



July 11, 2014

MEMORANDUM FOR ANDREW M. SLAVITT

Principal Deputy Administrator  
Centers for Medicare & Medicaid Services

FROM: EDGAR M. SWINDELL   
Associate General Counsel for Ethics  
Designated Agency Ethics Official

SUBJECT: Limited Pledge Waiver under E.O. 13490, § 3, and Limited Authorization  
Pursuant to 5 C.F.R. § 2635.502(d)

The purpose of this memorandum is to provide a limited waiver of the restrictions in Section 1, Paragraph 2, of Executive Order 13490 (the Ethics Pledge or E.O.), and a limited authorization, pursuant to 5 C.F.R. § 2635.502(d), to permit your participation, subject to certain restrictions and conditions, in extant particular matters involving specific parties that involve the UnitedHealth Group (UHG), its subcomponents or subsidiaries, including your former employer, Optum and its operating companies, such as Quality Software Services, Inc. (QSSI) and the Lewin Group. I have consulted with the Office of the Counsel to the President concerning this waiver and notified the Office of Government Ethics (OGE). This document will be made publicly available on the OGE website.

This limited waiver and limited authorization is issued in the public interest to allow your participation in the implementation of the Affordable Care Act (ACA) and the systems supporting the health insurance marketplaces. Your management skills, budgetary acumen, and knowledge of systems integration gained from over twenty years' experience in technology and health care are considered essential to that effort. The recusal obligations to which you would otherwise be subject, absent this action, would render you unable to carry out effectively your duties as the Principal Deputy Administrator of the Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

## I. Background Regarding Your Appointment and Recusal Obligations

### Current Duties

You have been appointed to serve as the CMS Principal Deputy Administrator. CMS administers the Medicare and Medicaid programs, which provide health care to almost one in every three Americans. Medicare provides health insurance for more than 44.6

million elderly and disabled Americans. Medicaid, a joint federal-state program, provides health coverage for some 50 million low-income persons, including 24 million children, and nursing home coverage for low-income elderly. CMS also administers the State Children's Health Insurance Program that covers more than 4.4 million children. While serving as the Principal Deputy Administrator for CMS, you are responsible for the overall executive leadership, direction, and coordination of all federal health care financing programs under Titles XI (Administrative Simplification, Quality Improvement Organizations and other miscellaneous provisions), XVIII (Medicare), XIX (Medicaid) and XXI (Children's Health Insurance Program or CHIP) of the Social Security Act, as amended. More specifically, among your many duties, you oversee the establishment of program goals and objectives and the development of policies and standards to accomplish these goals. You work with states, other HHS and federal agencies, and non-governmental organizations and industry stakeholders in administering health care financing programs. Your duties encompass responsibility for the development and implementation of health quality and safety standards, including evaluation of their impact on the utilization, quality, and cost of health care services. You have broad responsibility to oversee the development of methods, systems, procedures and specifications for Medicare claims processing and improvements to program management. Additionally, you have broad responsibility for development of policies and procedures relating to assessment of CMS contractor performance. Likewise, you have overall responsibility for the development, coordination, evaluation, review and promulgation of CMS policy related to eligibility, coverage of benefits, reimbursement and other matters for Medicare, Medicaid, and CHIP. Your duties also include overseeing the critical and time sensitive mission of implementation of the ACA at CMS which encompasses insurance marketplaces, electronic enrollment in the federal marketplaces through healthcare.gov, and the ACA as it impacts all of the other above responsibilities.

#### Recusal Obligations Resulting from Prior Employment

You were previously employed by Optum, which owns QSSI, and is an operating business of UHG. UHG also owns United Healthcare which offers health benefit plans and services for large national employers, public sector employers, mid-sized employers, small businesses, and individuals; health and well-being services; services dealing with chronic disease and other specialized issues for older individuals; Medicaid plans, Children's Health Insurance Programs, and health care programs; Medicare Advantage Plans; Prescription Drug Plans under Medicare Part D, and health services, including commercial health and dental benefits. United Healthcare has a network of 820,000 physicians and other health care professionals, and approximately 6,000 hospitals and other facilities nationwide.

QSSI has worked with CMS since 2006 and is one of the many contractors currently working on the online health care marketplaces. In your prior position, you were responsible for Optum's business strategy, public policy, corporate development, marketing, and international and federal government businesses. Additionally, your responsibilities in your prior position included working with HHS on the QSSI contracts

related to healthcare.gov and the health insurance exchanges created by the ACA. There were approximately 18 contracts that created the health care insurance exchanges. QSSI had contracts for the Exchange Data Services Hub, Enterprise Identity Management (EIDM) system, and is currently the ACA testing contractor for functionality of the federal health insurance marketplaces and related ACA implementation systems.

