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PPACA IMPLEMENTATION FAILURES: ANSWERS FROM HHS

HEARING

BEFORE THE

COMMITTEE ON ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRTEENTH CONGRESS

FIRST SESSION

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PPACA IMPLEMENTATION FAILURES: ANSWERS FROM HHS

WEDNESDAY, OCTOBER 30, 2013

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
WASHINGTON, DC.

The committee met, pursuant to call, at 9:02 a.m., in room 2123, Rayburn House Office Building, Hon. Fred Upton (chairman of the committee) presiding.

Present: Representatives Upton, Hall, Barton, Whitfield, Shimkus, Pitts, Walden, Terry, Rogers, Murphy, Burgess, Blackburn, Gingrey, Scalise, Latta, McMorris Rodgers, Harper, Lance, Cassidy, Guthrie, Olson, McKinley, Gardner, Pompeo, Kinzinger, Griffith, Bilirakis, Johnson, Long, Ellmers, Waxman, Dingell, Pallone, Eshoo, Engel, Green, DeGette, Capps, Doyle, Schakowsky, Matheson, Butterfield, Barrow, Matsui, Christensen, Castor, Sarbanes, McNerney, Braley, Welch, Lujan, Tonko, and Yarmuth.

Staff Present: Clay Alspach, Chief Counsel, Health; Carl Anderson, Counsel, Oversight; Gary Andres, Staff Director; Ray Baum, Senior Policy Advisor/Director of Coalitions; Mike Bloomquist, General Counsel; Sean Bonyun, Communications Director; Matt Bravo, Professional Staff Member; Megan Capiak, Staff Assistant; Karen Christian, Chief Counsel, Oversight; Noelle Clemente, Press Secretary; Paul Edattel, Professional Staff Member, Health; Brad Grantz, Policy Coordinator, O&I; Sydne Harwick, Legislative Clerk; Brittany Havens, Legislative Clerk; Sean Hayes, Counsel, O&I; Kirby Howard, Legislative Clerk; Alexa Marrero, Deputy Staff Director; Nick Magallanes, Policy Coordinator, CMT; Carly McWilliams, Professional Staff Member, Health; Brandon Mooney, Professional Staff Member; Gib Mullan, Chief Counsel, CMT; Katie Novaria, Professional Staff Member, Health; Monica Popp, Professional Staff Member, Health; Andrew Powaleny, Deputy Press Secretary; Chris Sarley, Policy Coordinator, Environment & Economy; Heidi Stirrup, Health Policy Coordinator; John Stone, Counsel, Oversight; Tim Torres, Deputy IT Director; Tom Wilbur, Digital Media Advisor; Jessica Wilkerson, Staff Assistant; Ziky Ababiya, Minority Staff Assistant; Phil Barnett, Minority Staff Director; Stacia Cardille, Minority Deputy Chief Counsel; Brian Cohen, Minority Staff Director, Oversight & Investigations/Senior Policy Advisor; Hannah Green, Minority Staff Assistant; Elizabeth Letter, Minority Assistant Press Secretary; Karen Lightfoot, Minority Communications Director and Senior Policy Advisor; Karen Nelson, Minority Deputy Committee Staff Director for Health; Stephen

Salsbury, Minority Special Assistant; Roger Sherman, Minority Chief Counsel; and Matt Siegler, Minority Counsel.

Mr. UPTON. Good morning, everyone. Good morning.

Secretary SEBELIUS. Good morning.

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

Mr. UPTON. Energy and Commerce Committee welcomes the President's point person on health care, Secretary Sebelius, as part of our continuing oversight of the healthcare law, and we look forward to a thoughtful conversation on a number of issues, including transparency and fairness.

Over the months leading up to October 1 launch, the Secretary and her colleagues at HHS repeatedly looked us in the eye and testified that everything was on track, and despite the numerous red flags and lack of testing, they assured us that all systems were a go. But something happened along the way. Either those officials did not know how bad the situation was, or they did not disclose it. And sadly, here we are now 5 weeks into enrollment, and the news seems to get worse by the day.

HealthCare.gov was down last night at 5 o'clock p.m. It was also down on Monday, and it crashed last weekend. And even this morning when we attempted to view the site before the hearing, we were hit with an error message.

But this is more than just a Web site problem. That was supposed to be the easy part, remember? Americans were assured that their experience would be similar to other online transactions, like purchasing a flight or ordering a pizza, and that their sensitive personal information would always be secure. But after more than 3 years to prepare, malfunctions have become the norm, and the administration has pivoted from saying they're on track to setting a new target date of November 30th. And for those few Americans who have successfully applied, will the Web site glitches become provider glitches come January 1st?

Americans are scared and frustrated, and this situation should rise above politics. Many folks at home watching us today have spent hours or even days trying to sign up. They continue to take time away from work or loved ones, but have made little progress, and soon they may worry about being on the wrong side of their government, facing potential penalties.

I recently spoke to a woman from Buchanan, Michigan, who was excited to sign up, but has since become very disillusioned after spending hours on the phone and Web site with little success. There are also millions of Americans coast to coast who no doubt believed that the President repeated promises that if they liked their plan, that they would be able to keep it, no matter what. They are now receiving termination notices, and for those who lose their coverage, they like—they may be losing their faith in their government.

Today's hearing is about fairness for the American people who are losing their coverage or seeing their premiums skyrocket as high as 400 percent. This hearing is also about transparency. While the administration continues to boast the number of Americans that have applied, they intentionally withhold precise enrollment

numbers. Why? These numbers are critical to fully understand the status engaging the progress of implementation.

Lead contractor CGI testified only last week that they had the data, but needed the administration's permission to release it. We asked the Secretary on October 8th for those figures, but we still have not received a response. We hope to get one today. The American people deserve answers as well as the peace of mind that promises will be kept. The Secretary has an opportunity today to embrace transparency and start restoring the public's faith in the administration and the government.

[The prepared statement of Mr. Upton follows:]

PREPARED STATEMENT OF HON. FRED UPTON

The Energy and Commerce Committee welcomes the president's point person on health care, Secretary Sebelius, as part of our continuing oversight of the health care law. We look forward to a thoughtful conversation on a number of issues including transparency and fairness.

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But something happened along the way—either those officials did not know how bad the situation was, or they did not disclose it. Sadly, here we are, now five weeks into enrollment, and the news seems to get worse by the day. Healthcare.gov was down last night at 5:00 p.m. It was also down on Monday, and it crashed last weekend. And even this morning when we attempted to view the site before this hearing, we were hit with an error message.

But this is more than just a Web site problem—that was supposed to be the easy part. Americans were assured their experience would be similar to other online transactions like purchasing a flight or ordering a pizza and that their sensitive personal information would be kept secure. But after more than three years to prepare, malfunctions have become the norm and the administration has pivoted from saying they are "on track" to setting a new target date of November 30. And for those few Americans who have successfully applied, will the Web site glitches become provider glitches on January 1?

Americans are scared and frustrated, and this situation should rise above politics. Many folks at home watching us today have spent hours or even days trying to sign up. They continue to take time away from work or loved ones but have made little progress, and soon they may worry about being on the wrong side of their government, facing potential penalties. I recently spoke to a woman from Buchanan, Michigan, who was excited to sign up, but has since become disillusioned after spending hours on the phone and Web site with little success. There are also millions of Americans coast to coast who no doubt believed the president's repeated promise that if they liked their plan, they'd be able to keep it "no matter what." They are now receiving termination notices, and for those who lose the coverage they like, they may also be losing faith in their government.

Today's hearing is about fairness for the American people who are losing their coverage or seeing their premiums skyrocket as high as 400 percent. This hearing is also about transparency. While the administration continues to boast the number of Americans that have "applied," they intentionally withhold precise enrollment numbers. Why? These numbers are critical to fully understanding the status and gauging progress of implementation. Lead contractor CGI testified last week that they had the data, but needed the administration's permission to release it. We asked the Secretary on October 8 for those figures, but still have not received a response. We hope to get one today.

The American people deserve answers as well as the peace of mind that promises will be kept. The secretary has an opportunity today to embrace transparency and start restoring the public's faith in the administration and government.

# # #

Mr. UPTON. I yield to my colleague, the ranking member of the committee, Mr. Waxman.

Mr. WAXMAN. Thank you, Mr. Chairman.

I am pleased Secretary Sebelius is here today. She's here to discuss the Affordable Care Act. Just like with Medicare Part D, the launch of the new Web site has not gone well, but just like Medicare Part D, the early glitches in this rollout will soon be forgotten.

A lot of the discussion today will focus on that Web site. This is an important issue, and I want to learn what the Secretary can tell us about the problems being experienced and how they will be fixed.

But we should keep this issue in perspective. The Affordable Care Act is working. It has been improving the health security of millions of Americans for the past 3 years. Because of the Affordable Care Act, more than 7 million people on Medicare have saved more than $8 billion on their prescription drugs. More than 100 million Americans have access to free preventive coverage and no longer face lifetime limits on their coverage. Over 10 million Americans have received rebates from insurance companies. And, finally, this January, the worst abuses of insurance industry will be halted. Never again will a family be denied coverage because their child has a chronic health condition. Never again will individuals see their premiums shoot up because they got sick or faced an unexpected medical expense. Never again will a woman have to pay twice as much as a man for the same insurance.

That is why allowing insurers to continue offering deficient plans next year is such a bad policy. The law says that all plans except those that were grandfathered in 2010 must meet the new consumer protection standards. If we don't enforce this policy, insurance companies can continue offering flimsy coverage that disappears when people actually need it. And no one should want that.

It is understandable that there will be a focus today on what isn't working, but we must also remember what is working. The health insurance plans that are being offered in the exchanges are good plans; their premiums are much lower than expected. Sixty percent of the uninsured individuals shopping in the new marketplaces will be able to get coverage for less than $100 per month. Half of the young adults will be able to get coverage for less than $50 per month. And since Congress adopted the Affordable Care Act, healthcare costs across the whole economy have grown at their lowest level in decades.

The success of the Affordable Care Act is due to the efforts of many people, but one individual more than any other is responsible for all the good that has been accomplished, and that is our witness today Secretary Sebelius.

So I would urge my colleagues to stop hyperventilating. The problems with HealthCare.gov are unfortunate, and we should investigate them, but they will be fixed, and then every American will finally have access to affordable health insurance.

Thank you, Mr. Chairman.

Mr. UPTON. Thank you.

Before we swear in Secretary Sebelius, I want to clarify Energy and Commerce Committee practice for the swearing in of witnesses. The committee typically has two types of hearings, oversight hearings and hearings that focus on legislation and policy. Secretary Sebelius, for example, has testified previously before our committee to discuss issues related to the HHS budget or other policy matters. As is the case with all policy witnesses, Secretary Sebelius was not required to take the oath prior to testifying.

Today's hearing is different. It is an oversight hearing. It is a long-standing committee practice to swear in all witnesses at oversight hearings, whether they be private citizens or Cabinet Secretaries.

Mr. WAXMAN. Mr. Chairman, I thank you for your comments, and I just want to join you in simply explaining that swearing in of a witness before an oversight committee hearing has always been under oath. That is a standard procedure of this committee when we're conducting an oversight hearing. So it may seem strange to have the Secretary of Health and Human Services have to be sworn in, but all witnesses in an oversight hearing are sworn in, and that is our procedure.

Mr. UPTON. Thank you.

So I would now like to introduce our witness for today's hearing. The Honorable Kathleen Sebelius is the Secretary of the Department of Health and Human Services. She was appointed to this position in April of 2009, and was sworn in as the 21st Secretary on April 28th, 2009.

So I will now swear you in, if you would rise.

As Ranking Waxman and I just discussed, the committee is holding an investigative hearing, and, when doing so, have had the practice of taking testimony under oath.

Do you have any objection to testifying under oath?

Secretary SEBELIUS. No, sir.

[Witness sworn.]

Mr. UPTON. You are now under oath and subject to the penalties set forth in Title 18, section 1001 of the U.S. Code.

You may now give a 5-minute summary of your written statement. Welcome again, and thank you for being here.

TESTIMONY OF HON. KATHLEEN SEBELIUS, SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Secretary SEBELIUS. Well, thank you, Chairman Upton.

Mr. UPTON. You got to use that mic. You don't know how many people want to hear you this morning.

Secretary SEBELIUS. Thank you, Chairman Upton, Ranking Member Waxman, members of the committee.

I left my position as Governor of Kansas 4 ½ years ago for the opportunity to continue work I've been doing for most of my over 35 years of public service; to expand the opportunities for all Americans regardless of geography, or gender, or income to have affordable health coverage. During my years as a State legislator, as an elected insurance commissioner, as head of the National Association of Insurance Commissioners, and as a two-term Governor, and now as HHS Secretary, I have worked on that effort that I care deeply about.

There are still millions of Americans who are uninsured as well as underinsured, people who have some coverage at some price for some illness, but have no real protection from financial ruin and no real confidence they'll be able to take care of themselves and their families if they have an accident or an illness. And for them a new day has finally come.

In these early weeks access to HealthCare.gov has been a miserably frustrating experience for way too many Americans, including many who have waited years, in some cases their entire lives, for the security of health insurance. I am as frustrated and angry as anyone with the flawed launch of HealthCare.gov, so let me say directly to these Americans, you deserve better. I apologize. I'm accountable to you for fixing these problems, and I'm committed to earning your confidence back by fixing the site.

We're working day and night and will continue until it's fixed. We've recently added new management talent, additional technical expertise, and a new general contractor to identify, prioritize, and manage fixes across the system in two broad categories: performance, which deals with speed and reliability; and function, which deals with bugs and problems in the system.

Our extensive assessment has determined that HealthCare.gov is fixable, and I want to just outline a couple of the improvements we've made to date. We now have more users successfully creating accounts. We can process up to 17,000 account registrations per hour, or nearly 5 per second. Instead of some of the users seeing a blank screen at the end of the application process, they can now see whether they're eligible for financial assistance and make more informed decisions. Because we've improved performance, customers can now shop for plans quickly; filtering plans takes seconds, not minutes. Users are getting fewer errors and timeout messages as they move through the application process. And the system has been strengthened with double the size of servers, software that's better optimized, and a high-capacity physical database which replaces a virtual system.

The chairman referred to outages this weekend and again yesterday, and I would suggest to the committee that if you read the statement of Verizon, who hosts the cloud service, it is the Verizon server that failed, not HealthCare.gov, and it affected not only HHS, but other customers.

We still have a lot of work to do. We have a plan in place to address key outstanding issues. It includes fixing bugs in software that prevented it from working the way it's supposed to, and refreshing the user experience so folks can navigate the site without encountering error messages, timeout, and slow response times. And by the end of November, we're committed that the vast majority of users will be able to review their options, shop for plans, and enroll in coverage without the problems way too many have been experiencing.

But consumers are using the site every day and continue to do so, and problems are being solved, but we know that we don't have a fully functioning system that consumers need and deserve. We are still at the beginning of a 6-month open enrollment which extends through the end of March, and there's plenty of time to sign up. Just to put it in perspective, the average open enrollment for

an insurance plan is 2 to 4 weeks. The new marketplace has a 26-week open enrollment, and those who enroll by December 15th will be able to access their benefits on day one.

Even with the unacceptable problems with HealthCare.gov, which we are committed to fixing, the Affordable Care Act by any fair measure is working for millions of Americans who are benefiting from new health security, young adults, Americans living with preexisting health conditions, seniors on Medicare. The 85 percent of Americans who already have health coverage are protected with new rights and benefits. The 15 percent of our neighbors and friends who are uninsured have affordable new options in a competitive market. And cost growth for health care is lower than it's been in years.

Millions of Americans are clearly eager to learn about their options and to finally achieve health security made possible by the Affordable Care Act. My commitment is to deliver on that promise.

Thank you, Mr. Chairman.

Mr. UPTON. Well, thank you very much.

[The prepared statement of Secretary Sebelius follows:]

STATEMENT OF

KATHLEEN SEBELIUS

SECRETARY
U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES

ON
AFFORDABLE CARE ACT IMPLEMENTATION

BEFORE THE

U. S. HOUSE COMMITTEE ON ENERGY & COMMERCE

OCTOBER 30, 2013

Testimony of Kathleen Sebelius
U.S. Department of Health and Human Services
on Affordable Care Act Implementation
House Committee on Energy & Commerce
October 30, 2013

Good morning, Chairman Upton, Ranking Member Waxman, and members of the Committee. On October 1st, we launched one of the key provisions of the Affordable Care Act—the new Health Insurance Marketplace, where people without health insurance, including those who cannot afford health insurance, and those who are not part of a group plan, can go to get affordable coverage. Consumers can access the Marketplace in several ways—through a call center, by filling out a paper application, with the help of in-person assistance, or by going online and filling out an application on HealthCare.gov.

Over the past few weeks, millions of Americans have visited HealthCare.gov to look at their new health coverage options under the Affordable Care Act. In that time, nearly 700,000 applications have been submitted to the Federal and state marketplaces from across the Nation. This tremendous interest—with over 20 million unique visits to date to HealthCare.gov—confirms that the American people are looking for quality, affordable health coverage. Unfortunately, the experience on HealthCare.gov has been frustrating for many Americans. Some have had trouble creating accounts and logging in to the site, while others have received confusing error messages, or had to wait for slow page loads or forms that failed to respond in a timely fashion. The initial consumer experience of HealthCare.gov has not lived up to the expectations of the American people and is not acceptable. We are committed to fixing these problems as soon as possible.

Improvements Already Made to HealthCare.gov

To build the Marketplace, CMS used private sector contractors, just as it does to administer aspects of Medicare. CMS has a track record of successfully overseeing the many contractors our programs depend on to function. Unfortunately, a subset of those contracts for HealthCare.gov have not met expectations. Among other issues, the initial wave of interest stressed the account

service, resulting in many consumers experiencing difficulty signing up, while those who were able to sign up sometimes had problems logging in.

In response, we have made a number of improvements to the account service. We have updated the site several times with new code that includes bug fixes that have improved the HealthCare.gov experience. We continue to add more capacity in order to meet demand and execute software fixes to address the sign up and log in issues, stabilizing those parts of the service and allowing us to remove the virtual "waiting room." Today, more individuals are successfully creating accounts, logging in, and moving on to apply for coverage and shop for plans. We are pleased with these quick improvements, but we know there is still significant, additional work to be done. We continue to conduct regular maintenance nearly every night to improve the consumer experience.

Reinforcements

To address the technical challenges with HealthCare.gov, we are putting in place tools and processes to aggressively monitor and identify parts of HealthCare.gov where individuals are encountering errors or having difficulty using the site, so we can prioritize and address them. We are also working to prevent new issues from cropping up as we improve the overall service and deploy fixes to the site during off-peak hours on a regular basis.

To ensure that we make swift progress, and that the consumer experience continues to improve, our team has called in additional help to solve some of the more complex technical issues we are encountering. We are bringing in people from both inside and outside government to scrub in with the team and help improve HealthCare.gov. Specifically, we are bringing on board management expert and former CEO and Chairman of two publicly traded companies, Jeff Zients, to work in close cooperation with our HHS team to provide management advice and counsel to the project. Mr. Zients has led some of the country's top management firms, providing private sector companies around the world with best practices in management, strategy, and operations. He has a proven track record as Acting Director at the Office of Management and Budget and as the Nation's first Chief Performance Officer. Working alongside our team and

using his rich expertise and management acumen, Mr. Zients will provide advice, assessments, and recommendations.

Our team has also brought in additional experts and specialists drawn from within government, our contractors, and industry, including veterans of top Silicon Valley companies. These reinforcements include several Presidential Innovation Fellows. This new infusion of talent will bring a powerful array of subject matter expertise and skills, including extensive experience scaling major IT systems. They are part of a cross-functional team that is working aggressively to diagnose the parts of HealthCare.gov that are experiencing problems, learn from successful states, prioritize issues, and fix them.

As part of our team's efforts to ramp up capacity and expertise with the country's leading innovators and problem solvers, our contractors—including CGI, the lead firm responsible for the Federally-Facilitated Marketplace technology—have secured additional staff and made additional staffing commitments. They are providing and directing the additional resources needed for this project.

Expanding Access to Affordable Coverage Through the Health Insurance Marketplace

We are committed to improving the consumer experience with HealthCare.gov, which serves as an important entry point to the new Marketplace. The new Marketplace is a place that enables people without health insurance, including those who cannot afford health insurance, and those who are not part of a group plan, to finally start getting affordable coverage.

Just a few weeks into a six-month open enrollment period, while some consumers have had to wait too long to access the Marketplace via HealthCare.gov, the Marketplace is working for others and consumers are also utilizing the call center, paper applications and in-person assistance to apply for coverage.

The idea of the Marketplace is simple. By enrolling in private health insurance through the Marketplace, consumers effectively become part of a form of statewide group coverage that

spreads risk between sick people and healthy people, between young and old, and then bargains on their behalf for the best deal on health insurance. Because we have created competition where there was not competition before, insurers are now eager for new business, and have created new health care plans with more choices.

The bids submitted by insurers provide clear evidence that the Marketplace is encouraging plans to compete for consumers, resulting in more affordable rates. The weighted average premium for the second-lowest-cost silver plan, looking across 47 states and DC, is 16 percent below the premium level implied by earlier Congressional Budget Office estimates.[1] Outside analysts have reached similar conclusions. A recent Kaiser Family Foundation report found that, "while premiums will vary significantly across the country, they are generally lower than expected," and that fifteen of the eighteen states examined would have premiums below the CBO-projected national average of $320 per month for a 40-year-old in a silver plan.[2]

This is good news for consumers. In fact, some insurers lowered their proposed rates when they were finalized. In Washington, D.C., some issuers have reduced their rates by as much as 10 percent.[3] In Oregon, two plans requested to lower their rates by 15 percent or more.[4] New York State has said, on average, the approved 2014 rates for even the highest coverage levels of plans individual consumers can purchase through its Marketplace (gold and platinum) represent a 53 percent reduction compared to last year's direct-pay individual market rates.[5] Furthermore, states are using their rate review powers to review and adjust rates accordingly. In Oregon, the state has reduced rates for some plans by as much as 35 percent,[6] and in Maryland, the state has reduced some rates for coverage offered through the Marketplace by almost 30 percent,[7] offering consumers an even better deal on their coverage for the 2014 plan year.

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[1] http://aspe.hhs.gov/health/reports/2013/MarketplacePremiums/ib_marketplace_premiums.cfm#_ftnref18
[2] http://kaiserfamilyfoundation.files.wordpress.com/2013/09/early-look-at-premiums-and-participation-in-marketplaces.pdf
[3] http://hbx.dc.gov/release/dc-health-link-applauds-aetna-decision-cut-rates
[4] http://www.oregonlive.com/health/index.ssf/2013/05/two_oregon_insurers_reconsider.html
[5] http://www.governor.ny.gov/press/07172013-health-benefit-exchange
[6] http://www.oregonlive.com/health/index.ssf/2013/06/oregon_slashes_2014_health_ins.html
[7] http://www.kaiserhealthnews.org/stories/2013/july/26/maryland-marketplace-premiums-exchange.aspx

In addition to the more affordable rates resulting from competition among insurers, insurance affordability programs, including premium tax credits and cost-sharing reductions, will help many eligible individuals and families, significantly reducing the monthly premiums and cost-sharing paid by consumers. Premium tax credits may be paid in advance and applied to the purchase of a qualified health plan through the Marketplace, enabling consumers to reduce the upfront cost of purchasing insurance. In addition, cost-sharing reductions will lower out-of-pocket payments for deductibles, coinsurance, and copayments for eligible individuals and families. A recent RAND report[8] indicated that, for the average Marketplace participant nationwide, the premium tax credits will reduce out-of-pocket premium costs by 35 percent from their unsubsidized levels.[9]

CBO has projected that about 8 in 10 Americans who obtain coverage through the Marketplace will qualify for assistance to make their insurance more affordable, an estimated 20 million Americans by 2017.[10] A family's eligibility for these affordability programs depends on its family size, household income, and access to other types of health coverage.

The fact is that the Affordable Care Act delivered on its product: quality, affordable health insurance. The tremendous interest shown in HealthCare.gov shows that people want to buy this product. We know the initial consumer experience at HealthCare.gov has not been adequate. We will address these initial and any ongoing problems, and build a website that fully delivers on this promise of the Affordable Care Act.

Other Benefits of the Affordable Care Act

While we are working around the clock to address problems with HealthCare.gov, it is important to remember that the Affordable Care Act is much more than purchasing insurance through HealthCare.gov. Most Americans—85 percent—already have health coverage through an employer-based plan, or health benefit, such as Medicare, Medicaid, or the Children's Health Insurance Program (CHIP). For these Americans, the Affordable Care Act provides new benefits

[8] http://www.rand.org/content/dam/rand/pubs/research_reports/RR100/RR189/RAND_RR189.pdf
[9] This is a simple calculation based on Figure 6 of the RAND study, available at the link above.
[10] http://www.cbo.gov/sites/default/files/cbofiles/attachments/44190_EffectsAffordableCareActHealthInsuranceCoverage_2.pdf

and protections, many of which have been in place for some time. For example, because of the Affordable Care Act, millions of young adults have been able to stay on their parents' plans until they are 26. Because of the Affordable Care Act, seniors on Medicare receive greater coverage of their prescription medicine, saving them billions. Because of the Affordable Care Act, for millions of Americans, recommended preventive care like mammograms is free through employer-sponsored health coverage. And in states where governors and legislatures have allowed it, the Affordable Care Act provides the opportunity for many Americans to get covered under Medicaid for the first time. In Oregon, for example, a Medicaid eligibility expansion will help cut the number of uninsured people by 10 percent, as a result of enrollment efforts over the last few weeks, resulting in 56,000 more Americans who will now have access to affordable health care.

The Affordable Care Act is also holding insurers accountable for the rates they charge consumers. For example, insurance companies are now required to justify a rate increase of 10 percent or more, shedding light on unnecessary costs. Since this rule was implemented,[11] the proportion of rate filings requesting insurance premium increases of 10 percent or more has plummeted from 75 percent in 2010[12] to an estimated 14 percent in the first quarter of 2013,[13] saving Americans an estimated $1.2 billion on their health insurance premiums.[14] These figures strongly suggest the effectiveness of review of rate increases.

The rate review program works in conjunction with the so-called 80/20 rule (or Medical Loss Ratio rule),[15] which generally requires insurance companies in the individual and small group markets to spend at least 80 percent of premiums on health care and quality improvement activities and no more than 20 percent on administrative costs (such as executive salaries and marketing) and profits. In the large group market (generally coverage sold to employers with more than 50 employees), insurers must spend at least 85 percent of premiums on medical care

[11] Health Insurance Rate Review – Final Rule on Rate Increase Disclosure and Review: http://www.gpo.gov/fdsys/pkg/FR-2011-05-23/pdf/2011-12631.pdf
[12] http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/rate-review09112012a.html
[13] http://aspe.hhs.gov/health/reports/2013/rateIncreaseIndvMkt/rb.cfm
[14] http://aspe.hhs.gov/health/reports/2013/acaannualreport/ratereview_rpt.cfm
[15] Medical Loss Ratio Final Rule: https://www.federalregister.gov/articles/2012/05/16/2012-11753/medical-loss-ratio-requirements-under-the-patient-protection-and-affordable-care-act

and quality improvement activities. If insurers fail to meet their medical loss ratio requirement, they must provide rebates to their customers.

New rules will help make health insurance even more affordable for more Americans beginning next year.[16] Marketplace health insurance plans will be prohibited from charging higher premiums to applicants because of their current or past health problems or gender, and will be limited in how much more they can charge Americans based on their age.

Conclusion

The Affordable Care Act has already provided new benefits and protections to Americans with health insurance, and we are committed to improving the experience for consumers using HealthCare.gov so that Americans can easily access the quality, affordable health coverage they need. By enlisting additional technical help, aggressively monitoring errors, testing to prevent new issues from cropping up, and regularly deploying fixes to the site, we are working to ensure consumers' interaction with HealthCare.gov is a positive one, and that the Affordable Care Act fully delivers on its promise.

[16] Health Insurance Market Rules: http://www.gpo.gov/fdsys/pkg/FR-2013-02-27/pdf/2013-04335.pdf

Mr. UPTON. I appreciate you being here this morning, and we worked with our leadership to see that we don't have votes on the House floor this morning so we won't be interrupted. I appreciate your time for sure. And in an effort to allow every Member to ask a question, we're going to be reducing the time for questions to be just 4 minutes so that hopefully we can get through all the Members that are here. And I'm going to be pretty fast with the gavel, let me just say. So we've got plenty of questions, so let's try and get through them.

You know, I think everyone in America remembers the President's words: "If you like your healthcare plan, you can keep it. Period." Under the Affordable Care Act, insurance policies that were in effect on March 23rd, 2010, when the law was enacted, would be grandfathered. Then a few months later, despite the President's word, you all at HHS helped promulgate a new reg that in your own review showed that it effectively could deny perhaps as many as more than 50 percent, maybe even higher, of those holding individual policies, the right to renew their own insurance plan.

And I would guess that there are a lot of us on this panel today that are hearing from angry and confused constituents, who are now being forced to go onto an inept Web site, whether they like it or not, to shop for a new replacement policy. They're finding premiums often more than 100 percent what they were paying before, some even as high as 400 percent, as I've heard from, and rising deductibles as well.

So when was the President specifically informed of the regulation change? And, if so, was it pointed out that this totally undermines his biggest selling point?

And I would note that on the screen in the statement that he made more than 3 years after the regulation change was promulgated, the President said again, "So the first thing you need to know is this: If you already have health care, you don't have to do anything."

So he's been on the same page from the very start, yet the regulations changed months after the bill was enacted that are now causing perhaps millions of Americans to be denied the ability to renew their individual coverage.

Why was that change made, and did the President know it?

Secretary SEBELIUS. Well, Mr. Chairman, there was no change. The regulation involving grandfathered plans, which applied to both the employer market and the individual market, indicated that if a plan was in effect in March of 2010 stayed in effect without unduly burdening the consumer with reducing benefits and adding on huge costs, that plan would stay in effect and never have to comply with any of the regulations of the Affordable Care Act. That's what the grandfather clause said.

The individual market, which affects about 12 million Americans, about 5 percent of the market, people move in and out, they often have coverage for less than a year, a third of them have coverage for about 6 months, and if a plan was in place in March of 2010, and again did not impose additional burdens on the consumer, they still have it. It's grandfathered in.

Mr. UPTON. But why not let the consumer decide whether they want to renew it or not? Why were regulations promulgated in the

summer of 2010 that then undermined the ability for those folks to re-sign up, which is one the reasons for the large number of cancellation notices?

Secretary SEBELIUS. There were no regulation change. We outlined the grandfather policy so people could keep their own plan. We then began to implement the other features of the Affordable Care Act. So if someone is buying a brand new policy in the individual market today or last week, they will have consumer protections for the first time. Many people in the individual market are medically underwritten. That will be illegal. Many women are charged 50 percent more than men. That will be illegal. You cannot again eliminate someone because of a preexisting health condition, you can't dump someone out or lock someone out.

So those provisions—but if, again, a plan is in place and was in place at the time that the President signed the bill, and the consumer wants to keep the plan, those individuals are grandfathered in, and that's happening across the country in the individual market.

Mr. UPTON. We're learning, in fact, that folks who did have a plan who liked it, in fact, are being told that it's canceled in the last—my time has expired. Let me yield to the ranking member Mr. Waxman for 4 minutes.

Mr. WAXMAN. Thank you, Mr. Chairman.

I had to smile at your line of questioning because everybody expected this hearing was about the Web site. That's all we've been hearing about is the Web site.

But that's not the only complaint we've been hearing about since the Affordable Care Act was adopted. We were told by our Republican friends that millions of jobs would be lost, and, in fact, there have been a gain of 7 million jobs. They said that the costs for health care would skyrocket, and, in fact, the opposite is true. They said there would be a massive shift to part-time jobs, and the evidence doesn't support that. They said tens of millions will lose their insurance, but, in fact, everybody in this country is going to have access to health insurance because they won't be discriminated against. They said that it would explode the deficit, and yet all the reputable organizations, like the Congressional Budget Office, have told us that it's going to save us $100 billion over 10 years.

So we've had a litany of objections from the Republicans about the Affordable Care Act, which has driven them to such a frenzy, they even closed the government.

So now we have you before the committee. And you're being asked—I suppose later you'll be asked about the Web site. But let me pursue this question about individuals who have gotten notices that they're going to have their individual insurance policies canceled. They'll be able to get another plan, won't they?

Secretary SEBELIUS. Actually, it's the law that they must get another plan. Continuous coverage is part of the law.

Mr. WAXMAN. So——

Secretary SEBELIUS. And that wasn't the case in the past.

Mr. WAXMAN. So the Affordable Care Act, we're going to end the worst abuses of insurance companies, we're going to create consumer protections in the marketplace that they will be able to buy a policy even if they've been sick in the past, that women won't be

charged more than men, that we're not going to let insurance companies deny coverage because of preexisting conditions, and we're not going to let them put these lifetime caps. And there will be an essential benefit package, so you're not just buying some things and not having other things covered, you're going to have the minimum that everybody should have: prescription drugs, mental health coverage, doctors and hospitals.

Are these important consumer protections?

Secretary SEBELIUS. Well, I would say, Mr. Waxman, they're very important. As a former insurance commissioner, I can tell you that the individual market in Kansas and anywhere in the country has never had consumer protections. People are on their own. They could be locked out, priced out, dumped out, and that happened each and every day. So this will finally provide the kind of protections that we all enjoy in our healthcare plans. As part of a group, as part of a plan that has prenegotiated benefits, we enjoy that kind of health security. And individuals buying insurance on their own, farm families, entrepreneurs mom-and-pop shops, young adults have never had that kind of health security.

Mr. WAXMAN. Well, now they're going to have this health security. And most of the plans, as I understand it, that they're no longer going to be able to keep don't meet all the standards of the law.

Secretary SEBELIUS. Well, again, I think you may have heard Pat Geraghty from Florida Blues, who was on some of the Sunday shows, and he talks about the fact that the Florida plans want to keep their customers. They have new plans to offer. They feel that a lot of people, and these are Mr. Geraghty's words, will have a much better plan at a similar or lower cost; 50 percent of these 11 to 12 million people qualify for a subsidy, qualify for some financial help purchasing insurance for the first time ever.

Mr. WAXMAN. The bottom line is that people with good coverage, like Medicare, Medicaid, employer coverage, can keep that. People with grandfathered plans in the individual market will be able to keep it. But if insurance companies sold you a new, modified health insurance policy after the date of the enactment that does not meet the law's standards, then those people will be able to go into the exchange and buy a real solid health insurance plan that won't discriminate against them or anybody else. I think that's a good result, I'm pleased with it, and I think most people will be as well.

Mr. UPTON. Gentleman's time has expired.

The chair would recognize the vice chair of the committee Ms. Blackburn.

Mrs. BLACKBURN. Thank you, Mr. Chairman.

Madam Secretary, before, during, and after the law was passed, the President kept saying, "If you like your healthcare plan, you can keep it." So is he keeping his promise?

Secretary SEBELIUS. Yes, he is.

Mrs. BLACKBURN. OK. What do you say to the 300,000 people in Florida you just mentioned or to the 28,000 in Tennessee that cannot get health insurance, their plans are terminated? Is he keeping his promise to them?

Secretary SEBELIUS. Well, first of all, Congresswoman, they can get health insurance. They must be offered new plans, new options,

either inside the marketplace, or if they don't qualify for a financial subsidy, they can shop in or out of the marketplace.

Mrs. BLACKBURN. What do you say to——

Secretary SEBELIUS. They absolutely will have new coverage.

Mrs. BLACKBURN. What do you say to NBC News, who says millions are going to lose their coverage?

Secretary SEBELIUS. In all deference to the press corps, many of whom are here today, I think that it's important to be accurate about what is going on, and I would defer again to the president of the Blues plan. People will have ongoing coverage, they will be offered new plans——

Mrs. BLACKBURN. Madam Secretary, let me tell you something——

Secretary SEBELIUS [continuing]. In the market right now will qualify——

Mrs. BLACKBURN. What do you say to Mark and Lucinda in my district who had a plan, they liked it, it was affordable, but it is being terminated, and now they do not have health insurance?

Secretary SEBELIUS. Insurance companies cancel individual policies year in and year out. They are a 1-year contract with individuals. They are not lifetime plans. They are not an employer plan. Your constituents will have lots have options in the market.

Ms. BLACKBURN. It's what they wanted and I will remind you, some people like to drive a Ford, not a Ferrari, and some people like to drink out of a red Solo cup, not a crystal stem. You're taking away their choice.

Let's put the screen shot up.

I want to go to the cost of the Web site and talk about the Web site. This is what is happening right now with this Web site. We've had somebody in the back trying to sign on. It is down. It is not working.

Last week I asked for the cost from each of the contractors that were with us last week. So can you give me a ballpark of what you have spent on this Web site that does not work that individuals cannot get to? What is your cost estimate?

Secretary SEBELIUS. So far, Congresswoman, we have spent about $118 million on the Web site itself, and about $56 million has been expended on other IT to support the Web.

Ms. BLACKBURN. OK. Would you submit a detailed accounting of exactly what has been spent? And when do you expect constituents to stop getting these kind of error messages?

Secretary SEBELIUS. Again, I talked to the president of Verizon over the weekend on two occasions. Verizon hosts the cloud, which is not part of the Web site; it is a host for a number of Web sites.

Mrs. BLACKBURN. Right.

Secretary SEBELIUS. The Verizon system was taken down Saturday night into Sunday. It was down almost all day Sunday. They had an additional problem that they notified us about yesterday, and it continues on. So I'd be happy to talk to the president of Verizon and get him to give you information about the Web site.

Ms. BLACKBURN. Let me come back to that, because I want to get to this issue of exactly who was in charge of this project, because you're now blaming it on the contractors and saying it's Verizon's fault.

So let me ask you this: Did you ever look at outsourcing the role of the system integrator? And obviously you did not, from the contractors that we had last week. You all—they had several different people, whether it was you, or Gary Cohen, or Michelle Snyder, or Henry Chao, that they thought were in charge. So who is responsible for overseeing this project? Is it you or your designee?

Secretary SEBELIUS. Let me be clear, I'm not pointing fingers at Verizon, I'm trying to explain the way the site operates. We own the sites. The site has had serious problems. I know that——

Ms. BLACKBURN. Who is in charge, Madam Secretary?

Secretary SEBELIUS. The person now in charge as an integrator is QSSI, one of our——

Ms. BLACKBURN. Who was in charge as it was being built——

Secretary SEBELIUS. The CMS team was in charge up until——

Ms. BLACKBURN. At that team, who is the individual——

Secretary SEBELIUS. Michelle Snyder is the——

Mrs. BLACKBURN. Michelle Snyder is the one responsible for this debacle.

Secretary SEBELIUS. Well, excuse me, Congresswoman, Michelle Snyder is not responsible for the debacle. Hold me accountable for the debacle. I'm responsible.

Mrs. BLACKBURN. OK. Thank you. I yield back.

Mr. UPTON. The chair recognizes Mr. Dingell from the great State of Michigan.

Mr. DINGELL. Thank you for your courtesy. I have a few questions I'll be asking on behalf of the Congresswoman Shea-Porter, but I'll do that by writing. I ask unanimous consent that I be prepared to revise and extend my remarks.

Mr. UPTON. Without objection.

Mr. DINGELL. Mr. Chairman, I would like to begin by thanking you, welcoming the Secretary to a room in which her distinguished father, former Governor of Ohio, served for so many years.

I begin my questions by quoting from an expert for whom I have enormous respect. He said as follows: "As I mentioned earlier, the new benefits and its implementation are hardly perfect. Rather than trying to secure and to scare and confuse seniors, I would hope that we could work together as we go through the implementation phase to find out what is wrong with the program and if we can make some changes to fix it. Let us do it, and let us do it in a bipartisan fashion. It is too big a program and is too important to too many people to do that. But having said that, it does appear that it is working. Let us admit it, you know, and not keep beating a dead horse." My beloved friend Mr. Barton, who I think gave us the beginning of our efforts today.

Madam Secretary, I've seen reports of consumers receiving plan cancellation notices from their insurance companies saying that plans are no longer available. Does the ACA require insurance companies to discontinue the plans that people had when the law was passed, yes or no?

Secretary SEBELIUS. Not when the law was passed if the plans have not changed. No, sir. That's the grandfather clause.

Mr. DINGELL. Now, that's because the plans that existed prior to the passage of the law are grandfathered in, as you have said.

Secretary SEBELIUS. That's correct.

Mr. DINGELL. So if an insurance company is no longer offering a certain plan, that's because that insurance company made a decision to change their policies, and that caused them to take away the grandfathered status from the insurance purchaser; is that right?

Secretary SEBELIUS. That is correct.

Mr. DINGELL. Now, Madam Secretary, I want you to submit for the record a statement of what it is we can do about insurance companies that run around canceling the policies of their people. And I don't have time to get the answer, but I want to get a very clear statement from you as to what you can do so we can take some skin off some folks that have it coming.

Secretary SEBELIUS. Again——

Mr. DINGELL. Madam Secretary, it's my understanding that these decisions of a business character are most common in the individual insurance market, and that much turnover already exists and existed prior to the enactment of the legislation.

Secretary SEBELIUS. That's correct.

Mr. DINGELL. Is that correct?

Secretary SEBELIUS. Yes, sir.

Mr. DINGELL. Is it correct that 35 to 67 percent of the enrollees in the individual market leave their plan after 1 year for different reasons?

Secretary SEBELIUS. A third are in about less than 6 months in the individual market, and over 50 percent are in for less than a year, yes, sir.

Mr. DINGELL. Now, in the cancellation letters which move around from the insurance companies, some insurance companies are suggesting an alternative plan at a higher price. Do they have the right to do that?

Secretary SEBELIUS. Well, they have a right to do that, sir, but consumers have a right to shop anywhere to compare plans, and they have choices now that they've never had before and some financial assistance coming their way for about 50 percent of those people.

Mr. DINGELL. And they have no right to enforce that——

Secretary SEBELIUS. Oh, absolutely not.

Mr. DINGELL [continuing]. Demand on the insurance——

Secretary SEBELIUS. No one is rolled over into a plan. And, in fact, individuals for the first time ever will have the ability to compare plans, to shop, and to make a choice inside or outside the marketplace.

Mr. DINGELL. Looks to me like the insurance companies are trying to inflict on their customers the view that this is their right, and that this is the only option available to them; is that correct?

Secretary SEBELIUS. Well, I think that insurance companies would like to keep their customers. Having said that, customers for the first time have a lot of choices because they can't be locked out of the——

Mr. DINGELL. Companies have no right to enforce that view on the customer.

Secretary SEBELIUS. There is no rule that says you have to stay with your company or you have to be rolled over.

Mr. DINGELL. And you don't have to believe them——

Mr. UPTON. Gentleman's time has expired.

Mr. DINGELL [continuing]. When they come forward and tell you that you've got to buy a particular policy; is that right?

Secretary SEBELIUS. Absolutely.

Mr. UPTON. Gentleman's time has expired.

The chair would recognize the gentlemen from Texas Mr. Barton.

Mr. BARTON. Thank you, Mr. Chairman. Before I ask my questions, we have a former member of the committee on the Democrat side from the great State of Kansas in the audience, Mr. Slattery. And we're glad to have you.

And, Madam Secretary, we're glad to have you, too.

Secretary SEBELIUS. Thank you, sir.

Mr. BARTON. There is a famous movie called The Wizard of Oz, and in The Wizard of Oz, there was a great line. Dorothy, at some point in the movie, turns to her little dog Toto and says, "Toto, we're not in Kansas anymore." Well, Madam Secretary, while you're from Kansas, we're not in Kansas anymore. Some might say that we are actually in The Wizard of Oz land, given the parallel universes we appear to be habitating. Mr. Waxman and most of those on the Democrat side think things are great. You, apparently, although you did apologize, and you have said it's a debacle, you also seem to think that the Affordable Care Act is great. Well, myself and others have a different view. Ultimately the American people will decide.

Now, last week, when the contractors were here, I focused my attention on the apparent lack of privacy in the Web site.

If we'll put up the first slide that I had last week, if we can.

This is what's public, Madam Secretary, and it's basically a disclaimer that says that any unauthorized attempt to upload information or change information on the Web site is prohibited. It really doesn't say anything about privacy. But you do have to accept that in order to go forward with the application.

