

THE AFFORDABLE CARE ACT ON SHAKY GROUND: OUTLOOK AND OVERSIGHT

HEARING
BEFORE THE
SUBCOMMITTEE ON HEALTH
AND THE
SUBCOMMITTEE ON OVERSIGHT AND
INVESTIGATIONS
OF THE
COMMITTEE ON ENERGY AND
COMMERCE
HOUSE OF REPRESENTATIVES
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¹ Mr. Slavitt did not respond to questions for the record.

² Available at: <http://docs.house.gov/meetings/IF/IF02/20160914/105306/HHRG-114-IF02-20160914-SD003.pdf>.

THE AFFORDABLE CARE ACT ON SHAKY GROUND: OUTLOOK AND OVERSIGHT

WEDNESDAY, SEPTEMBER 14, 2016

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
JOINT WITH THE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 10:00 a.m., in room 210 Capitol Visitor Center, Hon. Joe Pitts (chairman of the subcommittee) presiding.

Members present: Representatives Pitts, Barton, Guthrie, Shimkus, Murphy, Blackburn, McMorris Rodgers, Lance, McKinley, Griffith, Bilirakis, Long, Ellmers, Bucshon, Flores, Brooks, Mullin, Hudson, Collins, Barton, Upton (ex officio), Green, Engel, Schakowsky, Castor, Matsui, Tonko, Yarmuth, Schrader, Kennedy, Cardenas, and Pallone (ex officio).

Staff present: Gary Andres, Staff Director; Jennifer Barblan, Counsel, Oversight & Investigations; Elena Brennan, Staff Assistant; Adam Buckalew, Professional Staff, Health; Rebecca Card, Assistant Press Secretary; Karen Christian, General Counsel; Ryan Coble, Detailee, Oversight & Investigations; Paige Decker, Executive Assistant; Paul Edattel, Chief Counsel, Health; Emily Felder, Counsel, Oversight & Investigations; Jay Gulshen, Legislative Clerk; Brittany Havens, Professional Staff, Oversight & Investigations; Charles Ingebretson, Chief Counsel, Oversight & Investigations; Emily Martin, Counsel, Oversight & Investigations; Chris Sarley, Policy Coordinator, Environment & Economy; Jennifer Sherman, Press Secretary; Adrianna Simonelli, Prof. Staff Member, Health; Heidi Stirrup, Health Policy Coordinator; Luke Wallwork, Staff Assistant; Gregory Watson, Legislative Clerk, Communications and Technology; Jean Woodrow, Director, Information Technology; Jeff Carroll, Minority Staff Director; Ryan Gottschall, Minority GAO Detailee; Tiffany Guarascio, Minority Deputy Staff Director and Chief Health Advisor; Chris Knauer, Minority Oversight Staff Director; Elizabeth Letter, Minority Professional Staff Member; Miles Lichtman, Minority Staff Assistant; Dan Miller, Minority Staff Assistant; Rachel Pryor, Minority Health Policy Advisor; Samantha Satchell, Minority Policy Analyst; Arielle Woronoff, Minority Health Counsel; and C.J. Young, Minority Press Secretary.

OPENING STATEMENT OF HON. JOSEPH R. PITTS, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. PITTS. The subcommittee will come to order. The chair will recognize himself for an opening statement. Today's hearing is especially timely as we learn startling news over the summer, confirming our worst fears that some of the most significant health insurers—United Health, Aetna, Humana—are opting out of the Affordable Care Act's health insurance exchanges. This is concerning on several levels, the most basic being for individuals who are paying more only to get less.

One of the most ambitious aspects of the Affordable Care Act, the ACA, was the creation of the health insurance marketplaces. Proponents of the ACA said it would increase market competition and lead to lower costs for consumers and insurers, but in fact just the opposite has happened. Consumer health insurance options are now more limited and insurers have been driven out of the ACA marketplace. The exchanges have faced numerous problems: lower than expected enrollment with sicker people enrolling; larger, unpredictable operational costs; and insurers leaving the exchanges.

Of particular concern are the persistent vulnerabilities of the application, eligibility, and enrollment processes. Just this week, the Government Accountability Office released two reports detailing the severity of the lack of real safeguards in the exchanges. Of the 18 fictitious applications GAO made for subsidized plans in 2015, 17 received coverage. GAO was initially 15 for 15 in 2016, with one fictitious applicant enrolling in three different states at the same time.

Also of interest, Section 1322 of the ACA established the Consumer Operated and Oriented Plan, CO-OP program, but these too are failing, one as recently as Tuesday, and disrupting coverage for thousands of enrollees. CO-OPs were set up to increase competition, but instead of the original 23 CO-OPs funded with 2.3 billion taxpayer dollars only six are still in existence, further reducing coverage for thousands of people in the middle of the plan year, resulting in higher out-of-pocket costs and changing doctors.

Our Oversight and Investigations Committee has conducted critical work in this area as well as on the functionality of state-based exchanges. The staff reports we will review today are thorough and provide a sad reminder of the failed promises this misguided law delivers.

We have before our committees today some of the very officials who can answer our questions surrounding these troubling reports: the acting CMS administrator, the HHS OIG deputy inspector general for Audit Services, and the Government Accountability Office.

I look forward to hearing about the oversight work conducted by the GAO and HHS OIG, as well as the steps taken by CMS to improve the exchange risks and CO-OP programs. The chair now recognizes the ranking member of the Health subcommittee, Mr. Green, 5 minutes for his opening statement.

[The prepared statement of Mr. Pitts follows:]

PREPARED STATEMENT OF HON. JOSEPH R. PITTS

Today's hearing is especially timely as we learned startling news over the summer, confirming our worst fears, that some of the most significant health insurers—UnitedHealth, Aetna, Humana—are opting out of Obamacare's health insurance exchanges. This is concerning on several levels—the most basic being for individuals who are paying more only to get less.

One of the most ambitious aspects of the Affordable Care Act (ACA) was the creation of the health insurance marketplaces. Proponents of the ACA said it would increase market competition and lead to lower costs for consumers and insurers. But in fact, just the opposite has happened. Consumer health insurance options are now more limited, and insurers have been driven out of the ACA marketplace.

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**OPENING STATEMENT OF HON. GENE GREEN, A
REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS**

Mr. GREEN. Thank you, Mr. Chairman. It is just 6 years since enactment and 3 years since the major reforms of the Affordable Care Act, the ACA, went into effect. The law is delivered on a principal goal of covering millions of previously uninsured Americans. Today, 20 million more people have insurance, health insurance, and the percentage of the uninsured Americans is at an all-time low. This is a historic and dramatic improvement over where we were as a nation before the ACA and should not be undervalued.

All this is achieved in spite of relentless political opposition, constant efforts to undermine and chip away at the law, severe underfunding, and the inherent challenges of launching a stabilizing and new marketplace. As we look at the future of the ACA great opportunities exist to improve the law, but we can't take them unless we move from this bitter partisanship. It is long past time for some to accept the ACA as the law of the land and get back to work on behalf of the American people.

Prior to the Affordable Care Act, the individual health insurance market was deeply broken. People were sold junk plans at high cost, many individuals with preexisting conditions were essentially

locked out of the market altogether and plans could drop you at the moment you got sick, the time when you needed the coverage the most. As a result of the ACA, the newly insured, previously insured are protected from the worst abuses in the industry and the standard for what plans must cover is significantly more robust.

Marketplace premiums are currently 12 to 20 percent lower than the Congressional Budget Office predicted when the ACA was passed. Premiums for 150 million Americans with employer coverage have grown more slowly than before the law was enacted. The marketplace created under the Affordable Care Act is in its relative infancy, but with almost every new market there is an adjustment period in the early years. We saw this when Medicare Advantage and Part D programs were created.

Recent reports of high premium increase and carriers entering and exiting the exchanges have garnered much attention. We have seen similar headlines in years before, but the reality on the ground has yet to reflect the predictions of doom and gloom. Insurers will both enter and exit the marketplace as they navigate the new landscape of millions of new customers and consumer protections.

It is no surprise that companies are adapting at different rates to the market. They compete for business on cost and quality rather than cherry picking customers and denying coverage to people with preexisting conditions. The Affordable Care Act is working; like any law it is not perfect. It would take an earnest effort on the part of Congress and the States and regulators to bring forth solutions that further stabilize the market. This can only be done if we are honest and separate overblown portrayals that don't reflect the facts of the meaningful critiques.

For several reasons 2017 is the unique transition year. One reason is that the programs designed to support the market in the early years are ending and will have a one-time effect on cost. Yet we also see the marketplace risk pool strengthened by robust outreach efforts to the young adults not yet taking advantage of the opportunity to get coverage.

The Department of Health and Human Services, HHS, is also taking steps such as developing new processes to prevent misuse of special enrollment periods and curb abuse of short-term plans that keep healthy customers out of the risk pool.

Nineteen states also need to expand Medicaid. In my district in Texas, and Texas is one of those 19 states, if they expanded Medicaid 50,000 of my constituents would have Medicaid, if the state expanded it. The law was designed on the assumption that all states would, and refusal to do distorts the health care ecosystem.

A recent report from HHS shows that not only does Medicaid expansion have enormous economic benefits for states, but on the average marketplace premiums in expansion states are 7 percent lower than those non-expansion states. The ACA has led to higher consumer satisfaction and lower uninsured rates. Data supports the further stabilization of the marketplace in the future.

It is now time for Congress to put aside partisanship and finally come together and improve the law. The American people are counting on it. And I look forward to hearing from our witnesses, and I thank you, Mr. Chairman, and I yield back my time.

Mr. PITTS. The chair thanks the gentleman and now recognizes the gentleman from Pennsylvania, Dr. Murphy, chair of the O&I Subcommittee, 5 minutes for an opening statement.

OPENING STATEMENT OF HON. TIM MURPHY, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. MURPHY. Thank you, Mr. Chairman. This committee began its investigation of the state-based exchanges in the spring of 2015, and we aimed to examine why the state exchanges failed to correctly and effectively utilize billions in federal grant funding. The committee requested and received documents from the 17 original state exchanges, and over the course of two hearings we heard testimony from state exchanges' leaders and federal officials.

Our investigation found that the Center for Medicare & Medicaid Services, CMS, effectively wasted \$4.6 billion in grants due to excessively careless management and oversight. Disappointingly, and despite the fact that four out of the 17 state exchanges have now closed down, a very small and very inconsequential amount of improperly spent federal dollars have been recouped by CMS.

We were told that state exchanges would be self-sustaining by January 1st, 2015, and afterwards any continued use of federal grant money would be illegal. Yet today every state exchange is still using federal money. Moreover, some state exchanges went so far as to violate federal rules and use Medicaid dollars to pay for unallowable state-based exchange expenses. The details and findings from the committee investigations are outlined in our report that was released yesterday, September 13, 2016.

In addition to the work that we have done on state exchanges, the subcommittee held a hearing last November on the CO-OPs and their costly failures. We examined the factors that contributed to the collapse of now 17 out of 23 CO-OPs, what oversight mechanisms CMS used to monitor the CO-OPs, and the likelihood that the federal government would recoup any of the loans awarded to the failed CO-OPs.

Since the hearing in November, five more CO-OPs have closed leaving only six of the original 23 remaining. And these failed CO-OPs have cost the taxpayers a total of \$1.8 billion. Similar to the state exchanges, the committee's investigation into the CO-OPs found that they were disadvantaged from the start. Rigorous loan agreements, restrictions to obtain outside capital, and flawed premium stabilization programs made financial stability near impossible.

What ultimately contributed to the failure of CO-OPs, however, was CMS mismanagement and ineffective oversight as they failed on numerous occasions to assist the CO-OPs when needed. Recently, HHS OIG released a report which found that the majority of CO-OPs are nearing bankruptcy, making it highly unlikely that the remaining six CO-OPs will pay back any of their loans. This will result in the loss of even more taxpayer money and leaving hundreds of thousands of Americans displaced with insurance coverage. The details and findings from the committee's investigation are outlined in our report that we released yesterday.

While we look forward to a productive dialogue with our witnesses today, I want to note that on behalf of this committee we are deeply troubled by the findings of this investigation. Ultimately, what we are seeing is the Affordable Care Act failing the American people. The objective of the law was to provide health insurance to those who could not afford it, yet these findings prove that the ACA is accomplishing just the opposite.

Hundreds of Americans have been uprooted from their plans and left without any insurance coverage, thousands I should say. Both of the committee reports suggest recommendations for legislative and administrative changes to address the concerns highlighted in the reports. It is my hope then that we are able to have an honest and open conversation about the reality of this legislation and discuss solutions rather than continue to identify its well known problems.

I thank the witnesses for testifying today and look forward to hearing the questions, and with that Mr. Chairman I yield back.
[The prepared statement of Mr. Murphy follows:]

PREPARED STATEMENT OF HON. TIM MURPHY

Today, we are here to examine two failed programs of the Affordable Care Act (ACA): the State-Based Exchanges and the Consumer Oriented and Operated Plans, known as “CO-OPs”. First, I want to highlight and thank the HHS Inspector General and the Government Accountability Office for their continued participation and good work for this Committee. This hearing, as part of the ongoing oversight of the ACA, will specifically focus on the current state of implementation and challenges of the State-Based Exchanges and CO-OPs.

The Committee began its investigation of the State-Based Exchanges in the spring of 2015. We aimed to examine why the state exchanges failed to correctly and effectively utilize billions in federal grant funding. The Committee requested and received documents from the 17 original state exchanges, and over the course of two hearings, heard testimony from state exchange leaders and federal officials.

Our investigation found that the Centers for Medicare & Medicaid Services (CMS) effectively wasted \$4.6 billion in grants due to excessively careless management and oversight. Disappointingly—and despite the fact that four out of 17 state exchanges have closed down—a very small, and very inconsequential, amount of improperly spent federal dollars have been recouped by CMS.

We were told that state exchanges would be self-sustaining by January 1, 2015 and afterwards, any continued use of federal grant money would be illegal. Yet today, every state exchange is still using federal money. Moreover, some state exchanges went so far as to violate federal rules and used Medicaid dollars to pay for unallowable state-based exchange expenses. The details and findings from the Committee’s investigation are outlined in our report that was released yesterday, September 13, 2016.

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What ultimately contributed to the failure of CO-OPs, however, was CMS’ mismanagement and ineffective oversight, as they failed on numerous occasions to assist the CO-OPs when needed. Recently, HHS-OIG released a report which found that the majority of CO-OPs are nearing bankruptcy, making it highly unlikely that the remaining six CO-OPs will pay back their loans. This will result in the loss of even more taxpayer money and leaving hundreds of thousands of Americans dis-

placed with insurance coverage. The details and findings from the Committees' investigation are outlined in our report that was released yesterday, September 13, 2016.

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Today we will hear from CMS' Acting Administrator Andy Slavitt, the Deputy Inspector General for Audit Services at the HHS OIG Ms. Gloria Jarmon, and Director of Audit Services for GAO's Forensic Audit and Investigative Services mission team, Mr. Seto Bagdoyan. I thank the witnesses for testifying today and look forward to hearing answers to our questions.

Mr. PITTS. The chair thanks the gentleman and now recognizes the ranking member of the Oversight and Investigation Committee, Ms. DeGette from Colorado, 5 minutes for opening statement.

OPENING STATEMENT OF HON. DIANA DEGETTE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO

Ms. DEGETTE. Thank you so much, Mr. Chairman. I have been wondering about the Affordable Care Act. Do you know if it covers treatment for *deja vu*, because there seems to be a mass outbreak of that on Capitol Hill when it comes to the ACA. Here are some of the symptoms.

One, between the Health Subcommittee and the Oversight Subcommittee as you heard that I am ranking member of, we have had over 40 hearings on the ACA since it became law in 2010. Two, we have been through 6 years of efforts to repeal and undermine the law. Three, we have seen any number of administration officials, some of whom are sitting here today, interrogated by hostile members of Congress about their work to implement the law. These same officials have been the target of countless letters requesting briefings and documentation of every single aspect of their work.

But despite the hours and hours spent on these efforts, House Republicans have nothing to show for it. Mr. Murphy, my chairman on the Oversight Subcommittee, just mentioned the recent Oversight & Investigations hearings that we have had in our committee. Instead of conducting a good faith review of these issues followed up by targeted, thoughtful bipartisan legislation to improve the law as Congress did on other major pieces of health care legislation like the Medicare Part D program that was passed by the Republican Congress some years ago, this Congress has used its oversight powers to highlight failures over and over again while offering no solutions.

As we just heard from Mr. Murphy we have had two hearings this Congress on the ACA state insurance marketplaces, but again we are going to hear today about how some states struggle to set up exchanges and make them work as efficiently as possible. As you heard, we had a hearing earlier this Congress about the CO-OPs and I am sure we are going to hear today again about the fact

that many CO-OPs, including one in my state of Colorado, have failed or are facing challenges.

This is not news, folks. What would be news is if the majority would actually sit down with us and try to work out some solutions to help more and more Americans get affordable and expansive health care insurance. I am not saying that these issues are not worth congressional attention. But what I am saying is it is time to stop having this kabuki dance over and over again, and it is time to start figuring out how we can fix the Affordable Care Act.

Highlighting solutions or making important course corrections requires a willing Congress and at this point my colleagues on the other side of the aisle don't seem to be willing to admit to the public that the law has actually helped millions of people and it simply needs fixing rather than being repealed.

Now in conversation privately with me, many of my colleagues on the other side of the aisle offer thoughts that perhaps we can work on this together in the next Congress. But in the meantime, all we are doing is having hearing after hearing and wasting a lot of time and money that could be spent giving more insurance to more people on these hearings.

Let me just briefly in the final remaining seconds that I have remind people of what the ACA has done even with the flaws that it has. We have had historic reductions in the number of uninsured people in this country. The CDC reported last week that the uninsured rate is at a historic low, the lowest that we have had in four decades. That is an accomplishment. Since the passage of the ACA, 20 million previously uninsured Americans now have coverage. This includes millions of young adults who can now stay on their parents' plans until age 26.

I just want to interject a personal note here. My daughter Francesca who everybody on this committee knows, she just graduated from college. She is 22 years old. She is also a type 1 diabetic. Francesca just left to go teach in Madrid for a year, to teach English in Madrid for a year, and she is on my insurance. And because of the Affordable Care Act she can't get thrown off of my insurance because she has a preexisting condition or because she is over 21. And furthermore, we were able to get her a year's worth of diabetic supplies before she left for Madrid.

There are thousands of families in the United States who are benefiting in the way my family has, and I am going to fight until the end to make sure that they can keep these benefits and that we can keep expanding it so that every American has high quality health insurance. I yield back.

Mr. PITTS. The chair thanks the gentlelady and now recognizes the Chairman of the full committee, the gentleman from Michigan, Mr. Upton, 5 minutes for an opening statement.

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

Mr. UPTON. Thank you, Mr. Chairman. So in 2009, the American people were promised a new health care system, one that would give patients a one-stop shop to choose a plan that would be affordable. And of course at that time we remember the President saying you will have your choice of a number of plans that offer a few dif-

ferent packages, but every plan would offer an affordable basic package.

So 6 years later the facts tell, I think, a different story. Major health insurers like Aetna, Humana, United fleeing the exchanges, leaving as many as one third of counties and seven entire states with only one carrier. And with New Jersey's collapse this week, 17 CO-OPs have now closed their doors costing taxpayers nearly \$2 billion and resulting in tens of thousands of Americans without a plan. And today, just 12 states are running their own exchange, 12. Premiums are off the charts; competition has dramatically declined; all in all, the everyday patient is left paying for fewer choices.

But every number has a name and each one of these patients indeed have a story to tell. Karen from Lawton, Michigan tells us she pays \$700 for insurance. She and her kids are in the process of choosing between having a home or having health insurance and moving back with her folks. She says because of the Affordable Care Act my insurance has doubled. Please, you have to do something to help me, help the hardworking middle class in this country.

Lisa lives about an hour east of Karen and her kids. She is paying \$744 a month for a plan with a \$3,000 deductible. Before the ACA she paid less than \$300 a month for her family's health care, and my bet is she wishes she had the plan she had before. Greg who lives with his wife of 40 years in Kalamazoo is feeling the pain. He says ACA is a disaster; has been from the start. I think he is right.

When this law was sold to struggling Michiganders and patients across our country, they were promised that as many as 21 million new individuals would get coverage through exchanges by the end of 2016. Sadly, even with the individual and employer mandates, this number is set to come in at about half, simply one reason why House Republicans have offered a better way to help patients get and keep health insurance.

Our solution puts patients first, improves the quality of care, lowers health care costs, restores freedom and flexibility, it also keeps patients on their parents' insurance until they are 26 years old and will not deny coverage based on preexisting conditions. We want to lead the world in cures and treatments, and our plan builds upon this important work outlined in the 21st Century CURES Act to help deliver cures now.

Recent nonpartisan analysis of our reform plan found that solutions would, in fact, lower premiums by 10 to 35 percent, increase access to doctors and boost medical productivity all while cutting the deficit by nearly half a trillion dollars over the next decade. The ambitious plan, one where nobody would be priced out of health care, everyone in Michigan, these three—Karen, Lisa and Greg—and across America deserves access to quality and affordable health care. I yield the balance of my time to the gentlelady from Tennessee.

[The prepared statement of Mr. Upton follows:]

PREPARED STATEMENT OF HON. FRED UPTON

In 2009, the American people were promised a new health care system: one that would give patients a one-stop shop to choose a plan that would be affordable. At the time, the president said, and I quote, "You will have your choice of a number of plans that offer a few different packages, but every plan would offer an affordable, basic package."

Six years later, the facts tell a different story. Major health insurers—like Aetna, Humana, and UnitedHealth—are fleeing the exchanges, leaving as many as one-third of counties and seven entire states with only one carrier. With New Jersey's collapse this week, 17 CO-OPs have now closed their doors, costing taxpayers over \$1.8 billion and resulting in tens of thousands of Americans without a plan. And today, just 12 states are running their own exchange.

Premiums are off the charts. Competition has dramatically declined. All in all, the everyday patient is left paying more for fewer choices. But every number has a name. And each one of these patients has a story to tell.

Take Karen from Lawton, Michigan. She pays \$700 a month for her insurance. Karen and her kids are in the process of choosing between having a home, or having health insurance and moving back in with her parents.

"Because of the Affordable Care Act my insurance has doubled. Please," Karen pleaded, "you have to do something to help the hard working middle class in this country."

Or Lisa, who lives about an hour east of Karen and her kids. She's paying \$744 a month for a plan with a \$3,000 deductible. Before the Affordable Care Act, Lisa paid less than \$300 a month for her family's health care.

Greg, who lives with his wife of 40 years in Kalamazoo, is feeling the pain too. "The ACA is a disaster," Greg said. "has been from the start."

Greg's right. When this law was sold to struggling Michiganders and patients across our country, they were promised that as many as 21 million individuals would get coverage through exchanges by the end of 2016. Sadly, even with the individual and employer mandates, this number is set to come in at about half.

