS. Could you research that for us and get us that information from 2014 who that person would have been?

Mr. SLAVITT. I certainly could try.

Mr. BURGESS. So outside of the formal rulemaking process did anyone outside the executive branch communicate with Health and Human Service leadership or CMS about prioritizing reinsurance payments or the resinsurance program generally?

Mr. SLAVITT. Not to my knowledge. But again I wasn't here, but not to my knowledge.

Mr. BURGESS. Multiple reports in the press during the years 2012, 2013, 2015 about episodes where all of the insurance executives were going down to the White House and meeting with the President and his team and Secretary Sebelius. Would there be any way the committee could know if these reinsurance payments were part of those discussions that occurred at the White House?

Mr. SLAVITT. Not to my knowledge.

Mr. BURGESS. Would there be any internal office memoranda that would have been generated by these meetings? Would the Secretary's office have responded to the White House with any emails? We need to see those types of communications.

Mr. SLAVITT. Yes, not that I have seen.

Mr. BURGESS. Well, again, we have asked for the production of some documents but what has been produced has not been particularly helpful. Are there additional documents that you are working on to provide to the committee?

Mr. SLAVITT. Yes. I know we've provided a number of documents and I know that we're working on more.

Mr. BURGESS. When could the committee expect to receive those documents?

Mr. SLAVITT. I think quite soon. We're just, I can't give you a date until I check with my team, but we can get back to your staff and make sure we get this to you as quickly as we can. I know they're working on it.

Mr. BURGESS. To me quite soon is April 18th because that is when our income taxes are due. Could it be that soon?

Mr. SLAVITT. I can't commit to Monday, no.

Mr. BURGESS. You know it has been a repetitive problem in this subcommittee, and it is not just with HHS, as with Department of Energy during Solyndra where it just seems like there was a deci-

sion made internally to change the rules on behalf of the administration. And it is troubling, this committee continues to be troubled by that and unfortunately today's hearing is just additional evidence that we are not there yet as far as the transparency part.

Thank you, Mr. Chairman, I will yield back.

Mr. MURPHY. Mr. Hudson, you are recognized for 5 minutes.

Mr. HUDSON. Thank you, Mr. Chairman. And thank you, sir, for being here today. I heard you answer an earlier question about that once the transitional reinsurance program ends in 2017, the question of given that United Health pulled out were you concerned about other companies pulling out of the program, and you indicated that you didn't think there was much concern of that.

But I am just curious as you are looking at that who are you discussing this with? Are you talking to folks in the marketplace? How are you basing your decision that you think the market is stabilized?

Mr. SLAVITT. So I'll start with some data. In 2016, the average individual had, nine out of ten individuals had three or more health plans to choose from. So what we call a full shelf is present in 90 percent of the country. Now obviously people are just beginning the rate filings process for 2017, and so we're going to see and we'll certainly have to let that speak for itself as people make their decisions.

I anticipate there will be additions and subtractions, and in formal conversations that I've had with people throughout the industry including State departments of insurance who of course are monitoring these things very closely and what I hear from companies themselves is indeed that. There may be some people to pull out of certain markets and there will be people that enter additional markets but that I don't see the overall equation changing.

Mr. HUDSON. OK. So it is not your anticipation then that you are going to see a whole lot more companies withdrawing from these exchanges once this reinsurance, I mean, supplement is there? I mean, it is obviously creating a large liability for these companies and we are already seeing some pull out while they have still got the subsidy in place.

Mr. SLAVITT. Yes. Our job is to make sure that people can see it coming so they can price for it. But what people expect of Government and what I expected when I was in the private sector was some predictability and some visibility. So as long as they know in advance, as they've long known that this is a 3-year temporary program, then as they submit bids for the coming year they can submit them knowing what they now know about the population which they didn't know earlier and about the fact that there will no longer be a reinsurance program.

Mr. HUDSON. Right. Well, has CMS discussed methods to convince some of these insurers to stay in the exchanges in the event that you see a dropout following the termination of this transition period?

Mr. SLAVITT. You know, most of the conversations that occur, occur locally within a State between the State department of insurance and the rate submission process. That is generally handled there locally. We do whatever we can to support and make sure

that we are balancing out the marketplace so that it can be a functional marketplace with stability and with predictability.

So we tend to, I would say we tend to focus on the big policy decisions that will make the market healthy for the long term, not so much on the micro decisions that will affect an individual plan here and there.

Mr. HUDSON. Well, when you start with these policy options what are you talking about exactly?

Mr. SLAVITT. So to give you an example, we focused recently on the rules for special enrollment periods and what should be required of an individual to demonstrate that they're eligible for insurance during a special enrollment period, in other words outside of the open enrollment period.

Getting that right is important because if the rules are too lenient then you end up with people who may just apply for insurance when they get sick which disrupts the market, and if they're too tight it will keep people, citizens who deserve coverage and need coverage, away from having the coverage.

So those are the kinds of policy decisions that we recently have been making decisions around, and I think it's our job to watch the marketplace because it's still early, see what's working and what's not working and make adjustments. And I expect good Government will be continued with small adjustments along the way.

Mr. HUDSON. OK. But other than just going through the State exchanges, you haven't had any discussions or any discussions about specific things you could do with companies thinking about pulling out of the exchange without this transitional subsidy, that there is no really plans or discussion of any other ways to try and convince them to stay?

Mr. SLAVITT. Yes. I wouldn't characterize that our job is to convince them to stay nor would I tell you that we've heard concerns about the transitional policy going away. I think people because they've long understood that it was a 3-year plan that hasn't been a major topic of discussion at least to my knowledge.

Mr. HUDSON. OK, thank you. Mr. Chairman, as my time is expiring I will yield back.

Mr. MURPHY. Thank you. I know we have votes coming up in a few minutes so we will move quickly. Mr. Green is recognized for 5 minutes.

Mr. GREEN. Thank you, Mr. Chairman. Administrator Slavitt, thank you for being here today, and I want to thank you for making the Affordable Care Act and health reform work.

It first rolled out in our district in a very urban area of Houston. Before the Affordable Care Act we were one of the highest in the country of people who worked but didn't get insurance through their employer. When it first rolled out we identified 20,000 people who were able to get health insurance and each renewable time we have increased that.

My frustration is that just recently we identified 50,000 of my constituents in urban Houston would be able to get health care if the State would have expanded Medicaid, 50,000 just in our district, and that is with a hundred percent Federal reimbursement to State. Not a penny of State dollars for 3 years would have to go to that, so it is just frustrating.

My colleagues have been throwing around the 3.5 billion figure. It is even part of today's title, but I think it is important to talk about that number in context. Last month, the Congressional Budget Office came out with a new Affordable Care Act estimate stating that, quote, compared with the projection made by CBO and JCT, the Joint Committee on Taxation, in March of 2010 just before the ACA was enacted, the current estimate of the net cost of insurance coverage over the 2016 to '19 period is lower by $157 billion, lowered by 25 percent. And I repeat: $157 billion under budget. That is not something we see here in the halls of Congress very often. That is 157 billion left in the Treasury.

And I know that the insurance market and these estimates are complex, and we have been talking about how important reinsurance has been in creating stability in the market while new consumer protections are created. My first question, is it fair to say that reinsurance has played at least a role in the success covering so many people while coming in substantially under budget?

Mr. SLAVITT. Yes, Congressman.

Mr. GREEN. We know that consumers win when the health insurance premiums are low, but how does that impact the U.S. Treasury?

Mr. SLAVITT. Well, because the insurance premiums for modest income Americans are subsidized in effect with tax credits, everything we do to improve affordability for consumers directly reduces the obligation of the Federal Government. And so this $157 billion under budget is, I think, in part a result as you point out of good stewardship and effective execution of some of these programs like reinsurance.

Mr. GREEN. So does that suggest at the end of the day the decision to prioritize reinsurance payments and make sure this program works effectively as intended by the statute has been a good deal for the taxpayers?

Mr. SLAVITT. It has.

Mr. GREEN. I want to thank you for that. There are many recent examples of counterproductive action by Congress to thwart the overall goals of health reform. Successful attempt by Republicans to limit payments to insurers under the risk corridor program resulted in payouts of only 12 cents on the dollar that insurers originally expected to receive. That was hailed as a victory by my Republican friends, but it only served to undermine and destabilize the health insurance market while mainly harming smaller insurance.

Administrator Slavitt, if Congress takes the legislative action to limit reinsurance payments what would be the effect on premiums for consumers?

