AUTHENTICATED
U.S. GOVERNMENT
INFORMATION
GPO

STATUS OF THE AFFORDABLE CARE ACT IMPLEMENTATION

HEARING

BEFORE THE

COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRTEENTH CONGRESS

FIRST SESSION

OCTOBER 29, 2013

Serial No. 113–FC13

Printed for the use of the Committee on Ways and Means



U.S. GOVERNMENT PUBLISHING OFFICE

21–119 WASHINGTON : 2016

For sale by the Superintendent of Documents, U.S. Government Publishing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2104 Mail: Stop IDCC, Washington, DC 20402–0001

COMMITTEE ON WAYS AND MEANS

DAVE CAMP, Michigan, *Chairman*

SAM JOHNSON, Texas
KEVIN BRADY, Texas
PAUL RYAN, Wisconsin
DEVIN NUNES, California
PATRICK J. TIBERI, Ohio
DAVID G. REICHERT, Washington
CHARLES W. BOUSTANY, JR., Louisiana
PETER J. ROSKAM, Illinois
JIM GERLACH, Pennsylvania
TOM PRICE, Georgia
VERN BUCHANAN, Florida
ADRIAN SMITH, Nebraska
AARON SCHOCK, Illinois
LYNN JENKINS, Kansas
ERIK PAULSEN, Minnesota
KENNY MARCHANT, Texas
DIANE BLACK, Tennessee
TOM REED, New York
TODD YOUNG, Indiana
MIKE KELLY, Pennsylvania
TIM GRIFFIN, Arkansas
JIM RENACCI, Ohio

SANDER M. LEVIN, Michigan
CHARLES B. RANGEL, New York
JIM MCDERMOTT, Washington
JOHN LEWIS, Georgia
RICHARD E. NEAL, Massachusetts
XAVIER BECERRA, California
LLOYD DOGGETT, Texas
MIKE THOMPSON, California
JOHN B. LARSON, Connecticut
EARL BLUMENAUER, Oregon
RON KIND, Wisconsin
BILL PASCRELL, JR., New Jersey
JOSEPH CROWLEY, New York
ALLYSON SCHWARTZ, Pennsylvania
DANNY DAVIS, Illinois
LINDA SÁNCHEZ, California

JENNIFER M. SAFAVIAN, *Staff Director and General Counsel*
JANICE MAYS, *Minority Chief Counsel*

CONTENTS

	Page
Advisory of October 29, 2013 announcing the hearing	2
WITNESS	
Ms. Marilyn Tavenner, Administrator, Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services, Washington, DC	6

STATUS OF THE AFFORDABLE CARE ACT IMPLEMENTATION

TUESDAY, OCTOBER 29, 2013

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, DC.

The committee met, pursuant to call, at 10:04 a.m., in Room 1100, Longworth House Office Building, the Honorable Dave Camp [Chairman of the Committee] presiding.

[The advisory of the hearing follows:]

HEARING ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

Chairman Camp Announces Hearing on the Status of the Affordable Care Act Implementation

1100 Longworth House Office Building at 10:00 AM
Washington, October 22, 2013

House Committee on Ways and Means Chairman Dave Camp (R–MI) today announced that the Committee will hold a hearing on the problems Americans are experiencing with the Obama Administration's launch of the Affordable Care Act (ACA). The Committee will hear testimony from Marilyn Tavenner, Administrator of the Centers for Medicare & Medicaid Services (CMS) at the U.S. Department of Health and Human Services (HHS). CMS is the Federal agency that oversees the operation of the Exchanges through the Center for Consumer Information and Insurance Oversight (CCIIO). **The hearing will take place on Tuesday, October 29, 2013, in 1100 Longworth House Office Building, beginning at 10:00 A.M.**

In view of the limited time available to hear from the witnesses, oral testimony at this hearing will be from the invited witness only. However, any individual or organization not scheduled for an appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

President Obama has acknowledged that the October 1 launch of the health care Exchanges was unacceptable. Americans have been unable to create accounts, and individuals continue to receive repeated error messages and inaccurate information from www.healthcare.gov. According to *Consumer Reports,* only 1 in 35 individuals were able to create an account on www.healthcare.gov. Recently, the Administration announced a "tech surge" of the "best and the brightest" to fix the problems, but experts have warned the "online system required such extensive repairs that it might not operate smoothly until after the December 15 deadline for people to sign up for coverage starting in January."

The Ways and Means Committee has conducted extensive oversight of the implementation of the Affordable Care Act to ensure that the Administration is implementing the law as promised. Despite significant reports about the difficulties they were encountering in building the Exchanges, Administration witnesses dismissed such reports. Instead, they repeatedly assured the Committee that warnings from nonpartisan independent auditors were wrong, including the Government Accountability Office, which reported the Administration was behind schedule and at risk of experiencing enrollment problems.

The significant and ongoing problems with the launch of the Exchanges further exacerbates the challenges facing American families. Individuals are unable to create accounts, navigate the website and receive accurate information about cost and choices, while insurers are receiving inaccurate enrollment data. Despite these ongoing malfunctions, millions of Americans will be forced to deal with these challenges as they attempt to either comply with the individual mandate to buy coverage or pay a tax.

This hearing will examine the status of efforts by CMS, HHS and the Obama Administration to identify the problems plaguing the launch of the Exchanges and the specific plans to fix the design flaws. The hearing will seek answers to why the Exchanges are not working, whether the Exchanges will be ready to fulfill all of their required functions and what steps are being taken to ensure that CMS and HHS will be able to accurately verify subsidy eligibility—prior to the distribution of premium tax credits and cost sharing subsidies.

In announcing the hearing, Chairman Camp stated, **"After spending over $600 million, the American people want answers to some very basic questions**

about the launch of ObamaCare. Why doesn't the website work? Why were the American people told everything would be ready, when it was clear that was not the case? How deep are the problems and how long will it take to get those problems fixed? And most importantly, if people can't navigate such a dysfunctional and overly complex system, is it fair for the IRS to impose tax penalties?"

FOCUS OF THE HEARING:

The hearing will focus on the status of the Obama Administration's implementation of the Affordable Care Act.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, *https://waysandmeans.house.gov*, select "Hearings." Select the hearing for which you would like to submit, and click on the link entitled, "Click here to provide a submission for the record." Once you have followed the online instructions, submit all requested information. ATTACH your submission as a Word document, in compliance with the formatting requirements listed below, **by the close of business on Tuesday, November 12, 2013**. Finally, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225–1721 or (202) 225–3625.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be provided in Word format and MUST NOT exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, telephone, and fax numbers of each witness.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Note: All Committee advisories and news releases are available on the World Wide Web at *http://www.waysandmeans.house.gov/*.

Chairman CAMP. This hearing will come to order.

Good morning. I would like to welcome Marilyn Tavenner, the Administrator at the Centers for Medicare and Medicaid Services at the U.S. Department of Health.

Welcome to the committee today. I look forward to your testimony, and I look forward to the hearing to really get an honest, straightforward assessment of the status of the health care law.

Six months ago, Health and Human Services Secretary Sebelius told this committee a dozen times that the administration will be ready on October 1. We now know the administration was not ready, and just last week Secretary Sebelius suggested they could have used 5 years to get the exchanges up and running.

Despite having more than 3 years to get the system up and running, officials at the Centers for Medicare and Medicaid Services who are charged with implementing the exchanges added, and I quote, "Due to a compressed time frame, the system wasn't tested enough." And, frankly, 3 years should have been enough. And had the administration provided more forthcoming answers and shared in a transparent manner the reality of the challenges it was encountering in the implementation process, I suspect many of these glitches could have been avoided.

While the Web site can eventually be fixed, the widespread problems with Obamacare cannot. Almost daily we hear reports of Obamacare increasing costs, harming job creation, and forcing Americans off their current plan. These problems can't be fixed through a technical surge or tech surge, and they are not just a glitch in someone's health care coverage or job.

Not a week goes by that I don't hear examples from the people I represent in Michigan and job creators about the increasing costs and how Obamacare is making it harder for businesses to invest, grow, and hire people. Just last month, Meridian Public Schools in my district announced that it would be cutting the schedules of hourly workers to fewer than 30 hours per week as a result of Obamacare. And this month, the Detroit Free Press reported that at least 146,000 Michiganders have received cancellation notices for their current health plan due to Obamacare. In fact, based on what little information the administration has disclosed, it turns out that more people have received cancellation notices for their health care plans this month than have enrolled in the exchanges.

The widespread acknowledgement that the health care exchanges were not tested months in advance as promised is cause for concern, but the concerns don't stop there. The Treasury Inspector General warned in August that it was not confident about the IRS' ability to protect confidential taxpayer information or to prevent fraud, and neither am I.

On top of that, the exchange does not give individuals the information they need to make an informed health care decision. When going through the options, how are Americans able to see if they are even eligible to be in the exchange, if their current doctor is in the plan, what the real costs of their premiums will be, and how much their copay will be?

No amount of Web site fixes can make right the President's broken promises that health care costs will be lowered by $2,500 or that Americans will be able to keep the plan they have and like.

Those are worthy goals, reducing costs and maintaining coverage, and they are ones that we should all work together to accomplish.

I would be remiss if I didn't remind my colleagues that the alternative put forward by Republicans at the time was the only plan scored by the nonpartisan Congressional Budget Office as actually reducing premiums. Democrats chose to go down another path, and that is where it has led us. Instead of plowing forward with this unworkable law, the administration should at a minimum seriously consider delaying the law for families and individuals, just as it has done for big business. If they fail to do so, I fear we could see a fundamental breakdown of the insurance market, where premiums will skyrocket, pricing millions of Americans out of health care, yet still be forced to pay the individual mandate tax.

Administrator Tavenner, we cannot solve a problem until we realize the full extent of the problem. Your answers today and in the future will be critical to this committee's oversight of the health care law and, more importantly, to our work to make sure Americans have access to affordable health care.

Before I recognize Ranking Member Levin for the purpose of an opening statement, I ask unanimous consent that all members' written statements be included in the record. And without objection, so ordered.

Chairman CAMP. I now recognize Ranking Member Levin for his opening statement.

Mr. LEVIN. Thank you, Mr. Chairman and colleagues.

And, Marilyn Tavenner, a warm welcome.

We start this hearing facing a basic reality: Democrats want to make the Affordable Care Act work, congressional Republicans don't. That reality has been reflected in 40-plus efforts by Republicans to repeal, dismantle, or defund the Affordable Care Act. That reality was reflected in their zeal shutting down the government and jeopardizing the full faith and credit of our Nation, damaging our Nation's global standing and leading to enduring harm, costing our economy $24 billion, tens of thousands of jobs, a dramatic drop in consumer confidence.

Now, having still failed to derail the ACA, the Republican focus of attack has shifted. The new front relates to HealthCare.gov. There very clearly are challenges to implementing new, pioneering access to health care. Consider these headlines. You can see them there. For example, "Problems Plague Rollout," NPR reported. "Plagued by Delays and Confusion Over Coverage," said the San Francisco Chronicle.

These headlines are from 2005 as Medicare Part D was launched. That year, in dramatic contrast to the Republican conduct to date, Democrats who had opposed that law worked to make it a success, working with Republicans on a bipartisan basis, Republicans who had passed that law to address many problems, and most importantly, we worked with our constituents to ensure they could sign up.

The reality is that the Affordable Care Act, which Republicans are failing to work on with Democrats, is working quite effectively in States running the marketplaces. You can see from that slide.

[Slide]

Mr. LEVIN. In Kentucky, more than 26,000 people have enrolled for coverage. In New York, more than 37,000 have signed up. And in Washington State, more than 35,000 people had enrolled as of a week ago. And the irony is that Republicans have erected hurdles to States throughout the Nation taking responsibility for implementing the law.

The Web site for the Federal insurance marketplace must be fixed, and it is being fixed. This gentleman from Salt Lake City, Mr. Sherburne, is among those who have enrolled. A self-employed father of three, he has been uninsured for years, paying cash for doctor visits and the occasional trip to the emergency room, he told his local newspaper. Once he got into the marketplace Web site, he compared 38 plans and got coverage for his family for $123 a month. And I quote, "Once they get the bugs worked out, it will work well and bring peace of mind to a lot of people," end of quotes. And he added, "I am thrilled to have coverage, period."

Prior to this year, what awaited Mr. Sherburne and tens of millions of other Americans who don't get health insurance through their employer, but rather had to sign up on their own, was a maze of invasive personal medical history questions within applications that seemed to never end. When individuals did get through the process, too often a preexisting condition, no matter how minor, was used to deny coverage, to charge exorbitantly high premiums, or to exclude needed benefits. Thankfully, these days are behind us. They are behind us.

This hearing provides a chance for every Member of this committee to proceed in a constructive, not a destructive manner, and for the Administrator to lay out how the Web site is being fixed, as it must be, and for everyone on this committee to join in this effort to make available, not to prevent access to quality, affordable coverage for every American. I yield back.

Chairman CAMP. Thank you.

Today we will hear from the Administrator for the Centers for Medicare and Medicaid Services at the U.S. Department of Health, Marilyn Tavenner.

Your written statement will be made part of the record and members have received it, but you will be recognized for your oral testimony for 5 minutes. Welcome.

STATEMENT OF MS. MARILYN TAVENNER, ADMINISTRATOR, CENTERS FOR MEDICARE & MEDICAID SERVICES, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Ms. TAVENNER. Thank you, Chairman Camp, Ranking Member Levin, and Members of the Committee.

On October 1st, we launched one of the key provisions of the Affordable Care Act, the new marketplace, where people without health insurance, including those who could not afford it and those who were not part of a group plan, could go to get affordable coverage.

We know that consumers are having difficulty enrolling via the marketplace Web site. It is important to note that the Affordable Care Act, however, is more than just a Web site. It creates a new market which allows people to access quality affordable health care, it allows them to have insurance options, it creates a pooling

of consumers into Statewide group plans that can spread the risk between sick people and healthy people, between young and old, and then bargains on their behalf to get them the best deal on health insurance. By creating competition where there wasn't competition before, insurers are now eager for new business and they have created new health care plans with more choices. The premiums for coverage were lower than expected and millions of Americans will also qualify for tax credits to make the coverage even more affordable.

We know that consumers are eager to purchase this coverage, and to the millions of Americans who have attempted to use HealthCare.gov to shop and enroll in health care coverage, I want to apologize to you that the Web site has not worked as well as it should. We know how desperately you need affordable coverage. I want to assure you that HealthCare.gov can and will be fixed, and we are working around the clock to deliver the shopping experience that you deserve. We are seeing improvements each week and, as we have said publicly, by the end of the November the experience on the site will be smooth for the vast majority of users.

Over the past month, millions have visited HealthCare.gov to take a look at new health care coverage under the Affordable Care Act, and in that time nearly 700,000 applications for coverage have been submitted across the Nation. More than half of those are in the Federal marketplace alone. This tremendous interest confirms that American people are looking for quality affordable health care coverage.

We know that the consumer experience has been frustrating for many Americans. Some have had trouble creating accounts and logging into the site, while others have received confusing error messages or had to wait for slow response times. This initial experience has not lived up to our expectations or the expectations of the American people, and it is not acceptable.

We are committed to improving performance and have already made progress. In the first few days when the site went live, few customers could create an account. Now over 90 percent can. We have updated the site several times, fixing bugs and improving the HealthCare.gov experience, and we have added more capacity in order to meet demand.

We are pleased with these quick improvements, and parts of the system are already working well. For example, the data hub, the routing tool that provides an efficient and secure way to verify information submitted by consumers, is sending determinations to the marketplace in less than 1.2 seconds. Social Security has reported 4.2 million transactions with the hub and the IRS has responded to more than 1.3 million requests.

Even with this success, we know there is still significant work to do, and we have called in a team of experts, led by Jeff Zients, to analyze the site, identify and prioritize fixes. We have spent the last week going over that. And while these problems will require a lot of hard work, the bottom line conclusion is this HealthCare.gov site is fixable.

To get the job done, we have identified a clear path forward, a lot of fixes that will be undertaken one by one. To ensure the work is done as quickly and as efficiently as possible, we have enlisted

the help of QSSI to serve as general contractor for this project. They are familiar with the complexity of the system and the work they have provided for HealthCare.gov, the Federal data hub, is working well and performing as it should. QSSI has the skills and expertise to help us address these problems. They will work with leadership and contractors to prioritize the needed fixes and make sure they get done.

We are committed to improving the consumer experience with HealthCare.gov. While we continue this work, I encourage people to continue to apply by phone, by mail, or by finding local help in their community.

The fact is the product of the Affordable Care Act, a marketplace for quality affordable health insurance, will work. The product is not going away and the people are not going to continue to wait. We know the price is not changing. We know Americans have time to apply and enroll in affordable coverage.

Thank you, Chairman Camp.

[The prepared statement of Ms. Tavenner follows:]

STATEMENT OF

MARILYN TAVENNER

ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES

ON
AFFORDABLE CARE ACT IMPLEMENTATION

BEFORE THE

U. S. HOUSE COMMITTEE ON WAYS AND MEANS

OCTOBER 29, 2013

Testimony of Marilyn Tavenner
U.S. Department of Health and Human Services
Centers for Medicare and Medicaid Services
on Affordable Care Act Implementation
House Committee on Ways and Means
October 29, 2013

Good morning, Chairman Camp, Ranking Member Levin, 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

[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

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.

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.

---

[7] http://www.kaiserhealthnews.org/stories/2013/july/26/maryland-marketplace-premiums-exchange.aspx
[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

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 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.

---

[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

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 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.

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

Chairman CAMP. Well, thank you.

Administrator Tavenner, how many people have enrolled in the exchanges?

Ms. TAVENNER. Chairman Camp, that number will not be available till mid-November. We have over 700,000 who have completed applications.

Chairman CAMP. So you know the applicants, but do you know the enrollees? Do you have an idea of how many of those applicants became enrollees? Because that is really the number that matters.

Ms. TAVENNER. We will not have that till mid-November. We have people who are shopping now. We expect the initial number to be small, and I think you have seen that in our projections, and that was the Massachusetts experience as well.

Chairman CAMP. I have to tell you, the numbers I am hearing from insurers in my home State of Michigan are not good, of enrollees, it's a very small number. In fact, I think I could have a meeting in my office, and have all of them fit in, of the people who have successfully enrolled in the plans. I understand that CMS' stated goal is 7 million enrollees by the end of March. Is that correct?

Ms. TAVENNER. That is correct.

Chairman CAMP. And I think critically important, of that 7 million, 2.3 million of those need to be young and healthy. I think those are your metrics. Is that correct?

Ms. TAVENNER. I don't have that metric with me, but I will check on it.