The next slide shows what's not public. This is in the source code. We tried to determine this morning if it was still in the source code, but it's been pointed out the Web site is down.

This is much more, what I would say, frightening to me. It says you have no reasonable expectation of privacy regarding any communication or data transiting or stored on the information system. At any time and for any lawful government purpose, the government may monitor, intercept, search and seize any communication or data transiting or stored on the information system. Any communication or data transiting or stored on this information system may be disclosed or used for any lawful government purpose.

Cheryl Campbell of CGI Federal said she was aware of it, but said that it wasn't her responsibility to put that in the source code. Were you aware of it, and was it your responsibility to put this in the source code?

Secretary SEBELIUS. Mr. Barton, I did not put things in the source code. I can tell you it's my understanding that that is boilerplate language that should not have been in this particular contract because there are the highest security standards are in place, and people have every right to expect privacy.

Mr. BARTON. All right. Now, the last time we could check, this was still there. You're given almost unlimited authority under the

Affordable Care Act to administer it. Will you commit to the committee and to the American people that, one, you do want to protect their privacy; and, two, you will take this out, fix it, make sure that it doesn't have bearing on people that try to apply through the Web site?

Secretary SEBELIUS. Yes, sir. And we have had those discussions with CGI, and it is under way. I do absolutely commit to protecting the privacy of the American public, and we have asked them to remove that statement. It is there in error, it needs to be taken down, and we should be held accountable for protecting privacy.

Mr. BARTON. Well, thank you, Madam Secretary. I sincerely appreciate that, and I'm sure the American people do, too.

My last question, or it's really a comment. I've introduced H.R. 3348, which says let's make this system voluntary for the first year, since we're having so many problems, and let the American people decide. What that means is if people choose not to participate, they would not be charged the penalty for nonparticipation.

Would you support such a reasonable approach to this while we work out the problems in the system?

Secretary SEBELIUS. No, sir.

Mr. BARTON. OK. Well, that's an honest answer.

Mr. UPTON. Gentleman's time has expired.

Mr. BARTON. Thank you, Madam Secretary.

Mr. UPTON. Chair would recognize the gentleman from New Jersey Mr. Pallone.

Mr. PALLONE. Thank you, Mr. Chairman.

I know we're not in Kansas, but I do believe increasingly we're in Oz because of what I see here. So this "Wizard of Oz" comment by my colleague from Texas, I think, is particularly apropos given what we hear on the other side of the aisle.

I don't know how you keep your cool, Madam Secretary, you know, with this continuous effort on the part of the GOP to sabotage the ACA, to scare people, and bring up red herrings. And I think that this privacy issue is another red herring, and I'm going to ask you a question about that.

But before that I just wanted to say, this whole idea that's being brought up today that somehow, you know, policies are being canceled, and people don't have alternatives, it's just another red herring. You know, what I think my colleagues on the other side forget is that this is not socialized medicine; this is, in fact, private insurance in a competitive market. And if I'm an insurance company, and all of a sudden everyone else is selling a better policy with better benefits at a lower price, I can't continue to sell a lousy skeletal policy that doesn't provide benefits and costs more because I'll be out of the market.

And so that's what's happening here. Insurance companies are canceling lousy policies with high prices because they can't compete, and that's what's going to happen when you have a private insurance market, which is what we have here. We don't have a government-controlled system; we have private markets. So I just wanted to make that point.

But I have to drill down on what Mr. Barton said here. You know, before reform, the individual insurance market was dysfunctional, premiums would shoot up if people got sick, their coverage

could be canceled if they had a preexisting condition, and they did not have secure quality coverage. Now, I've heard my Republican colleagues say that patient health information will be at risk in this application process, and this is flat out false. In fact, the ACA makes a giant leap forward for protecting health information by taking it completely out of the insurance application process, by banning discrimination based on preexisting conditions.

Mr. Barton, again, is raising this red herring, just like the cancellation of insurance, by talking about privacy. But, Madam Secretary, prior to the ACA, when people applied for insurance coverage, did insurers make them provide a long, detailed, and basic medical history, but now, because the law bans discrimination based on preexisting conditions, individuals will not have to have provide this information in their applications? So regardless of this clause, please comment on the privacy issue and why it's irrelevant.

Secretary SEBELIUS. Well, Mr. Pallone, in the past any individual American who was in an employer-based coverage, in government coverage like the ones we enjoy, in Medicare, in Medicaid, in the VA, a whole variety of plans, that's about 95 percent of insured Americans, had no medical underwriting, had group protections, had consumer protections. The people who were outside that consumer-protected space were individuals buying they own coverage in an individual market. Medical underwriting, demanding health records, and often going through extensive doctor interviews and getting health records was a standard for that market. Pricing could vary widely depending on gender, depending on health condition. People could be denied coverage, and were frequently.

That's the market that is currently being reformed with consumer protections. If a person had a policy in place in March of 2010, liked that policy, and the insurance company made no changes to disadvantage the consumer, those policies are in place, you keep your plan, you like it, and that goes on.

For the people who, though, had a medically underwritten policy, were paying more than their neighbor because they happened to be female, could not get their health condition for a fixed hip written into their insurance plan, they will have a new day in a very competitive market. Twenty-five percent of the insurers are brand new to the market, and they are offering competitive plans.

Mr. PALLONE. Mr. Chairman, could I just ask that this document——

Mr. UPTON. Sure. Put it in the record. Without objection.

Mr. PALLONE. Thank you.

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

Mr. UPTON. The chair would recognize Mr. Hall.

Mr. HALL. Thank you, Mr. Chairman.

Madam Secretary, I think Congresswoman Blackburn asked you about the Federal Government, how much they spent today, and they are spending some money as we speak, aren't they? It's down right now, isn't it? You projected ongoing problems.

Secretary SEBELIUS. I'm sorry, sir. I'm having a hard time hearing. What was the——

Mr. HALL. She asked you how much it had spent today, and I'm asking what you expect to pay in addition to that on repairs that

the Web site's going to require, and they're requiring them as we speak here. So those are things you projected, you knew they would happen, and they will happen. But you surely looked ahead, and you have some estimate of what is going to happen.

Secretary SEBELIUS. Yes, sir.

Mr. HALL. And going to cost.

Secretary SEBELIUS. For our two major contractors, who are QSSI, a subsidiary of United, and for CGI, there are obligated amounts. For CGI, who is in charge of the entire application, there has been $197 million obligated, and that is to last through March of 2014. And as I said before, about $104 million has been expended in that obligated amount.

Mr. HALL. I'm going try to be here in 2014 to be sure that your testimony is correct, OK?

I'm just joking with you.

Secretary SEBELIUS. OK.

Mr. HALL. Were you born in Kansas? Meade, Kansas?

Secretary SEBELIUS. I was not. I was born in Cincinnati, Ohio. I married a Kansan and went to Kansas.

Mr. HALL. All right. I was in third grade there, and I thought I saw you on a tricycle there one day.

Secretary SEBELIUS. Well, it was an illusion.

Mr. HALL. Let me ask you a question. Have you ever rejected a financial bill from one of the contractors? Have you ever?

Secretary SEBELIUS. Have I ever——

Mr. HALL. Rejected a financial bill from one of them.

Secretary SEBELIUS. Sir, again, our——

Mr. HALL. Well, I guess you can say yes or no.

Secretary SEBELIUS. Our accounting office does a routine audit and review of every bill that comes in before they do it. I do not personally. I want to be very accurate about I don't personally pay contracts, negotiate contracts. By law and by precedent, that's really illegal for someone who isn't a warranted contract officer to engage in the debate or discussion around Federal contracts.

Mr. HALL. How much has the administration spent on the exchanges in total; not just HealthCare.gov, but all of the exchanges?

Secretary SEBELIUS. I'm sure——

Mr. HALL. How difficult is that figure to give me or if you can't give——

Secretary SEBELIUS. I would like to get it to you in writing very quickly.

Mr. HALL. Madam Secretary, I don't know how much time I've got left, but I'd like to talk about a couple of businesses in my district who are struggling with how to move forward. One is a manufacturer, and one is in the pet boarding and training business. One has 85 employees, and the other has 56. Here's some quotes from some of their recent letters.

"The situation we're in is we would have to pay $170,000 in penalties under Obamacare. This is another example of the government picking winners and losers. We are the losers. There's no way I can be competitive if I have to raise my prices to cover $170,000. Here are my options: Do not pay the penalty, raise my prices, and go out of business, 85 people lose their jobs; layoff 35 employees

who don't have to pay the penalty, and move more production to this country. Reduce 35 jobs."

And here's a quote from the other: "Since our high-labor, low-margin business cannot afford to pay for insurance for our employees, we're faced with either closing our business, perhaps through bankruptcy, so there are heavy financial obligations that would continue whether we operate or not; fire enough employees to get under 50 employees limits and close some of our business. Even if we close the location, we cannot escape many expenses such as rental agreements."

What am I supposed to tell these people?

Secretary SEBELIUS. Well, sir, I think that in the employer market, about 95 percent of all American businesses are exempt from any kind of requirement to cover employer-employee insurance, and they are outside the law. They continue to be outside the law. But they will have some new options for those who want to cover their employees, and some new tax credit possibilities.

For large employers, about 96 percent of them already cover their employees. And, as you know, the penalty that your constituents refer to is not a penalty that is imposed in 2014. It is being discussed with businesses about what kind of information is exchanged, and it will take place in 2015.

Mr. HALL. I thank the——

Mr. UPTON. Gentleman's time has expired.

Mr. HALL. He's going to use the gavel on me if you don't hush.

Mr. UPTON. Gentleman's time has expired.

Mr. HALL. I yield back my time.

Mr. UPTON. The chair would recognize the gentlelady from California Ms. Eshoo.

Ms. ESHOO. Thank you, Mr. Chairman.

Welcome, Madam Secretary. You're a distinguished woman. You have distinguished yourself and your State, the offices that you've held, and now working for the American people, and I salute you for it.

I want to really congratulate my Republican pals for being absolutely 1,000 percent consistent. You love what's wrong with the Web site, and you detest what's working in the Affordable Care Act. And I think that that is on full display here.

But let's get back to the Web site, because that's what the hearing is about. It's my understanding that November 31st is a hard date for having everything up and running. Do you have—now, HHS did testify in September that they were 100 percent confident that the site would be launched and fully functional on time on October 1st. That didn't work. Do you have full confidence in this new hard date?

Secretary SEBELIUS. Congresswoman, I can tell you that the assessment that we have made is that it will take until the end of November for an optimally functioning Web site. I know that the only way I can restore confidence that we get it right is to get it right. So I—I have confidence, but I know that it isn't fair to ask the American people to take our word for it. I've got to fix this problem, and we are under way doing just that.

Ms. ESHOO. But are you confident that—I think I said November 31st, which is——

Secretary SEBELIUS. I thought it was a trick question.

Ms. ESHOO [continuing]. Does not exist. But November 30th. You have confidence in November 30th?

Secretary SEBELIUS. I do.

Ms. ESHOO. Is there any penalty to QSSI or CGI for not delivering on what they promised?

Secretary SEBELIUS. Well, I think the—as you can see, we have a—obligated funds for a contract. We certainly have not expended all these funds. And we expect not only the CMS team, but our contractor partners to fulfill their obligations and——

Ms. ESHOO. But if they fail to fulfill their obligations—I don't know what's in the contract—is there a penalty?

Secretary SEBELIUS. There isn't a built-in penalty, but I can tell you that paying for work that isn't complete is not something that we will do.

QSSI, as you know, has taken on a new role as integrator. The hub that they built and have in operation is working extremely well not only for the Federal exchanges, but all the State-based markets are using the hub. And that's why we had confidence in their ability to actually take this next role on and coordinate the activities moving forward, which have to be driven with a very clear set of outcomes, very accountable timelines and deadlines, and they will be helping to manage that process.

Ms. ESHOO. On the issue of security, there was a security breach that arose recently, that I read about at any rate. And what I think is very important here, because the issue of privacy has been raised, and I think that that has been answered, because, very importantly, there isn't any health information in these systems, but there is financial information.

So my question to you is has a security wall been built, and are you confident that it is there, and that it will actually secure the financial information that applicants have to disclose?

Secretary SEBELIUS. Yes, ma'am. I would tell you that there was not a breach. There was a blog by a sort of skilled hacker that if a certain series of incidents occurred, you could possibly get in and obtain somebody's personally identifiable——

Ms. ESHOO. But isn't that telling? Isn't that telling?

Secretary SEBELIUS. And we immediately corrected that problem. So there wasn't—it was a theoretical problem that was immediately fixed.

I would tell you we are storing the minimum amount of data because we think that's very important. The hub is not a data collector. It is actually using data centers at the IRS, at Homeland Security, at Social Security to verify information, but it stores none of that data. So we——

Ms. ESHOO. Thank you.

Secretary SEBELIUS. So we don't want to be——

Mr. UPTON. The gentlelady's time has expired.

The chair recognizes Mr. Shimkus.

Mr. SHIMKUS. Thank you, Mr. Chairman.

Welcome, Madam Secretary.

Madam Secretary, before I start my questions, the Washington Post gave the administration and the President, yourself, four Pinocchios on this whole debate of if you like the insurance you

have, you can keep it. Would you recommend to the president that he stop using that term? Wouldn't that be helpful in this debate?

Secretary SEBELIUS. Well, sir, I think he used the term at the time that the law was passed, and he continued to say——

Mr. SHIMKUS. And as of September 26th also, so——

Secretary SEBELIUS. That is why we wrote the grandfather——

Mr. SHIMKUS. So the answer is you don't buy—you don't believe that The Washington Post, and therefore——

Secretary SEBELIUS. Well, I haven't read The Washington Post.

Mr. SHIMKUS. Well, we'll hand this down to you——

Secretary SEBELIUS. Thank you.

Mr. SHIMKUS [continuing]. So you can see it. Have you ever shopped, I know you have, but this is at a grocery store with a coupon?

Secretary SEBELIUS. Yes.

Mr. SHIMKUS. Have you ever used a coupon?

Secretary SEBELIUS. Yes.

Mr. SHIMKUS. So the coupon gives you the terms and conditions of when you go to the checkout to get whatever is off the price of the goods. When you all added the "See Plans Now" option, you, in essence, gave the searcher, in essence, a coupon based upon what they're seeing there. The desire was, let people know what the price is; however, as the news reported, and I followed up in last week's hearing, was that if you are under 50 years old, you get quoted the price of someone who is 27. If you are older than 50, could be 64, you get quoted a price of someone who is 50 years old. Isn't that misleading?

Secretary SEBELIUS. Well, sir, the learn side of the Web site, which has been up since actually late 20——

Mr. SHIMKUS. So that is truthful, then? If you quote a price——

Secretary SEBELIUS. It is clearly a hypothetical situation that allows people to——

Mr. SHIMKUS. OK. On the "See Plans Now" option, are you saying this is a hypothetical? That is not what it says on the site. It says this is the price when you put in your age. And if your age is 49, it quotes you as if you are 27.

Secretary SEBELIUS. Sir, the only way someone can get an accurate information about their price is to get their individual——

Mr. SHIMKUS. Let me ask you another——

Secretary SEBELIUS [continuing]. Eligibility determined.

Mr. SHIMKUS. When did you decide to use this below 50 at 27 and above 50 at 50 years old? When did you make that decision?

Secretary SEBELIUS. That was decided by the team as we put up——

Mr. SHIMKUS. By who? Who made the——

Secretary SEBELIUS. I will get you that information.

Mr. SHIMKUS. The problem with the whole debate is you all won't tell us who made the decision.

Secretary SEBELIUS. I can tell you I did not design the site.

Mr. SHIMKUS. So who?

Secretary SEBELIUS. I will get the——

Mr. SHIMKUS. Well, who made the decision on the 27-year-old quote for someone who is 50?

Secretary SEBELIUS. I just said I will get you that information, sir.

Mr. SHIMKUS. Thank you. Let me go to—because it is misleading, and the White House insists it didn't mislead the public, and of course, we find out that you did. Let me finish on this debate. It is another transparency issue. If someone, a constituent of mine or someone in this country, has strongly held pro life views——

VOICE. Oh, here we go.

Mr. SHIMKUS [continuing]. Can you commit to us to make sure that the Federal exchanges that offer that is clearly identified and so people can understand if they are going to buy a policy that has abortion coverage or not? Because right now, you cannot make that determination.

Secretary SEBELIUS. Sir, I—I don't know. I know exactly the issue you're talking about. I will check and make sure——

Mr. SHIMKUS. Here's——

Secretary SEBELIUS [continuing]. That——

Mr. SHIMKUS. OK. Thank you.

Secretary SEBELIUS [continuing]. Is clearly identifiable.

Mr. SHIMKUS. Well, here's——

Secretary SEBELIUS. You're saying——

Mr. SHIMKUS. Here's our request. Can you provide for the committee the list of insurers in the Federal exchange who do not offer as part of their package abortion coverage?

Secretary SEBELIUS. I think we can do that, sir.

Mr. SHIMKUS. Well, you should be able to do it.

Secretary SEBELIUS. I——

Mr. SHIMKUS. So——

Secretary SEBELIUS. I just said——

Mr. SHIMKUS. No. You said if we can do it.

Secretary SEBELIUS. No. I think we can do that, is what I said.

Mr. SHIMKUS. I think or I know we can do it?

Secretary SEBELIUS. Sir, I can't tell you what I don't know firmly right now. I know that is the plan. I will get that information to you. I——

Mr. UPTON. Gentleman's time has expired.

The chair recognizes Mr. Engel from New York.

Mr. ENGEL. Well, thank you, Mr. Chairman.

Madam Secretary, I appreciate your coming today to answer questions about the Affordable Healthcare Act.

You know, my Republican colleagues' actions here remind me a story I read when I was a little boy, and that is the story of Chicken Little, who ran around yelling, "The sky is falling. The sky is falling," but unlike Chicken Little, my Republican colleagues are actually rooting for the sky to fall.

Republicans are holding this hearing today under the auspices of an investigative hearing, as if they want to get to the bottom of what went wrong with the Web site in order to help fix it.

But I don't think, Madam Secretary, there's one person in this room who is naive enough to actually think that the Republicans want to see this law work. They voted over 40 times to repeal the law. They shut down the government and threatened to force a default in order to stop it. They're rooting for failure.

Madam Secretary, can you tell us what would be the impact on Americans' health insurance if Republicans had been successful in their efforts to defund or repeal the Affordable Care Act?

Secretary SEBELIUS. Well, I think that the estimates of the Congressional Budget Office is that would have increased the deficit by about $110 billion in the first decade and close to a trillion dollars in the second decade. We know that we have 42 or 43 million Americans without health insurance at all, some of them Medicaid eligible and some in the—over the Medicaid eligibility. Thirty governors so far, Republicans and Democrats, have declared their support for moving ahead with Medicaid expansion, but absent that, the Affordable Care Act, those folks would be without any kind of health security.

And in the private market, what we know is it takes a real toll, but I'd say the biggest issue is not just the financial toll, not the community toll, not the country toll, which is significant. I have a good friend who runs the cancer center at the University of Kansas. I was with him and cancer researchers recently, and he said that if you get a cancer diagnosis, you are 60 percent more likely to live 5 years and beyond if you have insurance than if you don't. I think that's a pretty powerful statement for why we need affordable healthcare for all of our citizens.

Mr. ENGEL. Well, thank you. The Republicans have not been able to defund or repeal it, but they have denied requested funding. They've raised specious arguments about death panels and socialized medicine. And they've worked to intimidate groups that could help the implementation effort. There has been the spreading of misinformation about the cost of coverage, we hear some of that today, and to actively dissuade the uninsured from seeking coverage.

So, Madam Secretary, how have these tactics impacted your ability to implement the Affordable Care Act?

Secretary SEBELIUS. Well, I don't think there's any question that a lot of people need a lot of information. I think it's one of the reasons we had millions visit the site, try to visit the site. It's why I am so frustrated and disappointed that the site is not fully functional and why I'm so committed to getting it functional, because clearly there is a demand. We need to get information to people about the law. This is the law. This is not any longer a debate. It was a law passed by both Houses of Congress, signed by the President of the United States, upheld by the Supreme Court. The president was reelected. It is the law, and people have benefits and rights under that law, and we've got to get that information so they can make good choices for themselves and their families.

Mr. ENGEL. Well, thank you. It is the law, and frankly, I find it disconcerting that my Republican colleagues have done nothing but root for this law to fail for the last 3 and a half years, and now there's a big show here of being upset at problems with the Web site, of keeping people from signing up for coverage fast enough.

So I would just say to my colleagues on the other side of the aisle, you're really on the wrong side of history here. The Web site will be fixed and millions of Americans will be able to get quality affordable health insurance coverage through the Affordable Care Act.

And, again, I thank you for being here today, Madam.

Mr. UPTON. Mr. Pitts, chairman of the Health Committee.

Mr. PITTS. Thank you, Mr. Chairman. Welcome, Madam Secretary.

Secretary SEBELIUS. Mr. Pitts.

Mr. PITTS. Have you personally tried to register or enroll on the Web site?

Secretary SEBELIUS. Sir, I created an early lite account so I would see the prompts that were coming to people who were interested. I did work my way to the application feature fairly early on, but frankly, I have affordable healthcare, so I didn't try the eligibility.

Mr. PITTS. No. I just wondered if you'd been through the process that millions of Americans are having to go through.

Madam Secretary, the initial Web site crashes appear to be largely a result of the decision to prevent browsing of the plans. CGI Federal testified at our hearing last week that they had designed the Web site to allow users to browse and compare plans before having to create an account. Ms. Campbell told us that 2 weeks prior to the October 1st launch, they were told to turn off the browsing feature. Were you aware in September that this decision was made?

Secretary SEBELIUS. Sir, I wasn't aware of that particular decision. That was made by the CMS team. I was aware that we were paring back some features to not put additional risk on the Web site. It seems——

Mr. PITTS. And who made that decision?

Secretary SEBELIUS [continuing]. Ironic at this point.

Mr. PITTS. Who made that decision?

Secretary SEBELIUS. Administrator Tavenner made that decision.

Mr. PITTS. And do you know why that was made?

Secretary SEBELIUS. Yes, sir. Because we were anxious to get the Web site up and running and functional, which we clearly have failed to do to date, although I would suggest the Web site has never crashed. It is functional but at a very slow speed and very low reliability and has continued to function.

Having said that, they pared down some of the features, feeling that it would be better to load them in later. One was the shop-and-browse feature, another was the Spanish version of the Web site, and the Medicaid transfers. All three of those issues——

Mr. PITTS. All right.

Secretary SEBELIUS [continuing]. Were pared down in September——

Mr. PITTS. Thank you.

Secretary SEBELIUS [continuing]. To not load the system.

Mr. PITTS. Thank you.

Last week, CGI Federal and QSSI testified that CMS was responsible for end-to-end testing and that they believed that months of testing would have been preferable to 2 weeks. Do you believe that 2 weeks was enough time to complete testing of the entire system?

Secretary SEBELIUS. Clearly not.

Mr. PITTS. And when were you made aware of the result of the test, including the one where the system collapsed with only a few hundred users?

Secretary SEBELIUS. Sir, leading up to the October 1st date, we had regular meetings with not only a team at CMS but administrators involved. I was made aware that we were testing, and as we found problems, we were fixing those problems. And I think there is a CGI report at mid-August identifying some problems. And between August and October, that became the punch list for CGI to fix those problems. That's why you test.

Mr. PITTS. Now, in the Washington Post, on October 21st, there was an article that said about a month before the exchange opened, a testing group of 10 insurers urged agency officials not to launch the site, because it was riddled with problems. Were you aware in September that insurers recommended a delay in the launch of the exchange?

Secretary SEBELIUS. I was not aware that they recommended delay. I know everyone was concerned that there were risks and there were likely to be problems with a brand new integrated insurance system. I don't think anyone ever estimated the degree to which we've had problems in the system, and certainly the contracting partners did not.

Mr. PITTS. And did HHS respond to the insurers' recommendation to delay the launch?

Secretary SEBELIUS. Sir, I wasn't in the meeting. I don't know what occurred in the meeting——

Mr. PITTS. Can you find out——

Secretary SEBELIUS [continuing]. And I don't know who they talked to.

Mr. PITTS [continuing]. And answer that question for us?

Secretary SEBELIUS. Sure. I will get back to you.

Mr. PITTS. Thank you.

Thank you, Mr. Chairman.

Mr. UPTON. Mr. Green.

Mr. GREEN. Thank you, Mr. Chairman.

Madam Secretary, thank you for taking time to be here today. I represent parts of eastern north Houston, Harris County, and our district has one of the highest uninsured rates in the country. Even worse, we have one of the highest rates of people who have jobs but don't receive their insurance through their employer. It's for this reason that I believe Houston would be a good place for you to come and spread the word about the tremendous benefits of the Affordable Care Act, however, we learned your offices—you're unable to attend because of scheduling conflicts. And hopefully we can have an agreement that sometime in the future you will come to the fourth largest city that probably has the highest number of uninsured in a metropolitan area. And, of course, we're in the State of the Texas, that has the highest uninsured in the country.

It's important to me and our constituents to get it right, and that's why I share your and the President's disappointment the Web site is not working as planned. November 30th is not soon enough. Many of my constituents have been waiting for years to be able to purchase health insurance, and we owe it to them to get

the marketplaces up and running. The contractors have not served our country well and should fix it or not be paid.

Now we're hearing about the cancellation letters being sent by insurance companies to their customers notifying them that their plans are no longer offered.

Are these Americans losing their healthcare coverage because of the Affordable Care Act, or is it because these plans were changed after the enactment of the act?

Secretary SEBELIUS. I would say it's the latter, sir. If a plan was in place since the enactment of the act, no one would have received a cancellation letter.

Mr. GREEN. So if somebody in America had an insurance plan before the act and the President was correct, if you like what you have, you could keep it.

Secretary SEBELIUS. Yes, sir.

Mr. GREEN. The plans were changed, and so now they have to comply with the new law.

Secretary SEBELIUS. They could either choose to be grandfathered and keep the same plan, which meant the same benefits. And actually the regulation allows insurance companies to charge medical inflation, plus the trend line, so they didn't have to charge the same price; they could increase it. They could increase copays, they could increase coinsurance. What they couldn't do is cancel benefits that the policyholder relied on, they couldn't disadvantage the policyholder. But if that plan is in effect, absolutely, it is still in effect.

Mr. GREEN. OK. But some of these millions of letters we're hearing about are probably because their plans changed after——

Secretary SEBELIUS. Well, absolutely. And, again, in the individual market, plans change every year.

Mr. GREEN. Yes.

Secretary SEBELIUS. Insurers design new products.

Mr. GREEN. Even in the small business market, that happens.

These plans are not allowed now because they're completely inadequate; they don't offer the minimum essential benefits. Is that correct.

Secretary SEBELIUS. That is correct.

Mr. GREEN. OK. And having been a State legislator, and I know as Governor of Kansas, I assume every State has some type of minimum mandated benefits that they have for their health insurance plans.

Secretary SEBELIUS. They do, but it applies, again, sir, in the past usually to the group markets, where 90 percent of covered Americans get their policies. This market has always been the Wild West.

Mr. GREEN. OK.

Secretary SEBELIUS. They didn't have protections.

Mr. GREEN. The Americans who received those letters from their companies about cancellations, they're eligible to purchase plans on the exchange?

Secretary SEBELIUS. Or out of the exchange. Individuals who aren't interested in some kind of financial help can go outside the exchange, inside the exchange. Their insurer can offer them plans. They have choices they've never had before.

Mr. GREEN. And because of the benefits of the Affordable Care Act, 80 percent of their premium dollar will come back to them.

Secretary SEBELIUS. That's correct.

Mr. GREEN. OK.

Secretary SEBELIUS. That's correct.

Mr. GREEN. And that's not true. And I know it's not true in Texas, but I don't know any States that have that 80 percent requirement.

Secretary SEBELIUS. Well, no State had it, I would suggest, in that kind of broad base prior to the Affordable Care Act. So it's an 80/20——

Mr. GREEN. Let me give you an example of one of the plans I found out during case work a few years ago. A large company provided $25,000 maximum benefit for their employees in the year. Most of employees didn't know about it, and—until this one constituent found out that she had cancer, and the bill ended up being $300,000. And so that's some of those plans that are not being allowed to be sold now. Is that correct?

Secretary SEBELIUS. Well, not only would the plan have a limit on out-of-pocket cost per year, it will have a limit on a lifetime out-of-pocket cost, and it will take away the notion that you would run out of your coverage in the middle of a treatment, which a lot of plans do.

Mr. GREEN. I know I'm out of time, but it's like buying a car. It may look good, but if it doesn't have a motor, it's no good to have that car. So that's why the Affordable Care Act has——

Secretary SEBELIUS. You save a lot of gas, but it doesn't get you anywhere.

Mr. UPTON. The gentleman's time has expired.

The gentleman from Oregon, Mr. Walden.

Mr. WALDEN. Thank you very much, Mr. Chairman.

Governor, Secretary, we're delighted to have you before the committee. You and I both know how important this issue is to all Americans that we get it right. So I hope you can appreciate we're trying to understand what we missed along the way, and one of the things that bothered me was the letter that was sent from your agency to the GAO back in June 6th. And I'll read in part, it said, "We're in the final stages of finalizing and testing the IT infrastructure that will support the application enrollment process. HHS is extremely confident that, on October 1, the marketplace will open on schedule and millions of Americans will have access to affordable, quality health insurance."

I'm just an average guy from a small town in Oregon. When I read that, it tells me you believed everything was good to go, the testing was in place and we should have full confidence everything would work. Correct?

Secretary SEBELIUS. That's the letter I signed, yes, sir.

Mr. WALDEN. Yes. Actually——

Secretary SEBELIUS. Or whoever.

Mr. WALDEN [continuing]. It was signed by your assistant.

Secretary SEBELIUS. Yes.

Mr. WALDEN. But——

Secretary SEBELIUS. Yes.

Mr. WALDEN [continuing]. The same point. And so I went into this believing in your response, your agency's response to GAO that things were ready to go, we should have full confidence, because when somebody uses the word "extremely confident," it tells me you're extremely confident.

Second piece. Then when we had the testimony from the witnesses last week, I asked them about the end-to-end testing and what the industry standard would be, and they said it really should have been months, especially for a project of this magnitude, and yet we heard it was only 2 weeks. Now, in August, GCI told CMS in their report——

Secretary SEBELIUS. CGI.

Mr. WALDEN. I'm sorry. CGI. Thank you. On August 9th, that there was not enough time in the schedule to conduct adequate performance testing. Did that make its way all the way to you, and do you think there was adequate time?

Secretary SEBELIUS. Sir, clearly, as I've said before, we did not adequately do end-to-end testing. The products were not locked and loaded into the system until the third week in September. Each of the component parts——

Mr. WALDEN. Right. They——

Secretary SEBELIUS [continuing]. Was tested——

Mr. WALDEN. They told us that.

Secretary SEBELIUS [continuing]. Validated, independently validated——

Mr. WALDEN. And so all of those——

Secretary SEBELIUS [continuing]. But end-to-end——

Mr. WALDEN. I'm sorry. All those worked, though, right? They told us last week that their individual modules were tested and met specification. Do you concur with that analysis, based on what you know?

Secretary SEBELIUS. I do concur with the testing that was done, yes.

Mr. WALDEN. OK. So it really was the end-to-end, which is why some of us thought we should delay until it could be done right, to avoid this very collapse that now is upon us. And I realize not everybody agreed to that.

The second piece here gets back to the Washington Post, which I realize you haven't had, and I understand, a chance to read this morning, but the four Pinocchios about the President repeatedly saying if you have a plan, you will keep a plan. We all heard that to mean, I've got a plan with a company, I'll continue to have it even if they make minor changes, when in fact your own rules as written said, no, that really isn't what's going to happen. If minor changes are made, that means the plan changed; that means you don't get it.

Secretary SEBELIUS. Well, sir, that isn't true. The rules did not say what you just suggested. And I think the estimate given that there would be turnover in the market was really an outside projection. It wasn't our rules. It was a snapshot of what happens in the market, that plans change so——

Mr. WALDEN. Sure.

Secretary SEBELIUS [continuing]. Dramatically——

Mr. WALDEN. Every year.

Secretary SEBELIUS [continuing]. Over time, that the estimate was they wouldn't be—not because of our rules, but because of insurance companies' business decisions——

Mr. WALDEN. Well, but you set up——

Secretary SEBELIUS [continuing]. Marketing plans.

Mr. WALDEN [continuing]. What those market rules looked like they have to comply with, correct?

Secretary SEBELIUS. Only if they chose not to grandfather the policy. That's the——

Mr. WALDEN. But that meant they couldn't make any changes.

Secretary SEBELIUS. Any grandfathered polices stayed in place still would be in place——

Mr. WALDEN. Right. But not if they made——

Secretary SEBELIUS. None of these rules apply.

Mr. WALDEN. But if they made any change——

Secretary SEBELIUS. No. They could make changes in pricing. They could make changes in benefits. They couldn't dramatically disadvantage the consumer, but they could have trend lines. They—they had a wide corridor to make sure that the—a similar plan—so if a consumer liked the plan, the plan, if it stayed in place——

Mr. WALDEN. So here's what—the practical implication, I've got letters from constituents all over my district who have gotten letters from their insurers who say because of Obamacare, they're no longer going to be in the individual market, or at least with that plan in the individual market. And the result is this person from Cove, Oregon, said, I was paying $600 a month for a $3,000 deductible. Now it costs me $800 a month for a $5,000 deductible. I've got others here I'll put in the record. A woman whose job, she had 40 hours, now down to 29, neither has health insurance nor enough income to live on her own because of the way this law is getting implemented.

I realize my time's expired.

Mr. UPTON. The gentlelady from Colorado, Ms. DeGette.

Ms. DEGETTE. Thank you very much, Mr. Chairman.

And thank you, Secretary, for being with us today.

I want to follow up on a couple of those questions that Mr. Walden was asking you about CGI. As you know, Chairman Issa last night released this document, a monthly project status report from CGI last night. It looks to me it's sort of a technical document that has a punch list of outstanding open issues, and some of them do highlight items that upon first read seem to be alarming. For example, one of the entries that, due to the compressed schedule, there's not enough time built in to allow for adequate performance testing. And this certainly in retrospect sounds bad, but the day of the document that Chairman Issa released is September 6th. And then, on September 10th, 4 days later, CGI came in to this committee and testified under oath, quote, "CGI Federal is confident it will deliver the functionality that CMS has directed." And we're—we're trying to figure out, or at least I'm trying to figure out how CGI is now coming in and saying, you know, we warned everybody that this wasn't going to be ready, when they came in and directly told me that they would be ready to launch on October 1st.

So it kind of raises the question how these statements can be reconciled. One explanation is that CGI was lying to this committee. I think that's unlikely. Another is that CGI thought that the items flagged in the report were like a punch list that could be addressed.

So here's my question to you, Madam Secretary. Was CGI telling your department the same thing that they told the committee on September 10th, that the company was confident that its programs would be ready?

Secretary SEBELIUS. Congresswoman, all of the contractors testified here in September and again, I think, last week before this committee, and the testimony was fairly similar, that they were ready to go in September. They were asked in—last week if they had suggested that we should delay the launch date. Each of them said no. I think the chairman asked those questions.

Ms. DEGETTE. So they never asked you to delay the launch date?

Secretary SEBELIUS. They did not. And, frankly, I think it is not valuable at this point——

Ms. DEGETTE. Right.

Secretary SEBELIUS [continuing]. To do a lot of pointing blame, fixing the blame. What I want to do is fix the problem.

Ms. DEGETTE. And so do I.

Secretary SEBELIUS. I think we need the whole team to move ahead——

Ms. DEGETTE. But——

Secretary SEBELIUS [continuing]. And we will report back regularly.

Ms. DEGETTE. Right. But we're relying on these contractors——

Secretary SEBELIUS. I understand.

Ms. DEGETTE [continuing]. To fix this. And so that goes to my last question, which is, Mr. Zients has now come in, and he says the site is going to be functional for the vast majority of users by the end of November. Is that right?

Secretary SEBELIUS. That's correct.

Ms. DEGETTE. And given what CGI told us, and the other vendors, do you believe that that is correct? Do you believe it will be pretty much ready to go by the end of November?

Secretary SEBELIUS. I do. And I think that we are making improvements each and every day. It is easier to use now than it was 2 weeks ago. It is way from where we need it to be——

Ms. DEGETTE. So it's not like it's all going to be fine by the end of November. It's beginning to improve already. Is that your testimony?

Secretary SEBELIUS. It is a continuous process, as Web sites are. Patches are made, fixes are made on an ongoing basis.

Ms. DEGETTE. Thank you.

Secretary SEBELIUS. And as we find issues, like Congresswoman Eshoo talked about, we are fixing them in real-time.

Ms. DEGETTE. And you're going to guarantee, yes or no, that people will have privacy when they go on this site?

Secretary SEBELIUS. Absolutely.

Ms. DEGETTE. Now, I just want to say one last thing. I was on the Washington Journal program where callers call in this morning, and I had a man, Max, call in, and he said he got one of those letters from the insurance companies that his insurance was can-

celled, so what he did is he went onto the Web site and he—under the Federal exchange, and he found a better plan, and now he's going to sign up. So I would hope that that's what everybody would be able to do.

And I thank you, Mr. Chairman.

Mr. UPTON. Mr. Terry.

Mr. TERRY. Thank you, Mr. Chairman.

And I'm pleased to hear that the Web site will be fully operational by the end of November. And would you be able to—would you come back to our committee so we could see if that's actually accomplished and how it was accomplished?

Secretary SEBELIUS. I will make every effort to do that.

Mr. TERRY. OK. You were Governor and State insurance commissioner in Kansas. And I reached out to our State insurance commissioner and Governor and found out that they have absolutely no data about Nebraskans who have either tried to enroll or enroll. As you know, Nebraska is one of the States that opted not to do their own exchange and rely on the Federal exchange. So it's interesting to me that neither our insurance commissioner nor the Governor's office had any data about Nebraskans and enrolling in these plans.

I also asked our insurance commissioner if they knew who the navigators were and whether they had to apply to be certified or licensed, in essence like an insurance agent would be. And they told me they have no clue who's been authorized by HHS to be a navigator and work with people in Nebraska. So this is concerning to me, so I'm going to ask you a few questions along this line.

First of all, do you have data on how many people in general in the United States have tried to enroll in a plan through this Web site?

Secretary SEBELIUS. No, sir. We do not have any reliable data around enrollment, which is why we haven't given it to date.

Mr. TERRY. All right. Or have any data on how many people have tried to enroll but, because of the problems, have not been able to accomplish that?

Secretary SEBELIUS. No, sir. I can tell you I met with insurers last week, and one of the priority fixes is the so-called 834s, the document that——

Mr. TERRY. OK.

Secretary SEBELIUS [continuing]. Sends an individual's name——

Mr. TERRY. The——

Secretary SEBELIUS [continuing]. To a company and verifies it.

Mr. TERRY. But——

Secretary SEBELIUS. That is one of the systems that is not working.

Mr. TERRY. I appreciate that. And the contractors I asked specifically about the information of how many people have tried to enroll and enroll, and they say that they do have those numbers, but can't tell us that because of a contract with HHS saying that they—they're gagged on that information.

Secretary SEBELIUS. I would suggest——

Mr. TERRY. So could I——

Secretary SEBELIUS [continuing]. That the numbers are not reliable according to the——

Mr. TERRY. Well, I tell you what——

Secretary SEBELIUS [continuing]. Insurance agents and according to us.

Mr. TERRY. What my question is going to be, though, will you, on the record right now, authorize them to give us those numbers and let us determine whether those are reliable?

Secretary SEBELIUS. No, sir. I want to give you——

Mr. TERRY. All right.

Secretary SEBELIUS [continuing]. Reliable, confirmed data from every State and from the Federal marketplace. We have said that we will do that on a monthly basis by the middle——

Mr. TERRY. So——

Secretary SEBELIUS [continuing]. Of the month. You will have that data, but I don't want to turn over anything that is not confirmed and reliable, and that's what we'll do.

Mr. TERRY. Well, but that data out there exists, and——

Secretary SEBELIUS. Sir, I would——

Mr. TERRY [continuing]. You will not let us have it now.

Secretary SEBELIUS. I would tell you right now it is not reliable data. According to the insurance companies who are eager——

Mr. TERRY. Well, the——

Secretary SEBELIUS [continuing]. To have customers, they are not getting reliable data all the way through the system.

Mr. TERRY [continuing]. Number of people——

Secretary SEBELIUS. It's one of the real problems that we have.

Mr. TERRY [continuing]. That have clicked on and tried to get it or enrolled, I'm not asking about what they enrolled in or whether they came in and said they were 65 and were quoted something that they were 27 years old. That should be a pretty reliable number just——

Secretary SEBELIUS. The system——

Mr. TERRY [continuing]. On the surface, so would you——

Secretary SEBELIUS [continuing]. Isn't functioning, so we are not getting that reliable data. Insurers——

Mr. TERRY. All right.

Secretary SEBELIUS [continuing]. Who I met with said that that is the case. We know that there's 700,000 applications that have been——

Mr. TERRY. The reliability of that data certainly flies in the face of the testimony from the contractors.

All right. I yield back.

Mr. UPTON. Ms. Capps.

Mrs. CAPPS. Thank you, Mr. Chairman. Thank you, Secretary Sebelius, for your presence here today and your testimony.

While I, too, am frustrated with the flawed rollout of HealthCare.gov, I do appreciate your longstanding commitment to improving the health care options for all Americans and in fixing this Web site quickly.

I think it's important to note that in my home State of California and other States as well, the new exchange marketplace, we call it Covered California, is working. And rates, constituents are finding that rates are as much as 29 percent less than those that they found on the marketplace last year. I'm thankful my constituents now have this option.

And as I look around to implementation nationwide, it seems clear to me that political decisions in individual States have really made the difference for consumers. The governors and legislators, State legislators that embraced this law are delivering for their communities, but those elected who are trying to ignore the opportunities presented and continue to throw up roadblocks both here in Congress and in State legislators should not now seem surprised that there are significant bumps along the way.

This seems to me to be completely disingenuous. Having embraced the law since open enrollment began October 1st, Californians have started nearly 180,000 applications, with more beginning every day.

I know my time is limited, but I want to have a second to mention a conversation I had just last night with a telephone town hall to my district on the central coast of California. One of the first callers I heard from was a mother from Santa Barbara, her name's Meryl, and she wanted to tell me the story of her son. Her son is 28 years old and he had been paying $425 a month for his insurance before the Affordable Care Act. She was happy to report that he has already applied through Covered California and has found a policy that works better for him and has all the essential health benefits covered, which his former policy did not, and now will only cost him $109 a month. This is significant savings for Meryl's son, and this is a story that's being repeated at least in California often.

So there are millions of residents in many States who have now set up their own Web sites and marketplaces. In those States, tens of thousands of people are now as we speak signing up for coverage, and this is demonstrating that the Affordable Care Act is working.

In New York and Washington, over 30,000 people have enrolled; in Oregon, over 50,000 people have been enrolled; Kentucky, 31,000 people have been enrolled. We could go on and on. The success of the State exchanges, which is where this is meant to be implemented, shows how badly this law is wanted and needed, how much it will be of help to so many people who want quality, affordable health care.

So my three quick questions to you are this, Madam Speaker: What is your assessment of how this first month has gone in the States that are running their own marketplaces, which this Congress intended that the Affordable Care Act work?

Secretary SEBELIUS. Well, everything we hear from the State-based markets is that they are doing well. They have not submitted data yet. We, again, are working with them around a monthly schedule so that they will confirm Medicaid data and enrollment data, and we'll see the real numbers at the end of the month and make sure that the—they're available to the public, but everything we hear is that they see the same demand, they are eager to enroll folks, and that that is going smoothly.

Mrs. CAPPS. And what do you think this success shows about the demand and the interest for affordable health insurance on the part of constituents?

Secretary SEBELIUS. Well, I don't think there's any question that in spite of a series of roadblocks and blockades and a lot of misinformation driven by about a $400 million marketing campaign last

year, Americans are eager to see what their benefits may be under the law, what their opportunities are, how to get health security for themselves and their families. And we want to make sure that they see those benefits. The Web site is one of the ways to do that. The call center, on-the-ground enrollment, personal outreach are a variety of ways.