This is simply one reason why House Republicans have offered a better way to help patients get—and keep—health coverage. Our solutions put patients first, improve the quality of care, lower health care costs, and restore freedom and flexibility. It also keeps patients on their parents insurance until they are 26 years old, and will not deny coverage based on pre-existing conditions. We want to lead the world in cures and treatments, and our plan builds upon the important work outlined in the 21st Century Cures Act to help deliver cures now.

A recent non-partisan analysis of our reform plan found that the solutions would lower premiums by 10 to 35 percent, increase access to doctors, and boost medical productivity—all while cutting the deficit by \$481 billion over the next decade.

It's an ambitious plan—one where nobody would be priced out of health care. Everyone in Michigan—Karen, Lisa, Greg—and across America deserves access to quality, affordable health care.

Mrs. BLACKBURN. And thank you, Mr. Chairman, and thank you all for being here to talk with us today. We do look at this plan and we realize that the Affordable Care Act product is unaffordable and that it is indeed on shaky ground as the hearing title reflects.

I will spend some of my time today talking with you about the special enrollment periods. I come from Tennessee. We had TennCare. We know that these special enrollment periods have a tendency to get these programs into trouble. Lack of verification, inappropriate verification, delayed verification, all of a sudden what you do is end up with a plan that is on shaky ground and with out-of-balance risk pools.

So as you look at the imbalance within these, we will want to drill down on that just a little bit. I do have legislation, H.R. 5589, the Plan Verification and Fairness Act that would get to the heart of this issue because it is a problem that worsens every single day. And when you have a SEP where there is not the appropriate oversight or due diligence, then you do end up with the imbalances in these risk pools.

So welcome, we look forward to the hearing, and I yield back.

Mr. PITTS. The chair thanks the gentlelady and now recognizes the ranking member of the full committee, the gentleman from New Jersey, Mr. Pallone, 5 minutes for opening statement.

OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. Thank you, Mr. Chairman. This will be our committee's 10th hearing on the law, the Affordable Care Act, just this Congress, and while I continue to hope that my Republican colleagues will come to their senses and finally hold a hearing to work in a bipartisan way to improve the ACA, unfortunately once again this will not be that day.

It is clear that the GOP just wants to repeal the ACA and continue to point out problems with the health care system in general without proposing any alternatives. And we are here today to discuss four reports on different aspects of the Affordable Care Act, two of which were only made available to staff and the public on Monday.

Now one report by the Office of the Inspector General on the conversion of start-up loans by CO-OPs found that no wrongdoing occurred. The report simply found that the CO-OPs were in compliance with CMS guidance and accounting principles when converting start-up loans.

Another report released by the GAO this month examines health insurance market concentration and competition in 2014 finding that enrollees tend to be concentrated among only a few issuers. However, since this report analyzes data collected prior to the implementation of the ACA's insurance exchanges, it does not shed light on whether the exchanges have affected market concentration. We will also be discussing a report that is a continuation of the GAO's fake shopper investigation in which GAO used fake identities and fake documents to attempt to enroll in coverage through the health insurance marketplaces and Medicaid.

And let me just start by saying that I will continue to be critical of the way the GAO carried out this investigation. It is inconceivable to me that anyone would be skilled enough or motivated enough to try to fraudulently gain health insurance coverage this way, particularly since there is no possible scenario in which an individual could financially gain from gaming the system.

Even if someone were to obtain health insurance with fraudulent information, they would still need to pay premiums and any other out-of-pocket costs associated with their plan to actually get medical services. Nevertheless, for the third year in a row GAO continues with this farce. They created false identities and attempted to enroll in coverage concluding that the system remains vulnerable to fraud.

Republicans have translated this conclusion to mean that this sort of fraudulent enrollment is rampant in the marketplace, and I think to use this deeply flawed GAO report to try to say that people can get so-called free health insurance is utterly ridiculous. In fact, GAO's fake shoppers paid premiums each month and did not seek any health care. This report fails to answer two very impor-

tant questions. Is this a real problem, and if it is how can we fix it? These are questions Democrats are interested in answering, yet once again GAO has not provided CMS with the information and the fake identities it created. This information could help the agency learn from GAO's work and fix potential vulnerabilities in the systems.

Now Democrats care about program integrity and oversight, but once again I suspect this hearing is not about oversight but about headlines. As I have already said, it seems entirely unrealistic that some of the most vulnerable individuals in this country would have the desire, time, money and expertise to fraudulently gain coverage the way GAO did in their study, and GAO's lack of recommendations in this report is very disappointing. We and the Administration rely on GAO for unbiased reports and recommendations, and these fake shoppers provide neither.

Now let me talk about the success of the ACA because Republicans would make you think that the health care system was better off before the ACA. We can't forget that thanks to the ACA, the uninsured rate is at an all-time low, 20 million more people now have health coverage, and the vast majority are satisfied with their coverage. It is important to remember that because of the ACA, Americans now have access to free preventive services, kids can stay on their parents' plan up to 26, and there are no lifetime or annual limits on coverage. Since the enactment of the ACA, the solvency of the Medicare Trust Fund has been extended for 13 years. In addition, unnecessary hospital readmissions in Medicare have fallen for the first time on record, resulting in a hundred thousand fewer readmissions in 2015 alone.

The ACA's marketplaces are new. The ACA's consumer protections are new. As with almost every new law there will be necessary changes and adjustments, but what is different about this law is that we have not been able to make those changes. Instead of working together to make sure the law works for everyone, my colleagues on the other side of the aisle have tried to repeal this law more than 60 times and we have met resistance at every turn.

There are absolutely ways that we can improve upon the ACA's successes, expand access to affordable coverage, and reduce the number of uninsured. Unfortunately, no one on the Republican side wants to improve anything. All we hear from my colleagues on the other side is negativity. My colleague from Tennessee who I love is still talking about TennCare. I don't know how many times I am going to hear about TennCare. I mean, I don't even think TennCare exists anymore. If it does, it is certainly not what it was.

And this is what we get. We just get the constant hearings, efforts to say, oh, everything is terrible, everything stinks, but whenever we have any suggestion from the—I don't hear anything from the other side of the aisle other than, whatever has been proposed and whatever we try to do to change the system and make it better, which truly has been successful, needs to be repealed, needs to be thrown out without any suggestion about any alternative that is meaningful.

So obviously I am not too happy with this hearing today, Mr. Chairman, but nonetheless—

Mr. PITTS. The gentleman's time is expired.

Mr. PALLONE [continuing]. You will continue.

Mr. PITTS. The chair thanks the gentleman for his opening statement. As usual, all the members' written opening statements will be made a part of the record.

At this point I will introduce our panel. We have one panel and I will introduce them in the order of their presentation. First, Mr. Andy Slavitt, acting administrator of the Center for Medicare & Medicaid Services, CMS; Ms. Gloria Jarmon, deputy inspector general for Audit Services in the Office of Audit Services within the Office of Inspector General, U.S. Department of Health and Human Services; and Mr. Seto Bagdoyan, director of the Forensic Audits and Investigative Service for the U.S. Government Accountability Office.

Thank you for coming today. We look forward to your testimony. Your written testimony will be made a part of the record. You will each be recognized for 5 minutes for a summary. You are aware that the committee is holding an investigative hearing, and when doing so has had the practice of taking testimony under oath. Do you have any objection to testifying under oath?

The response is no. The chair then advises you that under the rules of the House and the rules of the committee you are entitled to be advised by counsel. Do you desire to be advised by counsel during your testimony today?

The response is no. In that case, if you would please rise and raise your right hand, I will swear you in.

[Witnesses sworn.]

Mr. PITTS. The response is I do. You are now under oath and subject to the penalties set forth in Title 18 Section 1001 of the United States Code. You may now give a 5 minute summary of your written statement. The chair recognizes Mr. Slavitt for 5 minutes.

STATEMENTS OF ANDY SLAVITT, ACTING ADMINISTRATOR FOR CENTERS FOR MEDICARE & MEDICAID SERVICES; GLORIA JARMON, DEPUTY INSPECTOR GENERAL FOR AUDIT SERVICES, OFFICE OF AUDIT SERVICES, OFFICE OF INSPECTOR GENERAL; AND SETO BAGDOYAN, DIRECTOR OF FORENSIC AUDITS AND INVESTIGATIVE SERVICE, U.S. GOVERNMENT ACCOUNTABILITY OFFICE

STATEMENT OF ANDY SLAVITT

Mr. SLAVITT. Chairman Pitts and Murphy, Ranking Members Green and DeGette, members of the subcommittees, thank you for the invitation to this hearing to discuss the progress we have made as a country under the Affordable Care Act as well as key priorities for improvement.

With the enactment of the law we've taken a significant step together as a nation to provide for the first time access to quality care to all Americans regardless of their health or financial status. For millions of Americans this represents the largest shift in how our health care system works since the creation of Medicare more than 50 years ago.

As you all know well, Medicare which has lifted millions of seniors out of poverty was launched amidst great uncertainty. It has

succeeded by continually evolving to reflect the needs of our seniors, adjusting to cover prescription drugs, new modes of treatment, and payments which support high quality care delivery. I continue to appreciate Congress' leadership on Medicare's latest evolution, MACRA, and hope we can continue to work together to fulfill your vision of a payment program that is focused on affordable, high quality patient care.

Undertaking fundamental change is rarely easy. From the outset, we knew that like Medicare the implementation of the Affordable Care Act would be a multiyear process. As we look to the fourth open enrollment, we are very proud of what we've accomplished so far. More than 20 million people now have coverage because of the law. And at 8.6 percent, the uninsured rate for Americans is the lowest on record.

Let me turn to our priorities. First, CMS is learning from the early years of implementation using data and feedback to refine our policies to build a strong, sustainable marketplace. The recommendations and input of the GAO and OIG who have together conducted over 50 ACA audits have been especially valuable in our efforts to strengthen our processes and controls.

In this vein we've made improvements to the marketplace so that it continues to function properly, predictably, and securely. This has included changes to risk sharing mechanisms, program integrity, and eligibility rules. We are targeting bad actors for using the marketplace inappropriately, and we have significantly increased compliance with documentation requirements. Our mantra is to continually learn and adjust.

Second, we stand ready to work with states to expand Medicaid eligibility and finish the job of covering all Americans. Expanding Medicaid not only helps low income people gain access to care, but helps reduce marketplace premiums for middle income families, and data shows marketplace premiums are about 7 percent lower in states that expand Medicaid.

Third, we know that costs are a critical consideration both for purchasing coverage and for taxpayers. The good news for the vast majority of Americans is that the Affordable Care Act offers important protections to keep coverage affordable. Even if premiums were to rise substantially next year, the vast majority of federal marketplace consumers will still be able to choose a plan for less than \$75 per month.

And the good news for taxpayers is that we've achieved these historic coverage gains at a 25 percent lower cost than the CBO originally projected. And this has also benefited newly covered Americans. Going into 2017, independent experts calculate that marketplace premiums are currently 12 to 20 percent lower than initial predictions. There's no question that as a country more people are paying less, getting more and with greater consumer protections than before the ACA.

But of course any conversation on the cost of health insurance is actually a conversation about the overall cost of care and the value that we get for the money that we spend. At CMS, access and affordability for the 140 million Americans we serve every day is critical. This is why we must work to keep medications affordable, prevent waste and coordinate care, and why we have a special task

force focusing on access to care in rural America, for costs and the lack of competition have long created concerns.

Personally, it's been very rewarding to serve at CMS during a time of so much transformation. For the vast majority of my 25 years in health care it didn't seem possible that we'd ever achieve a real reduction in the uninsured rate or see a time that having a preexisting condition didn't disqualify a person from coverage.

As the marketplace continues to grow and mature, we'll continue to listen, add new capabilities and adapt to best serve American patients and taxpayers. Thank you and I'll be happy to answer any questions.

[The prepared statement of Andy Slavitt follows:]

STATEMENT OF

ANDY SLAVITT
ACTING ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

THE AFFORDABLE CARE ACT

BEFORE THE
UNITED STATES HOUSE COMMITTEE ON
ENERGY & COMMERCE
SUBCOMMITTEE ON HEALTH
AND
SUBCOMMITTEE OVERSIGHT & INVESTIGATIONS

SEPTEMBER 14, 2016

**U.S. House Committee on Energy & Commerce
Subcommittee on Health
and
Subcommittee on Oversight & Investigations
Hearing on
The Affordable Care Act
September 14, 2016**

Chairmen Pitts and Murphy, Ranking Members Green and DeGette, and members of the Subcommittees, thank you for the invitation to discuss the Centers for Medicare & Medicaid Services' (CMS') continuing work to implement the Affordable Care Act and provide consumers with affordable access to high-quality health coverage.

Thanks to the Affordable Care Act, Americans' access to the health insurance market has fundamentally transformed in only a few years. Before the Affordable Care Act, consumers were frequently denied health care coverage or charged exorbitant rates if they had pre-existing conditions. People who managed to find insurance coverage often learned that it would not cover the care that they needed when they became sick—or that insurance companies could cancel their policies entirely. Annual or lifetime limits capped the value of coverage consumers had when they faced serious illness.

Since 2014, for the first time, we have a health insurance system that is providing access to quality care to all Americans regardless of their health or financial status. Millions who were previously denied or unable to afford coverage for chronic conditions or even routine care are now able to get the care they need. Pre-existing conditions no longer preclude individuals from gaining health insurance, and consumers have better access to comprehensive, affordable coverage. Consumers now have the comfort of knowing that if their employment changes or they lose coverage for any reason, they can purchase affordable coverage through the Marketplace—regardless of their personal health history. As of earlier this year, an estimated 20 million more people have coverage because of the law,¹ and at 8.6 percent, the uninsured rate

¹ <https://aspe.hhs.gov/sites/default/files/pdf/187551/ACA2010-2016.pdf>

for Americans is the lowest on record.² We achieved these remarkable results at a lower cost than the Congressional Budget Office (CBO) originally projected, with coverage provisions costing 25 percent less than original estimates.³ And, despite concerns about rate increases, premiums charged by Exchange health plans remain well below what CBO initially predicted. Overall, independent experts calculate that Marketplace premiums are currently 12 percent to 20 percent lower than CBO predicted when the Affordable Care Act was enacted.^{4,5} If rates had come in as CBO predicted, and grown with medical trend, consumers likely would pay more next year than they actually will, even with this year's rate changes.

The changes the Affordable Care Act made to our health system are providing countless Americans with the security that comes from knowing they will have access to health care when they need it. At the same time, this fundamental shift—to a health insurance market that serves all consumers, regardless of their health history—is new for all involved—consumers, insurers, and state regulators, thus requiring all of us to learn from what has worked and build on these successes, while making refinements and adjustments when necessary. Health insurance issuers need to build new business models for the individual market, where they can be successful by providing the care people need and compete on cost and quality.

Many health plans are meeting this challenge with a variety of innovative approaches, with the Marketplace serving as a laboratory for innovations and strategies that are helping us build a better health care system. For example, Blue Cross Blue Shield in Florida closely analyzed its prospective Marketplace customers and learned that those purchasing coverage in the new market differ significantly from the consumers they served in the individual market before the Affordable Care Act. Based on this research, the company was able to tailor plans to meet the needs of different communities, including innovative care delivery through interdisciplinary teams that that focused on improving care for high-risk populations in particular

² <http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201609.pdf>

³ <https://www.cbo.gov/publication/51385>

⁴ <http://kff.org/health-reform/perspective/how-aca-marketplace-premiums-measure-up-to-expectations/>

⁵ <http://healthaffairs.org/blog/2016/07/21/obamacare-premiums-are-lower-than-you-think/>

communities. In Massachusetts, Blue Cross Blue Shield of Massachusetts is using a payment model that pays doctors and clinicians based on the quality, efficiency, and effectiveness of the care they provide. This approach is saving money while giving patients better care than similar patients in other states.⁶

While many issuers have adopted innovative, successful approaches to the significant changes in the market, it is not surprising that others have encountered more challenges. Many companies are adjusting their geographic coverage, provider network, care management, and pricing approach now that they have information about how Marketplace consumers are accessing care. The approaching fourth Marketplace Open Enrollment presents an opportunity to build on what we have learned and put the Marketplace on even stronger footing through a series of major outreach improvements and important policy changes.

Building on Successes in Open Enrollment Four

The Marketplace was designed to make it easy for individuals to comparison shop for health care plans that meet their needs, and research shows that the Marketplace is delivering on this goal. Consumers say they can now access primary care and prescription drugs they could not afford before the Affordable Care Act, and a majority are satisfied with their coverage.⁷ More than 80 percent of consumers selected plans with primary care visits covered below the deductibles, and on average, nearly seven services—beyond preventive services—were covered below deductibles in the HealthCare.gov states in 2015.⁸ J.D. Power and Associates found that consumers who bought coverage through the Marketplace in 2015 generally were more satisfied than those with other types of insurance, including employer coverage.⁹

⁶ <http://www.nejm.org/doi/full/10.1056/NEJMsa1404026>

⁷ <http://www.commonwealthfund.org/publications/issue-briefs/2016/may/aca-tracking-survey-access-to-care-and-satisfaction>

⁸ <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-07-12.html>

⁹ <http://www.jdpower.com/press-releases/2015-health-insurance-marketplace-exchange-shopper-and-re-enrollment-hix-study>

Nonetheless, we know that premium increases are a challenge for families. Fortunately, as the market adjusts, the Marketplace is designed to insulate most consumers from large rate increases. As a result of financial assistance and the ability to shop around, the vast majority of HealthCare.gov consumers could still choose plans for less than \$75 per month even if all plan premiums rose substantially next year.¹⁰ Premium changes typically vary from issuer to issuer and even across plans offered by the same issuer, so the lowest-priced plan one year may not be the lowest-priced plan the next year.

CMS is hard at work preparing for the fourth Marketplace Open Enrollment, beginning on November 1. Earlier this year, we finalized several policy changes and enhancements,¹¹ including provisions to: (1) help consumers with surprise out-of-network costs at in-network facilities; (2) provide consumers with notifications when a provider network changes; (3) give insurance companies the option to offer plans with standardized cost-sharing structures called “simple choice plans”; and (4) in a pilot program, provide a rating on HealthCare.gov of each Qualified Health Plan’s relative network breadth (for example, “basic,” “standard,” or “broad”) or quality rating to support more informed consumer decision-making.

We have learned more about what kinds of outreach are most effective as we seek to reach out to the remaining Americans who are uninsured and eligible to enroll in Marketplace coverage. Our outreach efforts will put a special emphasis on communicating with those Americans who paid the Individual Shared Responsibility Payment for 2015 and on facilitating 26-year-olds’ transitions from their parents’ plans to Marketplace coverage.

We are making it easier for issuers to conduct outreach to young adults moving off their parents’ plans. Specifically, new guidance from the Department of Labor makes clear that the sponsors of employer plans can – and are encouraged to – provide additional information that will help young adults understand their options and enroll in Marketplace coverage as appropriate. Along with issuing new policy guidance, we are strongly encouraging insurers to contact these consumers with targeted information about Marketplace options.

¹⁰ <https://aspe.hhs.gov/sites/default/files/pdf/206741/APTCMarketplace.pdf>

¹¹ <https://www.federalregister.gov/articles/2016/03/08/2016-04439/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2017>

We also are undertaking smarter, more timely, and targeted email and other outreach campaigns. These efforts will complement our successful in-person outreach and assistance programs. Research during the 2016 Open Enrollment showed that young adults are almost twice as likely as older consumers to enroll when they receive an email about Marketplace coverage. During the upcoming Open Enrollment, we will draw on lessons learned this year about the ways to make email outreach more effective.

Additionally, this year we will be able to email consumers with important proactive reminders in near-to-real time if they open accounts to start applying or finish applications to select plans, and we will send each consumer a reminder after selecting a plan to pay their first premiums as the last step to gaining coverage. We've learned that sending an email with the right information, at just the right time, can make a significant difference in whether someone gets covered, and those are lessons we will act on this year.

Policy Changes to Build a Strong Marketplace for the Long-Term

CMS is committed to building a stable, sustainable Marketplace that serves consumers for years to come. One of the most significant things CMS is doing is making adjustments and refinements along the way. With the benefit of three years of data and experiences to analyze and inform our policies, CMS has proposed or taken a number of actions to: (1) better reflect the risk associated with high-cost enrollees; (2) better reflect the risk associated with enrollees who are not enrolled for a full 12 months; (3) strengthen the risk pool; and (4) support issuers in entering the Marketplace and in growing their Marketplace businesses. These actions, coupled with other related improvements already underway, will help to make the Marketplace an even more attractive market for consumers and health plans alike.

Supporting Issuers with High-Cost Enrollees and Updating Risk Adjustment

One of the core tenets of the Affordable Care Act has been that people with pre-existing conditions finally have access to the coverage they need. The law's risk-adjustment program plays an important role in providing issuers both the incentives and the financial support to design products to serve all Americans. By reducing incentives for issuers to design products

that attract a disproportionately healthy risk pool, risk adjustment lets them design products that meet the needs of all consumers, protecting consumers' access to a range of robust options. Based on significant input from all marketplace participants, earlier this year, CMS made a number of changes to improve the stability, predictability, and accuracy of the risk-adjustment program for issuers. These changes include better modeling of costs for preventive services, changes to the data update schedule, and earlier reporting of preliminary risk-adjustment data where available. CMS also recently proposed additional changes in the Proposed Notice of Benefit and Payment Parameters for 2018.¹² We are seeking comment on a number of approaches for addressing the costs of healthier enrollees. Our goal is to update risk-adjustment for all types of enrollees, to ensure that issuers can have confidence in the program as they design products to attract all types of consumers. These proposals could help to bring more certainty into the Marketplace, helping issuers account for the risk of all enrollees, while continuing to ensure that all Americans have access to the care they need.

Strengthening the Marketplace Risk Pool

Along with helping issuers cover enrollees with more serious health needs, we also recognize the importance of balancing the mix of enrollees in the Marketplace risk pool. CMS has undertaken a variety of efforts to help strengthen the risk pool, and is seeking comment on several additional proposed improvements.

Special enrollment periods (SEPs) exist to ensure that people who lose coverage or experience other qualifying events have the opportunity to enroll in coverage. We are committed to making sure that SEPs are available to those who are eligible and are equally committed to avoiding any misuse or abuse of SEPs. In 2016, we took a number of steps to ensure appropriate use of SEPs, such as introducing a confirmation process under which consumers enrolling through common

¹² <https://www.federalregister.gov/articles/2016/09/06/2016-20896/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2018>

SEPs are directed to provide documentation to confirm their eligibility.^{13,14} Recently, we announced that we are planning a pilot to evaluate a pre-enrollment verification process.¹⁵ Our intent in conducting such a pilot would be to evaluate the impact of pre-enrollment verification of SEP eligibility on compliance, enrollment, continuity of coverage, the risk pool, and other outcomes. We continue to seek information on additional steps related to SEP outreach or policy we could take as soon as the 2017 plan year to strengthen the risk pool.