Chairman CAMP. Okay. I believe those are numbers that CMS has put out.

The Associated Press reported in early September that there was a memo prepared by the Assistant Secretary for Planning and Health. Are you aware of that press story and that memo? I think it went through your office to Secretary Sebelius.

Ms. TAVENNER. That went through the enrollment numbers?

Chairman CAMP. Yes. And it said that there were month-to-month predictions of enrollment numbers showing a path to the 7 million that I mentioned.

Ms. TAVENNER. Right.

Chairman CAMP. Could you make that memo available to the committee?

Ms. TAVENNER. Certainly.

Chairman CAMP. According to the press report, the memo estimated that 494,620 people would sign up for health insurance under the program by October 31st. Now, we are obviously very near that date. Have you met that estimate?

Ms. TAVENNER. I will not have those numbers available till mid-November.

Chairman CAMP. So do you not know? Do you not have any idea of how many people have enrolled or are you——

Ms. TAVENNER. Folks are still in the process of enrolling both in the State-based exchanges and in the Federal exchange, and we will have those numbers available in mid-November.

Chairman CAMP. Are you getting those numbers?

Ms. TAVENNER. Am I getting those numbers? Not yet. Not from the States.

Chairman CAMP. You have no numbers on who is enrolled? So you have no idea?

Ms. TAVENNER. We will have those numbers available in mid-November.

Chairman CAMP. So no one is forwarding even weekly updates on how the system is working?

Ms. TAVENNER. I think we have seen some of the press, and I think that was on the graph earlier, about what States have listed. We will get those numbers in mid-November.

Chairman CAMP. I understand you are not publicly releasing those numbers, but I am asking do you have any idea of on a weekly basis how many people enroll? I mean, how do you not know how many people have enrolled?

Ms. TAVENNER. Chairman Camp, we will have those numbers available in mid-November.

Chairman CAMP. But is your staff updating you on those? Are you getting those on a periodic basis? I realize you are not prepared to give this to the committee, even though this is a government program and we are trying to do oversight here and we are trying to understand what the problems are, but do you have some idea of what those problems might be in terms of the numbers?

Ms. TAVENNER. I am not quite sure what you are asking me.

Chairman CAMP. Well, you have said that 700,000 people have completed the application process, so clearly you are getting some information. Do you have any idea of how many of those can move to the next step of enrolling, looking at plans, how many are eligible, how many have decided to enroll?

Ms. TAVENNER. Once individuals complete the application, then they go into the shopping experience, where they can look at plans. We do get numbers on the number of applications, and then we need to break those out. And that is why I have said, this is part of the rollout that we will give in mid-November for the October data.

Chairman CAMP. Okay. So you do have the applications, which is the 700,000 number——

Ms. TAVENNER. Yes.

Chairman CAMP [continuing]. But you don't have how many people successfully enrolled.

Ms. TAVENNER. I am saying people are still in the process of enrolling.

Chairman CAMP. Of those 700,000, do you know how many of those are eligible for Medicaid at this point?

Ms. TAVENNER. We have some information on who is eligible for Medicaid, and then obviously States have their own information about that, and it depends on whether a State has expanded or not and what is going on inside. It is very State specific.

Chairman CAMP. Can you share with the committee the information you have about those that have enrolled that are eligible for Medicaid?

Ms. TAVENNER. We will also have that information available in mid-November as well.

Chairman CAMP. Because that would mean of those 700,000, a significant portion would not be in the exchange if they are qualifying for Medicaid. Isn't that correct?

Ms. TAVENNER. We will have that information available to you in mid-November.

Chairman CAMP. Yeah, but the law is that if they are eligible for Medicaid they are not enrolling in the exchange. That is my question.

Ms. TAVENNER. Correct.

Chairman CAMP. So there could be a significant portion of that 700,000 that would not be enrolling in an exchange. Is that correct?

Ms. TAVENNER. There could be numbers in there that will be eligible for Medicaid, that is correct.

Chairman CAMP. Do you know how many of the 700,000 have qualified employer-sponsored insurance and therefore will not be eligible for the exchange?

Ms. TAVENNER. Those individuals who have employer-sponsored insurance, usually at the end of the application they are asked that, and if that is the case, they usually don't proceed.

Chairman CAMP. Do you know how many of those 700,000 are young adults, say, under the age of 26 who might choose to stay on their parents' plan if it is cheaper?

Ms. TAVENNER. I do not.

Chairman CAMP. And do you know how many are undocumented aliens and who may not be eligible to enroll in the exchange?

Ms. TAVENNER. So as you are aware, we actually have a connection through the data hub to check for that, and if they are not eligible, they do not complete the application and they do not go on to shop.

Chairman CAMP. But of these 700,000, do you have any idea how many are just looking and how many are trying to enroll?

Ms. TAVENNER. We actually look at the people who are shopping, and obviously the majority of the people who are completing applications are there to actually purchase insurance, and so they continue to go through the shopping experience.

Chairman CAMP. Well, there are media reports that say as many as 80 percent of that 700,000 number are actually eligible for Medicaid. Is that a number you would dispute?

Ms. TAVENNER. I don't know where that media report is or how they would get that information.

Chairman CAMP. Well, if that is true, I mean, that is the only information we are getting, frankly, today. I, frankly, would have hoped for a little bit more from you. But if that is true, then less than 140,000 of these applicants are potentially enrollees in the exchange, and that is assuming they don't have employer-provided coverage, that is assuming they can't stay on their parents' plan or are otherwise ineligible in some other way. But that means you are likely to hit less than one-quarter of this October estimate of 494,620. How many people did you estimate would enroll between November 15th and December 15th, which we are 2 weeks off from that period?

Ms. TAVENNER. I don't have that in front of me. I will be happy to get you that information.

Chairman CAMP. If you could get that to the committee, I would certainly appreciate that.

But I think given that the back end systems aren't working and insurers have resorted to manually enrolling people one by one, I just think the system literally doesn't have the human resource capacity to manually enroll the numbers that are being projected here.

I assume that many people who are holding off are the young and healthy, so the risk pools in these exchanges are not going to align with the projections. So I think not only are we going to miss the 7 million enrollee target, it appears that we are going to miss the demographic makeup as well, and that is going to be very important to have a functioning system. If the demographics are wrong and there aren't as many young people enrolling, what happens then, what happens to premiums?

Ms. TAVENNER. I think the premiums are locked down for 2014, so obviously the next 6 months of enrollment are critical. And I will remind you that enrollment does occur till March 31st of 2014. I will also remind you that the Massachusetts experience was very slow initially and that it started to ramp up over time. We expect the same type of projections.

Chairman CAMP. But it doesn't look like you are even meeting your own projections that you had prepared.

Ms. TAVENNER. I have not listed any information on enrollment. I think there are some assumptions you are making.

Chairman CAMP. Well, I am just referring to this Associated Press memo that I appreciate you are willing to give to the committee that said that half a million people would sign up by October 31st and that they would enroll. But if we don't meet this demographic of 2.3 million young people, I mean, it is very clear that premiums will go through the roof, whether in the next few months or in the future. And if that is where we are headed, and it appears that we are, how will you provide relief to individual Americans who don't want or can't afford this insurance, and how do we prevent the premium spike in 2015 as insurers will readjust their prices to reflect the actual enrollee demographic?

Ms. TAVENNER. Currently, if you look at the premiums for 2014, we did not see premium spikes, we actually saw a very competitive marketplace. In fact, we have over 200 issuers just in the Federal exchange alone who have offered more than 3,000 plans at very competitive prices. So markets have as many as 54 plans in a market. We have also seen 25 percent new issuers in markets. So far what we have seen is the absolute opposite of what you are suggesting.

Chairman CAMP. Have you enrolled in the plan?

Ms. TAVENNER. I have employer-sponsored insurance. I would not be eligible for the plan.

Chairman CAMP. From the Federal Government? Is that what you mean?

Ms. TAVENNER. Yes.

Chairman CAMP. So you are not participating in Obamacare?

Ms. TAVENNER. I am participating in employer-sponsored insurance, which 85 percent of the country does.

Chairman CAMP. So you have government insurance. Have you gone on the site and tried to enroll or tried to shop for plans?

Ms. TAVENNER. I haven't gone on to shop for the plans. I went on, actually signed up for an account just to see what it looked like and go through the application process, but did not sign up for coverage. I am not eligible for coverage, nor did I shop.

Chairman CAMP. I just want to mention to you a letter that I received from my district. And this man wrote me and said, "My wife has been recently informed by her insurance carrier that her health care policy does not comply with the Affordable Care Act. Now we must purchase a new policy to get the same coverage at an 18 percent increase in our premium." So what happened to the if you like your insurance you can keep it question? What would you say to that individual?

Ms. TAVENNER. Well, I would take them back to pre-Affordable Care Act days where in fact if you were in the individual market, you were living at a 50 percent churn. Half the people in the individual market prior to 2010 didn't stay on their policies. They were either kicked off for a preexisting condition, they saw their premiums go up at least 20 percent a year, and there were no protections for them. And sometimes they were in plans that they thought were fine until they actually needed hospitalization; then they found out it didn't cover hospitalization or it didn't cover cancer.

So I would take them back to the fact that since 1986, health care costs and coverage have been the number one issue for small businesses for the last 20 or 30 years and we have been talking about it for the last 20 or 30 years. That is actually why I came into this job, is to try to deal with this issue.

So now what I would say is this: Now if, in fact, the issuer has decided to change the plan, didn't have to, plans were grandfathered in, in 2010. If they didn't make significant changes in cost sharing and this sort of thing, they could keep the plan that they had. But some insurance companies have decided, and I think that is what you were referring to in your opening statement, that they want to offer new plans. And if they offer new plans, they have to come into the requirements of the Affordable Care Act, which are you have to offer the 10 essential coverage benefits, you cannot judge people on preexisting, you cannot discriminate based on sex. There are lots of things that are required under the Affordable Care Act that actually protect consumers.

But these premium increases were going on a long time prior to the Affordable Care Act, and, in fact, we have seen the most premium moderation in the last 3 years than we have seen probably in 15 or 20 years. That is what I would say to them. I would try to explain to them the real issues.

Chairman CAMP. Well, the carrier told them that the plan didn't comply. But nothing you said had anything to do with how they can get their costs down. And I think that is the real problem that we are seeing here, is that the costs are——

Ms. TAVENNER. Right. So what I would tell that individual is if their carrier is telling them they are changing the plan and they are offering an increase, that they would need to go take a look at what is available in their State and in their market, which is certainly something that is available to them through the exchange.

Chairman CAMP. Yeah, at an 18 percent increase.

All right. With that, I will recognize Mr. Levin.

Mr. LEVIN. Well, thank you.

A warm welcome.

The chairman talked about the Web site, and you said it is going to be fixed. And I might say, if everybody would pitch in to make it work, the goals that have been set would be more readily met. That is what happened with the prescription drug program. We all pitched in to make it work. And it had major problems at the beginning, and instead of standing in the way we said, we didn't vote for it, let's make it work, and it began to work. If we all had the same spirit about ACA, it would be more than helpful.

But then the chairman asked you about the notices that are coming from the insurance companies, and I would like to ask you about that. A gentleman from Michigan who had an $800 Blue Cross plan got this notice from Michigan Blue Cross, went into the Web site with the help of navigators, and ended up with a Blue Cross Silver HMO plan with tax credits in that case. And instead of $800 a month, it is $77 a month.

And let me refer you to the interview on "Meet the Press" with the Blue Cross Florida Chief Executive Officer. He was asked by David Gregory, in Florida the oldest and largest health care plan provider, Florida Blue Cross, confirmed it is cutting 300,000 policies. And this is what the chairman of Blue Cross of Florida said: "We are not cutting people," and I quote. "We are actually transitioning people. What we have been doing is informing folks that their plan doesn't meet the test of the essential health benefits; therefore, they have a choice of many options that we make available through the exchange, and, in fact, with subsidy, many people will be getting better plans at a lesser cost."

So this has become a matter of legitimate discussion, and I think all of us would appreciate your addressing it.

Ms. TAVENNER. Yes, sir. Again, going back to prior to the Affordable Care Act days, these individuals in a small group or individual market had no protections, they had no guarantees of coverage, and they were still being charged somewhere between 20 percent or more of premium increases year over year. So they could be kicked out at any time for a preexisting condition. Sometimes they thought they had coverage when they did not, and when they went in and had a cancer diagnosis or a cardiac diagnosis, they found out maybe they had a $5,000 hospital limit or they had certain disclaimers. Then, of course, there was always, if you were diagnosed with asthma or high blood pressure or some other chronic disease, you might not be able to get coverage at all. So that is what is different. So that is the first part.

The second part is in 2010 we told issuers to try to give some transition time, if they wanted to keep policies as they were currently defined, whether they were in a group market or an individual market, they could. And so some of them elected to do that. Now some of them are moving to the new standards, and the standards under the Affordable Care Act are pretty simple. You have to have the 80 percent MLR. So you can't be taking money more than the 20 percent to marketing, advertising, profit. You had to meet the 10 essential health benefits. You had to define copay, deductible, and diseases in clear and understandable terms so peo-

ple would know what they were buying. You had to have choices among plans. And then there are folks in the individual market who when they go on the site may qualify for tax credits. Some in some States may actually qualify for Medicaid expansion.

But this problem existed long before the Affordable Care Act. Now folks are transitioning to the new standards of the Affordable Care Act, which guarantee you can't be denied, you won't be kicked off of a policy because you develop a problem, you may be eligible for tax credits depending on your income. So these are important protections that are now available through the Affordable Care Act, and I think that is important.

Mr. LEVIN. Thank you.

I yield back.

Chairman CAMP. All right. Mr. Johnson is recognized.

Mr. JOHNSON. Thank you, Mr. Chairman.

Ms. Tavenner, thank you for being here.

You know, I have been hearing from folks back home who, rightfully so, are very serious about their concerns and fears about their health care. Steven from Plano tried to purchase insurance through the exchange, but ended up more confused and frustrated. Operators on the 1–800 line didn't have answers to his specific questions. They simply reiterated that anyone could sign up for the exchange, but he should wait until later that evening or the next day to apply since the systems were having technical difficulty.

Worse, a single father and police officer in Plano went to renew his 11-year-old daughter's plan. She has no medical problems, yet her premiums doubled—doubled. Those are the real stories of fathers, mothers, sons and daughters who have to live with a law that up to now has completely failed them.

Ms. Tavenner, the administration delayed the employer mandate for 1 year. The Treasury witness before the committee testified the reason the administration granted big business a 1-year delay is, quote, "Employers and their representatives have requested transition relief for 2014 because of concerns about the difficulty or costs of complying with the employer mandate."

Secretary Sebelius appeared before this committee and repeatedly said Obamacare was ready. It clearly wasn't.

Doesn't the failed launch indicate many individuals are going to have to at least have as much difficulty complying with the individual mandate as big business had with the employer mandate? Yet from the announcement last night, you have only given individuals a 6-week delay. CMS announced 700,000 people had submitted applications for exchange coverage nationwide, but with all the challenges you have been facing, there are some serious questions about what these applicants know.

CBS news reported, quote, "The shop and browse feature is not giving consumers a real picture. In some cases, people could end up paying double what they see on the Web site." So how many applicants applied based on the wrong premium information? Do you know?

Ms. TAVENNER. The completed applications were done, the 700,000. These were individuals who completed applications and figured out if they were eligible for a tax credit. I do not know

where CBS news is getting their information about erroneous tax credits, so I can't address that.

I will say that in the individual mandate issue, that folks can apply through March 31st. We have said publicly that we will have the Web site in good working order by the end of November. We have always predicted that folks would increase their interest in enrollment in December and probably again in March, and so we believe that we are in good shape to handle that.

Mr. JOHNSON. Well, if you have identified the problem and are taking steps to identify who received faulty price information, apologize—and provide the right information—are you doing that now?

Ms. TAVENNER. Yes, sir. If we have given people the wrong information, we will certainly correct it, but I am not sure what CBS news is referring to.

Mr. JOHNSON. I would like to bring to your attention a story which ran last week in Mother Jones with the headline, quote, "How HealthCare.gov Could Be Hacked." Let me just quote from the article. "Security experts say the Federal health insurance Web site is vulnerable to a common technique that hackers use to steal personal information."

As you may know, I am chairman of the Social Security Subcommittee, and one of my longest outstanding priorities has been to protect Americans' Social Security numbers. So for the record, is the Obamacare Web site 100 percent safe from hackers who could steal Americans' personal information, including their Social Security numbers, yes or no?

Ms. TAVENNER. We follow all the standards to protect information, including Social Security numbers.

Mr. JOHNSON. Are you trying to say yes?

Ms. TAVENNER. Am I trying to say yes that we follow the standards to protect information? Yes, sir.

Mr. JOHNSON. You know, folks are confused and scared. They have heard the horror stories and are now experiencing them firsthand. How can they trust the Federal Government to not only fix the Web site, but more importantly, give them the assurance that their personal information will be safe and their health care will be affordable, that if they want to keep their current plan, they can do so?

The problems don't stop at the technical failures of a Web site. The real problem stems from the colossal failure to deliver what this law promised the American people.

Thank you, Mr. Chairman.

Chairman CAMP. All right. Thank you.

Mr. Rangel is recognized.

Mr. RANGEL. Thank you so much, Mr. Chairman.

And welcome to our distinguished committee. You may wonder why the administration appears to be under such severe attack by some Members of this committee, especially as it relates to our goal to provide health care for 30 million Americans that can't afford or don't have access to it, but it should give you some small comfort to know that historically the Republican Party always fought vigorously against these types of programs. I don't think that one Re-

publican voted for the Social Security Act, even though those old enough to enjoy the benefits.

Chairman CAMP. That is not accurate.

Mr. RANGEL. Well, we will see maybe one or two. I don't know.

Chairman CAMP. No.

Mr. RANGEL. But they opposed Medicare. I spoke with President Johnson, and he shared with me at the ranch people that had signed off on Medicare. And anyway, it is big government. Even if it saved lives, who cares. You are against big government. So why should Obama be spared the attack because he wants Americans to be healthy and strong and productive? We have to be consistent, and you guys and ladies have been.

What I don't understand is that people aren't born as Republicans and Democrats, and there has to be somebody, regardless of party label, that has suffered the embarrassment and the pain of being denied an insurance policy because they have been sick before. The people who actually need health care the most are too high a risk for some of the insurance companies, and this body, Republicans and Democrats, allowed things like this to happen.