You confirm that you are not entitled to any deferred compensation from your former employer, other than the UHG retirement plans reported on your OGE 278 Public Financial Disclosure Report. You have resigned from, severed financial ties to, relinquished all claims for compensation against, and agreed to divest all stocks, stock options, and financial investments in UHG within time frames specified in your ethics agreement. Upon completion of these obligations, you will have no continuing financial interests in Optum, QSSI, or UHG, and as a result, under the law, will be empowered to participate fully in particular matters of general applicability, such as regulation and policy determinations, that affect the healthcare-related industries in which your former employer operates, except those particular matters of general applicability that have a special or distinct effect on the identified party other than as part of a class.

However, absent a waiver of Section 1, Paragraph 2 of the Ethics Pledge and an authorization under 5 C.F.R. § 2635.502(d), you will be prohibited from participating officially in particular matters involving specific parties in which UHG, its subcomponents, or subsidiaries is a party or represents a party, including meetings at which representatives of these entities seek official action.<sup>1</sup> Covered particular matters would include any specific proceeding affecting the legal rights of the parties, or an isolatable transaction or related set of transactions between identified parties. Frequently cited examples of such “specific party matters” include contracts, grants, licenses, product approval applications, program waivers, contractual bonus or quality award determinations, investigations, disputes, disallowances, administrative adjudications, and court litigation. Optum, QSSI, and UHG are participants in specific party matters before CMS; for example, the QSSI contracts related to healthcare.gov and the health insurance exchanges created by the ACA are specific party matters, as are the Medicare Advantage contracts under which United Healthcare Medicare & Retirement provides health insurance coverage in exchange for a fixed monthly premium per member from CMS. Additionally, Optum includes the Lewin Group which is currently the contractor for statistical analysis for CMS as required under the Improper Payments Elimination and Recovery Act; any CMS contracts with the Lewin Group are specific party matters.

Although the majority of such specific party matters would not rise to the level of the Office of the Administrator for participation or disposition, the CMS Administrator envisions a need for you to become involved in policy direction, management, and oversight of those specific party matters involving your former employer that involve implementation of health care reform under the ACA, including insurance marketplaces, electronic enrollment in the federal marketplaces through healthcare.gov, and systems

---

<sup>1</sup> This restriction applies to any subsidiary that UHG controls. Pursuant to 5 C.F.R. § 2635.102(k), the corporation would be deemed to control a subsidiary if it owns 50% or more of the subsidiary’s voting securities.

integration and coordination to ensure operability, as you have unique expertise in these matters because of your work in the private sector for Optum. Accordingly, in order to undertake these functions and to meet with representatives of your former employer for these limited purposes, your appointing official has requested a limited waiver of Section 1, Paragraph 2 of the Ethics Pledge with respect to your two-year, specific party matter recusal obligation as to this former employer, and a limited authorization to release you from the parallel one-year regulatory recusal period. An Ethics Pledge waiver may be issued when the “literal application of the restriction is inconsistent with the purpose of the restriction” or when “it is in the public interest to grant the waiver.” An authorization under 5 C.F.R. § 2635.502(d) with respect to this former employer may be issued if the interest of the Government in your participation outweighs any concern that a reasonable person may question the integrity of the Government’s programs and operations.

## II. Ethics Commitments by Non-Career Employees in the Executive Branch – E.O. 13490

### Background Regarding the Ethics Pledge

The Ethics Pledge provides that a political appointee will not, for a period of two years from the date of appointment, participate in any particular matter involving specific parties that is directly and substantially related to the appointee’s former employer or former clients, including regulations and contracts. *See* E.O. 13490, § 1, ¶ 2. The reference to “regulations,” which normally are considered particular matters of general applicability rather than particular matters involving specific parties, encompasses only those rules that have a special or distinct effect on the identified party other than as part of a class.

The E.O. defines “former employer” to include any person for whom the appointee has, within the two years prior to the date of his appointment, served as an employee, officer, director, trustee, or general partner. For purposes of Section 1, Paragraph 2 of the Ethics Pledge, UHG, including Optum, QSSI, and any other UHG subcomponents or subsidiaries, is your former employer.