CMS also is reaching out to the small number of consumers enrolled in both Medicare and Health Insurance Marketplace coverage with financial assistance. We are doing this to make sure they end their Marketplace coverage with advance payments of the premium tax credit because they are receiving Minimum Essential Coverage (MEC) Medicare, and thus are not eligible for this financial assistance. In March 2016, we also added a pop-up to the Marketplace application with information about Medicare for Marketplace applicants aged 64 and over, to increase consumer awareness and understanding of the rules regarding Medicare enrollment and eligibility for Marketplace coverage. In summer 2016, CMS began sending email notices to existing Marketplace consumers who will turn age 65 the following month. This notice helps educate consumers about the eligibility rules pertaining to Medicare and Marketplace coverage with financial assistance and potential tax liability, and provides instructions on how and when to end a Marketplace plan with this assistance due to Medicare enrollment.

CMS is seeking information regarding concerns that some health care providers or third party entities may be inappropriately steering their Medicare and Medicaid patients into the individual market in order to receive higher reimbursement rates.¹⁶ CMS's request for information and letters to providers informing them of this announcement focus on situations where patients may be steered away from Medicare or Medicaid benefits, which can, among other concerns, result in

¹³ For more information on SEPs, visit <https://www.healthcare.gov/coverage-outside-open-enrollment/special-enrollment-period/>

¹⁴ See <https://blog.cms.gov/2016/01/19/clarifying-eliminating-and-enforcing-special-enrollment-periods/> and <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-02-24.html>

¹⁵ <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/FAQ-Regarding-Verification-of-SEPs.pdf>

¹⁶ <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2016-Press-releases-items/2016-08-18-2.html>

beneficiaries experiencing disruptions in the continuity and coordination of their care as a result of changes to their network of providers. These actions reflect ongoing efforts by CMS to address possible issues in the Marketplace that could affect the integrity of the programs for both consumers and issuers, and the costs of the individual insurance coverage, while at the same time help ensure patients are enrolled in the right plan for them. CMS also is seeking comments on a coordination of benefits policy that similarly is intended to ensure individuals entitled to Medicare and Medicaid are appropriately enrolled in those programs.¹⁷

Removing Obstacles to Issuer Entrance, Growth, and Innovation

As we look forward, it is clear that the issuers that will be most successful in the long term are likely to be those with innovative approaches to this new Marketplace and its consumers. CMS recently proposed new policies that would give issuers additional flexibility and freedom to offer innovative products and to remove obstacles to issuers growing their businesses and entering more markets.¹⁸ For example, CMS proposed more flexibility for innovation around plan design by issuers, particularly around bronze plan offerings, while still protecting the coverage on which consumers rely. This proposal is intended to help ensure that issuers can offer bronze plans with at least one major service before the deductible, as well as offer high-deductible health plans (that can be paired with health savings accounts) at the bronze level of coverage. Enrollment data from the Federally-facilitated Marketplaces shows that consumers prefer plans that cover and pay for services below the deductibles.

We also have included proposals to give new and growing issuers more flexibility in calculating their medical loss ratios to be more accurately reflective of their experience, and to avoid instances where issuers who are adjusting their individual market or group market portfolios would inadvertently trigger bans on participating in the individual or group market. These measures generally would promote stability in the individual and small group markets, and would encourage issuers to enter or stay in the Marketplaces.

¹⁷ <https://www.federalregister.gov/articles/2016/09/06/2016-20896/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2018>

¹⁸ <https://www.federalregister.gov/articles/2016/09/06/2016-20896/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2018>

Moving Forward

Thanks to the Affordable Care Act, our country's health-insurance system has transformed from one that too often excluded the sick to a system that guarantees access to care for all, regardless of health status. This type of fundamental change rarely is easy, and from the outset, we knew that implementation of the Affordable Care Act would be a multi-year process. Every day we learn more to help us improve our operations and enhance the consumer experience by making the purchasing of health insurance easier and simpler for our customers.

As the Marketplace continues to grow and mature, our most important priorities include studying data, listening to a range of market participants, testing different approaches, and adapting to what we see and hear. We have a number of tools to make adjustments and are confident in our ability to make the Marketplace an even more attractive market for consumers and health plans alike. We look forward to continuing to benefit from suggestions from customers, assisters, brokers, issuers, and other key stakeholders on ways to improve our operations to ensure the American people gain the peace of mind that comes with health insurance coverage.

Mr. PITTS. The chair thanks the gentleman and now recognizes Ms. Jarmon 5 minutes for your summary.

STATEMENT OF GLORIA JARMON

Ms. JARMON. Good morning, Chairman Pitts and Murphy, and Ranking Members Green and DeGette, and other members of the subcommittee. Thank you for the opportunity to testify today about the Office of Inspector General's oversight of health insurance marketplaces. As part of our strategic plan to oversee implementation of the Affordable Care Act, we have completed a significant body of audits and evaluations addressing federal and state marketplaces and other ACA provisions.

Our marketplace oversight work focuses on payment accuracy, eligibility systems, management and administration, and security and data of systems. My testimony today focuses on our most recent work which is the Consumer Operated and Oriented Plans, or CO-OPs, and state marketplaces.

Regarding our CO-OP work, we recently looked at the conversion of start-up loans into surplus notes. These notes are bond-like instruments issued to provide capital. We conducted this review to assess whether the CO-OPs complied with the Centers for Medicare & Medicaid Services guidance and applicable accounting principles.

We found that the CO-OPs generally complied with this guidance and applicable accounting principles when converting start-up loans into surplus notes. However, CMS did not adequately document the potential impact of the conversions on the federal government's ability to recover the loan payments if the CO-OPs were to fail.

Based on our findings, we recommended that CMS improve the decision making process for any future conversions of start-up loans to surplus notes, and document any potential negative impact from changes in distribution priority, and to quantify the likely impact on the federal government's ability to recover loan payments.

Following up on these recommendations, we are currently reassessing the CO-OPs' financial condition to determine if any improvements were made in 2015 and 2016. We are also monitoring the actions made by CMS to address underperforming CO-OPs. This work is expected to be issued during fiscal year 2017.

Regarding our state marketplaces work we recently completed a series of reviews to determine whether marketplaces had effective internal controls in place to ensure that individuals signing up for health insurance and receiving financial assistance through insurance affordability programs are eligible. We reviewed the first open enrollment period at seven state marketplaces. We found certain internal controls were effective. However, most of the state marketplaces had some ineffective internal controls for ensuring that individuals were enrolled in a qualified health plan in accordance with federal requirements.

With respect to establishment grant funds, we are in the process of completing a series of state marketplace reviews and their use of these funds. This work primarily focuses on whether marketplaces allocated costs to their establishment grants in accordance with federal requirements. Recently issued reports have deter-

mined that some states reviewed used allocation percentages based on outdated estimated enrollment data instead of updated data that was available. Based on these findings we recommended that the states refund misallocated amounts or work with CMS to resolve the misallocated amounts.

With respect to privacy and security of state marketplaces we have completed reviews of data and system security at five states and are close to completing reviews of two others. All of the states for which we have completed reviews have implemented some security controls to protect personally identifiable information or PII. However, vulnerabilities existed in those states and each had at least one vulnerability that if exploited could have exposed PII and other sensitive information. States generally agreed with our recommendations to improve security, and in many instances reported taking action to correct identified vulnerabilities.

In closing, we appreciate the committee's interest in this important issue and continue to urge CMS to fully address our recommendations related to improving oversight and financial solvency of the CO-OP program and state marketplaces. OIG is committed to providing continued oversight of these programs to help ensure that they operate efficiently, effectively and economically.

This concludes my testimony. I would be happy to answer your questions.

[The prepared statement of Gloria Jarmon follows:]



Testimony Before the United States House of Representatives
Committee on Energy and Commerce
Subcommittee on Health
Subcommittee on Oversight and Investigations

*"The Affordable Care Act on Shaky Ground:
Outlook and Oversight"*

Testimony of:
Gloria L. Jarmon
Deputy Inspector General for Audit Services

Office of Inspector General
U.S. Department of Health and Human Services

September 14, 2016

10:00 a.m.

Location: HVC-210 U.S. Capitol Building

Testimony of:

Gloria L. Jarmon

Deputy Inspector General for Audit Services

Office of Inspector General, U.S. Department of Health and Human Services

Good morning, Chairman Pitts, Chairman Murphy, Ranking Members Green and DeGette, and members of the Subcommittees. I am Gloria Jarmon, Deputy Inspector General for Audit Services for the Office of Inspector General (OIG), U.S. Department of Health and Human Services (HHS). Thank you for the opportunity to appear before you today to discuss OIG's oversight of health insurance marketplaces.

The Patient Protection and Affordable Care Act (ACA) established health insurance exchanges (commonly referred to as "marketplaces") to allow individuals and small businesses to shop for health insurance in all 50 States and the District of Columbia. States can choose to operate their own State marketplaces. Thirteen States (including the District of Columbia) are operating their own State marketplaces. The ACA provided funding assistance to States for planning and establishing State marketplaces.

OIG has identified oversight and operation of the health insurance marketplaces as a Top Management Challenge for HHS. OIG has completed a significant body of audits and evaluations regarding the Federal and State marketplaces and other ACA provisions of high interest and concern to the Department, Congress, and other stakeholders and plans more work in this area. OIG's marketplace oversight strategy focuses on four areas that we have determined to be most critical: payment accuracy, eligibility systems, management and administration, and security of data and systems. (See the Attachment for a list of OIG's completed ACA work related to the marketplaces.)

Today, I will discuss the Consumer Operated and Oriented Plan (CO-OP) program and the State marketplaces, but I would like to note that OIG has performed multiple reviews related to the operations of the Federal marketplace, including reviews related to (1) systems for determining consumers' eligibility for qualified health plans and insurance affordability programs, (2) enrollment, (3) advance premium tax credits for individuals enrolled in qualified health plans, (4) the security of marketplace data and information technology (IT) systems, and (5) contracting.

OIG's Oversight of the CO-OP Program

The ACA established the CO-OP program to foster the creation of nonprofit health insurance issuers to offer qualified health plans. The ACA authorized the Secretary of HHS to provide startup and solvency loans to help establish CO-OPs. Startup loans were intended to help CO-OPs cover approved costs for beginning operations. CMS has awarded \$2.44 billion to 23 CO-OPs, of which \$358 million was for startup loans; the remaining \$2.08 billion was for solvency loans. The startup loans were originally treated as debt that each CO-OP was expected to repay within 5 years of the disbursement. Solvency loans were structured to comply with applicable State insurance laws to meet capital reserve requirements and were expected to be repaid within 15 years. State insurance regulators require insurance issuers to maintain specified levels of capital reserves to continue to conduct business.

OIG's past work related to the CO-OP loan program examined the Centers for Medicare and Medicaid Services' (CMS) selection process for awarding financial loans to CO-OPs, early implementation of the loan program, and the financial solvency of the CO-OPs. On the basis of that work, we concluded that CMS awarded CO-OP loans in accordance with applicable Federal requirements, but we also identified several risks that indicated a critical need for additional CMS oversight of the CO-OPs as they prepared to become operational. For instance, we identified a risk that CO-OPs could exhaust all startup loan funding before they became fully operational or before they earned sufficient operating income to be self-supporting. We also found that after becoming operational, most CO-OPs had lower-than-expected enrollment numbers and significant net losses and that these factors might limit some CO-OPs' ability to repay loans. We made recommendations to CMS to improve its oversight of the loans and of the financial solvency of the CO-OPs.¹ Twelve of the original 23 CO-OPs had closed as of December 31, 2015. After issuance of our reports, 4 additional CO-OPs closed (as of August 31, 2016), leaving only 7 of the original 23 CO-OPs in business.

In my testimony today, I will focus on OIG's most recent work, which examines the CO-OPs' conversion of startup loans into surplus notes (a bond-like instrument issued to provide needed capital). On July 9, 2015, CMS issued a memo to the CO-OPs that provided guidance to allow the CO-OPs to amend their startup loan agreements. According to the guidance, the amendments would allow CO-OPs to convert startup loans into surplus notes. Under the terms of a surplus note, CO-OPs are not required to make any repayment on a surplus note that could lead to financial distress or default. Loan conversions were intended to improve capital levels and to meet the 500-percent risk-based capital (RBC) requirements generally imposed by CMS, which represented the minimum amount of capital needed to support the CO-OP's business operations.² In accordance with National Association of Insurance Commissioners accounting principles, CO-OPs that converted their startup loans into surplus notes could record and report these loans as capital and surplus rather than as debt in financial filings with regulators.

In August 2016, OIG issued a report examining CMS's oversight and approval of CO-OPs' conversions of startup loans into surplus notes.³ This work stemmed from a hearing entitled "Examining the Costly Failures of Obamacare's CO-OP Insurance Loans" held before the United States House Committee on Energy & Commerce, Subcommittee on Oversight & Investigations, on November 5, 2015. The hearing addressed financial challenges that CO-OPs faced and the effects on consumers and taxpayers. During the hearing, members expressed interest in OIG auditing the conversions of startup loans to surplus notes.

OIG determined that the 12 CO-OPs that converted startup loans to surplus notes on or before December 31, 2015, complied with CMS guidance and applicable accounting principles when

¹ *Early Implementation of the Consumer Operated and Oriented Plan Loan Program; The Centers for Medicare & Medicaid Services Awarded Consumer Operated and Oriented Plan Program Loans in Accordance with Federal Requirements, and Continued Oversight Is Needed; Actual Enrollment and Profitability Was Lower Than Projections Made by the Consumer Operated and Oriented Plans and Might Affect Their Ability To Repay Loans Provided Under the Affordable Care Act*

² On the basis of a health insurance issuer's size and risk, RBC estimates the minimum amount of capital needed to support the issuer's business operations. Issuers with a higher level of risk must reserve a larger amount of capital. RBC is usually expressed as a percentage. CMS generally required CO-OPs to maintain an RBC of 500 percent but allowed for lower levels to increase the long-term sustainability of some CO-OPs.

³ *Conversions of Startup Loans Into Surplus Notes by Consumer Operated and Oriented Plans Were Allowable but Not Always Effective*.

converting startup loans into surplus notes. However, CMS did not adequately document the potential impact of the conversions on the Federal Government's ability to recover the loan payments if the CO-OPs were to fail. Although the conversions provided increased levels of capital and surplus, 4 of the 12 CO-OPs approved for conversions ceased operations within 6 months of the conversion. Despite the conversions allowing CO-OPs to record the startup loans as capital and surplus instead of debt, RBC percentages were at levels below the CMS requirement of 500 percent for four of the eight operational CO-OPs as of December 31, 2015. On the basis of these findings, OIG made two recommendations to CMS to improve the decision-making process for any future conversions of startup loans to surplus notes: to document any potential negative impact from changes in distribution priority and to quantify the likely impact on the Federal Government's ability to recover loan payments.

We are reassessing the CO-OPs' financial condition to determine whether any improvements were made in 2015 and 2016, and to monitor actions by CMS to address underperforming CO-OPs. That work is expected to be issued during fiscal year 2017. We continue to keep abreast of emerging issues related to the CO-OP program and will determine whether additional oversight is warranted.

CMS's Oversight of State Marketplaces

OIG's work has covered various aspects of State marketplace operations, such as enrollment services and eligibility determinations, States' use of establishment grant funds, and security of the marketplaces' data and systems.

Enrollment and Eligibility

OIG recently completed a series of reviews to determine whether State marketplaces had effective internal controls in place to ensure that individuals signing up for health insurance and receiving financial assistance through insurance affordability programs are eligible to do so. OIG reviewed the first open enrollment period (October 2013 through March 2014) at seven State marketplaces⁴ and assessed internal controls over three broad areas: (1) verifying applicants' identity, (2) determining applicants' eligibility for enrollment in a qualified health plan and eligibility for insurance affordability programs, and (3) maintaining and updating eligibility and enrollment data.

On the basis of our reviews of sampled applicants at the State marketplaces, we determined that certain internal controls were effective at the State marketplaces. These included internal controls for verifying applicants' incarceration status, verifying changes reported by enrollees that affect their eligibility, and maintaining applicant data and documentation related to resolving inconsistencies. However, we found that most of the State marketplaces had some ineffective internal controls for ensuring that individuals were enrolled in a qualified health plan in accordance with Federal requirements. Examples of ineffective internal controls included deficiencies in performing identity-proofing verification, appropriately calculating and verifying applicants' annual household income, verifying applicants' eligibility for minimum essential

⁴ The seven State Marketplaces we reviewed were Colorado, District of Columbia, Kentucky, Minnesota, New York, Vermont, and Washington. In addition, OIG prior work included separate reviews at California and Connecticut.

coverage through employer-sponsored insurance, and resolving inconsistencies in applicants' eligibility data. OIG made a number of recommendations to the State marketplaces for implementing specific procedures to better ensure that eligibility determinations are accurate and performed in accordance with Federal requirements. OIG also recommended in some instances that a State marketplace redetermine the eligibility of sample applicants on the basis of our audit findings. We plan to assess CMS's oversight of the seven State-based marketplaces.

States' Use of Establishment Grant Funds

The ACA provided \$5 billion in funding assistance to the States for the planning and establishment of marketplaces,⁵ but grants had to be awarded before January 1, 2015; after January 1, 2015, marketplaces were required to be self-sustaining, meaning they could not use grant funds for operational purposes. CMS also provided guidance stating that after January 1, 2015, these Federal funds may not be used to cover maintenance and operating costs, which include rent, software maintenance, telecommunications, utilities, and base operational personnel and contractors.

In planning and establishing the marketplaces, States could use establishment grant funds for a variety of activities, including those that could benefit multiple State health programs. Accordingly, CMS's Funding Opportunity Announcements and subsequent grant award terms and conditions required marketplaces to allocate shared costs among Medicaid, the Children's Health Insurance Program, and qualified health plans consistent with Federal cost principles.⁶

OIG is completing a series of reviews of CMS establishment grants at eight State marketplaces across the Nation.⁷ This work covers the period from the inception of the marketplace through December 31, 2014, and has primarily focused on whether marketplaces allocated costs to their establishment grants in accordance with Federal requirements. As of today, we have issued three reports on State marketplace establishment grants.⁸ OIG reported that two of these States did not properly allocate costs for establishing a health insurance marketplace to their establishment grants in accordance with Federal requirements. These States used allocation percentages based on outdated, estimated enrollment data instead of the updated, better data that were available. We made recommendations to the States to refund to CMS misallocated amounts or work with CMS to resolve the amounts misallocated to the establishment grants.

In addition to reporting problems with the allocation of costs, OIG raised concerns about the level of detail in CMS's guidance regarding the types of operational costs that State marketplaces would not be able to charge against the Federal establishment grant after January 1, 2015. In

⁵ CMS provided several different funding opportunities to States, including early innovator cooperative agreements, planning and establishment grants, and establishment cooperative agreements.

⁶ 2 CFR part 225.

⁷ Colorado, District of Columbia, Kentucky, Maryland, Minnesota, New York, Nevada, and Vermont.

⁸ *Nevada Misallocated Costs for Establishing a Health Insurance Marketplace to Its Establishment Grants*, *The District of Columbia Claimed Allocated Costs to Its Establishment Grants in Accordance With Federal Requirements*, and *Maryland Misallocated Millions to Establishment Grants for a Health Insurance Marketplace*.

April 2015, OIG issued an early alert⁹ to CMS, encouraging it to provide more specific guidance to State marketplaces about what it considered to be operating costs. OIG stated that without detailed guidance, State marketplaces might have used, and might continue to use, establishment grant funds for operating expenses after January 1, 2015, contrary to law. In response to the OIG early alert, in June 2015 CMS updated and issued revised guidance¹⁰ that provided examples of allowable activities (e.g., outreach, education, and stabilizing marketplace IT systems) for which States could use establishment grant funds after January 1, 2015. The revised guidance further clarified the kinds of costs that CMS considered unallowable (e.g., rent, hardware/software maintenance, telecommunications, and utilities) because they were related to ongoing operations. OIG has not independently assessed the effectiveness of CMS guidance in ensuring that establishment grant funds were not used for operating costs after January 1, 2015. As part of our oversight of State marketplaces' use of establishment grant funds, we are considering additional work related to marketplace operational expenses incurred after January 1, 2015, and CMS's activities to prevent and detect use of establishment grant funds for unallowable purposes.

Data and Systems Security

Because the State marketplaces handle consumers' personally identifiable information (PII), OIG identified the security of the marketplaces' data and systems as a critical oversight area. CMS requires that marketplaces follow Federal IT security standards and additional requirements, including standards related to (1) monitoring, periodically assessing, and updating security controls and (2) developing and using secure electronic interfaces.

To date, we have completed reviews of data and systems security in five States and are close to completing reviews of two others.¹¹ All States for which we have completed reviews implemented some security controls to protect PII; however, vulnerabilities existed in those States, and each had at least one vulnerability that, if exploited, could have exposed PII and other sensitive information. Multiple States had weaknesses in patch and vulnerability management and failed to conduct required periodic penetration testing, which is an authorized attempt to locate and exploit vulnerabilities. Without an annual external network penetration test, a State cannot ensure that adequate controls are in place to defend against external threats that could result in unauthorized access to consumer PII and sensitive system information. States generally agreed with our recommendations to improve security and in many instances reported that they took immediate action to correct vulnerabilities identified by OIG.

Conclusion

OIG is committed to continued oversight of the Federal and State marketplaces and related programs to help ensure that they operate efficiently, effectively, and economically. Given the magnitude and complexity of these programs, close oversight is essential. OIG has a substantial body of work underway and planned to ensure that taxpayer dollars are spent for their intended

⁹ *Early Alert: Without Clearer Guidance, Marketplaces Might Use Federal Funding Assistance for Operational Costs When Prohibited by Law.*

¹⁰ FAQs on the Clarification of the Use of 1311 Funds for Establishment Activities (June 8, 2015).

¹¹ We have completed reviews of California, Colorado, Kentucky, New Mexico, and Washington and are close to completing reviews of Minnesota and New York.

purposes in a system that operates efficiently and is secure. Our ongoing and planned marketplace work will examine critical issues, such as payment accuracy, eligibility systems, management and administration, and security of data and systems. We will continue to make recommendations for improvements, as appropriate, and follow up, as necessary, with CMS and States to encourage prompt implementation of our recommendations.

Thank you, again, for inviting OIG to speak with the Subcommittees today. We hope that our work and this testimony will assist you in your oversight efforts.