When I was a kid, if my mother took three of us, three children to see a doctor and we weren't sick, they would think she was crazy, because you couldn't afford a doctor. Now health care will provide you getting the type of treatment to avoid you being sick and having to lose your dignity in impersonal emergency rooms that provide the most expensive health care that we have. But Republicans, who have always been admired for being fiscal conservatives, have certainly seen the price of health care, the lack of quality that we may have today, soar to become such a part of our national budget that, in my opinion, it is a threat to our national security, because as prone as some of you are to enter into conflict with other countries, you need healthy young people to fight these wars. And health care is important from birth throughout one's life.

So I don't know how you are going to explain when this program, which is destined to succeed, how politically you are going to explain your positions today. And since your entire political program is locked into hatred for the President and this program, it seems to me that we have to find other ways for us to politically combat each other, because I hate to see the day that there is no Republican Party and I have to rely just on my party for justice and fair play. And so we have to come together some kind of way to see what is best for America.

Now, you may not like this program, and it certainly has been disappointing as a start, but what I want to see more from this committee is how can we improve and get quality health care for all Americans. This has to be a part of the goal that all of you have. And you also have to recognize that when we are lucky enough to have public servants to work for the administration, whether Democrat or Republican, that they are servants the same way we are and they deserve some dignity as well.

And so for America, I hope and have every reason to believe, like Social Security, like Medicare, that the goodness of the program will prevail. And if there is anything that we can do to help you, and there may be some Republicans that will join with me, to make certain that we get rid of what is not working and make certain

everyone has access to health care, I wish I could see the politics involved in this, because I am a partisan, but a stronger America means a stronger party, and that is what we are here for. And I just want to thank you for your dedication and for you to recognize that it is all political and we have to do our job and get on with it. Thank you for your service.

Chairman CAMP. All right. Thank you.

Mr. Brady is recognized.

Mr. BRADY. Just a quick fact check on the blast from the past. Republicans did support Social Security and Medicare, and more recently Republicans were the ones that reformed Medicare to add that important prescription drug benefit so we could have seniors lead healthier lives, stay out of hospitals, and enjoy their grandchildren more.

What has become abundantly clear, the flaw is not the Web site, the flaw is the law itself. This is what happens when you inject 159 new Federal agencies, bureaucracies, and commissions between you and your health care. And this was supposed to be the easy part. Just wait until you see the government making decisions about patient care, about reimbursements and treatments that you receive from your local doctor and hospital.

Ms. Tavenner, I have a great deal of respect for you, and I suspect many Republicans do, yet the White House, Secretary Sebelius, you, and your staff made repeated claims to the American public and to Congress that everything would be ready on time, everything was a go. None of that proved to be true. Now we are told everything will be okay very soon. So why should the American people believe you now?

Ms. TAVENNER. Congressman Brady, I would go back to what has worked in the last 3½ years since the Affordable Care Act was implemented. We have been able to make a difference in the lives of coverage of young people, we have been able——

Mr. BRADY. But specifically on the Web site and the exchanges, why should the American people believe you now? You have had nearly 4 years to get it ready. Now you are saying in 4 weeks more it will be great. So what is different? Why should anyone believe these claims?

Ms. TAVENNER. Because I think we have identified two major problems. One had to do with the initial volume. And despite our best volume projections, we underestimated the volume, the interest in the site.

Mr. BRADY. But you know that the volume isn't the same as the applicants in the enrollment, that you, yourself, visited the site. Clearly you weren't shopping for it. Others did as well.

Ms. TAVENNER. Right.

Mr. BRADY. So to Chairman Camp's point, the number of applicants, the number of enrollees, apparently still not known, is pretty modest. Wouldn't you agree?

Ms. TAVENNER. Well, but I would tell you that the number of visitors to the site and the number of people interested in completing applications was larger than even our initial projections. And we worked our projections off of the 7 million number that Chairman Camp mentioned. We also worked it off our history with

Medicare Part D. So we have added capacity to the system and we have improved system performance. So that is the first thing.

The second thing is we have found some what I will call functional or glitches, as we call them in the public term, in the actual application itself which we are repairing, and that is the gradual improvements that you will see over the next 4 weeks and that is why I am confident about the end of November.

Mr. BRADY. Well, can I tell you, my constituents are frightened. Like millions of Americans, they are now being forced out of the health care plan that they like. The clock is ticking on a Web site that is broken. Their health care isn't a glitch. It is what they depend upon.

So, you know, you have been described as the quarterback of the Obamacare rollout. I am sure that is not the term you chose for yourself. But can you guarantee no American will experience a gap in their health care?

Ms. TAVENNER. So what I can guarantee is that we have a system that is working. We are going to improve the speed of that system——

Mr. BRADY. Excuse me.

Ms. TAVENNER. Yes?

Mr. BRADY. You are saying the system right now is working?

Ms. TAVENNER. I am saying it is working, it is just not working at the speed that we want and at the success rate that we want, and those are the things we are working on. We also have alternative methods for folks. They can use the call center, they can use paper applications, and then we have in-person assistants available in each State. So I can guarantee you that we can reach out to each individual and help them select a plan and enroll. So, yes, sir.

Mr. BRADY. But to my point, this is not supposed to be fixed until November 1st. People have just 2 weeks to apply, enroll, be confirmed. So what happens on January 1st, when they have an illness, they need patient care then, they have not heard back from the government? What do they do then?

Ms. TAVENNER. They have until March 31st to enroll.

Mr. BRADY. No, but their plan has been cancelled, as millions of Americans have found out.

Ms. TAVENNER. You are talking about people who——

Mr. BRADY. What my constituents want to know, what happens?

Ms. TAVENNER. The individuals who have received notices from their issuers is a different situation. They can certainly obviously sign up, transfer, as we talked about earlier with Blue Cross of Florida, or they can go on the exchange or call the call center——

Mr. BRADY. But my point is, it has been cancelled, they don't have health care, they have tried to get on the Web site unsuccessfully, they don't know if they are enrolled, it is January 1st, they are facing a gap in coverage. What do you tell them?

Ms. TAVENNER. I am telling you they can call the call center today and we will help them. They can go online, and if they are not successful, we can help them through the call center. We also have people in their individual markets that can help them in person. So there are more methods than just the Web site, and I think that is important.

Mr. BRADY. I think what has become clear as well is Obamacare is not ready. The question is, why don't we make it voluntary? Why don't we give Americans a choice so they are not forced into this health care that they don't want?

Mr. Chairman, yield back.

Chairman CAMP. Mr. McDermott is recognized.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

Mr. Rangel has asked me to correct something. The vote coming out of this committee was on a party line vote. There were no Republicans who voted for it when it left this committee. When Social Security——

Chairman CAMP. Will the gentleman yield?

Mr. MCDERMOTT [continuing]. There were 81 who finally voted for it, mostly progressives, but there are none less in the Congress.

Chairman CAMP. Yes, 84 percent of Republicans voted for the Social Security act 77 years ago. I am glad we are debating current events here, Mr. McDermott.

Mr. MCDERMOTT. Reclaiming my time, Mr. Chairman. With the way my Republicans colleagues have been fretting over the success of the Affordable Care Act exchanges, you would never know they spent $24 billion shutting down the country to get rid of it. Suddenly they seem desperate to see a bill that they didn't want actually work. It is like the "Annie Hall" joke: The exchanges are terrible and not enough people can enroll.

Now, this is one of the biggest reforms our country has ever made and we are only 4 weeks into it. Medicare wasn't built in a day. Part D didn't roll out without snags along the way. As others have mentioned, many of the Republicans who are now calling for blood over this rollout were begging for patience on Part D. The kinks of that rollout were easily brushed off by many GOP alarmists who sit on this dais. We waited 6 months to hold an oversight hearing on Part D. We are barely 4 weeks into this one, and we are already declaring it dead. It is premature death.

We would have all loved to see this launch be seamless and smooth, but we can't get caught up in the glitches and the technical difficulties and lose our perspective. Help lines are up and running. I want to put the first chart up, because I think that you need to know that it is working in some States in this country. We have had a health plan finder in the State of Washington that has been out on the street before October 1. In Washington State we were ready to go and we have got 92,000 people who have now enrolled.

Now, there is a difference between enrolling and being approved, having your plan approved, because you have to make your first payment. So when you talk about enrollment, you may be talking about something different. You are not comparing apples and oranges.

But there are States in which it is working. People can sign up by mail, in person. We had actually a mobile signup van that is going around the State stopping in small towns and giving people a chance to talk to somebody. And 49,000 people are already in the program, not just finished the application.

Now, there have been some glitches, even in our State, but we got around them. Our country does have a serious problem, how-

ever, with access to quality health insurance, and it is not being caused by Web sites. All of the computer programmers in the world aren't going to be able to help the 180,000 Hoosiers that fall into the affordable coverage gap because Indiana isn't expanding its Medicaid. Of course, that is nothing compared to Georgia's 400,000 people who aren't going to get anything, or Florida's 760,000.

And then, of course, there is Texas. Texas is always the best and they are not going to be outdone. Texas boasts 1,460,430 people who will simply get nothing, no Medicaid, and I guess they can come to the government exchange, which people here want to kill. That is over a million Texans, working poor with minimum wage jobs, multiple of them, and they are just trying to get by.

Now, they could be covered at no cost to themselves or the State of Texas, but instead the GOP wants to see this President fail because they would rather let their constituents go uninsured than compromise. Those Texans and Floridians and Hoosiers are simply out of luck.

Meanwhile, in other red States, like Kentucky, they have enrolled already 26,000 people through the State exchange or expanded Medicaid. Arkansas, now, they don't want it, either, and they don't want to accept the Medicaid money. They constructed their own way, in cooperation with the Federal Government, and they have got 56,000 people enrolled in Arkansas. Now, here is a red State that worked very hard to partner with the Federal Government and arrive at a solution that is working for its residents.

It is time really to start working together. Forty-four attempts to repeal this law. It is now law, folks. It is now up and running. It is going to run. And it is time to stop this kind of sniping and get together and figure out how to make it work. No one on our side thinks the law is perfect.

Chairman CAMP. All right. Thank you. Time has expired.

Mr. Ryan is recognized.

Mr. RYAN. Thank you. And thanks for being here.

I think what we are seeing here are all these rude awakenings that the American people are waking up to find; you know, promises made and promises broken. We had a hearing here in this room on August the 1st with the IRS, and the IRS confirmed that the delay in the employer reporting requirements would mean that the IRS would not have the data on the so-called back end from employers until 2016 to verify if an individual had been given an offer of affordable employer-sponsored health insurance in 2014. Now, the reason this matters is that determines whether a person is eligible for a taxpayer-funded subsidy or not.

To mitigate this, Dan Werfel, the IRS Commissioner, told us that, quote, "We are going to help the individual at the front end when they are navigating through the exchange to understand whether they have an employer plan."

Let me ask you this: Of the 700,000 applicants you have received, how many of them did you verify whether or not they have been offered employer-sponsored insurance?

Ms. TAVENNER. The verification of employer-sponsored insurance is part of the application process. So if, in fact, that was available to them, they would not go on and complete the application.

Mr. RYAN. So it is just a self-attestation. Is that what you are saying? You had no way of corroborating this?

Ms. TAVENNER. We actually ask some additional questions. If you have gone online and go through the application, it actually requests some additional information. And we have ways of verifying whether or not employer-sponsored coverage was offered. So it is not just as simple as yes or no. If they don't have it, it is a no, and so we accept that. If it is a yes, then we try to work with them to see if they are eligible for anything or not.

Mr. RYAN. Okay. So I look at yesterday, you released a report that purported to talk about premiums for young adults. The report admits, quote, "These estimates do not take into account the tax credit eligibility requirements relating to other minimum essential coverage or tax filing requirements." Young adults on their parents' plans.

Let me ask you this. Are you proactively finding out if individuals under the age of 26 who are eligible to stay on their parents' plan are doing that or not? Because they are not eligible for a subsidy then as well.

Ms. TAVENNER. Right. So what we have seen is since the Affordable Care Act we have over 3 million young adults who are getting coverage through their parents' plans, which is pretty much the pool that we anticipated. So they are going through their parents' plan.

Mr. RYAN. No, but when they go on the Web site, are you verifying whether or not their parents have a plan that they are eligible for before determining whether they, themselves, get a subsidy?

Ms. TAVENNER. It is part of the application process. I can get you more information on that.

Mr. RYAN. Well, here is the point. Look, 2 weeks ago in the CR we passed a law that President Obama signed, quote, "Prior to making such credits and deductions available, the Secretary shall certify to Congress that the exchanges verify such eligibility consistent with the requirements of the act."

Here is the question. Are we really verifying at the front end whether a person is actually eligible for these subsidies or not? Here is why this matters. If they are not eligible for the subsidy, and then once we reconcile these records, they get taxed the money back off of their refund.

And so this is what I mean when I say rude awakenings. People are signing up for insurance, they are getting tax credit subsidies funded by taxpayers. The IRS is already telling us they are confused about how to do this. You are not telling us whether or not you are proactively determining whether, say, an under-26-year-old is actually eligible for the subsidies you are trying to sell them. And the problem is once we learn whether or not they were eligible, and if they weren't, people in good faith will be signing up for subsidies that they are actually not eligible for.

Ms. TAVENNER. I think you are asking a different question, which is, are we doing 100 percent income verification on everyone?

Mr. RYAN. And subsidy eligibility verification.

Ms. TAVENNER. Yes. So part of the question in the application process is, are you dependent on your parents? Are you dependent

on your parents' tax plan? So that is part of the questioning that goes on. And if so, we move them in that direction. But more importantly, part of what you are asking is the income verification, which is done in 100 percent of the cases.

Mr. RYAN. I am not asking about income verification.

Ms. TAVENNER. Okay.

Mr. RYAN. I am asking about, if a person signs up, were they offered credible employer insurance? Because the employer mandate has been delayed you don't have that verification tool, so you had to come up with a new verification tool to determine their eligibility for subsidies. Because if a person is offered insurance at their job——

Ms. TAVENNER. Right.

Mr. RYAN [continuing]. That meets your definition of credible insurance, then they can't get Obamacare subsidies.

Ms. TAVENNER. That is correct.

Mr. RYAN. If a person is 25 years old and they go on the Web site and they say their income is X, and that is eligible for subsidy, they can get that subsidy. But if they were eligible to be on their parents' plan they are not allowed to get that subsidy.

Ms. TAVENNER. That is right.

Mr. RYAN. The question is, are you filtering that?

Ms. TAVENNER. Yes.

Mr. RYAN. Because here is the problem. If you get this wrong, the way the law works is you have to take that money back in their tax refund. Tax refunds matter. People plan their lives around their tax refunds.

Ms. TAVENNER. I understand that.

Mr. RYAN. They plan their spring breaks for their kids. They plan their car payments, their bills. And what people in this country don't yet know is that if you get this wrong, which you have already acknowledged you are not doing it right, they are going to get their tax refund taken away from them because they will have signed up for a subsidy that they weren't eligible for which they didn't even know.

Ms. TAVENNER. And if you have been on the site, this is part of the clear instructions to folks, including the under age 26, including the fact that you are basically completing this application under penalty of perjury. It is very clear. There is also help instructions on each site to explain each process, what is credible employer coverage, what happens if you are under 26. It is all available on the Web site.

Mr. RYAN. Okay. So if they get it wrong, they are the one who is going to get taxed.

Chairman CAMP. Okay. Time has expired.

Mr. Lewis.

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

Thank you, Madam Administrator, for being here. Thank you for all your hard work and for your years of service.

I happen to believe that health care is a right and not a privilege, that it is not just for the fortunate few, but all citizens of America.

Now, the Affordable Care Act is the law of the land. It was passed by the Congress, signed into law by the President of the

United States, and upheld by the United States Supreme Court. There have been more than 40 attempts to repeal the act, and it did not succeed. And by attempting to repeal it, Members of this body, Members on the other side of the aisle closed down this government and threatened the economy of the United States, costing us more than $24 billion.

This reminds me of another period in our history not so long ago. During the 1950s, many Southern Senators signed the Southern Manifesto after the Supreme Court decisions of 1954. And those Senators, along with many Southern governors, subscribed to the doctrine of interposition and nullification, and some even massive resistance. That is what we saw on the part of the Republican Members of the House and some of the Republicans in the Senate.

The Affordable Care Act is working. It is helping to make health care affordable and accessible to hundreds, thousands, and millions of our citizens who never had it before. When I was growing up in rural Alabama, we couldn't afford to see a doctor. None of the poor people in Alabama, in Georgia, in Kentucky, in Arkansas, and all across the Deep South can see a doctor. We must do what is right, what is fair, and what is just.

Now, Madam Administrator, I have a chart here this morning, and I want you to walk us through this chart. And I want to use my remaining time for you to explain to the Members of the Committee the success and the benefits of the ACA. There have been a deliberate and systematic attempt on the part of the majority in the House and the minority in the Senate to make it impossible for all Americans to receive quality health care. And some of us will not stand for it. We will stand up and fight for what is right, for what is fair, and what is just. Health care is a right and not a privilege. Walk us through the chart.

Ms. TAVENNER. Let me start with the 78 million consumers saving $3.4 billion on their premiums. This is due to some of the work that was done around the medical loss ratio. These were benefits that actually went in forms of checks to individuals. I actually got thank you notes from people that I have never heard of, that I have never met thanking me for getting a rebate back. It could go to the individual or it could go back into their premium for the following year.

Seventeen million children with preexisting conditions used to be able to be denied coverage, this goes back to the flaws in the individual market that existed prior to the Affordable Care Act; 6.6 million young adults able to stay on their parents' health insurance plan, that is critical, particularly at the time with what we were going through with our economy; 7.1 million seniors in the donut hole. And let me remind you that in addition to that, you saw our release yesterday about the Part B premium being flat for next year. That is some of the work of the Affordable Care Act in controlling costs.

And let me just say, going back to your point, Congressman, is that if we had the highest outcomes, if we had the lowest infant mortality, if we had the longest lifespan, maybe what we were paying would be worth it. But it is not the case. As you know, our country does not look good in terms of overall health statistics, and

certainly the South is suffering from that more than the rest of the country.

Mr. LEWIS. Thank you very much.

With that, I yield back my time.

Chairman CAMP. All right. Thank you.

Mr. Nunes.

Mr. NUNES. Thank you, Mr. Chairman.

Madam Administrator, just in response to Mr. Ryan's question, we went through the Web site, and we don't see anywhere where it shows that if you are under 26 that there is a verification.

Ms. TAVENNER. So let me also say one thing that I had wrong. As a young adult you can stay on your parents' policy and you can get your coverage that way.

Mr. NUNES. But the question was there was no check on the subsidy.

Ms. TAVENNER. Or you may go as an individual and you would be eligible for a subsidy. There is no penalty.

Mr. NUNES. Well, if you are 26, if you are under the age of 26——

Ms. TAVENNER. You can go either way.