Mr. SLAVITT. Anything that hurts the affordability of health care is in my view something that we really ought to be very, very careful about because it's counterproductive. And I think it's all of our jobs to figure out how to continue to reduce the cost of health care for American citizens and for the entirety of the program, and reinsurance has been a vital tool to do that.

Mr. GREEN. So this would be detrimental and disruptive to the individual market?

Mr. SLAVITT. Yes.

Mr. GREEN. If premiums did increase it seems likely that that would be the consequences for the Treasury.

Mr. SLAVITT. That would come in many cases, particularly subsidized care, subsidized tax credits, it would come directly out of the U.S. Treasury if premiums were to increase as a result of that.

Mr. GREEN. Well, I hope today's hearing is not simply another attempt to find new ways to obstruct and undermine the Affordable Care Act through the legislative process. Congress should be pursuing action to improve the functioning of the ACA and help individuals get covered, not engaging in efforts to destroy it.

I have said this many times at this committee, no law we have ever passed in Congress is perfect, but for the last 6 years all we have seen is repeal after repeal instead of sitting down working across the aisle to make sure it is best for the taxpayer and it is also best for the people who need that insurance. And I yield back my time.

Mr. MURPHY. Thank you. We are going to recognize Ms. Blackburn if we can get that done. And I want to say there are two other members who want to come back and ask, and then also Mr.——

Mrs. BLACKBURN. Yes, thank you.

Mr. MURPHY [continuing]. But Ms. Blackburn will be recognized.

Mrs. BLACKBURN. Thank you so much, Mr. Chairman. Mr. Slavitt, I have got a couple of quick questions. I want to follow up on something that Dr. Burgess was saying and something the chairman had mentioned to you in the beginning. You say that you feel like that the rule gives you the authority, or the law gives you the authority to change the rule.

Mr. SLAVITT. Yes, we believe we have the statutory authority.

Mrs. BLACKBURN. OK. Can you point out to me explicitly where it says that? Is there any way that you can read this and then tell me that we are not explicit in what this says and where you could have put rules in place and then go back and you change your mind and you decide to rework this? So can you point to me, can you submit to us the memo that says this is where we think we misread the law the first time and then we changed our mind?

Mr. SLAVITT. Sure. Thank you for the question.

Mrs. BLACKBURN. Do you know that memo exists?

Mr. SLAVITT. The entire legal reasoning was made public in the regulations, so we can make sure to get you a copy of that.

Mrs. BLACKBURN. OK. Well, that would be helpful, because I was a little bit confused when you said you didn't know what the process was or what the decisions were because you were not there. But then you turned around and you said that it was a public and transparent process. And in answering Ms. DeGette you said that there was advice given and you knew that there were memos to that effect.

So I think what we would like to see from you, since the law is pretty explicit I think we would like to see from you explicitly which memo and know what person decided that this was going to be a good idea. So will you submit that for us and can we have it within the next week?

Mr. SLAVITT. Yes. We will submit the legal reasoning to you, absolutely.

Mrs. BLACKBURN. OK. That will be good if you can give us that entire paper trail. In answering another question you said that you thought it was important for the insurers—I just want to be sure I understood this right—for the insurers to see the money coming so they can price for it.

Mr. SLAVITT. I believe what I had said or intended to say, can't remember exactly what I said, is that we give enough visibility and clarity as to the rules and enough time that the insurance companies know what's coming and know what to expect. And that way if we are aiming to lower premiums for Americans, which of course we all are, that that can be effective.

Mrs. BLACKBURN. So you think that we have got to put additional taxpayer funds into this program in order for the premiums to come down because we don't have enough money that people are paying, or the insurance costs too much, or they have access to the queue not to the care so the hospitals still have a tremendous amount of uncompensated care; is that what I am to understand from you?

Mr. SLAVITT. No, Congresswoman, and I apologize if you misinterpreted me. No taxpayer funds have gone into this program. These are funds that come from the insurance companies, from the employers and from individuals to fund and smooth out large losses like the ones I talked about.

Mrs. BLACKBURN. OK. So then they have to have that money in order to get the prices down, which means the consumer who is buying the product is going to pay more so the insurance company has access to the money to put back in the product; is that correct?

Mr. SLAVITT. Yes, I don't agree with that characterization, with respect.

Mrs. BLACKBURN. OK.

Mr. SLAVITT. I think——

Mrs. BLACKBURN. So the money just exists?

Mr. SLAVITT. No, I think——

Mrs. BLACKBURN. So OK, let me move on. If we can manufacture money I guess we can manufacture a lot of things. In the reinsurance program what insurance company has gotten the most money?

Mr. SLAVITT. I don't know the answer to that, but I would——

Mrs. BLACKBURN. Would you find that out and get it to us?

Mr. SLAVITT. Sure. We'll look at that.

Mrs. BLACKBURN. OK.

Mr. SLAVITT. Yes.

Mrs. BLACKBURN. That sounds great. In the interest of time, I will yield back.

Mr. MURPHY. Thank you. I know we have a vote now, and there is, I think, three members, Mr. Flores, Mr. Mullin and Ms. Brooks want to come back. Can you stick around and we will just do this after votes real quick? We will go right to the questions and then wrap it up. I appreciate that. Thank you very much. We will be back after votes.

[Recess.]

Mr. MURPHY. All right, we are reconvening this hearing from Oversight and Investigations on unlawful reinsurance payments, and now I am going to recognize the gentleman from Oklahoma, Mr. Mullin, for 5 minutes.

Mr. MULLIN. Thank you, Mr. Chairman. And thank you for being here today and thank you for hanging over as we had to run and vote. They don't seem to care about hearings. They just call votes whenever.

Anyways, look, there is a couple of questions that I think is very important to us so we can get an understanding. One, if you could answer this the best you can. I understand that on March 21st, 2014, HHS issued a proposed rule for making payments that are required by law under the reinsurance program. It is my understanding that this rule accurately reflect what was required by statute, the payments being made in three areas, one to the Treasury, insurance companies and to cover administration costs; is that correct?

Mr. SLAVITT. I believe so.

Mr. MULLIN. You believe so?

Mr. SLAVITT. Yes.

Mr. MULLIN. I mean that is what the law is, right?

Mr. SLAVITT. Yes.

Mr. MULLIN. Then ten days later HHS issued another proposed rule that completely changed what was proposed in the first rule. Now the payments would go to the insurance companies and the Treasury would only get payments until a certain threshold was made for the insurance companies; is that correct?

Mr. SLAVITT. It is, yes.

Mr. MULLIN. Can you explain why?

Mr. SLAVITT. So because the statute was silent on how to handle situations where either a lower amount or greater amount——

Mr. MULLIN. What do you mean silent? It specifically addressed the three issues. It doesn't speak, it is a statute. It is written.

Mr. SLAVITT. Yes, it is written to address the estimated collection of $12 billion. What it doesn't address is what happens if a lower amount is collected or a higher amount is collected, which is why the agency felt the need to put out a public regulation.

Mr. MULLIN. In the statute, it specifically says that it is to go to the Treasury, insurance company, and to cover administrating costs, not the insurance companies and then pay only after a certain threshold. That wasn't specified in it; is that correct?

Mr. SLAVITT. The rules specified how to handle——

Mr. MULLIN. No, no. The statute, not the rule. Not what you guys issued, the statute.

Mr. SLAVITT. I'm speaking of the statute, Congressman.

Mr. MULLIN. Yes. Well, you mentioned rule. Go ahead.

Mr. SLAVITT. Yes, so the statute speaks clearly to what happens if $12 billion is collected in the first year. What—again, this is before my time—but what the agency needed to do is to put forward, and they put forward for public comment 2 years ago——

Mr. MULLIN. Has that public comment been made public yet?

Mr. SLAVITT. Yes.

Mr. MULLIN. The opinions have been made back, the response has been made back to the committee?

Mr. SLAVITT. Yes.

Mr. MULLIN. OK.

Mr. SLAVITT. Yes. It sought public comment on how to address situations like the one that arose where less than $12 billion was collected.

Mr. MULLIN. Now what did the public comments suggest?

Mr. SLAVITT. Public comments suggested that the policy of first taking care of reimbursing the claims of the insurers was the proper policy and was legally supportive.

Mr. MULLIN. By whom, because that wasn't the intent of the original statute and that is I am asking the question. We obviously don't support it going back to the insurance companies. Intention was to help pay down the debt. And yet after a rule was issued, ten days later you reissued another rule stating basically what you guys felt needed to be done.