And I would tell your colleague, Mr. Congressman, I'd be happy to get you the list of the Nebraska folks who are on the ground. It's available easily. It's public record. So I'd be happy to send it to you so you can share it with your insurance commissioner and governor.

Mr. TERRY. Thank you.

Mr. UPTON. The gentlelady's time is expired. The gentleman from the great State of Michigan, Mr. Rogers.

Mr. ROGERS. Thank you. I thank you, Madam Secretary, for being here. A short time, I'll get through some questions here if I can.

Is it your testimony that every night to try to increase the functionality of the system, you're hot swapping codes? So my understanding is that between 2 and 4, write new code, put it into the system. Yes or no?

Secretary SEBELIUS. Clearly I am not hot swapping code. There is a——

Mr. ROGERS. No, no.

Secretary SEBELIUS [continuing]. Technical team that periodically——

Mr. ROGERS. You're in charge of the operation that hot swaps code on functionality. You're trying to improve the functionality. Yes?

Secretary SEBELIUS. Yes.

Mr. ROGERS. So that happens every night. Yes?

Secretary SEBELIUS. No. I don't think it does happen every night. It happens periodically during the hours of 1:00 and 5:00, but it is not a nightly feature.

Mr. ROGERS. Great. Has each piece of that code that's been introduced into the system been security tested?

Secretary SEBELIUS. That's my understanding, yes, sir. And the——

Mr. ROGERS. Each——

Secretary SEBELIUS [continuing]. Testing——

Mr. ROGERS. Each piece of that code has been tested. Yes or no?

Secretary SEBELIUS. I could not—I don't know——

Mr. ROGERS. OK. That's a——

Secretary SEBELIUS [continuing]. But I can tell you that security——

Mr. ROGERS. That's a much safer answer, trust me.

Secretary SEBELIUS [continuing]. Is an ongoing operation, that as code is loaded, you need to retest over and over and over again. So whether it's pre-tested, I can't tell you.

Mr. ROGERS. All right.

Secretary SEBELIUS. I know——

Mr. ROGERS. You need to pre-test the code.

Secretary SEBELIUS [continuing]. It is simultaneous——

Mr. ROGERS. Has any end-to-end security tests been conducted since HealthCare.gov went live on October 1st, yes or no?

Secretary SEBELIUS. My understanding is there is continuous testing as the temporary authority to operate calls for.

Mr. ROGERS. Yes or no, has an end-to-end security test been conducted since HealthCare.gov went live, yes or no?

Secretary SEBELIUS. I will find out exactly what testing they're doing. I know they're doing simultaneous testing as new code is loaded.

Mr. ROGERS. Are there any end-to-end security tests run after every new piece of code is put in—I'm not talking about testing the code now. I'm talking about an end-to-end security test——

Secretary SEBELIUS. I can tell you how——

Mr. ROGERS [continuing]. That covers across the boundaries.

Secretary SEBELIUS [continuing]. Frequently it's done——

Mr. ROGERS. Well, I can tell——

Secretary SEBELIUS [continuing]. But I will get you that information from my techs.

Mr. ROGERS. I can tell you they're not, and I'd be interested to hear why not.

If you'd go to Tab 2 quickly in your book, I'm going to read three things——

Secretary SEBELIUS. I'm sorry. What book, sir?

Mr. ROGERS. You have to tab there that if you go toTab 2, right there—well, while you're looking, I'll read. It's dated September 27th and it is to Marilyn Tavenner. Let me just read a couple of pieces here. There are inherent security risks with not having all code tested in a single environment. Finally, the system requires rapid development and release of hot fixes and patches, so it is not always available or stable during the duration of the testing.

Secondly, the security contractor has not been able to test all of the security controls in one complete version of the system.

And if you look in the first part, which is most troubling of all, it says, due to system readiness issues, the security control assessment was only partly completed. This constitutes a risk that must be accepted before the marketplace day one operations.

And so let me tell you what you did. You allowed the system to go forward with no encryption on backup systems. They had no encryption on certain boundary crossings. You accepted a risk on behalf of every user of this computer that put their personal financial information at risk because you did not even have the most basic end-to-end tests on security of this system.

Amazon would never do this, ProFlowers would never do this, Kayak would never do this. This is completely an unacceptable level of security. And here's the scary part: We found out after the contractors last week that an end-to-end test hadn't been conducted on security, not functionality, because if it's not functioning, it's not secure. You are ongoing hot patches without end-to-end tests. The private contractors told us it would take a very thorough 2 months just for an integrated end-to-end security test that I'll tell you has not happened today. Why? Because you're constantly adding new code every night to protect the functionality of the system. You have exposed millions of Americans because you all, according to your memo, believed it was an acceptable risk. Don't you think you

had the obligation to tell the American people that we're going to put you in the system, but beware, your information is likely to be vulnerable? Would you commit today, Secretary, to shut down the system and give an end-to-end security test so that these Americans——

Secretary SEBELIUS. No, sir.

Mr. ROGERS [continuing]. Could have their information?

Secretary SEBELIUS. If you read the memo——

Mr. ROGERS. Oh, I have read it.

Secretary SEBELIUS [continuing]. It goes on to say that weekly testing of our Brda devices, including interface testing, daily, weekly scans are going on. This is a temporary authority——

Mr. ROGERS. Candidly, that's not what the memo says——

Secretary SEBELIUS [continuing]. A temporary——

Mr. ROGERS [continuing]. Number one——

Secretary SEBELIUS. It does.

Mr. ROGERS [continuing]. And number two, the contractors will tell you this is——

Mr. WAXMAN. Mr. Chairman, a point of order.

Mr. UPTON. The gentleman——

Mr. WAXMAN. I think the witness ought to be allowed to answer what was a speech by the colleague, because he's raised a lot of issues.

Mr. UPTON. If the gentlelady will answer, we'll move——

Mr. ROGERS. You mean there's——

Mr. UPTON [continuing]. We'll move——

Mr. ROGERS [continuing]. Giving speeches here today? That's shocking.

Mr. UPTON. Does the Secretary wish to respond briefly?

Secretary SEBELIUS. Sir, I would just say this document is a document signed by Administrator Tavenner which discusses mitigation strategies for security that are ongoing and upgraded, and an authorization to operate on a permanent basis will not be signed until these mitigation strategies are satisfied. It is underway right now, but daily and weekly monitoring and testing is underway.

Mr. ROGERS. Mr. Chairman, there are people using this system today, and she's just admitted again the system isn't secure nor has it been——

Secretary SEBELIUS. I did not say that, sir.

Mr. WAXMAN. Mr. Chairman, she didn't admit that. You said it, but she didn't say it.

Mr. UPTON. Gentleman's time is expired, Mr. Doyle.

Mr. DOYLE. Thank you, Mr. Chairman. Madam Secretary, welcome. Those of us who fought for this law, who voted for this law have a vested interest in its success, and the concerns that you hear expressed on this side of the panel are real, because we want to see Americans get health care. I think it's somewhat disingenuous for my colleagues on the other side of the podium here to have this faux anger and this faux concern over a bill that they absolutely want to fail and have rooted for its failure and have voted over 40-some times to repeal this bill, never putting an alternative plan on the floor for the American people, but just to simply say they want to make sure this plan doesn't succeed.

And I think their real fear is that the plan will succeed and the American people will learn of the real benefits of this plan, not the propaganda campaign that's gone on by the Republicans for the last 3 years.

Madam Secretary, I think one of the keys to the success of this plan is that we get young people to enroll in this plan, and I have some questions about some enrollment concerns. Now, I understand that you've said approximately 700,000 people have applied for coverage via the HealthCare.gov and the State exchanges. Is that——

Secretary SEBELIUS. They've completed an application.

Mr. DOYLE. Right. Which is different from enrollment.

Secretary SEBELIUS. That's correct.

Mr. DOYLE. So my question is, are you expecting—I know you don't have exact numbers yet, but are you expecting a large number or a small number of enrollments during the first month? What are your thoughts on that?

Secretary SEBELIUS. Well, our projections prior to launch were always that there would be a very small number at the beginning. We watched the Massachusetts trend, which started slowly and built. I think there's no question that given our flawed launch of HealthCare.gov, it will be a very small number.

Mr. DOYLE. Yes. I mean, in the Massachusetts plan, I think the first month, it was 123 people signed up, less than 1 percent of the overall first year enrollment in that first month. And we saw the same kind of numbers in Medicare Part D the first month of open enrollment back in 2006.

Madam Secretary, young Americans are the most likely age group to be uninsured, and a lot of us are concerned that because of the problems that we've been having with the Web site, that a lot of these young folks may not come back on. You know, they have very short attention spans. I've got four kids that all work on the Internet, and if they can't get something in 5 minutes, they're on to something else.

What do we do and what plans are in place by your department to encourage young people to go back and revisit that site and to make sure that we're getting young people looking at that site and accessing it?

Secretary SEBELIUS. Well, step number one is fix the site, because we don't want people to be invited back and then have a bad experience a second time around. I think that's absolutely right. The site is particularly important to tech savvy younger generation folks, who we need to enroll. I think that we have—so fixing the site is step one, and step number two is getting information to folks that the law even exists. A lot of young people haven't followed this dialogue for the last 3–½ years or been paying attention——

Mr. DOYLE. Yes. I think we need a real——

Secretary SEBELIUS [continuing]. And think they don't need health insurance.

Mr. DOYLE [continuing]. A real marketing campaign and we need to really reach out to——

Secretary SEBELIUS. Yes.

Mr. DOYLE [continuing]. Young people——

Secretary SEBELIUS. We intend to do that.

Mr. DOYLE [continuing]. Especially at the end of November, when you say this site is going to be working a lot better, to make sure they're checking that site out.

Secretary SEBELIUS. You bet.

Mr. DOYLE. One of my four kids is self-employed. He's 33 years old. He's paying about $140 a month right now for a Blue Cross plan. He's eligible for a subsidy. We browsed that site. He's going to be able to get coverage for about half of what he's paying right now. And that's good news for us, because I think my wife is paying his premiums, so I think we're going to save the money.

Secretary SEBELIUS. Well, I would——

Mr. DOYLE. But I think it's important—we had to prod him to go on that site and enroll. And I think for a lot of young people, they're not going to do it unless it's easy, so it's important we get that fixed. Thank you.

Secretary SEBELIUS. I agree.

Mr. UPTON. Dr. Murphy, chairman of the Oversight Subcommittee.

Mr. MURPHY. Thank you, Madam Secretary, and welcome. You had mentioned that the people who did technology on the Web site made a number of mistakes. You mentioned Verizon. When we had them before our committee last week, they said it wasn't their fault, they were told, but then HHS, there were some problems there.

Secretary SEBELIUS. Sir, Verizon wasn't involved in the Web site.

Mr. MURPHY. I——

Secretary SEBELIUS. Verizon hosts the cloud.

Mr. MURPHY. Right. With the data.

Secretary SEBELIUS. I just need to clear that up.

Mr. MURPHY. I understand that.

Secretary SEBELIUS. They were—not the Web site.

Mr. MURPHY. But they had a role, CGI had a role, over companies, et cetera. I'm just curious in this process, what decisions did you make that affected this, for better or worse, in terms of the data, the ease or problems with the moment and being able to track how many people are actually enrolled?

Secretary SEBELIUS. My decisions, specifically to design the Web site, I was not involved. I am prohibited to choose contractors. We go by the——

Mr. MURPHY. OK.

Secretary SEBELIUS [continuing]. Federal procurement, and I got regular reports on exactly what was done and how it was——

Mr. MURPHY. What about the part with regard to getting data in terms of how many are people even enrolled or trying to enroll? Did you have any decisions in that process?

Secretary SEBELIUS. Again, the application process at this point does not work end-to-end very well——

Mr. MURPHY. Right. I understand it doesn't work. That's obvious.

Secretary SEBELIUS [continuing]. And we do not have reliable data about the end——

Mr. MURPHY. I'm just trying to find out if you had asked them to say, look, I'm in charge of this. I'm going to want a regular report. How many people have tried to enroll, how many people have enrolled. Have you—did you ask that question in the plan?

Secretary SEBELIUS. We have prioritized for our contractors that specific fix. And believe me, the insurance companies are eager for us to get reliable data to make sure——

Mr. MURPHY. I'm just trying to——

Secretary SEBELIUS [continuing]. That their data matches ours, and that is not there yet.

Mr. MURPHY. I appreciate that. I'm just trying to find out if you've told them that was part of the plan and what they're doing.

Real quick. We're hearing from thousands of people who have had their policies cancelled. In fact, I heard from one insurer in Pittsburgh that just cancelled 30,000 individual policies. Now, they said they expect 50,000 to 30,000 to enroll in the exchange plans. Just so you know, to date so far the number of people who have signed up for their plan is 10, 10.

Now, I'm concerned a lot of these individuals and their families aren't going to be make it by January 1, so I'm wondering, do you know how many families will not have been able to keep their insurance by January 1? Do you have any matrix that can help you understand what that number's going to be?

Secretary SEBELIUS. Sir, by law that has been in place for a while at the State level, insurance companies must give their customers a 90-day notice about a policy change——

Mr. MURPHY. Right.

Secretary SEBELIUS [continuing]. Or a plan cancellation, 90 days.

Mr. MURPHY. I'm just wondering if you have a mechanism whereby you will know. Is something built into the system whereby you be——

Secretary SEBELIUS. Will I know if your constituent signed up for an individual plan? No.

Mr. MURPHY. People across America. And do we know how many policies will be cancelled or be enrolled? I mean, is it 1,000? 10,000? 1 million? 5 million? Do we know?

Secretary SEBELIUS. We know that in the individual market, a number of the plans being sold are not grandfathered and are not currently meeting the law. Those notices have gone out. We know that there are about 12 million people in the individual market. A number of them have grandfathered plans, a number of them have plans which meet the essential health benefits. So I can try to get those numbers.

Mr. MURPHY. Well, let me put a face on that. A person named Paul wrote to me and says, I'm supposedly one of the families that this act was supposed to help, but it's in fact hurting more, would make it harder for my family to live. We will have less money for food and other essential items. I have a wife and four children to take care of. Another person wrote, I had a 2013 plan, which if you include the premiums and out-of-pocket, total liability was $5,300. For 2014, the same program liability is $9,000. Single mom writes, I want to convey I'm one of the millions of people who's having their health insurance cancelled because it does not meet the standards of Obamacare. I liked my insurance. I especially liked the price, and now I'm being forced to sign up for something that will be way more expensive. As a single mom who is self-employed, I'm worried about how I'm going to pay my bills.

I hope you have a mechanism to track who these people are, that she's not eligible for other subsidies, but the costs are really going to be driving her down.

Secretary SEBELIUS. Well, sir, again, I would suggest that there is no requirement that any of those consumers sign up for a plan suggested by their company at a higher price. They have now options——

Mr. MURPHY. But if a plan changes——

Secretary SEBELIUS [continuing]. Without health underwriting, without pre-existing conditions, with some guarantees around how much out-of-pocket costs that——

Mr. MURPHY. She's searching around, and she can't find a plan she can afford.

Secretary SEBELIUS [continuing]. They never had before.

Mr. MURPHY. She can't find a plan she can afford.

Mr. UPTON. The gentleman's time is expired. The gentleman from North Carolina, Mr. Butterfield.

Mr. BUTTERFIELD. Mr. Chairman, before my time begins, I have a parliamentary inquiry.

Mr. UPTON. Yes. Go ahead.

Mr. BUTTERFIELD. Mr. Chairman, I'm always sensitive to committee decorum, and before I do it this morning, I want to ask unanimous consent that I be allowed to display the Democratic Twitter handle.

Mr. UPTON. Go right ahead.

Mr. BUTTERFIELD. Hearing no objection. Thank you.

Secretary Sebelius, thank you so very much for coming today. I would like to ask you about the document that my Republican colleagues have just released. This document is an authority to operate memorandum, to operate the federally-facilitated marketplace for 6 months and implement a security mitigation plan. This document, as I understand it, describes security testing for HealthCare.gov. It says that security testing of the marketplace was ongoing since its inception and into September of this year. In fact, it says that, quote, throughout the three rounds of security control assessment testing, all of the security controls have been tested on different versions of the system.

That's good news, but the bad news is that it goes on to say that because of system readiness, a complete security assessment of all the security controls in one complete version of the system were not tested.

This document indicates that CMS postponed a final security assessment screening, but in its place, CMS did put in place a number of mitigation measures, and it concluded that these measures would mitigate any security risk.

Question: Are you familiar with this document?

Secretary SEBELIUS. Yes, sir.

Mr. BUTTERFIELD. Is it correct that this document recommends implementing a dedicated security team to monitor, track, and ensure the mitigation plan activities are completed?

Secretary SEBELIUS. Yes, it does.

Mr. BUTTERFIELD. Now, is it correct that this document recommends monitoring and performing weekly testing on all border devices, including Internet-facing Web servers?

Secretary SEBELIUS. More than recommended. It's underway.

Mr. BUTTERFIELD. Is it correct that this document recommends conducting daily and weekly scans?

Secretary SEBELIUS. Yes, sir.

Mr. BUTTERFIELD. Does this document recommend conducting a full SCA test on the marketplace in a stable environment?

Secretary SEBELIUS. Yes, sir.

Mr. BUTTERFIELD. Is it correct that this document recommends migrating the marketplace to CMS's virtual data center environment in the first quarter of next year?

Secretary SEBELIUS. Yes, it does.

Mr. BUTTERFIELD. My understanding is that an independent security expert, the MITRE Corporation, is performing security testing on the code that powers the Web site on an ongoing basis. Is that correct?

Secretary SEBELIUS. That is correct. And MITRE did an assessment of the system, gave us a preliminary report. They are in the process of posting their final report. That did not raise flags about going ahead, and the mitigation strategy was put in place to make sure that we had a temporary authority to operate in place while the mitigation was going on, and then a permanent authority to operate will be signed.

Mr. BUTTERFIELD. Finally, do you have confidence in these and other measures you are taking to protect the security of Americans' personal information?

Secretary SEBELIUS. I do, sir.

Mr. BUTTERFIELD. Thank you. This is the third time you said it during the hearing, and we believe you. Thank you.

What you're telling us is that these remedial actions and the ongoing security testing from MITRE are protecting the security of the Web site. That's a message that is important for the public to hear. My Republican colleagues do not want this Web site to work. I am convinced of that. They want to block the ACA at all costs and even shut down the government to stop the law.

For the last 4 years, they have taken every glitch, every simple glitch and hiccup in the law and tried to exaggerate its significance, and that's happening today and it's so disappointing.

Thank you, Mr. Chairman. I yield back.

Mr. UPTON. Dr. Burgess.

Mr. BURGESS. Mr. Chairman, I wonder if I might make a unanimous consent request also.

Mr. UPTON. Yes. Go ahead.

Mr. BURGESS. I would like to request unanimous consent that my opening statement, which we were not allowed to give could be made part of the record for this hearing.

Mr. UPTON. No. Without objection.

Mr. BURGESS. And further, I do have a number of questions. Many have come from constituents. I'd also like to be able to submit those as questions for the record.

Mr. UPTON. Without objection.

[The prepared statement of Mr. Burgess follows:]

PREPARED STATEMENT OF HON. MICHAEL C. BURGESS

The Affordable Care Act is quickly becoming the poster child for the failure of big government. It's a stunning train wreck that is coming down the tracks toward us.

Since the law was passed in 2010 this Committee has repeatedly questioned the officials from the Department of Health and Human Services (HHS), the Center for Medicare and Medicaid Services (CMS), the Treasury Department, and the White House. I was told, time and time again, by all of these officials that the ACA would "definitely" be ready to go live on October 1, 2013.

On February 16, 2011, the former director of the Center for Consumer Information and Insurance Oversight (CCIIO), Mr. Steve Larsen, assured me everything would work on Day 1:

Mr. {Burgess.} You are betting on all this stuff working.

Mr. {Larsen.} I think we are going to flip the switch and the lights are going to go on.

On April 18, 2013, Kathleen Sebelius, Secretary of Health and Human Services, sat before the Energy and Commerce Committee and told me:

Dr. {Burgess.} They are to go live online on October 1st. And I guess the question on everyone's mind this morning is, will you be ready?

Secretary {Sebelius.} Yes, sir, and the exchanges——

Dr. {Burgess.} I will take that as a yes.

Secretary {Sebelius.} Open enrollment will start October 1st. The exchanges will be up and running on January 1st.

Dr. {Burgess.} Are you talking about work around plans?

Secretary {Sebelius.} No, we are not. We are moving ahead. We have the federal hub on track and on time. We are moving ahead with the marketplaces that we will be individually responsible for and we're working very closely with our state partners on their plans and their time table for the state based marketplaces.

Dr. {Burgess.} So the federal hub will be available?Secretary {Sebelius} Yes.

The following week, on April 24, 2013, Gary Cohen, the current director of CCIIO, testified before theEnergy and Commerce Committee:

Dr. {Burgess.} The Secretary was here last week and I asked her about contingency plans and she said there are no contingency plans. Everything will be ready. So which is it? Everything will be ready or you are planning for contingencies?

Mr. {Cohen.} Everything will be ready but we are also planning for anything that, when we go into operation, if the situations come up that we need to address, we will be ready to address those situations and make sure that the experience for American consumers is as seamless and as good as it can be.

On August 1, 2013, Marilyn Tavenner, the current CMS Administrator, testified before the Energy and Commerce Committee:

Dr. {Burgess} When can Texans expect to go online and be able to get information about how expensive coverage will be in the exchange?

{Ms. Tavenner.} So the information about what is available in the exchange will be available to them October 1.

And just a little over one month ago, on September 19, 2013, days before the Exchanges were scheduled to go live, Gary Cohen, CCIIO Director, testified before the Energy and Commerce Committee again:

Dr. {Burgess} Will the enrollment process be ready October 1 of this year?

Mr. {Cohen.} Consumers will be able to go online, they will be able to get a determination of what tax subsidies they are eligible for, they will be able to look at the plans that are available where they live, they will be able to see the premium net of subsidy that they would have to pay, and they will be able to choose a plan and get enrolled in coverage beginning October 1.

Yet, here we are, 30 days after October 1 and the American people are still waiting to see a fullyfunctional law. The failures of the healthcare.gov Web site are just the beginning of the dysfunction that is to come as the implementation of President's signature law moves forward into 2014. After spending hundreds of millions of dollars the American people deserve some concrete answers and not empty political posturing.

In addition to the hearings this Committee held to question Administration officials, I had private meetings with Jay Angoff, former CCIIO director and later senior adviser to Sebelius; Nancy Deparle, former Director of WH Office of Health Reform; Henry Chao, Deputy Chief Information Officer; and Steve Larsen, former

CCIIO director. It seems I was having the meetings the Secretary was supposed to be having.

Despite the array of public and private meetings with officials from the range of agencies involved in implementing the President's health care law, I still do not have the answers to questions about the law's basic functionality. At this point, I'm not even sure who is in charge of this program because no one knows what is going on. Unless someone is willing to admit that there are problems, how can we ever hope to fix it?

# # #

Mr. BURGESS. And ask the Secretary for her attention to those so we could get answers, because they, after all, are important questions. OK. Thank you, Mr. Chairman.

It just came to my attention that on CNN's Web site, that the site was hacked just last week. And I will be happy to make this available to you. I don't think the——

Secretary SEBELIUS. The CNN Web site?

Mr. BURGESS. CNN ran a story that the HealthCare.gov Web site was hacked last week. And, again, I will get this to you, and would appreciate your response to that.

Mr. Terry had asked a question about he wanted to get the information about the number of people who had signed up. You said you wouldn't provide that, because it wasn't accurate. Would you provide us with the number of people who have been able to enroll on the telephone? The President gave an 800 number during his speech. Could we get a number of people who have enrolled on the telephone?

Secretary SEBELIUS. No, sir. We do not have reliable enrollment data. We will have that to you by the middle of November, as we committed to. We are collecting State data, we are collecting telephone data, we are collecting paper data, we are collecting Web site data. We want it to be reliable——

Mr. BURGESS. OK.

Secretary SEBELIUS [continuing]. And accountable, and that's what we will have.

Mr. BURGESS. Reclaiming my time. The telephone data doesn't seem that it would be that difficult to compile since the number is likely quite low. Now——

Secretary SEBELIUS. The telephone goes through the system, sir.

Dr. BURGESS [continuing]. You have, or the President designated a, I call him a glitch czar, Jeffery Zients. And you're familiar it was his appointment to oversee——

Secretary SEBELIUS. I asked him to serve in this capacity, yes, sir.

Mr. BURGESS. Many of us on the Subcommittee of Oversight Investigations in Energy and Commerce were not as comforted as you by that selection, because if you will recall, Mr. Zients' history with this subcommittee it not great. He was involved with Solyndra. We asked him to come and talk to us about Solyndra in 2011. He refused, requiring a subpoena to be issued by this subcommittee.

Will you commit to making Mr. Zients available to our subcommittee for our questions?

Secretary SEBELIUS. Congressman, you are welcome to ask Mr. Zients to come before the committee. He is volunteering his serv-

ices to us for a period of time. He has been appointed by the president to start in January as the head of the National Economic Council. He was the deputy director at OMB for management and performance. I am thrilled that he is willing to take on this assignment and help us drive the management, but——

Mr. BURGESS. Again, his appearance here will be important.

Now, a lot of people are asking if the President's words leading up to this law, if they matter. And the statement in The Washington Post today edited the President's statement to say, if you like your health care plan, you will be able to keep your health care plan if we deem it adequate. That seems like a more operational statement, and especially if you go back just a few years into the Federal Register, and I'm quoting here from the Federal Register from July 23rd of 2010, just a few months after the law was signed, the interim rule for dealing with the grandfathering written into the Federal record, because newly-purchased individual policies are not grandfathered, the Department expects that a large population of individual policies will not be grandfathered, covering up to and perhaps exceeding 10 million people.

I hope the President was apprised of that before he made these statements, because clearly his statement wasn't operational.

Secretary SEBELIUS. Again, that's an insurance company choice. And that was a snapshot——

Mr. BURGESS. But——

Secretary SEBELIUS [continuing]. Of what the market looks like.

Dr. BURGESS [continuing]. Your——

Secretary SEBELIUS. The President made it clear, and our policy was to put——

Mr. BURGESS. In——

Secretary SEBELIUS [continuing]. A grandfather clause in both employer-based coverage and in——

Mr. BURGESS. Right. But in the——

Secretary SEBELIUS [continuing]. Individual coverage.

Mr. BURGESS. [continuing]. Federal Register, those were the comments that were recorded. Now, I do have to——

Secretary SEBELIUS. No. This isn't a government takeover of anything. These are private insurance plans——

Mr. BURGESS. I do have to ask you this.

Secretary SEBELIUS [continuing]. Making private decisions.

Mr. BURGESS. I do have to ask you this: You serve at the pleasure of the President, we're all aware of that, but we have had many of your employees here in front of this committee, and you do have to ask yourself, are they just being purposely misleading, or are they really not that smart? So I'm going to ask you this morning, for the sake of the future of health care in this country, will you please ask for the resignation of Gary Cohen, because he's repeatedly come to this committee and misled us?

Secretary SEBELIUS. I will not, sir.

Mr. UPTON. The gentleman's time has expired.

Mr. WAXMAN. Mr. Chairman, a point of personal privilege. I just think the record ought to be clear about Jeffrey Zients. He was invited with less than a week's notice to come before this committee. He couldn't make it that day. He asked for some other day. He went to OMB and had nothing to do with the Solyndra contract,

and he did come before us and talk about it, but his sole role was to represent OMB. And I don't think he ought to have any—there ought to be any disparagement of Jeffrey Zients. He's a very well-regarded public servant.

Mr. UPTON. The gentleman's statement will stand. Ms. Matsui.

Ms. MATSUI. Thank you, Mr. Chairman. Welcome, Madam Secretary. Now, we all agree the Web site problems must be resolved, as this country invented and developed the Internet and the concept of the Web sites, so there are high expectations. The fact that the hired private contractors could not build a ready Web site in nearly 3 years is inexcusable, and after its fix, I hope the administration will hold those at fault accountable, but we can't lose sight of the big picture that when this is all said and done, every American will have affordable quality health insurance and health care. This is the goal, I believe, of all Democrats and Republicans.

The ACA's working in California, and it's working in my district in Sacramento, and I just want to tell you about a letter I got from a constituent:

"Dear Congresswoman Matsui, as a self-employed contract employee, I've had individually purchased health insurance for 11 years now, insurance that has gone up every year, sometimes more than once; insurance that wouldn't let me add my daughter when my ex-husband stopped his insurance policy that covered them both; insurance that I have underused for fear they would drop me; insurance that has just dropped me anyway because they decided they will no longer offer individual plans. This could have happened to me at any time. I'm so grateful the Affordable Care Act provisions make it possible to get health insurance beginning in January for me and my daughter.

"As all this is happening, I have finished graduate school and started my own business. Slowly but surely, things are happening, and I expect to be hiring my first employees in the next 6 months. The provisions of the ACA are helping me in this, too. I can clearly see what it would cost me to provide health benefits for my future employees, understand these costs and build my business plan accordingly." And that is just one of the letters I received.

Now, I've also heard from my colleagues on the other side of the aisle complain again and again about how health care reform is increasing health care costs, but the empirical evidence shows something quite different. The recent trends in Medicare spending growth are really quite remarkable. Medicare spending growth is at historically low levels, growing by less than one half of 1 percent in fiscal year 2012, following slow growth in 2010 and 2011. The same is true on the private side of health care. Personal consumption expenditures on health care, everything from health insurance, to drugs, to hospital care rose by just over 1 percent in the past year. This is the slowest increase in nearly 50 years.

Madam Secretary, what does this data tell us about what has happened to health care costs since the ACA became law?

Secretary SEBELIUS. Well, Congresswoman, you're absolutely right. In the last 3–½ years since the President signed the Affordable Care Act, we have seen a great slowdown in the extraordinary cost increases year in and year out for health care, in the Medicare plan, in the Medicaid plan, in private insurance, and in underlying

healthcare costs, which affect every American. Some of that is to do with some of the features that are currently in place around different care delivery and different payment systems that we are helping to drive, given the tools that we have, with the Affordable Care Act: more quality outcomes, trying to prevent hospital readmissions, looking at hospital-acquired infections, medical homes that prevent people in the first place or help them stay healthy in their own homes and in their own places.

Ms. MATSUI. So it's true that the private insurance costs are growing at the slowest rate in decades also; is that true?

Secretary SEBELIUS. That is true.

Ms. MATSUI. Am I also correct that ACA premiums are coming in even lower than predicted by experts like the CBO?

Secretary SEBELIUS. Well, they're on average about 16 percent lower than was estimated that those premiums would be. And that's the premium, not accounting for the number of uninsured or underinsured Americans who will then qualify for financial help. Since they don't have employer coverage, they get some help from the taxpayers paying for that coverage.

Ms. MATSUI. Thank you, Madam Secretary.

Mr. UPTON. Dr. Gingrey.

Mr. GINGREY. Thank you, Mr. Chairman.

Madam Secretary, when you spoke at the Democratic National Convention in Charlotte last September, one of the first statements you made about the Affordable Care Act was, quote, "But for us Democrats, Obamacare is a badge of honor, because no matter who you are, what stage of life you're in, this law is a good thing. First, if you already have insurance you like, you can keep it." And I end the quote.

I'd call this a red hearing that misled voters, intentional or not. Now, perhaps had you known that millions would lose their coverage, families would face financial disaster, as one constituent recently told me, or that the exchange rollout would be plagued by a multitude—multiple delays we've seen, you would not consider it such a badge of honor.

The fact is your words and those of the President as he campaigned last year that "if you already have insurance you like, you can keep it" seems to be directly refuted by the millions of cancellation notices already sent to Americans just in the past few weeks. Whether your statement was inaccurate, or, as Mr. Hoyer said yesterday, not precise enough, it does strike me that millions of individuals who, by listening to speeches like yours, voted believing one thing now find themselves without coverage and are now scrambling to find coverage in a marketplace that offers more expensive plans with fewer options.

In response to my constituents' calls for help, I created a portal on my Web site—no patches or fixes needed—that allows those who have experienced problems to reach out and tell me about their personal experiences. In just the last few days, my office has received dozens of complaints regarding increases in their monthly premiums. I received one such notice from a mother in her early fifties, who just received a notice that not only will her insurance premium double, but she will also have to switch insurers to keep her doctors due to the effect of the Affordable Care Act.

Can you imagine receiving notices like this? I can tell you that just in my district, the 11th of Georgia, many more are experiencing this situation. Madam Secretary, this is akin to telling seniors that in a few weeks their Medicare coverage will be dropped, or their premiums would double. Now, I know that neither you nor the administration would ever advocate for such a policy, yet here you are subjecting those currently in the individual market to such government intervention. And I would hope that you would agree with me in recognizing that these increases are a heavy hardship on my constituents, on all of our constituents, Republicans or Democrats.

Now I'll get to my questions. You know the healthcare law included a hardship exemption from the individual mandate, yet the administration has failed to finalize the application form for the hardship exemption 3–½ years after we passed this law. As of today can an individual apply for a hardship exemption from the individual mandate on HealthCare.gov, yes or no?

Secretary SEBELIUS. I don't know——

Mr. GINGREY. I do. It's no.

On October 15, Politico reported that if the online system for getting into Obamacare coverage is rickety, the system for getting out of the mandate doesn't even exist yet. HHS says it will take another month at least for the administration to finalize the forms for the hardship exemption from the individual mandate.

Why has it taken 3–½ years to finalize a simple application form for an exemption from the individual mandate?

Secretary SEBELIUS. Well, sir, as you know, the individual mandate is not in place until next year. We have made it very clear that if somebody is Medicaid eligible in a State that doesn't choose to expand Medicaid, they will be exempted from——

Mr. GINGREY. My last question. An estimated 16 million people in the individual market have or will receive cancellation notices stating their health insurance coverage does not meet minimum coverage requirements of the Affordable Care Act. The bill specifically grants you, Madam Secretary, the power to determine the criteria for a hardship exemption. Will you provide all of these individuals a hardship exemption since the Affordable Care Act has taken away their plan? Will you do that?

Secretary SEBELIUS. No, sir. And I think those numbers are far from accurate. Ninety-five percent of Americans who have health insurance will be in a continuous plan, Medicare, Medicaid, employer-based, VA, 95 percent. Five percent, who are in the individual market, a portion of those 5 percent, a portion of them, about 12 million people, a fraction of those 12 million, will have a plan that doesn't meet the criteria and has not been grandfathered in. They are indeed receiving notices. Many of those individuals, half of them, will be eligible for financial help getting a new plan, and they have many more choices in the marketplace. So we will not have a blanket exemption for them.

Mr. GINGREY. Sounds like a hardship to me, Madam Secretary.

Mr. UPTON. Gentleman's time has expired.

Mrs. Christensen.

Mrs. CHRISTENSEN. Thank you, Mr. Chairman.

And thank you, Madam Secretary, for being here. And thank you for all that you and your staff at HHS has done in implementing the Affordable Care Act to ensure that it would provide the many benefits that children, to women, to Medicare beneficiaries, and to ensure security to those who already have insurance as well as lower costs.

Of course, the biggest complaint has been about the application and the enrollment Web site, but we have heard over and over from you that those are being addressed. But you would recall, and I know my colleagues would recall, that Congressman Rush and I have always been concerned about those who do not have Internet access, those who are uncomfortable using the Internet and would not use it. So I just wanted to just remind everyone that there are other avenues for enrolling, either by telephone or by paper, either alone or with the help of a certified, you know, application assistant.

But my question goes to one of the rumors that's been circulating. There are many rumors about how the Affordable Care Act has affected part-time workers. And some of my colleagues on the other side claim that the companies are moving workers to part-time jobs because of the healthcare reform law, and that low-wage workers are being detrimentally affected. And I understand why these claims are being made, as just another part of the ongoing effort to undermine the law. Would you take a few minutes to just set the record straight on the "part-time" issue?

Secretary SEBELIUS. Certainly. Ninety-five percent of businesses in this country are small businesses, under 50 full-time employees, and there is no responsibility that any of those employers have to provide health coverage for their employees. On the other hand, there are now tax credits available for some of the smaller employers who want to offer coverage to actually come into the marketplace.

For the other businesses, the businesses hiring 50 or more, there is a standard that says an employee is considered full time if he or she works 30 hours a week, and that really came from a market snapshot with help from the Small Business Administration of where employee benefits were in the private market based on hours of work, what was a part-time or a full-time employee.

What we know about the economic data is the high point of part-time workers was in 2008 and 2009, at the height of the last recession. It has been decreasing each and every year. There is no data to support the fact that there is an uptick based on the impending Affordable Care Act. I am sure that there may be some individual employers making some business decisions about how many workers they want full time and how many part time, but I can tell you there is no economic data or employment data that supports the notion that this is an effect of the law.

Mrs. CHRISTENSEN. So, in fact, it's my understanding that part-time workers are at the lowest percentage of workers in many, many years right now. And——

Secretary SEBELIUS. Well, and for the first time, as you know, Congresswoman, part-time workers will have options for affordable health coverage. They've never had that before. They've never had options in the marketplace. They've never had some help pur-

chasing coverage for themselves and their families. Their full-time colleagues have, but they have not. So they will have options.

Mrs. CHRISTENSEN. And just to be clear, I had another really long question, but the last part of it, it would be fair to say that at every point along the way, you expected this Web site to work based on everything that you had been told by the contractors up until that point.

Secretary SEBELIUS. Well, I expected it to work, and I desperately want to get it working.

Mrs. CHRISTENSEN. More than anyone else, I am sure.

Secretary SEBELIUS. I can't tell you how frustrated I am, and we are committed to fixing it. And the only thing that I think builds back the confidence of the public is fixing it.

Mrs. CHRISTENSEN. Thank you, Mr. Chairman.

Mr. UPTON. Gentlelady's time has expired.

Mr. Scalise.

Mr. SCALISE. Thank you, Mr. Chairman, for holding the hearing.

And thank you, Secretary Sebelius, for being with us.

Last week when the contractors that built the system were here, I had asked them all under oath if they had actually delivered the system they were contracted to build, and all four of them answered "yes." So I want to ask you, did the contractors deliver the system that you contracted them to build?

Secretary SEBELIUS. I don't think I can accurately answer that question. What we know is we have a system that doesn't function properly.

Mr. SCALISE. We definitely know that.

Secretary SEBELIUS. As we fix things, we will know more about what is broken along the way, and I'll be able to——

Mr. SCALISE. So would someone in your office—somebody in your office oversaw this implementation and received the product.

Secretary SEBELIUS. That's true.

Mr. SCALISE. And they either said, this is the product we contracted and paid hundreds of millions of dollars to build, or it wasn't. Does somebody in your office have the ability to——

Secretary SEBELIUS. Well, I think that we can say that the products tested, individually verified, individually function——

Mr. SCALISE. But clearly it was an integrated system.

Secretary SEBELIUS. They don't work well together. And——

Mr. SCALISE. Well, but I used to write programs for a living. I developed software products for a living. If you're developing an integrated system, it's irrelevant if one isolated component works by itself, but when you plug it in together it doesn't work, that's a system that doesn't work.

One of the questions I had and others had, somebody in your agency made a decision weeks, literally weeks, before the deployment to change the system instead of going from a browser ability where somebody, just like on Kayak or just like on Amazon.com, could go shop for products, look at prices before they purchased, which is how consumers are used to doing this. You all made the decision to change it around and gather all their information first before you could let them see prices. Was that you who made that decision?

Secretary SEBELIUS. No, sir.

Mr. SCALISE. Was that Ms. Tavenner?

Secretary SEBELIUS. It was Ms. Tavenner and a team who looked at not imposing additional risks on the system.

Mr. SCALISE. Did that team make the decision because they knew once people actually saw the prices—and we're getting reports from all of our constituents of dramatically higher prices than what they were expecting. Did you make the decision because you knew that when they saw the prices, they might not want to buy the products, so you wanted to gather their information first?

Secretary SEBELIUS. Sir, first, I did not make the decision. I was informed about the decision. We did it in——

Mr. SCALISE. Did you agree with the decision?

Secretary SEBELIUS [continuing]. September rolling off a number of features. And clearly they can see the products. Note, there is no requirement to buy anything.

Mr. SCALISE. Look, I spent over 2 hours trying to get into the system. I never once got to a point where I could see a price. I did get kicked out many times and got some of those blanks screens other people got.

I do want to share some stories with you from some of my constituents, because we started a page on our Facebook and on Twitter. We are collecting what's called Share with Scalise. People are sending us stories. And we're getting lots of stories from my constituents. I want to read you a few of them.

Randall from Mandeville said, "My healthcare premium went up 30 percent. That's over $350 a month increase."

We had Michelle from Slidell: "Our insurance premiums are going up $400 a month, and our deductible has increased."

And then you've for the Sean from Covington, who said, "My current plan through United Healthcare is no longer being offered in 2014 due to Obamacare. In fact, I received a letter stating that the new healthcare law was indeed the reason for the removal of my current healthcare plan."

Madam Secretary, what would you tell Sean, who liked his plan and now has lost it? And he was promised by you and the President he'd be able to keep that plan. What would you tell Sean now that he's lost his plan?

Secretary SEBELIUS. I would tell Sean to shop in the marketplace and out of the marketplace, and he will find——

Mr. SCALISE. Do you really think that's an acceptable answer——

Secretary SEBELIUS [continuing]. And he will find competitive prices.

Mr. SCALISE [continuing]. To Sean?

Secretary SEBELIUS. Again, if United chose not to keep Sean's plan in effect for Sean——

Mr. SCALISE. Because of the law.

Secretary SEBELIUS. Sir, the law said if you keep Sean's plan in place, if he liked his plan, if you only——

Mr. SCALISE. Sean likes his plan——

Secretary SEBELIUS [continuing]. Applied trendlines to Sean, then the plan is still there.

Mr. SCALISE. You and I may disagree over who you work for. I work for Sean. You work for Sean, Madam Secretary. Sean lost his plan that he liked. And there are thousands and millions of Seans

throughout this country that lost the plan they like because some bureaucrat in Washington said, we think your plan's not good enough; even though you like it, even though you were promised you could keep it, you're now not able to keep that plan. I think you deserve to give Sean a better answer than you just have to go shop for something else even though you lost your plan.

Mr. UPTON. Gentleman's time has expired.

Mr. SCALISE. I yield back the balance of my time.

Mr. UPTON. Gentleman's time has expired.

Mr. McNerney.

Mr. MCNERNEY. Thank you, Mr. Chairman.

Thank you, Madam Secretary, for coming today.

I'm going to follow up on Mr. Doyle's line of questioning. One concern I have with the fallout from the Web site is that many users who tried to sign up and were discouraged because of the problems will now be too discouraged to come back once the site is fixed. So what do you plan to do to get those folks to come back?

Secretary SEBELIUS. Well, sir, we intend to invite them back formally, by email, by message, but we don't want to do that until we're confident that they will have a different experience. So fixing the site is step one, and then inviting people back to the site to make it clear that when our timetable is fulfilled, they have 4 months to shop for affordable health coverage on a fully functioning site.

We know we're going to have to spend special time and attention on young and healthy Americans, who don't start out thinking they need health insurance, aren't aware of the law, certainly don't want to use a failed or flawed site. So we're going to have to spend some particular attention on them.

Mr. MCNERNEY. Thank you.

Have the software specifications for the Web site and its related software elements, including the test specifications—has that changed since the initial rollout?

Secretary SEBELIUS. I know that there certainly are some changes, because—since October 1st? I'm sorry.

Mr. MCNERNEY. Yes. Since the rollout, the specifications.

Secretary SEBELIUS. The specifications haven't changed. We are certainly fixing—as I say, speed and reliance is one of the issues we're taking a look at. That's the performance side. But there also are some functionality sides that things do not work as they can, including the enrollment passed on to insurers. So we are fixing functionality. And I don't think that's a change in the specs; I think it is actually making the system work the way it should.

Mr. MCNERNEY. Well, are you—or is the Department doing prioritization on the problems?

Secretary SEBELIUS. Yes.

Mr. MCNERNEY. Could you describe that a little bit?