Mr. NUNES [continuing]. To Mr. Ryan's point, you can get a free subsidy and get that back on your tax return. That was the point Mr. Ryan was making. And there is nowhere——

Ms. TAVENNER. You are eligible for a subsidy, yes.

Mr. NUNES. You are eligible. So you can be on your parents' health care. And you are still eligible for a subsidy.

Ms. TAVENNER. But I will remind you part of what you complete on the application is do you have coverage. You are also under penalty of perjury. So you have to tell the truth on your application. That is kind of a requirement.

Mr. NUNES. Okay. In your submitted testimony you attributed the problems to HealthCare.gov Web site to a subset of contractors. Is that correct?

Ms. TAVENNER. I don't think I said that it was due to a subset of contractors. I said we had two issues that we were dealing with. The first was capacity, in that our first few days the volume was more than we anticipated, so we had to add capacity. We had a problem with account creation, with the email account creation, which was subsequently fixed.

Mr. NUNES. So on your August 1 testimony to the House Energy and Commerce Committee, to Congressman Pitts' question, do you remember this question?

Ms. TAVENNER. You will have to ask the question.

Mr. NUNES. He asked, and I quote, "Do the contractors who HHS is paying to build these exchanges have certain targets or milestones that they have to meet?" You replied, "Absolutely." Congressman Pitts then asked you, "Can you tell us today that every contractor has met these targets and is on time?" You replied, "Yes, sir, I can."

So it seems there are two possibilities here. First, the exchanges were progressing fine for years, just as you repeatedly told Congress, and the breakdown resulted solely from problems with a few contractors that suddenly occurred 60 days before Obamacare was open to the public. Or the second possibility is, is that there were

problems much earlier that were being reported in the press, but you did not tell Congress about these. Which is closest to the truth?

Ms. TAVENNER. If I remember the questions correctly, what Congressman Pitts was asking me related to the hub, and the hub was progressing on time and on schedule. It still is. The hub has actually operated pretty much flawlessly. And most of the questions were around the hub.

Mr. NUNES. So it has been also reported that neither criminal background checks nor high school diplomas will be required for so-called navigators to be hired to help Americans access the exchanges. Is this true?

Ms. TAVENNER. Could you repeat that? I am sorry.

Mr. NUNES. Neither high school diplomas nor criminal background checks will be done on the folks that you hire to help Americans navigate the Obamacare Web site.

Ms. TAVENNER. I don't think that that is true. Are you talking about through the navigator program? There are standards, and I can get you those standards.

Mr. NUNES. Okay. Well, it has been a press report.

Has anyone in the White House or anyone else asked you to delay divulging enrollment numbers as it regards to Mr. Camp's question at the beginning?

Ms. TAVENNER. No. I think if you remember, we had said all along that we were going to release our first numbers the middle of November.

Mr. NUNES. So no one at the White House, no one in the entire Obama administration has asked you not to release those numbers.

Ms. TAVENNER. We have made a group—we made the decision that we were not releasing the numbers till mid-November.

Mr. NUNES. And you don't know, you have no idea what those numbers are at this point?

Ms. TAVENNER. I told you we would release the numbers in mid-November.

Mr. NUNES. Okay. I will take that as you don't want to answer the question.

Did you ever argue to Secretary Sebelius, or to anyone at the White House, or to anyone else that the exchanges would not be ready October 1 and that a delay in launching them would be warranted?

Ms. TAVENNER. I did not ever argue that we should delay the exchanges. What I did present to the Secretary in September is that there were certain functions that we should delay beyond October 1, and I think those have been very much in the press. That had to do with the automation of SHOP. It had to do with the Spanish-language Web site. It had to do with Medicaid account transfers. So that was presented in September as things we would not bring live October 1.

Mr. NUNES. Before my time expires, I want to yield quickly just 5 seconds to Mr. Ryan.

Mr. RYAN. Look, I find it puzzling we have to explain to administration officials how the law works. The law is if you are under the age of 26 and you are eligible to stay on your parents' plans you cannot receive subsidies.

Ms. TAVENNER. You are right.

Mr. RYAN. And there is nothing, nothing on your Web site that tells an under-26-year-old those facts. So you are encouraging people to sign up for insurance and a subsidy that they may not be eligible for and they don't even know this.

Ms. TAVENNER. Congressman Ryan, I am happy to go back and check on that and get you information.

Mr. NUNES. Yield back.

Chairman CAMP. All right. Thank you. Time has expired.

Mr. Neal.

Mr. NEAL. Thank you, Mr. Chairman.

I think one of the differences here in the legislative modeling is the way that we attempted to repair the drug prescription benefit, known as Part D, in terms of addressing the donut hole. We didn't suggest that we wanted to repeal the law. We simply said to repair it. And I remind everyone that part of it was gimmickry as it related to the donut hole as well. But our position was let's improve it. And in the Affordable Care Act, I think that you could safely say that that has happened.

Now, I want to go to a broader argument here, and that is that 97 percent of the people in Massachusetts are covered, and virtually every child in Massachusetts is covered. We are in the midst of marketing the open enrollment plan. And I got to tell you the marketing is terrific.

But I want to come to another point, and that is the following. There is a great picture at Faneuil Hall, where much of the American Revolution was designed and hatched, of Governor Romney—or as we know him on this committee, Paul Ryan's running mate, the other guy on the ticket—Ted Kennedy, the Heritage Foundation, and the governor sets his hand to this legislation, which has become a model for applicability, efficiency, and success. Hardly perfection. But what a grand possibility. Why, in your estimation, has the Massachusetts plan worked?

Ms. TAVENNER. I think the Massachusetts plan over time has allowed individuals to not have to worry about preexisting. It is required that they have insurance. It is required that they participate in group coverage, a group market. It is the same principles we have applied through the Affordable Care Act. And it has been a huge success. They started out very slowly. It took them years to get to where they are today. But they do have good coverage. And if you look at their outcome, they have got excellent outcomes in health care as well.

Mr. NEAL. The business community worked with the governor, worked with a Democratic legislature that has three Republicans in the State Senate, and they came to the conclusion that using the discipline of the marketplace could be part of the solution. And getting everybody in was the ideal. And then we would argue about many of the other matters. But getting everybody signed up was a key component, and we would use the private sector to discipline price. Correct?

Ms. TAVENNER. That is correct.

Mr. NEAL. So I guess the argument we have here is, why wouldn't we be trying to sand the edges of the ACA to make it work as opposed to this determination to make sure that it doesn't work?

Yield back my time.

Chairman CAMP. Thank you.

Mr. Tiberi is recognized.

Mr. TIBERI. Thank you, Mr. Chairman.

Thank you, Ms. Tavenner, for coming today. You have got a great reputation. Thank you for your service. You have got a very difficult job to do. Best of luck in doing it.

I want to just make a note to you and to the members of the audience here. On September 30, the Republican House passed a continuing resolution that funded government and delayed for 1 year the individual mandate and the implementation of this bill. That was on September 30. That died in the Senate, delaying this for 1 year.

The reasons why we believe that was the right policy, and I think history will show that it is, is what we have seen in the 28 days since, and that is the disastrous unveiling of this bill. You don't have to be a Member of Congress and talk to constituents to understand the difficulty that the implementation has caused in people's daily lives. And as Mr. Brady said, the nervousness and the fear.

You have been telling us that there are other options, in addition to the Web site. The President actually has gone out and sold that pretty well. So if a constituent of mine goes and makes the phone call to try to find out some information, can she find out by calling the phone number if the doctor in her current network is covered?

Ms. TAVENNER. She cannot find out through the phone call if the doctor—and that is I think true—that was true in the market prior to the Web site.

Mr. TIBERI. Can she find out if the plan costs more than her current plan?

Ms. TAVENNER. Yes, I think she can find that out.

Mr. TIBERI. By calling the phone number?

Ms. TAVENNER. Yes. What happens is they work them through the application. The call center would help them.

Mr. TIBERI. She has to actually apply before she can shop.

Ms. TAVENNER. Well, yes, that is important because it is important to understand if she is eligible for a tax credit, because that affects the prices that she would pay.

Mr. TIBERI. So can she find out the cost of a plan without signing up or comparison shop without signing up?

Ms. TAVENNER. So if you are not interested in the tax credit and you just want to know what rates are available, we actually have on the Web site the ability to do that. So, yes.

Mr. TIBERI. But the Web site is not working.

Ms. TAVENNER. No, this is actually on the front end. What is not working sometimes are some of the pieces inside the application. But if she is just interested in rates in her market, that is available through the Web site. There is also the ability, and we have a link with that on the Web site, to use Kaiser's site that also allows them, if they believe they are eligible for tax credits, to actually go in and simulate what that would be like for them.

But if they want to know, if they are not interested in tax credits, they just want to know what is available to them, which I have had several friends who have said to me, I know I am not eligible

for a tax credit, I just want to see what rates are available in the individual market.

Mr. TIBERI. But they have to sign up to do that.

Ms. TAVENNER. No, they do not.

Mr. TIBERI. You are positive on that.

Ms. TAVENNER. I am positive on that.

Mr. TIBERI. Isn't the person who is on the phone with my constituent who is trying to find out if their doctor is in network or——

Ms. TAVENNER. No, you asked a different question. Doctor in the network I said is not available through the Web site.

Mr. TIBERI. Right. So the person who is making the phone call, my constituent is talking to somebody on the other line, aren't they accessing the same information on the Web site that our constituents are encouraged not to do because the Web site is not working?

Ms. TAVENNER. So two different issues. If they are completing an application then they would complete the application and we would give them information. But if you are just interested in knowing what the insurance rates are in your area, that is actually available without completing an application. You can just go on the Web site and get that information.

Mr. TIBERI. But if they are accessing the phone network because they can't access the Web site——

Ms. TAVENNER. They can give them that information.

Mr. TIBERI. Isn't that person they are talking to accessing the same Web site?

Ms. TAVENNER. Yes. But it is not inside the application.

Mr. TIBERI. So we are asking people to call and talk to a person who is accessing the same Web site that we are encouraging our constituents not to use because it is not working right.

Ms. TAVENNER. Let me try this again. The problem that we have in the Web site sometimes is in the application process itself. Inside the application people were getting stuck in the application process. What you asked me is can you get plan information without completing the application process, therefore not getting into the problems. And the answer to that is yes.

Mr. TIBERI. Okay. Let me just tell you the concern that I have——

Ms. TAVENNER. Okay.

Mr. TIBERI [continuing]. That you are going to have to deal with, and the members of the other side of the aisle won't acknowledge. We understand the Affordable Care Act is the law of the land. We do. But we also understand from our constituents that there is a disaster of a rollout that is occurring, not a hiccup, but a disaster of a rollout that is occurring. I have constituents who have said to me their doctor is not going to be covered in the new plan. Their plan is going to be more expensive. And finally, a constituent who said, let me get this straight, Congressman, you guys passed a bill that tells me that I am transitioning, you are telling me to transition to another plan, and you are telling what that plan is going to be. It is not going to have the same benefits that I have now. I am going to pay more. But you are going to give me a tax credit back so I can pay less, even though it is going to cost more.

That is just crazy. And for us not to acknowledge that is crazy is just so disappointing and discouraging.

I yield back.

Chairman CAMP. The time has expired.

Mr. Doggett.

Mr. DOGGETT. Thank you, Mr. Chairman.

While I am troubled by the determination of our Republican colleagues to destroy the rights of Americans to access affordable health care, I recognize that the promise of affordable health care can also be denied through a management failure. I share some of the concerns that have been raised here this morning. And if there were even one Republican Member of this committee who wanted to fix the shortcomings in the act and to learn lessons from the roll-out about how to improve access, we could have a constructive hearing that focused on those limitations and how to address them. At the top of the list for any Texan would surely be the million people that, when we thought we were providing protection when we enacted this law, who are getting absolutely nothing out of it.

The limitations with the Web site are a part of the concern that I have. Let me ask you specifically, will the SHOP Web site for small businesses that was delayed be fully functional during November?

Ms. TAVENNER. Yes. We will institute the SHOP component at the end of November.

Mr. DOGGETT. Will the twice-delayed Spanish-language version of HealthCare.gov be fully operational in November?

Ms. TAVENNER. By the end of November, yes, sir.

Mr. DOGGETT. There are estimates that three out of four eligible individuals for the Web site need some in-person assistance—eligible for tax credits—will need some assistance in person to access that. That is why the navigators, for one, are so very important. In large measure because of the statute, people in Maryland get 15 times as much money per individual uninsured eligible for the exchange for the tax credits as do people in Texas. People in California get about four times as much. It makes it all the more important that the navigator system work as well as the Web system works.

I have had some concerns about the way that navigator system works and have been asking whether it is possible to get prompt reports about whether the navigators are doing their job and whether they are accessing people, whether by paper, phone, or Web. I have been told that there are no progress reports that will be available on those navigators and what they are doing until after the beginning of the year. Surely, there are some reports that you can make available that will tell us whether these navigators are doing any more than the little I have seen them do in my part of Texas.

Ms. TAVENNER. Yes, sir. You should not have to wait till the first of the year.

Mr. DOGGETT. You can get us progress reports?

Ms. TAVENNER. Yes, sir.

Mr. DOGGETT. When you announced the navigator grants for Texas, there was an indication in the original notice that there would be a second round of navigator grants. Instead, it appears

that contracts were reached with two national firms to provide enrollment assistance, and those firms are at least required to provide in some cases weekly reports on their progress. In what way are those enrollment assistance two companies—I believe the one for Texas is called Cognosante, they got a total of about $30 million, much more than any individual entity as a navigator in Texas—in what way are they being integrated with the local navigators and assistance counselors to reach out to the uninsured?

Ms. TAVENNER. And I can get you that information. But I will tell you that there are navigators inside each of the Federal exchange States that we awarded contracts to. But in addition to that, there are volunteers through the Texas Hospital Association and others. And I can get you a full report of that.

Mr. DOGGETT. Okay. Well, I am interested, and today is not the first time I have asked for a full report as to how these enrollment assistance folks came into being and how they are involved with local folks. We have had to set up, in San Antonio and in Austin, our own network to try to make up for what we did not get in the way of Federal assistance at the local level. And these new enrollment assistance people, I am interested in getting prompt progress reports on them also to see what they have actually done, if they have actually signed anyone up, and what kind of people they are signing up, and whether this is, the navigator system, the enrollment assistance system, the certified counselors are any better organized and coordinated than the Web site and the 55 contractors have been.

Another area of concern——

Chairman CAMP. Time has expired, Mr. Doggett.

Mr. Reichert is recognized.

Mr. REICHERT. Thank you, Mr. Chairman.

This law started out on a troubling note right from the beginning. Republicans were not a part of the process, weren't asked to be a part of the process in building this law. And Nancy Pelosi herself said we must pass the law to find out what is in the law.

And as one of my colleagues mentioned this morning, let's just sand around the edges. We have done some sanding around the edges. And that is basically due to the fact that the Republicans have been calling attention to some of the issues that now we are becoming aware of because people are now beginning to read the law and finding out what is in it. So three programs have been completely halted since the law has passed. Seven others have been repealed and have had funding rescinded, and they have been signed into law. Now, that takes Republicans and Democrats and the President of the United States to agree to all those things for those things to happen.

I think that most people feel right now it is not time for any sanding to take place, but the chainsaw needs to come out. So we are going to keep on, and we are going to be persistent.

Were you working for CMS on January 29, 2010?

Ms. TAVENNER. January 29?

Mr. REICHERT. Were you part of the process in working to help implement Obamacare?

Ms. TAVENNER. I actually was not working for CMS January 29, 2010.

Mr. REICHERT. Okay. When did you start working to implement the health care law?

Ms. TAVENNER. I actually came to CMS late February of 2010.

Mr. REICHERT. Late February. Do you know if you can keep your health care plan if you like it?

Ms. TAVENNER. Do I know that I can keep my health care plan?

Mr. REICHERT. Do you know if it is true, as the President has said and many Democrats have said, if you like your health care plan you can keep it? Is that a true statement?

Ms. TAVENNER. There were health care plans that were grandfathered——

Mr. REICHERT. Is that a true statement?

Ms. TAVENNER. It is a true statement that plans were grandfathered in.

Mr. REICHERT. Okay. Thank you for that answer. So if you like your doctor you can keep your doctor, too. Is that a true statement?

Ms. TAVENNER. I think doctors come and go inside networks.

Mr. REICHERT. So if a person has a doctor and they want to go to that doctor and the doctor is in the network, they can still go to that doctor? They can keep their doctor if they like their doctor?

Ms. TAVENNER. If that person is in a plan where that doctor is in the network, they can keep that doctor.

Mr. REICHERT. On January 29, 2010, and it has been reported even today in some of our papers, the President knew years ago you are not going to be able to keep your health care plan. You are not going to be able to keep your doctor in this health care plan. He talked to the Republican retreat on January 29, 2010, and he said, when he was asked the question about keeping your doctor or your health care plan, he said, quote, "For example, you know, we said from the start that this was going to be important for us to be consistent in saying to people if you can have your—if you want to keep your health insurance you have got it, you can keep it, that you are not going to have anybody getting in between you and your doctor and your decision-making." And then he says, "And I think that some of the provisions that got snuck in might have violated that pledge."

Are you aware of some of those provisions that got snuck in that might have violated that pledge?

Ms. TAVENNER. I do not know what you are talking about.

Mr. REICHERT. I just gave you a quote from the President of the United States, your boss.

Ms. TAVENNER. No, you are asking me the provisions that were snuck in, and I don't know.

Mr. REICHERT. Yeah. Are you not familiar with the health care law?

Ms. TAVENNER. I am very familiar with the health care law.

Mr. REICHERT. The President apparently is aware of some provisions that were snuck into the law that says that, you know what, you are not going to be able to keep your health care plan, you are not going to be able to keep your doctor. But yet you just said you can. So you must not be aware. You didn't read the law,

as Nancy Pelosi said you should, when the thing was passed. Otherwise, you would know about those provisions.

You know, in Washington State my constituents can't keep their health care plan; 290,000 individuals in Washington have received notices canceling their health care plan. Do you know that that is happening? Have you heard those stories?

Ms. TAVENNER. I am aware that there are issuers in States who are canceling their old plans, which were grandfathered in, and moving to new plans which have to meet the requirements.

Mr. REICHERT. So what you just said about keeping your health care plan isn't true.

Ms. TAVENNER. No, they could keep it. The issuers chose——

Mr. REICHERT. No, they can't keep it. They just got cancellation notices. You can't keep it. The President says you can't keep it. Why are you saying you can? I don't understand.

Chairman CAMP. All right. Time has expired.

Mr. Thompson is recognized for 5 minutes.