Mr. SLAVITT. And I understand that there is a difference of opinion because——

Mr. MULLIN. Well, it is not an opinion it is a statute, which is why when it is law and when we have a question about it and we want clarification on it and we ask a committee, or we ask HHS for a response to it, we would like clarification. What we never get is clarification.

Mr. SLAVITT. Well, we believe that there's a statutory authority. That legal reasoning was put forward publicly.

Mr. MULLIN. So if there was clarification that needed to be clarified why wouldn't you come back to the committee and seek clarification on it? I mean, because a statute is a statute of what it was, and so other than issuing a rule and then ten days later coming back and issuing another rule, why wouldn't you just simply come back here? We feel like what happened is that HHS decided to ignore what the statute was, what the intent of Congress was and decided to make your own decisions.

Mr. SLAVITT. I don't think that's the case. It was put forward——

Mr. MULLIN. Well, then how else do you explain it? Because you never came back here, and we were asking questions and clarifications and we weren't receiving those.

Mr. SLAVITT. This is 2 years ago. It was put forward for public comment for everyone including the committee to opine on the very public reasoning that was——

Mr. MULLIN. It is my understanding when the committee asked for clarification there was none issued.

Mr. SLAVITT. I'd have to go back and check on that but it's not my recollection. But I wasn't here, but that's not what I learned.

Mr. MULLIN. Well, we were still asking questions. We are here today trying to get the questions figured out.

Mr. SLAVITT. Yes. And we're doing our best to provide answers including the legal and the policy reasons and that's what I'm here today to answer.

Mr. MULLIN. All right, thank you. I yield back.

Mr. MURPHY. The gentleman yields back, and I now recognize the gentleman from Texas, Mr. Flores, for 5 minutes.

Mr. FLORES. Thank you, Chairman. And thank you, Mr. Slavitt, for joining us today. A couple of preambles I wanted to share with you, and I know you have heard a couple of these already, before we get into the questions.

The CRS memo that we have talked about earlier today determined that the statute is not ambiguous and that CMS actions contradict the plain language of the law. And then in February of 2016, in front of the Health Subcommittee of this committee, Secretary Burwell was asked about the legal basis for diverting the funds and she provided no legal justification.

So it seems to me like we are still struggling to find the legal justification under which the funds were diverted. I do have some fact based questions to start with. The first one is how much money have you collected for the reinsurance program in 2014 from all the States?

Mr. SLAVITT. I'll get back to you on the precise number. We have it here somewhere.

Mr. FLORES. I mean, I would assume you have got that number in preparation for this committee meeting since that is what we are talking about.

Mr. SLAVITT. It's $9.7 billion.

Mr. FLORES. 9.7?

Mr. SLAVITT. Yes.

Mr. FLORES. OK. And for the Treasury you collected zero, I am assuming?

Mr. SLAVITT. For 2014 that's correct.

Mr. FLORES. OK. And how much did you pay the insurance companies that year for calendar 2014?

Mr. SLAVITT. I think it was 8 billion.

Mr. FLORES. 8 billion. And the $1.7 billion difference, where did that go?

Mr. SLAVITT. That's still in a pool to be used against claims that come through the reinsurance pool.

Mr. FLORES. Moving to 2015, how much did you collect for reinsurance?

Mr. SLAVITT. 6.5 billion.

Mr. FLORES. 6.5. The law says that it was supposed to be 6, and then to the Treasury you were supposed to collect too. I am assuming that was zero?

Mr. SLAVITT. No, that'll be $500 million to the Treasury.

Mr. FLORES. You did give 500 million to the Treasury, oK.

Mr. SLAVITT. We will. We will, yes.

Mr. FLORES. You will or you did?

Mr. SLAVITT. We will, yes.

Mr. FLORES. OK. And then what were the aggregate insurance company payments for that fiscal year, for that calendar year?

Mr. SLAVITT. Payments in—yes, they have not been made yet.

Mr. FLORES. No payments, so you are sitting on 6 ½ billion dollars from 2015, and a billion seven for 2014. Now 2016, what do you estimate to collect this year? What have you collected and what do you estimate full year collections to be?

Mr. SLAVITT. I don't have an estimation yet.

Mr. FLORES. I am sorry?

Mr. SLAVITT. I don't have an estimation yet.

Mr. FLORES. OK. What do you anticipate collecting for the Treasury for this year?

Mr. SLAVITT. I don't yet have an estimation.

Mr. FLORES. OK. Now I understand you have made early payments? CMS has made early payments to the insurance companies for 2016? What is that number?

Mr. SLAVITT. That was 2.7 billion.

Mr. FLORES. 2.7 billion for early payments to the insurance companies, OK. Moving back to the underlying issue, CMS changed its mind between March the 11th and March the 21st. As my colleague from Oklahoma said a few minutes ago, in light of the CRS memo, which contradicts the position of CMS with regard to compliance with the statute, will CMS correct its rule to back to the original interpretation of March the 11th?

Mr. SLAVITT. Congressman, we still believe we have the statutory authority to issue the rule that was issued.

Mr. FLORES. OK, so you are not going to change back to the original?

Mr. SLAVITT. No. We believe the rule of what we're following is supported by the statute.

Mr. FLORES. I disagree with you, but there we are.

Moving to the second question, self-insured private companies, basically self-funded companies that are self-funding their employee health plans, are contributing to the traditional reinsurance fund even though they continue to cover employees and they haven't dropped employees from coverage, thereby forcing them to buy coverage on the exchanges. In other words, they aren't contributing to the reinsurance issues or to the potential draw on reinsurance, and some of these companies have paid out huge sums, over $50 million, to bring into this program that ultimately aids insurance companies.

How can we justify the payouts to the insurance companies from these private companies who have maintained self-insured plans for the benefit of their employees and that don't have any stake in the exchanges? How do we justify that?

Mr. SLAVITT. That's what the statute contemplated originally, is my understanding.

Mr. FLORES. OK. And then so my question is how do you justify the payouts to the insurance companies from the employers that have no stake in the exchanges? Why did you change the formula and pay them more?

Mr. SLAVITT. Again this is all before my time, but that appears to be what the statute contemplated and exactly what happened.

Mr. FLORES. Just as an editorial comment, I used to be a CEO and I could not blame my predecessor. I could not say it was before my time. When my board asked me a question they wanted me to provide an answer, not to say, well, that is before my time. So I just want you to know my opinion on that. Thank you, I yield back.

Mr. SLAVITT. Understood, thank you.

Mr. MURPHY. I believe then that is all the questions we have from our members. So I want to thank you, Mr. Slavitt, for being here today. I want to ask you one quick question. Can we get a commitment from you that the CMS will provide the documents pursuant to our March 23rd request in a timely manner? These are the ones regarding the reinsurance program.

Mr. SLAVITT. Yes, Mr. Chairman.

Mr. MURPHY. Thank you. And because what we have got so far are the publicly available documents. Any idea when? Can you please tell us when CMS will produce these documents?

Mr. SLAVITT. We are working hard on it. We'll follow up with your staff. As you know we have schedule on some other documents we're working for you, so we can just put that right on the schedule and make sure we get you dates certain.

Mr. MURPHY. We would like that.

Mr. SLAVITT. OK.

Mr. MURPHY. Thank you very much. So in conclusion, thank you so much for being with us today. And I want to remind members they have ten business days to submit questions for the record, and I ask Mr. Slavitt to respond promptly to those requests as well. And with that, this hearing is adjourned.

[Whereupon, at 11:38 a.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON ENERGY AND COMMERCE

April 13, 2015

TO: Members, Subcommittee on Oversight and Investigations

FROM: Committee Majority Staff

RE: Hearing entitled "Unlawful Reinsurance Payments: CMS Diverting $3.5 Billion from Taxpayers to Pay Insurance Companies."

On April 15, 2016, at 9:30 a.m. in 2123 Rayburn House Office Building, the Subcommittee on Oversight and Investigations will hold a hearing entitled "Unlawful Reinsurance Payments: CMS Diverting $3.5 Billion from Taxpayers to Pay Insurance Companies."