Secretary SEBELIUS. Yes. As of last week, when Jeff Zients joined us for the short-term project, we asked him to lead a sort of management team. We have pulled in all of our contractors as well as additional talent that they may have available. We have talked to tech folks in and out of the private sector and insurance, some of their tech experts, to get all eyes and ears; made a full assessment; developed a plan for fixes along the way; have a punch list for

going after those fixes; and we are doing a daily tech briefing and blog to tell people what we have found, what we have fixed, what is coming next, what the functionality is. And we intend to do that until it's fully functional.

Mr. MCNERNEY. Thank you, Madam Secretary.

Looking past the initial problems with the ACA rollout, do you think that the Affordable Care Act will be successful in bending the healthcare cost curve and reducing the fraction of our national economy that goes for health care?

Secretary SEBELIUS. Well, I think that we have already had some success. I think the goal is to continue to achieve that. A fully insured population arguably with preventive care, with an opportunity to see a primary care doctor and not go through the emergency room will in and of itself reduce costs. Having people identified earlier who may have serious problems in managing those problems will reduce health costs. But I think the delivery system also needs some considerable help in paying for not number of procedures, number of tests, number of prescriptions, but paying for health outcomes.

Mr. MCNERNEY. Thank you, Mr. Chairman.

Mr. UPTON. Mr. Latta.

Mr. LATTA. Well, thank you very much, Mr. Chairman.

And, Madam Secretary, thank you so much for being with us today. Appreciate your testimony so far today.

What I'd like to do is I'll get these to you because there's so many we've received. These are questions that we've received from our constituents back home specifically about what's going on with the Web site and for them. And so what I'll do, I'd like to get those to you. But there's a lot of questions here, and a lot of thought's gone into a lot of these questions.

But if I could start with last week's testimony when four of the contractors were here. And in one of the questions that I had posed to Ms. Campbell from CGI, in her testimony she had stated that they delivered the Medicare.gov and also the FederalReporting.gov. And I had asked at that time were those sites more or less complicated than the site we're talking about here today. And she said, of course, the site today was more complicated. And in the questioning and from her testimony—and we've been hearing about this end-to-end testing that wasn't happening, that we had individuals out there saying that about 2 weeks had been done. But I'd asked her about was there a sufficient enough time when they did Medicare.gov. And the response that she gave me back was on Medicare.gov, which was a less complicated site, and she stated that "we had sufficient time to test the system before it went live." And I asked her in a follow-up then, "What was that sufficient time?" And she said, "We had a number of months before the system went live at that time."

And I just want to make sure, because, again, sometimes things don't get reported accurately, but—in the U.S. News there was a report on October the 18th of this year, and there's some questions going back and forth. I just want to make sure that you were quoted properly. Said, "'After 2 weeks of review,' the HHS Secretary concluded, 'we didn't have enough testing specifically for high volumes for a very complicated project. The online insurance

marketplace needed 5 years of construction a year of testing,' she said. 'We had 2 years and almost no testing.'" Is that correct?

Secretary SEBELIUS. I don't know the quote. I never suggested that we needed 5 years.

Mr. LATTA. OK. That's just——

Secretary SEBELIUS. I don't know what that's from or what that——

Mr. LATTA. That's one of the things we're going to check.

Secretary SEBELIUS. We clearly did not ever have 5 years. The law was signed in March of 2010.

Mr. LATTA. OK. And then last week when you were down in Texas, you were being asked by a reporter about the system and the launch. And one of the parts of the question was that at what point did you realize the system wasn't going to be working the way that you envisioned before the launch, and why didn't we stop it before the launch? And, again, this is what was reported: "We knew that if we had another 6 months, we'd probably test further, but I don't think anyone fully realized both the volume caused such problems, but volume's also exposed some of the problems we had."

Now, going back, though, to Ms. Campbell's statement that they tested more extensively on a system that was not as complicated, but HHS, CMS decided to go forward with only a very short period of testing. Do you think that was acceptable?

Secretary SEBELIUS. Well, clearly, looking back, it would have been ideal to do it differently. We had a product that, frankly, people have been waiting decades to have access to affordable health care. Medicare existed well before the Web site. Medicare is a program that started 50 years ago. The Web site was an additional feature for consumer ease and comfort. And so they were not launching Medicare, they were not delivering health benefits to seniors, they were putting together an additional way to enroll in Medicare.

I would suggest, sir, that we had deadlines in the law, that people had benefits starting January 1st. We wanted an extensive open enrollment period so that a lot of people who were not familiar with insurance, didn't know how to choose a doctor or choose a plan, had never been in this marketplace, or people who needed to understand fully what the law offered had ample time to do that.

So the date that I was, again, required to select for open enrollment, that's, again, part of the statute, how long would open enrollment be. We picked that date. All the contractors that began early in this process in the fall of 2010, when we issued—I'm sorry, 2011, when we issued the initial contracts to CGI and QSSI, knew the October 1st date. That was not changed. It wasn't added to.

As we got closer to the system, one of the reasons, again, that we pared down what needed to launch on October 1st was an attempt to minimize the risks to the system to get people to their ability to see clearly what they were entitled to, what the plans were, and, if they chose to, to enroll. Clearly the testing should have been longer, should have been more sufficient.

Mr. UPTON. Gentleman's time has expired.

Mr. Braley.

Mr. BRALEY. Thank you, Mr. Chairman.

Madam Secretary, people who are watching this hearing might be under the assumption that there's some kind of political debate going on over the Affordable Care Act. I think people in Iowa don't care anything about who's winning the political debate. They want these problems fixed, and they want them fixed now. And I think that's the responsibility of everyone in this room to make sure that that happens.

I tried to go into the marketplace on October 7, and I encountered problems immediately dealing with the security code questions which required you to select dates. One of them was type a significant date in your life. Today is my birthday, so I put that in. I tried three different ways of entering that data and got a message each time: "Important, this is not a valid answer." Same thing for the third date entry. And a lot of times when you're registering online for anything, and you have to put a date in, there will be a little prompt there that tells you what the format is you're required to enter.

Do you know, have we solved this problem in the security code area?

Secretary SEBELIUS. Yes, sir. One of the initial issues was just getting people into the site. And the ID proofing, which is a two-step process, one is that you give some preliminary information and you set up a password, but the second, to ensure that your personal data can't be hacked, can't be interfered with, is the second step where some personalized questions, which only can be verified by you, are indeed part of that.

Again, that was an initial hold-up in the system. We focused a lot of attention on that in the first several days. It was fixed, only to then discover that there were system problems throughout the application. And that piece has been fixed, but I would suggest it also was a function of trying to make sure we had the highest security standards, that we were not cavalier about someone's personal information being able to be addressed and attached. And it was a functionality that didn't perform properly, but does now.

Mr. BRALEY. One of the things that keeps coming up in this hearing, because you are from Kansas, is references to The Wizard of Oz. And people went to see the wizard because of the wonderful things that he did. And the Affordable Care Act is doing a lot of great things in Iowa. The Des Moines Register wrote that "Iowans buying health insurance on the government's new online marketplace will face some of the lowest premiums in the country. It's increasing competition in our State. Iowa consumers are able to choose from 40 health plans in the marketplace."

You've mentioned the growth of healthcare spending is at the slowest rate in 50 years. Fifty thousand Iowa seniors have received prescription drug rebates. Bans on preexisting conditions are allowing people to get coverage and switch carriers. And now insurance premium increases are subject to review and can be rejected by the people reviewing those plans.

But all of these good things don't mean anything unless we solve these problems. And what I need to know is how confident are you that the problems will be fixed by December 1st?

Secretary SEBELIUS. Well, again, Congressman, I have committed to that date because that is the assessment of both inside and out-

side experts have analyzed, and I think they kicked all the tires and looked at all the system. I know that there's no confidence in that date until we deliver on the date. I am well aware of that, and that's on me.

Mr. BRALEY. Since Americans were supposed to have 6 months to sign up, would you support ensuring they still have 6 months by extending the open enrollment period for 2 more months?

Secretary SEBELIUS. At this point, Congressman, they will have a—fully 4 months of fully functional all ways to sign up. And again, there are alternate ways and the Web site right now that people are getting through.

The open enrollment period is extraordinarily long. It's about six times as long as a typical generous open enrollment period. And it's important for the insurance partners to know who is in their pool so, again, they can stay in the market next year and know who they are insuring. So we think that the timetable will allow people 4 months' time to fully use the Web site. They can use it right now, they can use the call center, they can go to navigators, they can enroll.

Mr. UPTON. Gentleman's time has expired.

Mr. Harper.

Mr. HARPER. Thank you, Mr. Chairman.

Thank you, Madam Secretary, for being here today. I'm sure there are other things you'd rather be doing, but we welcome the opportunity to have this conversation.

I'm going to ask the clerk to bring you a document for you to look at so I can ask you a couple of questions.

If you can go to page 8 on that, I have highlighted an item there. But this is a copy of a CGI slideshow from October 11 discussing technical issues that must be addressed within the Web site. And on page 8 of what I've handed you, CGI recommended that CGI and CMS have a review board to agree on which issues can technically be solved and which should politically be solved. Was such a review board convened?

Secretary SEBELIUS. Sir, I cannot tell you. I've never seen this document, and I'm not aware of this recommendation.

Mr. HARPER. But CGI is responsible for the Web site, correct? Or for the operation?

Secretary SEBELIUS. CGI is responsible for the application.

Mr. HARPER. For the application of this.

Secretary SEBELIUS. Yes.

Mr. HARPER. Does it surprise you that in a slideshow that they gave in October 11th, they acknowledge political reasons for——

Secretary SEBELIUS. Sir, again, I've never seen this document. I have no idea what that means. Did you ask CGI when they came last week?

Mr. HARPER. Can you find out for us if such a review board was done and if any decisions were made on political reasons or any other reasons and find that out for us?

Secretary SEBELIUS. Sir, I—that question needs to go to CGI, but I can ask them to report to you.

Mr. HARPER. If you will do that.

Secretary SEBELIUS. This is their document, if I understand. This is not our document.

Mr. HARPER. Would you turn to page 9 of that document, please? And it states "Challenges" on page 9 in this presentation by CGI. And it says, under "Challenges," "Unable to determine at this time whether low enrollment counts are attributable to system issues or due to users choosing not to select or enroll in a plan."

So those are two completely different issues, obviously. If it is a system issue, that's something you have confidence at some point will be resolved, correct?

Secretary SEBELIUS. Yes, sir.

Mr. HARPER. And if it's a user selection issue, that's an entirely different story; is it not?

Secretary SEBELIUS. Yes, sir.

Mr. HARPER. OK. Now, when you used the phrase earlier about a punch list, that's like having somebody move into a house. Someone's buying a new house, and they go through, and they've been told this house is going to be ready for you to move in on October 1st. They load up the van, they come in. And they get in, and it's not finished. Part of the plumbing's not right, the wiring's wrong, and they go in.

This creates the situation where, health care shouldn't be a zero-sum game. I mean, we want to be fair to everyone. We want to help people who are vulnerable, but at the same time we shouldn't have to hurt folks. We've got people in my district, in my State, who are getting notices of cancellation. They are being told of higher premiums that they're having. And these are great concerns that we have. And how do we work through that?

And I want to say I appreciate you accepting responsibility for these initial rollout failures that we've had, but who is ultimately responsible? It is the President, correct?

Secretary SEBELIUS. For the Web site? I would say that we are.

Mr. HARPER. I would say that the President is ultimately responsible for the rollout, ultimately.

Secretary SEBELIUS. No, sir. No, sir. We are responsible for the rollout.

Mr. HARPER. But who do you answer to?

Secretary SEBELIUS. I answer to the President.

Mr. HARPER. So is the President not ultimately responsible, like a company CEO would be?

Secretary SEBELIUS. Sir, he's the President of the United States. I have given him regular reports. And I am responsible for the implementation of the Affordable Care Act. That's what he asked me to do, and that's what I'll continue to do.

Mr. HARPER. So you're saying that the President is not responsible for HHS?

Secretary SEBELIUS. Sir, I didn't say that.

Mr. HARPER. OK. So the President ultimately is responsible. While I think it's great you're a team player and you're taking responsibility, it is the President's ultimate responsibility, correct?

Secretary SEBELIUS. You clearly—whatever. Yes. He is the President. He is responsible for government programs.

Mr. HARPER. My time is expired.

Mr. UPTON. Gentleman's time has expired.

Mr. Lujan.

Mr. LUJAN. Mr. Chairman, thank you very much. Before I begin, I'd like to ask unanimous consent to submit into the record some articles from New Mexico publications, the Albuquerque Journal, and Albuquerque Business Journal, the first entitled "Small Business Owner: Health Exchange Will Save Me $1,000 a Month."

Mr. UPTON. Without objection.

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

Mr. LUJAN. Thank you, Mr. Speaker. And I see my time did begin there, so I'll try to get through this, Mr. Chairman.

Madam Secretary, I was intrigued by a line of questioning by Congressman Green, asking questions about the individual marketplace. How volatile was the individual marketplace before the Affordable Care Act became law?

Secretary SEBELIUS. I would say it wasn't a marketplace at all. It was unprotected, unregulated, and people were really on their own.

Mr. LUJAN. Madam Secretary, the Kaiser Family Foundation reports that over 50 percent of individuals that have coverage in the individual market churn out of coverage every year. They either lose coverage, they are priced out or drop it. Is that consistent with what you're aware of?

Secretary SEBELIUS. That's an accurate snapshot. About a third of the people are in for about 6 months, and over half are in for a year or less.

Mr. LUJAN. So individuals that were in the individual marketplace before the passage of the Affordable Care Act did not have the same protections as those that were in group coverage.

Secretary SEBELIUS. That's true.

Mr. LUJAN. And would those individuals in the individual marketplace sometimes have higher copays?

Secretary SEBELIUS. Higher copays, unlimited out-of-pocket costs for often coverage that was medically underwritten or excluded whatever medical condition they had in the first place.

Mr. LUJAN. So these were typically 1-year contracts. If they use the plan because they got sick or in a car accident or a victim of domestic violence, sometimes they'd be thrown off their plans, or their rates would go up.

Secretary SEBELIUS. Yes.

Mr. LUJAN. I think that's important to note, Madam Secretary.

And I'm intrigued as well that my understanding is last month HHS conducted an analysis that found that nearly 6 out of 10 uninsured Americans getting coverage through the marketplace will pay less than $100 per month; is that correct?

Secretary SEBELIUS. They will have a plan available for less than $100 if that's their choice, yes.

Mr. LUJAN. And that number would be even higher, would be better, if more States chose the option of using Federal funds to expand Medicaid to cover their low-income population?

Secretary SEBELIUS. Oh, very definitely. That's just a marketplace snapshot. Those are people who will be in the marketplace.

Mr. LUJAN. Madam Secretary, I don't think that I've heard anyone from the other side of the aisle today, my Republican colleagues, ask you how can Congress work with you and support you in fixing this Web site and fixing this problem. I hope that we all

agree we want this Web site fixed. I would yield to anyone that would disagree.

Seeing no one accepting that, I'm glad to hear that we agree with this.

Now, Madam Secretary, what can Congress do to work with you to fix this Web site?

Secretary SEBELIUS. Well, I'm not sure that there is hands-on work that you can do, maybe we have some technical expertise, but I would say getting accurate information to constituents is helpful; letting people know that they can check out the facts and the law; that they may be entitled to some financial support; that cancellation of policies means that the policy that they had may not exist, but they have a lot of choices of new policies and a law that now says they must be insured in a new policy, that they don't have to be insured by their company at a higher price.

Mr. LUJAN. I appreciate that, Madam Secretary.

Going back to the individual marketplace, Madam Secretary, did this Congress in previous years before the Affordable Care Act make it illegal for health insurance companies to raise rates on someone after they submitted a claim for going to the hospital or becoming sick or getting rid of preexisting conditions?

Secretary SEBELIUS. No, sir.

Mr. LUJAN. Madam Secretary, one last note here. It seems that we've received some horrible news here that there are bad actors already taking place of fraudulent Web sites that imitate the healthcare exchange or misleading seniors into disclosing their personal information. I've signed onto a letter to you led by my colleague, Representative Raul Ruiz out of California, to request that you prioritize fraud-prevention efforts. What's the administration done to prevent these fraudulent acts and protect personal information?

Secretary SEBELIUS. I can tell you, Congressman, that the President felt very strongly that that needed to be part of our outreach effort, which is why the Attorney General and I convened representatives of State attorneys general, insurance commissioners, the U.S. attorneys, and the Justice Department and the Federal Trade Commission, which has jurisdiction, to make sure that we first got out ahead of some of this developing consumer outreach.

No one should ever give personal health information, because personal health information is not needed for these policies any longer. That's a red flag. We want to make sure that people turn over potential fraudulent acts. We have put training in place for navigators. We have our law enforcement doing——

Mr. UPTON. Gentleman's time has expired.

I would just note that, with the indulgence of the Secretary, we're hoping that we can have all Members ask some questions, but we also know that with 4 minutes, we're going to have a little trouble. So I'm going to ask unanimous consent that we try limit our questions and answers to no more than 2 minutes. And I've talked to Mr. Waxman. Is that OK? Because otherwise there will be a lot of folks who will not be able to ask a question at all.

Secretary SEBELIUS. Mr. Chairman, I would commit to if the questions get submitted, we would be happy to provide timely answers also to make sure——

Mr. UPTON. Can I do that? So with that, we'll try 2 minutes.

Mr. Lance.

Mr. LANCE. I guess I won the lottery on the 2 minutes. Madam Secretary.

Mr. UPTON. Time has expired.

Mr. LANCE. Twenty seconds, Mr. Chairman.

On the Web site, Madam Secretary, the contractors testified last week that they needed more than 2 weeks for end-to-end testing. Why, in your opinion, was there not more than 2 weeks?

Secretary SEBELIUS. Again, we had products—the insurance policies themselves by companies were loaded into the system. So wecould test up until then, but it wasn't until September, mid-September, that that was done. And, again, the contractors said, we would have loved more testing time, but we think we're ready to go ahead.

Mr. LANCE. I believe that will ultimately be a dispute between CMS and HHS and the contractors. And if there's anything we can do regarding that, because obviously that didn't work. And I had thought, given this signature issue with the President, that the Web site would be ready.

Number two, in my judgment, the President's statements were overstatements. The four Pinocchios is an indication of that. There's a report in the New Jersey newspapers this morning that 800,000 people in New Jersey who purchased their policies in individual or small-employer markets will be affected by this.

Mr. Walden in a previous question mentioned the fact that in an individual market you would be able to keep your policy grandfathered. Yet regulations issued by HHS say that grandfathered status would not be continued for so much as a $5 change in a copay. Is that accurate, and do you believe that that is a significant change?

Secretary SEBELIUS. Sir, we gave, I think, in the grandfather regulations a guide for how pricing could change, medical inflation, and I think it was in most cases a plus 15 percent. There were some individual consumer outfacing issues that were more rigid than that. But I would say that in terms of having companies being able to collect a profit margin, that was certainly built into the grandfather status.

Mr. LANCE. I think that's too little a change, respectfully.

Mr. UPTON. Gentleman's time has expired.

Mr. Tonko.

Mr. TONKO. Thank you, Mr. Chair.

And welcome, Honorable Secretary. Thank you for fielding our questions and for responding when you were extended the courtesy to offer a response.

As a strong supporter of the Affordable Care Act, I'm frustrated, and I think it's fair to say that the American people are frustrated as well. And I heard you here many times this morning say you're frustrated.

I think by and large people want this law to work. When I talk to folks back home in the capital region of New York that I represent, even people who opposed the law initially aren't rooting for the failure of the Affordable Care Act. Instead, they want Congress to come together to fix these problems so that we can move on to

real issues that matter, like creating jobs and growing the economy.

My home State of New York, which also experienced Web site problems at the outset, has now completed enrollment determinations on over 150,000 New Yorkers, with more than 31,000 having already signed up for quality, low-cost health insurance. Given that many States have had success in overcoming these initial Web site issues, has HHS looked at what these State Web sites are doing as it searches for solutions to the fix HealthCare.gov?

Secretary SEBELIUS. Absolutely. And we shared a lot of the information going in. I think that the hub feature that we have in our Web site that all States are using, including the State of New York, is fully functional, and that's good news for New York and California and others who are running their own State Web sites. But we are learning from them, we've shared information with them, and we are eager for all the help and assistance moving forward.

Mr. TONKO. Thank you.

Similarly, many States made the illogical choice of rejecting Medicaid expansion contained in the ACA that would help some of their poorest citizens get access to the healthcare situation. This is despite the fact that Medicaid expansion is almost entirely financed by Federal dollars.

Can you comment broadly on HHS' plan in the future to encourage more States to run their own marketplaces and expand Medicaid so that the law can function as designed?

Secretary SEBELIUS. Well, absolutely. Most recently, last week, the State of Ohio did move into the Medicaid market. And we now have 30 Governors. I think 27 States have fully completed the process. Another three are in the process, Republicans and Democrats, some of whom sued us about the constitutionality of the act, who are now deciding that for the citizens of their State, they want to be part of the expanded Medicaid. And we will continue to have those conversations. It's not just about the marketplace, it's also about Medicaid.

Mr. TONKO. Thank you very much.

Mr. UPTON. Gentleman's time has expired.

Dr. Cassidy.

Mr. CASSIDY. You said that an individual policy is only cancelled if it changes significantly. But, to be clear, after May 2010, if coinsurance went up by any amount, even by a dollar, according to your regulations, that would not qualify as a grandfathered clause. Just to have that out there for the record. I gather even by a dollar.

That said, I get a letter from someone in my district, Adrian. She says that, oh, she lost her coverage. She lost her coverage because spousal coverage is gone. She's gone on the exchange, she doesn't qualify for a subsidy, but that her premium and out-of-pocket costs, under any plan, is $10,000 a year. She feels—she writes this—she feels betrayed by her government. Now, she has to sit there asking herself, is this fair? If you were she, do you think that this would be fair?

Secretary SEBELIUS. Dr. Cassidy, I want to start by the amount that you gave is not accurate. I was told it's $5, not a dollar.

Mr. CASSIDY. That's for the copay, not for the coinsurance. For the coinsurance, it's any amount. But I have limited time.

Do you think that if you were she, if you were Adrian, do you think this is fair? Loses her spousal coverage, now it's 10K, no subsidies?

Secretary SEBELIUS. Sir, I don't have any idea what she's looking at. I can tell you that, again, based on what we've seen in the market, what we've seen in the plans, people will be getting full insurance for the first time at competitive prices.

Mr. CASSIDY. Well, again, this is what she reports. Do you think it's fair—if what she reports is true, do you think it's fair?

Secretary SEBELIUS. I can't answer fair or not fair. I don't know what she was paying or what she was paying before——

Mr. CASSIDY. That's OK. Let's move on.

Secretary SEBELIUS. Did she have full insurance?

Mr. CASSIDY. Richard writes that his daughter received a note that his premium's going up because she's being lumped with older, costlier patients. Now, it's possible that the only people that sign up will be those who are more costly. Does HHS have plans on what to do if only those who are more costly sign up and premiums rise for everybody?

Secretary SEBELIUS. I think, sir, that's what we're trying to do to make sure that——

Mr. CASSIDY. But if only the costly——

Secretary SEBELIUS [continuing]. With the individual mandate——

Mr. CASSIDY [continuing]. Sign up, do you have plans?

Secretary SEBELIUS. That's the importance of the individual mandate that you've just outlined. Getting rid of preexisting conditions, making sure that people who come in——

Mr. CASSIDY. But if only the most costly sign up, do you have backup plans?

Secretary SEBELIUS. We will encourage others to sign up. It's why there's a penalty in place and why——

Mr. CASSIDY. Is this to assume that there are no backup plans? I don't mean to be rude, but——

Mr. UPTON. Gentleman's time has expired.

Mr. Yarmuth.

Mr. YARMUTH. Thank you, Mr. Chairman.

Madam Secretary, nice to see you.

I come to this hearing with a little bit different perspective. Kentucky is doing a great job with our exchange. As of this morning, we have 350,000 people that have explored the Web site, 59,000 started applications, 31,000 are now fully enrolled in new coverage, and 5,000 just in the last week. And I think, very importantly, more than 400 businesses have begun applying for their employees as well. So the idea that somehow this is going to be bad for businesses is not borne out in Kentucky.

Would it be safe to say that if 36 States had done what Kentucky and New York and California have done instead of 14, that the rollout would have been much smoother, and the Web site would have been much easier to construct?

Secretary SEBELIUS. I don't think there's any question that the—you know, in January of 2013, we knew how many States were not running their own Web site. In, I think, mid-February we learned

about partnerships. So it was not until that point that we learned that 36 States would actually be coming through the Web site.

Having said that, we should have anticipated, we should have planned better, we should have tested better. I don't think that's any excuse. But we clearly are a running very different vehicle for enrollment than we thought we were going to run in March of 2010.

Mr. YARMUTH. On the subject of cancellation of policies, isn't it true that, first of all, the Federal Government can't require insurance companies to sell insurance?

Secretary SEBELIUS. That they can't?

Mr. YARMUTH. Federal Government can't require insurance companies to sell insurance?

Secretary SEBELIUS. Yes, that's true. Yes, sir.

Mr. YARMUTH. And, in fact, insurance companies all over the country are making very difficult decisions now about where they want to participate and where they don't. And in some markets they are actually trying to get out of the market, canceling people, because they want to play in other markets and so forth. They are all making those decisions now.

Secretary SEBELIUS. Well, and we know we have more insurers, 25 percent more insurers, in the individual market than we did prior to the law being passed.

Mr. YARMUTH. So there are a lot of dynamics going on here that are not necessarily an indication that the President misled anybody. There are business decisions being made all over now.

Secretary SEBELIUS. Well, in cancellation of policies, again, the 1-year contract notice is a routine in the individual market. It has been in place for years. And for a lot of people, they are policies now; they are being canceled because they are being notified you can no longer being medically underwritten. We can't charge you more because you're a woman. We won't ever have the kind of limitation on what your policy can pay out or charge you exorbitant out-of-pocket rates. Those policies will cease to be offered in the marketplace.

Mr. UPTON. Gentleman's time has expired.

Mr. Guthrie.

Mr. GUTHRIE. Thank you, Madam Secretary, for being here. And last week Mr. Lau from Serco was here. I know the President's talked about the alternatives to the Web site is phone calling or using paper, paper application. And what he said, and I think you've said it with the phone, they take the paper applications, but they enter them into the same Web portal. So I know you get around the issue of getting on and getting logged off, but also—but there are still issues with data within the Web portal. As you said, you can't even get reliable data who's even signed up.

So he also said because of the surge in paper applications, it's, like, 6 to 8 weeks to process. So if November 30th is when this will be ready that they can use—and even if you do it now, 8 weeks, you're getting close to January 1st—if somebody does lose their insurance, so they're signing up for this, and they get to January 1st, even though you have a March 31st open enrollment, what happens to these? Is there a contingency plan for these people to continue their insurance?

Secretary SEBELIUS. Sir, I think that we have improvements every day on the speed of the site. Serco was giving you early snapshots of difficulty of accessing the site. I think that's greatly improved——

Mr. GUTHRIE. Well, they said just processing the paper, actually. OK.

Secretary SEBELIUS. I understand. But it is the site for—they put the application into the site and get a determination. That's part of what the process is.

So the site is part of the portal all the way through. This is an integrated insurance vehicle, and so that will improve. And we—again, with 4 months of continuous service, which is far longer than most people had, some of these cancellation numbers—Mr. Geraghty again pointed this out from Florida Blue Cross, but it's true of everyone else—these are not January 1st numbers, they are year-long numbers. So over the course of 2014, when an individual's policy is due to expire, that individual——

Mr. GUTHRIE. But somebody's could expire January 1st and not be able to get coverage if the Web site—and the vendors said they needed months to test, they would have liked to have months and months to test. That's what they said. So if we are going to get November—even if it works November 30th——

Secretary SEBELIUS. I would say we're testing as we go. This is beta testing going out right now. That's why we're fixing and how we can identify things. People are getting through every day. And we now know a lot more——

Mr. GUTHRIE. I know I'm out of—but the paper process, if it does take even 4 weeks, and it's November 30th, and people's cancel on January 1st, you—there needs to be a contingency for that person.

Secretary SEBELIUS. Well, again, typical insurance is 2 to 4 weeks of sign-up. They will have 2 full months of sign-up.

Mr. UPTON. Gentleman's time has expired.

Ms. Schakowsky.

Ms. SCHAKOWSKY. Thank you, Madam Secretary, for bringing to millions of Americans access to affordable, comprehensive healthcare coverage that's going to be there when they need it.

I want to thank you especially as a woman. Women can no longer—being a woman can no longer considered being a preexisting condition. Women can no longer be charged more than a man for the same coverage. Women have access to comprehensive benefits like prescription drugs, and free preventive screenings, and free contraceptive coverage, and maternity care, which is often left out of coverage. And the days of complicated pregnancy, or diabetes, or domestic violence being a preexisting condition, those days are over.

You know, I want to say to my colleagues, after a 3–1/2-year campaign to repeal, to discredit, to even shut down the government over Obamacare, I want to say, get over it. We all agree that there are problems, but these are problems that I see being fixed.

And so I want to ask one—oh, and I want to say that what we did under Medicare Part D can be an example of how we can work together. And, in fact, Chairman Upton and I both sent a letter asking for more money for community-based groups to help implement the program and make it work. We can work together.

So if you could just briefly say how are the navigators; how important are they in making this system work for the American people?

Secretary SEBELIUS. Well, what we know, Congresswoman, is that a lot of people are not Web savvy and are not frustrated by the Web site, because they don't have a computer, they don't want to use a computer, they don't trust a computer. They need a live human being to ask questions, get questions answered, talk about the plan, talk about insurance. So the navigators play a hugely important role.

We have about 2,500 trained navigators on the ground right now. We have thousands more community assisters who are trained and ready to go. About 45,000 agents and brokers have gone through specific Affordable Care Act training. But those individuals working with their clients, customers, and, in the case of navigators and community assisters, just the public at large, they are not paid by a company, they are not collecting a fee, they just want to help people get coverage, they are hugely important.

Ms. SCHAKOWSKY. Thank you.

Mr. UPTON. Gentlelady's time has expired.

Mr. Olson.

Mr. OLSON. I thank the chair.

And welcome, Madam Secretary.

Secretary SEBELIUS. Thank you.

Mr. OLSON. I'd like to open with a quote from an American icon. I'll hold up a poster. It says, "If a user is having a problem, it's our problem." I'm glad to hear that you embrace this philosophy during your testimony, ma'am.

Obamacare was signed into law 1,256 days ago, and since then there's been user problem after user problem after user problem.

Regarding HealthCare.gov, your Deputy Administrator for Consumer Information, Gary Cohen, testified 1 month ago, right where you're sitting, that—and this is a quote—"CMS has worked hard to test the infrastructure that will allow Americans to enroll in coverage confidently, simply, and securely," end quote. Yet according to Forbes and the Wall Street Journal, you told them that you needed 5 years of construction and 1 year of testing. The program has crashed and burned at least three times, and the user is still having problems. It's been down the whole time you've been testifying. The system is down at this moment.

My question, ma'am, is very simple: When did you know these changes were going down? A month? A day? A quarter? And did you tell the President what you knew?

Secretary SEBELIUS. Sir, I was informed that we were ready to launch on October 1st. The contractors who we had as our private partners told us and told this committee that they had never suggested a delay, and that is accurate. Our CMS team felt we were ready to go.

I told the President that we were ready to go. Clearly I was wrong. We were wrong. I—we knew that in any big, new, complicated system, there would be problems. No one ever imagined the volume of issues and problems that we've had, and we must fix it.

Mr. OLSON. Yes, ma'am.

Credible journalists said you know you needed 6 years to get the program up and running.

Secretary SEBELIUS. Sir, that quote has been repeated. I can guarantee you I would have never stated that, because the law was passed in March of 2010. I chose the open enrollment date. I don't know where that quote comes from, but that is not from me.

Mr. UPTON. Gentleman's time has expired.

Mr. Barrow.

Mr. BARROW. Thank you, Mr. Chairman.

And thanks for attending today, Madam Secretary. I suspect that deep down most people on this committee support the concept of reforming insurance markets so that more people have access to better insurance coverage. We have disagreements about the means used to get at those ends, which is ultimately why I voted against the Affordable Care Act.

But it seems that every day we're hearing of something new going wrong. I'm concerned that these short-term enrollment problems could become long-term insurance market problems. My constituents are already losing confidence in the Federal Government's ability to pull this thing off, and I think the only way to begin to restore their trust is to delay the individual mandate penalties until we're sure this system is going to work. It's not fair to penalize consumers when their noncompliance is not their fault.

We also need to take the time make sure additional fits and starts won't cause larger problems. Right now I'm less concerned about who's to blame, more concerned about what went wrong and how to fix it and how we're going to ensure it doesn't happen again.

Nearly all of our constituents want and need health insurance. It would be a huge mistake if we were so blinded by our love or our hatred for Obamacare that we miss opportunities to address its flaws.

Now to the subject of technical problems becoming market problems. Can problems of folks getting into the system snowball into risk pool problems where those who choose not to enroll can actually affect the cost of those who do choose to enroll?

Secretary SEBELIUS. Certainly. A risk pool needs a balanced market, so you need people who are older and sicker to be balanced with people who are younger and healthier. That's how a pool works.

Mr. BARROW. At what point are we going to see a problem having the risk pool if the tech problems cause—affecting the folks who are entering? What are we going to look for? What are we going to use to decide something needs to be done?

Secretary SEBELIUS. Well, again, sir, we will be monitoring during the 6 months of open enrollment, as will our insurance partners, who is coming into the pool. That's why we want to give this committee and others reliable, informed data about not only who it is, but what the demographics are and where they live. That's part of our target.

Mr. BARROW. If things aren't better by the end of this next month, at what point are we going to start thinking about further delays and imposing penalties?

Secretary SEBELIUS. Well, again, I think that having a defined open enrollment period is one of the ways that you then make an

assessment if you have a pool that works or not. You cannot have an unlimited open enrollment period with any insurance company, because that really doesn't work.

Mr. BARROW. Thank you.

Mr. UPTON. Mr. McKinley.

Mr. MCKINLEY. Thank you, Mr. Chairman.

Last week the CGI representative Campbell said she had met her contract obligations and met the specifications. And she said the only problem she had was with pace, but the pace wasn't part of the specification. We asked her what you would—you would testify to. Did—she said you would testify that she did complete her contract in accordance with the specifications. Would you?

Secretary SEBELIUS. Sir, I don't think until the product is working the way it's designed to work that anybody has finished their job. And that's really my interest.

Mr. MCKINLEY. Thank you. I'm sorry, with time, they've shortened our time.

So if she hasn't met their specifications, but yet we're still using her, so is the American taxpayer still paying the money to fix the problems that her company didn't do in the first place?

Secretary SEBELIUS. None of our contractors have been paid the amount of their——

Mr. MCKINLEY. Will she be paid for this work into the future as we go to correct this problem?

Secretary SEBELIUS. We will make that determination as the work goes forward. I would tell you, sir, that as we learn what needs to be fixed, how long it takes, we'll know more about whether they delivered.

Mr. MCKINLEY. I'm very sorry, but the time frame has been cut down.

Who owns the software now? Now that this has been developed with taxpayer money to develop the software to do this——

Secretary SEBELIUS. It is owned by the Centers for Medicaid & Medicare Services.

Mr. MCKINLEY. So it's all owned by us. OK.

Will they be able to use it by a license for other clients?

Secretary SEBELIUS. Not to my knowledge. I think it is specifically designed for the marketplace with these products in mind.

Mr. MCKINLEY. Thank you.

Then last question to trying to work——

Secretary SEBELIUS. And the clients are the American public.

Mr. MCKINLEY [continuing]. Under IV&V, and she testified that she thought that was something we should have done. Under HHS, you recommend or the HHS recommends that for software development, that they should have an independent verification and validation program, but it wasn't used in this case. Can you share with us in the—the time that's gone why we didn't use IV&V on something that's——

Secretary SEBELIUS. Again, I don't think that's accurate, sir. At every point along the way, there is independent testing. There is——

Mr. MCKINLEY. Independent.

Secretary SEBELIUS. Yes.

Mr. MCKINLEY. You recommend independent——

Secretary SEBELIUS. An outside——

Mr. MCKINLEY [continuing]. Verification and validation. Not someone within your staff.

Secretary SEBELIUS. Pardon me? There is a level of company self-attested testing, there is a level of CMS testing and then there is an independent test on each piece of the contracting; an independent, not CMS.

Mr. MCKINLEY. You've acknowledged it wasn't done independently, and that's the——

Mr. UPTON. The gentlemen's time——

Mr. MCKINLEY. It needs to be done independently. People that do not have a——

Mr. UPTON [continuing]. Has expired.

Secretary SEBELIUS. No.

Mr. MCKINLEY [continuing]. A dog in the fight.

Secretary SEBELIUS. It isn't CMS. I will get you the information. There are three levels of testing. One of them is independent for every piece of this contracting, yes.

Mr. UPTON. Mrs. Castor.

Ms. CASTOR. Good morning. When open enrollment began a few weeks ago, the people back home in Florida who are helping their neighbors sort through the new options for coverage, the navigators, were taken aback by how grateful people are to have a new pathway to the doctor's office and the care they need, affordable options. They're no longer being discriminated against because they had cancer and diabetes or asthma, and they are very grateful. They said to me directly it's like they found water in the desert.

Right now they are—surprisingly, they said it's taking time, because people want to sort through all of these options before they finally sign up at the end of the 26-week enrollment period.

So we must fix the marketplace, we must, to meet their expectations. And we have very high expectations for you and for the administration.

But I think it's important to point out the Affordable Care Act is more than just a Web site. Despite all the obstruction by Republicans in my home State of Florida, nationally, even going so far as to shut down the government, millions of Americans are already benefiting, and they are benefits that are not tied to HealthCare.gov.

So, Madam Secretary, let's clarify what's working, despite HealthCare.gov. Is it correct to say that many of the improvements that the ACA makes to employer coverage and to Medicare, where the vast majority of Americans who receive their coverage, are not dependent on HealthCare.gov?

Secretary SEBELIUS. That's correct.

Ms. CASTOR. And so the delays and problems with HealthCare.gov do not affect the millions of individuals, thanks to the ACA, who no longer have to worry about lifetime monetary caps on their coverage that previously sent them to bankruptcy?

Secretary SEBELIUS. That's absolutely true. And I think the quote that the President was quoted recently saying if you have health care, you can—you don't have to sign up for the new marketplace was referring to that large portion, the 95 percent of in-

sured Americans whose plans are solid, stay in place and move forward.

Ms. CASTOR. And I understand the frustration with the Web site. What I don't understand is why people are not similarly outraged by the lack of Medicaid coverage in many of our States. Do you find that hypocritical?

Secretary SEBELIUS. Well, I think it's very troubling that millions of low-income working Americans will still have no affordable option if States don't take advantage of the expansion program, leaving States bearing the cost of uncompensated care, families bearing the costs of parents who can't take care of their kids, workers not able to go to work, and people still accessing care through emergency room doors, the most expensive, least effective kind of care they could get.

Mr. UPTON. The gentlelady's time has expired. Mr. Gardner.

Mr. GARDNER. Thank you, Mr. Chairman. And thank you, Secretary Sebelius, for being here.

Here's my letter. This is the letter that my family got canceling our insurance. We chose to have our own private policy back in Colorado so we could be in the same boat as every one of my constituents, and yet my insurance policy has been canceled. The White House Web site says, if you like your health plan you have, you can keep it. Did I hear it wrong?

Secretary SEBELIUS. Again, sir, I don't know how long you've had your policy or what policy——

Mr. GARDNER. Why aren't you losing your insurance?

Secretary SEBELIUS. Pardon me?

Mr. GARDNER. Why aren't you losing your health insurance?

Secretary SEBELIUS. Because I'm part of the Federal Employee Health Benefits plan.

Mr. GARDNER. Where aren't you in the exchange? You're in charge of this law, correct? Why aren't you in the exchange?

Secretary SEBELIUS. Because I'm part of the Federal Employee Health Benefits plan.

Mr. GARDNER. Why aren't you in the exchange? Why won't you go into the exchange? You're a part of this law. You're literally in charge of this law. Should you be any different than all of the other Americans out there who are losing their health insurance today?

Secretary SEBELIUS. I'm part of the 95 percent with affordable available health coverage, as are——

Mr. GARDNER. You're part of a plan that——

Secretary SEBELIUS [continuing]. Most of your colleagues in this room.

Mr. GARDNER [continuing]. Most Americans don't have available to them. Why will you not agree to go into the exchange?

Secretary SEBELIUS. I am not eligible for the exchange.

Mr. GARDNER. I went into the exchange.

Secretary SEBELIUS. Because I have coverage in——

Mr. GARDNER. You can decide——

Secretary SEBELIUS [continuing]. The employee side.

Mr. GARDNER [continuing]. To drop the coverage of your employer. You have the choice to decide not to choose——

Secretary SEBELIUS. Well, I—that is not true, sir.

Mr. GARDNER. I chose not to go into the congressional——

Secretary SEBELIUS. Members of Congress are now part of the exchange thanks to an amendment——

Mr. GARDNER. Before——

Secretary SEBELIUS [continuing]. That was added by Congress, but I am not eligible——

Mr. GARDNER. Madam Secretary, with all due respect——

Secretary SEBELIUS. If I have affordable coverage in my workplace, I am not eligible to go into the marketplace.

Mr. GARDNER. With all due respect, Madam, I would——

Secretary SEBELIUS. That's part of the law.

Mr. GARDNER [continuing]. Madam Secretary, I would encourage you to be just like the American people and enter the exchange——

Secretary SEBELIUS. I——

Mr. GARDNER [continuing]. And agree to find a way to do that, Madam Chair.

Secretary SEBELIUS. It's illegal.

Mr. GARDNER. Madam Secretary. And I would like to show you an advertisement that's going on in Colorado right now. This is an advertisement that a board member of the Colorado exchange has put forward. Do you agree with this kind of advertising for——

Secretary SEBELIUS. I——

Mr. GARDNER [continuing]. Obamacare?

Secretary SEBELIUS. I can't see it. And, again, it's——

Mr. GARDNER. It's a college student doing a keg stand.

Secretary SEBELIUS. If the Colorado exchange did that, they are——

Mr. GARDNER. Do you approve of this kind of advertising?

Secretary SEBELIUS [continuing]. A State-based marketplace.

Mr. GARDNER. Do you approve of this kind of advertising?

Secretary SEBELIUS. I don't see it. I don't know what it is, and I did not approve it. This is a State-based marketplace.

Mr. GARDNER. That's a pretty big font, that's a pretty big picture of a keg——

Secretary SEBELIUS. I——

Mr. GARDNER [continuing]. And you can't see it?

Secretary SEBELIUS. Sir, do I approve of it.

Mr. GARDNER. You——

Secretary SEBELIUS. I've never seen it.

Mr. GARDNER. You have the ability to opt out, by the way, as a Federal employee. You could take the insurance. So I just——

Secretary SEBELIUS. If I have——

Mr. GARDNER. I would encourage you to make that decision.

Secretary SEBELIUS [continuing]. Available employer-based coverage, I am——

Mr. GARDNER. I would also like to submit a——

Secretary SEBELIUS [continuing]. Ineligible for——

Mr. GARDNER [continuing]. Waiver from my district from Obamacare, and hope that you will consider waiving Obamacare for the Fourth Congressional District.

Mr. UPTON. Gentleman's time has expired.

Mr. WAXMAN. Does your policy cover—never mind.

Mr. UPTON. Mr. Matheson.

Mr. MATHESON. Well, thank you, Mr. Chairman. And, Madam Secretary, thanks for your time. I just want to ask, on the issue

of the fixes to HealthCare.gov, we've had a lot of conversation about that today, and we've talked about confidence levels for being ready by a certain time, but I think one question that a lot of us have is can you define what the magnitude of the problem is? Is there a scale or a metric by which we can understand how bad this is today and how we're going to get to where we go to have it fixed?

Secretary SEBELIUS. Well, again, sir, I've been informed that the problems are in—and the reports I've seen are really in two areas. They are in the performance area, which is speed and reliability. It's too slow, it doesn't have reliable transfers. And in functionality. There are parts of the system that just don't make accurate transfers. So we have done an extensive assessment. They are prioritized, as I indicated earlier. One of the priorities is the enrollment features which pass individual information to the companies where they want to enroll. That is not reliable at this point. The companies are not getting accurate data. So it's an example of the kind of thing we know we need to fix.