The E.O. defines “former clients” as those persons for whom the appointee served personally as an agent, attorney, or consultant. Typical examples include a party to whom an attorney or other fiduciary personally provides professional advice on a billable hours basis or a recipient of individually tracked and billed consulting services rendered by an individual in a small, closely held company, such as a Subchapter S firm under which consulting revenues are passed through to the principal. For purposes of Section 1, Paragraph 2 of the Ethics Pledge, the clients or customers of UHG, including those of Optum, QSSI, and any other UHG subcomponents or subsidiaries, to whom you personally provided services—when charged as overhead costs and rendered as an executive directing your former employer’s fulfillment of its corporate obligations under multiple contracts with a broad customer base—generally are not considered your former clients.

Section 3 of the E.O. provides for waiver of the recusal provisions that apply with respect to a former employer or former clients. As the HHS Designated Agency Ethics Official (DAEO), I exercise that waiver authority in consultation with the Office of the Counsel to the President and pursuant to a delegation from the Director of the Office of Management and Budget. *See* Office of Government Ethics Memorandum Re: Authorizations Pursuant to Section 3 of Executive Order 13490, DO-09-008 (Feb. 23, 2009). The standard for waiving the restriction in the Ethics Pledge is that the literal application of the restriction is inconsistent with the purposes of the restriction, or that it be in the public interest to grant the waiver. *See* E.O. 13490, § 3(a). The E.O. states that “the public interest shall include, but not be limited to, exigent circumstances relating to national security or to the economy.” *Id.*, § 3(b).

#### Limited Waiver of Section 1, Paragraph 2 of the Ethics Pledge

Information provided by CMS and representations adduced by your appointing official demonstrate to my satisfaction that the public interest is served by permitting you, subject to certain limitations, to work on implementation of health care reform under the ACA generally, and in the context of a specific party matter involving your former employer, given the magnitude of the impact on the well-being of the American people, your central role in advising on health care reform programs, systems and policies, and the importance of your participation in coordinating health care reform with executive level officials at other federal agencies. Your record indicates that you are uniquely qualified for this task.

The information provided to me indicates that you bring an exceptional blend of managerial experience, health care industry acumen, and hands-on experience from working for the systems integrator for healthcare.gov, Optum. Those who attest to your qualifications aver that over the past 20 years you have worked to make health care systems more responsive and more consumer-oriented by leveraging technology, information, and market forces. You have founded and led various health information technology, data and analytics, and health care consulting and fulfillment organizations. Your responsibilities have included overseeing business strategy, public policy, corporate development, marketing, and international and federal government businesses.

Throughout your career, you have provided operational solutions to health care entities and consumers. Examples provided to me include: the founding of the health care industry’s first open innovation center, which now houses integrated clinical and claims research data; and the establishment of Optum 360, which provides end-to-end patient registration, billing, coding and collection management between health systems and patients. You also led the expansion into new areas of health care information technology and consulting, including cloud-based electronic medical records, quality measurement, consumer tools and portals, and clinical assessment businesses. I have been apprised that you oversaw the development of industry-wide innovations for consumers, providers and payers, several of which resulted in certain company-granted patents focused on improving health care delivery, payments or administrative efficiency. Reportedly, you were also a pioneer in crafting the online consumer health care shopping

experience and helped pave the way for service offerings to be made directly to consumers, including benefit offerings, access programs, and web portals.

Additionally, CMS finds you well qualified for the role of Principal Deputy Administrator because you have successfully overseen large budgets in your past positions and have skillfully directed large teams comprised of staff from various organizations. Most recently, you participated in the leadership of an organization with over 45,000 employees across 42 states and 14 countries. In another position, you oversaw the organization's growth from 3,500 to 13,000 employees. In another position, you founded your own company, developed its concept, raised \$38 million in venture capital financing, hired a management team and launched an Internet enabled consumer health technology business that provided health care services to underinsured and uninsured individuals nationwide.

In your previous positions, you have extensive involvement with state and federal health care programs, including oversight of Medicaid data warehousing and analytics, Medicaid program integrity, state and federal insurance exchanges, IT systems integration, Medicaid behavioral health, and long-term care services. Most recently, in October 2013, you were brought on to participate in the healthcare.gov initiative and played a critical role in improving the operability of the federally-facilitated marketplace. CMS attributes to you and your organization the marked improvement in coordination among the contractors working to repair the site in the midst of a challenging period.

CMS has informed me that they are unaware of any other candidate with this unique blend of skills and knowledge who is available and willing to take on this challenging and critical position. Moreover, if another candidate was available, he or she would likely bring similar former employment affiliations requiring recusal and would lack the specific familiarity and experience with health care marketplaces and, specifically, with healthcare.gov. Given the time sensitivity of the future marketplace rollouts under the ACA, any alternative candidate would not be able to master the complexities of the ACA implementation systems to be able to handle the immediate workload of the Principal Deputy Administrator.