After that, in order to make sure everyone has an opportunity to question, Mr. Levin and I have agreed to go to 3 minutes.

So you are recognized for 5 minutes.

Mr. THOMPSON. Can you start the clock again? They started it when you recognized me.

Chairman CAMP. All right. We will give you those 10 seconds back. There you go.

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

Ma'am, thank you very much for being here.

I want to thank my colleague from California who earlier pointed out that it wasn't you or CMS that set up this computer system, that you used private sector outside vendors. And I think that that speaks to an issue that at some point we need to look at, and that is our Federal procurement process, which is in part responsible for a lot of the problems that we have seen.

And I also want to thank Mr. Neal for pointing out that in fact when we work together we can avoid a lot of the problems that we are seeing. And we should be working together to make sure people have access to quality affordable health care rather than trying to find fault and blame and trying to defund or derail or sabotage a program that is designed to help people have access to quality affordable health care.

And nowhere is that seen better than looking at what we are doing in some of the States. And it is my understanding, and some of my colleagues have pointed it out today, that we have some States that are doing a pretty good job with their delivery of the Affordable Care Act. My home State of California has something called Covered California. And I understand that we have had about 125,000 applications that have been submitted, about 2 million unique visits to the Web site, and about 150,000 calls daily to Covered California, because people really do want to have coverage.

There has been many benefits in my home State. About 200,000 people are covered with preventive care. About 40,000 kids who have preexisting conditions now have coverage. About 100,000 seniors are getting preventive care under Medicare. I have had a number of people who have contacted me, and I will just mention two,

Samuel Calicura from Martinez, who said that he was paying $131 a week, and now he is paying $45 a month for his coverage. Cynthia Adams from Santa Rosa was paying 600 bucks a month. Now she is paying $134 a month.

Now, in full disclosure, as I have mentioned to you privately, I have had some terrible messages from people who are experiencing some real problems with the system. Usually it is insurance companies, as some of my colleagues on the other side of the aisle have mentioned, are canceling their grandfathered-in programs and policies and issuing new policies. And I have even had a community college in my district that is using the Affordable Care Act to reduce hours of part-time employees. So just about everything that has happened that has been bad in the last 3 years has been associated with Obamacare.

And I think we need to be able to draw the distinction and point people to these exchanges so they can do some comparison shopping and get these policies that will provide them with insurance. And I would like to see you guys do a more aggressive job in regard to that.

I would like to know from you, ma'am, how are the State exchanges working? And what effects are the problems of the Federal Web site having on State-run exchanges? And how are the new upgrades and the Web site fixes going to affect State-run exchanges such as Covered California?

Ms. TAVENNER. Let me say that the State-based exchanges are doing a very good job. And California, as you mentioned, has been a really nice success story. But there are large and small States. Obviously, California and New York are huge States that are having great success.

Where we have been able to work closely with them, and we talk with them daily, is obviously they use the hub for verification of information, and the hub has worked pretty much flawlessly. And I always knock on wood when I say that. So they have been able to get information. The problems that we are seeing inside the application process do not affect the State-based exchanges. So the information they need from us they are able to get.

You all may have been aware that there was an incident over the weekend with Verizon that took the whole site down. And when it did, it also took down the hub. So States were impacted during the day on Sunday and into Monday with an issue with Verizon. But other than that, they have been able to come and go and access the hub without difficulty.

Mr. THOMPSON. Thank you, Mr. Chairman. I yield back my time.

Chairman CAMP. Thank you.

Dr. Boustany is recognized for 3 minutes.

Mr. BOUSTANY. Thank you, Mr. Chairman.

Welcome. Good to see you.

I think in answering Chairman Camp earlier you established the fact that of the Nation's 2.7 million uninsured from 18 to 35 years of age, you are not going to reveal numbers on who has enrolled in that age group until sometime in mid-November. Is that correct?

Ms. TAVENNER. Yes, sir, mid-November.

Mr. BOUSTANY. Okay. Same goes for applicants? You will have no metrics on the number of applicants in that age group?

Ms. TAVENNER. We will release our metrics in mid-November.

Mr. BOUSTANY. Okay. How confident are you that those in this age group will actually sign up for the exchanges given that they don't actually get information on the plans unless they actually go through the application process?

Ms. TAVENNER. You know, we have actually had feedback from individuals who have worked through the application process, who have signed up, and there has been good representation, good stories in the young age group as well.

Mr. BOUSTANY. I mean this is a tech-savvy group. They are already being confronted with a major barrier with the Web site problems. And as you said earlier, ACA is much more than a Web site. I mean, we all know that they are going to see higher premiums, particularly in that age group. There has been a number of reports and studies that demonstrate that is going to be the case.

Clearly, the penalty is much lower than the cost of the insurance. And knowing something about the behavior of this age group, I have real concerns that we are going to see some adverse selection.

Ms. TAVENNER. Well, Congressman, I would remind you in this age group many of them will be eligible for tax credits. So that will also help with their premium costs. And also for those under the age of 30, there is an alternate catastrophic plan.

Mr. BOUSTANY. I understand. But if the premiums go up, then that means the subsidies go up. Is that correct?

Ms. TAVENNER. Well, the subsidies are based on your income.

Mr. BOUSTANY. Right. But if your income is what it is, and your premiums are going up, and we know there is upward pressure on premiums, then subsidies go up.

Ms. TAVENNER. But I will remind you what we saw in the premiums, which are locked and loaded for 2014, has actually been about 18 percent below what CBO estimates were for premium increases. So we have a good story to tell there.

Mr. BOUSTANY. But we see other evidence going longer term that we are going to see upward pressure on premiums as a result of the construct of this law. I have spent 30 years in medicine. I understand what this is going to do. And I have very deep concerns about what we are going to see with premium costs. But as premium costs go up, subsidies go up. That means the burden on the taxpayer goes up. That means deficits go up.

Ms. TAVENNER. So I will remind you that premiums were going up at double-digit increases prior to the Affordable Care Act. And what we are actually seeing is a moderation in premium increases for the last 3 years.

Mr. BOUSTANY. That is a false dichotomy, I mean, because there are other solutions to getting premiums down and actually lowering costs. So I don't accept that as a complete answer on the cost of these premiums.

Let me ask you this. Transparency is clearly very, very important. And will you or HHS or CMS, somebody in the administration provide information on the taxpayer's cost with regard to these subsidies for 2015 and beyond?

Ms. TAVENNER. I am sure that part of our information in reports we produce will include that information to you, yes, at the time.

Chairman CAMP. All right. Thank you.

Mr. Larson.

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

I would like to associate myself with the remarks of Mr. Thompson and Mr. Neal, and focus on an area that I think this committee could become eminently involved in.

First, I would like to point out what a success Connecticut has been. I want to commend Governor Malloy and Lieutenant Governor Wyman, who have headed that up with Kevin Counihan. Tremendous success, including more than a third of the people that have signed up for the program are under age 35. And so it demonstrates that when you are working together and cooperating, that indeed these things can work.

And as Mr. Neal pointed out, the thing that is astonishing from a Democratic view, if Democrats were to have their way in health care we would have had Medicare for all or a single-payer system. Instead, we opted for coming together and ending up with a program that was idea of the concept was the Heritage Foundation, piloted by a Republican governor in a Democratic State. And so we come up with a private sector initiative.

Here is the deal. The deal is this: that if this committee were to approach this issue the same way we did tax reform and say the following, we are going to take the very best of the public health system, the very best that the public health system can offer, including the National Institute of Science, the National Institute of Health, the Center for Disease Control, everything that our public health systems within our State has brought together over these many years, and then do that in combination with the private sector so that we can take the entrepreneurial advantage that the private sector can bring to this remedy, and then take science and technology, most notably the genomic project that is currently going on that has untold benefits.

What the American people want to see is to help them out, to solve their problem, to help them get better health care. They don't want to see this endless tastes great, less filling debate from the committee. I challenge the chairman, let's do what we did with tax reform. Let's break down into individual groups and solve this problem together so that we are taking the best of the public sector, the best of the private sector, and all that innovation, technology can bring to bear on changing the paradigm for the American citizen so it is their health and well-being that becomes the focus, not the ideology of either party, but the health and well-being of the American citizen.

That is what this should be about. And we can do it. And by taking both sides of what both parties and both ideas can bring to this discussion, the best of the private sector, the best of the public sector, and everything that science and technology and innovation can provide.

There is more than $800 billion annually in waste and inefficiency. This is the most inefficient economic system in the world. Can't we come together to solve that? Use this committee to lead

the way and set the example for what regular order can provide by challenging everybody to sit down, as we have in tax reform, and come up with a solution for the American public, not this ongoing debate.

Chairman CAMP. The time has expired.

Mr. Roskam.

Mr. ROSKAM. Thank you, Mr. Chairman.

Administrator, thanks for your time today.

So I have an independent recollection of driving around Chicagoland, I represent the western suburbs, and it was June of 2009. President Obama was in town giving the speech to the AMA. I knew I was going to be called on to make some comments afterwards. So I am listening to it on the radio. I am on Michigan Avenue, downtown Chicago, I am listening, I am listening, I am listening. And the President says this. It is a paragraph that you are familiar with, but I want to revisit it with you now in light of constituent contacts that I have had. He said this: "I know that there are millions of Americans who are content with their health care coverage. They like their plan and they value their relationship with their doctor. That means that no matter how we reform health care, we will keep this promise: If you like your doctor, you will be able to keep your doctor, period." No parentheses, no exclamations, no asterisks, period.

Continuing: "If you like your health care plan, you will be able to keep your health care plan, period. No one will take it away no matter what. My view is that health care reform should be guided by a simple principle: Fix what is broken and build on what works."

That was a declarative statement by the President of the United States selling, in anticipation, the passage of the Affordable Care Act. That deeply resonated with a lot of folks. He repeated it, repeated it, repeated it. Made other claims, like it is going to save $2,500 on average per family and so forth.

So here is my point. Diane Isser from Hoffman Estates is a 57-year old breast cancer survivor. It was reasonable for her to assume, based on the plain language of the President, not subsequent parsing, but the plain language of the President, that she would get to keep her coverage. And here is her new reality. She gets the letter from Blue Cross Blue Shield that says that they are unable to offer that coverage. Her rate goes from 363 a month to 713 a month, almost doubling. Now, she had a preexisting condition, so this is not a question of whether her breast cancer was covered or not. She is being moved into a Gold plan, which presupposes that she had decent coverage from before.

Can you understand the level of frustration and concern about what many Americans perceive to be a false claim from the administration? Not that it was somehow changed or now that, well, we have got this wonderful plan for your life that says we know better than you, we are going to tell you what kind of coverage you want. Diane knows exactly the type of coverage she wants. So that is one concern.

The other concern is, you have alluded to it, is the Web site. I have got another constituent, Denise Banages, from Lake in the Hills, who is a professional in this arena and has spent countless

hours advising clients. And, you know, the advice is take screen shots, protect yourself, and so forth.

My time has expired. But can you understand at least the level of frustration based on the claim of the President of the United States that people were going to be able to keep what they had and it is not turning out to be true as they understood that statement?

Ms. TAVENNER. I understand that for about 86 percent of America that had employer-sponsored insurance and they were satisfied with those plans and they still have those plans. What we were dealing with in the Affordable Care Act is the individual market where the constituent you talk about is lucky, she was able to have insurance. Many people were blocked out due to preexisting, due to other issues. And that is what we were trying to fix. That is what I understand.

Chairman CAMP. All right.

Mr. Blumenauer is recognized.

Mr. BLUMENAUER. So if I ask a 3-minute question will the Administrator have a chance to answer also?

Chairman CAMP. Give it a try and we will see.

Mr. BLUMENAUER. Thank you, Mr. Chairman.

I would like to just dive in a little bit to follow up on what my friend Peter was talking about, and, frankly, the sheriff who was acting like a district attorney with you a little while ago. Have we ever had the ability to force a doctor to stay in a particular plan? Is that sometimes beyond the control of the patient and the doctor in terms of networks?

Ms. TAVENNER. That is correct. Doctors have always had to individually negotiate.

Mr. BLUMENAUER. So we can have a framework, but you are not going to be able to force doctors to stay or insurance companies to keep them. They change all the time, don't they?

Ms. TAVENNER. That is correct.

Mr. BLUMENAUER. And this notion that somehow we would force insurance companies to never change policies. Haven't we seen a third to two-thirds of the individual market change in the course of a year for the typical patient?

Ms. TAVENNER. Absolutely.

Mr. BLUMENAUER. So it is not anything that my friend from the State of Washington, which has 7 million people, arguably at least a million households are either uninsured or in the individual market, that they would see several hundred thousand people every year who would have those individual policies change. Is that not true?

Ms. TAVENNER. That is true. Prior to the Affordable Care Act, what they were assured of is they had to worry about were they going to lose their coverage, what was going to happen with premiums. And they were still going through a churn of at least 50 percent a year. What we have done is we have stabilized the premiums, we no longer allow denial for any preexisting, and we are creating a more competitive market. And Washington is a great example.

Mr. BLUMENAUER. And many of these people who are subject to the churn, it is because they find out that they actually try and use the insurance——

Ms. TAVENNER. That is right.

Mr. BLUMENAUER [continuing]. And they find out, wait a minute, it is great insurance until you get sick, or until you bump up against artificially low caps, or having moving targets as insurance companies do deeper dives about eligibility. Isn't that part of the churn?

Ms. TAVENNER. That is true.

Mr. BLUMENAUER. Is that going to be possible anymore, that people will have limits and get thrown off, that people will be able to go back into the history and throw them off?

Ms. TAVENNER. They will not. They will not be able.

Mr. BLUMENAUER. Mr. Chairman, part of what is I find a little disconcerting is that people are in a never never world where they think that in the past we have been able to force insurance companies to continue to offer, that they have been able to force doctors to be in the networks. And this is entirely consistent with the intent of the Affordable Care Act, is to give them superior insurance without those problems. And I do think that we are not really talking about apples and oranges.

Thank you, Mr. Chairman. I will yield back.

Chairman CAMP. Thank you.

Mr. Gerlach for 3 minutes.

Mr. GERLACH. Thank you, Mr. Chairman.

Thank you for testifying today, Ms. Tavenner.

First, I want to go back to a question raised by Congressman Nunes, who was following up on a question by Chairman Camp about the release of the numbers as the total number of enrollees to date, and you said bottom line you are not going to release those numbers until mid-November. Then in response to Congressman Nunes' question, you specifically said we made a group decision not to do that, not to release them until mid-November. Who was part of that group to make that decision? What were the individuals that were part of that group's decision?

Ms. TAVENNER. I think it was in response to the question was did the Secretary or the White House direct me. And the answer to that was no, this was a group decision. We actually sat down with the Secretary and talked about what would make sense in terms of when we would release.

Mr. GERLACH. So who was the group. That is what I am asking. Individually, who made up that group?

Ms. TAVENNER. These were different components within HHS, different operating divisions. And then obviously we had conversations with White House staff as well.

Mr. GERLACH. Okay. And who was the White House staff you had conversations with?

Ms. TAVENNER. This would be members of the Domestic Policy Council, it could have been members of the budget office.

Mr. GERLACH. Who are their names? Do you recall?

Ms. TAVENNER. No, I don't recall. These were different series of meetings where we had a discussion about this.

Mr. GERLACH. Aware of any memos or email exchanges to that regard between the different component group members?

Ms. TAVENNER. I am not sure, but I am happy to go back and take a look at that.

Mr. GERLACH. Okay. If you can take a look at all of those emails and memos, and if you have those please share those with the committee if you would.

Secondly, in your testimony you indicate that the problems that are being experienced with the Web site is based, quote, "Unfortunately, on a subset of contracts for HealthCare.gov that have not met expectations." Is it the contracts that have not met the expectations or is it the contractors implementing the contracts that have not met expectations?

Ms. TAVENNER. I am not sure which quote you are referring to.

Mr. GERLACH. It is on the bottom of page two of your testimony.

Ms. TAVENNER. Okay. All right.

Mr. GERLACH. Quote, "Unfortunately, a subset of those contracts for HealthCare.gov have not met expectations." So is it the contracts that have not met expectations or was it the specifications of those contracts were not properly developed and properly executed or properly implemented? Or is it the contractors themselves that took a good contract and have not performed properly?

Ms. TAVENNER. So I think that in the case of the FFM site is what I was referring to, and we have been working with the contractor. We have had some issues with timing of delivery.

Mr. GERLACH. Who is that contractor?

Ms. TAVENNER. That contractor is CGI.

Mr. GERLACH. Okay. So it is the contractor in that instance that is not meeting expectations?

Ms. TAVENNER. Yes. But we are working with them.

Mr. GERLACH. Okay. Are there provisions in the contract with that company that if it fails to perform in any substantive way that it is to repay or refund back to the government for funds that you have allocated to it for the purpose of performance?

Ms. TAVENNER. I can get you the details on that.

Mr. GERLACH. Okay. There is also a tech surge underway.

Chairman CAMP. I am afraid time has expired.

Mr. Pascrell is recognized.

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

Despite our Democrats' opposition to Part D 10 years ago, we committed to making the best of the program. And because of all the changes that have occurred on the Part D prescription program, 90 percent of seniors right now are satisfied. And why are they satisfied? Well, in my district, before that vote, I made seniors know that I was going to vote no and oppose, and I told them the two reasons. The gap, the donut hole when you are paying for premiums and you are not getting any benefits. That was horrendous. And number two, an outside source was not sitting down and being the third party to negotiate the prices of prescription drugs.

So it lost. We lost the policy fight. And what did we do? We went back to our districts and we told our seniors, although we voted no, we personally believe and will work with the Bush administration to make it work. That is what we did. And how many of you stood up to do that? None. Zero. Zero.

Let's talk. Let's not water the wine here. Let's say it like it is. You refused to expand, many of these governors, Medicaid, they refused to set up State marketplaces, and leaving millions of dollars

in outreach on the table and education funding. And what happens?

Well, to those I say this, and to you I say this, who I deeply respect, here and off the floor of the committee and off the floor of the House: What are you going to do about the approximately 17 million children with preexisting conditions who can no longer be denied health insurance coverage? You want to go back? You want to say you are no longer covered any longer? You are going to tell the parents of those kids? Which one of you is going to stand up and tell the parents of those children the game is over, sorry, that was just a phase we were going through?

Mr. GRIFFIN. Will the gentleman yield?

Mr. PASCRELL. Yes, I will.

Mr. GRIFFIN. I would just tell you that——

Mr. PASCRELL. Where are you?

Mr. GRIFFIN. Right here. You asked a question, I am going to answer it. It is a false choice to say it is Obamacare or nothing. There are numerous proposals, including the one that I am a cosponsor of that deals with preexisting conditions.