Mr. MATHESON. And is there a way to have you set up your metrics to figure out if we're making progress in terms of if you're fixing those issues with speed and performance and functionality?

Secretary SEBELIUS. Again, with a team and Jeff Zients at the head of it reporting to Marilyn, there are definitely a comprehensive set of issues going forward that will be measured and accelerated.

Mr. MATHESON. Do you have target dates along the way if you want to meet the November 30th time to assume it's functional at what you want, do you have target or metrics along the way to make sure you're on that path?

Secretary SEBELIUS. My understanding is yes, there are sort of groups of targets, that fixes, as you know, can be loaded together.

Mr. MATHESON. Right.

Secretary SEBELIUS. It isn't one at a time, so they don't take days, but they're trying to determine with a specific path, it's one of the charges that QSSI has really looking at the umbrella of what needs to be fixed, prioritizing them, figuring out what destabilizes if something else is fixed, how they can be grouped together, and that report will be in later next week.

Mr. MATHESON. OK.

Mr. UPTON. The gentleman's time has expired. Mr. Pompeo.

Mr. POMPEO. Great. Thank you. Thank you for coming, Secretary Sebelius. It won't surprise you that I would like to talk about Kansas a little bit today. Much like with some of my colleagues that made references to the "Wizard of Oz," I don't think anybody not from Kansas should be able to do Oz allegories, but my story, the way I think about it is those folks worked awful hard to go down that yellow brick road, and at the end of the day when they got there and pulled back the curtain, they found out there was nothing that they didn't already have. And as we pull back the curtain on the Affordable Care Act, I think people are finding that it's not exactly what they are going to have worked so hard to find their way to as well.

I want to talk about two stories. There's this commitment that said if you like your plan, you can keep it. I have a letter I'll submit for the record from Mr. Brito in Kansas. You might know him.

I saw him the other night in Benton. He got the following letter from Blue Cross Blue Shield that says, because your current plan does not offer the benefits standards specified, you will be discontinued on December 31st. And it says, good news. And then there's a group of folks, Pizza Hut, you know the company from Kansas, franchisees, founded there.

Secretary SEBELIUS. Yes, I do.

Mr. POMPEO. Lots of those folks have now taken employees, families who were working there, and they've gone from having full-time jobs to part-time jobs, so they aren't able to keep the health care plan that they had either and the one that they wanted.

Why were the plans these folks had good enough when you were the insurance commissioner in Kansas and when you were Kansas's governor, but those plans today aren't good enough for those hardworking Kansas families?

Secretary SEBELIUS. Sir, I would tell you in the roles I had the honor of serving of in Kansas, I worked every day to try and eliminate some of the discriminatory features of the insurance industry that finally, with the Affordable Care Act, are gone. My successor and elected insurance Republican commissioner, Sandy Praeger and I worked on a whole series of plans to expand coverage. So I did——

Mr. POMPEO. But——

Secretary SEBELIUS [continuing]. Work on these issues. We were not able to necessarily——

Mr. POMPEO. So you thought these——

Secretary SEBELIUS [continuing]. Get them passed.

Mr. POMPEO. To use your words, you said these were, I think you said, lousy plans, and Ms. Tavenner said, not true insurance. You think that the plans that were offered when you were insurance commissioner weren't true insurance?

Secretary SEBELIUS. In the individual market, the insurance commissioner in Kansas and virtually every place in the country——

Mr. POMPEO. So if the——

Secretary SEBELIUS [continuing]. Does not have regulatory authority over the plans——

Mr. POMPEO. Let me ask the questions.

Secretary SEBELIUS [continuing]. And a lot of them are not insurance.

Mr. POMPEO. Were they true insurance plans when you were insurance commissioner?

Secretary SEBELIUS. A lot of them were not true insurance plans, no.

Mr. POMPEO. Thank you. I yield back.

Mr. UPTON. Gentleman from Vermont, Mr. Welch.

Mr. WELCH. Thank you. I'm going to try to just summarize correctly what I've been hearing. Number one, the Web site must be fixed, you've been very forthright, and you're going to fix it.

Number two, I'm hearing a tone change. We've had a real battle about health care. We had a battle in this Congress. It was passed. The President signed it. The Supreme Court affirmed it. A really brutal battle. There was an election where the American people affirmed it. And then the last gasp effort was the shutdown and the

threat of debt default. But what I'm hearing today is that there are problems and people want to fix them, because all of us represent people who are going to win or lose depending upon how effectively this is rolled out.

Third, there's some significant question about existing insurance policies, what the President said and so on, but let's acknowledge something. A lot of insurance companies were ripping off innocent American people by promising them insurance until they got sick, and then it got canceled because they "had a pre-existing condition that wasn't, 'disclosed.'" That's got to end. The challenge for us going forward is to make health care affordable.

So, Madam Secretary, my question is, is there any indication that there's been a slowing of premium increases as a result of the Affordable Care Act, because unless we can keep those premium increases down, they can't rise faster than the rate of inflation, wages and profits, all of us are going to lose.

Secretary SEBELIUS. Well, I would say the trends in the private market over the last 3 ½ years are that cost increases have slowed down, are rising at a lower rate than the decades before. And, in fact, in this individual market, the old individual market, the typical increase was 16 percent year in and year out, rate increase, and often that came with additional medical underwriting. So it gives you a sense of how the costs were.

We know that Medicare costs are down. We know that Medicaid costs actually had a decrease per capita last year, not an increase per capita, and underlying health care costs are down.

These rates in the new marketplace, have come in about 16 percent lower on average than was projected; not by us, but by the Congressional Budget Office. And we know that in many of these markets, they're much more competitive. I believe in market competitiveness. That actually drives down rates. The States where the most companies are participating have the lowest rates. And new companies have come in significantly below the old monopoly companies that often dominated this individual marketplace. So we're on a pathway. Are we there? No. But you're absolutely right: affordable coverage at the end of the day for everybody is the goal.

Mr. WELCH. OK. I yield back. Thank you, Madam Secretary.

Mr. UPTON. Madam Secretary, I'm trying to make sure that you're out of here by 12:30 before we start the second round of questions.

Mr. Kinzinger.

Secretary SEBELIUS. That was a joke, right.

Mr. MCKINLEY. I see sheer panic.

Madam Secretary, thank you for being here. You stated earlier to Mr. Harper that you give the President regular updates on the marketplace. The President stated that he knew nothing about the status and functionality of the marketplace. How often and what were the subjects of those updates?

Secretary SEBELIUS. Well, I think there were a series of regular meetings with the President, with some of our Federal partners, with offices of the White House, from the OMB to others on a monthly basis giving reports on policy and where we were going. None of those, I would say, involved detailed operational discus-

sions. That wasn't the level. It was, are we coming together? Do we have companies? Do we have plans?

Mr. MCKINLEY. Sure. And I understand that. I mean, obviously when it comes to the President of the United States, certain level of details, you have to see it kind of a 10-, 20,000-foot overview, but in terms of the actual functionality, whether it's the Web site or the marketplace, he was legitimately caught off guard on October——

Secretary SEBELIUS. Well, I assured him that we were ready to go. Everyone knew with a big plan that there were likely to be some problems. No one——

Mr. KINZINGER. OK.

Secretary SEBELIUS [continuing]. Anticipated this level of problems.

Mr. KINZINGER. And just a second, a quick question. Where is HHS getting the money to pay for these fixes? Is it coming from other HHS accounts? Have you used your transfer authority to move money from non-ACA programs to pay for the cost of implementing the President's health care program, and if so, from which programs have you drawn money to help with the fix that's not ACA-related?

Secretary SEBELIUS. Well, as you know, Congressman, it's been 2 years since we've had a budget at HHS and we also have not had—at the President's requested implementation budget authorized by the Congress, each of those years we have used not only resources internally, but I do have legal transfer authority that I've used and a non-recurring expense fund. We will get you all the details of that.

Mr. KINZINGER. Great. Thank you.

Secretary SEBELIUS. We've been reporting that to Congress regularly.

Mr. KINZINGER. So the answer is yes, though, there is some non-ACA money being transferred and used for the implementation of ACA?

Secretary SEBELIUS. There is money that is specifically designed for either outreach and education, so the health centers have hired education outreach people as part of their outreach for health personnel. I would say it's definitely a related cause to get expanded health care.

Mr. KINZINGER. Thank you. Thank you, Mr. Chairman.

Mr. UPTON. Mr. Sarbanes.

Mr. SARBANES. Thank you, Mr. Chairman. Thank you, Madam Secretary, for being here. My understanding is that a lot of the companies, insurers that have been offering plans in the individual market, the ones who are sending out these notices are actually repositioning themselves in the health insurance exchange to offer alternative plans. Is that correct?

Secretary SEBELIUS. Yes.

Mr. SARBANES. And in addition to those insurers who've been in the individual market, you now have a lot of other companies and insurers providing plans in the health insurance market?

Secretary SEBELIUS. That is true.

Mr. SARBANES. So the way I look at this is, I went to buy Orioles tickets a while back when the season was still underway, and I was

standing in line and I got up to the ticket window, and they closed the window, but I didn't have to go home, because they opened another window a few feet away.

So essentially what's happening is people are coming up on the renewal period, they're getting up to the window of the individual market, they're being told, well, that window's closed, but if you go right down the line here, there's another window that's open. And, by the way, when you get there, you will get better coverage potentially at reduced premiums, and if you go down to window three, there's some subsidies that may also be available to you.

So this notion that people are being turned away from an affordable product that provides good, quality care is preposterous. In fact, they're being steered to a place where they can get good quality coverage, in many instances much better than the coverage that they had before, at an affordable rate that is supported by the subsidies that can be available to many, many people.

This is what's so promising about the Affordable Care Act, and so I think it's important for people to understand that that window is not being shut, they're just being steered someplace else where they can get a good opportunity.

Secretary SEBELIUS. And I think the first option for those companies is to say we'd like to keep you here and here are the plans we're offering, but to be fair, customers will now have an opportunity to look across a landscape, which they couldn't before, they will have entry into those other windows, which many of them didn't have before with a pre-existing condition, and as you say, about 50 percent of this market will have financial help in purchasing health insurance, which none of them had before.

Mr. UPTON. Gentleman's time has expired. Mr. Griffith.

Mr. GRIFFITH. Thank you, Mr. Chairman.

Earlier in your testimony here today, you said a couple times the plans we enjoy, but then as you noticed with Mr. Gardner's eloquent testimony, that we're not going to be in the same plan that you're in after January 1. I was one of those who thought it was a good idea as a part of a proposal that was floating around the halls here in Congress that the President and the cabinet secretaries ought to also be in the marketplace and not have a special Federal plan that you will have after January 1, but that we will not.

The President, while that was being discussed, issued a veto threat. Did you discuss the veto threat with the President before he made it and have you discussed it with him since then? Yes or no on the first.

Secretary SEBELIUS. No.

Mr. GRIFFITH. No. And then I would have to ask you relating back to the contractors involved in this, CGI told us that the Spanish Web site was ready to go, that they thought everything was ready just as they did with the regular site, and obviously that didn't prove out, but that they were told not to implement it; likewise, the shop and browse section was ready to go. Do you think that they were misleading this committee when they made those comments?

Secretary SEBELIUS. I think what they believed is that that product, independent of the entire operational site, was ready and test-

ed. What—a determination was made. I was involved with the Spanish Web site——

Mr. GRIFFITH. Let me——

Secretary SEBELIUS [continuing]. And the Medicaid transfers to say let's minimize the risk for the whole site, let's load——

Mr. GRIFFITH. But let——

Secretary SEBELIUS [continuing]. These later.

Mr. GRIFFITH. But that raises the next question now, because one of the other contractors, QSSI, I believe it was, indicated to us that part of the problem was was that once you took away the ability to browse, everybody had to go through the business of setting up an account, and you stopped one of the browse—or CMS stopped one of the browsing options as well, and that that actually contributed to the logjam and contributed to the problems. So is he correct on that, that not allowing people just to look without having to sign up, wouldn't that have made it easier for the American people?

Secretary SEBELIUS. In hindsight, I think that probably would have been advantageous. I can tell you that the reason the decision was made going forward was to minimize risk. That didn't work so well, but adding additional features that didn't involve people actually wanting to get to what they would independently pay and what they would qualify for and what the plans were seemed to be things that could be added down the road. It was wrong.

Mr. UPTON. Gentleman's time has expired. Mr. Bilirakis.

Mr. BILIRAKIS. Thank you Mr. Chairman. I appreciate it very much. Thank you, Madam Secretary, for testifying today.

Madam Secretary, over the weekend, The New York Times wrote the following: "Project managers at the Department of Health and Human Services assured the White House that any remaining problems could be worked out once the Web site went live, but other senior department officials predicted serious trouble and advised delaying the rollout."

Can you confirm if this is true? Did any senior department officials predict serious problems, and did any senior department officials advise delaying the rollout of the exchanges or parts of the exchanges on October 1st? Can you——

Secretary SEBELIUS. I can tell you that no senior official reporting to me ever advised me that we should delay. You heard from the contractors on the 24th that none of them advised a delay. We have testing that did not advise a delay. So, not to my knowledge.

Mr. BILIRAKIS. Did they indicate to you that there were serious problems?

Secretary SEBELIUS. They indicated to me that we would always have risks, because this system is brand-new and no one has operated a system like this before to any degree. So we always knew that there would be the possibility that some things would go wrong. No one indicated that this could possibly go this wrong.

Mr. BILIRAKIS. Can you name some of these officials that gave you that advice that there were serious problems?

Secretary SEBELIUS. Again, we had a series of meetings with teams from CMS. I was always advised that there is always a risk with a new product and a new site, but never suggested that we delay the launch of October 1st, nor did our contracting partners ever suggest that to us.

Mr. BILIRAKIS. Thank you. Thank you, Madam Secretary.

Thank you, Mr. Chairman. Appreciate it. I yield back.

Mr. UPTON. Mr. Johnson.

Mr. JOHNSON. Madam Secretary, thank you for being here with us today. CMS was the integrator of the Web site prior to and leading up to the 1 October——

Secretary SEBELIUS. That's correct.

Mr. JOHNSON [continuing]. Rollout, correct? You've testified that you've now hired an outside company to serve as the integrator. Who is that?

Secretary SEBELIUS. One of our contractors is taking on an additional——

Mr. JOHNSON. Who is that?

Secretary SEBELIUS. QSSI——

Mr. JOHNSON. QSSI.

Secretary SEBELIUS [continuing]. Who built the hub.

Mr. JOHNSON. OK.

Secretary SEBELIUS. Yes, sir.

Mr. JOHNSON. This is the same company that told our committee last week that they were not only the developer of the hub and the pipeline, but also an independent tester of system?

Secretary SEBELIUS. Yes.

Mr. JOHNSON. You've acknowledged in your testimony today that inadequate testing played a significant role in this failed launch, so aren't you concerned that QSSI has lost its ability to be an objective independent arbitrator in addressing the problems that plague the system now, because they're part of the tester, part of the developer, part of the problem?

Secretary SEBELIUS. No, I haven't lost my confidence in them. I think the testing that they did is validating the pieces of the equipment. What we've said since the launch is that we did not do adequate end-to-end testing.

Mr. JOHNSON. OK.

Secretary SEBELIUS. That was not the QSSI responsibility.

Mr. JOHNSON. All right. And in this new role as integrator, are you going to be paying QSSI more than they were to be paid under their original contract? I would expect with this expanded role, they're going to get paid more. Right?

Secretary SEBELIUS. That discussion is underway in terms of what the role will entail, what the outlines are, yes, sir.

Mr. JOHNSON. OK. Well, hardworking American taxpayers have already paid for this implementation once. Do you think it's fair to ask taxpayers to pay more so that QSSI can now attempt to do something that Administrator Tavenner and her CMS team were unable to do right the first time?

Secretary SEBELIUS. Well, sir, I think the American taxpayers expect us to get the site up and running. As I told you earlier——

Mr. JOHNSON. Well, I'm certain that they did. They expected it the first time.

Secretary SEBELIUS. I understand. And so did I. We have not expended the funds that have been encumbered for the contracts.

Mr. JOHNSON. You know, we——

Secretary SEBELIUS. We have not——

Mr. JOHNSON. Madam——

Secretary SEBELIUS. And we will monitor every dime we spend from here on in and re-audit things that are going forward.

Mr. JOHNSON. Well, with that, Mr. Chairman, I yield back.

Mr. UPTON. Gentleman yields back. Mr. Long.

Mr. LONG. Thank you, Mr. Chairman. And thank you, Secretary, for being here today and giving your testimony.

Earlier today you said that, I'm responsible for the implementation of the Affordable Care Act. I've heard you referred to, and maybe yourself, as the point person for the rollout, the architect of implementing the Affordable Care Act. So you are kind of the President's point person, are you not, for this rollout?

Secretary SEBELIUS. Yes, sir.

Mr. LONG. Earlier you were asked—and there's a lot of things striking about the rollout of this and about the Affordable Care Act altogether, but the thing that's most striking to me is that when we have the point person for the rollout here and you're not going into the exchange—now, I've heard you say that—and you've got some advice from the folks behind you, but I'm asking you today, can you tell the American public, if your advisors behind you that if they happen to have given you some wrong information, if it is possible for you to go into the exchange like all these millions of Americans that are going to go into the exchanges, will you commit to forego your government insurance plan that you're on now and join us in the pool?

Come on in. The water's fine. All the Congressmen, all of our staff have to go into the exchanges. We have to go into the D.C. exchanges. And I will say that I tried to get on the Web site, I was successful during the hearing earlier, and I got to the D.C. exchange, which is where I have to buy from. I got part way through, and then when it got to the point to enter my Social Security number, I could not bring myself to do that from what I've heard from people like John McAfee and folks about the security.

Will you tell—if your advisors are wrong and it is possible for you, I'm not saying it is, but if it is, if it's possible for you to forego your government program you have now, will you tell the American public that, yes, I will go into the exchanges next year like everyone else?

Secretary SEBELIUS. Sir, the way the law is written——

Mr. LONG. It's a yes or no.

Secretary SEBELIUS. We have——

Mr. LONG. Let's say that you're wrong on that. Yes or no? If you're wrong——

Secretary SEBELIUS. I don't want to give——

Mr. LONG [continuing]. Will you, yes or no?

Secretary SEBELIUS [continuing]. Misinformation to the American public——

Mr. LONG. You what?

Secretary SEBELIUS [continuing]. I don't want to give misinformation.

Mr. LONG. I want you to go home and research it——

Secretary SEBELIUS. If you have affordable——

Mr. LONG. If——

Secretary SEBELIUS [continuing]. Coverage——

Mr. LONG. If you're wrong——

Secretary SEBELIUS. If you have affordable coverage——

Mr. LONG [continuing]. Will you go into the exchanges?

Secretary SEBELIUS. If I'm wrong——

Mr. LONG. If you can, will you? That's a yes or no. If you can, will you, ma'am?

Secretary SEBELIUS. I will take a look at it. I don't have any idea——

Mr. LONG. That's not an answer. That's not a yes or no.

Mr. UPTON. Gentleman's time has expired.

Mr. LONG. You're the architect of the whole program, and you won't go into it with the rest of the American public.

Secretary SEBELIUS. I did not say that, sir. I think it's illegal for me to——

Mr. LONG. If it's not illegal. If it's legal, will you go in?

Secretary SEBELIUS. If I have affordable coverage——

Mr. LONG. Come in. The water's fine.

Mr. UPTON. The gentleman's time has expired.

Mr. WAXMAN. I have a unanimous consent request. I'd like to—Madam Secretary, I'd like you to answer for the record, if you are able to do what the gentleman just suggested or follow the recommendation of Cory Gardner, our colleague from Colorado, and went in to buy an individual policy, would you be able to find one that would protect you from cheap shots, or do you think that it has to be mandated for coverage? I'll leave the record open for your response.

Mr. UPTON. We'll wait for that response to come back.

Secretary SEBELIUS. I'd gladly join the exchange if I didn't have affordable coverage in my workplace. I would gladly join it. And the D.C. market is an independent State-based market, even though D.C. is not a State. We do not run the D.C. market in the Federal marketplace.

Mr. UPTON. The gentlelady from North Carolina, Ms. Ellimers.

Mrs. ELLMERS. Thank you, Mr. Chairman, and I have a couple of questions. Thank you for being with us today, Madam Secretary. I'd like to go to the issue that has been raised by my colleagues on the left here about accurate information. Number one, I've heard the issue of Medicare Part D brought up many, many times. Although my colleagues all voted no against it initially, now they're extolling the virtues of Medicare Part D. Is Medicare Part D a mandate or is it voluntary?

Secretary SEBELIUS. It is voluntary.

Mrs. ELLMERS. It is a voluntary program.

Secretary SEBELIUS. Yes.

Mrs. ELLMERS. That's the first accurate piece of accurate information I would like to get.

You know, we're actually forcing millions of Americans to go to find a health care premium in some way, whether it's to go to the exchange or whether they are to be insured. Many of my constituents are reaching out to me, those with individual policies, and they are saying to me that my rates are going up 400 percent, my rates are going up 127 percent. These are my constituents. Now, we're talking about open enrollment, but it's forcing the issue, is it not? That if an American does not have health care coverage, they are essentially breaking the law. Is that not correct?

Secretary SEBELIUS. If someone can afford coverage and has that option and chooses not to buy coverage, they will pay a fee on their——

Mrs. ELLMERS. And that——

Secretary SEBELIUS [continuing]. Liability in their——

Mrs. ELLMERS. And it is a law, so therefore they are breaking the law.

Secretary SEBELIUS [continuing]. Next year's tax.

Mrs. ELLMERS. OK. You also brought up the issue when you were in Kansas, that you fought against discriminatory issues. Now, as far as essential health benefits, correct me if I'm wrong, do men not have to buy maternity coverage?

Secretary SEBELIUS. Policies will cover maternity coverage for the young and healthy.

Mrs. ELLMERS. Including men?

Secretary SEBELIUS. Under 30 years old will have so a choice also of a catastrophic plan which has no maternity coverage.

Mrs. ELLMERS. The catastrophic, but men are required to purchase maternity.

Secretary SEBELIUS. Well, an insurance policy has a series of benefits whether you use them or not, and one of the benefits will be——

Mrs. ELLMERS. And that is why——

Secretary SEBELIUS [continuing]. Coverage for mental health coverage——

Mrs. ELLMERS [continuing]. The health care premiums are increasing——

Secretary SEBELIUS [continuing]. Violence——

Mrs. ELLMERS [continuing]. As high, because we are forcing them to buy things that they will never need.

Thank you, Mr. Chairman.

Secretary SEBELIUS. The individual policies cover families. Men often do need maternity coverage for their spouses and for their families, yes.

Mrs. ELLMERS. Single male age 32 does not need maternity coverage. To the best——

Secretary SEBELIUS. He may not need——

Mrs. ELLMERS [continuing]. Of your knowledge, has a man ever delivered a baby?

Mr. UPTON. Gentlelady's time——

Secretary SEBELIUS. I don't think so.

Mr. UPTON [continuing]. Has expired. The gentlelady, Ms. Cathy McMorris Rodgers.

Mrs. MCMORRIS RODGERS. Thank you, Mr. Chairman. And Madam Secretary, although we were told repeatedly that if you liked your health insurance plan, you'd be able to keep it, we're now being told by the government that they have determined many existing plans to be lousy, subpar.

In reality, this law is becoming quickly less about helping Americans purchase affordable coverage and more about compelling millions of Americans into a struggling Medicaid program. In my home State of Washington, 90 percent of enrollees will be in Medicaid; 16,000 of them coming into a program that they were already eligible for; Colorado, 89 percent; Kentucky, two-thirds; Maryland, 97

percent. And these are States that are already struggling with their budgets, wondering how they're going to cover Medicaid, which is, as we all know, for the most vulnerable population.

So isn't it true that in States like Washington, they're going to have new, unexpected costs associated with a dramatic influx into Medicaid?

Secretary SEBELIUS. Well, Congresswoman, the Medicaid expansion provision of the Affordable Care Act is——

Mrs. MCMORRIS RODGERS. Are States going to face new costs——

Secretary SEBELIUS. The Federal Government pays 100 percent of the costs of newly insured for the first 3 years and gradually reduces——

Mrs. MCMORRIS RODGERS. These are existing——

Secretary SEBELIUS [continuing]. That cost to 90 percent.

Mrs. MCMORRIS RODGERS. These were people that were already eligible.

Secretary SEBELIUS. Well, existing people were——

Mrs. MCMORRIS RODGERS. And we know that two out of three doctors don't accept new Medicaid patients, we know that current provider rates are going to drop at the end of 2014. So isn't it true that existing Medicaid enrollees are going to further compete for scarce resources in these States?

Secretary SEBELIUS. If the citizens of Washington who are signing up were eligible for Medicaid, they certainly will be entitled to enroll in Medicaid now. The newly insured will be——

Mrs. MCMORRIS RODGERS. I'm concerned——

Secretary SEBELIUS [continuing]. Fully paid for. The doctors have additional fees.

Mrs. MCMORRIS RODGERS [continuing]. That the most vulnerable in this country are going to lack access to the care that they they're going to receive. And I know time is short, Madam——

Secretary SEBELIUS. Well, I think that's absolutely true. And in States that are choosing not to expand Medicaid, it's particularly dire.

Mrs. MCMORRIS RODGERS. It's——

Secretary SEBELIUS. So I would love to work with you on that——

Mrs. MCMORRIS RODGERS. It's existing Medicaid.

Secretary SEBELIUS [continuing]. Expansion.

Mrs. MCMORRIS RODGERS. And finally, I just wanted to inform the Secretary, you told us several hours ago when the hearing started that the Web site was down. If you look at the screen, several hours later, HealthCare.gov is still down. You promised this system would be ready on October 1st. You're clearly wrong.

So before I leave you today, I would just impress upon you, this is more than a broken Web site. This is a broken law. Millions of Americans are getting notices their plans are being canceled. I yield back my time.

Mr. UPTON. Gentle——

Mr. WAXMAN. Meh, meh, meh.

Mr. UPTON. Gentlelady's time has expired.

I would do a couple things here. First I'm going to ask unanimous consent that the written opening statements for any member on the committee be introduced into the record. And without objec-

tion, the documents will be there. I also would ask unanimous consent to put the document binder and other documents presented to the Secretary during questioning into the record without objection. So ordered.

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

Mr. UPTON. Let me just say in conclusion, we do look forward to having you back in December to get an update on where we are, and we'll work with your schedule to find a right time and date early that week. I want you to know, we're going to want real numbers. You will have them by then, is that right, in terms of the signup? You'll have them in the next couple of weeks, so——

Secretary SEBELIUS. That's correct. We'll have them by mid November.

Mr. UPTON. We look forward to getting those done. We appreciate, we really do appreciate your time this morning to take questions. And I apologize to all the members who we had to shorten the time, but those things happen when we have this much interest. We look forward to continuing to get an update and look for your continued work.

Mr. WAXMAN. Mr. Chairman, and——

Mr. UPTON. Yes.

Mr. WAXMAN [continuing]. From our side of the aisle, we want to work with you. And I would hope on the other side of the aisle, they would take that same approach. Let's do something constructive, not just negative attacks against a bill that I think is going to be a Godsend for millions of Americans. Thank you for being here.

Secretary SEBELIUS. Thank you.

Mr. UPTON. Thank you. The hearing is adjourned.

[Whereupon, at 12:40 p.m., the committee was adjourned.]

[Material submitted for inclusion in the record follows:]

PREPARED STATEMENT OF HON. MARSHA BLACKBURN

For four years, the president told Americans that if they like the health insurance plan they have, they can keep it. The facts today show this is not the case. Everyday, my office gets letters from constituents letting us know they have been thrown off their current plan. Adding insult to injury, the Web site to buy one of the presidents plans doesn't even work. For those that are able to get through, many are finding their premiums going up, not down. The botched rollout of this law simply confirms everyone's worst fears about government run health care. If they government can't figure out how to run a Web site, how will they be able to figure out how to take care of us. Today we continue our investigation into these issues of behalf of all Americans whose lives are affected by this law.

# # #

PREPARED STATEMENT OF HON. GREG WALDEN

Thank you, Mr. Chairman and Ranking Member, for holding this very important hearing. The fact is that the rollout of healthcare.gov has been a failure at every turn. The federal exchange still isn't working for millions of Americans who visit the Web site trying to enroll. In my home state of Oregon, our state run exchange, Cover Oregon, still hasn't even gone online. A month after they were supposed to be up and running, they have yet to sell even one single private insurance policy through the exchange Web site.

But what's most troubling is that Obamacare isn't just a Web site. In fact, the Web site is supposed to be the easy part. And now, we're seeing more and more cracks in the foundation. This administration promised, in unequivocal terms that, "If you like your doctor, you will be able to keep your doctor, period. If you like your health care plan, you'll be able to keep your health care plan, period. No one will take it away, no matter what."

Despite White House rhetoric, millions of Americans are receiving cancellation notices in the mail. In Oregon alone, 150,000 people are losing their insurance plans. Health insurance they liked and that their President promised they could keep. I've heard from dozens of people living in Oregon's Second Congressional District who are now struggling to make ends meet because their premiums are doubling, their deductibles are going up, and they're getting worse coverage for it. It's just another broken promise from the administration.

And the problems don't end there. What's next? What new hurdle is about to be thrown in the way of the American people? For one, the Affordable Care Act required the Centers for Medicare and Medicaid Services (CMS) to rebase home health payments. The stated goal was to align payment with costs. The law gave CMS the authority to rebase the payments by as much as 3.5 percent per year from 2014 through 2017. Rather than implement these cuts gradually seeing the effect as they go—or on a year by year basis, CMS regulations recommend payments be rebased by the full 3.5 percent every year for all four years. Taken as a whole, these cuts result in a 14 percent cut to Medicare home health payments.

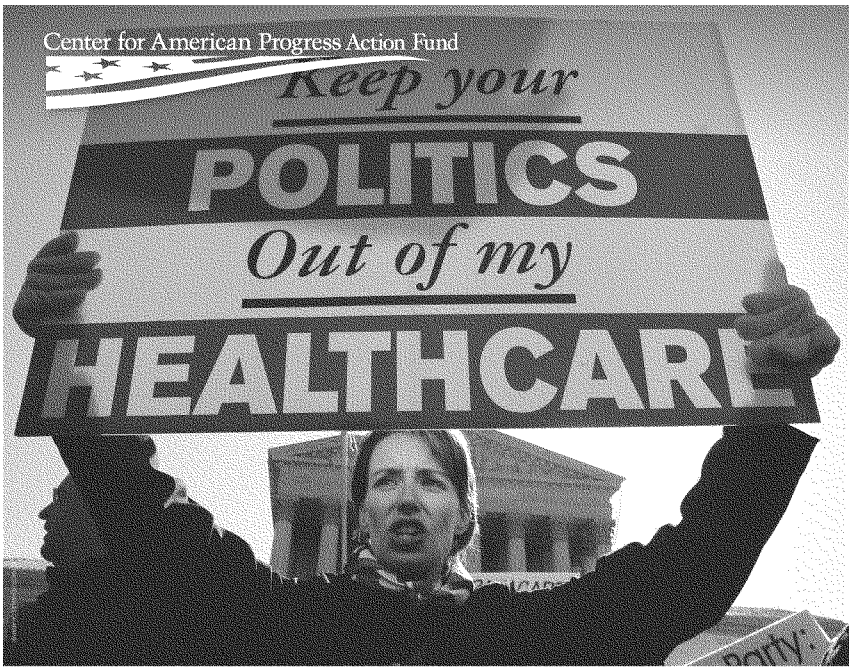
These policies might seem like something done in a vacuum to bureaucrats in D.C. But they have significant and lasting effects for people living in the real world. My home District is 70,000 square miles. We stretch across a distance roughly as far as Cincinnati to Baltimore. We're mountainous, we're rural, and some counties are without a physician, let alone a hospital. For the Oregonians I represent, access to home health providers is crucial.

My family and I have seen first-hand the powerful impact that compassionate and highly skilled home health nurses provide. We've used it with our own loved ones and know how meaningful it is to be able to recover at home, in familiar surroundings, with your family by your side. It would be devastating for the people in Oregon's Second District—and throughout rural America if these services were no longer available to them.

Unfortunately, the Affordable Care Act could limit access to home health. CMS's cuts to home health would result in negative Medicare margins for home health care providers in nearly every single state. Oregon's margins would fall to negative 26.5 percent.

I was one of 142 members of the House who sent a letter to Administrator Tavenner expressing our concerns about this very issue back in September. To date, we haven't heard back. But this issue is not one that is going to go away. As we move from one crisis point with the flawed implementation of the government takeover of health care to the next, this issue will, inevitably, come to the forefront. Too many of our nation's seniors and rural residents depend on the availability, reliability, and affordability of home health care services.

Thank you again Mr. Chairman and Ranking Member. I look forward to hearing what the administration plans to do to protect Americans from a fatally flawed law that reduces access to health care, increases costs, cuts Medicare, and puts a barrier of government red tape between patients and their doctors.



Exposing the Anti-Obamacare Sabotage Campaign

Tony Carrk September 2013

Center for American Progress Action Fund

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Introduction and summary

Since the Affordable Care Act, or ACA—commonly referred to as Obamacare—was signed into law in March 2010, its opponents have tried everything they can to undo it at both the federal and state levels. Their motivations are clear: Not only do they dislike the law, but they are also afraid of the consequences of it working the way it should. A successful law that provides millions of Americans with access to health care, better benefits, and lower costs undermines these opponents' extreme conservative ideology. The effort to undermine the law is a sabotage campaign, plain and simple.

This report intends to expose the sabotage campaign in its many forms. Some methods of sabotage are obvious; other methods are more stealth. All of these methods, however, have one purpose: to make implementing Obamacare impossible, and thereby stop people from gaining access to better health coverage at more-affordable costs.

The methods of sabotage discussed in this report include:

- How the House of Representatives has voted 41 times to repeal or dismantle the Affordable Care Act
- How federal lawmakers have used intimidation to keep people from educating the public about the law and hinder those who enroll members of the public
- How Georgia Insurance Commissioner Ralph Hudgens, for example, said he would do anything he could to be an Obamacare "obstructionist"
- How 22 states have refused to expand Medicaid, putting access to health coverage at risk for millions of Americans
- How 27 states decided not to run their own state marketplace, instead forcing the federal government to step in

- How six states informed the federal government that they would not be enforcing the consumer protections of the law, including stopping insurers from denying coverage based on a preexisting condition
- How 16 states have imposed their own regulations on navigators. The restrictions vary, and some have the effect of making it near impossible for organizations to enroll residents in the new marketplaces.
- How some states have prohibited officials and navigators from even talking about the benefits of the law with residents
- How some states want to make it a felony to enforce or implement the Affordable Care Act

As Thomas Mann of the Brookings Institution said:

> *There has been a full-court press from Day One from the opposition to characterize and demonize the [Affordable Care Act.] The campaign against the law after it was enacted, the range of steps taken, the effort to delegitimize it—it is unprecedented. We'd probably have to go back to the nullification efforts of the Southern states in the pre-Civil War period to find anything of this intensity.*[1]

The campaign against the law after it was enacted, the range of steps taken, the effort to delegitimize it—it is unprecedented.

It is unfortunate that many conservatives are resorting to a sabotage campaign to refight old political battles, but this is not the only possible approach. A better approach would be for Congress and state lawmakers—regardless of where they stood when it was passed—to work together to make the Affordable Care Act work as well as possible. Even among those who oppose the law, a majority wants to see elected officials work together to make it work.[2] The Affordable Care Act is the law of the land. There will undoubtedly be bumps in the road and problems that arise, but we can identify and fix them.

On this approach, the evidence is clear: In those states where lawmakers are working together to implement the law, the law is working. Implementing the Affordable Care Act will be a serious undertaking and will require all of us to do our part, but the country—and millions of Americans—will be better off for it.

Sabotage at the federal level

Defund, default, delay

To date, the Republican-controlled House of Representatives has voted 41 times[3] against the Affordable Care Act. These votes range from full repeal of the law to banning federal money that would be used to implement the law to targeting certain provisions to undo or postpone implementation of the law.

Not content with what they say are symbolic measures, however, some Republican members of Congress have employed a more confrontational strategy that carries serious economic consequences. A growing number of Republican House[4] and Senate[5] members insist that the continuing resolution that keeps the government open include an amendment to defund the Affordable Care Act—or they will vote against it. In other words, unless the Affordable Care Act is stopped, they will shut down the government. A government shutdown would severely hurt our economy, immediately throwing hundreds of thousands of people out of work and potentially leading to disruptions in things such as Social Security checks and paychecks to our troops on the frontlines.

Another sabotage strategy is to insist on defunding the Affordable Care Act when Congress considers raising the debt ceiling this fall. An aide to House Majority Leader Eric Cantor (R-VA) said last month that the debt limit debate is a "good leverage point"[6] to force action on the Affordable Care Act. Two years ago, the mere threat of the government defaulting on its obligations led to the first-ever downgrade of the nation's credit rating.[7] Actually defaulting would cause a worse global financial crisis than what we experienced in 2008.

Not surprisingly, the defund strategy is unpopular with the vast majority of Americans. In a recent Kaiser Health survey,[8] 57 percent of respondents disapproved of the strategy to defund the law. Another poll found that just 6 percent of registered voters surveyed—and only 7 percent of Republicans—agreed with the defund strategy.[9]

Increasing opposition among Republicans to the defund strategy has led to an emerging proposal that would ask for a one-year delay in the implementation of the Affordable Care Act in exchange for Congress raising the debt ceiling.[10] Make no mistake: Their goal here is the same as that of all of the other strategies they have employed. While it would be nice to believe that these lawmakers are pursuing delaying implementation in an effort to work with the Obama administration to improve the law and ensure it is implemented smoothly, it would also be naïve. A vote to delay is a vote to repeal. Not only that, but delaying the law would leave more Americans without insurance and could raise premiums as much as 27 percent.[11]

Intimidation

Another anti-Obamacare sabotage-campaign tactic is intimidation. The goal of this strategy is to scare people and organizations away from helping the Obama administration enroll or educate Americans about the new marketplaces.

Starting October 1, millions of Americans will be able to sign up for a health plan that fits their needs and budget; coverage will begin on January 1, 2014. The new marketplaces allow consumers to choose from a variety of plans that work best for them. They also provide consumers better benefits and more protections. Insurers offering plans on the new marketplaces cannot deny coverage based on a preexisting condition, and they cannot charge women more than men for the same coverage. To help make coverage more affordable, consumers can be eligible for premium tax credits, and the law sets limits on how much consumers can spend out of pocket for medical costs, including on deductibles and co-pays. The new plans will have to offer a set of benefits called essential health benefits. These plans will offer better coverage at affordable costs.[12]

In June of this year, Health and Human Services Secretary Kathleen Sebelius said that she was in talks with the National Football League, or NFL, about partnering with it to help educate Americans about the benefits of the Affordable Care Act.[13] Days later, however, Senate Minority Leader Mitch McConnell (R-KY) and Senate Minority Whip John Cornyn (R-TX) sent a letter to not just the NFL but also to Major League Baseball, or MLB; the National Hockey League, or NHL; the National Basketball Association, or NBA; NASCAR; and the Professional Golfers' Association, or PGA, warning them not to do so. "Given the divisiveness and persistent unpopularity of this bill, it is difficult to understand why an organi-

zation like yours would risk damaging its inclusive and apolitical brand by lending its name to its promotion," the senators wrote.[14] Moreover, House Republican Study Committee Chair Steve Scalise (R-LA) sent his own letter[15] to the commissioners of the NFL and NBA, requesting information on what the Department of Health and Human Services asked for regarding help raising awareness for the Affordable Care Act.

Having sports teams promote health care marketplaces is not new. After all, the Boston Red Sox began partnering with the Commonwealth Health Insurance Connector Authority in 2007 to educate residents of Massachusetts about the landmark health legislation signed by former Massachusetts Gov. Mitt Romney (R) in 2006.[16] Still, the sabotage tactic had some effect. A spokesman for the NFL responded, saying that the league had "no plans" to engage with the Affordable Care Act.[17] But this tactic has its limits. One promising development was the Baltimore Ravens' announcement that the team would help Marylanders learn about the new marketplaces that begin enrolling people October 1.[18]

Obamacare opponents have also spread their tactics of intimidation to the very organizations that are helping enroll Americans in the new health care marketplaces. In late August, Republicans on the House Committee on Energy and Commerce sent letters to more than 100 organizations that received federal grants to serve as navigators of the Affordable Care Act.[19] Many of these civic and charitable organizations, such as the Ohio Association of Foodbanks and the Epilepsy Foundation of Florida, are not accustomed to the daily Washington political fight. The timing is questionable as well, given that they received the letter requesting voluminous amounts of information as they are preparing for open enrollment in the new marketplaces to begin on October 1. And Commerce Committee Republicans did not target every navigator grant recipient; organizations were targeted in a handful of states—Arizona, Florida, Georgia, Indiana, Louisiana, Missouri, North Carolina, New Jersey, Ohio, Pennsylvania, and Texas—which are also among the states with the highest rates of uninsured populations.[20]

This sabotage tactic has been met with strong condemnation. As the American Enterprise Institute's Norm Ornstein stated:

> *Requests for documents are not unprecedented; the Oversight and Investigations Subcommittee of Energy and Commerce did it all the time under Democrats. But this is qualitatively different. The scope and the timing simply smell. Oversight would commonly mean that after a program has been implemented*

> *you look to see if it was done well and if there was fraud or malfeasance or misfeasance. This is intimidation and another effort at sabotage.*[21]

Washington and Lee University School of Law Professor Timothy Jost added that the letter was "an obvious attempt at intimidation of navigator programs, most of which are nonprofits that don't have the resources to hire lawyers to fight this, nor the time to respond at this very busy time. ... This attempt to bully these programs is shameful."[22] The executive director of the Ohio Association of Foodbanks, Lisa Hamler-Fugitt, called the letter "quite offensive" and said it was "absolutely shocking."[23]

Refusing to help

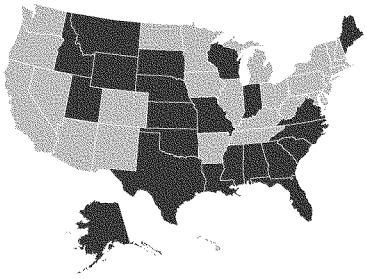
Another method of sabotage that Obamacare opponents plan to use is simply doing nothing.[24] That is what Reps. Tim Huelskamp (R-KS) and Jason Chaffetz (R-UT) appear to be doing. Both have stated that they will not help constituents who call and ask for more information about the benefits of the Affordable Care Act and how to enroll. "We know how to forward a phone call," Chaffetz said.[25] It will be interesting to see if their Republican colleagues follow suit as open enrollment approaches.

Sabotage at the state level

Opting out of Medicaid expansion and running a marketplace

The Affordable Care Act extends access to affordable health insurance to millions of Americans. One of its provisions to provide coverage was to expand Medicaid, the federal-state health program for low-income people. Under the law, eligibility for Medicaid would expand in 2014 to allow those with incomes up to 133 percent of the federal poverty line to enroll,[26] which in 2013 is $15,417 for individuals and $26,347 for a family of three.[27] The federal government agreed to pay for the full cost of expanding the program for the first three years and no less than 90 percent of the cost after that.

FIGURE 1
22 states refusing to expand Medicaid so far



Source: Kaiser Family Foundation, "Status of State Action on the Medicaid Expansion Decision, as of September 3, 2013," available at http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/ (last accessed September 2013).