**ATTACHMENT: RELATED OFFICE OF INSPECTOR GENERAL
REPORTS**

Report Title	Report Number	Date Issued
Payment Accuracy		
<i>Conversions of Startup Loans Into Surplus Notes by Consumer Operated and Oriented Plans Were Allowable but Not Always Effective</i>	<u>A-05-16-00019</u>	08/04/2016
<i>Nevada Misallocated Costs for Establishing a Health Insurance Marketplace to Its Establishment Grants</i>	<u>A-09-14-01007</u>	02/17/2016
<i>CMS Could Not Effectively Ensure That Advance Premium Tax Credit Payments Made Under the Affordable Care Act Were Only for Enrollees Who Paid Their Premiums</i>	<u>A-02-14-02025</u>	12/31/2015
<i>The District of Columbia Claimed Allocated Costs to Its Establishment Grants in Accordance With Federal Requirements</i>	<u>A-03-14-03300</u>	11/04/2015
<i>Actual Enrollment and Profitability Was Lower Than Projections Made by the Consumer Operated and Oriented Plans and Might Affect Their Ability to Repay Loans Provided Under the Affordable Care Act</i>	<u>A-05-14-00055</u>	07/29/2015
<i>CMS's Internal Controls Did Not Effectively Ensure the Accuracy of Aggregate Financial Assistance Payments Made to Qualified Health Plan Issuers Under the Affordable Care Act</i>	<u>A-02-14-02006</u>	06/16/2015
<i>Early Alert: Without Clearer Guidance, Marketplaces Might Use Federal Funding Assistance for Operational Costs When Prohibited by Law</i>	<u>A-01-14-02509</u>	04/27/2015
<i>Review of the Accounting Structure Used for the Administration of Premium Tax Credits</i>	<u>OEI-06-14-00590</u>	03/31/2015
<i>Maryland Misallocated Millions to Establishment Grants for a Health Insurance Marketplace</i>	<u>A-01-14-02503</u>	03/26/2015
<i>The Centers for Medicare and Medicaid Services Awarded Consumer Operated and Oriented Plan Program Loans in Accordance With Federal Requirements, and Continued Oversight Is Needed</i>	<u>A-05-12-00043</u>	07/30/2013
<i>Early Implementation of the Consumer Operated and Oriented Plan Loan Program</i>	<u>OEI-01-12-00290</u>	06/16/2013
Eligibility Systems		
<i>Not All of the Vermont Marketplace's Internal Controls Were Effective in Ensuring That Individuals Were Enrolled in Qualified Health Plans According to Federal Requirements</i>	<u>A-01-14-02507</u>	03/09/2016
<i>Not All of the District of Columbia Marketplace's Internal Controls Were Effective in Ensuring That Individuals Were Enrolled in Qualified Health Plans According to Federal Requirements</i>	<u>A-03-14-03301</u>	02/22/2016

Report Title	Report Number	Date Issued
Eligibility Systems – continued		
<i>Not All of the Minnesota Marketplace's Internal Controls Were Effective in Ensuring That Individuals Were Enrolled in Qualified Health Plans According to Federal Requirements</i>	<u>A-05-14-00043</u>	02/12/2016
<i>Not All of the Washington Marketplace's Internal Controls Were Effective in Ensuring That Individuals Were Enrolled in Qualified Health Plans According to Federal Requirements</i>	<u>A-09-14-01006</u>	01/19/2016
<i>Not All of the Colorado Marketplace's Internal Controls Were Effective in Ensuring That Individuals Were Enrolled in Qualified Health Plans According to Federal Requirements</i>	<u>A-07-14-03199</u>	12/28/2015
<i>The Kentucky Marketplace's Internal Controls Were Generally Effective in Ensuring That Individuals Were Enrolled in Qualified Health Plans According to Federal Requirements</i>	<u>A-04-14-08036</u>	10/14/2015
<i>Not All Internal Controls Implemented by the New York Marketplace Were Effective in Ensuring That Individuals Were Enrolled in Qualified Health Plans According to Federal Requirements</i>	<u>A-02-14-02020</u>	09/21/2015
<i>Not All of the Federally Facilitated Marketplace's Internal Controls Were Effective in Ensuring That Individuals Were Properly Determined Eligible for Qualified Health Plans and Insurance Affordability Programs</i>	<u>A-09-14-01011</u>	08/06/2015
<i>Marketplaces Faced Early Challenges Resolving Inconsistencies With Applicant Data</i>	<u>OEI-01-14-00180</u>	07/02/2014
<i>Not All Internal Controls Implemented by the Federal, California, and Connecticut Marketplaces Were Effective in Ensuring That Individuals Were Enrolled in Qualified Health Plans According to Federal Requirements</i>	<u>A-09-14-01000</u>	06/30/2014
Management and Administration		
<i>HealthCare.gov: Case Study of CMS Management of the Federal Marketplace</i>	<u>OEI-06-14-00350</u>	02/22/2016
<i>CMS Did Not Identify All Federal Marketplace Contract Costs and Did Not Properly Validate the Amount To Withhold for Defect Resolution on the Principal Federal Marketplace Contract</i>	<u>A-03-14-03002</u>	09/18/2015
<i>CMS Did Not Always Manage and Oversee Contractor Performance for the Federal Marketplace as Required by Federal Requirements and Contract Terms</i>	<u>A-03-14-03001</u>	09/14/2015
<i>Federal Marketplace: Inadequacies in Contract Planning and Procurement</i>	<u>OEI-03-14-00230</u>	01/20/2015
<i>An Overview of 60 Contracts That Contributed to the Development and Operation of the Federal Marketplace</i>	<u>OEI-03-14-00231</u>	08/26/2014

Report Title	Report Number	Date Issued
Security of Data and Systems		
<i>Public Summary Report: Washington State Implemented Security Controls Over the Web Site and Database for Its Health Insurance Exchange but Could Improve Protection of Personally Identifiable Information</i>	<u>A-09-15-03005</u>	06/01/2016
<i>Public Summary Report: Connect for Health Colorado Generally Protected Personally Identifiable Information on Its Health Insurance Exchange Web Sites and Databases but Could Continue To Improve Information Security Controls</i>	<u>A-07-15-00454</u>	02/10/2016
<i>The Centers for Medicare and Medicaid Services' Implementation of Security Controls Over the Multidimensional Insurance Data Analytics System Needs Improvement</i>	<u>A-06-14-00067</u>	09/21/2015
<i>California Implemented Security Controls Over the Web Site and Databases for Its Health Insurance Exchange but Could Improve Protection of Personally Identifiable Information</i>	<u>A-09-14-03005</u>	04/30/2015
<i>Health Insurance Marketplaces Generally Protected Personally Identifiable Information but Could Improve Certain Information Security Controls</i>	<u>A-18-14-30011</u>	09/22/2014
<i>Observations Noted During the OIG Review of CMS's Implementation of the Health Insurance Exchange-Data Services Hub</i>	<u>A-18-13-30070</u>	08/02/2013

Mr. PITTS. The chair thanks the gentlelady and now recognizes Mr. Seto Bagdoyan 5 minutes for your opening statement summary.

STATEMENT OF SETO BAGDOYAN

Mr. BAGDOYAN. Thank you and good morning, Chairman Pitts and Murphy, Ranking Members Green and DeGette, and members of the subcommittees. I'm pleased to be here today to discuss three recently issued GAO reports on health care issues.

This morning at the subcommittee's request I'll focus my remarks on the results of undercover testing of enrollment processes and related controls used by the federal marketplace and the California state marketplace under the ACA for coverage year 2016. I'd note that these results are not definitive regarding the entire application population. Our work focused on identifying indicators of potential enrollment fraud, vulnerability and risk for further review as I'll highlight shortly. We discussed our results with CMS and the California exchange and their responses are included in our final report.

In terms of what's at risk, ACA coverage is a substantial financial commitment for the federal government. About 11 million enrollees have coverage of which up to 85 percent receive subsidies. CFBO estimates subsidy costs for fiscal year 2017 at about 56 billion and totaling 866 billion for the next 10 years. In this regard I would note that while subsidies are paid directly to insurers, they nevertheless represent a financial benefit to enrollees in the form of reduced overall costs. That is, premiums and deductibles.

Turning to our coverage year 2016 results, we initially obtained subsidized qualified health plan or Medicaid coverage for all 15 fictitious applicants. In doing so we successfully worked around all primary enrollment process checks, namely identify proofing, submitting documents to clear inconsistencies, and filing tax returns to reconcile subsidies.

We subsequently maintained coverage for 11 applicants to the present that is well into the coverage year, even though some had not filed tax returns or submitted documentation to clear information inconsistencies as required. Our subsidies totaled about \$60,000 on an annualized basis. We failed to maintain coverage for three applicants because of payment issues, and for one applicant whose coverage was eventually terminated because of intentional failure to submit requested documentation.

These results, combined with those from our earlier work involving coverage years 2014 and 2015, form a consistent pattern of three principal interrelated fraud risk indicators which we're pursuing further during our ongoing ACA related work. First, no year-on-year changes in the enrollment processes and controls are readily apparent, suggesting that these remain fundamentally vulnerable to fraud at multiple points along their entire spectrum—front, middle, and end—raising the overall program integrity risk for ACA.

Second, applicants intending to act fraudulently to obtain coverage in which they're not otherwise entitled, such as our fictitious applicants, could exploit the enrollment process and its various accommodations such as self-attestation, deadline extensions, and re-

laxed standards for resolving inconsistencies to their advantage and maintain policies virtually through the entire coverage year.

Third, even if such applicants subsequently are flagged and lose their coverage for administrative compliance issues they're able to apply for new coverage the following open season as allowed by program rules, thus engaging essentially in a form of health coverage arbitrage.

In closing, I'd underscore that a program of this scope and scale is inherently at risk for fraudulent activity and accordingly it is essential that a high priority is placed on implementing effective preventive enrollment processes and controls up front and help narrow the window of opportunity for such risk and safeguard the government's substantial investment. In this regard CMS told us that it's responding to eight recommendations we made in our February 2016 report and if executed well and then sustained this represents a major opportunity to address the vulnerabilities we identified to reduce risk and enhance program integrity.

Chairman Pitts and Murphy, this concludes my remarks. I look forward to the subcommittee's questions. Thank you.

[The prepared statement of Seto Bagdoyan follows:]



United States Government Accountability Office

Testimony

Before the Subcommittees on Health
and Oversight and Investigations,
Committee on Energy and Commerce,
House of Representatives

For Release on Delivery
Expected at 10:00 a.m. ET
Wednesday, September 14, 2016

HEALTH CARE

Results of Recent Undercover Testing for Patient Protection and Affordable Care Act Coverage, and Review of Market Concentration in the Private Insurance Markets

Statement of Seto J. Bagdoyan, Director,
Forensic Audits and Investigative Service

Chairmen Pitts and Murphy, Ranking Members Green and DeGette, and Members of the Subcommittees:

I am pleased to be here today to discuss enrollment for health-care coverage obtained through the health-insurance marketplaces, or exchanges, established under the Patient Protection and Affordable Care Act (PPACA).¹ PPACA subsidies are available to those eligible to purchase private health-insurance plans from a marketplace who meet certain income and other requirements. With those subsidies and other costs, the act represents a significant, long-term fiscal commitment for the federal government. According to the Congressional Budget Office, the estimated cost of subsidies and related spending under the act is \$56 billion for fiscal year 2017, rising to \$106 billion for fiscal year 2026, and totaling \$866 billion for fiscal years 2017–2026.²

While subsidies under PPACA are generally not paid directly to enrollees, participants nevertheless benefit financially through reduced monthly premiums or lower costs due at time of service, such as copayments.³ Because subsidy costs are contingent on who obtains coverage, enrollment controls that help ensure only qualified applicants are approved for subsidized coverage are a key factor in determining federal expenditures under the act. In addition, PPACA provided for the expansion of the Medicaid program.⁴ Under the expansion, states may choose to provide Medicaid coverage to nonelderly adults who meet income limits and other criteria. The federal government is to fully reimburse states through calendar year 2016 for the Medicaid expenditures of "newly eligible" individuals who gained Medicaid eligibility

¹Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010) ("HCERA"). In this testimony, references to PPACA include any amendments made by HCERA.

²Related spending includes marketplace grants to states and other items.

³Enrollees can pay lower monthly premiums by virtue of a tax credit the act provides. They may elect to receive the tax credit in advance, to lower premium cost, or to receive it at time of income-tax filing, which reduces tax liability.

⁴PPACA provides states with additional federal funding to expand their Medicaid programs to cover adults under 65 with income up to 133 percent of the federal poverty level. Because of the way the limit is calculated, using what is known as an "income disregard," the level is effectively 138 percent of the federal poverty level. In this testimony, the term "state" includes the District of Columbia.

through the expansion.⁵ According to the Office of the Actuary of the Centers for Medicare & Medicaid Services (CMS), federal expenditures for the Medicaid expansion are estimated at \$430 billion from 2014 through 2023.

The private health-insurance market has historically been highly concentrated—that is, a small number of issuers in a market enrolled a significant portion of the people in that market.⁶ A highly concentrated market may indicate a less competitive market and could affect consumers' choice of health-plans and their premiums. PPACA contained a number of provisions that took effect in 2014 and could affect market concentration among health issuers.

My statement will summarize the findings of three recently issued reports⁷ and will (1) describe the results of our undercover testing of eligibility and enrollment controls for the federal Health Insurance Marketplace (Marketplace) and selected state-based marketplaces for the 2015 and 2016 coverage years, and (2) discuss findings from our review of private health-insurance market concentration in three markets: individual, small-group, and large-group.⁸

For our report in which we conducted undercover testing for the 2015 coverage year, we submitted, or attempted to submit, 18 fictitious applications by telephone and online. Ten of these applications tested

⁵The "newly eligible" reimbursement rate drops to 95 percent in calendar year 2017, 94 percent in calendar year 2018, 93 percent in calendar year 2019, and 90 percent afterward.

⁶We use the term "issuer" when referring to the insurance entities that are licensed by a state to engage in the business of insurance in that specific state.

⁷GAO, *Patient Protection and Affordable Care Act: Final Results of Undercover Testing of the Federal Marketplace and Selected State Marketplaces for Coverage Year 2015*, GAO-16-792 (Washington, D.C.: Sept. 9, 2016); *Patient Protection and Affordable Care Act: Results of Undercover Enrollment Testing for the Federal Marketplace and a Selected State Marketplace for the 2016 Coverage Year*, GAO-16-784 (Washington, D.C.: Sept. 12, 2016); and *Private Health Insurance: In Most States and New Exchanges, Enrollees Continued to be Concentrated among Few Issuers in 2014*, GAO-16-724 (Washington, D.C.: Sept. 6, 2016).

⁸The individual market offers health insurance coverage directly to individual consumers other than in connection with a group health plan, while under the small-group market and the large-group market individuals obtain coverage through a group plan typically maintained by small employers and large employers, respectively.

controls related to obtaining subsidized coverage available through the federal Marketplace in New Jersey and North Dakota, and through state-based marketplaces in California and Kentucky. We chose these states based partly on range of population and whether the state had expanded Medicaid eligibility under PPACA. The other 8 applications tested controls for determining Medicaid eligibility.⁹

For our report in which we conducted undercover testing for the 2016 coverage year, we submitted 15 fictitious applications for subsidized coverage through the federal Marketplace in Virginia and West Virginia and through the state-based marketplace in California. Our applications tested verifications related to (1) applicants making required income-tax filings, and (2) applicants' identity or citizenship/immigration status.¹⁰ For both coverage years, the results of our undercover testing, while illustrative, cannot be generalized to the overall population of applicants or enrollees.

For our report on private-health insurance market concentration and changes in issuer participation, we determined market share using enrollment data from the 2011 through 2014 Medical Loss Ratio datasets that issuers are required to report annually to CMS. To obtain 2014 enrollment data for the issuers in the exchanges, we analyzed Unified Rate Review data that certain issuers are required to report to CMS. For both datasets, enrollment for each issuer is available only at the state level, and 2014 data are the most recent available.¹¹

We conducted the work upon which this statement is based in accordance with generally accepted government auditing standards. We conducted our related investigative work in accordance with investigative standards prescribed by the Council of the Inspectors General on Integrity and Efficiency.

Background

PPACA provides for the establishment of health-insurance marketplaces to assist consumers in comparing and selecting among insurance plans

⁹See GAO-16-792 for additional details on our objectives, scope, and methodology.

¹⁰See GAO-16-784 for additional details on our objectives, scope, and methodology.

¹¹See GAO-16-724 for additional details on our objectives, scope, and methodology.

offered by participating private issuers of health-insurance coverage.¹² Under PPACA, states may elect to operate their own health-insurance marketplaces, known as state-based marketplaces, or they may rely on the federal Marketplace, known to the public as HealthCare.gov.¹³ These marketplaces were intended to provide a single point of access for individuals to enroll in private health-plans, apply for income-based subsidies to offset the cost of these plans—which, as noted, are paid directly to health-insurance issuers—and, as applicable, obtain an eligibility determination or assessment of eligibility for other health-coverage programs, such as Medicaid or the Children’s Health Insurance Program.¹⁴ CMS, a unit of the Department of Health and Human Services (HHS), is responsible for overseeing the establishment of these online marketplaces, and the agency maintains the federal Marketplace.

To be eligible to enroll in a “qualified health plan” offered through a marketplace—that is, one providing essential health benefits and meeting other requirements under PPACA—an individual must be a U.S. citizen or national, or otherwise lawfully present in the United States; reside in the marketplace service area; and not be incarcerated (unless incarcerated while awaiting disposition of charges).¹⁵ To be eligible for Medicaid, individuals must meet federal requirements regarding residency, U.S. citizenship or immigration status, and income limits, as well as any additional state-specific criteria that may apply.

Marketplaces are required by PPACA to verify application information to determine eligibility for enrollment and, if applicable, determine eligibility

¹²Specifically, the act required, by January 1, 2014, the establishment of health-insurance marketplaces in all states. In states not electing to operate their own marketplaces, the federal government was required to operate a marketplace.

¹³Specifically, according to the Department of Health and Human Services (HHS), for the 2016 coverage year, there were 38 states using the HealthCare.gov system. Among all consumer health plan selections, about 76 percent (8.4 million) were in states using the HealthCare.gov system.

¹⁴Individuals may also continue to apply for Medicaid coverage or the Children’s Health Insurance Program through direct application to their respective state agencies. According to CMS officials, eligibility requirements are generally the same for both programs. In this statement, our testing was only for Medicaid eligibility.

¹⁵In this statement, we use “qualified health plan” to refer to coverage obtained from private insurers, as distinguished from enrollment in a public health program such as Medicaid.

for the income-based subsidies or Medicaid. These verification steps include validating an applicant's Social Security number, if one is provided;¹⁶ verifying citizenship, status as a U.S. national, or lawful presence by comparison with Social Security Administration or Department of Homeland Security records; and verifying household income with tax-return data from the Internal Revenue Service (IRS), as well as data on Social Security benefits from the Social Security Administration.¹⁷

Under PPACA's eligibility verification process, "inconsistencies" are generated when individual applicant information does not match federal data sources—either because information an applicant provided does not match information contained in data sources that a marketplace uses for eligibility verification at the time of application, or because such information is not available. If there is an application inconsistency, the marketplace is to determine eligibility using the applicant's attestations and ensure that subsidies are provided on behalf of the applicant, if qualified to receive them, while the inconsistency is being resolved. Under the marketplace process, applicants may be asked to provide additional information or documentation for the marketplaces to review to resolve the inconsistencies.

In addition to the two related reports discussed in this statement, we have issued a body of work in which we examined enrollment and verification controls of the federal and state marketplaces. For example, in February 2016, we issued a report addressing CMS enrollment controls and the agency's management of enrollment fraud risk. That report included eight recommendations to CMS to strengthen its oversight of the federal

¹⁶A marketplace must require an applicant who has a Social Security number to provide the number. 42 U.S.C. § 18081(b)(2) and 45 C.F.R. § 155.310(a)(3)(i). However, having a Social Security number is not a condition of eligibility.

¹⁷For further background, see Department of Health and Human Services, Office of Inspector General, *Not All of the Federally Facilitated Marketplace's Internal Controls Were Effective in Ensuring That Individuals Were Properly Determined Eligible for Qualified Health Plans and Insurance Affordability Programs*, A-09-14-01011 (Washington, D.C.: Aug. 6, 2015); GAO, *Patient Protection and Affordable Care Act: IRS Needs to Strengthen Oversight of Tax Provisions for Individuals*, GAO-15-540 (Washington, D.C.: July 29, 2015); and GAO, *Healthcare.gov: CMS Has Taken Steps to Address Problems, but Needs to Further Implement Systems Development Best Practices*, GAO-15-238 (Washington, D.C.: Mar. 4, 2015).

Marketplace.¹⁸ CMS concurred with our recommendations, and implementation is pending.

In terms of concentration in the private health-insurance market, in December 2014 we reported that, from 2010 through 2013, enrollment in most states was concentrated among the largest issuers in each of the three types of health-insurance markets: the large-group market (under which individuals obtain coverage through a group plan maintained by large employers), the small-group market (under which individuals obtain coverage through a group plan maintained by small employers), and the individual market (coverage sold directly to individual consumers other than in connection with a group health-plan).¹⁹

As mentioned above, PPACA contained provisions that could affect market concentration among health issuers. For example, the law required the establishment of individual health-insurance exchanges, as well as Small Business Health Options Programs ("SHOPs"), within each state by 2014.²⁰ These exchanges are a new type of market where eligible individuals and small employers, respectively, can compare and select among qualified insurance plans offered by participating issuers.

PPACA does not require issuers to offer plans through these exchanges but instead generally relies on market incentives to encourage their

¹⁸GAO, *Patient Protection and Affordable Care Act: CMS Should Act to Strengthen Enrollment Controls and Manage Fraud Risk*, GAO-16-29 (Washington, D.C.: Feb. 23, 2016). We also testified on preliminary results of our undercover testing in July 2014 and October 2015. See GAO, *Patient Protection and Affordable Care Act: Preliminary Results of Undercover Testing of Enrollment Controls for Health Care Coverage and Consumer Subsidies Provided Under the Act*, GAO-14-705T (Washington, D.C.: July 23, 2014); and *Patient Protection and Affordable Care Act: Preliminary Results of Undercover Testing of the Federal Marketplace and Selected State Marketplaces for Coverage Year 2015*, GAO-16-159T (Washington, D.C.: Oct. 23, 2015).

¹⁹GAO, *Private Health Insurance: Concentration of Enrollees among Individual, Small Group, and Large Group Insurers from 2010 through 2013*, GAO-15-101R (Washington, D.C.: Dec. 1, 2014). For group health plan purposes, federal law defines a small employer as having an average of 1 to 50 employees on business days during the preceding calendar year and employing at least 1 employee on the first day of the plan year; however, states may instead elect to define the term as an employer having an average of 1 to 100 employees on business days during the preceding calendar year. See 42 U.S.C. §§ 300gg-91(e), 18024(b).

²⁰States may establish separate individual and SHOP exchanges or a single exchange to serve both individuals and small employers.

participation. Issuers seeking to offer a health plan in an individual exchange or SHOP must first have that plan approved by the exchange in the state. About a third of the states chose to operate their exchanges in 2014 and approved issuers for participation. In the remaining states electing not to establish and operate their own exchange, PPACA required HHS to carry out these responsibilities. As reported in August 2014, most of the largest issuers holding the majority of the market in the 2012 individual and small-group markets participated in the 2014 exchanges, although most of the numerous smaller issuers in those markets did not.²¹

The Marketplaces Approved Subsidized Coverage for the 2015 Coverage Year for 17 of 18 of our Fictitious Applicants

Our undercover testing for the 2015 coverage year found that the health-care marketplace eligibility determination and enrollment process for qualified health-plans—that is, coverage obtained from private insurers—was vulnerable to fraud. The federal Marketplace or selected state-based marketplaces approved each of 10 fictitious applications we made for subsidized health-plans. Although 8 of these 10 fictitious applications failed the initial online identity-checking process, all 10 were subsequently approved. Four applications used Social Security numbers that, according to the Social Security Administration, have never been issued, such as numbers starting with “000.” Other applicants obtained duplicate enrollment or obtained coverage by claiming that their employer did not provide insurance that met minimum essential coverage.