Mr. PASCRELL. Let me take back the time, sir. Let me take the time back. Are you serious, what you just said? Are you really serious? After what we have gone through, after what we have gone through in the last 3½ years? You can sit there and say that you had a legitimate alternative after these years? We have gone through 44 votes, 48 votes now of you trying to dismantle this legislation. You call that cooperation? I don't. I don't call that cooperation.

Mr. GRIFFIN. Will the gentleman yield? You are asking a question.

Chairman CAMP. The gentleman's time has expired.

Dr. Price is recognized.

Mr. PRICE. Thank you, Mr. Chairman.

Welcome, Madam Administrator. I appreciate your testimony today and the work that you are doing. I think the American people are looking in at this hearing and just shaking their heads. I spent over 20 years taking care of patients, and this is about patients. And what we on this side of the aisle want is the highest quality of care for all Americans, a system that is affordable and accessible and provides the greatest number of choices and continues innovation in our health care arena so that folks can have the highest quality of care.

But our belief is firmly, and I think that it is playing out now, is that the ACA violates every one of those principles. That is why we oppose this policy.

There is not enough time, Mr. Chairman, to correct all of the record that has been stated, but here is an article from the New York Post I would like to insert into the record. Elderly New Yorkers are in a panic after getting notices that insurance companies are booting their doctors from the program as a result of the shifting landscape under Obamacare. Quote, "UnitedHealthcare told Dr. Leibowitz that because of 'significant changes and pressures in the health care environment' he would be getting the ax on January 1." Not that they were trying to force him into it, but that he would be getting kicked off the program.

Forcing insurance companies to change their plan? You bet they are. Here is from CareFirst Maryland. An individual sent me this letter. Quote, "The ACA requires you to pick a new plan to maintain coverage because your current plan will cease to exist at the time of your renewal through the ACA."

Chairman CAMP. Without objection, the letters will be in the record.

[The information follows:]

www.chicagotribune.com/news/opinion/editorials/ct-edit-obamacare-1025-jm-20131025,0,3836534.story

chicagotribune.com

Editorial: Now Democrats know what's in Obamacare

Obamacare is faltering under its own bureaucratic weight

5:57 PM CDT, October 24, 2013

advertisement

"We have to pass the bill so that you can find out what is in it ... " then-U.S. House Speaker Nancy Pelosi on Obamacare legislation, March 9, 2010.

Not long after she uttered that infamous phrase, Pelosi got her way. She stampeded House Democrats to vote for a massive, complex Obamacare plan that few lawmakers in either party had time to understand. She and Democratic Senate leaders ramrodded Obamacare without a single Republican vote.

Democratic lawmakers voted for a bill without a clear idea of how well it would work.

Now they know.

Obamacare is faltering under its own bureaucratic weight. Massive computer problems are preventing people from signing up for coverage in the new online marketplaces. Worse, many people who finally manage to log in suffer sticker shock at high insurance premium or deductible prices.

Democrats are breaking ranks. And, predictably, there's a rising cry to fire people who are responsible for the mess, including Health and Human Services Secretary Kathleen Sebelius.

"Somebody's got to man up here, get rid of these people," said Rep. Rick Nolan, D-Minn., who didn't name names but characterized the president's response to the rollout as "weak."

"There are people like myself who supported the Affordable Care Act, but I'm not oblivious to the fact that this layout has done harm and damage to the brand," he said.

The brand? Obamacare's got all the appeal of MySpace, Friendster or BlackBerry now.

On Thursday, government contractors who built the system told a House committee that they did not have enough time to test the system before its debut. We already knew that. The law piled thousands of pages of rules and regulations on employers, individuals, insurers. Those rules were *still flowing* out of the administration even as the exchanges were being readied to open.

Sebelius is set to testify next week. She's saying that President Barack Obama didn't know about the problems with the health insurance website before it went live.

Really? We know Obama's busy, but didn't he see those Government Accountability Office warnings that many technical hurdles needed to be overcome for the system to start on time?

Obama and Sebelius promise a "tech surge" to fix all the computer problems. But as Democrats now see, the problems with the law they passed aren't buried in a thicket of computer code.

•The promise that the law would deliver affordable care? Ask those Chicagoans who face deductibles that are thousands of dollars higher than their current coverage. The sticker shock is nationwide: People in some of the poorest rural areas must choose from some of the nation's highest-priced plans, The New York Times reports.

•The president's oft-repeated promise that you can keep your current coverage if you want to? Insurers are telling many Americans that their existing policies won't be renewed, so they'll have to shop for new ones.

•You can keep your doctors? In some plans insurers cut costs by offering people narrow networks, excluding some of the best physicians and hospitals.

Congress can start to fix this mess by delaying the mandate that everyone have insurance or pay a penalty. As it is now, people

must sign up for insurance by March 31 to avoid penalties.
The feds already have granted a one-year reprieve on the companion mandate that *employers* provide insurance or pay fines. The administration has allowed any number of carve-outs for other special pleaders.
A delay in the *individual* mandate isn't a special break. It's simple fairness.
In the rush to pass Obamacare, Democratic leaders reassured lawmakers that Americans would love it, once they understood it. Alas, we all understand it — better than the lawmakers who enacted it did.

Copyright © 2013 Chicago Tribune Company, LLC

WALL STREET JOURNAL ARTICLE:

WSJ
Federal Health Site Stymied By Lack of Direction
By CHRISTOPHER WEAVER and LOUISE RADNOFSKY

Absence of Single Leader, Disjointed Bureaucracy Tied to Troubles

A team of young policy experts energized by President Barack Obama's health law toiled for three years in a Bethesda, Md., office building to draw up specifications for the federally run insurance marketplace.

Forty miles away at the Centers for Medicare & Medicaid Services' Baltimore headquarters, longtime agency computer experts with different bosses oversaw building the site's software and hardware components.

And in Washington, White House advisers worked to preserve the law

through treacherous politics, sometimes stalling final decisions about the site, HealthCare.gov, to avoid controversy ahead of the 2012 presidential election.

As it becomes clear that no single leader oversaw implementation of the health law's signature online marketplace—a complex software project that would have been difficult under the best circumstances—the accounts of more than a dozen current and former officials show how a disjointed bureaucracy led to the site's disastrous Oct. 1 launch.

Problems persisted Sunday. A federal data hub that verifies the identity and income of people applying for subsidized insurance from 14 state-run exchanges and 36 exchanges run by the federal government failed when the company hosting the hub lost its network connectivity, the administration said.

Divergent agency cultures, political directives that clashed with operational deadlines, a compressed timeline and dispersed geography led to the federal site's technical failures, those people said. The glitches have locked out millions of users, left insurers to sift through flawed data and given new ammunition to Republican detractors of the health law.

A White House official said its experts were involved in policy making and some interagency coordination. They were briefed on the website's development, but relied on the technical team of CMS, as the Medicare and Medicaid agency is known, for operational decisions, the official said.

The administration last week named a single person to fix the exchange, veteran troubleshooter Jeffrey Zients, and a single company, Quality Software Services Inc., a unit of UnitedHealth Group Inc. that already held a contract to build part of the site, to act as general contractor on the effort. Mr. Zients gave the government's first specific estimate for when the site would have most problems

repaired: the end of November.

Key work to create the website was given to CMS, which had experience running a site for Medicare drug plans. But the agency, which is overseen by Health and Human Services Secretary Kathleen Sebelius, had a siloed management structure, and no single unit was designed to pull off a mammoth task like HealthCare.gov.

In one camp were computer experts reporting to a veteran CMS official, Michelle Snyder, who were among the first to recognize the scale of the problems facing the website, current and former officials say, such as errors in the calculation of insurance prices and eligibility determinations.

But a separate policy arm built the road map for what the exchange needed to accomplish, with strained communication with its computer counterparts; that team reported to Gary Cohen, a former California lawyer.

Word of the software problems was slow to reach Mr. Cohen, who testified to Congress on Sept. 19 that the exchange was on track even as the agency's computer experts were working around the clock at a key contractor location to hammer out a host of unanticipated flaws.

Ms. Snyder and Mr. Cohen referred requests for comment to the CMS media office.

In a statement, Julie Bataille, the CMS communications director, said: "The CMS administrator, Marilyn Tavenner is in charge of the agency's implementation of the Affordable Care Act." She said delegating tasks to different arms of the agency is the norm and that "business and infrastructure personnel have been, and continue to, work closely together to ensure improvements are rapidly deployed."

When CMS presented HealthCare.gov to White House officials over

the summer, they displayed a demonstration version of the website composed of screen-shots of the real exchange and overlaid with interactive features.

That version recreated the user interface, but didn't include the underlying mechanics—such as identity verification and eligibility determinations—that have foiled the site's launch. Displaying such versions for demonstration purposes is common in the computer industry. But it left senior officials unaware of the more complicated and ultimately troubled workings of the exchange.

Meanwhile, critical deadlines to begin testing the real system were already slipping by, current and former officials and insurance executives said.

The administration's most senior officials, including President Obama in a Rose Garden address last week, have acknowledged they were unprepared for the depths of the exchange's flaws, which have prompted some Republicans to call for Ms. Sebelius's resignation.

CMS agency didn't respond to specific questions, including about the test version of the website presented to senior officials.

HealthCare.gov is the highest-profile experiment yet in the Obama administration's effort to modernize government by using technology, with the site intended to become a user-friendly pathway to new health insurance options for millions of uninsured Americans.

"This was the president's signature project and no one with the right technology experience was in charge," said Bob Kocher, a former White House aide who helped draft the law.

The outcome—a partially finished product that, despite improvements, has allowed only a trickle of users to enroll—also jeopardizes the core of the health overhaul. Sicker, older consumers

who expect to need health services are more likely to fight through the glitches to sign up for insurance plans, insurers worry. Without enough healthier people to offset their costs, that could drive rates up next year.

"The more time this goes on, it becomes more of an issue for all insurers," said Allan Einboden, chief executive of Scott & White Health Plan in Temple, Texas, which so far has enrolled about 30 exchange customers, most age 50, a potential early sign of trouble.

As the delays continue, congressional Republicans contend the requirement that people obtain coverage or pay a fine, central to the law, should be abandoned for a full year, and the argument is gaining some traction among Democrats.

The Obama administration's management troubles with the site trace to the first days after the law cleared Congress in March 2010, people familiar with the matter say.

That April, a new Health and Human Services agency was formed to oversee the laundry list of health-law provisions affecting private insurance. The new Office of Consumer Information and Insurance Oversight attracted senior state-level officials, former insurance-industry experts and enthusiastic staffers drawn to what appeared to be the center of the health-overhaul push, according to people who worked there.

But the office cycled through four leaders in three years. Mr. Cohen, the current chief, was appointed in August 2012.

Less than a year after its inception, the insurance office was subsumed by CMS in part to protect the new office from congressional budget axes, then wielded by a new Republican House majority, former officials familiar with the matter said.

The combination of the two agencies led to a culture clash as parts of exchange development were assigned to career civil servants in other units of CMS, people from both sides say.

President Obama's advisers, including his most prominent health aide, Jeanne Lambrew, frequently weighed in on regulations and website design carried out by the insurance office, but weren't focused on computer issues, said former White House officials and others familiar with the matter.

Ms. Lambrew didn't respond to requests for comment.

While officials in the insurance office continued drafting the road map for the exchange, computer experts reporting to Ms. Snyder were given oversight of contractors hired to help carry it out. The CMS experts also were given the task of being the so-called systems integrator, an unusual job for the agency, acting as a sort of general contractor to cobble together the components of the site.

Government contractors said the arrangement contributed to confusion over their roles. "It was like building a bridge by starting from both sides of the river," one person familiar with the development said. "You hoped they met in the middle."

The CMS computer arm was charged with setting deadlines for contractors, people familiar with the matter said. These officials were expected to attend meetings called by policy makers to hammer out details of the website specifications, the people said. One person said computer workers skipped some of these sessions altogether. CMS declined to comment on the sessions.

Politics intervened, too, people familiar with the matter said. Key regulations stalled inside the White House Office of Management and Budget for months while the Supreme Court weighed the constitutionality of the law and the president campaigned for re-

election in the 2012 contest.

In one case, a rule governing the design of plans to be sold on the exchange was completed and signed by Ms. Tavenner, the CMS administrator, on May 15, 2012, approved by Ms. Sebelius that Aug. 6 but not released publicly until Nov. 26, three weeks after the election, regulatory records show.

HHS spokeswoman Joanne Peters said many of the law's major regulations were released before November 2012.

As the launch neared, the exchange's managers were increasingly disconnected. By early September, the CMS computer arm had sent personnel to work with contractors at a key site in Herndon, Va., operated by CGI Group Inc., one of the main contractors.

Testing of the system by insurers that had been scheduled for July didn't begin until the third week of September, said people familiar with the development and insurance executives who participated in testing. Dozens of features of the site were behind schedule, they said.

On Oct. 1, nearly three million consumers stormed the site. It crashed as the first wave sought to create accounts.

Mr. PRICE. Thank you, Mr. Chairman.

I have some specific questions I would like to have you answer. When did CMS become aware of the problems with the Web site?

Ms. TAVENNER. I think CMS became aware of the problems within the first week, when we had the volume surge.

Mr. PRICE. CMS didn't have a clue that there was going to be a problem on October 1, when the Web site went live. Is that correct?

Ms. TAVENNER. The problems that we saw in the first week we attributed to volume. Once the volume started to back down——

Mr. PRICE. How about before October 1, was there any sense at all that there were going to be problems with the Web site?

Ms. TAVENNER. No. There are always going to be issues with a new Web site, what I would call the customary glitches that you see, but no, not this.

Mr. PRICE. Did you have any meetings with the White House prior to the rollout date on October 1 to inform them of any problem that you anticipated?

Ms. TAVENNER. No, not of any problems I anticipated. I talked earlier about programs that we decided to delay, the SHOP, the Spanish.

Mr. PRICE. Have you been involved with any conversations with Secretary Sebelius or the administration about delaying the individual mandate?

Ms. TAVENNER. About delaying the individual mandate? No. We have discussed the individual mandate at some degree, but not about delaying it.

Mr. PRICE. There was a hearing last week in Energy and Commerce. CGI, one of the contractors, said that there is hidden source code on the site that says applicants have no reasonable expectation of privacy and that this was due to a decision that CMS made. Did you all make that decision?

Ms. TAVENNER. I will have to get back to you on that. I am not sure what they were talking about in that comment.

Mr. PRICE. Thank you. My time has expired.

Chairman CAMP. Thank you.

Mr. Crowley.

Mr. CROWLEY. Thank you, Mr. Chairman.

Ms. Tavenner, I think you have noticed, and I have lost count at 22, I think you were asked 22 times when the information will be available. Just to clarify for the last time, that information will be available sometime at the end of November. Is that correct?

Ms. TAVENNER. That is what I said, mid-November, many times.

Mr. CROWLEY. I want to make this clear to all my colleagues. The information, so we can be clear, will be available at the end of November. Is that correct?

Ms. TAVENNER. Mid-November.

Mr. CROWLEY. Mid-November. I am sorry. I was a little early. Mid-November. I had to get it straight for myself as well. I appreciate that.

Now, you understand that this is from the same party that attempted to repeal the Affordable Care Act over 40 times? You understand that, don't you?

Ms. TAVENNER. I do understand that.

Mr. CROWLEY. So you understand that repetition is a part of the rote here, that the more you ask it, the more you try to repeal things, maybe you feel better about it, but I wanted to be cognizant of that.

Ms. Tavenner, you mentioned that over 700,000 people have completed the application that then allows them to shop and compare plans with their exact prices and available tax credits. So does that show the system is working even with the problems that you have already started addressing?

Ms. TAVENNER. Yes, sir. The system is working. We would like it to work better, and that is what we have committed to do by the end of November.

Mr. CROWLEY. So really the key measures right now are the interest in the site is so impressive in terms of how many people are beginning to take the first steps of the process to for the first time afford insurance for themselves in this country. Is that correct?

Ms. TAVENNER. That is correct.

Mr. CROWLEY. Ms. Tavenner, you are aware that every Member on that side of the aisle, the Republican side of the aisle, to a person is opposed to the Affordable Care Act?

Ms. TAVENNER. Yes, sir.

Mr. CROWLEY. You don't have to answer the question. I am being a little rhetorical.

Do you understand that they don't want you to succeed? You don't have to answer that question. They shut down the government of the United States of America in an attempt to repeal the Affordable Care Act. It doesn't pass the laugh test that they somehow care about getting this right, or you in your performance as Administrator, of getting this right and making sure that this health care law is enacted properly.

We Democrats are looking for problems to fix. My Republican colleagues, when it comes to this issue of the Affordable Care Act, they are looking for problems to exploit.

We can fix a broken Web site. What we cannot fix are broken ideas and a broken agenda, and that is what they have offered to the American people. I am not asking you to comment. I am just making a rhetorical statement and questions to you. But it is very sad. They have nothing to offer, and therefore they will attack and tear down. It is much easier to tear down the building than to build a building up. And I appreciate the work that you are doing to get this right, to make it work for the American people.

And with that, I yield back the balance of my time.

Chairman CAMP. All right. Thank you.

Mr. Buchanan and then I will go to Mr. Smith. So Mr. Buchanan is recognized.

Mr. BUCHANAN. Thank you, Mr. Chairman.

And welcome, Madam Administrator.

Last week in Florida—I represent a part of Florida, but obviously looking at Florida as the only member of the Ways and Means there—we had over 300,000 people have been notified, some cancellations, some adjustments, they claim, to their thing. That is one carrier, Blue Cross Blue Shield, so it is probably hundreds of thousands more than that. And it seems it is this one group in general,

not just in Florida, but across the country got reported yesterday, I think, which are independent contractors. You might look at a group like realtors, for example, that are self-employed, that they are the most at risk in terms of their insurance or trying to find insurance. They are getting the cancellations.

And then a part of that report, as you probably know or read, is that they have known about it for 3 years, the administration has known about it. Are they going to come forward and just express the concern about this one category, I think it is 16 million people, up to 80 percent are at risk that might lose their insurance?

Ms. TAVENNER. I am not sure what question you are asking.

Mr. BUCHANAN. I am just talking about people that are independent contractors, like realtors, one segment that are getting notices from Blue Cross Blue Shield.

Ms. TAVENNER. Right.

Mr. BUCHANAN. One of the gentleman mentioned from Washington, but in Florida last week we got 300,000 notices from Blue Cross Blue Shield. It seems like it is concentrated on the small business person, you know, someone that is a sole proprietor or an independent contractor.

Ms. TAVENNER. I think the individuals who are getting these notices tend to be small business or individually insured. But I am not aware of realtors or any one group, but I can check into that.