Shortly after the Affordable Care Act was signed into law, however, the state of Florida filed a lawsuit challenging its constitutionality, specifically the Medicaid-expansion provision. Twenty-six other states would eventually join the lawsuit.[28] When the Supreme Court upheld the Affordable Care Act in 2012, it also ruled that each state could opt out of expanding Medicaid without losing its entire federal Medicaid funding. To date, 22 states are not currently expanding Medicaid. As a result, millions of Americans in those states will not have access to this affordable health care option—the only option for many.[29]

Another provision of the law allows states to set up their own "marketplaces," or exchanges, for individuals and small businesses to shop for the right health plan. If a state decided not to run its own marketplace, the federal government operates

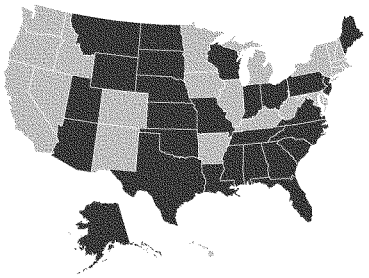
it. Only 16 states and the District of Columbia chose to run their own marketplaces, and seven states are running exchanges in partnership with the federal government. The remaining 27 will default to federally run marketplaces.[30] While having the federal government run the marketplace with no state assistance does not jeopardize the access to health care for those states' residents, it is an indication of whether the state is willing to cooperate to make the law work or could take a more combative approach.

Restricting navigators

Similar to federal lawmakers, state lawmakers have targeted navigators—the groups who will help millions of Americans sign up for insurance in the new marketplaces—as a way to sabotage the law. In July, the Department of Health and Human Services released its final rule regulating navigators in federally facilitated marketplaces, including those states partnering with the federal government.[31] States have suggested these rules are insufficient. Attorneys general from 13 states wrote Secretary Sebelius requesting more information on navigator standards and guidelines.[32] Other states have imposed their own requirements on navigators. The Commonwealth Fund found that 19 of the 34 states with federally facilitated marketplaces—including the seven states with a partnership exchange—introduced legislation imposing state requirements on the navigators.[33] Sixteen of those states have enacted these state-specific requirements.[34]

One might ask: What's the harm in making sure that groups charged with helping

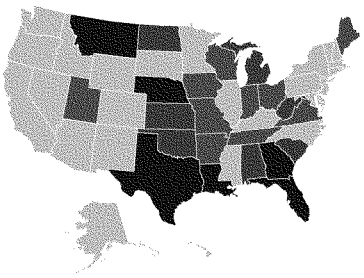
FIGURE 2
Federally run marketplaces



Source: Kaiser Family Foundation, "State Decisions For Creating Health Insurance Exchanges, as of May 28, 2013," available at http://kff.org/health-reform/state-indicator/health-insurance-exchanges/ (last accessed September 2013).

FIGURE 3
Restricting navigators

- States requesting more information on navigator standards
- State-specific navigator requirements
- Both



Source: Letter from Patrick Morrisey and others to Secretary Kathleen Sebelius, August 14, 2013; Katie Keith, Kevin W. Lucia, and Christine Monahan, "Will New Laws in States with Federally Run Health Insurance Marketplaces Hinder Outreach?", *The Commonwealth Fund Blog*, July 1, 2013, available at http://www.commonwealthfund.org/Blog/2013/Jul/Will-State-Laws-Hinder-Federal-Marketplaces-Outreach.aspx

Americans enroll in the new marketplaces actually perform their duties? Many of the state laws require a navigator to obtain a state license, undergo a background check, and receive additional training. As The Commonwealth Fund found, though, some of these laws can have the opposite effect—making it near impossible for the navigators to successfully do what they are supposed to do. More-restrictive standards that impose more obstacles and hurdles over which navigators must jump could keep some of the navigator organizations from serving in the very areas that the law was intended to help, such as places with high uninsured populations.[35] States have passed laws banning navigators from offering advice about the benefits of health plans. How can a consumer make an informed decision without that type of information?

In Georgia, for example, navigators need a license from the state insurance commissioner, Ralph Hudgens, who notoriously commented that he would do "everything in [his] power to be an [Obamacare] obstructionist."[36] The state law also requires each navigator to pay a $50 fee and complete 35 hours of training—more training than required under the federal rule—undergo a background check, and pass a test.[37]

Missouri's navigator law is another extreme example. It prohibits navigators from receiving federal funds until they are state licensed. Moreover, navigators cannot "provide advice concerning the benefits, terms and features of a particular health plan, or offer advice about which exchange health plan is better or worse for a particular individual or employer."[38]

The Missouri navigator law appears to be an extension of the ballot measure that state residents approved in November 2012, which bans state officials from establishing or operating a state-based marketplace unless the people or state lawmakers approve. The measure went even further, however, saying that state and local officials cannot provide "assistance or resources of any kind" to help with the federal exchange unless federal law specifically requires it.[39]

Ohio has a similar law that does not allow navigators to negotiate with insurers or provide advice about health plans.[40] That law has led at least one navigator, the Cincinnati Children's Hospital Medical Center, to return its $124,419 grant to enroll uninsured people at its main hospital and two satellite locations. A West Virginia navigator grant recipient, West Virginia Parent Training, also returned its grant.[41]

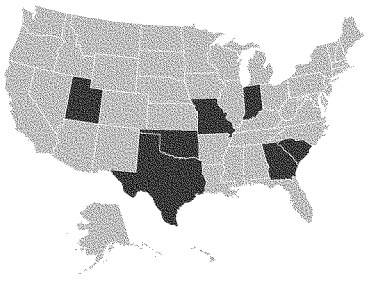
A measure introduced in both Ohio and Missouri would "suspend the licenses of insurance carriers who accept federal subsidies" through one of the exchanges under the Affordable Care Act.[42]

Florida is another example of a state that is finding ways to restrict navigators. Most notably, the state health department issued a directive to county health departments that they would not be permitted to conduct outreach at the offices.[43] This added scrutiny led a navigator in Florida, Cardon Outreach, to return more than $800,000 in federal money it has received to help enroll Floridians. Cardon Outreach's general counsel Charles Koble said in an email that, "The emerging state and federal regulatory scrutiny surrounding the Navigator program requires us to allocate resources which we cannot spare and will distract us from fulfilling our obligations to our clients."[44]

Refusing to enforce Obamacare

States have also tried to sabotage the Affordable Care Act by creating an interstate health compact. Seven states have signed statutes creating an interstate health compact, the goal of which is to essentially repeal the Affordable Care Act within the states that join the compact.[45] Congress must approve these statutes before the health compacts can take effect, so it is unlikely this will happen anytime soon.

FIGURE 4
Creating an interstate health compact



Source: National Conference of State Legislatures, "26 States Consider Health Compacts to Challenge Federal PPACA," June 2013, available at http://www.ncsl.org/issues-research/health/states-pursue-health-compacts.aspx

As discussed, 27 states have decided to not create their own state-based marketplace and instead must have a federally facilitated one. Under the law, states must enforce the provisions and regulations related to the marketplaces and market reforms unless they notify the federal government that they will not. Six states have informed the federal government that they will not enforce these reforms,[46] such as prohibiting insurance companies from denying coverage because of a preexisting condition, charging women more than men, and ensuring that insurers use consumers' premium

dollars for care, not profits. Those states are Texas, Arizona, Alabama, Missouri, Oklahoma, and Wyoming.

Other states have proposed making it a crime to enforce the Affordable Care Act.[47] In Indiana, a lawmaker introduced a measure that declared the Affordable Care Act void and said that anyone who knowingly attempts to implement or enforce the Affordable Care Act in the state would be committing a Class D felony.[48] South Carolina introduced a similar piece of legislation, declaring the Affordable Care Act "null and void" and "establish[ing] criminal penalties and civil liability" for those aiding in its implementation.[49] Legislators in Oklahoma introduced a measure that would have made it punishable by up to five years in prison for anyone in the state to follow the Affordable Care Act.[50]

A better approach

The sabotage campaign that opponents of the Affordable Care Act are waging at the federal and state levels is not the approach we should take. A better approach is for lawmakers, irrespective of where they stood at the passage of the Affordable Care Act, to work together to make it work. A new *USA Today*/Pew Research Center poll released this week found that 51 percent of those who oppose the law want to see elected officials work together to make it work.[51]

That is not to say that Democrats and Republicans are not coming together to find solutions to help make the law work. States with Republican governors and state legislatures have agreed to expand Medicaid, as in Arizona,[52] or create a state-based exchange, as in Idaho.[53]

As Republican Kansas Insurance Commissioner Sandy Praeger, who is working with the Obama administration to make sure health plans meet federal standards, said, "We're just trying to do what's best for our consumers. … If state regulators are not going to do anything, then consumers will be the ones who suffer."[54] And Colorado State Rep. Bob Gardner (R), who voted against the state creating its own marketplace, now says he has "become convinced" that it is the right thing to do and that the new exchange "is on a road to success."[55]

First and foremost, the reason we should take this better approach is because the Affordable Care Act will provide access to health coverage to millions of Americans, some for the first time. It also provides better benefits and more protections by ending some of the worst insurer abuses, and it will lower costs.

Second, we need to recognize that the Affordable Care Act is the law of the land and highly unlikely to be repealed at the federal level, given that President Barack Obama won re-election in 2012 and the makeup of the Senate. The Supreme Court has upheld its constitutionality. Repeated attempts to sabotage the law do not move us forward; they just ensure that we keep refighting the same political battles.

Lastly, there is a growing amount of evidence showing that the law is working as it was intended to, debunking the attacks that opponents continue to make. One of the fiercest attacks against the law is that it would increase premiums, but a new report shows that nearly 6 in 10 of the uninsured are expected to obtain coverage next year for less than $100.[56] According to a Kaiser Family Foundation survey that analyzed premiums for the 2014 marketplaces in states that have already released that information, premiums were lower or lower than expected.[57] When federal tax credits are factored into the equation—something that many analyses conveniently forget to take into account—premiums were reduced even more.

The RAND Corporation released a study showing that these attacks are "overblown." In fact, workers at firms with fewer than 100 employees are expected to pay 6 percent less in premiums in 2016 than they would have had Obamacare not been passed.[58]

In states that are working to implement the Affordable Care Act successfully, the results show that the law is working:

- Minnesota, a state expanding Medicaid and running its own marketplace, released the lowest premium rates among all the states that have released their information.[59]
- In New York, another state that has set up its own exchange and is expanding Medicaid, regulators have approved premium rates that are at least 50 percent lower than those currently available. With federal subsidies, the rates will be even lower.[60]
- In Oregon and Maryland, state regulators forced insurers to lower premiums, and consumers can now save up to 30 percent in some cases.[61]

Make no mistake: Obamacare is working to make health coverage more affordable for millions of Americans.

It makes sense why opponents want to wage this sabotage campaign: They see that the law can succeed when people work together to make it succeed. Indeed, there will be some bumps in the road as the Affordable Care Act is implemented, but the coming weeks are an important time to begin enrolling millions of Americans in these new health marketplaces. Our mindset should be on working together to fix these marketplaces and finding ways to improve the law, not on putting up obstacles that set the law up for failure and then cheering when something goes wrong for political gain. We would all be better off if we helped make the Affordable Care Act work.

A closer look at states

Texas

Texas has the highest rate of uninsured residents in the nation, with more than one in four Texans under age 65 without health insurance—more than 5.7 million Texans.[62] The Affordable Care Act would have more of an impact in Texas, but unfortunately, Texas lawmakers have been at the forefront of sabotaging the law.

Texas Gov. Rick Perry (R) and Texas lawmakers have refused to expand Medicaid, which would have provided health coverage to more than 1.7 million Texans.[63] In addition, lawmakers refused to create their own marketplace for new health plans, defaulting to the federal government.[64] Almost half of Texas's uninsured population is estimated to be eligible to purchase insurance on the new marketplace, although the Perry administration is apparently not going to help publicize the exchange. Perry spokeswoman Lucy Nashed said the state was "not interested in implementing Obamacare, including the exchange."[65]

Texas is one of the six states that informed the federal government it would not implement insurance reforms under the Affordable Care Act, such as making sure that insurance companies cannot deny coverage based on preexisting conditions.[66] Texas is also one of the states trying to form an interstate health compact that would essentially repeal the Affordable Care Act within the state of Texas if it were enacted.[67]

While the state is not helping implement the new marketplace, the navigators helping enroll Texans are under increased scrutiny. Greg Abbott, the Texas attorney general, wrote the federal government asking for more information about guidelines for the navigators.[68] State lawmakers imposed their own regulations on the navigators in addition to the requirements the federal government has put in place,[69] and Commerce Committee Republicans targeted navigators in Texas with letters requesting additional paperwork.[70]

Florida

Florida has the second-highest rate of uninsured residents in the nation—nearly 25 percent of, or 3.8 million, Floridians.[71] Unfortunately, state lawmakers appear to be spending more time sabotaging the Affordable Care Act, which can help these millions of uninsured people, instead of helping implement it successfully.

Medicaid expansion was set to be a huge success story in Florida. Gov. Rick Scott (R-FL) endorsed accepting federal aid to expand eligibility for the program and provide health coverage to an estimated 1.3 million Floridians. The state legislature had other plans, however, and refused to endorse Gov. Scott's position.[72] What's more, Florida refused to establish its own state marketplace. The state also passed a law requiring insurers to send consumers a form that details how much of a premium increase is due to the Affordable Care Act. The form can be highly misleading, however, and not convey accurate comparisons of premium rates.[73]

Florida lawmakers also stripped the state insurance commissioner's authority to approve, modify, or outright reject premium-rate increases for two years.[74] That ability is one of the components that the Affordable Care Act calls for to prevent excessive premium-rate hikes.

Navigators have undergone intense scrutiny in Florida. When Commerce Committee Republicans sent letters to navigators requesting more information, they did not send them to every state, but they did send them to Florida navigators.[75] Florida lawmakers have kept the pressure on as well. Florida Attorney General Pam Bondi wrote Secretary Sebelius raising concerns about the navigator program.[76] Moreover, the state legislature passed and Gov. Scott signed a law mandating that navigators be fingerprinted and made to undergo background checks.[77] Perhaps most notably, the state health department issued a directive to county health departments, saying that navigators would not be permitted to conduct outreach at the county offices. Pinellas County Commissioner Kenneth Welch pushed back on the directive, calling it "purely political" and said it made "no sense whatsoever," that it was "ridiculous," and that the Scott administration was "reaching for any way to obstruct anything that's related to the Affordable Care Act."[78]

As a result of the added scrutiny, a navigator in Florida, Cardon Outreach, has returned the more than $800,000 in federal money it has received to help enroll Floridians. Said Koble, Cardon Outreach's general counsel, in an email, "The

emerging state and federal regulatory scrutiny surrounding the Navigator program requires us to allocate resources which we cannot spare and will distract us from fulfilling our obligations to our clients."[79]

Georgia

Georgia Insurance Commissioner Hudgens made clear comments last month on what the state is doing to implement the Affordable Care Act: "Everything in our power to be an obstructionist."[80]

True to that sentiment, Georgia has been at the forefront of the Obamacare sabotage campaign. There are more than 1.8 million uninsured Georgians—representing more than one in five people in the state under age 65[81]—yet the state refused to accept federal aid to expand the Medicaid program and has refused to establish its own state-run marketplace. Georgia is also a member of the interstate compact that would essentially repeal the law but needs congressional approval to go into effect.[82]

Navigators in the state have undergone increased scrutiny. The state attorney general, Sam Olens, wrote Secretary Sebelius about concerns over the program,[83] and state lawmakers imposed their own requirements on navigators above those the federal government has set, including requiring navigators in Georgia to obtain a license from the state insurance commissioner.

Each person helping the uninsured has to pay a $50 license fee and complete 35 hours of training, more than the federal government requires. Licenses must be renewed every year, and people are required to pay the fee upon each renewal.[84]

Missouri

Missouri has more-restrictive measures against the Affordable Care Act, placing it among the top states sabotaging the law.

For one, Missouri will not accept federal aid to expand Medicaid. In addition to making it harder for the nearly 351,000 Missourians who would have been eligible,[85] this decision has already had adverse consequences. St. Louis ConnectCare, a leading provider of outpatient medical services for the poor, announced last

month that it would lay off 88 employees—more than half of its staff.[86] Melody Eskridge, president and CEO of ConnectCare, said that the layoffs were a result of the state not expanding Medicaid. "Without Medicaid expansion, money to serve the uninsured and underinsured was going to dry up," she said.[87]

Navigators in Missouri have considerable obstacles standing in their way. State lawmakers passed very restrictive measures for navigators, forbidding them from even discussing the benefits of the law. The state law says that navigators cannot "provide advice concerning the benefits, terms and features of a particular health plan, or offer advice about which exchange health plan is better or worse for a particular individual or employer."[88] Another proposal in Missouri would "suspend the licenses of insurance carriers who accept federal subsidies" through one of the exchanges under the Affordable Care Act.[89] Not to mention that Commerce Committee Republicans sent a letter to navigators in Missouri asking for more information, essentially demanding more paperwork at the same time that navigators are focusing on reaching out to people and signing them up for the new marketplaces. [90]

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About the author

Tony Carrk is the Director of the Health Care War Room at the Center for American Progress Action Fund and Center for American Progress. He previously worked at CAP and CAP Action, where he helped provide content and rapid response during the passage of the Affordable Care Act. He has worked on a variety of campaigns, including two presidential cycles.

Acknowledgements

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Small biz owner: Health exchange will save me $1,000 a month

Dennis Domrzalski

Albuquerque Business First

Date: Tuesday, October 1, 2013, 4:19pm MDT

The New Mexico Health Insurance Exchange saved one Albuquerque small business owner $1,000 a month in insurance premiums Tuesday.

Michael Cadigan, president and owner of the Cadigan Law Firm P.C., said he signed up the firm's four employees Tuesday for an insurance policy and got a quote that was $1,000 less a month than he's currently paying.

"I was very pleasantly surprised. I thought it was going to be an administrative nightmare and it literally took me 15 minutes once I found everybody's birthdates, Social Security numbers and ZIP codes," Cadigan, a former Albuquerque city councilor, said. "They gave me a quote that would save me $1,000 over what I was paying at Pres [Presbyterian Health Plan], so I'm psyched."

Cadigan said he chose a gold level plan, which pays 80 percent of medal expenses, for the firm.

"I selected gold and it gave me 17 choices and I signed up for Blue Cross and Blue Shield of New Mexico," Cadigan said. "I thought this was going to be an all-day thing, so I had a Diet Coke handy, was well rested and I had a good lunch, and it was almost disappointing" that it was so easy.

"I was blown away," he said. "I hope it's not too good to be true."

Cadigan said he believes the large pools of people created by the Affordable Care Act might have led to his lower insurance premiums.

"The problem before was that small businesses couldn't get a decent rate because there was no economy of scale for small businesses," Cadigan added. "This [ACA] puts us all into one box."

Cadigan had advice for business owners who want to shop on the exchange: have your employees' Social Security numbers, birthdates and ZIP codes handy because you'll need to enter those into the exchange's computer system.

"I found this 100 times easier than going through brokers and being put on hold," Cadigan added. "They don't ask you whether someone has had cancer, all they want is their birth date and their Social Security number and they are in."

At least 100 New Mexico small businesses signed up to buy health insurance on New Mexico's exchange during its first six hours of business Tuesday.

How NM health exchange fared in its first week

Dennis Domrzalski
Reporter- *Albuquerque Business First*
Oct 4, 2013, 2:57pm MDT

As of Friday morning, 428 small businesses had signed up to buy insurance through the New Mexico health insurance online marketplace, said NMHIX Interim CEO Mike Nunez.

The New Mexico Health Insurance Exchange keeps growing.

As of Friday morning, 428 small businesses had signed up to buy insurance through the online marketplace, said NMHIX Interim CEO Mike Nunez. That was up from 292 businesses Thursday morning.

And 812 employees of those businesses have signed up to shop on the exchange, Nunez added.

The exchange went live at 6 a.m. Oct. 1 and signed up 29 employers in its first 45 minutes.

The exchange is a place where businesses with fewer than 50 employees, and individuals, can buy health insurance. Four insurers are selling policies to businesses and their employees, and one is selling only to individuals.

Nunez said the exchange's goal is to sign up 72,000 individuals and 8,400 employees of small businesses in its first year.

Albuquerque attorney Michael Cadigan, owner of the four-person Cadigan Law Firm P.C., said this week that he saved $1,000 a month in insurance premiums by going through the NMHIX.

Editorial: NM business exchange has very healthy start

By Albuquerque Journal Editorial Board | Fri, Oct 4, 2013

Three days into signups on Obamacare's online insurance exchange, the New Mexico sky hasn't fallen.

So much for Chicken Little going without treatment for that head wound.

New Mexico's Small Business Health Options Program hasn't reported the website glitches of other states – ranging from Minnesota to Texas, New York to Washington. By noon on Day 1, more than 100 businesses had accounts. By 4 p.m., it was 170. At 8 a.m. on Day 2, it hit 292. And by Thursday afternoon, 355 businesses had signed up.

In addition, calls for help were handled, on average, in 149 seconds.

Exchange interim CEO Mike Nuñez summed it up with "I think we've had a good start."

Considering the sturm und drang surrounding the federal exchange for individuals, that's an understatement. So, clearly, was the pre-Oct. 1 claim that few individuals would sign up for insurance coverage under the individual mandate; it appears high demand was behind many of the website crashes. The first day, Healthcare.gov got at least 2.8 million visits, seven times the number of simultaneous users ever recorded on the medicare.gov site.

But there's good news beyond New Mexico doing something right for its small businesses and their employees. The Affordable Care Act's open-enrollment period lasts for six months, leaving plenty of time for necessary state and federal improvements to the largest insurance expansion in coverage in nearly 50 years.

And plenty of time for even Chicken Little to sign up.

This editorial first appeared in the Albuquerque Journal. It was written by members of the editorial board and is unsigned as it represents the opinion of the newspaper rather than the writers.

'Good start' for NM insurance exchange

By Journal and wire report | Wed, Oct 2, 2013

Americans got their first chance Tuesday to shop for health insurance using the online marketplaces that are at the heart of President Barack Obama's health care overhaul, but government websites designed to sell the policies struggled to handle the traffic.

However, New Mexico's exchange, which opened at 6 a.m. Tuesday, reported no first-day glitches.

It allowed small businesses to enroll on its own Small Business Health Options Program website, known as the SHOP exchange, and linked individuals who were looking for insurance to the federal exchange website.

Exchange interim CEO Mike Nuñez said that more than 100 employers had accounts by noon.

"I think we've had a good start," Nuñez said.

In contrast to businesses that could use the state-run exchange, individuals had to use a federally operated computer system to shop for insurance, and Nuñez acknowledged it struggled to handle demand. There also were long waits for people who sought help from a federal call center.

"We're certainly hearing frustration all over the state," Nuñez said of problems with the federal exchange.

Nuñez said the biggest difficulty for individuals involved security. The system asks the applicant to choose a security question that can be used to verify the site visitor's identity in the future. Some applicants haven't been able to get the security question in place and could not complete enrolling.

Nuñez said wait times for assistance with New Mexico's call center typically were five minutes or less – far shorter than encountered with the federally operated telephone hotline.

New Mexico began work in May to establish its exchange, and officials decided to use a federal online system for individuals because there wasn't enough time to meet this month's federal deadline for preparing a state-run computer system for the expected heavy demand from individuals.

Federal agencies were working to fix the sites, which represent the biggest insurance expansion in coverage in nearly 50 years. There should be time to make improvements. The open-enrollment period lasts for six months.

Administration officials said they are pleased with the strong consumer interest, but on a day of glitches they refused to say how many people actually succeeded in signing up for coverage. They gave inconsistent answers on whether a common problem had been cleared up or was still being corrected.

By Tuesday afternoon, at least 2.8 million people had visited the healthcare.gov website, said Medicare administrator Marilyn Tavenner, whose office is overseeing the rollout of the Affordable Care Act. The website had seven times the number of simultaneous users ever recorded on the medicare.gov site.

In Obama's home state, dozens of people who came to a Champaign, Ill., public health office to sign up for coverage found computer screens around the room flashing an error message: "System is unavailable."

Kimberly Shockley – logging in from Houston – and Mike Weaver, who lives in rural southern Illinois, ran into the same glitch as many others: They could not get past the security questions while trying to set up their personal accounts through healthcare.gov.

"I'm frustrated, very frustrated," said Shockley, a self-employed CPA. She spent more than an hour trying to get the security questions to work without success. When she clicked on a drop-down menu of suggested security questions, none appeared. She then tried to create her own questions, but that didn't work either.

Weaver, a self-employed photographer, said he also ran into problems with the drop-down menus. And when they started working, he still wasn't able to set up his account.

Other state-operated sites also experienced trouble.

Minnesota got its site running after a delay of several hours. Rhode Island's site recovered after a temporary crash. A spokesman for the New York Department of Health blamed difficulties on the 2 million visits to the website in the first 90 minutes after its launch. Washington state's marketplace used Twitter to thank users for their patience.

Exchange officials in Colorado said their website would not be fully functional for the first month, although consumers will be able to get help applying for government subsidies during that time. Hawaii's marketplace wasn't allowing people to compare plans and prices.

Journal staff writer Winthrop Quigley contributed to this report.

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
DOCUMENT BINDER INDEX

November 19, 2013

"Security of HealthCare.gov"

Exhibit Number	Document
1	Centers for Medicare & Medicaid Services-Red Team Discussion Document
2	Centers for Medicare & Medicaid Services, September 27, 2013 Memorandum; Federally Facilitated Marketplace-DECISION
3	Centers for Medicare & Medicaid Services, September 3, 2013 Memorandum; Authorization Decision for the Federal Facilitated Marketplaces (FFM) System
4	Centers for Medicare & Medicaid Services-Office of Information Services; Health Insurance eXchange (HIX) August-September 2013 Security Control Assessment (SCA) Report; Final Report, October 11, 2013
5	Email Exchange between CMS and MITRE, Subject: Onsite at CGI; July 27, 2013

From: Potyraj, Regina (CGI Federal) [redacted]
Sent: Friday, September 06, 2013 3:57 PM
To: 'Sheila.burke[redacted]'; 'Mark.oh[redacted]'; 'Tyrone.thompson[redacted]'; 'Van, Hung B. (CMS/OIS)'; 'paul.weiss[redacted]'; 'Melinda.Lewis[redacted]'
CC: Calem, Mark (CGI Federal); Winthrop, Monica (CGI Federal); FFE CCIIO Communications
Subject: HHSM-500-2007-000151 Task Order HHSM-500-T0012 (Monthly Status Report for August 2013)
Attachments: FFE12-010 FEPS-FFM Monthly Status Report - August2013.docx

Hello,

Please find attached CGI's Monthly Status Report for August 2013.

Best regards,

Regina

Regina Potyraj | Executive Consultant | CGI Federal | O: 703-272-6133 | C: 703-869-1074 | regina.potyraj@cgifederal.com

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Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
7500 Security Blvd.
Baltimore, MD 21244-1850

FEPS - FFM
Monthly Project Status Report, Reporting Period – August 2013

Last Modified: AUTODATE

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REVISION HISTORY

Version	Date	Organization/Point of Contact	Description of Changes
1.0	03/06/2013	CGI Federal	Baseline Template

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1. Project Execution

1.1. Significant Work Accomplished This Month

1.1.1. Deliverables

Table 1 identifies the deliverables completed during the reporting period.

Table 1: Deliverables

Document Name	Delivery Date
HIX Configuration Management Plan August 2013	8/6/13
HIX Contingency Plan August 2013	8/6/13
HIX PIA August 2013	8/6/13
HIX E-Authentication Workbook August 2013	8/6/13
HIX Safeguard Procedures Report August 2013	8/6/13
Section 508 Product Assessment (EE)	8/9/13
Plan Preview User Guide	8/9/13
SRD/RTM (EE & PM)	8/15/13
System Design Document (EE & PM)	8/15/13
Interface Control Document (EE & PM)	8/15/13
Business Service Definition (EE)	8/15/13
User Guide (EE)	8/15/13
LCM /PCM (EE & PM)	8/15/13
Service Sequence Diagram (EE)	8/15/13
UI Specifications (EE)	8/15/13
Service Specifications (EE & PM)	8/15/13
Test Cases (EE & PM)	8/15/13
SoapUI Project (EE)	8/15/13
Draft Test Summary Report (EE & PM)	8/15/13
Defect Reports (Comprehensive and 508) (EE & PM)	8/15/13
Release Plan Report (EE)	8/15/13
508 PAT (EE & PM)	8/15/13
Release Notes	8/15/13
EVM Reports – July 2013	8/26/13
Draft SRD/RTM (EE & FM)	8/30/13
System Design Document (EE & FM)	8/30/13
User Guide (EE)	8/30/13
LCM/PCM (EE & FM)	8/30/13
O&M Manual (FM)	8/30/13
Service Sequence Diagrams (EE & FM)	8/30/13
Service Specifications (EE & FM)	8/30/13
Test Cases (EE)	8/30/13
SoapUI Project (EE)	8/30/13
Draft Test Summary Report (EE & FM)	8/30/13

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FEPS - FFM

Document Name	Delivery Date
Defect Reports (Comprehensive and 508) (EE & FM)	8/30/13
Release Plan Report (EE & FM)	8/30/13
Release Notes	8/30/13

1.1.2. Upcoming Deliverables

Table 2 identifies the upcoming deliverables planned to CMS.

Table 2: Pending Deliverables

Document Name	Proposed Date
High Level Technical Design Document (Cross Module)	9/6/2013
System Requirements Document/Requirements Traceability Matrix (E&E and PM)	9/6/2013
System Design Document (E&E and PM)	9/6/2013
Interface Control Document (E&E)	9/6/2013
LCM (E&E and PM)	9/6/2013
PCM (E&E and PM)	9/6/2013
Gateway Service Specifications (E&E)	9/6/2013
Data Service Specifications (E&E and PM)	9/6/2013
Business Service Specifications (E&E and PM)	9/6/2013
Service Sequence Diagram (E&E and PM)	9/6/2013
UI Specifications (E&E and PM)	9/6/2013
User Guide (E&E, ESD and PM)	9/6/2013
Business Service Definition (E&E)	9/6/2013
Test Case (E&E and PM)	9/6/2013
Defect Report (E&E and PM)	9/6/2013
Test Summary Report (E&E and PM)	9/6/2013
508 PAT (E&E and PM)	TBD
Release Plan Report (E&E and PM)	9/6/2013
Release Notes (Cross Module)	9/6/2013
Day 1 Complete Documentation Package (E&E)	9/16/2013

1.1.3. Meetings

The various meetings CGI team members participate in during the month are discussed, in detail, during the FEPS Touch Base Calls.

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1.2. High Level Status by Work Stream

Table 3 provides a high level status overview of accomplishments, for each work stream, reflecting the current reporting period.

Table 3: High Level Status by Work Stream

Workstream	Status
Task Order Management	• Participated in weekly FFM and IPT Status meetings • Participated in daily status calls and ad hoc "Tiger Team" meetings • Attended monthly Contracts meeting • Prepared and delivered monthly EVM reports • Prepared and delivered Release documentation • Conducted Staffing/Recruiting in support of on-going work • Managed overall FFM Integrated Schedule • Managed project risks and issues and maintaining log • Implemented IQ Suite – daily task tracker and management-level status dashboards
Technical Solution Architecture & Ops Support	• Finalized design and detailed task plan for preparing the production environment for performance testing (prod prime) to commence on 09/16 and then the soft launch (merging prod prime, additional capacity, and current prod) to commence on 09/23 • Finalized the release schedule / build cadence and planned any additional dev/test/impl environment setup aligned to this plan • Supported the SCA to yield a successful audit; mitigated the 1 critical finding • Conducted internal performance testing; tuned configuration settings in multiple tiers; identified an Alfresco issue and will validate fix from software vendor in early Sep; identified longer running MarkLogic queries inside Plan Compare and will optimize in early Sep • Improved build and deployment processes • Improved process/tools for incident tracking and defect tracking • Worked with TWS team to set up all required Production jobs in TWS
Regional Technical Support & Training	• Delivered E&E and ESD 8/30 guide updates • Delivered first round of ESD training material to CMS • Prepared White House captivate demo • Facilitated Alpha Issuer calls and troubleshooting webinars • Liaison to CMS External testing PMO and teams • Began internal prep meetings for preparing IMPL1A for Issuers and States by 9/16 • Facilitated connectivity troubleshooting sessions with DSH and Issuers • Triaged Issuer reported defects/issues

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FEPS - FFM

Workstream	Status
Operations & Maintenance	• Supported Help Desk • Conducted smoke and regression testing support for code plan preview and plan compare deployment • Conducted end to end testing support of EE module • Generated CALT/QC Reports • Team on loan to different pods (2xBA, 9xDev, 3xQA)
Help Desk	• Received and processed 1880+ tier two Help Desk Tickets during the month of August • Participated in weekly help desk calls with CMS CCIIO • Participated in daily triage calls with CMS OIS • Integrated IQ Suite into the help desk team • Provided IQ Suite overview training and revised internal help desk procedures • Participated in numerous triage calls to identify and resolve issuer challenges • Provided various reports in support of data calls for CMS
Plan Management	• Completed capture of 3,034 NAIC plans via Plan Transfer – SERFF. • Deployed Plan Transfer—OPM into Production, captured all 117 OPM plans. • Deployed Plan Preview for individual and SHOP into Production. • Developed Plan Preview defect fixes and implemented changes to support Dental plan requirements changes. • Supported Security Controls Assessment testing of Plan Preview; no findings reported by SCA testers. • Completed development of Ratifications, Certifications functionality.
Financial Management	• Delivered SBM & CSR Amount Calculation Functionality • Successfully processed NAIC-HI and DC SBM submission files in Production • Executed a total of 149 test cases and resolved 71 defects in total • Completed 75% of integration testing with OFM on HIGLAS Interface • Completed designs and kick-off development on APTC/CSR/XUF Functionality
E&E	• Successfully launched My Account Lite • Conducted significant development and testing in support of Oct 1 launch and future releases: o Individual Application o Enrollment o Plan Compare o ESD o My Account o Notices

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Workstream	Status
	o Call Center Integration o Direct Enrollment o Account Transfer o SHOP • Integrated with Informatica • Successfully tested Direct Enrollment functionality with Issuers • Successfully tested Call Center APIs with NGD • Successfully sent 834 enrollment transactions to Issuers

1.3. Upcoming Major Milestones

Table 4 presents key milestones occurring during the next reporting period.

Table 4: Upcoming Major Milestones

Milestone	Due Date	Status
Operational Readiness Review	9/4/13	On track
Code Freeze for Day 1 Functionality	9/5/13	On track
Demo for White House	9/5/13	
Production Readiness Review	TBD	
Day 1 Deployment to Production	TBD	
Soft Launch	9/23/13	
Open Enrollment	10/1/13	

1.4. Project Dependencies – 30 Day Outlook

Table 5 presents high-level items on which CGI is dependent upon to begin key tasks in the work plan.

Table 5: Project Dependencies

Workstream	Dependency	Responsible Party	Due Date	Status
Business Architecture	Blueprint Baselining	BAH	Various	On Hold
Development	Business Requirements	CMS	See Project Schedule and Outstanding Requirements Report	In Progress
Development & Testing	Firewall Requests	URS	Various	In Progress

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1.5. Open Risks

Table 6 presents the top risks currently open in the risk register.

Table 6: Open Risks

CALT ID	Title	Description	Date Opened	Risk Status	Probability & Priority	Impact	Mitigation Strategy
art151840	Limited Testing Timeframes	The timeframes for testing in Dev and Test2 are not adequate to complete full functional, system, and integration testing activities.	8/5/2013	2-Open	5 - Near Certainty	4 - Significant	Work with CMS to establish a realistic schedule that will allow for the necessary testing.
art151898	Revised requirements for interacting with EIDM/ Experian	Revised requirements for interacting with EIDM/Experian when interacting with FARS (for consumers who have called Experian and been manually ID Proofed) have been created, which will require EIDM to create an additional service (i.e., to fetch the FARS data for a consumer). The risk is that this CGI is dependent upon EIDM to create the service in a timeframe that will allow FFM to consume.	8/14/2013	2-Open	5 - Near Certainty	5 - Severe	Discuss with CIS regarding the priorities of these changes and if it can be postponed as post-Day 1.
art151841	Plan preview allows issuers to only test ten predefined scenarios.	As directed by CMS, plan preview allows issuers to only test ten predefined scenarios. This covers a small subset of combinations of inputs, increasing the chances of missing data issues or system defects.	8/19/2013	2-Open	5 - Near Certainty	3 - Moderate	CGI will conduct testing beyond the 10 identified scenarios to the extent possible prior to Oct. 1.
art151842	Informatica not installed in Test2 or Prod Prime	Informatica is required to conduct testing of Contact Information including, USPS Models. Code requiring Informatica cannot be fully tested in the TEST2 and Prod Prime environments until Informatica is installed.	8/19/2013	3-Mitigation Implemented	4 - Highly Likely	4 - Significant	Work with MIDAS and IDL to get Informatica installed and working in Test2 and Prod Prime. 8/28 - We have confirmed and tested the set up in test2. We'll be able to confirm in prod prime this weekend when we do the next deployment.

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1.6. Open Issues

Table 7 presents the outstanding open issues currently being mitigated by the team.

Table 7: Open Issues

CALT ID	Title	Description	Date Opened	Status	Impact	Priority	Estimated Due Date	Corrective Action
artf151836	CGI does not have access to necessary tools to manage envs in test, imp, and prod.	CGI does not have access to necessary tools to manage envs in test, imp, and prod. Specifically (1) we don't have access to central log collection/view (2) we don't have access to monitoring tools. We have repeatedly asked CMS and URS but have not been granted this access.	8/5/2013	1-Open/New	5 - Severe	1 - Highest	8/26/2013	Provide access to existing tools that are operated by URS. We have requested this access but it has not been granted. 1. Document which tools we need, for which environments, and by when (Joel) 6/18 2. Keith to request a weekly call with Peter Um (Keith, CC, Joel, Peter) to discuss progress of monitoring. Communicate needs to Peter and explain implications of not having access. 3. Joel to take lead. Keith to request the meeting. 6/13
artf151837	Not Enough Time in Schedule to Conduct Adequate Performance Testing	Due to the compressed schedule, there is not enough time built in to allow for adequate performance testing.	8/9/2013	1-Open/New	3 - Moderate	1 - Highest	8/27/2013	Work with CMS to determine if any shifts can be made to allow for more time for performance testing.
artf151835	Hub Services are Intermittently Unavailable	Hub services are intermittently unavailable which affects FFM development and testing activities. This also impacts issuer testing in the Test2 environment.	8/13/2013	1-Open/New	4 - Significant	1 - Highest	8/29/2013	CGI Ops team will put a monitor in place (4-5 items) to alert whenever the Hub goes down. We will notify developers and the Hub so they are aware. We will log outage stats over time.
artf151839	Requests to support UAT	The CGI FFM QA team is receiving numerous emails, calls for demos, walk-throughs, questions, functionality requirements clarifications, environment setup, etc. directly from the CMS (OIS/CCIIO/OC) UAT users and staff, bypassing the established ACA UAT vendor.	8/23/2013	1-Open/New	3 - Moderate	2 - High	8/23/2013	Clarify the UAT process with CMS and the ACA testing vendor's management, such that the CGI FFM QA team is not required to support UAT.

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FEPS - FFM

CALT ID	Title	Description	Date Opened	Status	Impact	Priority	Estimated Due Date	Corrective Action
artf151989	EIDM - Reference Code Issue	FFM is not receiving the Reference Code as a response from the Submit User Info or the Modify User service. (Consequently, we cannot show the consumer the reference code to use when calling Experian to attempt to be manually ID Proofed). This impacts our ability to deliver the Manual ID Proofing items.	8/24/2013	1-Open/New	4 - Significant	2 - High	8/27/2013	EIDM needs to send the Reference Code as a response from the Submit User Info or the Modify User service.
artf151838	Lower Environments do not have required configurations in place	The lower environments are not configured with EIDM, Akamai, and sometimes required connectivity. Thus full integration testing cannot take place in these environments causing untested code to be promoted to higher environments.	8/8/2013	3-In Progress (Implementing Actions)	4 - Significant	1 - Highest	8/9/2013	1. Review list of existing integrations in all environments 2. Work with CMS to make a plan to address gaps 8/28 - Plan is currently being addressed based on priority.

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DATE:

TO: Marilyn Tavenner

FROM: James Kerr, Consortium Administrator for Medicare Health Plans Operations
Henry Chao, Deputy Chief Information Officer & Office of Information Services Deputy Director

SUBJECT: Federally Facilitated Marketplace–DECISION

ISSUE:

The Federal Information Security Management Act (FISMA) requires that the various Federally Facilitated Marketplace (FFM) systems - Enterprise and Eligibility (E&E), Financial Management (FM), and Plan Management (PM) successfully undergo a Security Control Assessment (SCA). Due to system readiness issues, the SCA was only partly completed. This constitutes a risk that must be accepted and mitigated to support the Marketplace Day 1 operations.

BACKGROUND:

CMS utilizes independent and specialized contractors to test the security readiness of its systems. Testing of the Marketplace has been on-going since inception as part of the CMS Expedited Life-Cycle process with the latest security testing occurring in September of 2013. As with all new systems which are pending launch, there are inherent security risks with not having all code tested in a single environment, finally, the system requires rapid development and release of hot-fixes and patches so it is not always available or stable during the duration of testing.

From a security perspective, the aspects of the system that were not tested due to the ongoing development, exposed a level of uncertainty that can be deemed as a high risk for FFM. Although throughout the three rounds of SCA testing all of the security controls have been tested on different versions of the system, the security contractor has not been able to test all of the security controls in one complete version of the system.

The risk associated with issuing an ATO for the FFM will be reduced by instituting a two-part mitigation plan.

First, CMS will implement the following security processes for the first year of operation of FFM:

- Establish a dedicated security team under the Chief Information Officer (CIO) to monitor, track and ensure the mitigation plan activities are completed. The CIO and the Chief Information Security Officer (CISO) will report weekly on the progress to the Health Reform Operations Board;

Page 2 – The Administrator

- Monitor and perform weekly testing of all border devices, including internet facing web servers;
- Conduct daily/weekly scans using the CISO's continuous monitoring tools
- Conduct a full SCA test on FFM (E&E, FM and PM) in a stable environment where all security controls can be tested within 60/90 days of going live on October 1st.

Second, CMS will migrate the Marketplace systems to CMS' Virtual Data Center (VDC) environment in Q1-2014. This environment has been through a full security assessment and has an authority to operate.

RECOMMENDATION:

Issue an Authority-to-Operate (ATO) for six months and implement the mitigation plan. The six-month period will allow the Marketplace to normalize its development activities while enabling the security team to closely monitor activities and perform a complete SCA.

DECISION:

Approve [redacted] Date SEP 27 2013

Disapproved_____ Date_____

Marilyn Tavenner

Attachment: Federally Facilitated Marketplace Decision Memo Risk Acknowledgment Signature Page

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services

[redacted]

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Federally Facilitated Marketplace Decision Memo
Risk Acknowledgment Signature Page

We acknowledge the level of risk the Agency is accepting in the Federally Facilitated Marketplace (FFM). The mitigation plan does not reduce the risk to the FFM system itself going into operation on October 1, 2013. However, the added protections do reduce the risk to the overall Marketplace operations and will ensure that the FFM system is completely tested within the next 6 months.

Reviewer [redacted] Date 9-27-2013
Teresa Fryer

Reviewer [redacted] Date 9-27-2013
Tony Trenkle

Reviewer [redacted] Date 9-27-2013
Michelle Snyder

From: Alford, Justin (CGI Federal) [redacted]
Sent: Tuesday, September 10, 2013 1:28 PM
To: booth, jon
CC: Martin, Rich (CGI Federal); Winthrop, Monica (CGI Federal); Wallace, Mary H. (CMS/OC); Reilly, Megan C. (CMS/OC); Patel, Ketan; trefzger, william; Pressley, Erin L. (CMS/OC); Weiss, Paul (CGI Federal)
Subject: Updated Script for End-to-End FFM
Attachments: Individual Application and Plan Compare Demo_End_to_End_Griffith_Update.zip

Jon,

Attached is the updated script that includes My Account, Individual Application, and Plan Compare. I was able to get it into one, reasonably-sized file – so this file should supersede the one I sent earlier this morning.

Please let me know if you have questions and if you can let me know you received it, I'd appreciate it.

Thanks,
Justin

Justin Alford | Director, Consulting | CGI Federal [redacted]

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From: Alford, Justin (CGI Federal)
Sent: Monday, September 09, 2013 6:05 PM
To: booth, jon
Cc: Martin, Rich (CGI Federal); Winthrop, Monica (CGI Federal); Wallace, Mary H. (CMS/OC); Reilly, Megan C. (CMS/OC); Patel, Ketan; trefzger, william; Pressley, Erin L. (CMS/OC); Weiss, Paul (CGI Federal)
Subject: RE: screen cam version of the FFM

Hi Jon,

Per the updated scenarios and screenshots, we will have that completed this evening and it will be available first thing tomorrow morning.