Given your extensive background in health care and health care systems including the healthcare.gov site, and your ability to oversee and direct large organizations with numerous stakeholders, you are the most qualified Administration official to assist with the health care reform efforts at CMS. These efforts go directly to the health and well-being of the American people and present the types of exigent circumstances that the waiver provision was designed to permit.

Accordingly, I hereby certify that it is in the public interest for you to participate, subject to certain limitations outlined below, in those specific party matters involving your former employer that involve implementation of health care reform under the ACA, including insurance marketplaces, electronic enrollment in the federal marketplaces through healthcare.gov, and systems integration and coordination to ensure operability. For example, you may participate in meetings where personnel from your former

employer may be present to discuss technical issues or progress on existing contracts to support health care reform systems including the healthcare.gov site, the Exchange Data Services Hub, and the EIDM system. Likewise, you may weigh in on or make decisions on policy matters or technical direction that could result in the necessity of your former employer having to perform additional compensated work under existing contracts to implement health care reform under the ACA.

#### Limitations on the Waiver of Section 1, Paragraph 2 of the Ethics Pledge

To ensure the integrity of the procurement process and to avoid any appearance of special access or advantage for your former employer, you must adhere to certain limitations which are necessary to mitigate the appearance concerns that normally inhere in such situations. To that end, this limited waiver and limited authorization is expressly conditioned upon the limitations enumerated below that circumscribe your discretion in acting on matters that redound to the future financial benefit of your former employer. Pursuant to E.O. 13490, § 3(a), I waive the restriction in Section 1, Paragraph 2, of E.O. 13490, on participation in those particular matters involving specific parties where UHG, its subcomponents, or subsidiaries is a party or represents a party to the particular matter as delineated above, subject to the following exceptions.

With respect to the existing HHS contracts to which this limited waiver and limited authorization pertain, you will be permitted to evaluate and oversee performance under these contracts and direct work that may result in additional charges to the Government under the existing contracts, but you will be required to recuse from participation in the consideration, determination, settlement, negotiation, or resolution of any contract:

- (1) performance bonus or award fee decisions;
- (2) payment disputes;
- (3) material modifications or extensions;<sup>2</sup>
- (4) compliance audits; and
- (5) litigation.

These actions involving your former employer, should they come to you for your participation, must be elevated to the CMS Administrator, the HHS Deputy Secretary, or HHS Chief of Staff, as appropriate, for disposition without your input or recommendation. With respect to recompetitions or requests for proposals for new work in the areas to which the existing contracts pertain, you will be permitted to develop and

---

<sup>2</sup> A contract modification generally is material if changes in the type of work, performance period, and costs fall outside the scope of the awarded contract to a degree which would not have reasonably been anticipated by potential offerors and which, as a result, would require full and open competition, absent a sole source justification. *See* 48 C.F.R. part 6. Your participation in policy matters or technical direction that necessitates additional compensated work by your former employer within the scope of existing contracts to implement health care reform under the ACA is permitted by this limited waiver and thus not subject to the recusal requirement.

approve the statement of work notwithstanding that your former employer may be a potential bidder. However, under the terms of this limited waiver and limited authorization, you must recuse from participation in any sole source contract awards to your former employer during the two year period covered by the Ethics Pledge, and similarly recuse from evaluation of bid proposals and award selection determinations for any recompetition of existing contracts or request for proposals for any new contract in which your former employer has submitted a bid. In the event that your former employer is awarded a sole source contract or competitively selected for an add-on or new contract, and provided that you have recused as required under the terms of this waiver, you may undertake oversight and implementation with respect to the new contract in the same manner as is authorized under this waiver for the existing contract.

This limited waiver does not affect your obligation to comply with the provisions of the Ethics Pledge in other contexts. Therefore, you may not participate in your official capacity in any particular matter involving specific parties where UHG or any of its subcomponents or subsidiaries is a party or represents a party which falls outside of the scope of this waiver. Please note that the examples of specific party matters that fall outside of the scope of the limited waiver and limited authorization that are provided in this document are intended to be illustrative rather than to provide a comprehensive listing. In light of the broad range of business activities undertaken by UHG and its subsidiaries and subcomponents, a number of specific party matters could come before you in your official capacity as Principal Deputy Administrator from which you would be required to recuse. For example, you may not participate in the evaluation or oversight of the Medicare Advantage contracts under which United Healthcare Medicare & Retirement provides health insurance coverage in exchange for a fixed monthly premium per member from CMS. Similarly, you are precluded from directing any statistical analysis work undertaken by the Lewin Group under contract to CMS, or participating in a meeting with UHG staff regarding the administration of the Medicare Part D program in regard to prescription drug plans offered by a UHG subcomponent.