Section 1341 of the Patient Protection and Affordable Care Act (PPACA) established the transitional reinsurance program, a risk mitigation program for health insurers. Under this program, the Centers for Medicare and Medicaid Services (CMS) collects contributions from health insurers, and then uses those contributions to make reinsurance payments to health insurers who enroll high-risk individuals. Notably, PPACA also requires that a portion of the contributions for the reinsurance program be deposited to the U.S. Treasury. The statute specifically states that a portion of the contributions "shall be deposited into the general fund of the Treasury of the United States and may not be used for the [reinsurance] program."[1] Despite the plain text of the law, CMS has been diverting billions of dollars intended for the U.S. Treasury to insurance companies as reinsurance payments. The Subcommittee is conducting oversight to understand why CMS is diverting billions to the health insurers.

I. WITNESS

- Andy Slavitt, Acting Administrator, Centers for Medicare and Medicaid Services

II. BACKGROUND

The Patient Protection and Affordable Care Act requires health insurance companies to provide coverage to individuals regardless of the individuals' health status, medical history, or pre-existing conditions. To mitigate the financial risk caused by this broad requirement, the PPACA also created three programs: the permanent risk adjustment program; temporary risk corridors program; and the temporary transitional reinsurance program. These programs are commonly referred to as the "three Rs."

[1] 42 U.S.C § 18061(b)(4).

Permanent Risk Adjustment Program:

This program is intended to mitigate the effects of "adverse selection."[2] Adverse selection occurs when individuals who are in the most need of health care services may be more likely to enroll in more generous—and therefore expensive—plans, while individuals who do not expect to need as much health care services enroll in less generous—and therefore cheaper—plans.[3] The permanent risk adjustment program transfers funds from lower risk plans to higher risk plans based on average actuarial risk.[4]

Temporary Risk Corridors Program:

This temporary program is supposed to protect against inaccurate premiums by sharing risk in the first three years of the PPACA rollout (2014–2016).[5] CMS collects funds from Qualified Health Plans (QHPs) with lower than expected claims and makes payments to QHPs with higher than expected claims.[6]

Transitional Reinsurance Program:

This temporary program is intended to help stabilize individual market premiums during the first three years of the ACA rollout (2014–2016).[7] CMS collects contributions from health insurers for the program.[8] CMS regulations control the contribution amounts, and health insurers use this information to help set their premium rates. From the fund created by the contributions, CMS makes reinsurance payments to insurers who enroll high-risk individuals. CMS is required by law to contribute a portion to the U.S. Treasury and a portion to help cover administrative costs.

III. TRANSITIONAL REINSURANCE PROGRAM

Under section 1341 of PPACA, a portion of the contributions collected for the transitional reinsurance program is supposed to be deposited to the U.S. Treasury. The statute provides:

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[2] Memorandum to the Committee on Energy and Commerce, "Information on the ACA Transitional Reinsurance Program," (Feb. 23, 2016) (on file with Committee).
[3] *Id.*
[4] Explaining Health Care Reform: Risk Adjustment, Reinsurance, and Risk Corridors, Jan. 22, 2014, http://kff.org/health-reform/issue-brief/explaining-health-care-reform-risk-adjustment-reinsurance-and-risk-corridors/ (last visited April 5, 2016).
[5] *Id.*
[6] *Id.*
[7] *Id.*
[8] The transitional reinsurance program collects contributions from contributing entities to fund reinsurance payments. A contributing entity means a health insurance issuer or a self-insured group health plan. "The Transitional Reinsurance Program – Reinsurance Contributions," Center for Consumer Information & Insurance Oversight, Centers for Medicare and Medicaid Services, https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/The-Transitional-Reinsurance-Program/Reinsurance-Contributions.html (last visited April 11, 2016).

> [A]ny contribution amounts described in paragraph (3)(B)(iv) [the U.S. Treasury contribution] shall be deposited into the general fund of the Treasury of the United States and may not be used for the program established under this section.[9]

Initially, the Department of Health and Human Services (HHS) obeyed the statute. According to HHS' final rule issued on March 11, 2014, and similar to its 2013 rule, CMS planned to allocate contributions to the reinsurance program among the health insurers, the U.S. Treasury, and administrative costs.[10] The final rule also contemplated what would happen if CMS collected less than the statutory guidelines. CMS set out in its final rule that if "the total amount of contributions collected is *less than* or equal to $8.025 billion, we will allocate approximately . . . 24.9 percent of the reinsurance contributions collected to the U.S. Treasury."[11]

Ten days later on March 21, 2014, however, the Administration issued a different proposed rule, completely reversing course. Contrary to its March 11, 2014 final rule, HHS' March 21, 2014 proposed rule prioritized contributions to the health insurers.[12] The proposed rule stated:

> Due to the uncertainty in our estimates of reinsurance contributions to be collected, and to help assure that the reinsurance payment pool is sufficient to provide the premium stabilization intended by the statute, we propose to revise our allocation of reinsurance contributions collected and adopt a similar prioritization in the event that reinsurance collections fall short of our estimates. Specifically, if collections fall short of our estimates for a particular benefit year, we propose to alter the allocation so that the reinsurance contributions that are collected are allocated first to the reinsurance pool and administrative expenses, and are allocated to the U.S. Treasury once the targets for reinsurance payments and administrative expenses are met.[13]

CMS further stated that it would allocate the first $10 billion received in 2014 to insurers before allocating any funds to the U.S. Treasury or for administrative costs. CMS finalized this rule on May 27, 2014, confirming its proposed rule.[14] The timeline below highlights how CMS changed its policy from allocating contributions to prioritizing contributions to health insurers:

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[9] 42 U.S.C. § 18061(b)(4).
[10] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2015; Final Rule, 79 Fed. Reg. 13744, 1376–77 (Mar. 11, 2014).
[11] *Id.* at 13777 (emphasis added).
[12] Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond; Proposed Rule, 79 Fed. Reg. 15808, 15820–21 (Mar. 21, 2014).
[13] *Id.*
[14] Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond; Final Rule, 79 Fed. Reg. 30240, 30252 (May 27, 2014).

Transitional Reinsurance Program Rulemaking Timeline

March 23, 2011: The Patient Protection and Affordable Care Act passed. Section 1341 established the *transitional reinsurance program*. The law stated, in part, that a portion of the reinsurance contributions from the health insurers shall be deposited into the U.S. Treasury.[15]

March 11, 2013: HHS issued a final rule, entitled "HHS Notice of Benefits and Payment Parameters for 2014." This rule allocated contributions to the reinsurance program among the health insurers, the U.S. Treasury, and administrative costs.[16]

Dec. 2, 2013: HHS released its proposed rule, entitled "HHS Notice of Benefits and Payment Parameters for 2015." In this rule, HHS allocated contributions to the reinsurance program among health insurers, the U.S. Treasury, and administrative costs.[17]

March 11, 2014: HHS issued its final rule, entitled "HHS Notice of Benefits and Payment Parameters for 2015." This rule allocated contributions to the reinsurance program among the health insurers, the U.S. Treasury, and administrative costs. The final rule also stated that the U.S. Treasury would be allocated funds proportionally even if actual contribution collections were below $8.025 billion (the targeted amount plus administrative costs in statute).[18]

March 21, 2014: HHS issued its proposed rule, entitled "Exchange and Insurance Market Standards for 2015 and Beyond." In this rule, HHS reversed course on how contributions to the reinsurance program are allocated. In this proposed rule, HHS stated it would allocate the first $10 billion received in 2014 for reinsurance payments to insurers.[19]

May 27, 2014: HHS issued its final rule, entitled "Exchange and Insurance Market Standards for 2015 and Beyond." HHS affirmed its reversal in its March 21 proposal, stating "we finalize our allocation proposal, with one modification, so that, in the event of a shortfall in our collections, reinsurance contributions will first be allocated to the reinsurance payment pool, and second to administrative expenses and the U.S. Treasury."[20]

[15] 42 U.S.C. § 18061(b)(4).
[16] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014; Final Rule, 78 Fed. Reg. 15459-15460 (Mar. 11, 2013).
[17] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2015; Proposed Rule, 78 Fed. Reg. 72322, 72342–43 (Dec. 2, 2013).
[18] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2015; Final Rule, 79 Fed. Reg. 13744, 13776–77 (Mar. 11, 2014).
[19] Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond; Proposed Rule, 79 Fed. Reg. 15808, 15820–21 (Mar. 21, 2014).
[20] Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond; Final Rule, 79 Fed. Reg. 30240, 30252 (May 27, 2014).

CMS issued payments in 2015 for the 2014 benefit year based on the methodology in the "Exchange and Insurance Market Standard for 2015 and Beyond" final rule. Further, CMS has already issued early partial reinsurance payments this year for the 2015 benefit year. The U.S. Treasury has not received any reinsurance payments to date.

