NEAL R. GROSS & CO., INC.

RPTS PORRECO

HIF106020

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, D.C.

The subcommittee met, pursuant to call, at 9:30 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).

This is a preliminary, unedited transcript. The statements within may be inaccurate, incomplete, or misattributed to the speaker. A link to the final, official transcript will be posted on the Committee's website as soon as it is available.

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, Oversight Associate, Oversight and Investigations; Charles Ingebretson, Chief Counsel, Oversight and Investigations; Chris Santini, Policy Coordinator, Oversight and Investigations; Jeff Carroll, Minority Staff Director; Ryan Gottschall, Minority GAO Detailee; Tiffany Guarascio, Minority Deputy Staff Director and Chief Health Advisor; Chris Knauer, Minority Oversight Staff Director; Una Lee, Minority Chief Oversight Counsel; Elizabeth Letter, Minority Professional Staff Member; Andrew Souvall, Minority Director of Communications, Outreach and Member Services; and Arielle Woronoff, Minority Health Counsel.

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 three-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 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.

I now recognize the ranking member of the subcommittee, Ms. DeGette of Colorado, for five minutes.

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 six 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 six 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 follows:]

**********COMMITTEE INSERT**********

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 five minutes.

The Chairman. Thank you, Mr. Chairman. This hearing does continue the subcommittee's thoughtful and necessary oversight of the President's health care 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.

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

Mr. Pallone. Thank you, Mr. Chairman. When we passed the Affordable Care Act into law more than six years ago, we dramatically changed the health care 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 health care 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, 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.

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. Slavitt. I do.

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 five-minute summary of your witness statement.

STATEMENT OF ANDY SLAVITT, ACTING ADMINISTRATOR FOR THE CENTERS FOR MEDICARE & MEDICAID 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 health care 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, two 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:]

**********INSERT**********

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 follows:]

**********COMMITTEE INSERT**********

Mr. Murphy. I recognize myself for five 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 five minutes to Ms. DeGette.

Ms. DeGette. Oh, okay. 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 health care 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 three 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. -- 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. Okay. 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 registry for everybody to see so they could see comment 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. Okay. 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, 2015, we have 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. Okay. 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 three 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. -- discrepancies. Okay, thank you. I yield back.

Mr. Murphy. The gentlewoman yields back. I now recognize the vice chairman of the committee, Mr. McKinley, for five 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 five 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 five 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. Okay. 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. -- 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 health care 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 five 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 five 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. -- 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 five 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 health care 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 National 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 decision 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 five 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. Okay. 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 three-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 small adjustments along the way.

Mr. Hudson. Okay. 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 three-year plan that hasn't been a major topic of discussion at least to my knowledge.

Mr. Hudson. Okay, 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 five 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 three 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 six 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. -- 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. Okay. 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. Okay. 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. Okay. 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. Okay. 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. Okay.

Mr. Slavitt. I think --

Mrs. Blackburn. So the money just exists?

Mr. Slavitt. No, I think --

Mrs. Blackburn. So okay, 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. Okay.

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.

[Whereupon, at 10:41 a.m., the subcommittee recessed, to reconvene at 11:26 a.m., the same day.]

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 five 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 two 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. Okay.

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 two 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 five 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. Okay. And for the Treasury you collected zero, I am assuming?

Mr. Slavitt. For 2014 that's correct.

Mr. Flores. Okay. 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, okay.

Mr. Slavitt. We will. We will, yes.

Mr. Flores. You will or you did?

Mr. Slavitt. We will, yes.

Mr. Flores. Okay. 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 six and a half 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. Okay. What do you anticipate collecting for the Treasury for this year?

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

Mr. Flores. Okay. 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, okay. 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. Okay, 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 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. Okay. 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. Okay.

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.]