To assist you in complying with your recusal obligations, I am including an overview of several CMS programs that may give rise to specific party matters from which you would be required to recuse should they involve UHG or its subsidiaries or subcomponents as a party or representative of a party.

***Examples of Programs Relating to Health Reform Under the ACA that May Give Rise to Specific Party Matters that Fall Outside the Scope of this Limited Waiver and Limited Authorization:***

Under the ACA, CMS promotes health care access, implements certain insurance market reforms, and promotes the availability of insurance coverage through the Marketplaces (also known as Exchanges).

***Market Reform Standards***

HHS may initiate actions to enforce market reform standards which could impact issuers and parent companies such as UHG under title XVII of the Public Health Service Act

(PHS Act), where the state, which would otherwise be the primary enforcer, has notified HHS that it will not enforce or where HHS has determined that the state has substantially failed to enforce. Enforcement is conducted through the imposition of civil money penalties (CMPs). Examples of provisions that are subject to this type of enforcement include: guaranteed availability and renewability, essential health benefits (EHB), actuarial value levels (metal tiers and catastrophic plans), and cost-sharing limits, prohibition on annual and lifetime limits, prohibition on pre-existing condition exclusions, and the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). PHS Act §§ 2722 (pre-ACA), 2723 (as added by ACA); 45 C.F.R. part 150.

#### *Risk Adjustment, Risk Corridors, and Reinsurance Programs*

The Risk Adjustment, Risk Corridors, and Reinsurance programs provide for certain types of payments to insurers to counteract any potentially destabilizing effects of the various market reform and insurance exchange provisions and requirements. These programs are designed to address the risk that insurers might need to increase their premiums, for example, because their policies must cover individuals with pre-existing medical conditions. Issuers and parent companies, such as UHG, could be subject to audits, penalty assessments, debt collection, enforcement actions, and litigation surrounding the implementation and operation of the Risk Adjustment, Risk Corridors, and Reinsurance programs, as described more fully below.

Data Collection: In states where HHS is operating a risk adjustment or reinsurance program on behalf of a state, an issuer must establish a dedicated data environment and provide data access to HHS. Issuers could be subject to CMPs where they fail to comply with data submission and storage requirements. Issuers could also face enforcement actions for failing to adhere to the reinsurance data submission requirements or failure to comply with risk adjustment issuer requirements, such as failing to remit risk adjustment charges. If an issuer fails to establish a dedicated data environment or to provide HHS access to the required data, HHS may assess a risk adjustment default charge. 45 C.F.R. §§ 153.400, 153.405, 153.540, 153.740, 156.800(c).

Audits: HHS has the authority to conduct audits of issuers to assess compliance with the reinsurance program requirements, risk corridor standards, and risk adjustment requirements. 45 C.F.R. §§ 153.405(i), 153.540, 153.620(c).

Debt Collection: HHS may also seek to collect a debt owed to the federal government by the issuer for failure to pay the required reinsurance contribution, risk adjustment or risk corridor amounts. 45 C.F.R. § 156.1215(c).

#### *Qualified Health Plans*

HHS may also initiate actions to enforce standards applicable to issuers of qualified health plans (QHPs) in the Federally-facilitated Exchanges (FFE) and Federally-facilitated Small Business Health Options Programs (FF-SHOPs). Enforcement is conducted formally through the imposition of CMPs and/or decertification of QHPs. Informal enforcement is conducted through a “progressive approach,” including technical

assistance, notices and warning letters, and voluntary corrective action plans. Compliance Reviews and periodic audits of financial records may also be conducted. Examples of provisions that are subject to this type of enforcement include: network adequacy and essential community provider requirements; non-discrimination provisions; requirement to charge the same premium for a QHP when offered through and outside the Exchange; and compliance with FFE/FF-SHOP operational standards. 45 C.F.R. §§ 156.705, 156.715, 156.800, 156.805, 156.810. HHS may impose CMPs for improper use or disclosure of information provided by an Exchange applicant, ACA § 1411(h)(2); 45 C.F.R. § 155.285(a)(1)(iii), or for the provision of false or fraudulent information on an Exchange application, ACA §1411(h)(1); 45 C.F.R. §155.285(a)(1)(i) – (ii).