Thanks,
Justin

Justin Alford | Director, Consulting | CGI Federal [redacted]

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From: booth, jon
Sent: Monday, September 09, 2013 8:57 AM

To: Alford, Justin (CGI Federal)
Cc: Martin, Rich (CGI Federal); Winthrop, Monica (CGI Federal); Wallace, Mary H. (CMS/OC); Reilly, Megan C. (CMS/OC); Patel, Ketan; trefzger, william; Pressley, Erin L. (CMS/OC); Weiss, Paul (CGI Federal)
Subject: RE: screen cam version of the FFM

Justin,

Following up to our conversation this weekend.

Per our discussion, we will use the current Captivate demo for the Secretary briefing this week. No need for any new product there.

For the training video, we will expect an updated script from CGI including matching screenshots and test data. Please advise on when we will receive that document.

Thanks,

Jon

From: Booth, Jon G. (CMS/OC)
Sent: Saturday, September 07, 2013 9:24 AM
To: Justin Alford (CGI Federal)
Cc: Rich Martin; Monica (CGI Federal Winthrop; Wallace, Mary H. (CMS/OC); Reilly, Megan C. (CMS/OC); Patel, Ketan (CMS/OC); Trefzger, William (CMS/DWO); Pressley, Erin L. (CMS/OC); Paul Weiss (CGI Federal)
Subject: Fwd: screen cam version of the FFM

Justin, per my earlier email, see below. Let me know if CGI can get the latest demo video ready by COB Monday for the Secretary demo. That will save us from needing to use a real environment.

Paul, for the training video we'd like to pull in TPG as we did earlier in the year. Any concerns with this? If everyone is OK we will get the training video moving on Monday.

Begin forwarded message:

From: "Oh, Mark U. (CMS/OIS)" [redacted]
Date: September 6, 2013, 5:57:07 PM EDT
To: "Booth, Jon G. (CMS/OC)" [redacted], "Trefzger, William (CMS/DWO)" [redacted]
Cc: "Patel, Ketan (CMS/OC)" [redacted], "Reilly, Megan C. (CMS/OC)" [redacted], "Wallace, Mary H. (CMS/OC)" [redacted] "Pressley, Erin L. (CMS/OC)" [redacted]
Subject: RE: screen cam version of the FFM

Thanks Jon – this is a great approach.

Best,

Mark

From: Booth, Jon G. (CMS/OC)
Sent: Friday, September 06, 2013 3:13 PM
To: Oh, Mark U. (CMS/OIS); Trefzger, William (CMS/DWO)
Cc: Patel, Ketan (CMS/OC); Reilly, Megan C. (CMS/OC); Wallace, Mary H. (CMS/OC); Pressley, Erin L. (CMS/OC)
Subject: Re: screen cam version of the FFM
Importance: High

Mark,

I discussed this with Mary to make sure I had the correct understanding of our needs. I think we need 2 Captivate videos, outlined below.

- First, we may need to demo the site to the Secretary next Wednesday and we are looking to use a video for this so that we don't need to lock down any environments (seems like that will be impossible next week)
- Second, we need 2 versions of a training video — one version which would be a run-through (much like the one above, could possibly reuse the same file) and one which would ha a script/narration applied and might be longer with more pauses on specific screens. I am looping Erin Pressley into this as CSG can provide better guidance on the training video. On the last video we produced for public release, CGI brought in their 508 sub TPG to assist with scripting and 508 compliance. If possible, we should bring them in on this. We have resources on that subcontract.

For the first video, are you OK with Megan and I working with Justin over the weekend? If possible, we'd like to get the video against the current test2 build which has better integration of the components.

Thanks,

Jon

From: <Oh>, Mark Oh BB [redacted]
Date: Friday, September 6, 2013 11:49 AM
To: William Trefzger BB [redacted]
Cc: Ketan Patel BB [redacted] Jon Booth [redacted]
Subject: screen cam version of the FFM

Hey Bill – I have an assignment to work with OC and get a screen cam version of the FFM, walking through from application filing to completing an enrollment. Once produced, this would be distributed for training for the version in Path one (10/1).

Due date for delivery is 9/15th. Who can I work with on this? You guys had done a nice one for the marketplace already...and this one is for the prime time.

Best,

Mark

FFM Daily Meeting with CMS and CGI Federal (CGI) Contracts and Project Management Staff
Meeting Agenda
Minutes

Date:	**October 25, 2013**	
Time:	1:30 to 2:00 pm (note new time)	
Participants:	Allisan Hafner (CMS)	Betsy Burton (CGI)
	Star Blondell (CMS)	Rich Martin (CGI)
	Angela Hitchcock (CMS)	
	Dan Kane (CMS)	
Call-in Information:	Dial-in Number: [redacted]	
	Conference Code: [redacted]	

The objective of this daily meeting between CMS and CGI contracts and project management staff for the FFM project is to discuss the items listed below in order to proactively identify risks and confirm that both CMS and CGI staff are working within the current project scope and pricing. Both CMS and CGI believe that daily meetings will foster transparency related to scope and price, given the pace of development and related roll-out requirements.

1.1 Agenda Items and Discussion

1. **Activities planned for the next 4 to 5 days**
   CGI received a revised Technical Direction Letter October 23, which addresses various activities to be performed over the next ten days including defect resolution, timeout issues and establishing environments.

   Update: 10/23 – CGI is in receipt of the revised TDL dated 10/23 related to the critical path.

   Meeting: 1024 – CGI requested an extension to COB Friday in order to respond more fully to the TDL; CMS granted an extension to 10:00 a.m.

   Update: 10/25- CGI provided its comments to the TDL so that CGI and CMS can be better aligned across both organizations. We will continue to work towards the items listed in the TDL as clarified.

   Meeting: 10/25 – CMS confirmed receipt of CGI's comments on the TDL, which are intended to make sure both parties are aligned given the number of avenues for technical direction (e.g., IT CCB, GTL, other CMS management). CMS confirmed that technical direction should only come from Hung Van as the GTL and that CGI should validate with Hung any technical direction coming from others. CMS will be providing a response to CGI's comments on the TDL.

2. **Contract Scope and Price** – As part of the 10/17 meeting, CMS requested that CGI identify work items directed by CMS technical staff, which are not within the current set of activities planned for the rest of the base period or have a potential financial impact on the task order funding. Accordingly, CGI has added a table at this end of this section to capture that information.

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a. Modification 7 for EIDM Work–CMS issued a change order via Modification 7 for CGI to develop an alternative EIDM solution. The change order assumes that CGI can prioritize current work and funding to accommodate the temporary EIDM work-around, which was not identified as part of existing set of tasks within the statement of work. In accordance with the modification, CGI has the right to submit a change order proposal within 30 days of the modification. At this time, CGI is evaluating the financial impact of the EIDM solution on current funding.

   Update: 10/16: Per activity list above, CGI has been engaged in development of the temporary EIDM solution. Concurrently, CGI is evaluating the financial impact.

   Meeting: 10/16: CGI and CMS clarified that Modification 7 is a change order within the general scope of work to develop a temporary alternative identity management solution for FFM, which CGI and CMS did not anticipate at the time the revised budget was developed. Diverting technical resources to the alternative EIDM solution will create delays in performing other scheduled work and may have a financial impact unless remaining scope is revised to fit within the current funding. CGI will evaluate impact and provide a response to CMS by November 3 with proposed budget and/or scope recommendations.

   Update: 10/17: No change.

   Update: 10/18: CGI is reviewing hours and costs incurred to date on the workaround EIDM solution and assessing costs to complete.

   Meeting: 10/18: CMS requested that CGI provide a ROM estimate for the EIDM workaround by mid-week, if possible.

   Update: 10/21 and 10/22 – CGI is working on the ROM estimate.

   Update: 10/23 – CGI has provided ROM estimate based on current status of workaround.

   Meeting: 10/23 – Paul Weiss asked about the status of the EIDM workaround. Given improvements in the current EIDM, CMS had provided direction to hold off on further development until needed. At this time, there are approximately three more days of development for two to three developers and five days of testing for a team of testers in addition to the work performed to date.

b. Increase in Red Hat resources – CGI received direction from CMS technical staff to increase the number of resources supporting Red Hat software. The initial direction was followed up by an email notifying CGI of an impending Technical Direction Letter to support the increase in Red Hat resources. CGI is currently evaluating the financial impact of adding eight more Red Hat resources to the team.

   Update: Based on CMS direction, Red Hat has identified resources. CGI is evaluating the financial impact.

   Meeting: 10/16: Based on updated information, CGI indicated that Red Hat resources had reported to the FFM team over the weekend. CGI will determine the appropriate number of Red Hat resources in discussion with Red Hat and provide official authorization to the subcontractor, once the financial implications are assessed.

   Update: 10/17: CGI is evaluating scope and price for an additional 8 Red Hat Resources and will provide its assessment to CMS as soon as possible.

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Meeting: 10/17 - Hung Van discussed the Red Hat requirements. CGI is providing further information as follows: Red Hat will provide engineering support for the SOA-P product to help assist diagnosing technical issues and resolve setup, configuration, scalability and tuning of all Red Hat products used in the FFM ecosystem (Linux, JBoss SOA-P, BRMS, jPBM, EWS, Gluster, and HornetQ). Red Hat will provide consulting support to assist CGI Federal on technical aspects of the software – specifically on the Analysis/identification, debugging, and resolution of issues related to FFM application design with or without respect to use of Red Hat products.

Update: 10/18: In addition to the current contingent of Red Hat resources on the project, Red Hat provided 4 resources on Monday to provide immediate and targeted troubleshooting support for production issues. In order to effectively and efficiently address production issues related to Red Hat products, CGI believes it will need to increase its Red Hat resources beyond the amount contained in the extended base period proposal. Our technical team is assessing number of resources and timeframe over the weekend.

Meeting: 10/18: CMS asked if CGI needed a technical direction letter to bring on additional Red Hat resources since Red Hat was already included in the base period extension. CGI's concern is that increasing Red Hat resources, without other adjustments to planned activities, will have a financial impact, therefore, CGI suggested that it should provide a ROM estimate for the Red Hat resources and possible tradeoffs.

Update: 10/21 and 10/22 –We had received approval for certain Red Hat staff from Carolyn Robinson via email; these Red Hat are engineers which are bundled into the premium license price. Based on current FFM status, CGI is continuing to evaluate the need for additional Red Hat consultants, who are billed on a T&M basis.

Meeting: 10/22- Paul clarified that the 10/13 email from Carolyn Robinson was an acknowledgement that Henry Chao provided technical direction for Red Hat staff within the scope and current funding of the task and that a TDL would follow. CGI indicated that it may still need additional Red Hat consultants to support FFM troubleshooting and performance tuning.

Update: 10/23 – CGI is working with Red Hat to get additional information on requested support.

Update: 10/24 – Red Hat is providing three to four Technical Account Managers (TAMs) specific to this project, working both onsite and remotely, for performance tuning and product optimization at no additional charge for up to three weeks.

c. 24 x 7 development expectations – CGI raised an issue of CMS technical staff expectations for 24 x 7 development timelines, which were not anticipated. CGI will provide additional information regarding this item.

Update: 10/16: Paul Weiss provided an excerpt from the SoW for discussion on 10/16.

Meeting: CMS clarified that it was not expecting 24 x 7 development, but rather 24 x 7 operations and maintenance support such as managing production issues, code issues, application trouble shooting and servers going down. CGI believes the language in the SoW is vague with respect to whether the requirement is

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related to monitoring the applications' performance or the overall infrastructure, i.e., Terremark environment. CGI will reach out to its technical team to provide additional information to CMS on this issue.

Update: 10/17: In process

Meeting: 10/17: Paul Weiss requested that CGI provide a description of what CGI is doing to meet the requirements of the SoW related to operations and maintenance support for tomorrow's meeting.

Update: 10/18: CGI is monitoring the FFM system in production while addressing system issues and continued development.

Meeting 10/18: CGI and CMS discussed O&M responsibilities since the system is essentially in both the development and production phase. CGI is providing O&M support for the functionality in production but will provide further clarification.

Update: 10/21 and 10/22: Gathering additional info for CMS.

Meeting: 10/22: Lyandra Emmanuel asked for documentation of the 24 x 7 operations and maintenance support by close of business.

Update: 10/23: Briefing of operational support provided to CMS, which is under review by CMS.

d. Production Monitoring support – Per the 10/16 discussion, CMS clarified its expectations regarding production monitoring support, which was described as 24 x 7 monitoring and support of the actual production environment. CGI and CMS agreed to review the FFM statement of work as it relates to production environment support.

Update: 10/16: Paul Weiss provided an excerpt from the SoW for discussion on 10/16.

Meeting: 10/16: Hung Van provided clarification to CMS' expectations as noted in the revised issue statement above, which will be used going forward. From CGI's perspective, it appears that there may be an overlap between the XOC's functions and CGI's scope with respect to monitoring as noted in item e above. Typically, operations and maintenance includes application monitoring only. CGI will review the SoW and XOC charter with its technical team.

Update: 10/17: CGI is evaluating the SoW with its technical team and will provide further feedback to CMS.

Meeting: 10/17: Paul Weiss requested that CGI provide a description of what CGI is doing to meet the requirements of the SoW related to production monitoring for tomorrow's meeting.

Update: 10/18: CGI uses automated monitoring tools including JON and Tivoli to monitor the production environment. We monitor various indicators to measure system stability, responsiveness and availability. Email alerts are generated for system unavailable incidents. We have an on call schedule to respond to incidents in during off business hours. CGI does not monitor the supporting infrastructure provided by Terremark.

Meeting: 10/18: CGI provided additional description of its current monitoring process and on-call service functions.

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e. Additional work for Strategi –On 10/16, CGI notified CMS that its subcontractor, Strategi identified additional work that it had been requested to provide by CMS. CGI met with Strategi this morning to determine scope and price before providing any authorization to proceed.

Meeting: 10/17: CMS reiterated the need to obtain either CO or COR approval for new and/or expanded tasks based on CMS technical direction. CGI provided information on Strategi's role on the project.

Update: 10/18: CGI is working with Strategi to refine the scope of work related to issuer onboarding metrics and development of a production data cleanup strategy to determine impact on price and/or planned activities.

Meeting: 10/18: CGI will finalize Strategi scope and review any financial impact in the context of other tasks as identified in the list above.

Update: 10/21 and 10/22: CGI is finalizing the Strategi scope and estimated price with respect to other work activities and requirements.

Update: 10/24 - Strategi's work on Issuer Onboarding & Reporting has been reduced post 10/1; they have been asked to assist in production data clean-up but CGI is reviewing current funding allocated to Strategi prior to authorization.

f. Use of Mixpanel and New Relic tools to monitor user access:

Meeting: 10/21 – CGI has been directed to implement mixpanel, a monitoring tool for the User Interface.

Update: 10/23 – CMS has a license for mixpanel through 10/31/13, which is being leveraged for the FFM. CGI is obtaining quotes to extend the license. Mixpanel pricing is based on the number of data points tracked per month. For example, the cost to track 2M data points is $2K/month; however, the exchange will be much higher than that going forward.

Update: 10/25- CGI is also using New Relic to monitor the application and assist in identifying performance improvements. CMS has an existing license which is being leveraged for FFM.

g. Industry Experts- CGI has been directed by bring on industry experts to assist in performance issues and troubleshooting the solutions. At this time, a minimum of five experts have been identified to provide assistance. High level ROM is provided below.

Meeting: CGI and CMS discussed the financial impact of the industry experts, which is estimate at $1.2M (ROM). Paul asked whether those resources are replacing current staff, therefore mitigating the impact. In fact, the industry experts are providing solution and architecture reviews around stabilization and performance tuning while CGI is performing issue analysis, bug fixes, and other production related support in addition to code development and deployment. The Red Hat resources are focused on fine-tuning and optimizing the products used in the system.

Meeting: 10/24 – CMS inquired as to cost and status of the industry experts who were characterized as White House Fellows or otherwise covered by government funding elsewhere. CGI clarified that the recommended industry experts are in the private industry, although some may have involved in government fellowship

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programs in the past. Therefore, CGI is working through consulting agreements, scope and price with them.

Update: 10/25: CGI has negotiated price reductions with the industry experts but is still working on schedule and timeline, at which time CGI can refine the ROM. The price reductions are worth approximately $200k.

h. Repurposing of VMs and environments -CMS provided direction late yesterday regarding VM allocation, which will impact the schedule to establish the various environments (TEST0, IMP0, Test1 and Imp 1A) outlined in the TDL response. In order to accommodate the call center, CGI is repurposing a VM specifically for the call center (instead of sharing) which requires CGI to redeploy three to five staff members to configure the VM appropriately. This will have an impact on CGI's ability to establish the environments identified in the TDL.

Scope and/or Price Impact

Issue	Impact on Scope	Impact on Price and ROM estimate
Temporary EIDM solution	Not included in activities planned for the base period	ROM estimate is between $250k and $300k based on current status of the workaround.
ROMS for software	Received TDL dated 10/23/13 - Cost for increase in Terracotta and MarkLogic software is not included in current funding	MarkLogic licenses (20) $2,942,161.61 Terracotta licenses $2,417,399.98 Total impact - $5,359,561.59
Red Hat Resources	Increase in level of effort related to need for troubleshooting system	Resources provided over the weekend of 10/4 do not have a material impact. Red Hat is currently providing Technical Account Managers at no additional cost for up to three weeks.
Strategi	Potential increase in level of effort for Strategi based on development of processes for tracking manual issuer testing processes and issuer attestation of Direct Enrollment testing completion. Also assistance with development of production data cleanup.	Reviewing current funding to determine redirection of resources.
Use of Mixpanel	Implement Mixpanel , a monitoring tool for the UI to help collect metrics on user events within the application.	Leveraging a license that CMS already has on hand through 10/31. CGI will provide further information for extended license if needed.
Additional technical experts	Per direction from the administration, CGI will engage additional industry experts with experience in large scale, complex systems using multiple tools.	Current ROM estimate is approximately $1M to $1.2M.
Direction on VM allocation and environments	Allocation and reconfiguration of the VM specifically for the call center will impact CGI's schedule to establish the environments identifed in the TDL since ti requires redeploying	N/A

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Issue	Impact on Scope	Impact on Price and ROM estimate
	resources. The schedule will need to be evaluated	

Paul Weiss expressed concern that the list of items with financial impacts has grown without any corresponding tradeoffs identified. We discussed the fact that CGI and CMS would need to evaluate tradeoffs collaboratively once the financial impacts were determined, given the project dynamics and high level involvement.

3. Financial Notification

The CMS contracting officer asked that CGI provide notification of funds expended earlier than the 75% notification required by the task order. Accordingly, CGI will provide notification of percent of expended funds as well as planned expenditures for the next 60 days so that both parties can plan accordingly. Given the current set of TDLs, CGI is re-evaluating the planned costs for the next 60 days and will provide an update.

Funding Notification

	Funded/Expended	Percent of Funds Expended
Current Funding as of Modification 7	$196,037,115.85	
Cumulative Amount to be invoiced through 9/20	$118,130,622.92	60.26%
Estimated cost for next 60 days (including Adobe) *	$47,000,000	
Estimated Amount to be Expended	$152,130,622.92	77.86%

*currently re-assessing estimated costs given increase in resources related to the go-live and associated activities.

4. **Risks** – Given multiple technical directions related to additional staff, expanded infrastructure and other items, there is a potential financial impact on the project. It is imperative to discuss trade-offs in order to stay within budget.

5. Walk-ons

CGI discussed the fact that the FFM team is large and includes CGI and subcontractor staff working side by side with CMS staff in the same office and at a fast pace. In order to clarify lines of communication, CGI has reminded its subcontractors that they can take direction that changes their scope, schedule or price only from authorized CGI staff so that CGI can more effectively manage funding and planned activities. CGI and CMS staff will work collaboratively so that CGI can provide appropriate direction.

10/22- There are a number of CMS staff on CGI site who occupy approximately three conference rooms and two offices. Due to the increased size of the FFM project staff, CGI will need to obtain additional space, which may impact CMS seating.

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1.2 Action Items Summary

No.	Action Item	Responsible	Date Due
1	CGI and CMS to review SoW for production support as it relates to the production environment	Paul Weiss, Hung Van, CMS Betsy Burton, Monica Winthrop, CGI technical staff	10/18/13
2	Financial impact of EIDM solution	CGI	11/3/13
3	Financial impact of additional Red Hat resources	CGI	ASAP
4	Financial impact of additional Strategi resources	CGI	ASAP

1.3 Completed Action Items

No.	Action Item	Responsible	Date Due
	CGI to check on status of ROMS for Terracotta and MarkLogic	Betsy Burton	10/16
	Akamai modification	CMS	10/18
	Terracotta and MarkLogic licenses authorized through TDL issued 10/23.	CMS	10/24

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ONE HUNDRED THIRTEENTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON ENERGY AND COMMERCE

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November 26, 2013

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20101

Dear Secretary Sebelius:

Thank you for appearing before the Committee on Energy and Commerce on Wednesday, October 30, 2013, to testify at the hearing entitled "PPACA Implementation Failures: Answers from HHS."

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

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

To facilitate the printing of the hearing record, please respond to these questions and requests by the close of business on Thursday, December 12, 2013. Your responses should be e-mailed to the Legislative Clerk in Word format at Sydne.Harwick@mail.house.gov and mailed to Sydne Harwick, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C., 20515.

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

Sincerely,

Fred Upton
Chairman

cc: The Honorable Henry Waxman, Ranking Member

Attachments

Attachment 1—Additional Questions for the Record

The Honorable Fred Upton

1. **Will you please update the committee on the timing of the interagency framework on mobile medical apps and other software? When you do expect it will be released? What areas do you expect it will cover?**

    a. **Do you expect that the interagency report will detail the barriers to successful regulation within each agency?**

    b. **Will you commit to working with this committee to take into account its concerns with the framework?**

Answer: As directed by the Congress in Section 618 of the Food and Drug Administration Safety and Innovation Act (FDASIA), the Food and Drug Administration (FDA) in consultation with the Federal Communications Commission (FCC), and the HHS Office of the National Coordinator for Health Information Technology (ONC) are working towards publishing a report that contains a proposed strategy and recommendations on a risk-based regulatory framework for health information technology (health IT) that promotes innovation, protects patient safety, and avoids regulatory duplication. We expect that the report will be issued soon.

As part of seeking broad input on developing that regulatory framework, FDA, FCC, and ONC established a multi-stakeholder working group under ONC's Health IT Policy Committee to provide recommendations on what to consider when proposing such a framework. The working group submitted its final recommendations to ONC's Health IT Policy Committee in September 2013.[1] These recommendations highlighted the importance of treating device functionality the same across platforms, and stated that FDA should expedite finalizing its guidance on mobile medical apps because of that guidance's critical importance in providing clarity to innovators.

FDA, FCC, and ONC are taking into account all of ONC's Health IT Policy Committee's recommendations, which adopted in full the working group's recommendations, in the development of a report that will propose a strategy and recommendations on a risk-based regulatory framework, as required by section 618 of FDASIA.

In addition, the three Agencies commit to working with the Energy and Commerce Committee and other stakeholders on the development of this regulatory framework. FDA, FCC, and ONC intend to seek public comment on the proposed framework via a number of mechanisms, including publishing a notice in the *Federal Register* and establishing a public docket at *www.regulations.gov*.

As Jeffrey Shuren, M.D., J.D., Director of FDA's Center for Devices and Radiological Health (CDRH), testified at the November 19, 2013, hearing of the Energy and Commerce Health Subcommittee, it is essential for the three Agencies to also work closely and collaboratively with the stakeholder community in trying to put in place a mobile medical apps regulatory framework that is responsive to the needs of the entire stakeholder community, including innovators, patients, and practitioners. Indeed, FDA considered all comments received from the stakeholder community as it worked to finalize its guidance on Mobile Medical Applications.

[1] http://www.healthit.gov/facas/FACAS/health-it-policy-committee/health-it-policy-committee-recommendations-national-coordinator-health-it.

For the report, FDA, FCC, and ONC have already received a great deal of input from stakeholders through the recommendations provided by the working group and adopted by ONC's Health IT Policy Committee, and from other meetings and venues in which the three agencies' representatives have participated. This input is helping to inform the report that will be and made available on each Agency's website, as required by section 618.

Although FDA does not expect that the report will explicitly discuss barriers to successful regulation, FDA, along with FCC and ONC, intends to continue working closely with the stakeholder community to identify and address barriers to the successful implementation of a regulatory framework for health IT, including mobile medical apps.

2. **On November 8, 2013, the Food and Drug Administration (FDA) issued a proposed rule which would enable a generic drug manufacturer to independently update product labeling without having to wait until the corresponding brand name product has received approval from the agency to do so.**

    a. **FDA stated that "[i]f this proposed regulatory change is adopted, it may eliminate the preemption of certain failure-to-warn claims with respect to generic drugs." Please explain how FDA came to this conclusion and provide the Committee with all documents and communications relating to this assessment.**

Answer: Because there is an ongoing rulemaking process at FDA concerning these issues, our responses to this and other questions reflect statements made publicly in the preamble to the proposed rule.

In two recent cases, the U.S. Supreme Court considered the issue of whether Federal law preempts State law tort claims against pharmaceutical manufacturers for failing to provide adequate warnings in drug product labeling ("failure-to-warn claims") (see *Wyeth v. Levine*, 555 U.S. 555 (2009) and *Pliva, Inc. v. Mensing*, 131 S.Ct. 2567 (2011)). In *Wyeth v. Levine*, the Court decided that Federal law does not preempt a State law failure-to-warn claim that a brand drug's labeling did not contain an adequate warning. The Court found that the drug manufacturer could have unilaterally added a stronger warning to product labeling under the "changes being effected" (CBE-0) regulation as applied to NDAs, and absent clear evidence that FDA would not have approved such a labeling change, it was not impossible for the manufacturer to comply with both Federal and State requirements. The Court reaffirmed that "through many amendments to the [Federal Food, Drug, and Cosmetic Act] and to FDA regulations, it has remained a central premise of Federal drug regulation that the manufacturer bears responsibility for the content of its label at all times" (555 U.S. at 570-571).

Two years later, in *Pliva v. Mensing*, the Court decided that Federal law does preempt a State law failure-to-warn claim that a generic drug's labeling did not contain an adequate warning. The Court deferred to FDA's interpretation of its CBE-0 supplement and labeling regulations for ANDAs, and found that Federal law did not permit a generic drug manufacturer to use the CBE-0 supplement process to unilaterally strengthen warnings in its labeling or to issue additional warnings through "Dear Health Care Professional" letters, which FDA "argues . . . qualify as 'labeling'" (131 S.Ct. at 2576). The Court found that, under the current regulatory scheme, it was impossible for a generic drug manufacturer to comply with its Federal law duty to have the same labeling as the corresponding brand drug (the reference listed drug or RLD) and satisfy its State law duty to provide adequate labeling (131 S.Ct. at 2578). Therefore, the Court held that the difference between new drug application (NDA or brand drug application) and abbreviated new drug application (ANDA or generic drug application) holders' ability to independently change product labeling through CBE-0 supplements leads to different outcomes on whether Federal labeling requirements preempt State law failure-to-warn claims.

FDA's proposed revisions to its regulations would create parity between brand drug manufacturers and generic drug manufacturers with respect to submission of CBE-0 supplements for safety-related labeling changes by allowing generic drug manufacturers to independently update product labeling under the same conditions as brand drug manufacturers. The proposal would allow generic drug manufacturers to independently change and promptly distribute revised product labeling (including a "Dear Health Care Provider" letter) at the time of submission of a CBE-0 supplement in order to communicate important, newly-acquired drug safety information. A generic drug manufacturer's CBE-0 supplement would be approved upon the approval of the same safety-related labeling change for the corresponding brand drug, unless approval of the NDA for the corresponding brand drug has been withdrawn. FDA intends for this proposed rule to level the playing field and to increase incentives for generic drug manufacturers to participate more actively in ensuring the timeliness, accuracy, and completeness of drug safety labeling.

b. Please explain how this assessment factored into the agency's decision to propose this rule.

Answer: The U.S. Supreme Court's decision in *Pliva v. Mensing* prompted FDA to evaluate its current regulations. This decision, as well as the recent decision in *Mutual v. Bartlett* (discussed below), may alter the incentives for generic drug manufacturers to comply with current statutory and regulatory requirements to conduct robust postmarket surveillance, evaluation, and reporting and to ensure that their product labeling is accurate and up to date. In the current marketplace, approximately 80 percent of dispensed drugs are generic drugs, and brand drug manufacturers may discontinue marketing after generic drug entry. FDA believes it is time to provide generic drug manufacturers with the means to independently update their product labeling to reflect data obtained through postmarket surveillance, even though this will result in temporary labeling differences among products.

c. In light of the *Mensling* (2011) and *Bartlett* (2013) decisions by the Supreme Court, please explain FDA's authority to promulgate such a rule.

Answer: FDA's authority to extend the CBE-0 supplement process for safety-related labeling changes to ANDA holders arises from the same authority under which our regulations relating to NDA holders and biologics license application (BLA) holders were issued. The FD&C Act provides authority for FDA to permit NDA holders and BLA holders to change their product labeling to include certain newly acquired safety-related information through submission of a CBE–0 supplement prior to FDA approval, and the statute similarly authorizes permitting ANDA holders to make the same type of changes prior to FDA approval.

As a result of the decisions in *Wyeth v. Levine* and *Pliva v. Mensing,* an individual can bring a product liability action for failure to warn against a brand drug manufacturer (NDA holder), but generally not a generic drug manufacturer (ANDA holder), and thus access to the courts is dependent on whether an individual is dispensed a brand drug or generic drug. This different result is based on the fact that, under current regulations, an NDA holder can file a CBE-0 supplement for safety-related changes but an ANDA holder cannot. In *Pliva* v. *Mensing,* the U.S. Supreme Court, after noting that "[w]e recognize that from the perspective of Mensing and Demahy, finding pre-emption here but not in Wyeth makes little sense," stated its view that "Congress and the FDA retain the authority to change the law and regulations if they so desire" (131 S. Ct. 2567, 2582).

3. **Section 505(j)(2)(C) of the Federal Food, Drug and Cosmetic Act (FFDCA) generally requires generic drug manufacturers to have the same labeling as the reference listed drug at the time of approval. FDA has long interpreted this provision as requiring generic drug products to maintain the same labeling as the corresponding brand name product throughout the lifecycle of the generic drug product. With respect to the rule proposed on November 8, 2013, how does FDA plan on addressing these seemingly inconsistent positions? Does FDA plan on amending other regulations in order to do so?**

Answer: At the time of FDA's adoption of the generic drug regulations in 1992, FDA believed it was important that product labeling for the reference listed drug (RLD or brand drug) and any generic drugs be the same to assure physicians and patients that generic drugs were, indeed, equivalent to their RLD. However, as the generic drug industry has matured and captured an increasing share of the market, tension has grown between FDA's requirement that a generic drug have the same labeling as its RLD, which facilitates substitution of a generic drug for the prescribed product, and the need for an ANDA holder to be able to independently update its labeling as part of its independent responsibility to ensure that the labeling is accurate and up to date.

In the current marketplace, in which approximately 80 percent of drugs dispensed are generic and, as we have learned, brand drug manufacturers may discontinue marketing after generic drug entry. FDA believes it is time to provide ANDA holders with the means to update product labeling to reflect data obtained through postmarket surveillance, even though this will result in temporary labeling differences among products while the FDA reviews the proposed labeling change. During its review of a generic drug manufacturer's CBE-0 supplement, FDA would consider submissions by the brand drug manufacturer and other generic drug manufacturers related to the safety issue and determine whether the labeling update is justified and whether modifications are needed. FDA would make an approval decision on proposed labeling changes for the generic drug and the corresponding brand drug at the same time, so that brand and generic drug products have the same FDA-approved labeling.

The proposed rule would likely reduce the variation between brand and generic drug labeling that currently takes place. Under current regulations, only brand drug manufacturers can independently update product labeling with certain newly acquired safety information and distribute revised labeling, before FDA reviews or approves the labeling change, by submitting a CBE-0 supplement. FDA generally has advised that a generic drug manufacturer may use the CBE-0 supplement process only to update its product labeling to conform with the FDA-approved labeling for the corresponding brand drug or to respond to FDA's specific request to submit a labeling change through the CBE-0 process. Accordingly, while FDA reviews a brand drug manufacturer's CBE-0 supplement, there currently is a difference between the brand drug labeling and generic drug labeling. Once FDA approves a change to the brand drug labeling, the generic drug manufacturer is required to revise its product labeling to conform to the approved labeling of the corresponding brand drug. FDA advises that this update should occur at the very earliest time possible; however, FDA has determined that there is often a delay, of varying lengths, between the date on which revised brand drug labeling is approved and the date on which the generic drug manufacturer submits such labeling updates. The proposed rule, if finalized, generally would reduce the time in which all generic drug manufacturers make safety-related labeling changes by requiring generic drug manufacturers to submit conforming labeling changes within a 30-day timeframe.

4. **FDA acknowledged in issuing the proposed rule that "there may be concerns about temporary differences in safety-related labeling for drugs that FDA has determined to be therapeutically equivalent." This is an understatement and very concerning. FDA proposes to address this by establishing a website listing all of the proposed labeling changes that are pending at the agency.**

    a. **Please explain in detail the various methods and plans FDA has considered to alleviate this inevitable confusion. In addition to the website, what else is FDA planning to do to consistently inform provider decision-making and ensure patient safety?**

    b. **Please explain how a website listing all of the proposed labeling changes pending at the agency does not add to the confusion.**

    c. **Please explain how this decision to allow different labels on therapeutically equivalent drug products enhances patient safety.**

Answer: To minimize confusion and make safety-related changes to generic drug labeling readily available to prescribing health care professionals and the public while the FDA is reviewing a CBE-0 supplement, FDA proposes to establish a dedicated Web page on which FDA would promptly post information regarding the safety-related labeling changes proposed by brand and generic drug manufacturers in CBE-0 supplements while FDA is reviewing the supplement (see proposed 21 CFR 314.70(c)(8) and 601.12(f)(2)(iii)). The proposed FDA web page is expected to enhance transparency and facilitate public access to new safety-related information for all products – biological products licensed under the Public Health Service Act as well as drug products approved under the FD&C Act. The public may subscribe to FDA's free email subscription service to receive an email message each time there is an update to this proposed FDA Web page.

The proposed FDA Web page would provide information about pending CBE-0 supplements for safety-related labeling changes, including but not limited to: The active ingredient, the trade name (if any), the application holder, the date on which the supplement was submitted, a description of the proposed labeling change and source of the information supporting the proposed labeling change (*e.g.*, spontaneous adverse event reports, published literature, clinical trial, epidemiologic study), a link to the current labeling for the drug product containing the changes being effected, and the status of the pending CBE-0 supplement (*e.g.*, whether FDA is reviewing the proposed labeling change, has taken an action on the CBE-0 supplement, or has determined that the supplement does not meet the criteria for a CBE-0 supplement).

It is expected that a valid safety concern regarding a generic drug product also would generally warrant submission of a supplement for a change to the labeling by the corresponding brand drug manufacturer, as well as other generic drug manufacturers. The CBE-0 supplements would remain posted on FDA's Web page until FDA has completed its review and issued an action letter. If the CBE-0 supplement is approved, the final approved labeling will be made available on the proposed FDA Web page through a link to FDA's online labeling repository.[2] After an adequate time period to communicate FDA's decision regarding approval of the CBE-0 labeling supplements and to facilitate submission of conforming CBE-0 supplements by other application holders, as appropriate, the original entry on FDA's Web page would be archived.[3]

[2] http://labels.fda.gov

[3] Approved labeling would continue to be available at http://labels.fda.gov.

If finalized, this rule would help ensure that healthcare practitioners and the public have access to the most current drug safety information, which may be used to inform treatment decisions based on the balance of potential benefits and risks of the drug product for each patient.

5. **FDA asserts in the proposed rule that the *Mensing* decision "alters the incentives for generic drug manufacturers to comply with current requirements to conduct robust postmarketing surveillance, evaluation, and reporting, and to ensure that the labeling for their drugs is accurate and up-to-date."**

    a. **Please explain how FDA came to this conclusion.**

    b. **Does FDA have evidence that generic drug manufacturers are not fulfilling such requirements?**

    c. **Does FDA have evidence that the *Mensing* decision led generic drug manufacturers to be less compliant with postmarketing surveillance, evaluation, and reporting requirements?**

Answer: Because this is an ongoing rulemaking process, in which the submission of comments on the proposed rule will result in an administrative record that FDA must review before deciding on what final regulation would be justified, it would not be appropriate for us to respond fully to these questions at this time. We do note, however, that a potential link between tort liability and regulatory compliance has been discussed in other contexts. As several Supreme Court Justices observed, *Pliva v. Mensing,* which exempted generic drug manufacturers from tort liability based on a failure to warn theory,

> creates a gap in the parallel Federal-state regulatory scheme in a way that could have troubling consequences for drug safety. As we explained in *Wyeth v. Levine*, '[s]tate tort suits uncover unknown drug hazards and provide incentives for drug manufacturers to disclose safety risks promptly.' 555 U.S., at 579... Thus, we recognized, 'state law offers an additional, and important, layer of consumer protection that complements FDA regulation.' Ibid. (*Pliva v. Mensing*, 131 S.Ct. at 2592) (dissenting opinion).

We do wish to clarify that the proposed rule focuses on the obligation to update labeling to reflect important newly acquired safety information, not on the more general legal obligation to report adverse drug experience information to FDA. Brand and generic drug manufacturers currently have the same requirements for developing written procedures for the surveillance, receipt, evaluation, and reporting of postmarketing adverse drug experiences to FDA. All drug manufacturers (both brand and generic) must promptly review all adverse drug experience information obtained or otherwise received from any source, including published literature, and comply with applicable reporting and recordkeeping requirements. Reporting requirements include submission of 15-day alert reports for serious and unexpected adverse drug experiences, periodic reports, an annual report (including a brief summary of significant new information from the previous year that might affect the safety, effectiveness, or labeling of the drug product, and a description of actions the applicant has taken or intends to take as a result of this new information) and, if appropriate, proposed revisions to product labeling.

6. **Please provide CMS's most up to date information on Recovery Audit Contactors (RAC) denials that have gone all the way through the appeals process – both in terms of claim numbers as well as dollar amount.**

Answer: CMS is diligent in its oversight of Recovery Auditors and their decisions. Each month CMS conducts accuracy reviews of decisions made by the Recovery Auditors. CMS reports appeal statistics in the annual Report to Congress and on its website.[4] The most recent published appeal statistics are for Fiscal Year (FY) 2011, and the total overturn rate for all Recovery Auditor decisions was 2.9 percent. The FY 2012 Report to Congress will include updated appeals statistics and will be released in Calendar Year 2014.

7. **Should CMS include metrics on the impact to hospitals in its RAC report to Congress, such as an evaluation or measurement of the amount of funds that are spent by providers in responding to RAC audits, pursuing appeals, and the length of time hospitals must wait for Administrative Law Judge?**

Answer: The annual report includes information on the performance of contractors in identifying underpayments and overpayments and recouping overpayments, including an evaluation of the comparative performance of RACs and savings to the program.

CMS is sensitive to the concerns of the provider and supplier communities and continues to work with these communities to reduce the burden of the review process. CMS has imposed documentation request limits on the number of medical records a Recovery Auditor may request in a 45-day timeframe. These limits help providers prepare for potential audits and encourage the Recovery Auditors to select only those claims with the highest risk of improper payment.

CMS ensures that claims reviewed by one entity are not reviewed by another contractor again, unless there is a concern of potential fraud. CMS also works to ensure that multiple review entities such as Recovery Auditors, Medicare Administrative Contractors, and Zone Program Integrity Contractors do not review the same providers and the same topics at the same time.

Requesting provider self-reported data would be difficult to acquire and independently validate as a part of the RAC report to the Congress, and would introduce additional provider burden.

8. **RACs are paid on a percentage basis in order to finance the program and to incentivize thorough reviews of Medicare paid claims. To what extent do you believe that changes in the financial incentives should be considered? For example, RACs must return any fee associated with an overpayment determination that is reversed on appeal. Should the program be changed so that RACs are paid only after a claim becomes final on appeal? Should there be a graduated incentive program that pays lower contingency fees the more RAC determinations are overturned on appeal?**

Answer: CMS continues to make improvements to the Recovery Audit Program to help alleviate provider burden, ensure the accuracy of Recovery Auditor determinations, and promote transparency within the program. CMS carefully and routinely monitors Recovery Auditor appeal overturn rates. CMS reviews this information, as well as other Recovery Audit program statistics, as we consider future revisions to the Recovery Auditor contracts.

[4] www.cms.gov/rac

9. **We understand that CMS has directed RACs to provide education and feedback to hospitals arising from their audit activity. However, we also hear that this education and feedback does not always occur. What has CMS done to investigate the extent to which RACs are providing education and feedback? Does CMS set standards for what type and quantity of education RACs must provide? Does CMS take into consideration how RACs provide education and feedback to providers when CMS evaluates the RACs? If so, by what measures are the RACs evaluated?**

Answer: As directed in their Statement of Work, Recovery Auditors are required to fully document their rationale for determinations in a Review Results Letter. However, the Recovery Auditors are not required to educate providers on correct CMS billing and payment policy. Educating providers in these areas is the responsibility of the Medicare Administrative Contractors (MACs). Through regularly scheduled meetings and provisions of their contractor Joint Operating Agreements, Recovery Auditors and MACs work closely together to ensure the MACs are supplying the providers timely and accurate information related to problem billing areas.

In addition to using the Recovery Auditors to identify overpayments, CMS also uses their findings to prevent future improper payments. Since October 2010, CMS released thirteen Medicare Provider Compliance Quarterly Newsletters that provided detailed information on 100 findings identified by the Recovery Auditors to educate the provider community on how to correct improper billing behavior.

The Honorable Marsha Blackburn

1. **I've recently heard from providers in my district who were terminated from their managed health care plans. What responsibility does CMS/HHS have in overseeing this process and do they have an understanding as to the reasons behind these actions?**

Answer: Issuers often alter provider networks and payments rates as a regular course of business. While issuers must adhere to new network sufficiency and essential community provider standards, they still have room to make business decisions that work for them. There are now Federal standards that require health plans to include sufficient networks of providers as well as essential community providers.

With regard to provider networks in the Medicare program, under Medicare rules, Medicare Advantage Organizations have the ability to establish and manage contracted provider networks as they choose, as long as they continue to furnish all Medicare Part A and B services, fully meet Medicare access and availability standards, and have a process in place to ensure that, in the case of a provider termination, continuity of care is maintained for patients affected by those terminations.

Medicare Advantage Organizations (MAO) may change provider networks at any time during the year. The Medicare statute (section 1854(a)(6)(B)(iii) of the Social Security Act) prohibits CMS from requiring any MAO to contract with a particular hospital, physician, or other entity or individual to furnish Medicare items and services, or requiring a particular price structure for payment under such a contract.

The Medicare Advantage network access standards are based on local patterns of care and are evaluated using the following criteria: (1) the number of providers by county and specialty type; (2) the travel distance to providers and facilities by county and specialty type; and (3) in some counties, the travel time to providers and facilities by county and specialty type. As it deems necessary, CMS requires MAOs to submit reports and a table that displays the physicians who remain in the network. CMS staff use this information to ensure that the provider network, including specialty providers, meet Medicare access and availability standards.

CMS' role is to ensure the plan's network remains adequate and monitor that the MAO is notifying affected beneficiaries (members) and providers according to the required timeframes: 30-day notice to beneficiaries and 60-day advance notice to providers.

CMS recognizes that Medicare regulations must be sufficiently flexible to allow Medicare Advantage Organizations develop high performance provider networks to ensure cost effective, quality care for enrollees.

