United States Senate
COMMITTEE ON THE JUDICIARY
WASHINGTON, DC 20510–6275

February 12, 2014

VIA ELECTRONIC TRANSMISSION

The Honorable Kathleen Sebelius
Secretary
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Sebelius:

Your reply to my November 7, 2013, letter was disappointing. My letter concerned the Department of Health and Human Services' (HHS's) decision not to apply the anti-kickback law to the most significant elements of the Patient Protection and Affordable Care Act (PPACA).[1] Although your response took three months to compose, it utterly failed to address the questions and information requests in my letter. Further, your staff has been uncooperative in arranging a briefing for my staff with the lawyers who reviewed this decision. This was surprising, given that you committed to me at the November 6, 2013, Senate Finance Committee hearing that you would "be glad to" provide such a briefing.

My November 7, 2013, letter to you and the Attorney General contained nine requests. Of those, you responded to only one—whether the HHS Office of Inspector General (OIG) was consulted. You failed to answer questions about:

- when this decision was finalized,
- who at HHS made the final decision on this issue, and
- whether this decision was approved by the Office of Management and Budget (OMB).

Additionally, in an effort to understand the rationale upon which this decision was based, I requested in my letter copies of all internal Department memoranda or advisory opinions regarding this issue, as well as records of all communications on this issue. Your reply ignored those requests. Instead, it simply provided me with the same conclusory statement[2] that you had already provided to Representative McDermott.[3]

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[1] Patient Protection and Affordable Care Act, Pub. L. 111-148, 124 Stat. 119 (2010).
[2] "After carefully reviewing the definition of 'federal health care program' and assessing various aspects of each program under Title I of the Affordable Care Act in consultation with the Department of Justice, the Department concluded that it does not consider QHPs, other programs related to the Federally-facilitated

Although you have now repeatedly referred to the Department's "careful review" regarding the definition of "federal health care program" and its "assessment of the various aspects of each program," you have avoided providing any substantive explanation of which aspects of each program support your decision and why.

For example, you failed to address the fact that private health care providers offering qualified health plans to individuals qualifying for federal health care subsidies under PPACA will receive such funds *directly* from the federal government. Instead, you simply stated that Title I of PPACA models the Marketplaces after the private health insurance market rather than Medicare's fee for service or Medicare Advantage programs. However, this sidesteps the issue. No one claimed that Marketplaces were intended to be modeled after Medicare's fee for service or Medicare Advantage programs.

What qualified health plans have in common with Medicare's fee for service and Medicare Advantage programs is that each receives substantial federal subsidies—funds provided by the American taxpayer. This fundamental element of PPACA exists regardless of how the so-called Marketplaces are structured. Section 1128B of the Social Security Act defines a "federal health care program" as "any plan or program that provides health benefits, *whether directly, through insurance, or otherwise*, which is funded directly, in whole *or in part*, by the United States Government . . . ."[4]

As you noted, PPACA provided that "[p]ayments made by, through, or in connection with an Exchange are subject to the False Claims Act if those payments include any Federal funds."[5] How is it possible, then, to claim that the insurance plans offered through the Marketplaces are not funded, at least in part, by the United States government?

You failed to address the fact that PPACA also contained language explicitly stating that anti-kickback violations would henceforth constitute a false claim under the False Claims Act.[6] Further, PPACA also revised the intent requirement with regards to anti-kickback violations, adding that "a person need not have actual knowledge of this section or specific intent to commit a violation of this section."[7] In the midst of adopting a major overhaul to the American health care system, Congress clearly moved to

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Marketplaces, or other programs under Title I of the Affordable Care Act to be federal health care programs . . . ." Letter from Secretary Kathleen Sebelius to Senator Charles Grassley, Feb. 6, 2014.

[3] "The Department of Health and Human Services does not consider QHPs, other programs related to the Federally-facilitated Marketplace, and other programs under Title I of the Affordable Care Act to be federal health care programs. . . . This conclusion was based upon a careful review of the definition of 'Federal health care program' and an assessment of the various aspects of each program under Title I of the Affordable Care Act and consultation with the Department of Justice." Letter from Secretary Kathleen Sebelius to Representative Jim McDermott, Oct. 30, 2013.

[4] 42 U.S.C. § 1320a-7b(f)(1) (2013) (emphasis added).

[5] 42 U.S.C. § 18033(a)(6)(a) (2013).

[6] "In addition to the penalties provided for in this section or section 1320a–7a of this title, a claim that includes items or services resulting from a violation of this section constitutes a false or fraudulent claim for purposes of subchapter III of chapter 37 of title 31." 42 U.S.C. § 1320a-7b(g) (2013).

[7] 42 U.S.C. § 1320a-7b(h) (2013).

strengthen the anti-kickback statute as applied to PPACA—not to make it irrelevant. Yet your decision treats the anti-kickback provision as having no applicability to the rest of the law in which it originated. That would render one provision of PPACA moot as applied to the rest of PPACA, with no evidence whatsoever that Congress intended such an odd result.

If "the Department is concerned about the possibility of hospitals, other health care providers, and other commercial entities supporting premium payments and cost-sharing obligations," as you acknowledge CMS's November 4, 2013, guidance states, Congress has already created a mechanism to deal with such practices.[8] That mechanism is 42 U.S.C. § 1320a-7b(b)—the health care anti-kickback law. Why not use the existing statutory mechanism rather than mere guidance to "discourage" the practice and encourage "issuers to reject such third party payments"?[9]

I again respectfully request that you honor your commitment to make your staff available for a briefing and provide a written reply that is actually responsive to the questions in my original letter. Please number your responses in accordance with the question number you are answering. Please reply by March 6, 2014. Should you have any questions regarding this letter, please contact Tristan Leavitt, Tegan Millspaw, or Rodney Whitlock. I look forward to your prompt response.

Sincerely,

Charles E. Grassley
Ranking Member

[8] Department of Health and Human Services, Centers for Medicare and Medicaid Services, Center for Consumer Information & Insurance Oversight, "Third Party Payments of Premiums for Qualified Health Plans in the Marketplaces," Nov. 4, 2013, *available at* http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/third-party-qa-11-04-2013.pdf.
[9] *Id.*