#### *Medical Loss Ratio*

The ACA requires health insurance issuers to submit data on the proportion of premium revenues spent on clinical services and quality improvement, also known as the Medical Loss Ratio (MLR). It also requires them to issue rebates to enrollees if this percentage does not meet minimum standards. HHS has authority to perform MLR audits and investigations, and take enforcement action. For example, HHS may impose CMPs if an issuer fails to:

- (1) submit annual MLR data;
- (2) submit a substantially complete or accurate report;
- (3) timely and accurately pay rebates owed;
- (4) respond to HHS inquiries as part of a non-compliance investigation;
- (5) maintain records used in compiling MLR reports and calculating and paying rebates;
- (6) allow access and entry to premises, facilities and records;
- (7) comply with corrective actions resulting from audit findings; or
- (8) accurately and truthfully represent data, reports, or other MLR information.

45 C.F.R. part 158.

#### *Termination of Direct Enrollment (Written Contracts)*

Some issuers have been granted a direct connection to the Federal Marketplace system that enables them to assist consumers in obtaining an eligibility determination from the Marketplace. Where an issuer misuses information or otherwise violates privacy or security requirements under the written agreement that authorizes the issuer's connection with the Federal Marketplace system, the issuer's direct connection may be terminated, thereby terminating the issuer's ability to provide direct enrollment services to consumers.

#### *Basic Health Program*

The Basic Health Program (BHP) is an optional state program authorized by section 1331 of the ACA, under which states will contract for "standard health plan" coverage for individuals with incomes above the Medicaid eligibility threshold up through 200 percent of the federal poverty line who would otherwise enroll in coverage through the Marketplace through qualified health plans (QHPs). Electing states will receive federal

payments equal to 95 percent of the amount that would have been paid in premium tax credits and cost sharing reductions had the individuals enrolled in QHPs through the Marketplace, which will be deposited into a trust fund to be used for premiums, cost sharing reductions, and additional benefits for enrollees.

CMS will exercise its authorities across a broad range of issues relating to BHP, including several which could lead to covered specific party matters, including the review of:

- (1) competitive processes for awarding contracts (and transition plans);
- (2) contract terms;
- (3) benefits and cost sharing levels;
- (4) availability and access; or
- (5) procedures for selecting BHP trustees.

This program is codified at 42 U.S.C. § 18051 and implementing regulations discussing the above review criteria are codified at 42 C.F.R. § 600.110.

These ACA-related matters, should they involve your former employer as a party or party representative, are expressly excluded from this limited waiver and limited authorization. In the event that any audit, penalty assessment, debt collection, enforcement action, or litigation matter—including, but not limited to, those described above—should arise that involves UHG, its subcomponents, or subsidiaries, as a party or representative of a party, you must remain recused and elevate them to the CMS Administrator, the HHS Deputy Secretary, or HHS Chief of Staff, as appropriate, for disposition without your input or recommendation.

***Examples of Programs Unrelated to Health Reform Under the ACA that May Give Rise to Specific Party Matters that Fall Outside the Scope of this Limited Waiver and Limited Authorization:***

Specific party matters not covered under the limited waiver and limited authorization may also relate to CMS programs and activities that pre-date or are unrelated to health care reform under the ACA.

***Medicare Parts A and B***

Medical providers and suppliers that wish to participate in the Medicare Part A and Part B programs must agree to follow Medicare's "Conditions of Participation." These conditions are set forth in regulations at 42 C.F.R. part 418 relating to health, safety, personnel, record-keeping and other facility regulations, which Medicare uses to ensure that its beneficiaries receive high-quality and effective services. In order to enforce these conditions, Medicare contracts with state survey agencies, or accepts accreditation from a Medicare-approved accreditation organization as alternate evidence that a provider is complying with Medicare's Conditions of Participation. If a service provider is determined by CMS to be out of compliance, the agency can require that the provider follow a corrective action plan; if the provider does not follow the plan, then the provider

will be terminated from the Medicare program. These enforcement actions give rise to both administrative and judicial appeal rights.