Mr. BUCHANAN. The other thing I wanted to mention, you said that you thought in the last couple, 3 years that rates have moderated. I can just tell you they have been going up 20, 25 percent in my district, in the last 3 years on average. They have got them down somewhat, they have made some adjustments.

The other point I just wanted to mention, I think you said, I am trying to quote what you said, you thought the system is working? Did you say that, that you thought the system, the ACA, is working?

Ms. TAVENNER. I think we have seen a lot of improvements in the ACA, yes, sir.

Mr. BUCHANAN. Let me tell you, it is a public relations nightmare. I hope that you honestly don't feel that you think the system is working. This is just an incredibly bad rollout. There is a lot that needs to be done. I can't imagine how you could think that the system is working.

And my concern is, frankly, with such bad experience, so many people going to the site, trying to get on and get insurance, why would they want to get involved in a product, if they have had such a bad experience up front, I have been in business 30 years, why would you want to get involved in a company or a product that in the next 2 or 3 years, or you have a concern or an issue, that you might get the same treatment where you can't get ahold of anybody?

Ms. TAVENNER. Well, I think if you talk to individuals who have successfully enrolled, they will tell you they are quite satisfied with what they were able to get in terms of pricing and product.

Mr. BUCHANAN. My sense, 70, 80 percent of people have not been able to get through. And I don't know how they can feel good

about moving forward with health care if they can't get even get online to do business.

Chairman CAMP. All right. Mr. Smith is recognized.

Mr. SMITH. Thank you, Mr. Chairman.

And thank you to Administrator Tavenner for sharing your insights here today. And I have heard from many citizens about this transition, and they are seeing higher premiums, higher deductibles, higher copays, and yet we hear that you are saying the premiums are actually going down.

Could you assure some of these Americans that are seeing higher premiums, virtually less coverage than they were previously experiencing, could you assure them that their premiums will be going down over time?

Ms. TAVENNER. So I can tell you that what I said is that compared to CBO estimates the premiums had actually come in about 18 percent less than CBO estimates. The other comment that I made is, if you look at large group insurance, that what we are seeing are some of the lowest trends in terms of premium increases, somewhere between 4 and 5 percent. So I can tell you based on trends, yes, it is coming down.

Mr. SMITH. Now, I have also heard from some citizens who went to the Web site with employer-provided coverage for that employee, but that employee had a family and he wanted to investigate in terms of whether or not in qualifying the exchange for the subsidy, and was virtually unable to do so.

Ms. TAVENNER. So what we have encouraged, there are some complicated families who are always going to need assistance, and that is why we have encouraged the use of the call center. There are some folks that when they complete the application they are going to have some difficult question and they are going to need to work with an in-person assistant. And so that is why the call center exists, and it is available 24/7, and a lot of folks are using it.

Mr. SMITH. The tax credit that you mentioned, basically suggesting that it is a remedy for some of the increased costs through the ACA, is that accurate?

Ms. TAVENNER. I didn't say it was an increased remedy. I said it is assistance to those individuals at lower income levels. If you talk to people about why they don't have health insurance, there are two reasons: they can't afford it and they are embarrassed to admit that they don't have it. So we are trying to help both. We are trying to get information out there that it is available to everyone and we are trying to help them with the cost.

Mr. SMITH. On the dates that you established, the mid-November for the numbers of participants——

Ms. TAVENNER. Yes.

Mr. SMITH [continuing]. Reaching coverage through the Web site, and then also November 30th for other problems being rectified——

Ms. TAVENNER. Yes.

Mr. SMITH [continuing]. How did you arrive at those dates?

Ms. TAVENNER. So we have said all along that we would have information available on enrollment and other metrics after the end of the first month. So the first month closes obviously this Thursday, so we will work with States to put together metrics that

will be available in mid-November. That is something we have talked about for months internally. That was an operations decision.

And then the second question, how we came about identifying the problems in the system and deciding the end of November is actually sitting down and looking at the problems, deciding how long it would take us to correct them, how long it would take for us to add the other issues, which are the issues of SHOP, Spanish, et cetera, and that is how we came up with the end of November. It wasn't just us. We also worked with the technical experts. That is part of the tech surge that you have read about.

Mr. SMITH. All right. Thank you.

Chairman CAMP. Ms. Schwartz is recognized.

Ms. SCHWARTZ. Thank you.

And thank you for this opportunity. And thank you for being here. We didn't talk about it too much, but a bit this morning, but really the purpose of this hearing is to really acknowledge the difficulties and really a deeply troubling initial rollout of the Web site that is supposed to enable all of our constituents and Americans to access health care coverage in these health care marketplaces. And the fact is, and you acknowledged some of this, there have been inexcusable and unacceptable rollout of the launch of this marketplace. And as you know, millions of Americans, and they are in all of our districts, are anxious to obtain the information on the options for affordable coverage with the consumer protections that you have pointed out.

We saw this interest when millions of Americans went online on 1 day, October 1, 2013. And the fact is that the administration really failed these Americans. They really had an experience they should not have had. Americans failed to be able to access the information on these options and to be able to enroll the way they expected to and hoped for.

The administration has failed to properly test the Web site, at least that is the way it has been reported, failed to take action to recognize and fix these problems along the way. And you did in the beginning acknowledge that this initial experience was not a positive one and essentially apologized. So I appreciate that, and I think so do they.

But you also have to acknowledge that that initial experience has actually done some damage to Americans' confidence in this Web site, in the marketplace, and even potentially the options that they would have available to get health coverage. So this is not only an opportunity for millions of uninsured and underinsured Americans to get affordable, meaningful health coverage, but it is also an obligation under law to make sure that this Web site works, because that is the way they are going to find out their options and to be able to enroll.

So, you know, going forward, there can be just no more excuses. We need to hear from you that there is actually a path forward. And you can be as specific and explicit as you possibly can be with us and with the public to help regain our confidence and the public's confidence in the ability of the administration and these subcontractors and contractors to get this right.

We have heard reports of a lack of coordination in implementing these different contracts. Can you speak to—and, again, if you could be specific about this—because I want to be able to go home and to be able to say this is going to work. And it has to work, because that is the way Americans will access this information and be able to sign up. And we all know those people who are underinsured, uninsured, and they are looking for these options.

So you need to give us some more explicit information about how you are going to better implement and better coordinate these contractors to get this right for the American people.

Ms. TAVENNER. And that is the information in my opening statement. We obviously brought on QSSI to serve in the general contractor role. We at CMS have been doing that, which is not unique. CMS tends to oversee most programs. But because of what I consider the failures in the initial rollout, we felt we needed to bring on additional expertise, so we have brought that on in terms of QSSI, which will be accountable to me. Obviously I am accountable for this. So I think that is one of the big things.

The second thing is we have identified two what I will call category issues. One had to do with system performance and speed. So these were actually people who could complete applications and do the work, yet the system was just slow. And we are an impatient society. So we have added capacity and other things to deal with that. And persistent performance. And I have some metrics there.

But on the other side are what I will call the defects, like the sticking in the application, where we are actually going through punch lists. And we are starting, and I hope you have noticed this, to do daily tech blogs, daily tech updates with the press to try to be more transparent about the problems and how we are fixing them so that you see continuous improvement.

Ms. SCHWARTZ. Which we appreciate.

Chairman CAMP. All right. And time has expired, so you will have to supplement anything further.

Ms. SCHWARTZ. It will be helpful to have that. Thank you.

Chairman CAMP. Thank you.

Mr. Paulsen.

Mr. PAULSEN. Thank you, Mr. Chairman.

Ms. Tavenner, thanks for being. I know you have got a tough job.

You know, before October I think much of the public was looking at the whole debate about Obamacare or the Affordable Care Act as some big political heated argument up on Capitol Hill, and, you know, many independent analysts for a long time, many years have been predicting that there are actually going to be higher premiums, these cancellations were going to be coming, you weren't going to be able to keep your doctor or your health insurance even though that was the promise that was laid out by the President in his State of the Union speech a long time ago.

And now these are being confirmed from our constituents. I mean, directly from our constituents we are hearing these stories about these challenges and their own expenses. And I look at Tricia from Bloomington, who contacted me, and she says her rates are going up 30 percent in January, and she has been looking at the exchange options and the available plans, but they are even more

expensive. I have also heard from Susan and Roger who are in Chanhassen. They like the plan they are on, they have been on it for a few years, the rates have been going on previously, but now they are going to go up another 20 percent. And the insurance company notes that a lot of that is due to the regulations associated with the Affordable Care Act. And they have looked at plans on the exchange as well, and they are more expensive, it is not the coverage they want. And they also have concerns about keeping their information private. And they don't qualify for the subsidies that are offered as well.

But let me ask this question, because I want to better understand how the administration came up with the November 30 date or deadline, because that is the new date, the October 1 has been moved to November 30. Jeff Zients has been hired now as kind of leading the effort. He said he has hired a new general contractor, they have a punch list of things to get done. So they have got milestones, testing dates, specific projects that need to get done.

Can you tell us a little bit more about what the administration did to lead to the conclusion that the exchanges now would be ready to go on November 30 and can you provide a list of the punch list items to the committee?

Ms. TAVENNER. So, yes, I can provide a punch list and some of the work that we are doing, that is not a problem, and I can give regular updates to the committee.

But how we came up with the November 30 date is we actually pulled in a team of external experts to take a look at the system, look at the problems, say, is it fixable and how long does it take? So that is the process. So you will see continuous improvement week over week, and we can give you some of those milestones.

Mr. PAULSEN. Okay. So for 3 years we have been preparing for October 1. Now we have got 2 months going into November 30. How do you know the schedule is going to be kept on November 30, and what happens if you miss that date? What happens if you miss November 30?

Ms. TAVENNER. The system is working. It is just not working as smoothly or as consistently as we want. So the system is built. The hub is working. We were able to correct the create account issue, which was a big sticking point in the beginning, and so now we are doing the rest of the fixes and improving system performance.

Mr. PAULSEN. If you could provide a punch list to the committee, I think that would be very helpful as we move forward to the November 30 deadline.

I yield back, Mr. Chairman.

Chairman CAMP. Mr. Marchant.

Mr. MARCHANT. We have reached out to our constituents to find out what they are experiencing trying to comply with the law. These are people that recognize it is the law, they are trying to comply, and they are frustrated.

The first group basically is getting on the Web site, sometimes it is taking hours, sometimes it is taking several days, but they are finally getting on there, and they are finding that they can get care, but that their premiums are raised significantly, sometimes double. That is the first group that we are hearing from.

The second group is a group that is receiving a cancellation from their insurance company. That prompts them to begin to think about it. They begin to think about complying with the law. These are not rebellious people. These are people that really sincerely are trying to comply with the law. And they are finding out that they can't keep their insurance company, they can't keep their doctor, and they genuinely believed the President when he said that they could. And these are people that now are very, very frustrated. They are going through this process. They are very angry, to begin with. Then they are very frustrated. And then they get into a very fearful state, because they are realizing that they have been told that the Web site will be up and running by November the 30th, but they are also confusing—maybe they are confusing the date that they must be signed up by December the 15th to have their policy go into effect on January the 1st. And most of them are experiencing some fear that they are going to genuinely have a gap in their service; regardless of the prices and the conditions, that they are going to have a gap in their service. And I think that is something you should really be concerned about, that there is going to be a huge gap.

The last group that I am hearing from, in Texas, we have worked for years to come up with a high risk pool, and we have a group of people that are not on Medicare, they are not on Medicaid, they are uninsurable, they have chronic illnesses, and they are very vulnerable.

Is there some effort being made by your organization to reach out specifically to those State high risk pools and give them some additional assistance and pay some close attention to that group? Because that group in many instances is the most vulnerable of any group in America.

Ms. TAVENNER. Yes. And let me remind you, this is the group that in previous years, before the Affordable Care Act, would have had no options, and now they are insurable. And these are folks that we are reaching out to. We are running the high risk pools in many States, but we also coordinate that with States who are running their own to help them transfer into——

Mr. MARCHANT. But in my——

Chairman CAMP. All right. Time has expired.

Mr. Davis.

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

Thank you very much for being here and answering our questions.

In Illinois, quite frankly, the launch has gone extremely well. As of October the 21st, almost 300,000 unique visitors had gone to get covered at Illinois.gov, with 132,344 visitors participating in the plan comparison screener on the Web site. Over 8,000 people called the Get Covered call center since its launch. The Medicaid expansion has been a huge success, as evidenced by approximately 100,000 people signing up for CountyCare prior to the October 1 launch date. This is a special waiver through which residents of Cook County can enroll early and start receiving health coverage in 2013 through Cook County facilities. In January, they will be rolled over into the regular Medicaid program.

Another innovative program in Illinois was an express enrollment process for SNAP recipients. In August, the State of Illinois sent a notice to about 123,000 SNAP recipients, that is, households with single adults, not disabled, offering them an option for express enrollment in the newly eligible group by signing and returning a form. As of October the 21st, the State had received about 46,000 of those forms back and about 26,000 people have been enrolled, and they are in the process of enrolling the rest.

Finally, the State has launched a new smart online application system called ABE.Illinois.gov, Application for Benefit Eligibility. The new site was launched October the 1st, and the Web site has been functioning smoothly. The most recent data shows that 47,766 accounts have been created on ABE, and 28,729 applications have been submitted for processing.

And we looked at how our newspapers have expressed their analysis of what was taking place. The Northwest Herald reported that through only 2 days, Get Covered Illinois had more than 230,000 visitors and nearly 800,000 page views with more than 5,000 applications. The Associated Press stated that Chicago hair stylist and bartender Mike Leon called the Federal call center after he tried the Federal Web site 5 days in a row and couldn't get it to work. The call center staff helped him, and he got through in 2 minutes. So our experiences have been perhaps different.

I thank you very much and yield back.

Chairman CAMP. All right. Thank you.

Ms. Black is recognized.

Mrs. BLACK. Thank you, Mr. Chairman.

And thank you, Ms. Tavenner, for being here today.

I want to go back to what Dr. Price said. This is really is about patients. And as a caregiver for over 40 years, I certainly know and have heard from my patients over the years about preexisting conditions. And I do think that we probably could have fixed that without having a total government takeover, as we are seeing here. It is not about politics, it is about patients.

And I want to go to something from my State. Since the October 1 launch date, I have received overwhelming number of stories from my constituents with concerns about the health care law. In fact, in my own hometown newspaper, The Tennessean, they reported that more than 28,000 Tennesseans are now losing access to the State-sponsored insurance program, which covered those with preexisting conditions, seniors, children, and small businesses. And one small business owner, Greg, from my district in Fairfield Glade, shared this story with me, and I want to share it with the committee: Diane, I operate a small painting business, and was very happy with the Cover Tennessee program for small businesses and their employees. It had a small copay and covered up to $25,000 each year. It covered 12 doctors visits and an annual physical at a reasonable cost. And this program is being cancelled effective January 2014 because it does not meet the minimum requirements of Obamacare. This directly contradicts the promise made by President Obama that we could keep our existing program.

They had affordable health care that they liked, but they didn't get to keep that. And I ask, is this right or is this just for this group of people? These 28,000 citizens of Tennessee are now forced

to find new coverage plans on the health care Web site that doesn't work. So I think when we talk about fairness and justice, we have got to remember, there are people out there that this is not fair and this is not just for.

But let me turn to another piece, and that is the implementation. We understand that the contractors who made the Web site did their own unit testing, but CMS was responsible for the end-to-end testing, or the system's integrated testing, making sure that each unit worked properly with the next unit. Now, that testing failed. And every contractor has said that CMS made that decision to move forward with the launching of the Web site. And you claim that you didn't know that there were surge problems with the Web site. But CMS is the project manager on this and CMS called the shots. So either there was incompetent management on your part or CMS' part, those that you work with, or you ignored those fundamental concepts that were taken into account when the Web site of this complexity and size was built.

I want to know why if sufficient systems integrated testing was not conducted and you made the decision to move forward with the Web site. So was there a systems integration testing that was actually done?

Ms. TAVENNER. So the testing was actually done. We started testing almost immediately. It was kind of continuous testing. I think what you are asking is did we do the testing across the hub and all the agencies——

Mrs. BLACK. That is right.

Ms. TAVENNER [continuing]. And the answer to that is yes. And so that was done. And then the question inside the FFM, did we do end-to-end testing in the FFM, and the answer to that is yes, that was done.

Mrs. BLACK. Okay. So those tests were done, stress tests, load tests, how you accounted for and tested for peak hours?

Ms. TAVENNER. Yes. So stress testing and load testing were done. In retrospect, the volume was we were projecting about three times the volume that we ever saw on the Medicare Part D experience, because we were dealing with a much smaller population. So in the first few hours of the site it had probably five times the volume that we ever projected. So in retrospect, we could have done more about load testing.

Mrs. BLACK. Mr. Chairman, I want to know if we can get a copy of those tests so that we can actually see what was done.

Chairman CAMP. If you can make those results available to the committee, we would appreciate it.

Ms. TAVENNER. [Nonverbal response.]

Mrs. BLACK. Thank you.

Chairman CAMP. Thank you.

And Mr. Young is recognized.

Mr. YOUNG. Thank you, Mr. Chairman.

And thanks so much for being here, Ms. Tavenner.

Ms. Tavenner, as a former project manager and management consultant, I am perplexed as to the genesis of some of these problems with respect to the Web site and the broader rollout, and so I would like to explore with you maybe what the problems were.

Let me step back and talk about the issue of openness and transparency. It was CBS News that last week reported that as we went into the summer of 2012 there were certain key regulations that contractors were waiting on, they had to be issued in order for them to continue to do their work, put forward requirements for their IT systems and put together HealthCare.gov. Could we put up a slide, please, to illustrate some of the regulatory issuance pattern?

[Slide]

Mr. YOUNG. We see that over the couple of years preceding the summer of 2012, we had 109 proposed regulations put forward by HHS. Then starting in the summer before the Presidential election we had zero regulations, all the way through the election. And since that time period we have seen 60 regulations put forward by HHS.

So my question to you, Ms. Tavenner, is that—and CBS News did indicate that some of the rules were ready to go back in June or July, according to one insider that they quoted in their report—so why did HHS stop issuing regulations, as the person on the inside, the so-called quarterback of this Web site?

Ms. TAVENNER. So the regulation process, I don't know that at any point we stopped issuing regulations. As you can see, it has been a continuous process. The regulations, we were basically——

Mr. YOUNG. But there was a gap you see right up there.

Ms. TAVENNER. I do see that gap.

Mr. YOUNG. How do account for that?

Ms. TAVENNER. That is like a 2-month gap. And I don't know that that would be unusual. If we were to go back, and I am happy to go back and map the last 4 years, we have probably had 2-month gaps at other intervals.