IV. CRS MEMORANDUM

In February 2016, the non-partisan Congressional Research Service (CRS) issued a memorandum, which addressed, in part, whether CMS has the authority to prioritize reinsurance payments to health insurers over the U.S. Treasury.[21] First, CRS wrote, although the statute does not speak to the timing of the deposits to the U.S. Treasury, the "miscellaneous receipts statute" requires the federal government to deposit money it receives "as soon as practicable" into the U.S. Treasury.[22] CRS did find that the CMS had the statutory authority to retain certain contributions as an exception to the "miscellaneous receipts statute."[23] CRS determined, however, that CMS' authority to retain and use these contributions is significantly qualified.[24] CRS pointed to the following provision:

> [A]ny contribution amounts described in paragraph (3)(B)(iv) [the U.S. Treasury contribution] *shall* be deposited into the general fund of the Treasury of the United States and *may not be used* for the program established under this section.[25]

Based on the language of the statute, CRS determined that CMS is only permitted to retain and use that part of each insurer's contribution that is attributable to (1) the reinsurance program, and (2) administrative expenses, but not the portion that is attributable to (3) the U.S. Treasury.[26]

CRS then examined what portion of each insurer's contribution is attributable to which category. Under CMS' current interpretation, no portion of an insurer's contribution is "attributable to the U.S. Treasury contribution until the aggregate amount collected meets the aggregate target for reinsurance payments."[27] CRS found, however, that the "statute appears to speak directly to the question of whether the U.S. Treasury contribution must be taken from each issuer's contribution." CRS concluded:

> [I]nsofar as CMS' interpretation allows the entire contribution of an issuer in any given year to be used only for reinsurance payments, such that no part of it is allocated for the U.S. Treasury contribution, then that would appear to be in conflict with a plain reading of § 1341(b)(4). Because the statute unambiguously

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[21] Memorandum to the Committee on Energy and Commerce, "Information on the ACA Transitional Reinsurance Program," (Feb. 23, 2016) (on file with Committee).
[22] *Id. See also*, 31 U.S.C. § 3302(b).
[23] *Id.*
[24] *Id.*
[25] 42 U.S.C. § 18061(b)(4) (emphasis added).
[26] Memorandum to the Committee on Energy and Commerce, "Information on the ACA Transitional Reinsurance Program," (Feb. 23, 2016) (on file with Committee).
[27] *Id.*

> states that 'each issuer's contribution' contain an amount that reflects 'its proportionate share' of the U.S. Treasury contribution, and that these amounts should be deposited in the General Fund of the U.S. Treasury, a contrary agency interpretation would not be entitled to deference under *Chevron*.[28]

CRS determined that, because the statute is not ambiguous, it appears that CMS' actions contradict the plain language of the law, suggesting that the Agency's action would not receive deference if it were challenged in court.

V. ISSUES

The following issues are expected to be examined at the hearing:

- What is CMS' legal position on whether or not the law requires a portion of the reinsurance contributions be allocated to the U.S. Treasury?
- Why did CMS change its position from allocating reinsurance contributions between the health insurers, the U.S. Treasury, and administrative costs to prioritizing reinsurance contributions to the health insurers?
- What is CMS' position on CRS' memorandum discussing the legality of prioritizing reinsurance payments to health insurers?

VI. STAFF CONTACTS

If you have any questions regarding this hearing, please contact Jessica Donlon, Emily Felder, or Brittany Havens of the Committee staff at (202) 225-2927.

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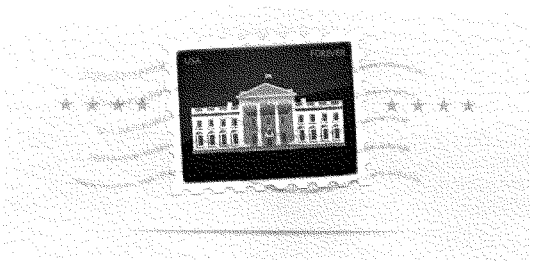
[28] *Id.*



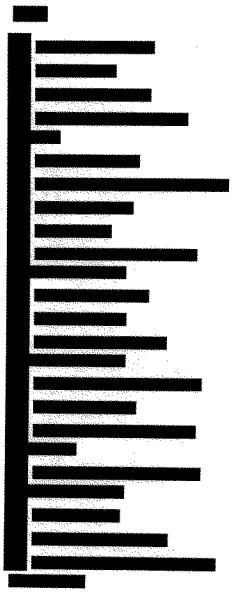
[redacted] [redacted]

Meet Brent Brown from Mosinee, Wisconsin. He never voted for President Obama, but in June, he wrote to the President thanking him for saving his life.

President Obama is traveling to Wisconsin today to talk with Americans like Brent who were able to sign up for health coverage thanks to the Affordable Care Act. The city of Milwaukee won the President's Healthy Communities Challenge by signing up 89,000 people for health coverage.

Check out Brent's letter to the President, and follow along today as President Obama visits Wisconsin:

> *To My President,*
>
> *I sincerely hope that this reaches you, as far too often praise is hard to come by. Apologies to people who deserve it perhaps even less so.*
>
> *I did not vote for you. Either time. I have voted Republican for the entirety of my life.*
>
> *I proudly wore pins and planted banners displaying my Republican loyalty. I was very vocal in my opposition to you–particularly the ACA.*
>
> *Before I briefly explain my story allow me to first say this: I am so very sorry. I understand written content cannot convey emotions very well–but my level of conviction has me in tears as I write this. I was so very wrong. So very very wrong.*
>
> *You saved my life. I want that to sink into your ears and mind. My President, you saved my life, and I am eternally grateful.*
>
> *I have a 'pre-existing condition' and so could never purchase health insurance. Only after the ACA came into being could I be covered. Put simply to not take up too much of your time if you are in fact taking the time to read this: I would not be alive without access to care I received due to your law.*
>
> *So thank you from a dumb young man who thought he knew it all and who said things about you that he now regrets. Thank you for serving me even when I didn't vote for you.*
>
> *Thank you for being my President.*
>
> *Honored to have lived under your leadership and guidance,*
>
> *Brent Nathan Brown*



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Congressional Research Service
Informing the legislative debate since 1914

MEMORANDUM February 23, 2016

To: House Committee on Ways and Means
[redacted]
House Committee on Energy and Commerce
[redacted]

From: Paulette C. Morgan, Specialist in Health Care Finance, [redacted]
Edward C. Liu, Legislative Attorney, [redacted]

Subject: Information on the ACA Transitional Reinsurance Program

You requested background information on the Transitional Reinsurance Program, one of three risk mitigation programs included in the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended). Specifically, you also requested answers to three questions:

1. What were the amounts required to be collected?
2. Does CMS have the authority to prioritize Reinsurance claimants over payments to the Treasury? If so what are the limits?
3. Does CMS have the authority to delay payments to the Treasury in one year and make it up in subsequent years?

This memorandum provides a brief description of the context for the three risk mitigation programs, and then provides a description of the transitional reinsurance program. It addresses each of your questions in order.

Because the issues addressed in this memorandum are of general interest to Congress, information included in this memorandum may be provided by the Congressional Research Service (CRS) to other congressional requesters or incorporated into a CRS report. Your identity as a requester would not be disclosed in either case.

ACA and Risk Mitigation Background

The private health insurance provisions in the ACA include market reforms that impose requirements on private health insurance plans.[1] Such reforms relate to the offer, issuance, generosity, and pricing of health plans, among other requirements, and are designed to increase the number of people who are able to purchase insurance. As part of a larger set of private health insurance market reforms,[2] the ACA requires

[1] For information, please see CRS Report R42069, *Private Health Insurance Market Reforms in the Patient Protection and Affordable Care Act (ACA)*.

[2] For more information, see CRS Report R43048, *Overview of Private Health Insurance Provisions in the Patient Protection and Affordable Care Act (ACA)*.

private health insurance issuers to provide coverage to individuals regardless of health status, medical history, and pre-existing conditions. Some individuals are eligible to receive premium tax credits and cost-sharing subsidies through a health insurance exchange (marketplace), which will increase the attractiveness of coverage by reducing its cost. Also, the individual mandate is in effect, which requires most individuals to maintain coverage or otherwise pay a penalty. All of the new health insurance market reforms and the expanded market of individuals seeking to purchase insurance, some of whom were previously uninsured and may have delayed receiving health care, contribute to the uncertainty insurers face in the early years of ACA implementation.