For eight additional fictitious applications, initially made for Medicaid coverage, we were approved for subsidized health-care coverage in seven of the eight cases, through the federal Marketplace and the two selected state-based marketplaces.

- Three of our applications were approved for Medicaid, which was the health-care program for which we originally sought approval. In each case, we provided identity information that would not have matched Social Security Administration records. For two applications, the marketplace or state Medicaid agency directed the fictitious applicants to submit supporting documents, which we did (such as a fake immigration card), and the applications were approved. For the third,

²¹GAO, *Patient Protection and Affordable Care Act: Largest Issuers of Health Coverage Participated in Most Exchanges, and Number of Plans Available Varied*, GAO-14-657 (Washington, D.C.: Aug. 29, 2014).

the marketplace did not seek supporting documentation, and the application was approved by phone.

- For four applications, we were unable to obtain approval for Medicaid but were subsequently able to gain approval of subsidized health-plan coverage. In one case, we falsely claimed that we were denied Medicaid and were able to obtain the subsidized health-plan when in fact no Medicaid determination had been made at that time.
- For one application, we were unable to enroll into Medicaid, in California, because we declined to provide a Social Security number. According to California officials, the state marketplace requires a Social Security number or taxpayer-identification number to process applications.

We submitted fictitious documentation as part of the application and enrollment process. According to officials from CMS, California, Kentucky, and North Dakota, the marketplaces or Medicaid office only inspect supporting documentation that has obviously been altered. Thus, if the documentation submitted did not show signs of alteration, it would not be questioned for authenticity.

The Marketplaces Approved Subsidized Coverage for the 2016 Coverage Year for all 15 of Our Fictitious Applicants, Even Those Who Had Not Filed Required Tax Returns

Our undercover testing for the 2016 coverage year found that the health-care marketplaces' eligibility determination and enrollment processes continued to be vulnerable to fraud. The marketplaces initially approved coverage and subsidies for our 15 fictitious applications, including 1 application for Medicaid, made through the federal Marketplace in Virginia and West Virginia and through the state marketplace in California. However, three applicants were unable to put their policies in force because their initial payments were not successfully processed. Therefore, we focused our testing on the remaining 12 applications — 11 applications for qualified health-plans, and 1 for Medicaid.

- For four applications, to obtain 2016 subsidized coverage, we used identities from our 2014 testing that had previously obtained subsidized coverage. The 2016 coverage year was the first year in which verification was required to ensure that applicants who previously received a specific type of federal subsidy under the act had filed a federal tax return. This was a condition for these applicants to retain this benefit in 2016. None of the four fictitious applicants had filed a 2014 tax return but all were approved for the 2016 subsidies. Marketplace officials told us that they allowed applicants to attest to

filing taxes if information from the IRS indicated that the applicant did not file tax returns. Marketplace officials said one reason they allow attestations is the time lag between when tax returns are filed and when they are reflected in IRS's systems.²² CMS officials said they are rechecking the 2014 tax-filing status and will remove subsidies for applicants that have not filed a 2014 tax return.

- For eight applications, we used new fictitious identities to test verifications related to identity or citizenship/immigration status and, in each case, successfully obtained subsidized coverage.

When the marketplaces directed 11 of the 12 applicants to provide supporting documents, we submitted fictitious documents as follows:

- For five applications, we provided all documentation requested, and the applicants were able to retain coverage.
- For three applications, we provided only partial documentation, and the applicants were able to retain coverage. Two of these applicants were able to clear inconsistencies through conversations with marketplace phone representatives even though the information provided over the phone did not match the fictitious documentation that we previously provided.
- For three applications, we did not provide any of the requested documents, and the marketplaces terminated coverage for one applicant but did not terminate coverage for the other two applicants.

Marketplace officials told us that without specific identities of our fictitious applicants—which we declined to provide, to protect the identities—they could not comment on individual outcomes. In general, however, they told us our results indicate their marketplace processes worked as designed. For example, according to officials from CMS, some of our application outcomes could be explained by decisions to extend document filing deadlines. CMS regulations authorize the Marketplace to extend the standard 90-day inconsistency resolution period if the applicant

²²Individual income tax returns are ordinarily due by April 15, but taxpayers can request a tax-filing deadline extension to October 15. IRS officials told us that assuming a return is complete, normal processing time is typically 3 to 12 weeks. Also, IRS updates in tax-return-filing-status information provided to marketplaces, which occur monthly, can add additional time.

demonstrates a good-faith effort to obtain the required documentation during the period.²³ Under good-faith-effort extensions for 2016, documentation requirements are not waived, but applicants were provided additional time to submit documents.

For Covered California applications, when our applicants could not clear online identity proofing and contacted representatives by phone, the representatives were correct in first seeking to direct the applicants to visit enrollment counselors, so they could verify identities in person. While in-person presentation of identity documentation is never required, the officials said, an in-person visit provides an opportunity to examine identity documents.

In discussing these outcomes for our fictitious applicants, federal and state marketplace officials reaffirmed, as we have reported previously, that the marketplaces do not seek to identify fraudulent document submissions. Federal Marketplace officials said document-review standards—in which CMS's documents-processing contractor is not required to examine documents for fraud—remain unchanged. Unless documents show signs of being visibly altered, they are accepted as authentic.²⁴ In response to our findings, the Department of Health and Human Services stated that it continues to strengthen marketplace controls.

²³For most types of inconsistencies, the standard resolution period is 90 days from the date a notice is sent to the applicant. However, for inconsistencies related to citizenship, status as a U.S. national, or lawful presence, the inconsistency period is 90 days from the date the notice is received by the applicant. To accommodate mail delivery time, for these inconsistencies CMS generally applies a standard resolution period of 95 days from the date the notice is sent to the applicant.

²⁴CMS officials told us that although contractor staff are not trained in fraud detection, there is an escalation process if staff believe there is a discrepancy between a document filed and examples provided in CMS guidance.

**Health-Insurance
Markets Remained
Concentrated in Most
States in 2014, While
Issuer Participation
Generally Decreased**

We found that enrollment in private health-insurance plans remained concentrated among a small number of issuers in most states in 2014, including in the newly established exchanges. On average, in each state, 11 or more issuers participated in each of three types of markets—individual, small-group, and large-group—from 2011 through 2014. However, in most states, the 3 largest issuers in each market had at least an 80 percent share of the market during the period. Beginning in 2014, issuers in the individual and small-group markets could sell coverage through the individual and SHOP exchanges established by PPACA. Not all issuers in these overall markets participated in the exchanges, and several exchanges had fewer than 3 issuers participating. Enrollment through these exchanges was generally more concentrated among a few issuers than was true for the overall markets. We did not assess the effect of the law on concentration and participation as 2014 was the first year of implementation for certain PPACA insurance reforms.

In nearly all states, we found that the number of issuers participating in individual markets decreased from 2013 to 2014, while fewer states' small-group and large-group markets had decreased participation. However, across the three types of markets, those issuers exiting each state market before 2014 generally had less than 1 percent of the market in the prior year. There were also issuers that newly entered state markets in 2014. Their market shares in 2014 varied across the three types of markets, with some entering issuers in the individual market capturing a market share of over 10 percent. Newly entering issuers generally captured a larger share of the enrollment sold through the exchanges than through the overall markets, and some captured a majority of their exchange market.

Chairmen Murphy and Pitts, Ranking Members DeGette and Green, and Members of the Subcommittees, this concludes my statement. I would be happy to respond to any questions that you might have.

**GAO Contact and
Staff
Acknowledgments**

For questions about this statement, please contact Seto Bagdoyan at (202) 512-6722 or bagdoyans@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement.

Individuals making key contributions to this statement include John Dicken, Director; Philip Reiff and William Hadley, Assistant Directors; Ariel Vega, Christopher H. Schmitt, Ranya Elias, Colin Fallon, James Murphy, Olivia Lopez, Madeline Messick, and Dee Abasute.

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James-Christian Blockwood, Managing Director, spel@gao.gov, (202) 512-4707, U.S. Government Accountability Office, 441 G Street NW, Room 7814, Washington, DC 20548



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Mr. PITTS. The chair thanks the gentleman. I will begin the questioning and recognize myself 5 minutes for that purpose. Let me just say in the beginning, GAO has been a great government watchdog for taxpayers, and while the undercover enrollment testing for the exchanges is thorough and helpful, troubling to learn just how bad the vulnerabilities of the ACA exchanges remain.

Mr. Bagdoyan, your testimony offered a preview of your agency's findings in this space. Let's examine a few of the numbers; talk about the fictitious scenarios. As I understand it, this is the first year that coverage eligibility must be verified to determine whether an applicant who previously received an exchange plan filed federal tax returns; is that correct?

Mr. BAGDOYAN. Yes, Mr. Chairman. That's correct.

Mr. PITTS. The GAO tested fictitious applicants that you previously used for plan year 2014. Now of the 15 applicants that you attempted to gain coverage for, all 15 were initially enrolled in plans. It is my understanding that still today, ten of these fictitious applicants are receiving monthly advanced premium tax credits, about \$1,100 a month, and all ten qualify for cost sharing reduction or CSR payments. Are any of these ten fictitious enrollees false applicants you used in 2014 who never paid federal taxes?

Mr. BAGDOYAN. Four of those, Mr. Chairman, are essentially revived identities from our 2014 work.

Mr. PITTS. Administrator Slavitt, CMS announced that APTC and CSR subsidies would be ended for 2016 enrollees who received APTCs in 2014 but did not reconcile these payments on their federal taxes. In one of these fictitious cases, a federal marketplace representative initially told the enrollee they were not approved for subsidies.

But after the fictitious enrollee verbally attested that they had filed a return, the representative approved the subsidized coverage even though it was a false attestation. Why does CMS allow applicants to self-attest to this safeguard designed to protect taxpayer funded premium credit?

Put your mike on.

Mr. SLAVITT. Yes, thank you, Chairman Pitts. And thank you to Mr. Bagdoyan for the work that you all have done.

I think with respect to the people who have, we call them people who have failed to reconcile who have received an advanced premium tax credit but haven't yet filed, many of those in our work with the IRS turn out to be people who are filing taxes for the first time. And so what happened is that when they came back to get coverage in 2015, if the IRS didn't have a file for them that they filed, they were not able to get coverage.

We did allow people to attest if they had an extension or if they had filed taxes and they claimed that the IRS hadn't received them yet, but that's not where we stop. And I think to the heart of your question, we had 19,000 people who so attested and many of them have since demonstrated that they have paid their taxes. And then as of this month, those that have not yet demonstrated that those people will be terminated from advanced pay on a tax credit.

Mr. PITTS. So how many individuals have had their coverage ended due to violating this safeguard?

Mr. SLAVITT. As of this month it will be several thousand. I don't have the exact figure here with me.

Mr. PITTS. OK. According to GAO, the IRS expressed concern to your agency about this attestation approach, and I also point out that a February 2016 report from GAO recommended that CMS conduct a risk assessment of potential exchange fraud. Has CMS conducted a risk assessment of the application eligibility and enrollment process?

Mr. SLAVITT. I'm not entirely sure what you're referring to. I do know that the GAO gave us a recommendation earlier to create a risk assessment framework through which we assess all of the potential risks to the exchanges, and we have indeed implemented that and it's actually been extremely helpful to us.

Mr. PITTS. And can you provide the committee with a copy of that report?

Mr. SLAVITT. The report from the GAO?

Mr. PITTS. Yes, the recommendations.

Mr. SLAVITT. The recommendations, sure. We'll get that.

Mr. PITTS. All right. We now have 3 years of undercover testing. The results have not improved, and I know I speak for taxpayers across Pennsylvania and our country when I say this is frustrating and alarming. I will yield the balance of my time to Cathy McMorris Rodgers for her comments.

Mrs. MCMORRIS RODGERS. In my home in Eastern Washington—oh, thanks—our state insurance commissioner recently approved premium increases for 2017. On average they are increasing by over 13 percent. Rate increases like these are being seen across the country and they are far from affordable. In my state they go from 4.6 percent to 22.75.

I want to take the moment here just to thank my colleagues for their efforts to come up with common sense solutions to ensure Americans will have access to high quality and the lowest cost possible, and we must respect the sacred relationship between the patient and the doctor. Thank you very much.

Mr. PITTS. The chair thanks the gentlelady and now recognizes the ranking member of the Health Subcommittee, Mr. Green, 5 minutes for questions.

Mr. GREEN. Thank you, Mr. Chairman, and thank our witnesses for being here today and the work you do. Let me talk a little bit about Texas' experience. Under the Affordable Care Act millions of Americans are able to access their vital care resources in our communities. In my state Texas we realized the following benefits.

During the last enrollment period over 1.3 million individuals selected a marketplace plan. Forty eight percent of those individuals were new consumers. Unfortunately, 1.2 million individuals who would otherwise be covered remain uninsured because Texas refused to expand the Medicaid. As I said earlier, 50,000 of that 1.2 million are my constituents.

As of 2015, the ACA provided community health centers grantees in Texas with over 470 million in funding to offer a broad array of primary care, extended hours of operation and hire more providers and develop clinical spaces. Medicare beneficiaries in Texas have saved more than \$971 million on prescription drugs because

of the Affordable Care Act and the closing of the donut hole that was created in 2003 with Medicare Part D.

And I am proud of the progress that we have in our country made with the ACA and I couldn't be more pleased with these results, but Congress could make it better by stopping the dozens of repeal efforts and help provide more health care for our constituents. Regardless of whether you supported the ACA 6 years ago or when it passed into law, it is hard to deny that there is historic success.

Before the Affordable Care Act was passed the insurance system was broken. Premiums were increasing rapidly. For example, in 2009–2010, according to Kaiser Family Foundation survey, the average increase in individual market premiums for individuals who were covered more than 1 year was 15 percent. Under the pre-ACA system there were no protections for consumers, and insurance companies could drop them within any time.

Administrator Slavitt, before the ACA was passed could an individual with preexisting condition be charged more for insurance than his or her healthy peers?

Mr. SLAVITT. Yes. In most places in the country, yes, that's correct.

Mr. GREEN. Before the ACA was passed could insurers protect their bottom lines by avoiding the sickest and costliest patients in the individual market?

Mr. SLAVITT. Yes, in almost every state in the country.

Mr. GREEN. Before the ACA was passed was there any mechanism for the federal government to review health insurance rates to ensure that the rates were reasonable; did consumers have any recourse if their premiums went up 20, 30 or 40 percent?

Mr. SLAVITT. No, not in most places, sir.

Mr. GREEN. Was there any out-of-pocket maximum or did consumers have to shoulder potentially tens or hundreds of millions, hundreds of thousands of dollars due to medical emergencies?

Mr. SLAVITT. There was not.

Mr. GREEN. Let me give you an example in my last time. When I was in business we had a printing company. We had 13 employees and one of my jobs as the manager of it was to negotiate for insurance rates. Small business, 13 employees; we could never get one of the top companies to give us bids. But we did select coverage because we also had a union contract for our line folks so we had to match what the union plan would have done, so we negotiated it and we would sign a 3-year contract and with renewal opening of the premiums every year.

Well, in my experience in that every year of that 3-year contract, they would come in and offer us, say, well, we need 20 or 25 percent more. We would negotiate it down. It ended up I almost had to negotiate every year with a new company.

But my experience was with 13 employees one of our carriers who had our insurance said, well, we need to raise your premiums substantially because one of your employees actually had a double mastectomy. And he said, what we would suggest, if you keep your group at 12 people and buy a separate plan for that 13th employee. And I said, well, I appreciate that option, but that particular lady is the owner's wife, and I will be glad to share you are willing to

put them out on an individual market. And believe me, our negotiations got much better.

That doesn't need to happen today because of the Affordable Care Act. And that is why it is successful, and it could be more successful if this Congress would do like we have done every other piece of legislation that has ever been passed. Something gets passed, you wait a few years and see what the problems are and you go back in and fix it. But we haven't had that opportunity since we have tried to repeal it over the last 6 years probably 60-something times.

But if you are looking for perfection in any piece of legislation you don't come to Congress. We compromise, we work to get things passed, so whatever we pass needs to be looked at by new congresses or next congresses to make sure we can fix it, but the Affordable Care Act has not been subjected to that because of the repeal. I would love to see a plan that would actually help expand coverage more than we have done.

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

Mr. PITTS. The chair thanks the gentleman and now recognizes the chair of the O&I Subcommittee, Dr. Murphy, 5 minutes for questions.

Mr. MURPHY. Thank you, Mr. Chairman.

Mr. Slavitt, first I want to ask, you had mentioned in your testimony that premiums have gone down in actuality or they have gone, they are less than what CBO estimated?

Mr. SLAVITT. I think what I said is after the second, after 2016, so current premiums are between 12 and 20 percent lower than ingoing estimates. And I can get you the cite for that.

Mr. MURPHY. Than estimates, they are lower than estimates?

Mr. SLAVITT. They're lower than they were estimated to be at this time. And I can get you the cite for that.

Mr. MURPHY. Well, I just want to deal with reality not estimates, because the CBO is not held in high esteem in terms of always being accurate.

Mr. SLAVITT. It wasn't CBO.

Mr. MURPHY. But estimates, have you shared this information with Aetna, United and Humana? Because the fact that they bailed out of the market saying this is out of control, maybe you have a breakthrough for them that all of these companies haven't seen.

It is amazing to me. Health care costs have gone up. I saw one Standard & Poor estimate said they have gone up about 69 percent in the last few years. Insurance premiums have gone up so there is adverse selection. People enroll and then they disenroll when they are well; co-pays and deductibles are still high.

So I hope you can show us the source of this. I don't want estimates. I want hard core data with regard to are premiums going up or not. All the data we see is they are going up. In the Pittsburgh market they are going up. In other communities they are going up. CO-OPs are failing because they can't handle the finances.

So unless something is heavily subsidized or old or a problematic health program, the costs are going up and that is why people aren't signing up. So it is not a matter of—I just want accurate data so we can deal with this, so please get us that.

Let me ask another question. The committee staff report that we released yesterday examines how CMS awarded federal tax dollars to state-based exchanges. The ACA states that state-based exchanges were supposed to be self-sustaining by January 1, 2015, but CMS gave them extensions so that state-based exchanges could continue to use federal money.

So Mr. Slavitt, your staff tells me that currently as of September 2016, every state-based exchange is still using federal money; is that correct?

Mr. SLAVITT. Yes. So to clarify, no new money has been certainly granted after that initial start-up date.

Mr. MURPHY. They are still using federal money?

Mr. SLAVITT. There are states that have no-cost extensions which essentially allow them to continue to complete the start-up activity that they began—

Mr. MURPHY. They are still using federal money. And again I say when you talk about premiums being down, the fact that they are subsidized is phony, is absolutely phony. How can you have a premium going down if you are still subsidizing it, if we are still bailing out insurance companies? Premiums aren't going down, it is being subsidized.

So when does CMS think that the federal money is actually going to run out? 2017? 2018?

Mr. SLAVITT. For state-based marketplaces?

Mr. MURPHY. Yes. Yes.

Mr. SLAVITT. I think it'll differ by state. I think we can get you the schedule of that.

Mr. MURPHY. And that is when we are really going to find out what premiums are if we are not bailing them out. When the federal money runs out do you think the state-based exchanges will be sustainable?

Mr. SLAVITT. Well, I think each state has its own calculation. As people are probably aware, Kentucky most recently has decided to move off of the state-based platform to the federal platform. I wouldn't necessarily say that was for reasons that they weren't sustainable, they just chose that they'd rather be on the federal platform than the state-based platform, and I think that happens for a variety of reasons.

Mr. MURPHY. That is obfuscating here, because these are not just things as, hey, let's all get together and let's just switch to a different platform. It is because they have been financial disasters.

And let's go to the CO-OPs. You have got 17 closures, one closed just this week. HHS OIG issued an audit just a few months ago finding that four of the remaining six CO-OPs fell below CMS risk-based capital requirements. So do you think all the remaining six CO-OPs will survive the next few months to enroll individuals for the 2017 plan year?

Mr. SLAVITT. So I think the assessment that the states will make and we will make it along with the states is whether or not the remaining CO-OPs have sufficient capital to get through 2017.

Mr. MURPHY. And we have given them \$1.8 billion in taxpayer loans of the 17 that have failed. So when you say sufficient capital we are going to have to give them more sufficient capital to help them?

Mr. SLAVITT. No, there is no additional capital. Congress has in fact rescinded, I think it was \$6 billion of capital that was due to the CO-OPs and that's, so part of the capital issues that they have. We have given the CO-OPs, in trying to level the playing field, more options to raise outside capital, and I think several of them may in fact do that.

Mr. MURPHY. Raise outside capital, so that outside capital being what? Premiums aren't paying for the plans then. They are getting other outside sources to help bolster the plans so it is not just shouldered by the people paying on premiums; am I correct?

Mr. SLAVITT. It would be the risk-based capital needed to support their ability to write business—

Mr. MURPHY. So I go back to my original point. If they have risk-based capital coming in, if they have federal subsidies coming in, anything you say about premiums going down, first of all, I doubt that is true because we are not hearing that from constituents. But the second thing is, if you are subsidizing it any reduction is false. I yield back.

Mr. PITTS. The chair thanks the gentleman and now recognizes the gentlelady from Colorado Ms. DeGette, 5 minutes for questions.

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

Mr. Bagdoyan, I wanted to clarify about the GAO's undercover study that they did here, a few things. As I understand it from your statement, there were 15 attempts in three states to get into the system; is that right? It wasn't actually 15 people, it was 15 attempts by the GAO fake shoppers to do this; is that right?

Mr. BAGDOYAN. These are essentially—

Ms. DEGETTE. Yes or no will work.

Mr. BAGDOYAN. No, that's not true.

Ms. DEGETTE. Fifteen attempts in three—OK, what was it then?

Mr. BAGDOYAN. It's 15 individuals attempting.

Ms. DEGETTE. Fifteen separate individuals?

Mr. BAGDOYAN. Yes, ma'am.

Ms. DEGETTE. I thought there was one individual that tried in three states, no?

Mr. BAGDOYAN. That was to test identity theft and—

Ms. DEGETTE. I see, OK. But it was 15 individuals in three states then.

Mr. BAGDOYAN. Correct.

Ms. DEGETTE. OK. Now these were the fake shoppers, these weren't actual consumers. These were people who were getting in to try to see if they could do this, right?

Mr. BAGDOYAN. Yes, these are fictitious people.