Additionally, with respect to reimbursement under Medicare Part A or Part B, participating providers and suppliers are typically paid standard rates, pursuant to predetermined payment methodologies. In the case of hospice care providers, such as Optum Palliative and Hospice Care, reimbursement rates are based on the acuity of the services provided in each appropriate category: routine home care, continuous home care, general inpatient care and inpatient respite care. Hospice facilities' reimbursement rates are also subject to a cap on reimbursement for inpatient services and a separate yearly aggregate cap, which limits the total amount of reimbursement to a hospice based on the number of patients to which the hospice provided services during the "cap year." Disputes regarding reimbursement amounts for institutional providers including hospices and inpatient hospitals may be resolved by appeal to either the Medicare Administrative Contractor or to the Provider Reimbursement Review Board (PRRB). Any continuing controversy may be appealed to the Secretary, and subject to judicial review as permitted by the Social Security Act. In general, the Principal Deputy Administrator of CMS has been delegated authority to conduct the final agency review of such matters. Some disputes regarding payment of specific claims, for both institutional providers and for physicians and suppliers, are appealable to the Office of Medicare Hearings and Appeals and the Departmental Appeals Board.

Any specific party matter arising under Medicare Part A or B, involving UHG or any of its subsidiaries or subcomponents as a party or party representative, including but not limited to questions of compliance with Medicare's Conditions of Participation, a corrective action, a payment dispute or otherwise, are expressly excluded from this limited waiver and limited authorization. As to all such matters described above involving your former employer, should they come to you for your participation, you must remain recused and elevate them to the CMS Administrator, the HHS Deputy Secretary, or HHS Chief of Staff, as appropriate, for disposition without your input or recommendation.

#### *Medicare Parts C and D*

With respect to the Medicare Advantage Part C and the Medicare Part D programs, specific party matters which may involve UHG, its subcomponents, or subsidiaries as parties or representatives of parties would include (all cites are to 42 C.F.R.):

- (1) contract determinations and appeals where CMS determines whether to award, has terminated, refused to renew, or refused to award a contract to an organization applying for a Medicare Advantage (MA) or Part D Plan contract (parts 422 and 423, subparts K and N);
- (2) appeals of quality bonus payment determinations and Part D payment appeals (§§ 422.260, 423.350);
- (3) disputes and appeals related to risk adjustment data verification audits and other payment-related data (§ 422.311; part 423, subpart G);
- (4) investigations, disputes, and appeals related to oversight or the imposition of

- intermediate sanctions and civil monetary penalties for compliance with the law governing MA and Part D plans (parts 422 and 423, subparts O and T);
- (5) disputes related to CMS action on overpayments to MA organizations and Part D Plan sponsors (no specific administrative process in Part C);
  - (6) recovery audit contractor determination appeals (subpart Z); and
  - (7) in Part D only, a dispute involving a drug manufacturer with respect to coverage gap discounts (§ 423.2330).

In some cases, Medicare beneficiaries may appeal coverage denials by a Part C or Part D plan through an administrative process that includes the Office of Medicare Hearings and Appeals and the Medicare Appeals Council. 42 C.F.R. part 422, subpart M; part 423, subpart U. Non-administrative claims against the MA organization or Part D plan sponsor by beneficiaries or network/contracted providers may result in CMS involvement. For example, recent action by an MA organization to terminate a number of network providers resulted in CMS investigation and correspondence activity and monitoring of litigation between the providers and the MA organization, even though CMS did not take any formal compliance action.

These Medicare Part C and Part D matters, should they involve your former employer as a party or party representative, are expressly excluded from this limited waiver and limited authorization. As to all such matters described above involving your former employer, should they come to you for your participation, you must remain recused and elevate them to the CMS Administrator, the HHS Deputy Secretary, or HHS Chief of Staff, as appropriate, for disposition without your input or recommendation.

#### *Medigap Plans*

HHS also retains the authority to impose civil and criminal penalties on persons and issuers for failure to meet all of the federal requirements relating to Medigap plans, such as UnitedHealthcare Medicare & Retirement. For example, issuers could be subject to civil and criminal penalties for knowingly selling coverage to a Medicare beneficiary that duplicates Medicare coverage; making a false representation with regard to the compliance of a policy with the federal requirements or in regard to a relationship with a federal agency or the Medicare program for the purpose of selling insurance; knowingly soliciting, advertising, or offering for sale Medigap policies by mail into a state if those policies have not been approved or deemed approved for sale within the state; failing to suspend a Medigap policy at the policyholder's request if the policyholder applies for and is determined eligible for Medicaid; failure to automatically reinstate a policy as of the date a policyholder loses medical assistance eligibility (if the policyholder provides timely notice of his or her loss of Medicaid eligibility); or failure to provide MLR rebates or credits owed. 42 C.F.R. part 403, subpart B.