Mr. YOUNG. So you think CBS News missed that?

Ms. TAVENNER. No. I don't know what CBS News did. I am just telling you. We have had a continuous regulatory process going on. We have worked with the public. There is obviously a lot of back and forth between us and OMB in the regulation process. It is not unusual for a reg to take 2 months, 4 months, or longer.

Mr. YOUNG. So you can assure us that partisan politics played absolutely no role in that?

Ms. TAVENNER. I think, again, the regulatory process was continuous. At no point were we not either working on white papers, proposed regs——

Mr. YOUNG. Right.

Ms. TAVENNER [continuing]. Just getting the work done.

Mr. YOUNG. As you know, as you have heard here today, there are real consequences to our constituents for the failures and shortcomings of this Web site. You have acknowledged that.

Ms. TAVENNER. Let me talk to you about the Web site.

Mr. YOUNG. Well, I have got limited time, so I am going to move on.

Ms. TAVENNER. Well, I thought you wanted me to explain the problems with the Web site.

Mr. YOUNG. One of my constituents——

Ms. TAVENNER. Do you want me to explain the problems with the Web site?

Mr. YOUNG. Submit supplemental material.

Ms. TAVENNER. First of all, I would just say it is not a Web site, it is an insurance program. Okay?

Mr. YOUNG. Okay.

Ms. TAVENNER. And sometimes I think we think it is like a Web site.

Mr. YOUNG. Right.

Ms. TAVENNER. Web site just, like, looks at things.

Mr. YOUNG. Right.

Ms. TAVENNER. This is a complicated program tied to 34 States, including very individualized Medicaid programs. People need to understand.

Mr. YOUNG. Thank you, Ms. Tavenner. I would like to go back to HealthCare.gov, which is the Web site associated with signing up for required government-sanctioned health care. And Marvin, one of my constituents, writes on behalf of his wife, who was told by her insurer that due to health care reform, effective 1/1/14, the policy in the name of said citizen has been or will be terminated as of January 1, 2014.

When can she sign up for her health care, Ms. Tavenner?

Ms. TAVENNER. And does it go on to talk about other policies or just says she is cancelled and that is it?

Mr. YOUNG. It goes on to say she is cancelled.

Ms. TAVENNER. She is eligible and she can sign up for a new plan——

Mr. YOUNG. She needs to sign up through the Web site.

Ms. TAVENNER. She can sign up through the Web site or she can go to that individual issuer.

Chairman CAMP. All right. Time has expired.

Mr. Becerra.

Mr. BECERRA. Thank you, Mr. Chairman.

Ms. Tavenner, thank you very much. Appreciate you being here. And I think it has become very clear, and I hope that in all the hearings that take place further that we understand that we have to work together, because it is unacceptable to have an important part of the health insurance program, this Web site, not work the way it should.

In fact, let me give you a quick example. There is a gentleman from Los Angeles, 34-year-old male, Andrew Stryker, and he had been reported in a number of press reports. He waited 3 hours to try to get on the Web site and finally had a chance to apply, and he says that that was tough. The good news for Mr. Stryker is that he is saving $6,000 as a result of being able to apply for the plan.

So it is unacceptable for anyone to have to wait even 3 hours. And even though he says that he would have waited all day given the result he got, what we want is for everyone to experience the $6,000 savings, maybe not that much, maybe more, but we want them to experience savings and to finally have the health security that you, every single Member on this committee has when it comes to health care. We don't have to worry about going bankrupt if we have to take our child to the doctor or to the hospital. And that is what Andrew Stryker now will have. And so let's fix this Web site. Let's not fixate on the Web site, let's fix the Web site.

Now, if I can have, I will put on the screen the application process.

[Slide]

Mr. BECERRA. Today if you apply for the Affordable Care Act insurance, you have essentially three pages, and the third page is really more a signature page than anything else, to apply to get onto a health insurance policy, a health insurance plan.

If we can have the next slide.

[Slide]

Mr. BECERRA. This is what the process was before the Affordable Care Act. You had some 12, 13 pages that you would have to fill out, many of them asking all sorts of very personal questions, very deep medical probing that was done, from strep throat, allergies, if you have ever suffered that, acne, all the way of course to whether you had cancer, heart disease. You could even be asked if you had learning disabilities.

Now, can you explain why it is that all of a sudden we can go from a 13-or-so-page application that really probes into your personal life to one that is only three pages long?

Ms. TAVENNER. I think as you are well aware, thanks to the changes in the Affordable Care Act, there is no longer the preexisting denial, everyone is entitled to insurance, which was part of the goal.

The other thing that I will say is people may talk about the Affordable Care Act, or Obamacare, but once you get through that and you actually talk to folks about what is going on for them, if they had a child with a preexisting condition, most of them had issues with insurance, they had to go through this complicated process, they like what they are getting now.

Mr. BECERRA. Yeah. So no longer will I get asked if I have heart disease or acne. I can apply and I won't have to worry about what my personal lifestyle is, I will be able to get insurance. And this 13-page application is now history for all those folks who go ahead and apply through the individual insurance market. So what I hope they will do is, again, fix the Web site so we can get to the process of giving folks like Andrew Stryker a $6,000 saving.

Chairman CAMP. All right.

Mr. BECERRA. Thank you very much. I yield back.

Chairman CAMP. Mr. Griffin and then Mr. Schock.

Mr. GRIFFIN. Thank you, Mr. Chairman.

Thank you so much for being here. I have heard a lot of good things about your work from Leader Cantor, Eric Cantor. So thank you for being here, and I wish you well.

I first wanted to say that as I tried to indicate earlier, it is really a false choice to say it is Obamacare or all the things that were never fixed in the health care world have to continue. There are many different options in between there. I have signed on to legislation that would also deal with preexisting conditions.

So I just want to make clear to the public, to imply that you have to take all of what Obamacare delivers to get to address preexisting conditions or you get none of that addressed, that is just not true. And we can have that debate.

I have heard from a lot of Arkansans. I want to read a message I got via Web site from a constituent. Her name is Jennifer in Lit-

tle Rock. She says, quote, "I am an Arkansas State employee, government worker. We received a newsletter from the Employee Benefits Division during open enrollment. Our insurance covers less now and costs more. It says, 'These changes were made to more closely align the plans with the Affordable Care Act.'" And in another sentence, quote, "Because of this, the value of the plans were lowered to be more in line with the law," end quote. "I am quite disgusted. Just because the Federal Government is starting a health insurance marketplace doesn't mean that my coverage needs to change, but it has, and it has changed for the worse. If you need a copy of this newsletter, please let me know. Thank you for working on this problem." I have a copy of the newsletter here.

So there are a lot of people that tell that story, and I have pages of it. Yes, there are people that are getting covered because of preexisting conditions. My point is, you don't have to do it this way. And that is why a lot of us continue to have a problem with the law. Yes, we have voted 43 times or so, but what the talking points don't tell you is seven of those votes became law because the President agreed to those things. So the idea that we have had the same exact vote 44 times is talking point nonsense.

But I guess what I would ask you is, are these increased premiums and increased copays, is that just the cost of providing more access to health care? What do I say to people who ask, why am I paying more? Do I just tell them, hey, that is a tax? We didn't call it a tax, but that is a tax you got to pay so that more folks have access. Is that fair? Is that what it is really?

Ms. TAVENNER. What I would say to those folks is it is going to depend on their individual, you know, situation, because if they are in a group market where they already had group employer-sponsored insurance, that is a different situation. If they are in an individual market, what you can say to them now is they now have access to health care and they now have a competitive market.

Mr. GRIFFIN. So if you are paying——

Chairman CAMP. All right. Time has expired.

Mr. Schock.

Mr. GRIFFIN. I appreciate you. Thank you.

Mr. SCHOCK. Thank you. With all this discussion about Web sites that don't work, let's talk about a Web site that does. On WhiteHouse.gov right now, if you go to WhiteHouse.gov, "Health Insurance Reform Reality Check." Headline: You can keep your health insurance if you like it. Currently on the Web site. Linda Douglass of the White House Office of Health Reform debunks the myth that reform will force you out of your insurance plan if you like it, force you to change doctors, period. To the contrary, reform will expand your choices, not eliminate them.

WhiteHouse.gov then cites three sources to substantiate their claim. One of them is a blog post by Linda Douglass, one of them is a video of a press conference that the President gave in July, and one of them is a teletownhall hosted by AARP. And if you click on them, interestingly, the first question that the President was asked at the teletownhall came from a woman named Margaret in Greeley, Colorado, and she says, "Mr. President, I have heard I could lose the health insurance that I have currently." And the President says to that question, and I am quoting: "Here is a guarantee that

I have made: If you have insurance that you like, then you will be able to keep that insurance, period." That is on WhiteHouse.gov Web site today. "Reality Check," is their headline, "on Health Insurance Reform."

Let me tell you, Ms. Tavenner, the reality check that millions of Americans in my district are getting. Michelle York from Triple Digit Trucking in Jacksonville, Illinois, just sent me this letter today, and it is from Blue Cross Blue Shield. "All plans must be compliant with the new health care law. Therefore, Blue Cross Blue Shield health insurance plan that you currently have now will no longer be available after December 31. Your premiums will go from $474 to $865, effective January 1, a nearly 100 percent increase."

She writes to me, Ms. Tavenner, "I do not understand how my current policy can legally be cancelled since I am already doing what I am supposed to do." What am I supposed to say to Ms. York in Jacksonville, Illinois?

Ms. TAVENNER. The first thing I would do is I would encourage her to go talk to the Web site or go to the call center and see what is available in the market.

Mr. SCHOCK. So wait a minute. She is told by the President, the WhiteHouse.gov today says if you have health insurance that you like, you will be able to keep it. She has health insurance that she likes, she has been paying her premiums, she wants to keep it, but she can't. Isn't that a lie?

Ms. TAVENNER. You know, there has always been the issue where issuers had the ability to stop offering a policy or change a policy.

Mr. SCHOCK. No, this is the not the issuers wanting to stop to offer a policy. The issuer is saying we are being mandated that we can't continue to offer this policy. It is a yes-or-no question. The WhiteHouse.gov Web site says if you want to keep the health insurance that you have got, you can keep it, and now they are being told they can't. That is a lie.

Ms. TAVENNER. Those issuers were grandfathered in, in 2010, and they are choosing to make a different decision now.

Chairman CAMP. All right.

Mr. Kind.

Mr. KIND. Thank you, Mr. Chairman.

Ms. Tavenner, thank you so much for your patience and your indulgence here today. Let me ask you to end on a high note, shall we speak. I think all the questions surrounding the ACA Web site have been asked and answered and exhausted. I know Secretary Sebelius will be here again tomorrow answering a lot of the same questions you just had. But really the key to all this, what we are trying to do is make sure that all Americans have access to quality affordable health care coverage in their life, period. There may be different ways of doing it and that, but the real key is affordable. What can we do to help bend the cost curve within the health care system so it is more affordable for all Americans.

Cost containment. You have been given a lot of tools under the Affordable Care Act for cost containment, trying to get better value, good quality of care at a much better price. What are you seeing

out there right now in that regard and whether or not it is sustainable in the future?

Ms. TAVENNER. That is a great question. What we have seen in our early work with the Innovation Center, and obviously chiefly targeted at the Medicare population, is the more we tie quality and outcomes to payment, the better results we are getting for the individual and the lower the cost trend. We have had probably 3 years of the lowest cost trend in Medicare that we have seen in the last 50 years. That doesn't mean that we don't have to keep fighting it every day. We also work with issuers on the private side so that they align their quality programs and their indicators the same as we so that the trend is just not a Medicare trend, it is across the entire environment.

Early success encouraging; a lot of work to do.

Mr. KIND. Yeah. I see recent data just came out about per-beneficiary costs for Medicare being revised downward yet again, and really that is going to be the key to our long-term unfunded liabilities that we are facing that are driving these budget deficits, these rising health care costs. I think there is a lot that is going.

And, Mr. Chairman, I would respectfully recommend that at some future hearing we call Ms. Tavenner back, mainly focused on cost containment within the health care system, so we can delve into it in greater detail. I yield back.

Chairman CAMP. I am sure she will be anxious to come back.

We have two more, Mr. Reed and then Mr. Kelly.

Mr. Reed.

Mr. REED. Thank you, Mr. Chairman.

And thank you, Ms. Tavenner. And we have worked together before, and I appreciate that relationship. And you have demonstrated to me in that relationship in those prior dealings a very high level of competence. And I have been listening to your testimony today, and I really want to focus on my oversight responsibilities on this committee.

You had indicated to Mr. Buchanan, Ms. Tavenner, that you were not aware prior to October 1 of any problems with the Web site. Did I misinterpret your response to Mr. Buchanan's question?

Ms. TAVENNER. No. We had tested the Web site and we were comfortable with its performance. Now, like I said, we knew all along that there would be, as with any new Web site, some individual glitches we would have to work out. But the volume issue and the creation of account issues was not anticipated and obviously took us by surprise and did not show up in testing.

Mr. REED. So that didn't show up in testing. So when I read the New York Times article that talked about confidential progress reports from Health and Human Services Department showing senior officials repeatedly expressed doubts that the computer systems for the Federal exchange would be ready on time, blaming delayed regulations, a lack of resources, and other factors, is that New York Times report inaccurate?

Ms. TAVENNER. We were working in a compressed time frame for sure, but how we chose to resolve some of that is some of the things that we delayed, the programs that we delayed, which I have been through, SHOP, Medicare account, transfer, Spanish, there were three or four programs that we said, okay, we will not

be able to adequately test those. We went through testing on the remainder of the Web site. We also had independent validation. Obviously your initial testing, you find areas, you correct them, you improve, but we went through the testing process.

Mr. REED. And I appreciate that. So you made some determinations to delay and suspend some of the programs.

Ms. TAVENNER. Yes.

Mr. REED. And then you had mentioned that you had done that through a group decision-making process. And then there were some question as to who was involved in that group decision-making process, and you were very hesitant to give any names involved in that group. Do you know the names of the people that were involved in that group?

Ms. TAVENNER. So the program delay recommendations were CMS. We made those recommendations to the Secretary in September. And I think I indicated——

Mr. REED. And then did she unilaterally make that decision to delay it or did she inform the White House of any indication——

Ms. TAVENNER. So I informed White House staff, I informed the Secretary of our decisions, and they supported it.

Mr. REED. Perfect. So who on the White House staff did you inform?

Ms. TAVENNER. I would be glad to get you that information.

Mr. REED. Why can't you give me that information?

Ms. TAVENNER. I am just saying it was staff within the White House. I am happy to get you that information. I just want to give you accurate——

Mr. REED. You don't know the name of the staff member? As you sit here today, you don't know the name of the staff member you directed that to?

Ms. TAVENNER. So I was talking to several staff. I am happy to get you that list.

Mr. REED. Why can't you tell me that name here?

Ms. TAVENNER. Because I would want to give you the entire list, I would want to give the date, I would want to give you correct information. I think that is appropriate, Mr. Chairman.

Chairman CAMP. All right.

Mr. Kelly.

Mr. KELLY. Thank you, Mr. Chairman.

Ms. Tavenner, thanks for being here. I know you have a great deal of experience in the private sector. You have done things. And I know we have had a lot of talk about how it is not working, but this failure to launch is really troubling to me, and it is all about the process. So my question, who is in charge of this? Was it you?

Ms. TAVENNER. Yes. I am in charge of the program.

Mr. KELLY. All right. So there is a little saying out there, you have got to inspect what you expect. Were there any expectations at all? Because we keep hearing that we just didn't expect this level, we didn't expect this level of volume. It is incredible for me to sit back and understand that that is possibly the case.

I think this was designed for failure from the beginning, and I tell you why I think that. It was never achieved to achieve success. It just wasn't. And if you are telling me the process, the bid proc-

ess, the people that got the final bid to build this site, there is no bid process, right?

Ms. TAVENNER. There was a bid process, yes.

Mr. KELLY. All right. So they competed against other people to get this bid?

Ms. TAVENNER. Yes.

Mr. KELLY. All right. Is there a performance bond included in that?

Ms. TAVENNER. Yes, I am sure there is, but I need to check on that.

Mr. KELLY. Okay. Well, I want to get an answer to that, because to my knowledge there was absolutely no performance bond.

Ms. TAVENNER. And I am not the contracting specialist.

Mr. KELLY. No, no, no, no, no. Well, but you are in charge of it. You have got to have oversight. And I am deeply disturbed that we are talking about a site that started off with an expectation of cost. It has gone way off the charts, and there is no concern about that. Right? This is not about health care. This is about a Web site that from the very beginning, after 3 years and all this investment, we still can't get up and onto it. And if I asked you a question, who is in charge, and you say you are, I am expecting to get answers from you as to who actually was there, how did these people get the bid, were they held accountable for their lack of performance, and is there a performance bond in there that allows the American people to recover some of their money, because not one penny came from the government, it came out of taxpayers' pockets.

Ms. TAVENNER. So I am happy to get you that information.

Mr. KELLY. Well, I got to tell you, and again, this has nothing to do with you. These cost overruns are off the chart, and the idea that somehow there is an answer in the future is unacceptable. We have driven the gap between what the American people expect, and what they expect do now expect is so little from the government.

You know, my little town of Butler, Pennsylvania, they had a bid for police cars. Do you know part of that bid was a 10 percent bid bond, performance bond that was included? I can't understand how a little town that has a $7.8 or $7.9 million budget can ask for those types of guarantees from bidders, responsible bidders, and the United States Government cannot.

And the cost of this, if it is actually true, and I want to get to the bottom of it, if it really started off and you expected somewhere around $100 million to be spent, and it is now up over $600 million and that doesn't include any of the other rollout costs, can we actually sit here and talk to the American people with any degree of confidence and saying, we have got your best interests at heart here. We have also got your wallets, and we are going to drain them.

This is an absolute incredible, incredible lack of efficiency and responsibility on behalf of the administration, and it doesn't surprise me. This is the way they operate with every single thing. And I can't believe that everybody is finding this out because of what they read in the newspaper. If you read the model, if you had the model, if you had the tests going, you couldn't possibly sit here today and say it is going exactly the way we expected.

Chairman CAMP. All right. Thank you. Time has expired.

As a reminder, any member wishing to submit a question for the record will have 14 days to do so. And if any members submit questions at this hearing, I would ask that the administrator respond in writing in a timely manner.

Chairman CAMP. Again, I want to thank Administrator Tavenner for her testimony today, and appreciate your continued assistance as we answer some of the questions that were raised at this hearing. And I appreciate your offer of regular updates as we move forward.

With that, this committee is adjourned.

[Whereupon, at 12:56 p.m., the committee was adjourned.]