Ms. DEGETTE. Thank you. Now in these type of schemes that the report discusses, these 15 fake shoppers, they pay their premiums but then they don't get any health care benefits; is that right?

Mr. BAGDOYAN. That's correct.

Ms. DEGETTE. And in fact they didn't try to get any health care benefits. They just wanted to see if they could get the premium rebate.

Mr. BAGDOYAN. That's correct, yes.

Ms. DEGETTE. Now, so I guess I am a little unclear about why somebody would do this in real life, if they pay the premium and then not try to get health care insurance. So I guess I wanted to

ask you, do you know of any actual cases of real people who did this?

Mr. BAGDOYAN. I do not.

Ms. DEGETTE. So you are not aware of any widespread fraud of actual people trying to do this, you just know it could be done theoretically?

Mr. BAGDOYAN. We know it could be done based on——

Ms. DEGETTE. Thank you.

Mr. BAGDOYAN [continuing]. The vulnerabilities of——

Ms. DEGETTE. Now I want to ask you something else because I am really supportive of efforts to root out fraud in the system, but I don't really understand how this is a useful exercise in the real world to see if someone could pay a premium, get a tax credit, and then not try to get insurance. I don't think that would happen in the real world, and so what I am wondering about is why this is useful.

But I want to ask about something else, and that is about this GAO report that was released by your agency on Monday. We are handing you a copy of that right now.

Mr. BAGDOYAN. Thank you.

Ms. DEGETTE. What this report did is it looked at enrollees' experiences during the first year of the ACA exchanges and it collected consumer satisfaction information. It is entitled and I am quoting—you can see it.

Mr. BAGDOYAN. Yes.

Ms. DEGETTE. Most enrollees reported satisfaction with their health plans, although some concerns exist. Do you have that?

Mr. BAGDOYAN. Yes, I do.

Ms. DEGETTE. Are you familiar with that report, sir?

Mr. BAGDOYAN. Yes, I am.

Ms. DEGETTE. Oh, you are familiar. So then you know that the main finding of the report is, "most qualified health plan enrollees who obtain their coverage through the exchanges reported overall satisfaction with their plans." Is that correct?

Mr. BAGDOYAN. That's correct, yes.

Ms. DEGETTE. Thanks.

Mr. Chairman, I would like to enter this report into the record.

Mr. PITTS. Without objection, so ordered.¹

Ms. DEGETTE. Thank you. Now there is another piece of evidence that shows what exactly we are trying to do here. We have one GAO report that shows 15 people, fake shoppers in three states trying to do something that no real person would do in real life, and then we have reports from the same agency on the same day about enrollee satisfaction taken from large national surveys.

But that is not the subject of this hearing today, only the other thing that is not likely to happen in real life. And so I just think we have to keep the record clear and we also again have to focus as we move forward on fixing the ACA.

I just want to ask you, Administrator Slavitt, a question about this new report about the census and the CDC data that both show that uninsured rates are at historic lows. The census showed that

¹The information has been retained in committee files and is also available at <http://docs.house.gov/meetings/IF/IF02/20160914/105306/HHRG-114-IF02-20160914-SD003.pdf>.

the uninsured rate fell to 9.1 percent in 2015 down from 13.3 percent in 2013; is that correct?

Mr. SLAVITT. Yes, that's correct.

Ms. DEGETTE. Now the CDC data showed a drop in the uninsured rate to 8.6 percent down from 16 percent in 2010; is that correct?

Mr. SLAVITT. That's correct.

Ms. DEGETTE. And so it really shows that there are now 20 million Americans who have health insurance because of the ACA's various coverage provisions; is that accurate?

Mr. SLAVITT. Yes that is.

Ms. DEGETTE. Thank you. I yield back.

Mr. PITTS. The chair thanks the gentlelady and now recognizes the gentleman from Illinois, Mr. Shimkus, 5 minutes for questions.

Mr. SHIMKUS. Thank you, Mr. Chairman. Welcome to our witnesses. And, you know, this is just a contentious issue and facts are important and data, and customer satisfaction viewed by our constituents is what drives a lot of this.

Mr. Slavitt, under the Affordable Care Act if you like your health care plan will you be able to keep it? Yes or no.

Mr. SLAVITT. If it continues to be offered, yes. If not, then you'd switch to, shop and find a different plan.

Mr. SHIMKUS. OK, so no, you can't if the plan that you had prior to the Affordable Care Act is no longer available to Americans.

Mr. SLAVITT. The plans available since the Affordable Care Act are at much better benefits than prior to the Affordable Care Act.

Mr. SHIMKUS. Let me ask the second question. If you like your doctor you will be able to keep it with no changes prior to the Affordable Care Act and now no.

Mr. SLAVITT. I think it's always been true that physicians and health plans continually change their relationships——

Mr. SHIMKUS. There are limited provider networks or you will pay extra, so that is no longer true. Are premiums lowered by \$2,500 for a family of four?

Mr. SLAVITT. I think if you are referring to the——

Mr. SHIMKUS. The promise by the President when he campaigned for this——

Mr. SLAVITT. I believe that analysis is that it's lower than it would have otherwise been if it continued to grow.

Mr. SHIMKUS. OK, then the answer is really no, premiums have increased. They haven't decreased. The promise was premiums on average would decrease by \$2,500 per family. Obviously premiums have gone up. The other promise was 80 or 90 percent of all Americans, the insurance will be stronger, better, and more secure. Do you think that is true?

Mr. SLAVITT. Yes.

Mr. SHIMKUS. Well, let me read you two notes from constituents of mine who obviously are living it. And these are follow-ups from meetings I had with the August break.

Before this terrible bill I paid \$78 a month for my child health care coverage premium and had a good plan. I now pay \$167.44 a month and have a much worse plan with high out-of-pocket cost. He recently got tubes in his ears, a common procedure, and it cost

us over \$5,000. That is why this is real to us and that is why we continue to have problems with the Affordable Care Act.

Another constituent wrote—he is a retired senior, doesn't qualify for Medicare yet. My wife and I pay a hundred percent of the premium cost for the Bronze plan we purchased through healthcare.gov. We had a Silver plan in 2015, but the cost of the plan increased roughly \$400 a month—that is a premium increase—so we downshifted.

Although retired, we do not yet qualify for Medicare and our investment income is too high to qualify us for subsidy assistance. On the surface that would seem to be a good thing, but we aren't that far above the income cutoff and without a subsidy assistance these premiums are taking a large percentage of our income and it is getting worse over time.

In 2015, we paid \$14,000, almost 15, 14.9, which was 22 percent of our adjusted gross income. This year our premiums will total \$15,369 which what I estimate to be about 23 percent of our income. We understand that our 2017 insurance companies in Illinois are requesting premium increases of about 30 percent. That would amount to a total annual premium of \$19,980.32 for our Blue Cross Bronze plan that will be almost 30 percent of our income for premiums alone.

So following up on the comments of my colleagues, we have a challenge and the premiums are up. And if you make the statement that the premiums are not up, then you disregard the fact that copays and deductibles are way up. So you keep siloed in premiums, premiums are going up that is not disputable, but you don't talk about the deductibles and you don't talk about the copays which are making it unaffordable for average income Americans under this health care plan and this health care policy.

Mr. Slavitt, what do you consider to be a competitive market? What is your definition of competition?

Mr. SLAVITT. So I grew up in Illinois.

Mr. SHIMKUS. And to think about Illinois—

Mr. SLAVITT. Yes.

Mr. SHIMKUS [continuing]. That is a good point, because before the Affordable Care Act we did not have a state public utility commissioner that set rates for health insurance. It was only after the Affordable Care Act. And we had a very robust, competitive market which we were proud about because our health insurance was driven by competition on price and quality without intervention of a government bureaucrat trying to dictate the terms of the negotiated agreement between a buyer and a seller. Go ahead.

Mr. SLAVITT. Here's what I could tell you. The uninsured rate in Illinois has dropped from about 15 1A½ percent to about 8.7 percent. I think that's great news for the state.

Mr. SHIMKUS. Are you disputing these numbers of my constituents that I mentioned in their stories?

Mr. SLAVITT. Absolutely not.

Mr. SHIMKUS. OK, I yield back my time.

Mr. PITTS. The chair thanks the gentleman. I now recognize the ranking member of the full committee, Mr. Pallone, 5 minutes for questions.

Mr. PALLONE. Thank you, Mr. Chairman. I want to ask my questions of Mr. Slavitt, but I have to say I continue to be amazed by Republican attempts to suggest that things were better before the ACA. I mean, it is clearly not the case.

Despite endless attempts by Republicans to repeal, undermine, and defund the law, the Affordable Care Act is making health coverage a reality for many Americans who didn't have coverage before. Census data released yesterday found that the uninsured rate was at 9.1 percent in 2015, down from 16 percent in 2010, and according to recent CDC data the uninsured rate had dropped to a historic low of 8.6 percent in the first quarter of 2016. For the first time more than 90 percent of all Americans have health insurance and that is without the expansion of Medicaid in states like Texas mentioned by our ranking member Mr. Green.

So Administrator Slavitt, can you put this reduction in the uninsured rate in historical perspective? How significant is this drop, and can you comment on how the different coverage provisions of the ACA have operated together to result in these gains in insurance coverage?

Mr. SLAVITT. Certainly, and thank you for the question. My entire career, which was in the private sector, had not seen any meaningful reduction in the uninsured rate, so seeing the kind of numbers you talk about occur are incredibly gratifying and I think a sign of progress. And as you say we have more progress to make. There are still millions of people who live in states that haven't chosen to expand Medicaid, and if they did the uninsured rate would be even lower.

Mr. PALLONE. Well, let me ask you this. I don't think there is any question that we have made great progress in providing coverage for individuals who were previously uninsured, but as the number of uninsured shrinks the remaining individuals who are eligible may be harder to reach. And it is incredible to me how many people still are not aware of the fact that they can go on the exchange and they have subsidies.

Most people aren't going to believe this, but within the last 6 months I had one of my constituents come up to me and say, and ask me when the federal government was going to make available health insurance to those who don't get it through their job. And I was like, well, we have the Affordable Care Act. You know, you can go on this exchange and you are eligible for a subsidy, because they gave me their information. And this was less than 6 months ago. It is just incredible.

So according to some experts, many of the remaining uninsured are actually still unaware or confused about how federal subsidies are available to help them purchase insurance. So could you tell me, how is CMS recalibrating its outreach in enrollment strategy in order to communicate with these harder to reach populations?

And also, am I correct in stating that more than 80 percent of individual market consumers were eligible for tax credits as are the majority of the remaining uninsured? So what is CMS doing to communicate with these individuals that there is a marketplace that they can get a subsidy?

Mr. SLAVITT. So you're exactly right. There are still several million individuals in this country who are eligible for health insur-

ance, many of them, in fact most of them below \$75 a month in premium and are still not aware. So we are extremely excited about open enrollment for this upcoming enrollment season that begins November 1st, and have a significant effort to make sure we figure out how to reach these new people and educate them.

A lot of it really requires in-person assistance. Health insurance, particularly if you've never had it is very complicated and people are sometimes intimidated by it. But we do find as I have noted earlier that once people are covered their satisfaction is high and they can start to afford their prescription medicines. So really, we need to enlist people at the local level continually and we're going to do that at this open enrollment.

Mr. PALLONE. I don't know. I don't want to put words in one of my GOP colleague's mouth, but I think it was Mr. Murphy who said something about reducing the amount of money that was available for state exchanges. And I don't know if it is the same thing. Maybe that is not the pot of money that they use for outreach.

But it disturbs me because I don't want to see the GOP efforts to say, look, we have got to cut back on this or cut back on that, reduce the money for outreach. But you do have that money available, right? That is not going to run out, the money that you use for this kind of outreach?

Mr. SLAVITT. That's right. And that is indeed what I think states who run their own exchanges are accountable for.

Mr. PALLONE. And so they will continue to have that money available for some in the foreseeable?

Mr. SLAVITT. That's right. They charge user fees typically or have other appropriations and they use it for that purpose. More is better.

Mr. PALLONE. Thank you very much.

Mr. SLAVITT. Thank you.

Mr. PITTS. The chair thanks the gentleman and now recognizes the gentleman from West Virginia, Mr. McKinley, 5 minutes for questions.

Mr. MCKINLEY. Thank you, Mr. Chairman. I think I am going to address my remarks primarily to Mr. Slavitt, if I could, please. Last fall I asked you if you could get back to us on why the premiums are so high in West Virginia. We have the seventh highest premium rate in the country. We have not heard back from you since last fall, almost a year ago. We are still waiting for that call about it, because we only have one exchange in the state and we have seen the premium increases logarithmically continue to increase.

So I need that answer. I am expecting that answer. But I am also saying that look, this past year we had a 24 percent hike in our premiums and now they are—excuse me. That is what we had was 24, then this year there was approval of 32 percent increase. And this coming year we have had a small group trying to penetrate to give a second option to West Virginia and they are asking for a 49.8 percent increase, and from what we understand they are likely going to get it.

So my question in part to you is what is the incentive for the regulators in West Virginia or any other state to hold down premium increases if we are going to be subsidizing so many of them?

Mr. SLAVITT. So thank you. I'd say on the one hand that the great news in West Virginia is that the uninsured rate has dropped from about 17 percent to about 7 1A½ percent. On the other hand as you point out, we are concerned with the cost of health care particularly in rural America. It has always been the case. This is not an ACA phenomenon. The lack of competition in some parts of the country are areas that we need to address.

I think that some of the protections in the ACA do help speak to the issue you raise. So for example, if an insurance company were to charge too much they're obligated to give back in rebates to the consumers.

Mr. MCKINLEY. I don't know how that ultimately breaks down, if I could. I don't know how that breaks down, because they are continuing to make these hikes and I don't think there is an incentive for the regulators to hold that down, especially if they are going to grant an increase of 50 percent hike with it.

Let me give you an example and maybe you can work my way through this, because it is going to work out she is going to have to have a subsidy again which falls back into why keep the premiums down if you are going to give them a subsidy. A 60 year old lady who is working, her husband just lost his job, and she was covered under his insurance policy. She was covered under his, so now she doesn't have insurance coverage. And in the past what she would have done—wait, she is 62. He is retired and he went on Medicare. She doesn't have coverage.

When we spoke to her she said, I would have gotten catastrophic coverage but I can't do that. I am not permitted to under the ACA, so now I have to go out and buy coverage. And it is going to cost her. The cheapest rate she could get was \$800. That means it is \$9,600 a year she is going to have to pay. But then I guess what you are going to say, you are going to step in and say, well, we are going to provide her premium. We are going to give her a subsidy to this; is that correct?

Mr. SLAVITT. What I'd say is I don't know this particular situation, glad to look into it. But I would say that for most people in America who are in that situation they just prior to the ACA weren't guaranteed access to insurance, particularly if they were one of the 129 million Americans who had a preexisting condition. So we think that's a really critical advance. We know that costs matter. We think the subsidies are important. We think the subsidies are a critical part of the law.

Mr. MCKINLEY. I appreciate it. I hope that we can do something, because at \$10,000 a year that is after taxes, how much she would be dedicating her income in that what she is making it is not a lot of money. But let me switch horses entirely on the thing—and I hope that you can get back to me on this other matter because you haven't the first time—but, and that is that we are site-neutral.

We have got a hospital complex in West Virginia that has been trying to get a permit for numbers of years. It took them several years to get this permit to build an ancillary hospital facility nearby. And as a result of being held up because of the government for

water permits and road permits, environmental permits, it didn't occur until after November of 2015.

And now as a result of that by virtue of them now having invested \$30 million into this under the site-neutral plan they will lose \$4 1A½ million of revenue for that hospital. I am asking if you can get back to us or have a conversation with us about how much more flexibility we can have to go beyond that because it was not of their doing. This was an arbitrary date of November of 2015 that was established.

And I really would like to hear this because it is going to have an impact. That \$4 1A½ million it is going to cost, it is going to be borne by somebody else. And that is once again in rural America what it is going to impact is where we have the cost shifting, and it doesn't have to happen if we could just have a little flexibility in dealing with that site-neutral deadline date. Can you get back to me?

Mr. SLAVITT. Yes. And I think as you're aware we're in the middle of a rulemaking process, so glad to get back to you and listen to comments, and particularly in this particular hospital situation make sure we understand all the details. So yes, we'll get back to you.

Mr. MCKINLEY. Very soon. Thank you very much. I appreciate it and yield back.

Mr. PITTS. The chair thanks the gentleman and now recognizes the gentlelady from California, Ms. Matsui, 5 minutes for questions.

Ms. MATSUI. Thank you, Mr. Chairman. I want to thank the witnesses for being here today. I have some few facts from California. The Affordable Care Act makes significant investments to improve the health of our nation and for Californians. I would like to highlight a few of these benefits.

Since last November over 1.5 million individuals in California have gained coverage through the health insurance marketplace. Because of the ACA there are 78,000 children in California that cannot be denied health coverage because of preexisting health condition. Between 2013 and 2014, the uninsured rate in California dropped by over 6 percentage points from 21.6 percent in 2014 to 15.3 percent in 2013.

And as the CDC reported last week, the national insurance rate is now at a historic low. Under the ACA health insurance companies must spend at least 80 percent of premium dollars on health care or improvement to care as opposed to administrative costs like salaries or marketing or they have to issue a refund. As of 2015, more than 490,000 Californians with private insurance coverage benefited for more than \$11 million in refunds.

The Affordable Care Act is doing great things in California and I am proud to see that. We see how Medicaid expansion has helped to bring the uninsured rate to its current historic low. Gallup data from earlier this year found that seven of the ten states with the largest reductions in uninsured rates were Medicaid expansion states. Gallup also found that states that have not expanded Medicaid were less likely to see improvement in their uninsured rates compared to states that have expanded coverage.

Unfortunately we are seeing a widening gap in the uninsured rates between expansion states and non-expansion states. Administrator Slavitt, do you expect that trend will continue in the states that continue to choose not to expand Medicaid?

Mr. SLAVITT. Yes, I do.

Ms. MATSUI. Administrator Slavitt, if all states chose to expand Medicaid do you imagine that we will see the uninsured rate drop even lower than where it is now?

Mr. SLAVITT. Yes, I think there's three to four million people easily that would be covered.

Ms. MATSUI. Thank you. We also know there are many other benefits to expanding Medicaid. For example, premiums on the individual insurance market on average 7 percent lower in states that have expanded Medicaid. I am hopeful that we can see the uninsured rate continue to drop and I hope more states do right by their citizens by choosing to expand Medicaid.

Now every time one provision of the ACA has a bump in the road we hear from our Republican colleagues that this is the end of health reform. But the fact is that the law is confirming benefits on millions of Americans across the country and it is important to put these issues in context.

Administrator Slavitt, we have heard that 2017 is a transition year for the marketplace. Why might we be seeing higher premium increases in 2017 than we saw in previous years?

Mr. SLAVITT. So I think there's two principal reasons and both of them I think are one-time effects. The first is that the law created a 3-year reinsurance pool that expires this year, so by definition that will increase premiums pretty meaningfully. Secondly, it's a fact that in the first couple years of the exchange the insurers priced without having data on what the claims costs would be. They now have that data.

I think in many cases in many states they've found that they've priced too low and I think are asking for and receiving some justifiable rate increases. But again the good news is medical cost trends across the country are very low, so once these one-time effects kick in, I think our expectation is that we will see a very normalized continued low rate of growth.

Ms. MATSUI. Now as the insurance market adjusts, the ACA has other measures in place like tax credits to keep premium affordable and provide choices for consumers. My understanding is that the majority of current marketplace consumers, in fact, benefit from these financial assistance measures.

Administrator Slavitt, how will these mechanisms including tax credits and the opportunity to shop around for different plans help consumers find affordable coverage as the market stabilizes?

Mr. SLAVITT. I think when consumers learn that the vast majority of them are able to purchase coverage for \$75 a month or less in premiums, it is absolutely astounding to them given the amount of financial security and health security that they've never been able to obtain before in their lives have had. So we think during the fourth open enrollment we're really eager for people who haven't yet heard about the marketplace and understand those benefits to come back.

Ms. MATSUI. Oh, I thank you and I yield back.

Mr. PITTS. The chair thanks the gentlelady and now recognizes the gentleman from Virginia, Mr. Griffith, 5 minutes for questions.

Mr. GRIFFITH. Thank you, Mr. Chairman.

Administrator Slavitt, on Friday last, CMS issued a five paragraph memo on risk corridor payments for 2015. Several insurance companies are suing the Administration over 2014 payments because they only collected 12.6 percent of what the industry requested to be made whole. In the last paragraph of the memo, your agency wrote, and I quote, as in all cases where there is a litigation risk, we are open to discussing resolution of those claims. We are willing to begin such discussions at any time, end quote.

Does CMS take the position that insurance plans are entitled to be made whole on risk corridor payments even though there is no appropriation to do so, yes or no?

Mr. SLAVITT. I think what we've always said is that the risk corridor payments are an obligation of the federal government and I think that—

Mr. GRIFFITH. Yes or no?

Mr. SLAVITT. I think that statement's just standard practice.

Mr. GRIFFITH. So it is yes?

Mr. SLAVITT. I'm sorry. Can you rephrase the question for me and I will—

Mr. GRIFFITH. I will restate it. Does CMS take the position that insurance plans are entitled to be made whole on risk corridor payments even though there is no appropriation to do so? And I took your answer as a yes; am I correct?

Mr. SLAVITT. Yes. It is an obligation of the federal government.

Mr. GRIFFITH. So it is a yes? Just waiting to hear you say yes.

Mr. SLAVITT. If that's how you interpret that. Yes, sure.

Mr. GRIFFITH. Seriously? All right. Do you intend to use the judgment fund to make the risk corridor payments to insurance plans? Yes or no?

Mr. SLAVITT. I would say that further questions are—I would not be comfortable commenting on any current legal proceedings and I'd prefer to—

Mr. GRIFFITH. You did an invitation to settlement. There is no appropriation for the funds. Are you intending to use the judgment fund, yes or no?

Mr. SLAVITT. Again this is a case before Justice and so I'd be more comfortable not talking publicly about that.

Mr. GRIFFITH. So what you are saying is is that you have turned this over to Justice and you have talked to the Justice Department about the various suits?

Mr. SLAVITT. I personally have not.

Mr. GRIFFITH. You have not. Can you get me the names by the 16th of September, because this is time-sensitive. Can you get me the names of those people that have spoken with Justice about this matter?

Mr. SLAVITT. Sure.

Mr. GRIFFITH. Thank you. I appreciate that. Now which insurance plans are suing or have indicated they intend to sue CMS or the United States in relationship to the risk corridor payments?

Mr. SLAVITT. I don't have a list with me, so I can get that to you.

Mr. GRIFFITH. And again because it is time sensitive can you get me a list by September 16th?

Mr. SLAVITT. Absolutely.

Mr. GRIFFITH. I appreciate that very much. Now you indicated you haven't spoken to Justice, but do you know of anyone in your Department that has discussed settlement plans with the Department of Justice?

