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Pallone Blasts Committee GOP's "Overblown Rhetoric and Blatant Misinformation" on ACA's Reinsurance Program

Energy and Commerce Ranking Member Frank Pallone, Jr. (D-NJ) today gave the following opening statement at an Oversight and Investigations Subcommittee Hearing on the Affordable Care Act's (ACA's) temporary reinsurance program.

When we passed the Affordable Care Act into law more than six 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.

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 10 percent. These are remarkable achievements.

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 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 "CMS's 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.

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