Such determinations, including the exercise of HHS' enforcement discretion, are covered specific party matters, and are expressly excluded from this limited waiver and limited authorization. As discussed above, if UHG or any of its subsidiaries or subcomponents is involved in such a penalty determination, should such a matter come to you for your participation, you must remain recused and elevate any such matters to the CMS

Administrator, the HHS Deputy Secretary, or HHS Chief of Staff, as appropriate, for disposition without your input or recommendation

### III. Impartiality in Performing Official Duties – 5 C.F.R. § 2635.502

#### Background Regarding the Recusal Obligation under 5 C.F.R. § 2635.502

The Standards of Ethical Conduct for Employees of the Executive Branch require an employee to take appropriate steps to avoid an appearance of any lack of impartiality in the performance of the employee's official duties. 5 C.F.R. § 2635.502(a). Under section 2635.502, when an employee knows that a person with whom he has a "covered relationship" is a party or represents a party to a specific party matter, and where the employee determines that the circumstances would cause a reasonable person with knowledge of the relevant facts to question his impartiality in the matter, the employee should not participate in the matter without informing an agency official and receiving authorization to participate. An employee has a "covered relationship" under this section with any entity for which the employee has, within the last year served, *inter alia*, as an employee or officer. 5 C.F.R. § 2635.502(b)(1)(iv). Accordingly, you have a "covered relationship" with UHG and its subcomponents or subsidiaries, including Optum, QSSI and the Lewin Group, for purposes of 5 C.F.R. § 2635.502.

As noted above, I have been informed by management at CMS, that the Department critically needs your participation in specific party matters including meetings and communications relating to health care reform implementation under the ACA, which includes health insurance marketplaces and the healthcare.gov website. Section 2635.502(d) directs that an agency designee may authorize an employee to participate in a particular matter involving specific parties, which would otherwise be subject to the recusal requirements of that section, if the designee makes a determination, in light of all relevant circumstances, that the interest of the Government in the employee's participation outweighs any concern that a reasonable person may question the integrity of the Government's programs and operations. Factors which may be taken into consideration include:

- (1) the nature of the relationship involved;
- (2) the effect that resolution of the matter would have upon the financial interests of the person involved in the relationship;
- (3) the nature and importance of the employee's role in the matter, including the extent to which the employee is called upon to exercise discretion in the matter;
- (4) the sensitivity of the matter;
- (5) the difficulty of reassigning the matter to another employee; and
- (6) adjustments that may be made in the employee's duties that would reduce or eliminate the likelihood that a reasonable person would question the employee's impartiality.

Limited Authorization Pursuant to 5 C.F.R. § 2635.502(d)

As the HHS DAEO, after weighing the factors articulated in 5 C.F.R. § 2635.502(d), I have determined that it is permissible to authorize your participation in particular matters involving specific parties where UHG, or its subcomponents or subsidiaries, are parties or party representatives as described above regarding the limited waiver of Section 1, Paragraph 2, of Executive Order 13490, subject to the same limitations and for the same reasons.

In particular, I have taken into account that you have agreed to divest your UHG stock holdings as directed and will have no personal financial interests in your former employer that would be affected by particular matters in which you participate. Further, the delineated limitations on this authorization circumscribe your role in the described matters and protect the procurement process. Equally important to this authorization determination is the highly sensitive nature of and critical need for your technical expertise in the described interactions that might be necessary with your former employer. CMS has indicated that you are the only available employee with this unique skill blend. As the CMS Principal Deputy Administrator, you are the Administration official with direct responsibility for advising the CMS Administrator and serving as the Acting Administrator in her absence. The importance of health care reform to the nation weighs against reassignment to others who have less expertise and management experience for this critical senior policy role. In light of these factors and the requirement that you abide by the aforementioned limitations, I hereby determine that the governmental interest in your participation outweighs any countervailing appearance concerns and authorize your participation in the particular matters involving specific parties as above described.

#### IV. Conclusion

In light of the breadth of your potential tasks under health care reform, I am issuing this limited waiver and limited authorization. Your disqualification from matters that are not covered by this limited waiver and limited authorization will not materially impair your ability to perform the duties of your position. This limited waiver and limited authorization does not affect your obligation otherwise to comply with other provisions of the Ethics Pledge and with all other Standards of Ethical Conduct for Employees of the Executive Branch and the HHS Supplemental Ethics Regulations. Additionally, when you leave government service, you will be subject to a range of post-Government employment rules. These rules will restrict your post-government employment activities including your ability to influence government actions on behalf of others by limiting your contacts to your former agency and other government officials.

If you have any questions about the interpretation of this document or its applicability to any specific situation, you should seek counsel from my office prior to participation.