Mr. SLAVITT. I know that our general counsel speaks to Justice regularly, so I assume that they have but I don't know any detail.

Mr. GRIFFITH. Well, I am assuming that you authorized the memo that I quoted earlier where you created an invitation to settle. I would assume that you know that there were some discussions with Justice prior to making an invitation to settle with these companies; is that not correct?

Mr. SLAVITT. That's correct.

Mr. GRIFFITH. That is correct. So there have been discussions by somebody with Justice about how you are going to settle and you don't know where the money is going to come from, but you assume somewhere it will come from.

Mr. SLAVITT. Yes. They're representing us so we in fact have talked to them. Yes.

Mr. GRIFFITH. All right. I am curious. Have you had any conversations about the lawsuits with your predecessor who is now a top representative for the insurance industry about the risk corridor situation? Yes or no.

Mr. SLAVITT. No.

Mr. GRIFFITH. And prior to issuing the memo, and I touched on this briefly but I want to make sure I am clear. Prior to issuing the memo, did Justice Department approve the memo that you released on Friday which had an invitation in the last part of it to settle the lawsuits?

Mr. SLAVITT. I believe they reviewed the language, yes.

Mr. GRIFFITH. All right. And has CMS spoken with any insurance plan directly or indirectly about settlement of the risk corridor lawsuits? Yes or no.

Mr. SLAVITT. CMS has had inquiries from insurance companies which we've then referred over to Justice.

Mr. GRIFFITH. And do you remember which insurance companies they were?

Mr. SLAVITT. I can get you that.

Mr. GRIFFITH. If you can get me that by September 16th I would greatly appreciate it—

Mr. SLAVITT. OK.

Mr. GRIFFITH [continuing]. Because it is a time-sensitive matter, as you can imagine.

Mr. SLAVITT. OK.

Mr. GRIFFITH. I do appreciate that. With the last few seconds that I have I am going to switch gears a little bit. And I have heard a lot of folks talk about the uninsured. One of the problems that I am having when I get my complaints in my district about Obamacare is underinsured; that with the copays and the deductibles and in order to afford the insurance because the rates have gone up, my folks are having to pay high deductibles.

They in essence don't have significant enough insurance, and when a catastrophic illness or injury occurs they are finding that they are having to sell off assets that they have had to work for for years including homes, et cetera. And I am just wondering, does anybody keep numbers on those who I would call the under-insured? They may have a plan but not one that keeps them from being financially crippled should they have a catastrophic illness or injury.

Mr. SLAVITT. Yes. The most recent numbers that I've seen despite the headlines show that in 2015 on the exchange the median deductible was \$850, which was a decrease from the prior year where it was \$900.

Mr. GRIFFITH. And all I can say, Administrator Slavitt, to that is that when folks come up to me at the New River Valley Fair, who are average hardworking folks in a relatively poor district, that is not what they are telling me. My time is up. I yield back.

Mr. PITTS. The chair thanks the gentleman and now recognizes the gentleman from Kentucky, Mr. Yarmuth, 5 minutes for questions.

Mr. YARMUTH. Thank you very much, Mr. Chairman. I thank the witnesses for appearing. This does sound a lot like the movie Groundhog Day. We have been through all of these arguments before and it becomes very frustrating. This hearing has a new title, The Affordable Care Act on Shaky Ground, and I would submit that if it is on shaky ground it is because Republicans both in Congress and across the country where they have the authority are planting dynamite in the ground under the system.

And I think that is why all of my colleagues have talked about the fact that we continue to ignore the incredible progress that has been made under the Affordable Care Act, not only the number of people who have been insured who were previously uninsured but also the people who have been protected now against significant financial loss or even unnecessary debt because they have coverage.

I want to talk about my state though. And in the chairman's report, the CMS's regulation of exchanges and so forth, it makes some statements about Kentucky's exchange that I think dramatically mischaracterized what has gone on there. The last time you were here I asked you a question because I knew our new governor at that time had promised to dismantle Kynect, our state exchange, during his campaign. And I asked you if you could think of any way in which any Kentucky resident would be better off on the federal exchange than the state exchange, and you answered you couldn't; is that correct?

Mr. SLAVITT. That's right.

Mr. YARMUTH. That is right. Do you think that anything happened in Kentucky between that answer and the time that Governor Bevin actually submitted his request or notification to you that he was going to disconnect Kynect to make that different?

Mr. SLAVITT. Not to my knowledge.

Mr. YARMUTH. And in fact, the reason he did that was not because of any reason that made sense either economically or in terms of providing service for our citizens, but because he has an ideological opposition to Kynect and promised to do it during the

campaign. You don't have to answer that; that is my characterization.

But now what he is doing is even worse, because while we had the most successful change, arguably, in the country that he has basically dismantled, we also have one of the most dramatic increases in, or reductions in uninsured because of expanded Medicaid. More than 400,000 Kentuckians now have coverage who didn't have it before.

And what Governor Bevin has done now is made a proposal for a waiver to change a lot of the Medicaid system in Kentucky. He has made a proposal to CMS which he counseled with you before, you and your staff, before he made the proposal in which you told him what might be acceptable and what might not be acceptable under the proposal; is that not correct?

Mr. SLAVITT. We did have a dialogue, yes.

Mr. YARMUTH. And in spite of that he has submitted a proposal to you which I think according to the law you are almost obligated to reject. On Page 15 of that proposal he says if this demonstration project is not approved I will dismantle Kynect. I will dismantle the Medicaid expansion in my state.

So what he is doing is setting up for you to reject the proposal and then he is going to dismantle Medicaid expansion in Kentucky, take insurance away from 400,000 of our citizens, jeopardize many providers who are now being compensated for the care they provide, and he is doing it again for ideological reasons.

So the point I want to make is that yes, there are a lot of problems and a lot of things going on in this state, in this country right now that may call into question the Affordable Care Act. But the things that are going wrong are things that Republicans are doing to sabotage the functioning of the act, the law.

And that is why we are so frustrated that instead of offering suggestions to improve the ACA—which we could in many, many ways; we all agree on that—the Republicans in Congress again hold hearings like this, vote time and time again, more than 60 times to repeal the ACA, and have never proposed an alternative that is anything but going back to where we were before the ACA when insurance companies controlled the system.

They want to throw it back in the private system. That is what Matt Bevin says he wants to do in Kentucky as if that is some noble objective. And the reason that they have not proposed a viable alternative to the ACA other than going back to the pre-ACA situation, I am convinced, is because the only other alternative is single payer. And if you listen to virtually every complaint that is raised during this hearing today and then every other hearing, those complaints would not exist under a single payer system.

Now I don't think anybody is ready to go there right now. We are going to end up there eventually, but I think we ought to start being honest with the American people about what the options are available to them and how important the ACA's success is to them as well. I yield back.

Mr. PITTS. The chair thanks the gentleman and now recognizes the gentleman from Missouri, Mr. Long, 5 minutes for questions.

Mr. LONG. Thank you, Mr. Chairman. And Mr. Slavitt, is it true that the current CEO of the federal exchange healthcare.gov is Kevin Counihan?

Mr. SLAVITT. Yes, sir.

Mr. LONG. It is also my understanding and I am sure you are aware that he was invited to testify here today but did not come. Do you know why he is not here?

Mr. SLAVITT. He's on travel today, sir.

Mr. LONG. I am sorry?

Mr. SLAVITT. He's traveling today, sir. I believe he's in South Carolina.

Mr. LONG. South Carolina.

Mr. SLAVITT. That's my understanding.

Mr. LONG. OK. Do you have any idea of where he was back on the September 6th or 7th, whenever Arizona, the same day that Arizona's Blue Cross Blue Shield mysteriously decided to sell plans in Pinal County? Do you know if he would have been in Arizona at that time?

Mr. SLAVITT. I don't know his schedule on September 6th or 7th.

Mr. LONG. OK. Can you tell me if Mr. Counihan has had conversations with Blue Cross Blue Shield of Arizona or Connecticut after the deadline to sell plans on the federal exchange?

Mr. SLAVITT. I don't know the timing, but I'm sure he's had conversations with most of the major health plans.

Mr. LONG. What was the first part of your answer? I am sorry. I couldn't hear you.

Mr. SLAVITT. I can't tell you the dates, but I'm sure he's had conversations with many of the major health plans.

Mr. LONG. But you don't know whether or not he has had conversations after the deadline?

Mr. SLAVITT. I don't have any knowledge of the dates he's had conversations.

Mr. LONG. OK. Have you yourself had conversations with Blue Cross Blue Shield of Arizona or Connecticut Care after the deadline to sell plans on the federal exchange?

Mr. SLAVITT. No.

Mr. LONG. No negotiations after the deadline is passed?

Mr. SLAVITT. I have not.

Mr. LONG. OK. Is it fair to say that both carriers were allowed to sell plans after your own deadline?

Mr. SLAVITT. I'm not sure. I don't know.

Mr. LONG. You are not sure that Pinal County was offering to sell plans?

Mr. SLAVITT. I'm not sure which deadline you're referring to, but I'm happy to investigate and we will then get back to you.

Mr. LONG. OK. I would appreciate if you would. So you are aware or not aware that deadlines have been passed and then plans were offered after these deadlines passed; you are aware of that or not aware of that?

Mr. SLAVITT. Well, I'd have to understand what deadlines you're talking about. I mean, we certainly give——

Mr. LONG. Sell the plans, but——

Mr. SLAVITT. We certainly give states dates in which we'd like to receive things. Sometimes if we don't receive them on those dates

I'm sure that we extend those deadlines, but I don't know that in this particular situation that that's occurred. But that certainly wouldn't be absolutely out of the question.

Mr. LONG. OK. But do you have any idea why there would be deadlines if the deadlines are not followed?

Mr. SLAVITT. Well, yes. Typically our team has to do work like loading plans and loading data and they like to have enough time to do that and do it right. But certainly we're going to always do what's in the best interest of the consumers and the Americans in the state to make sure that they have coverage options available. So if our team has to work a little harder or work over the week-end in order to do that that's the kind of dedication that we have on our team.

Mr. LONG. OK, thank you. In my district in August I had the opportunity to visit with a large school board there in the district, and I was kind of surprised at the end of the meeting when the chief financial officer that has been with the school district 33 years looked at me and volunteered that she said, I was thinking last night if I could ask you to do one thing for me as congressman that one thing would be to get rid of Obamacare.

And that honestly shocked me. Two of the more pressing problems with the law that she referred to were the 30-hour work week and the 26-week break for retired teachers. The 30-hour work week, also known as employer mandate, requires all businesses or organizations with 50 or more employees to provide health insurance for their employees who work more than 30 hours a week.

This particular school district currently has 921 full-time staff. The 26-week break is required for educational organizations that are unable to provide health insurance to faculty that recently retired. If ignored, the retired teacher would be seen as a continuing employee which would require them to offer health insurance.

These are the teachers, the retired teachers that know the children in those schools. They know the school, they know the system. They know the teachers and they have to take a 26-week break because of this law.

And Mr. Chairman, I write a weekly column called Long's Short Report and it just happened that today in our local paper, the Gannett paper, the Springfield News-Leader published my latest column on this very subject about my trip to the school district. So without objection, I would like to offer that into the record and I would encourage everyone to read that; get more of the details of how this law has affected school systems and small businesses.

Mr. PITTS. Without objection, so ordered.

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

Mr. LONG. I yield back.

Mr. PITTS. The chair thanks the gentleman and now recognizes the gentlelady from Florida, Ms. Castor, 5 minutes for questions.

Ms. CASTOR. Well, thank you, Mr. Chairman, and thank you to the witnesses for being here today. The progress that we have made since the adoption of the Affordable Care Act has been very significant. And before we turn to questions I wanted to focus on how meaningful it has been to my neighbors back home in the state of Florida.

In Florida we are fortunate. We have a very competitive marketplace so families and consumers have a lot of choices. They have good affordable options. In fact, it looks like in the coming year that 82 percent of marketplace consumers in Florida will be able to purchase coverage for less than \$75 per month.

During the last open enrollment period, 1.7 million Floridians signed up for coverage in the health insurance marketplace including over one million women and children. And this is important because we have very serious and growing concerns in Florida because of the spread of the Zika virus. The current Zika infection count in Florida is 800 individuals, including 86 pregnant women that we know of, so this is very concerning.

And what is especially troubling now is that Florida hasn't expanded Medicaid. So even though we have over 250,000 women ages 18 to 34 in my state who have gained quality affordable coverage in the marketplace, we have got more than that that should be covered, could be covered if the state expanded Medicaid. So you can see why this is particularly troubling at a time of a growing public health crisis.

But there is a lot of good news too. Over 3.1 million seniors are eligible for free preventive health services with no deductibles or copays and they are taking advantage of it. In 2014 alone, over 346,000 seniors in Florida received Medicare Part D prescription drug discounts worth over \$306 million, or on average \$884 back into the pockets of beneficiaries.

It is interesting that more than 38 percent or about 383,000 returning healthcare.gov consumers last year switched plans. And this is something that we could work on in a bipartisan way. It is very interesting. I guess we knew that Americans love to shop and compare and they are doing that. But we have got to work together to maintain these competitive marketplaces so they have the ability to do that. When they switched they saved on average about \$34 per year.

And then for the vast majority, about 60 percent of Floridians already have health insurance through their employers and I thought it was quite interesting that there the insurance premiums in Florida are now growing at the slowest rates on record. This is also something we have got to continue to analyze and make sure that this is the case overall.

But I would like to return to the Medicaid expansion challenge, because in the state of Florida we have got so many that are falling into the gap. And, you know, we know it is fiscally irresponsible not to expand Medicaid. We know the most important thing we could do for mental health coverage is to expand Medicaid.

But there is a new piece of data that Administrator Slavitt, I would like you to address. Medicaid expansion brings down marketplace rates. You said it brings down premiums by 7 percent. Is that just in the marketplace, is that overall and what is behind, what is going on in pressure in the marketplace?

Mr. SLAVITT. Well, no, that 7 percent is in the marketplace, and I think, for everyone here who has an interest in helping all of your constituents and all of their concerns about affordability that's really one of the top most important things that can be done is to eliminate all those places where people are uncovered.

And a lot of those people who don't get coverage through Medicaid sometimes find their way onto coverage in the marketplace and that drives up costs needlessly. So it's a critical priority that we complete the job and expand Medicaid wherever we can.

Ms. CASTOR. And one of the things that drives a lot of businesses and the folks of the Florida Chamber crazy is we are sending so much money up to the federal government because Medicaid is a state-federal partnership. We are not bringing those dollars back and putting them to work creating jobs and taking care of people. What happens to those dollars?

Mr. SLAVITT. Well, they certainly go to the states that have chosen to expand Medicaid. And I will just add one thing for, Congressman Yarmuth raised the question of Kentucky. There was a very interesting study in Kentucky a couple years ago which, I think, showed that Kentucky saw 40,000 new jobs and something to the effect of \$30 billion improvement to the state economy through 2021 in the expansion of Medicaid. So you can imagine the economic benefits on top of which you're already talking about are quite large.

Ms. CASTOR. Thank you very much.

Mr. PITTS. The lady yields back. The chair now recognizes the gentleman from Indiana, Dr. Bucshon, 5 minutes for questions.

Mr. BUCSHON. Thank you, Mr. Slavitt, for being here. This is directed at you. On mandates in the Affordable Care Act I want to talk about the age rating ratio. Many states are using a five-to-one ratio before 2010, meaning the most expensive plan can only cost five times more than the least expensive plan when it comes to patients' ages.

In my home state of Indiana we didn't have an age rating mandate. The President's plan moved this to three-to-one for all states regardless of their unique patient needs. This has led to sicker insurance pools and driven younger, healthier patients away from the marketplace, in my view. The baseline has increased, so the argument that the three-to-one ratio saves seniors money may not be true. In fact, I don't think it is true. It has just increased costs for younger people.

So my question would be, is would moving the ratio back to five-to-one have an immediate impact on the cost, do you think, for many people who would potentially enroll?

Mr. SLAVITT. No, I think this would have to be studied based upon two factors. What does it do to the economics or the cost and what does it do to the coverage and who benefits and who doesn't? So I think it's the kind of proposal that should be thoughtfully evaluated. I have not done that.

Mr. BUCSHON. OK. Would moving the ratio back to five-to-one attract younger, healthier patients to the plans? And the reason I say that is because according to CBO, "average spending among people who are 64 years or older is about 4.8 times as high as average spending among people who are 21 years old." That is cost to the health care system. So to me it would make sense if you could shift the baseline back and get the cost down for younger people, you would get more people into the plans and that might help balance the demographics, right?

Mr. SLAVITT. Yes. That could be one of the benefits. I haven't seen any studies on the topic, but—

Mr. BUCSHON. Well, I would encourage you to look at that because I actually have legislation to actually to allow states to do that because that is the premise.

A couple other questions on global surgical payments in MACRA, the replacement for the SGR, our language authorized CMS to use a representative sample of docs for reporting data on 10- and 90-day global surgical codes. But the most recent physician fee schedule is requiring all docs that perform relative procedures to report under the claims analysis section. And this is, in my view, not in line with the intentions of Congress in MACRA.

So what we need really is an appropriate representative sample. How the data is collected must change. The 10 minute reporting increments is, I can tell you as a surgeon—I was a surgeon before—is actually, it is impossible. So what I am asking for is for CMS to give time to work with surgical societies and other stakeholders to determine what is an accurate representative sample. This is really important. So what I am asking is can you commit, or whoever at CMS is responsible for this, to working with my office and other stakeholders to work this through?

Mr. SLAVITT. Absolutely. As you can imagine we've gotten a lot of feedback on this proposal. It's a proposal that I think we're still working through the comment period. But we absolutely need that input and we are committed to coming out with a final rule which does get that right.

Mr. BUCSHON. Well, that is really important because what we want is accurate data, right? At the end of the day we want accurate data.

Mr. SLAVITT. Right.

Mr. BUCSHON. One final question on the proposed rule for Medicare Part B model, I am very concerned by statements from the physician community that practices may be forced to send patients to hospitals to receive care, particularly oncologists particularly because hospital-based care can be more costly for beneficiaries.

I have seen estimates that suggest that even 15 percent of cancer treatment, for example, shifted to the hospital would actually cost Medicare an additional \$200 million. And the intent of this was to try to get down drug costs for people, and I understand that. There is bipartisan concerns to this rule, proposed rule, as you know, so what I would suggest is I would urge CMS to hold off on the rule until we can resolve some of these issues.

So the question I have is did CMS factor in the potential cost increase into its estimated savings from the program when it developed the proposed rule?

Mr. SLAVITT. So I think putting the proposal together we were, in fact, looking for that exact type of feedback relative to consequences and unintended consequences of anything we test. We've got a lot of feedback. We will take that feedback, including the specific feedback that you've mentioned which we have heard, into account when we finalize this.

Mr. BUCSHON. Well, I will appreciate that. And so if you do have an analysis of that different than what I suggested, on the in-

creased costs because of shifting care to hospitals, if you could share that with my office and the committee I would appreciate it.

Mr. SLAVITT. OK. We will look into that.

Mr. BUCSHON. I yield back.

Mr. PITTS. The chair thanks the gentleman and now recognizes the gentlelady from Illinois, Ms. Schakowsky, 5 minutes for questions.

Ms. SCHAKOWSKY. Thank you, Mr. Chairman. And I want to apologize to members of the panel. I was at another subcommittee hearing and was able to just arrive, but I thank you for being here to testify.

I wanted to just highlight some of the benefits of the Affordable Care Act to my state of Illinois. During the third enrollment period 388,000 people from my state were able to gain coverage by enrolling in the health insurance marketplace. In 2014, nearly 195,000 people in Illinois with Medicaid saved almost \$180 million on prescription drugs because of the Affordable Care Act with an average per person of \$925 per beneficiary. That is a big deal.

In 2015, the ACA funded 44 community health care centers in Illinois that provide primary and preventive health care to over 1.2 million Illinoisans including over 300,000 children and 900,000 racial and ethnic minorities. Over 475,000 Illinoisans have gained Medicaid or CHIP coverage since the first open enrollment period as a result of Illinois' decision to expand Medicaid, and since November of last year, 200,000 Illinois women gained access to preventive health care services with no cost sharing including reproductive health care, domestic violence counseling, and screening for cervical cancer.

Despite the challenges that we are facing in Illinois, this law is doing incredible things for my constituents and I am encouraged by the progress that we are seeing.

Mr. Slavitt, I wanted to talk to you about the increase in the cost of prescription drugs. How have rising drug costs, rising drug prices led to increases in insurance premiums and should we be doing more to control growing the cost of pharmaceuticals?

Mr. SLAVITT. This is an incredibly important question, Congresswoman, because when people are concerned as they should be about the cost of health insurance because the law requires that 85 percent of the cost be actual cost of health care, what they're really concerned about is the cost of the underlying health care system which is a top priority for us.

And prescription drugs and the insecurity that both seniors as well as people on lower incomes face when they can't afford their prescription drugs is a really significant issue and it's only getting worse. And we are troubled when we see large increases in prescription drug costs and we have proposals for it as you know to attempt to find ways to begin to control those costs in ways that still allow us to create cures and innovations for our country, but also allows those cures and innovations to be accessible to everybody in the country who needs them.

Ms. SCHAKOWSKY. Right. Also CMS has taken action I know to increase transparency for the price of drugs. For example, last year CMS released the Medicare Drug Spending Dashboard which details the price paid for many drugs covered by Medicare Parts B

and D. The Dashboard also includes the average annual price increase of each drug and the average annual cost to beneficiaries. And this data is incredibly helpful for policymakers and providers to gain a better understanding of how drug prices are impacting public health programs and consumers.

So Mr. Slavitt, why is increased transparency for drug pricing important and how will this information allow us to better protect Medicare, Medicaid and the beneficiaries?

Mr. SLAVITT. Well, first of all, these are federal dollars that we are spending and so, these in effect are people that are contractors to the federal government, and so it's important that taxpayers have insight into what we're spending our money on.

And because we are not, as you know, able to negotiate Part D prices because we're restricted to, we think it's important at least that there is visibility into what things cost and particularly when there's cost increases, because in effect that's at the heart of many of the concerns, I think, even at this hearing today. As some of those underlying costs go up people then see their insurance premiums go up and that's what they have to deal with, so we're trying to bring more visibility to the root cause as opposed to just the headline issues.

Ms. SCHAKOWSKY. Thank you and I yield back.

Mr. PITTS. The chair thanks the gentlelady and now recognizes the gentleman from Florida, Mr. Bilirakis, 5 minutes for questions. Put your mike on, please. Thank you.

Mr. BILIRAKIS. Sorry about that. Administrator Slavitt, last December HHS OIG issued a report titled, CMS Could Not Effectively Ensure That Advanced Premium Tax Credit Payments Made Under the Affordable Care Act Were Only for Enrollees Who Paid Their Premiums.

In the report, OIG stated that CMS was paying advanced premium tax credits based on the attestation of the insurance companies without verifying on an individual level that the monthly premiums were being paid. The OIG recommended that CMS institute an automated policy-based payment process to verify premium payments on a monthly or real-time basis.