The transitional reinsurance program is one of three programs included in the ACA to mitigate the financial risk that insurers face. The three programs are designed to mitigate the effects of different types of risk as insurers respond to the new market rules.

- The first program is a *transitional reinsurance program* (2014-2016) which is designed to compensate insurers for a portion of the cost of particularly high-cost enrollees with individual insurance coverage inside and outside of the exchanges. Prior to ACA implementation, there was little information available on the health spending or demand of individuals who were previously uninsured, and the degree to which they had delayed health care due to their lack of insurance. Insurers in the early years of the ACA would likely raise premiums to the extent possible to protect themselves against the high cost of this delayed care. However, some of the new marketplace rules limit the degree to which insurers could vary premiums. The transitional reinsurance program is designed to mitigate the financial risk associated with individuals who had delayed needed health care while they were uninsured. If an enrollee's total claims exceed a specified level (referred to as the attachment point), the insurer is paid a proportion of claims costs (referred to as the coinsurance rate) beyond the attachment point until total claims costs reach the insurance cap. The attachment point, coinsurance rate, and reinsurance cap together are the payment parameters that the Secretary of Health and Human Services (Secretary) must specify each year. This is a temporary program under the assumption that any care that was delayed due to a lack of insurance would be provided in the early years of the program. This program is addressed below.
- The second program is a *permanent risk adjustment* program intended to mitigate the effects of adverse selection in the individual and small group markets, both inside and outside of the new exchanges. Adverse selection is a phenomenon wherein individuals who expect or plan for high use of health services tend to enroll in more generous (and consequently more expensive) plans, whereas individuals who do not expect to use many or any health services tend to enroll in less generous (and less expensive) plans. The relative generosity of the insurance plan will thus attract higher or lower spending enrollees. Risk adjustment more accurately compensates insurers for the higher cost of sicker enrollees who tend to enroll in more generous plans, as well as more accurately compensating insurers for the lower cost of healthier enrollees who tend to enroll in less generous plans. As adverse selection is a phenomenon that is always present, risk adjustment is a permanent mitigation program.
- The third program is the *temporary risk corridors program* (2014-2016). This program is designed to mitigate the effects of mistakes the insurers may make when trying to predict the appropriate amount of premium to charge for individual and small group Qualified Health Plans offered inside and outside exchanges.[3] Insurers were faced with many

[3] Qualified health plans are plans that provide a comprehensive set of health benefits and comply with all applicable ACA market reforms. Plans offered on the health insurance exchanges, where individuals and small businesses can shop for and purchase (continued...)

questions at the start of health reform, such as whether young healthy individuals would sign up for insurance, or whether employers would choose to have their enrollees find insurance on the new marketplaces, or not. The insurers' assumptions about the answers to those questions can have an impact on the premiums they charge. But if their assumptions are wrong, they may end up underestimating or overestimating the premiums necessary to pay for their enrollees' claims. The risk corridors program is temporary under the assumption that insurers will be better able to estimate premiums under the new health reform rules after three years.

Description of the Transitional Reinsurance Program

The ACA[4] requires that a transitional reinsurance program be established in each state for 2014 through 2016.[5] Under the program, the Secretary collects reinsurance contributions from health insurance issuers and third party administrators on behalf of group health plans;[6] the Secretary then uses those contributions to make reinsurance payments to health insurance issuers[7] who enroll high-risk individuals in their individual market plans both inside and outside of the exchanges.

How much was required to be collected under the transitional reinsurance program?

The statutes specify that the aggregate collection for all states for the transitional reinsurance program equal $10 billion for plan year beginning 2014, $6 billion for plan year beginning in 2015, and $4 billion for plan year beginning in 2016. The statutes also specify that an additional contribution be collected; this amount is not part of the transitional reinsurance program, but rather a contribution to the United States Treasury. In addition, the statutes allow for the collection of additional amounts for administration. Table 1 includes the amounts that are required to be collected, as well as the amounts estimated by the Secretary for administration of the program for 2014, 2015, and 2016.

Table 1. Contribution Amounts related to the Transitional Reinsurance Program

	2014	2015	2016
Aggregate contribution for reinsurance programs for all states	$10 billion	$6 billion	$4 billion
Additional contribution to U.S. Treasury	$2 billion	$2 billion	$1 billion

(...continued)

private health insurance coverage, must be QHPs, with limited exceptions; QHPs may also be offered in the private market outside of exchanges. The risk corridors program applies to QHPs, and plans that are the same as or substantially the same as QHPs, that are available both on the exchanges, as well as outside of the exchanges. For information on private health plans in general and qualified health plans specifically, please see CRS Report R43233, *Private Health Plans Under the ACA: In Brief*.

[4] ACA, Section 1341.

[5] Though states are allowed to establish their own transitional reinsurance programs, only Connecticut chose to do so. For all other states, the Secretary is implementing the transitional reinsurance programs. Under the regulations governing the establishment of the transitional reinsurance programs, states have discretion in certain aspects of program implementation. However, Connecticut has chosen to follow the federal benefit and payment parameters for 2014 and 2015. For more information, see [http://ct.gov/hix/cwp/view.asp?a=4295&q=532146].

[6] A transitional reinsurance contributing entity is either (a) a health insurance issuer, or (b) for 2014 a self-insured group health plan regardless of whether it uses a third party administrator (TPA); for 2015 and 2016, a self-insured group health plan that uses a TPA for specified activities and specified degrees. See 45 CFR § 153.20. In 2015 and 2016, a self-insured group health plan that does not use a TPA is not considered a contributing entity.

[7] A health insurance issuer is eligible to receive transitional reinsurance payments for enrollees in a plan (i.e., a reinsurance-eligible plan) if the health insurance plan is offered in the individual market, except for grandfathered plans and health insurance coverage not required to submit reinsurance contributions under 45 CFR § 153.400(a). See 45 CFR § 153.20.

	2014	2015	2016
Administration	$20.3 million	$25.4 million	$32 million
Total Contribution Amounts	$12.02 billion	$8.03 billion	$5.03 billion

Source: Table created by CRS based on information in Section 1341 of the ACA; Department of Health and Human Services, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014, Final Rule," 78 *Federal Register* 15460, March 11, 2013; Department of Health and Human Services, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2015, Final Rule," 79 *Federal Register* 13775, March 11, 2014; and Department of Health and Human Services, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, Final Rule," 80 *Federal Register* 10775, February 27, 2015.

Though the statutes specified certain aggregate amounts to be collected and allowed the collection of amounts for administration, the statutes require the Secretary to establish a methodology for determining how much each health insurance issuer or group health plan (i.e., contributing entity) must contribute. The Secretary established a methodology where contributing entities pay a per person amount based on their enrollment.[8] The per person contribution (i.e., the per capita national contribution) was calculated as the sum of (a) the aggregate contribution for the reinsurance program, (b) the additional contribution to the U.S. Treasury, and (c) the cost of administration divided by the estimated number of enrollees in plans required to make reinsurance contributions. In other words:

National Per Capita Reinsurance Contribution =

(Reinsurance Contribution + Treasury Contribution + Administrative Cost)/HHS's estimate of enrollment in contributing entities.[9]

The national per capita reinsurance contribution was set at $63 in 2014, $44 for 2015, and $27 for 2016. For example, for 2014, each reinsurance contributing entity must pay $63 for each of their covered enrollees. For benefit year 2014, this resulted in collected contributions of approximately $8.7 billion as of June 2015, and the Secretary was estimated to collect an additional $1 billion on or before November 15, 2015.[10]

[8] Enrollment is to be based on the contributing entity's fully insured commercial book of business for all major medical products. See 45 CFR § 153.400. Contributing entities must submit an annual enrollment count to the Secretary by November 15 of 2014, 2015, and 2016. The regulations specify acceptable methods for calculating the annual enrollment of reinsurance contribution enrollees. See 45 CFR § 153.405.

[9] In order to estimate enrollment in entities required to make reinsurance contributions, as well as to estimate reinsurance payment parameters displayed in Table 2 of this memorandum, the Secretary developed a model, (the Affordable Care Act Health Insurance Model (ACAHIM)). This model is described in "Department of Health and Human Services, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters, Proposed Rule," 77 *Federal Register* 73160, December 7, 2012."