2. **Under the current technology infrastructure, how many separate servers or virtual servers in the cloud are being used to host and store data for healthcare.gov?**

Answer: The FFM and State-based Marketplace eligibility, redetermination, and appeals systems store certain eligibility and enrollment records in order to fulfill specific functions, including helping a consumer with an application or eligibility problem. This limited data storage is similar to what private issuers and the Medicare and Medicaid programs currently use to determine eligibility, enroll applicants into health coverage, process appeals, and perform customer service, as well as prevent fraud, waste, and abuse. Approximately 300 virtual servers (including Presentation, Application and Data servers) are used for hosting, and 16 large memory Marklogic Databases are used for storing data. Please note these figures will change as we add more servers as dictated by program or performance needs.

3. **Does your current system for healthcare.gov keep detailed error logs that can be referenced when difficulties with the website occur? If yes, will you please provide the committee a copy of these logs?**

Answer: CMS uses a variety of monitoring platforms to support HealthCare.gov. Earlier in October, the tech team put into place enhanced monitoring tools for HealthCare.gov, providing us with the data that enables us to get a high level picture of what's going on in the marketplace application and enrollment system. Thanks to this work, we are now better able to see how quickly pages are responding, and measure how changes improve a user experience on the site.

4. **CGI was first awarded a contract to work on this project in December of 2011. Do you know why they did not begin to write code until spring of 2013?**

Answer: The development and coding of the Federally-facilitated Marketplace began well before spring 2013. On September 30, 2011, CMS awarded a contract to CGI Federal to help build and support the information technology systems of the Federally-facilitated Marketplaces. With that contract, CGI was given a list of deliverables that began as early as 5 calendar days after the effective date of the contract and covered such items as the architectural diagrams, system design documents, data models, test cases, testing results, and other technical deliverables.

5. **How many rules or regulations pertaining to the ACA were issued between September 1 and November of 2012?**

Answer: CMS issued nine final and proposed rules pertaining to the Affordable Care Act during that time.

6. **As I am sure you know, unprotected passing of personal information—name, address, date of birth, social security number—is illegal under the Privacy Act of 1974 and a very serious concern of many people regarding information input into the healthcare.gov data hub. What processes are in place to prevent this information passing and protect consumer's right to privacy?**

Answer: CMS follows Federal law, government-wide security processes, and standard business practices to ensure stringent security and privacy protections, whether they apply on Healthcare.gov, through the FFM Call Center, with the paper application, or with the help of an in-person assister. Access to data provided to or obtained by the Marketplace during the application process is limited to authorized personnel through passwords, encryptions, firewalls, and secured systems. All personnel, including call center workers, people who handle paper applications and in-person assisters are trained in Privacy Act requirements.

7. **Has any or all party of healthcare.gov been audited to ensure compliance with the HIPAA Privacy, Security, and Breach Notification Rules?**

Answer: The Marketplace application on HealthCare.gov never asks for personal health information beyond what is normally asked for in Medicaid eligibility applications. This is due to the provisions in the Affordable Care Act, which prohibit issuers from denying applicants insurance based on pre-existing conditions or charging more based on health status. Consumers in the Marketplace do not need to disclose details of their medical history as they might have had to do to apply for health coverage in the past.

The Honorable John D. Dingell

1. **In New Hampshire, which has a state-federal partnership and only one insurer, HHS has accepted without question the state's signoff on the insurer's rates, deductibles, and network adequacy. This decision allowed one insurer, Anthem Blue Cross Blue Shield, to decide which hospitals and doctors will be included in the exchange. New Hampshire has very weak insurance regulations, especially with regards to network adequacy. And this one insurer now has a monopoly on the New Hampshire exchange and is offering a very narrow network. The network has gotten national attention because it drops ten of the states twenty six hospitals, impacting patients and the doctors who treat them. For example, some pregnant women in Congresswoman Carol Shea-Porter's district will have to drive more than an hour, past a doctor and hospital that have been excluded from the network, for routine prenatal care. Why did HHS fail to exercise its regulatory authority with regards to network adequacy and instead adopt a policy of deferring to state regulators in states like New Hampshire?**

Answer: Federal regulations at 45 CFR 156.230(a)(2) require a qualified health plan (QHP) issuer to maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance use disorder services, to assure that all services will be accessible without unreasonable delay. When CMS evaluated applications for QHP certification for the 2014 coverage year, they relied on state analyses and recommendations from states like New Hampshire, which have the authority and means to assess issuer network adequacy. The states are the traditional regulator of health insurance issuers, and have authority to require additions to networks if requirements of state law are not met. In this case, the New Hampshire Department of Insurance approved the network as adequate, and CMS will work with the Department to monitor adequacy during the benefit year.

The Honorable Joseph R. Pitts

1. **Please explain the steps a healthcare.gov user should take to determine whether the plans they are considering include abortion as a covered benefit?**
2. **In 1303(b)(3)(A) the Affordable Care Act specifies that "A qualified health plan that provides for coverage of the services described in paragraph (1)(B)(i) [abortion in cases other than rape, incest or to save the life of the mother], shall provide a notice to enrollees, only as part of the summary of benefits and coverage explanation, at the time of enrollment, of such coverage." Please describe how this notice is provided to individuals purchasing plans through the federally facilitated exchange website.**
3. **Rep. Chris Smith (R-NJ) has introduced a bill called the "Abortion Insurance Full Disclosure Act" (H.R. 3279). The bill would require the exchange to prominently display whether each plan includes abortion coverage. It also says if a plan includes abortion (and thus charges an abortion surcharge), the surcharge should be displayed anywhere the price is displayed. Do you support this legislation?**
4. **Please provide a list of all plans sold in each state on the federally facilitated exchange. For each plan please indicate whether the plan includes abortion as a covered benefit. If the plan includes abortion, please indicate the circumstances in which abortion is a covered benefit (e.g. all cases, cases of rape and incest, to save the life of the mother, etc.) In addition, for each plan that includes abortion in cases other than rape, incest or to save the life of the mother, please list the amount of the abortion surcharge described in 1303(b)(2)(i)(II) of the ACA.**

Answer to #s 1-4: CMS has not fully examined the legislation you mention, and cannot offer comment at this time. CMS is committed to ensuring that HealthCare.gov provides the key information consumers need to make an informed selection from among the Qualified Health Plans (QHPs) available to them. The Affordable Care Act requires that each plan in the Marketplace include a Summary of Benefits and Coverage and a link to the plan brochure, where consumers can learn more about which services are covered. The Affordable Care Act requires plans in the Marketplace to cover the ten essential health benefits. It is up to the issuer to determine which additional services they cover, and consumers may always contact issuers with any questions.

CMS did not separately collect information about issuers' estimates of the actuarial value of coverage of abortion services for which public funding is prohibited. Rather, issuers were directed to include the costs attributable to abortion services for which public funding is prohibited with costs attributable to non-essential health benefits to facilitate the accurate display of premium information. Consistent with section 1303(b)(3)(B) of the Affordable Care Act, specified information including any advertising used by the issuer with respect to the plan and any information provided by the Marketplace must specify only the total amount of the combined charges for coverage of abortion services for which public funding is prohibited and for all other coverage provided by the plan.

5. **According to CRS report R41137, "In certain instances, the [premium tax credit] amount may cover the entire premium and the tax filer pays nothing toward the premium." In such cases where the plan purchaser receives a 100% subsidy how does the insurance company collect the abortion surcharge described in 1303(b)(2)(i)(II) of the ACA?**

Answer: The premium tax credit established under section 36B of the Internal Revenue Code may be used only to cover or reduce the costs of essential health benefits covered by a QHP. Further, the tax credit may not be used to cover the costs of abortion services for which Federal funding is prohibited, consistent with section 1303(b)(2)(A) of the Affordable Care Act.

As described at 45 CFR 156.470, CMS implemented these requirements by collecting from issuers the portion of the total rate that is attributable to essential health benefits, excluding any costs attributable to coverage of services that are not essential health benefits, including abortion services for which Federal funding is prohibited. This amount is then used to calculate advance payments of the premium tax credit. Pursuant to sections 1303(b)(2)(B)(i) and 1303(b)(2)(D)(ii)(III) of the Affordable Care Act, the issuer of a qualified health plan that provides coverage for abortion services for which Federal funding is prohibited must collect a separate, non-subsidized payment from each enrollee of an amount equal to the actuarial value of these services, which the issuer may not estimate to be less than one dollar per enrollee per month. Therefore, it is not possible for a consumer to have no out-of-pocket premium responsibility for a qualified health plan that covers abortion services for which Federal funding is prohibited.

Example: An issuer charges a rate of $100 per month for a particular qualified health plan, of which one dollar is attributable to abortion services for which Federal funding is prohibited and four dollars are attributable to other non-essential health benefits. The premium tax credit eligible portion of the premium is $95, meaning that the maximum amount of premium tax credit a consumer could apply to the plan, if eligible, is $95 per month. Even if the consumer were eligible for a tax credit of $97 per month, the consumer remains directly responsible for five dollars per month. On the Federally-facilitated Marketplace website, the consumer would be advised of his or her out-of-pocket responsibility (in this example, five dollars) during plan shopping.

6. **For individuals who are eligible for cost-sharing credits, how will plans ensure compliance with section 1303(b)(2)(A)(ii)?**

Answer: As discussed at 45 CFR 156.430 and finalized in the HHS Notice of Benefit and Payment Parameters for 2014, HHS will provide to QHP issuers advance payments and reconciliation payments based on cost-sharing reductions provided for essential health benefits, which do not include abortion services for which Federal funding is prohibited, *see* 45 CFR 156.280(d)(1). Further, in accordance with 45 CFR 156.280(e)(1)(ii), issuers must not use any cost-sharing reductions or advance payments thereof to pay for abortion services for which Federal funds are prohibited. Instead, claims for such abortion services must be paid out of the separate allocation account established for this purpose, *see* 45 CFR 156.280(e)(3).

7. **Is abortion ever classified as a "preventive service" in plans sold on the federally facilitated exchanges?**

Answer: No.

8. **The Affordable Care Act (ACA) departs from the principles of the Hyde Amendment by allowing federal funding of Exchange plans that cover abortion on demand. Moreover, these abortion-covering plans will charge a mandatory abortion surcharge. ACA Section 1303 requires the issuer of an Exchange plan to collect "separate payments" from "each enrollee in the plan:" a "separate payment" in an amount equal of the actuarial value of the abortions for which public funding is prohibited, and a separate payment in an amount equal to the portion of the premium to be paid by the enrollee for all other services. Again, from a pro-life perspective, it is very disturbing that even enrollees who oppose abortion on moral or religious grounds must make such "separate payments," but nevertheless the law is the law until the Congress amends the statute, and the law must be enforced. Moreover, to do otherwise would leave the "abortion surcharge" as a hidden fee that the enrollee pays without the enrollee's knowledge.**

a. **With regards to the "Establishment of Allocation Accounts" requirement set forth in Sec. 1303(b)(2)(B), what guidance has HHS given issuers of plans that will participate in the individual market in the Federally-facilitated Exchanges for how to comply with this "separate payment" requirement? Note, this question does not pertain to the "segregation of funds" requirement set forth in Sec. 1303(b)(2)(C), but rather it pertains to the "Establishment of Allocation Accounts" requirement for "separate payments" set forth in Sec. 1303(b)(2)(B). What guidance has HHS given to state Exchanges with regards to issuers of plans in the respective state Exchange's individual market with regards to this "separate payments" statutory requirement? How does HHS intend to monitor and enforce this "separate payments" statutory requirement?**

Answer: Generally, HHS has sought to maximize the flexibility and discretion afforded to State-based Marketplaces within the parameters established by the Affordable Care Act. Consistent with this overall approach, HHS has not published specific guidance outlining how State-based Marketplaces should administer or oversee this specific statutory requirement. However, HHS has specified requirements in 45 CFR 156.280, which apply to issuers of all QHPs, including those in State-based Marketplaces. Additionally, 45 CFR 156.280(e)(2) specifically implements the "separate payments" requirement. State-based Marketplaces could provide additional direction to their QHP issuers if desired, provided that such direction is consistent with the statute and implementing regulations. Similarly, HHS recognizes that QHP issuers participating in the Federally-facilitated Marketplaces may take any of several potential approaches to collecting these separate payments based on their administrative and business practices, also provided that such approaches are consistent with the statute and implementing regulations.

b. **Again, within ACA Sec. 1303(b)(2)(B), "Establishment of Allocation Accounts," the ACA states: "In the case of an enrollee whose premium for coverage under the plan is paid through employee payroll deposit, the separate payments required under this subparagraph shall each be paid by a separate deposit." How does HHS intend to enforce this statutory requirement in the Federally-facilitated SHOP Exchanges? How does HHS intend to monitor and enforce this statutory requirement in the state Exchanges?**

Answer: Because the requirement to collect separate payments and to establish allocation accounts hinges on the presence of the premium tax credit and cost-sharing reductions, neither of which is available for coverage purchased through a SHOP Marketplace, the requirements established in section 1303(b)(2) of the Affordable Care Act and implementing regulations in 45 CFR 156.280 regarding separate payments and allocation accounts do not apply to issuers with respect to their offering of QHPs through a SHOP Marketplace. With respect to the separate payroll deposit, oversight and enforcement of this provision will be consistent with oversight and enforcement for the segregation of funds requirement, with which section 1303(b)(2)(E) of the Affordable Care Act charges state health insurance commissioners.

c. **With regards to the "Segregation of Funds" requirement set forth in ACA Section 1303(b)(2)(C), HHS stated in its "Pre-Regulatory Model Guidelines Under Section 1303 of the Affordable Care Act" that "[p]rior to establishment of the Exchanges, the OMB Circular A-133 Compliance Supplement will be amended to include guidance to assist auditors of State governments regarding compliance with Section 1303." Has such guidance been issued? If not, please explain why.**

Answer: The regulation at 45 CFR 156.280 specifies segregation of funds requirements for issuers to follow. While separate guidance has not been issued, this regulation serves as a guide for state regulators.

d. 45 CFR 156.280(e)(5)(iii) requires: "Each QHP issuer participating in the Exchange must provide to the State insurance commissioner an annual assurance statement attesting that the plan has complied with section 1303 of the Affordable Care Act and applicable regulations." The "Pre-Regulatory Model Guidelines Under Section 1303 of the Affordable Care Act" state that the term "State health insurance commissioner" includes "the relevant federal official in a given State that does not establish an Exchange."

i. For purposes of the Federally facilitated Exchanges, how does HHS intend to monitor that QHP issuers have made a truthful attestation to the U.S. Government that they have complied with all of Section 1303, including the "separate payments" requirement set forth in Sec. 1303(b)(2)(B), "Establishment of Allocation Accounts"?

Answer: HHS expects to employ a number of strategies to ensure that issuers of QHPs in the Federally-facilitated Marketplaces remain in compliance with QHP certification and other applicable standards, including applicable requirements in section 1303 of the Affordable Care Act. These strategies include, but are not limited to, post-certification monitoring, audits, consumer complaints, and technical consultation and assistance provided by CMS regional office account managers.

ii. For purposes of the state Exchanges, how does HHS intend to instruct the state health insurance commissioners to monitor that QHP issuers have made a truthful attestation to the state that they have complied with all of Section 1303, including the "separate payments" requirement set forth in Sec. 1303(b)(2)(B), "Establishment of Allocation Accounts"?

Answer: Consistent with section 1303(b)(2)(E) of the Affordable Care Act, state health insurance commissioners, or the appropriate state regulators, are responsible for collecting and reviewing issuers' plans related to segregation of funds. HHS does not plan to direct state insurance commissioners or other state officials in their efforts to enforce the requirements of section 1303.

iii. According to a Politifact report (http://www.politifact.com/rhode-island/statements/2013/oct/23/barth-bracy/anti-abortion-activist-barth-bracy-says-people-who/), "'The customer is not billed a separate fee,' Dara Chadwick, spokeswoman for HealthSource RI said in an email. The way the system is set up, the issuer of each plan (an insurance company such as Blue Cross) does not bill the customer directly. HealthSource RI does. She asserted that another portion of the law, subsection b(3), prohibits separate billing because abortions can only be mentioned in the summary of benefits when the person is enrolled." Based on this information is HealthSource RI in compliance with the separate payment requirement? Has your department had any interaction with HealthSource RI regarding the separate payment requirement?

Answer: CMS does not interfere with decisions undertaken by State-based Marketplaces as long as they do not violate the Affordable Care Act or its implementing regulations.

9. **HHS indicated that it tends to propose in the future rulemaking to exempt self-insured, self-administered plans from the reinsurance fee in 2014 and 2015. This would include but not be limited to multiple employer plans. What is the justification for this carve out? Is it correct that self-insured plans of any kind currently must pay the $63 fee to the reinsurance program but do not receive any benefit from the program? Why only exempt a small segment of self-insured plans from the fee?**

Answer: Section 1341(b)(1)(A) of the Affordable Care Act provides that "health insurance issuers and third party administrators on behalf of group health plans" make contributions. We believe an appropriate interpretation of this provision is that self-funded plans that do not use third-party administrators for core functions such as claims processing are exempt. We intend to propose to modify the definition of "contributing entity" in future regulations to reflect our revised interpretation.

10. **Please identify the dates on which you, your designee, or representatives from HHS, CMS, or CCIIO discussed healthcare.gov or any of its supporting systems with President Obama or any other White House official and identify those officials.**

Answer: HHS and CMS officials meet and speak regularly with executive branch entities, including the White House and the Office of Management and Budget.

11. **Please provide any materials created or used by you, your designee, or representatives from HHS, CMS, or CCIIO to brief or discuss healthcare.gov or any of its supporting systems with President Obama or any other White House official.**

Answer: The Department received a document request concerning the development of HealthCare.gov from the Committee on October 10, 2013, and has been working to provide appropriate documents to the Committee.

12. **Please identify the dates where you or Department officials discussed with the President the work and progress related to the creation and building of healthcare.gov, the data hub, exchange subsidy eligibility systems, and related work.**

Answer: I frequently attend White House meetings on the implementation of the Affordable Care Act, including dozens with the President in the last year alone. HHS and CMS officials meet with speak regularly with executive branch entities, including the White House and the Office of Management and Budget.

The Honorable Greg Walden

1. **On August 6 of this year, I sent you along with Secretary Perez a letter regarding a local Multiple Employer Welfare Arrangement (MEWA) plan offered by the Chamber of Commerce in Bend, Oregon. This health plan, which is fully insured and meets all state and federal laws, including those contained in the Affordable Care Act, serves 2,000 employees in my home District. However, the plan still has not been approved by the federal government as a multiple employer organization. With that background, I will make the same request I made in my still unanswered letter from three months ago: please inform me of the action you plan on taking to protect this plan or any other similar association health plan, offered to employees by local businesses in Oregon.**

Answer: As you know, all health insurance issuers must comply with rating reforms in the Affordable Care Act. CMS has provided guidance on how the Public Health Service Act views these arrangements, and depending on the group size, the issuer will need to comply with Fair Health Insurance Premiums (Public Health Service Act section 2701) and the single risk pool (Affordable Care Act section 1312(c)). The issuer can still differentiate this product, for example, by using administrative costs as a "plan-level modifier" in its pricing calculation. Premiums can be lower, reflecting low administrative costs, passing savings on to the consumers and keeping premiums down. Although the guaranteed availability requirement of the Affordable Care Act means that any person who wishes to purchase this product must be able to do so, the product may be sold exclusively via certain agents. In addition, the issuer may continue to use target marketing to certain members. By using these flexibilities, a fully-insured MEWA plan can continue while still complying with the single risk pool requirement of the Affordable Care Act.

2. **In a similar situation, the employees of a company in my District are members of a Teamsters union. Their union uses the Oregon Processors Employees Trust for their medical benefits. Although the trust's medical benefits for year-round, "Regular status" employees comply with the Affordable Care Act, their coverage for seasonal employees does not meet the ACA requirements. The union has informed this employer that they are not going to bring the plan up to the minimum requirements to comply with the Affordable Care Act. This scenario puts the business in a difficult situation: violate their union contract or violate the Affordable Care Act. With 80 seasonal employees who would be forced to purchase insurance through the exchange, the business would be facing tens of thousands of dollars in fines. What recourse do you suggest I offer to this business so that they are not forced to violate either union contract or the health care law?**

Answer: As you may know, on July 9, 2013, the Internal Revenue Service (IRS) published Notice 2013-45 providing for transition relief from sections 6055, 6056 and 4980H of the Internal Revenue Code. These provisions relate to information reporting for employers and issuers and employer shared responsibility. Pursuant to that notice, both the information reporting and the Employer Shared Responsibility Provisions will be fully effective for 2015. In addition, on December 28, 2012, IRS issued proposed regulations on "Shared Responsibility for Employers Regarding Health Coverage".[5] That regulation included proposed rules related to how seasonal employees would be counted for purposes of the employer shared responsibility provision. If you have additional questions about the application of employer responsibility provisions, I suggest that you reach directly to the IRS, as they are the Agency responsible for implementing those provisions.

[5] http://www.irs.gov/pub/newsroom/reg-138006-12.pdf

The Honorable Michael C. Burgess

1. **While we have heard a lot about the front end problems—like creating an account—isn't it true we may not even know the depth of other problems that may come as consumers continue upstream? What problems would you anticipate in the next few months as more users access the website and attempt to actually sign-up for plans?**

Answer: Unfortunately, the experience on HealthCare.gov has been frustrating for many Americans. The initial consumer experience of HealthCare.gov has not lived up to the expectations of the American people and is not acceptable. We are committed to fixing these problems as soon as possible. As part of our efforts to improve HealthCare.gov, we've established a new management structure, led by a general contractor, QSSI. This nerve center for technical operations is diagnosing problems and making quick decisions with developers and vendors to analyze, troubleshoot, prioritize and resolve issues in real time.

This team has put in place enhanced monitoring and instrumentation tools for HealthCare.gov -- providing us with data that enables us to get a high level picture of what's going on in the Marketplace application and enrollment process. We are now better able to see how quickly pages are responding, and measure how changes improve a user's experience on the site. We're also getting information on which parts of the application are causing the most errors--enabling us to prioritize what we fix next. We expect the vast majority of users will be able to successfully enroll through HealthCare.gov by the end of November.

2. **We have heard that various companies, contractors, insurers and others had daily contact with CMS just prior to launch (including conference calls)—were you involved in any of these calls? If so, who was on these calls and were White House staff involved?**

Answer: While I understand that CMS staff worked closely with contractors and issuers, I did not participate in daily operational calls.

3. **When did your pre-launch testing occur as integrated systems? (Also referred to as end-to-end testing)?**

Answer: The FFM eligibility and enrollment system consists of numerous modules. Each module of this system was tested for functionality. Each interface with our business partners and other Federal agencies was also tested. Numerous test cases were used to exercise the end-to-end functionality of the system, and through those tests, CMS was able to identify problems and address them. We know now that we underestimated the volume of users who would attempt to log onto the system at the same time, and therefore our testing did not include performance testing at the volume we experienced at launch.

We are encouraged that the Hub is working as intended, and that the framework for a better-functioning FFM eligibility and enrollment system is in place. By enlisting additional technical help, aggressively monitoring for errors, testing to prevent new issues from cropping up, and regularly deploying fixes to the site, we have already made significant improvements to the performance and functionality of the system.

4. **When healthcare.gov launched on October 1, it required people to set up an account, submit an application, and verify their identity prior to viewing their choice of health plans and costs. However, we have received word from the contractors involved in creating the website that there was originally a browsing feature available, but it was turned off prior to October 1. Who made this decision? Did you or someone in your office make the decision to turn off the browsing feature? If not, were you aware that the contractors were told to turn off the browsing feature?**

Answer: Marilyn Tavenner, as the Administrator of CMS, made the decision to disable the anonymous shopper function in September because the application had performance problems and deficiencies.

5. **Do you have a "Plan C" or contingency plan in place if the website is not fixed by November 30?**

Answer: Based on our analysis we will have it fully functioning by the end of November. We expect that the vast majority of users will be able to successfully enroll through HealthCare.gov. However, there will always be people who don't want to use the website, who would prefer to use a paper application, who need to speak with a call center or need additional in-person assistance.

We've always assumed that, based on Massachusetts' experience, the initial sign-up would be slow. And in fact, consumers have until December 15th to enroll for coverage beginning January 1. So while we don't like the problems we had in October, we do not think it will impact the timeline, because we have a six-month enrollment, so individuals will still have four months to apply for coverage by the end of March.

6. **Section 1303 of the ACA sets up a system in which those who enroll in plans that include abortion will pay an abortion surcharge. Since many Americans do not want to pay such a surcharge, it is important that consumers are able to ascertain which plans will charge the abortion surcharge and which will not. I have received reports that consumers are not able to obtain this information on the healthcare.gov website. What steps are you taking to make sure consumers can access information about abortion coverage and the possible surcharges?**

Answer: CMS is committed to ensuring that HealthCare.gov provides the key information consumers need to make an informed selection from among the QHPs available to them. The Affordable Care Act requires that each plan in the Marketplace include a Summary of Benefits and Coverage and a link to the plan brochure, where consumers can learn more about which services are covered. The Affordable Care Act requires plans in the Marketplace to cover the ten essential health benefits. It is up to the issuer to determine which additional services they cover, and consumers may always contact issuers with any questions.

The Honorable Steve Scalise

1. **How can an individual in Louisiana determine if a health insurance plan includes abortion coverage? No American should be put in a position where they have to violate their conscience with respect to their religious beliefs just to comply with the health care law. Will people be able to determine in a clear way on the federal website healthcare.gov whether or not a plan they are considering includes coverage for abortion services?**

Answer: Because Louisiana has enacted a state law consistent with section 1303(a)(1) of the Affordable Care Act, no qualified health plan certified to offer Marketplace coverage in Louisiana covers abortion services for which Federal funding is prohibited. Generally, CMS is committed to ensuring that HealthCare.gov provides the key information consumers need to make an informed selection from among the QHPs available to them. The Affordable Care Act requires that each plan in the Marketplace include a Summary of Benefits and Coverage and a link to the plan brochure, where consumers can learn more about which services are covered. The Affordable Care Act requires plans in the Marketplace to cover the ten essential health benefits. It is up to the issuer to determine which additional services they cover, and consumers may always contact issuers with any questions.

2. **Is an issuer permitted to deny or refuse to effectuate enrollment in a qualified health plan when a qualified individual or employer has been assisted with the submission of an application and plan selection to a federal facilitated marketplace by an insurance producer if (1) the state allows insurance producers to enroll applicants through an exchange and (2) the producer has completed the FFM certification and registration process? If so, why are issuers permitted to take such action?**

Answer: The Affordable Care Act requires issuers to accept all individual market applicants within the open enrollment period. The small and large group markets are guaranteed issue all year round with certain exceptions. If a consumer is refused enrollment into a QHP, please have the constituent contact the state Department of Insurance or CMS.

The Honorable Bruce Braley

1. **On April 29, 2013, the Center for Consumer Information and Insurance Oversight (CCIIO) published Set 15 of its ACA Implementation FAQs, which included a section on provider non-discrimination and Section 2706(a). Unfortunately, the FAQ includes information that is misleading and inaccurate and that I believe would change the meaning of the law. The ACA establishes many important patient protections, and provider non-discrimination is one of these protections of access to care. However, the misleading information in this FAQ only serves to undermine our efforts to improve access to care, and is contrary to both the language and the intent of this section of the ACA. Can you please explain why CCIIO appears to have weakened its provision that improves access to care by protecting our nation's doctors, nurses, and other licensed or certified caregivers from discrimination?**

Answer: The statutory language of section 2706(a) of the Public Health Service Act is applicable to non-grandfathered group health plans and health insurance issuers offering group or individual health insurance coverage for plan years (in the individual market, policy years) beginning on or after January 1, 2014.

Until any further guidance is issued, group health plans and health insurance issuers offering group or individual coverage are expected to implement the requirements of section 2706(a) using a good faith, reasonable interpretation of the law.

The Departments will work together with employers, plans, issuers, states, providers, and other stakeholders to help them come into compliance with the provider nondiscrimination provision and will work with families and individuals to help them understand the law and benefit from it as intended.

The Honorable Bill Cassidy

1. **Numerous actuaries and health care policy analysts have expressed concern that the new health insurance premiums will be far more expensive for young and healthy individuals than paying the individual mandate tax/penalty. This could dissuade them from not going on the Obamacare exchanges. Now that the majority of the individual market has been eliminated due to the new mandates and requirements of the health care law, many of these people will have no place to get health insurance policies if the health policies become unaffordable on the exchanges. Given the challenges Obamacare has faced since its rollout, it is disingenuous to argue that there is not a possibility of adverse selection in the exchanges. Therefore, what is the Administration's plan to provide health insurance to individuals if there is adverse selection in the exchanges and the health care policies become unaffordable?**

Answer: One of the things we've learned since the start of Open Enrollment on October 1 is that the demand for affordable health coverage is very, very high. And, in fact, a new Commonwealth Fund survey confirms just how eager Americans are to purchase coverage through the new Health Insurance Marketplace. The survey found that Americans across our country are aware of the Marketplace and plan to shop for affordable coverage. Some of those who are the most eager to purchase affordable coverage happen to be young, healthy adults. In fact, according to this study, one in five visitors to the Marketplace during the first month was age 19 to 29. A majority of all survey respondents (nearly 60 percent) say they are committed to shopping some more for a plan in the Marketplace and checking out their eligibility for financial help.

The Honorable Gus Bilirakis

1. **The Affordable Care Act has cost-sharing limits that are designed to protect consumers, including limits on deductibles of $2,000 for an individual and $4,000 for a family, in addition to the annual out of pocket maximum. Unfortunately, regulatory guidance issued by CMS has allowed insurance companies to ignore these statutory limits in order to meet the actuarial values of the metal tiers. As a result, we have seen many deductibles at the bronze and silver levels of more than $5,000, which as you know create barriers to accessing care. Could you please share why HHS is allowing these plans to ignore the deductible limits set forth by the law?**

Answer: Deductible limits apply to the small group market only. The HHS Final Regulation on standards related to essential health benefits implements the deductible provisions described in section 1302(c)(2) of the Affordable Care Act for non-grandfathered health insurance coverage and qualified health plans offered in the small group market, including a provision implementing section 1302(c)(2)(C) so that such small group market health insurance coverage may exceed the annual deductible limit if it cannot reasonably reach a given level of coverage (metal tier) without exceeding the deductible limit. As you

know, there is often a tradeoff between deductibles and premiums, and higher deductible plans tend to have lower premiums, making them more affordable for consumers.

2. **Individuals suffering from rare diseases or complex medical conditions need plans that provide a comprehensive provider network that includes multiple specialists required to manage and treat these conditions. These patients need to be able to easily search the Marketplace to find plans based with these in-network specialists. Explain the actions you are taking to ensure that enrollees have the necessary search tools to easily review a plan's network offerings and identify the providers included in that network?**

Answer: HealthCare.gov includes a function that allows consumers to preview plans without creating an account. Consumers can simply click and see the qualified health plan's summary of benefits and coverage, the online issuer provider network, and a list of covered prescription drugs. CMS will continue to post additional consumer materials on appeals and other consumer rights created by the Affordable Care Act in the future.

We encourage consumers to be informed shoppers, and to shop for the coverage that best fits their needs. In addition to shopping online through HealthCare.gov, consumers can seek the assistance of agents and brokers or a Navigator to assist with network questions.

3. **I hear of reports of Exchange networks being narrower than traditional commercial insurance. Does the Administration have data on how many doctors and hospitals are included in a typical plan? What are the minimal requirements for the provider network?**

Answer: Federal regulations at 45 CFR 155.1050 and 45 CFR 156.230 set forth network adequacy requirements for all Marketplaces. A QHP issuer must maintain a network that is sufficient in number and types of providers, to assure that all services will be accessible without unreasonable delay.

4. **Can you comment on a NY Times article highlighting how many Americans in rural communities have few options in the Exchange? In my home state of Florida there are only one or two insurance companies participating in the Exchange in 57% of our counties. Nearly a third of our counties have only one option available.**

Answer: The problem of rural and medically-underserved areas is a long-standing issue. We recognize the unique concerns of rural America, and the Affordable Care Act is working to help. Rural areas have fewer potential customers, fewer providers, and fewer issuers. This can result in limited competition. The Affordable Care Act has specific policies designed to encourage competition and lower premiums for Americans across the Nation, including Americans in rural areas.

First, the Marketplace encourage competition and choice by allowing Americans to easily shop and compare plans based on premiums, benefits, and cost-sharing. Many insurers are competing to offer plans in the Marketplace because they are interested in insuring new customers who are drawn to the lower-cost plans thanks to the premium tax credit.

Overall, about a quarter of the insurers proposing to offer individual plans in the Federally-facilitated Marketplace are new to the individual market. On average, consumers can choose from about 50 health plans in the Federally-facilitated Marketplace and 95 percent of Americans live in areas where there are at least two insurance companies in the Marketplace. We expect the number of insurers participating in the

Marketplaces will continue to grow over the next several years as consumers and the country become accustomed to the Marketplaces.

Second, CO-OPs, which are operating in 22 states, are offering new, consumer-oriented competition. For example, in their CO-OPs, they have provided consumers with a third choice in insurance companies. In Maine, the CO-OP provides Mainers with a second option in a market with very few issuers. In Nevada, the CO-OP provided a fourth choice.

The Affordable Care Act also calls for multi-state plans, administered by the Office of Personnel Management, to expand consumer choice in markets. Over 150 Multi-State Plan options are available through the Marketplace in 30 states and the District of Columbia.

The combined effect of the Affordable Care Act has increased competition and has helped premiums be about 16 percent lower than the premium level implied by earlier CBO estimates.[6]

Finally, besides increasing competition, there are many parts of the law that help lower premium rates for every American, including the rate review and medical loss ratio programs.

5. When Arkansas submitted its waiver for Medicaid expansion, the budget neutrality agreement that you approved says it would cost exactly the same amount to cover someone under Medicaid as under an Exchange plan. But the waiver says it will show improved access because rates are higher for Exchange plans that for Medicaid.

a. Could you explain the process of finding this waiver budget neutral?

Answer: Because these individuals could otherwise be eligible for Medicaid absent the demonstration, we examined the best available data to estimate a reasonable per member cost for individuals in the demonstration. This is consistent with how we determine budget neutrality for other Medicaid section 1115 demonstrations. We do not allow the state to accrue or spend any savings attributable to this population.

b. Did CMS actuaries run any analyses of this waiver?

Answer: Consistent with the process used for section 1115 demonstrations, the demonstration proposal was reviewed by a Federal Review Team with reviewers from various entities within Federal Government. The Office of the Actuary does not serve on the Federal Review Team.

c. GAO has previously questioned HHS's budget neutrality agreements as actually increasing federal costs. Can you explain what steps were taken to ensure this, unlike other waiver approvals, won't increase costs on federal taxpayers?

Answer: As indicated in our response to GAO's latest report on this issue, we believe our budget neutrality methodology is appropriate. Our review of the Arkansas waiver was consistent with how we have determined budget neutrality for other Medicaid section 1115 waivers covering the new adult group.

[6] http://aspe.hhs.gov/health/reports/2013/MarketplacePremiums/ib_marketplace_premiums.cfm#_ftnref18.

d. How did CMS reconcile the fact that Arkansas originally projected Medicaid expansion under FFS to cost $3,900 per person, but says in the waiver that now it will cost $5,666 per person.

Answer: We are not familiar with the $3,900 analysis, but the estimates used in the budget neutrality analysis for the demonstration were developed in a way that is consistent with how we determine budget neutrality in other Medicaid section 1115 waivers.

Attachment 2—Member Requests for the Record

During the hearing, Members asked you to provide information for the record. For your convenience, relevant excerpts from the hearing transcript regarding these requests are provided below.

The Honorable Marsha Blackburn

1. Would you please submit a detailed accounting of exactly what has been spent on healthcare.gov?

Answer: From enactment of the Affordable Care Act through September 30, 2013, HHS has obligated $490 million for Marketplace IT, and of that amount has spent $230 million. This includes the Healthcare.gov website, and all of the systems and services that support enrollment through the Marketplaces, such as the data services hub and the Federally-facilitated Marketplace IT systems. During that same time period, HHS has obligated approximately $175 million in other IT costs necessary to support the Marketplace IT systems, such as cloud computing and enterprise identity management.

The Honorable John D. Dingell

1. What can we do about insurance companies that are cancelling policies?

Answer: The Affordable Care Act provided an opportunity for insurance companies to maintain grandfathered plans as long as they want to in the future. These grandfathered plans may, but do not have to, comply with many of the market reforms included in the Affordable Care Act. Since enactment of the Affordable Care Act in 2010, many issuers have continued to renew employers' grandfathered plans under this provision. Additionally, issuers that renew plans prior to January 1, 2014, are generally able to renew those plans without having them comply with the new protections that take effect for plan or policy years beginning on or after January 1, 2014.

We encourage individuals who do receive a notice that their policy will be discontinued to shop on the Marketplace and review their coverage options. Some individuals may find they qualify for tax credits and/or cost-sharing help to make coverage more affordable.

The Honorable Ralph Hall

1. **How much has the Administration spent on the exchanges in total; not just healthcare.gov but all of the exchanges?**

   Answer: From enactment of the Affordable Care Act through September 30, 2013, HHS has obligated approximately two billion dollars on Marketplaces, and of that amount has outlaid $741 million.

The Honorable John Shimkus

1. **Who made the decision to quote anyone 49 years old and younger to be quoted as a 27 year old and anyone 50 years and older to be quoted as a 50 year old? When was this decision made?**

Answer: We had always envisioned window shopping as a tool that would be a part of HealthCare.gov at some point, however we chose to prioritize other functionality in order to be ready for an October 1 launch. We did include a list of plans and pre-tax credit examples of premiums on the homepage of HealthCare.gov day the site launched, and later rolled out our plan preview tool that allows consumers to see this information by entering some basic information about themselves and the coverage they are looking for. Consumers visiting the site are told that their rates may differ based on their individual circumstances and can call the Marketplace for more specific information. We plan to enhance this window shopping functionality in the coming months to provide consumers with additional information.

2. **When you go on the Federal Exchange, will an individual be able to determine if a plan includes abortion coverage or not? Can you provide for the committee the list of insurers in the Federal Exchange who do not offer abortion coverage as part of their package?**

Answer: CMS is committed to ensuring that HealthCare.gov provides the key information consumers need to make an informed selection from among the QHPs available to them. The Affordable Care Act requires that each plan in the Marketplace include a Summary of Benefits and Coverage and a link to the plan brochure, where consumers can learn more about which services are covered. The Affordable Care Act requires plans in the Marketplace to cover the ten essential health benefits. It is up to the issuer to determine which additional services they cover, and consumers may always contact issuers with any questions.

The Honorable Joseph R. Pitts

1. **In the Washington Post, on October 21, there was an article that said about a month before the exchange opened, a testing group of 10 insurers urged agency officials not to launch the site, because it was riddled with problems. Please provide the names of those that these insurers spoke to. Did HHS respond to the insurers' recommendation to delay the launch?**

Answer: As we stated even before HealthCare.gov launched, this is a complex project, and as with any large scale IT project, we expected there to be bumps in the road at launch. However, we did not anticipate the degree of problems with the system. Given the initial user experience, we now know that we underestimated the volume of users who would attempt to log onto the system at the same time, and therefore our testing did not include performance testing at the volume we experienced at launch.

Additionally, the Federal Marketplace is comprised of distinct pieces of functionality that, together, make up the full integrated system--plan management, eligibility and enrollment, and financial management. CMS prioritized essential functionality to be live on October 1 to ensure that consumers would be able to apply for eligibility and select a plan. Other functionality will come online over time. This is a complex project with a short timeline -- and as such issues were prioritized to meet the October 1 launch date.

The Honorable Lee Terry

1. **Do you have data on how many people in the United States have tried to enroll in a plan through healthcare.gov? Do you have any data on how people have tried to enroll but, because of the problems, have not been able to accomplish that?**

2. **I have reached out to our State insurance commissioner and Governor and found out they have no data about Nebraskans who have either tried to enroll or have enrolled. Would you please provide those numbers?**

Answer #1 and #2: We will be releasing enrollment numbers for the Federally-facilitated Marketplace and the state-based Marketplaces once a month for the preceding month.

The Honorable Mike Rogers

1. **Has any end-to-end security testing been conducted since healthcare.gov went live on October 1? Are there end-to-end security tests run after every new piece of code is put in?**

Answer: CMS protects the FFM through intensive and stringent security testing. CMS conducts continuous anti-virus and malware scans, and monitors data flow and protects against threats by denying access to known bad internet protocols and actors. Additionally, we conduct two separate types of penetration testing on a weekly basis. The most recent penetration testing showed no significant findings. Also on a weekly basis, CMS reviews the operation system, infrastructure, and the application software to be sure that these systems are compliant and do not have vulnerabilities. Vulnerabilities are often mitigated immediately on-site, and re-tested to ensure the strength of our systems' security. Vulnerabilities that cannot be mitigated immediately are tracked using the system's plan of action and milestones which provides a process for assigning responsibility, allocating resources, and identifying specific milestones and completion dates. For the FFM, we conduct Security Control Assessments on a quarterly basis, which is beyond FISMA requirements.

The Honorable Michael C. Burgess

1. **Would you please provide us with the number of people who have been able to enroll on the telephone?**

Answer: There are four ways to enroll in the Marketplace: online, using in-person assistance, a paper application, or over the phone. Consumers who wish to apply by phone can call our call center 24 hours a day, seven days a week. Customer service representatives can work with them to fill out there application, receive their eligibility determination, talk through plan options, and enroll in a plan. Consumers have flexibility on how they would like to complete the application

and enrollment process. For example, they could choose to start their application on the phone and finish their application online at a later time or start with a paper application and then enroll in a plan through the call center. Because many consumers may ultimately use more than one of the four pathways to enroll, it is difficult to classify an enrollment as having occurred only over the telephone.

The Honorable Gregg Harper

1. **During the hearing, we shared a copy of a CGI slideshow from October 11, discussing technical issues that must be addressed within the Website. On page 8 of that slideshow, CGI recommended that CGI and CMS have a review board to agree on which issues can technically be solved and which should be politically solved. Will you find out for us if such a review board was done and if any decisions were made on political reasons or any other reasons?**

Answer: Yes. An existing CMS Change Control Board (CCB), which was established early in the program for managing system change requests, was streamlined to be an integrated Marketplace CCB that addressed both operations management and systems changes. This CCB has been instrumental in prioritizing and determining which set of issues (i.e., change requests) should be worked on and become part of the system defects resolution process and enhancement implementations. In addition, the QSSI general contractor has instituted daily reviews with CMS and CGI since they were brought on board to drive the prioritization, resolution, and release scheduling for critical defects.

The Honorable Adam Kinzinger

1. **Where is HHS getting the money to pay for these fixes? Is it coming from other HHS accounts? Have you used your transfer authority to move money from non-ACA programs to pay for the cost of implementing the President's health care program? If so, from which programs have you drawn money to help with the fix that's not ACA-related?**

Answer: Currently, CMS is funding Marketplace efforts through its appropriation for Program Management and the Nonrecurring Expenses Fund. In Fiscal Year (FY) 2013, HHS used a number of resources at its disposal to ensure sufficient funding for implementation of Marketplaces, including the Secretary's Transfer Authority. The Department notified Congress on its use of the Secretary's transfer authority, which is similar to authority existing in other agencies, and allows for transfer of funds appropriated in an appropriations act for unanticipated needs. For instance, the Department also used the Secretary's transfer authority to provide CMS funding for the 1-800 Medicare call center when call volumes increased significantly under Medicare Part D implementation. The Department has also used the authority in previous years to fund programs such as the Ryan White AIDS Drug Assistance Program and the Administration for Children and Families Office of Refugee Resettlement assistance for unaccompanied alien children.

The Honorable Gus Bilirakis

1. **The New York Times wrote the following: "Project managers at the Department of Health and Human Services assured the White House that any remaining problems could be worked out once the web site went live, but other senior officials predicted serious trouble and advised delaying the rollout." Please provide the names of the officials that gave you the advice that there were serious problems.**

Answer: While HHS officials did expect there might be glitches in HealthCare.gov's operations on October 1, I was not advised to delay the rollout of HealthCare.gov. CMS Administrator Tavenner decided in September that certain functions of the website, such as the Spanish language website, the SHOP website, and the window shopping feature, not go live on October 1. The hope was that delaying these functions to focus on the core functions of HealthCare.gov would alleviate some of the anticipated glitches upon launch. HHS staff did not anticipate the magnitude of the functional and capacity problems seen upon HealthCare.gov's October 1 launch.

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