[10] Department of Health and Human Services, *Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2014 Benefit Year*, September 17, 2015, p. 4, https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RI-RA-Report-REVISED-9-17-15.pdf. This report was first published June 30, 2015, and then updated in September 2015. The Centers for Medicare & Medicaid Services confirmed in a January 8, 2016 phone conversation with CRS that, because the total contributions collected were less than $10 billion for 2014, that entire amount was allocated to the reinsurance program and nothing was allocated for administrative expenses or the U.S. Treasury, consistent with regulations. For benefit year 2015, CMS has collected $5.5 billion and expects to collect approximately $1 billion more by November 15, 2016. Department of Health and Human Services, *The Transitional Reinsurance Program's Contribution Collections for the 2015 Benefit Year*, February 12, 2016, https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/RIC_2015ContributionsGuidance.pdf. CMS indicates that the $5.5 billion already collected will be used entirely for reinsurance payments. Half of the projected $1 billion collection will also be used for reinsurance payments; the other half allocated on a pro rata basis for administrative expenses and the contribution to the U.S. Treasury.

In the event that total reinsurance contributions collected fall short or exceed the amounts specified in Table 1, the regulations specify allocation of funding. For 2014, the May 27, 2014 final rule specified that if total contributions collected were less than $10 billion, the entire amount of the collection would be allocated to the reinsurance program and none to the U.S. Treasury or administration;[11] if the collections were greater than or equal to $10 billion, but less than $12.02 billion, then $10 billion would be allocated to the reinsurance program, and 99% of the remaining collections ($2 billion/$2.02 billion) would be allocated to the U.S. Treasury, and 1% ($20.3 million/$2.02 billion) would be allocated to administrative expenses. For 2014, if total reinsurance contributions were to exceed $12.02 billion, $2 billion would be allocated to the U.S. Treasury, $20.3 million would be allocated to administrative expenses, and the balance would be allocated to the reinsurance program. A comparable allocation methodology would apply for 2015 and 2016.

Does CMS have the authority to prioritize reinsurance claimants over payments to the Treasury? If so what are the limits?

In the preamble to its May 27, 2014 final rule, CMS "sought comment on this proposal, including our legal authority to implement a prioritization of reinsurance contributions to reinsurance payments over payments to the U.S. Treasury."[12] These comments and CMS' responses to them noted that § 1341 "provides HHS with the discretion ... to determine the priority, method, and timing for the allocation of reinsurance contributions collected."[13]

One commenter observed that § 1341 "imposes few requirements on the expenditure of reinsurance contributions, stating that the statute does not specify that payments must be made to issuers and to the U.S. Treasury simultaneously, or that the U.S. Treasury must receive its full funding before reinsurance pool payments are made."[14] While it appears correct that § 1341 does not speak to the timing of deposits to the General Fund of the Treasury, the "miscellaneous receipts statute" states that money received by the federal government must generally be deposited in the Treasury as miscellaneous receipts "as soon as practicable."[15] An agency is permitted to retain money as an exception to the "miscellaneous receipts statute" if it has statutory authority to do so.[16] Section 1341 contains several such statements. First, § 1341(b)(1)(B) states that the reinsurance program shall collect payments from issuers and "use[] amounts so collected to make reinsurance payments."[17] Further, § 1341(b)(4) provides that:

> (A) the contribution amounts collected for any calendar year may be *allocated and used* in any of the three calendar years for which amounts are collected based on the reinsurance needs of a particular period or to reflect experience in a prior period; and

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[11] Department of Health and Human Services, "Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond," 79 *Federal Register* 30258-30259, May 27, 2014.

[12] 79 Fed. Reg. 30240, 30257 (May 27, 2014).

[13] *Id.* at 30258.

[14] *Id.*

[15] 31 U.S.C. § 3302(b). *See also* Government Accountability Office, 1 Principles of Federal Appropriations Law 6-167 (("This means deposited into the general fund ('miscellaneous receipts') of the Treasury, not into the agency's own appropriations, even though the agency's appropriations may be technically still 'in the Treasury' until the agency actually spends them."); and 10 Comp. Gen. 382, 384 (1931) ("It is difficult to see how a legislative prohibition could be more clearly expressed.").

[16] *E.g.* 72 Comp. Gen. 164, 165-66 (1993).

[17] 42 U.S.C. § 18061(b)(1)(B).

> (B) amounts remaining unexpended as of December, 2016, *may be used* to make payments under any reinsurance program of a State in the individual market in effect in the 2-year period beginning on January 1, 2017.[18]

However, this authority to retain and use amounts collected under the reinsurance program is significantly qualified. Section 1341(b)(4) goes on to state that:

> Notwithstanding the preceding sentence [subparagraphs (A) and (B) above], any contribution amounts described in paragraph (3)(B)(iv) [the U.S. Treasury contribution] *shall* be deposited into the general fund of the Treasury of the United States and *may not be used* for the program established under this section.[19]

This last statutory provision would appear to be a reaffirmation of the default rule under the "miscellaneous receipts statute," requiring that amounts received pursuant to (3)(B)(iv) be deposited in the Treasury "as soon as practicable."[20] Consequently, it appears that the agency is permitted to retain and use that part of each issuer's contribution that is attributable to the reinsurance program and any administrative expenses, but not that portion of the issuer's contribution that is attributable to the U.S. Treasury contribution.

Because the statute makes such a distinction, it raises the question of what portion of each issuer's contribution is attributable to which category. Section 1341(b)(3)(B)(iv), which defines the U.S. Treasury contribution, states that the reinsurance program "shall be designed so that ... each issuer's contribution for any calendar year ... reflects its proportionate share of" the U.S. Treasury contribution.[21] One reading of this clause is that the amount required to be paid by an issuer under the reinsurance program includes some share attributable to the U.S. Treasury contribution. In contrast, CMS' current position appears to be that no portion of an issuer's contribution is attributable to the U.S. Treasury contribution until the aggregate amount collected meets the aggregate target for reinsurance payments.[22]

Courts addressing the legitimacy of an agency's interpretation of a statute typically look to the Supreme Court's decision in *Chevron v. Natural Resources Defense Council*, which sets forth a widely accepted two-part test.[23] First, if Congress has spoken directly on the issue, then that statutory language or history must control. However, "if ... Congress has not directly addressed the precise question at issue," the agency's interpretation will stand so long as it is a reasonable one.[24] In other words, where a statutory provision is ambiguous and constitutes an implicit delegation to the agency to "elucidate" the provision, courts will generally give an agency significant discretion to fill in the gaps created by that ambiguity.[25]

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[18] 42 U.S.C.A. § 18061(b)(4) (emphasis added).

[19] *Id.* (emphasis added).

[20] 31 U.S.C. § 3302(b).

[21] 42 U.S.C. § 18061(b)(3)(B)(iv). The amount described in (b)(3)(iv) is in addition to the amount collected for reinsurance payments. *Id.*

[22] CMS has allowed contributing entities to make bifurcated payments in which an initial collection will occur on or around January 15, and a second collection on or around November 15 of a given year. At one point, the first collection was allocated towards reinsurance payments and administrative expenses, while the second collection was allocated only to the U.S. Treasury. 45 C.F.R. § 153.405(c); 78 Fed. Reg. 65046, 65051 (Oct. 30, 2013); 79 Fed. Reg. 13744, 13775-76 (Mar. 11, 2014). Subsequently, CMS issued a final rule revising this allocation formula such that the second collection would also be allocated to reinsurance payments to the extent that the first collection was insufficient to meet the statutory target amount. 79 Fed. Reg. at 30259.

[23] Chevron v. Nat'l Resources Def. Council, 467 U.S. 837, 842-845 (1984).

[24] *Id.*

[25] *Id.*

Under CMS' interpretation, some issuers' contributions for a given year would not include any amount allocated to the U.S. Treasury contribution. Specifically, all contributions would go towards reinsurance payments until the statutory target for reinsurance payments was reached. After that point, contributions would be allocated to the U.S. Treasury. However, the statute appears to speak directly to the question of whether the U.S. Treasury contribution must be taken from each issuer's contribution. Section 1341(b)(4) requires contribution amounts described in (3)(B)(iv) to be deposited in the U.S. Treasury, and (3)(B)(iv) describes a proportionate share of the aggregate U.S. Treasury contribution, reflected in "each issuer's contribution." Insofar as CMS' interpretation allows the entire contribution of an issuer to be used only for reinsurance payments, such that no part of it is used for the U.S. Treasury contribution, then that would appear to be in conflict with the plain text of § 1341(b)(4).

The statute explicitly provides CMS with some flexibility in how the payments of the contribution amounts will be implemented. Specifically, the statute permits the contribution amount to "be paid in advance or periodically throughout the plan year."[26] What is meant by a "periodic payment" is not defined in the statute, but Black's Law Dictionary defines it as "[o]ne of a series of payments made over time instead of a one-time payment for the full amount."[27] This would appear to give CMS the authority to spread payments of the contribution amount across a plan year. However, the combination of all periodic payments for an issuer ultimately comprises the "full amount." As discussed above, *each issuer's* contribution for any given year appears to be required to reflect the additional U.S. Treasury contribution. Therefore, even if the payments could be bifurcated in purpose *and* amount within a year, the total contribution for each issuer in a given year "shall" reflect "*its* proportionate share of" the U.S. Treasury contribution.

CMS noted in the preamble to its May 27, 2014 final rule that § 1341 is silent on how the agency should approach the distribution of reinsurance contributions if insufficient amounts are collected to fully fund all three components of the program (that is, reinsurance payments, administrative expenses, and payments to the U.S. Treasury).[28] While that may be true, the statute is clear that amounts from "each issuer's contribution" must reflect the U.S. Treasury contribution, and that this reflected amount from "each issuer's contribution" must be deposited in the U.S. Treasury.

CMS also asserts that § 1341(b)(3)(B)(iii) uses "mandatory language with respect to the collection of amounts for the reinsurance payment pool" by stating that the aggregate issuer contributions "shall ... equal" specific, statutory amounts for plan years 2014, 2015, and 2016.[29] In contrast, CMS argues that "more permissive language" is used with respect to the contributions for administrative expenses or the U.S. Treasury.[30] Section 1341(b)(3)(B)(ii) states that the contribution amount "can" include an amount to fund administrative expenses.[31] The use of the permissive "can" would appear to clearly establish that inclusion of administrative expenses in an issuer's contribution amount is optional. However, § 1341(b)(3)(B)(iv) states that the reinsurance program "shall be designed so that ... each issuer's contribution for any calendar year ... reflects its proportionate share of" the U.S. Treasury contribution.[32] CMS argues that the term "reflects" indicates a similar degree of permissiveness regarding the U.S. Treasury contribution.[33] A dictionary definition of "reflect" states that it can mean "to make manifest or

[26] 42 U.S.C. § 18061(b)(3)(A).

[27] BLACK'S LAW DICTIONARY (10th ed. 2014).

[28] 79 Fed. Reg. at 30258.

[29] 42 U.S.C. § 18061(b)(3)(B)(iii).

[30] 79 Fed. Reg. at 30258.

[31] 42 U.S.C. § 18061(b)(3)(B)(ii).

[32] 42 U.S.C. § 18061(b)(3)(B)(iv).

[33] 79 Fed. Reg. at 30258.

apparent."[34] It is not clear that the term admits of any significant discretion, particularly where the surrounding language of the clause includes aggregate statutory amounts of the same specificity as in clauses that CMS considers to be mandatory,[35] and further assigns to "each issuer's contribution ... its *proportionate share*" of those aggregate amounts.[36]

In conclusion, insofar as CMS' interpretation allows the entire contribution of an issuer in any given year to be used only for reinsurance payments, such that no part of it is allocated for the U.S. Treasury contribution, then that would appear to be in conflict with a plain reading of § 1341(b)(4). Because the statute unambiguously states that "each issuer's contribution" contain an amount that reflects "its proportionate share" of the U.S. Treasury contribution, and that these amounts should be deposited in the General Fund of the U.S. Treasury, a contrary agency interpretation would not be entitled to deference under *Chevron*.

Does CMS have the authority to delay payments to the U.S. Treasury in one year and make it up in subsequent years?

As described above, § 1341 requires the reinsurance program to be designed such that the contribution of an issuer for any given year reflects "its proportionate share" of the U.S. Treasury contribution. Additionally, these reflected amounts are required to be deposited in the General Fund of the Treasury, as soon as practicable.[37] If contributions to the U.S. Treasury were delayed for one year, that would appear to be inconsistent with this clear statutory mandate.

CMS has interpreted the statute in a similar manner. In its preamble to the May 27, 2014 final rule, it considered comments about deferring payments to the U.S. Treasury, but "concluded that we [CMS] have no authority to defer the collection of reinsurance contributions for those payments to the end of the program."[38]

[34] WEBSTER'S 9TH NEW COLLEGIATE DICTIONARY 989 (1983).

[35] 79 Fed. Reg. at 30258.

[36] 42 U.S.C. § 18061(b)(3)(B)(iv) (emphasis added).

[37] 31 U.S.C. § 3302(b).

[38] 79 Fed. Reg. at 30259.

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May 9, 2016

Mr. Andy Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Mr. Slavitt:

Thank you for appearing before the Subcommittee on Oversight and Investigations on Friday, April 15, 2016, to testify at the hearing entitled "Unlawful Reinsurance Payments: CMS Diverting $3.5 Billion from Taxpayers to Pay Insurance Companies."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

Also attached are Member requests made during the hearing. The format of your responses to these requests should follow the same format as your responses to the additional questions for the record.

To facilitate the printing of the hearing record, please respond to these questions and requests with a transmittal letter by the close of business on Monday, May 16, 2016. Your responses should be mailed to Jay Gulshen, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, DC 20515 and e-mailed in Word format to Jay.Gulshen@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Tim Murphy
Chairman
Subcommittee on Oversight and Investigations

cc: Diana DeGette, Ranking Member, Subcommittee on Oversight and Investigations

Attachments

Attachment 1—Additional Questions for the Record

The Honorable Susan Brooks

In February 2016, the non-partisan Congressional Research Service (CRS) issued a memorandum, which addressed, in part, whether CMS has the authority to prioritize reinsurance payments to health insurers over the U.S. Treasury. CRS determined that the statute is not ambiguous and CMS' actions contradict the plain language of the law.

1. When was CMS made aware of the February 2016 CRS memorandum?

2. CRS found that "the statute unambiguously states" each reinsurance contribution must contain an amount that reflects its "proportionate share" of the Treasury contribution. CRS further found that CMS' interpretation appears to be "in conflict with a plain reading" of the statute. Do you agree? Why or why not?

    a. What is CMS' position on CRS' memorandum?

3. Have there been internal discussions about the CRS memorandum?

    a. Has CMS or HHS created a memo or document in response to the CRS memorandum? If so, please provide that to the committee.

4. Since the CRS memorandum was issued, have there been discussions about reversing CMS' position to prioritize payments to insurance companies?

    a. Who has been involved in these discussions?

    b. When did these conversations occur?

5. CMS has already changed its mind once on how to allocate reinsurance payments. In light of the CRS memo, will CMS change its mind again – and go back to the original interpretation? Why or why not?

    a. Will CMS consider using the original methodology going forward, for the rest of the payments this year and in 2017?

    b. CMS changed its policy position once before through the rulemaking process. In other words, the rule isn't always the rule. So why can't CMS change its position back and actually follow the letter of the law?

Attachment 2—Member Requests for the Record

During the hearing, Members asked you to provide additional information for the record, and you indicated that you would provide that information. For your convenience, descriptions of the requested information are provided below.

The Honorable Tim Murphy

1. Before concluding the hearing, you committed that CMS would provide the documents pursuant to our March 23rd request in a timely manner. Please submit these documents to committee staff.

The Honorable Marsha Blackburn

1. During the hearing, you agreed to provide the Committee with the memo breaking down the legal justifications of this reinterpretation of the law. Please provide that memo, the full legal reasoning, and entire paper trail of behind that reasoning.

2. Which insurance company has received the most money from the reinsurance program?

The Honorable David McKinley

1. As discussed during the hearing, West Virginia's Health and Human Resources recently wrote a letter to CMS regarding rural hospitals and these reinsurance payments, and you agreed to take a good look at that letter. You further committed to continue working with my staff on this issue, and offered to have a rural health task force look into these concerns.

2. Additionally, you committed to working with the state of West Virginia to provide some technical assistance in drafting a Medicaid state plan amendment that would recognize the important roe that these care services and consequently clarify their eligibility for continued Medicaid DSH payments.

The Honorable Michael C. Burgess, M.D.

1. Who specifically within CMS was responsible for interacting with HHS leadership and with the White House on reinsurance payments in 2014? Was there a single individual or office?

2. Outside of the formal rulemaking process did anyone outside the executive branch communicate with HHS leadership or CMS about prioritizing reinsurance payments?

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