Yes or no, please, has CMS instituted automated policy-based payment process with insurers for the federal marketplace?

Mr. SLAVITT. Yes.

Mr. BILIRAKIS. OK, thank you. Are the state-based exchanges using an automated policy-based payment process at this time?

Mr. SLAVITT. I'd have to check.

Mr. BILIRAKIS. Please check. Does CMS have any plans of running the policy payment process against prior years to find individuals who may have improperly claimed cost sharing reductions and premium tax credits when they were not current on their payments?

Mr. SLAVITT. I'm not sure if that's even possible, but I'd be glad to get back with you.

Mr. BILIRAKIS. Please get back to us. I understand that the state exchanges are not participating, but I need clarification on that so please get back to me. Does CMS have a legal obligation to recoup advanced premium tax credits or cost sharing reductions that were

improperly claimed or paid? Do they have a legal obligation? Do you have a legal obligation, CMS?

Mr. SLAVITT. So I think it depends on the circumstances, but some of this is under the provenance of the IRS.

Mr. BILIRAKIS. OK. Well, again I want more clarification on that please.

Ms. Jarmon, has the OIG tested the automated policy payment process that CMS is using?

Ms. JARMON. Not yet. As part of our ongoing work I should mention we reported on it in December of 2015. As part of our follow-up on the open recommendations we'll be looking at that.

Mr. BILIRAKIS. When will you be looking at it?

Ms. JARMON. As part of our work in 2017.

Mr. BILIRAKIS. In 2017?

Ms. JARMON. Right. We're looking at it now but—

Mr. BILIRAKIS. So early part of '17?

Ms. JARMON [continuing]. It will be reported on sometime in 2017.

Mr. BILIRAKIS. Early part of '17 or—

Ms. JARMON. Probably sometime during the first part of '17, yes.

Mr. BILIRAKIS. I am going to keep track of that.

Mr. Slavitt, when CMS instituted this policy-based payment process for the federal marketplace how much did you find enrollment reduced? Can you give me that answer?

Mr. SLAVITT. I don't know. I don't know that it was material, but I'm certainly glad to get back to you on what that is.

Mr. BILIRAKIS. OK. Well, all right. Again I want to follow up so let's get together soon. I need these answers.

Mr. SLAVITT. OK.

Mr. BILIRAKIS. Thank you very much, and I will yield back, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman and now recognizes the gentleman from Oklahoma, Mr. Mullin, 5 minutes for questions.

Mr. MULLIN. Thank you, Mr. Chairman. And Mr. Slavitt, thank you again for being here. I know you and I have visited before, and the last time we visited you were in front of the O&I Committee and we were visiting about the risk medication program, the repayments that comes to it for the reinsurance. Are you recalling that?

Mr. SLAVITT. Was it risk adjustment or was it reinsurance?

Mr. MULLIN. Reinsurance.

Mr. SLAVITT. Reinsurance, OK.

Mr. MULLIN. Right. And at that time in the opening statement you said this year will add approximately 500 million to the U.S. Treasury. From the program as collections we will exceed the target amount to reimburse high cost claims for 2015. That was a quote from you; is that correct?

Mr. SLAVITT. Sounds right.

Mr. MULLIN. Have you made any payments to date to the Treasurer on those?

Mr. SLAVITT. I think our collection date, if I'm not mistaken—this is from the top of my head—is either November 15 or December 15. So we'll make the payment after that next collection.

Mr. MULLIN. So have you made any payments out of the reinsurance program?

Mr. SLAVITT. No. That'll be the payment we make when we——

Mr. MULLIN. Now have you made any payments to anybody out of the reinsurance program?

Mr. SLAVITT. Oh, to any companies?

Mr. MULLIN. Yes.

Mr. SLAVITT. This year?

Mr. MULLIN. Yes.

Mr. SLAVITT. I have to check.

Mr. MULLIN. I believe according to the information we received you have made several payments to carriers. In fact this was, the payments were made right before the open enrollment period. Are you familiar with that?

Mr. SLAVITT. You mean last year?

Mr. MULLIN. I believe so.

Mr. SLAVITT. Of last year, yes.

Mr. MULLIN. Yes. So has any payments to date been made to the Treasurer on this reinsurance program?

Mr. SLAVITT. As I said, the payment will be made after our next collection which is either November or December 15, I can't recall which.

Mr. MULLIN. OK. The reason why I ask this is because there has been a discussion of how much is supposed to be paid to the Treasurer and the federal law which says that the Treasurer should receive \$5 billion not \$500 million over the 3 years. Are you on target to hit the \$5 billion mark?

Mr. SLAVITT. I recall the conversation from that hearing. I believe that that's not our understanding of the law, so——

Mr. MULLIN. I know. And I believe the interpretation of the law seems pretty clear and you guys decided to change that without notice. I am still——

Mr. SLAVITT. No, I'm sorry. We went through notice. We went through a proper formal notice and comment period.

Mr. MULLIN. And you responded back to us. How do you interpret the law?

Mr. SLAVITT. I think the law was not clear in cases where less than \$12 billion——

Mr. MULLIN. Do you have it where you could read it?

Mr. SLAVITT. Pardon me?

Mr. MULLIN. Do you have it where you could read it, because it seemed pretty clear to us.

Mr. SLAVITT. The law, I believe, stated that what to do in cases where \$12 billion was collected. The law was silent on what happened if less than \$12 billion collected what the prioritization was.

Mr. MULLIN. Did you ask——

Mr. SLAVITT. Therefore we went through a formalized rule-making process.

Mr. MULLIN. Did you ask guidance from Congress on that before you made that——

Mr. SLAVITT. We asked guidance from Congress and the general public by making this an open rulemaking process and we received——

Mr. MULLIN. But in a public comment period you really don't have to respond back to Congress on that. Did you specifically ask for our guidance on that?

Mr. SLAVITT. I believe we asked for everybody's guidance during that process.

Mr. MULLIN. If that is the case then why has there been confusion on the payments on if that \$5 billion should be paid or shouldn't be paid?

Mr. SLAVITT. Because nobody in our comment period, if I'm not mistaken, objected to what we put forward in the proposal.

Mr. MULLIN. How long was that comment period open?

Mr. SLAVITT. I'll have to check. It was a standard comment period. It wasn't shorter than any normal period.

Mr. MULLIN. Because we have objected to it because we had you in O&I and had this conversation with you about it, so there has been a discussion on your interpretation of where the funds should go to. It seems to us or, well, let me say myself. It seems to me that the payments made to the insurance companies is questionable without paying it to the Treasurer in the amounts that is being repaid to them just to hold the premiums down.

And it is not working, because in Oklahoma the only program we have left on the exchange is Blue Cross Blue Shield. They went up 42 percent already this year and I believe they are asking to go up another 40 to 70 percent this year. We are seeing prices skyrocket across the country right now when we were told that this program was going to cost, or bring premiums down.

And the question I guess that I am trying to get to is your interpretation isn't working because it is still costing us more and the Treasurer isn't receiving the taxpayer dollars that we were promised in the \$5 billion. And so if it is not working, then let us work together and try changing it or at least the tax dollars could be used to, in the appropriate way. I yield back. Thank you.

Mr. PITTS. The chair thanks the gentleman and now recognizes the gentleman from New York, Mr. Tonko, 5 minutes for questions.

Mr. TONKO. I thank you, Mr. Chair. In the 6 short years since its passage, the Affordable Care Act has transformed the health care industry and made coverage more accessible, more affordable, and more secure. And I would like to take this opportunity to share some of the encouraging benefits of the law that we have witnessed in my home state of New York.

In New York, over 450,000 individuals applied for coverage in the marketplace during the ACA's third open enrollment period. As of 2015, the ACA has provided community health centers grantees in New York with over \$445 million in funding that offers a broader array of primary care services, extends hours of operations, hires more providers, and develops clinical spaces.

The nationwide uninsured rate continues to drop as the CDC reported last week. In New York State alone, the number of uninsured dropped by over 350,000 individuals between the years 2013 and 2014. New Yorkers, like all Americans, have seen substantial benefits because of this law, and it is indeed reassuring to know that our work has allowed for these results to impact favorably those in New York.

If I could continue on now with the issue of premium increases that I was hearing from the last individual, ever since the Republicans gained the majority in the House they have been sounding the alarm on the potential for skyrocketing premiums resulting from the reforms of the Affordable Care Act and the fact is that we have not seen this happen.

In fact, the nonpartisan Congressional Budget Office, or CBO, made predictions about premiums around the time of the ACA's passage, and so to Administrator Slavitt I ask, did CBO predict that average premiums for 2016 would be higher than what the insurers actually charged this year?

Mr. SLAVITT. That's correct.

Mr. TONKO. And why do you think premiums are coming down? Why are they lower than was expected or projected?

Mr. SLAVITT. I think that in some cases the premiums are lower because there's been good competition and good innovation and I think that's been a terrific and welcome part of the marketplace. And I think there's other occasions where the premiums were priced too low because I think no one knew exactly what things would cost, and therefore I think as a result we'll see more increases this year than we have in the past.

Mr. TONKO. While those early reports have suggested that we may see those higher premiums in 2017, and why, can you explain why that might be the case? Why would they be higher?

Mr. SLAVITT. I think there's two principal reasons and most of them—and the good news, I think, is a lot of these really are centered on one-time effects. One is that by design the reinsurance that supported the marketplace expires January 1, 2017, so there will be a meaningful increase just from that alone.

And then secondly, I think now that you have insurance companies that have a couple years' worth of data on what things actually cost they can use that information to price appropriately. And I'd like to remind people that as a country this is the very first time we have said to people that if you are sick we will take care of you and we will allow you to buy insurance anyway. No one knew when we entered into this exactly what that would cost, but the great news is we're doing it.

And no one likes to see costs go up and I don't think they're going to continue to go up beyond this year very significantly, on a large part because medical trends in this country are still at historic lows, but we would do something significant. We've got more work to do. We can do better. If Medicaid expands we'll do even better, and I look forward to continuing to work through this.

Mr. TONKO. So in a sense there is like an outlier effect that impacted 2017, and would you expect 2018 to be different?

Mr. SLAVITT. Far be it from me to predict the future, but 2018 will probably be a more normalized year and more in line with where past years have been the first couple of years.

Mr. TONKO. OK. With that—

Mr. GREEN. Mr. Chairman, could the gentleman yield me your last 10 seconds?

Mr. TONKO. Sure, absolutely.

Mr. GREEN. Thank you, Paul.

Our colleague from Oklahoma, I meant to try and get time there. Blue Cross requested 45 percent. Mr. Slavitt, has that been considered by the state of Oklahoma or by CMS? Isn't that a request and it is not an actual increase?

Mr. SLAVITT. Yes. I'm not sure exactly where that stands at this point. Yes.

Mr. GREEN. OK. Although I normally agree with Mr. Markwayne Mullin except on the football field but when our colleges play each other, so I will mention it to him later.

Mr. TONKO. OK, with that I yield back, Mr. Chair.

Mr. PITTS. The chair thanks the gentleman and now recognizes the gentleman from New York, Mr. Collins, 5 minutes for questions.

Mr. COLLINS. Thank you, Mr. Chairman. Before I ask Mr. Slavitt a couple of questions I would like to just maybe briefly for the committee highlight some of the latest, very troubling news on the Affordable Care Act as it impacts western New York, the area of Buffalo that I represent.

So in August, a month ago, Governor Andrew Cuomo's administration announced that the health insurance premiums for those on the state's Obamacare exchange will increase—this is after review—an average of 16.6 percent next year for over two million people enrolled in the program, many of them in western New York. Now I did say average. Some of the plans have already now been approved with a 29 percent increase and even 89 percent for one plan.

Now at the same time, the individual mandates compelling Americans to buy these health insurance plans with high premiums we are also continuing to see in our area big increase in deductibles and insurance companies facing multi-million dollar losses, terminating plans. So I am not sure how Mr. Slavitt could say he thinks this may be an outlier year.

We are not seeing any of those trends that wouldn't continue on into the future. I don't think the President, I don't think anyone at CMS ever will acknowledge what western New Yorkers are living day to day, and that is the Affordable Care Act, Obamacare, is fundamentally flawed. It can't be fixed and is imposing unsustainable, ever-increasing costs on Americans including my western New York constituents. Now perhaps the next administration will have a better understanding of the health care marketplace, the plight of the middle class, and we can finally get rid of this unaffordable plan.

But Mr. Slavitt, I would like to speak to you about an often overlooked aspect of the Affordable Care Act, a provision that many New Yorkers didn't know existed until they were kicked off their plans last year, kicked off in November last year.

So last October, 200,000 New Yorkers were informed out of the blue that they would be kicked off Obamacare's CO-OP Health Republic and forced to find a new plan immediately. This CO-OP was propped up by more than \$265 million of squandered taxpayer funding and lasted less than 2 years. The Health Republic of New York had the highest enrollment numbers in the nation so this wasn't a low enrollment problem, yet they lost 35 million in 2014, 53 million in the first half of 2015, basically the CO-OP was never

going to be able to operate properly, and despite all these warnings and losses and losses, CMS neglected to even place the CO-OP in a corrective action plan.

There is a couple words that come to mind—negligence, incompetence. So I guess, Mr. Slavitt, my first question is they weren't put into a corrective action plan, so if they are not what was the purpose of even having something we called corrective action plans?

Mr. SLAVITT. So certainly, and I will acknowledge that it's no secret that many of the CO-OPs across the country, not just New York, faced significant financial challenges. These are, you know, businesses that compete against much larger companies with limited capital bases and they have very little cushion for error.

And I think in the case of New York, they, in the beginning of 2015, if I have my timing right I thought they were in a relatively good financial position and saw losses mount as claims costs came in throughout the year, I would say even more aggressively than any plan we could put on paper. I had a whole team up in New York working with the CO-OP and working with the state. In fact, I think our auditors were ones that were pointing out some of the problems to the CO-OP.

Mr. COLLINS. Now I mean, let me just say you can't defend the indefensible. I hear you try. But, you know, Mr. Slavitt, even after this what CMS did was even more egregious. They forced current plans to take those people that were kicked off.

They told those plans they had to accept them at the low pricing that Health Republic was charging, in November when many of them had already hit deductibles, and the current health plans then suffered millions upon millions of dollars of additional losses because CMS said you have got to take these people. I am sorry their deductibles are burned out. You can only charge them what the low rates were to begin with.

And so what we ended up with, and I will use the words again, after losses and losses and them not being placed, it was negligence and incompetence of CMS which hurt taxpayers, hurt participants and hurt other health insurance companies, something I call a lose-lose-lose, and that to me was unacceptable. I yield back.

Mr. PITTS. The chair thanks the gentleman and now recognizes the gentleman from California, Mr. Cardenas, 5 minutes for questions.

Mr. CARDENAS. Thank you very much. I have a bit of a different narrative coming from the state of California as to what the Affordable Care Act has done for millions of Californians. I don't have time to speak to the tens of millions of Americans across America who are in a better position with their access to health care that they didn't have before, but that having been said the Affordable Care Act has improved millions of lives in my state.

For example, we have been able to expand Medicaid with over three million Californians having gained access to Medicaid or CHIP since 2013. I know you are not allowed to applaud in this room, but I am sure you are applauding inside. As of April of this year, 70 percent of Californians who were previously uninsured before the Affordable Care Act now have quality, affordable health insurance because of the Affordable Care Act.

Medicare beneficiaries in California have saved more than 1.2 billion on prescription drugs because of the Affordable Care Act. The expansion of preventive services with no deductible or copay under the Affordable Care Act allowed more than 3.6 million Californians with the Medicare to access preventive care services in 2014 alone.

I am pleased with the progress that has happened in California, but yet at the same time any time a law is passed—and with all due respect the Affordable Care Act is a product of the legislative bodies of the United States of America. And every time we have passed laws—I personally have been passing laws for 20 years both at the state, local, and here at the national level and I have never, ever written a law myself nor have I ever seen any one of my colleagues that I have served with in the last 20 years, Republican or Democrat, pass a perfect law that doesn't need some changes subsequent to the initial passage.

It is unfortunate I believe that we have a Congress of the United States, the majority parties that want to just tear down this law. It is unfortunate. What we should be doing is looking at the disparities and the things that need to be fixed. I know some of my colleagues on the other side of the aisle have been talking about some of those things, but it is one thing to just point out flaws and then throw up our hands and say, oh my gosh, isn't this horrible.

That is not our job as legislatively elected people, democratically elected individuals who are supposed to be responsible and make sure that we fix things when we see something wrong. And it is unfortunate that we haven't advanced but very small, small minor changes to the Affordable Care Act through the legislative process.

I do agree that there are many changes that need to be made, but I am appalled at the idea that we take opportunities like today to just say that this is wrong and it needs to be repealed. That is not the case. I for one in a portion of my life when I was a boy lived in a household where we didn't have access to health care. And what that meant was that my mother would give me some aspirin, send me to bed, and literally pray that I would wake up the next day feeling better. And if I didn't, what happened was my family with my hardworking father providing for 13 people, 11 children and him and my mother, every single day would go to work.

But because we didn't have health care coverage our only alternative was to show up in the emergency room when we thought somebody just might die. Because of the Affordable Care Act, now over 20 million people in this country who were in that situation literally overnight are no longer in that situation. And the number of people who are getting true access to health care is in fact growing.

That is what the Affordable Care Act is about. One life at a time through a massive law, thousands of pages that yes, it does have flaws. But the atrocity of the Affordable Care Act is subsequent to that law being enacted that we as a legislature, collectively, are not making the necessary changes that we all can easily identify.

It is embarrassing that in the most capable country in the world, in the most powerful elected bodies in the world that we effectively have done almost nothing to improve the health care of Americans since this law has been passed. I yield back.

Mr. PITTS. The chair thanks the gentleman and now recognizes the vice chair of the Health Subcommittee, the gentleman from Kentucky, Mr. Guthrie, 5 minutes for questions.

Mr. GUTHRIE. Thank you, Mr. Chairman. And I want to follow on that. Governor Bevin is actually trying to take a program that he inherited that was a hundred percent federal taxpayer paid for now the state has got to start putting money into the program and trying to make it work. He is trying to make the improvements that people say, well, Republicans over here—it is some political hit. He is actually trying to put a program together that worked.

I heard my colleague earlier talk about Kentucky and I heard him speak earlier back home during the break. And I went and met, spent hours with Kentucky's Medicaid Task Force and tried to figure out exactly what they are trying to do and what they are trying to do is make a program work.

Now you cited a study, we could continue to cut universities and education and move that money into Medicaid, hire people on the short term and create jobs in health care but it is not for long-term sustainability of our state. And so what Governor Bevin is trying to do is trying to treat the expanded population of able bodied, not traditional Medicaid of frail, elderly, disabled people that are chronically ill, he is trying to take able bodied and treat them more like traditional insurance.

And Mr. Slavitt, is it unreasonable to treat able bodied, non-traditional Medicaid, is it unreasonable to have a Medicaid program set up for them in an expanded state that treats it more like traditional insurance? That is what Governor Bevin is trying to do. Is that unreasonable?

Mr. SLAVITT. So I'm going to try to not get into commenting on the status of this waiver request given that we are just open for a public comment period and it would be inappropriate for me to do that.

Mr. GUTHRIE. OK. I was wondering a couple of things. A couple of things that I have heard my colleague from Kentucky call a poison pill, he says able bodied, not traditional Medicaid spent in Medicaid—should pay a premium that could be up to \$15 a month. We have heard people talk about paying 800, 900, \$10,000 a year—at \$15 a month.

The other one is if you are able bodied that you have to have a community engagement requirement. Go to work for 20 hours a week, go to do a service project for 20 hours a week or go to school for 20 hours a week because there is an ideological difference as my friend from Kentucky said earlier. One is, 25 percent of Kentucky is on Medicaid. The other ideological difference is let's create a system and a Medicaid program where people were transitioned off so they can improve themselves, go to school, become productive and move forward.

And that is exactly what Governor Bevin is trying to do. And if that is unreasonable to CMS, if that is unreasonable to my colleague from Kentucky, I know it is not unreasonable to the majority of Americans that people who receive something for free should have—should, one, to improve themselves have an education requirement at least to move forward and that is what Governor Bevin is trying to do.

I want to switch to one other state real quick. In Louisiana they just expanded Medicaid. This started July 1st. But in Louisiana they also are allowing people that are currently into the exchange if they want to continue in the exchange they can continue in the exchange even if they are Medicaid eligible.

And I have, if I could submit to the record The Advocate, which is a Baton Rouge newspaper, and I will quote from it. It says the State says that people who bought individual policies through the federal marketplace but now qualify for Medicaid under state expansion can keep their Obamacare plans if they prefer them over Medicaid. They just have to keep paying their premiums.

Mr. Slavitt, is that correct that if you qualify for Medicaid you can maintain your Obamacare premium subsidized in the marketplace?

Mr. SLAVITT. I'd have to look at the details of that. I'm not sure.

Mr. GUTHRIE. Well, when will CMS explicitly explain the rules of the road and how do we know CMS isn't inappropriately double-dipping? They could be Medicaid qualified and be receiving premiums. I don't think within the statute allows them to do that.

Mr. SLAVITT. Yes, let me check on that. I hadn't seen that article.

Mr. GUTHRIE. OK. Another one—

Mr. PITTS. Without objection, that article will be placed in the record.

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

Mr. GUTHRIE. Thank you. So moving on to another topic, in February of this year, Secretary Burwell said CMS would check whether exchange enrollees with subsidies are enrolled in Medicaid or CHIP. She said I quote, notices will be—let me start this over—whether exchange enrollees with subsidies are also enrolled in Medicaid or CHIP. And she said notices will be sent in May to consumers who are enrolled in both. Has that moved forward?

Mr. SLAVITT. Yes, it has.

Mr. GUTHRIE. Did that go forward in May or—there is a New York Times article has talked about it happening in August.

Mr. SLAVITT. I'm not sure of the date.

Mr. GUTHRIE. You don't have any consumers that have been disenrolled in Medicaid or exchange coverage as a result of this?

Mr. SLAVITT. I don't know how many, but I'd be happy to get back to you at your office.

Mr. GUTHRIE. OK, thank you. Any savings a taxpayer would appreciate.

Mr. SLAVITT. Yes.

Mr. GUTHRIE. Thank you very much and I yield back.

Mr. PITTS. The chair thanks the gentleman and now recognizes the gentleman from New York, Mr. Engel, 5 minutes for questions.

Mr. ENGEL. Thank you. Thank you, Mr. Chairman. Thank you, Mr. Green. Thank you for holding today's hearings.

Let me say this in terms of an overview. You know, any major bill or major undertaking that has been passed by Congress needs to be tweaked once we see how effective it is, what we see, when we see what the problems are. It is true with Medicaid and Medicare, it is true with any big bill, and that is true with the Affordable Care Act.

The way I look at it, the problem is our friends in the majority don't want to fix it. They want to break it so it will go away. There are some problems with it, there is no doubt about it. But if we didn't vote to repeal it 63 times and voted to improve it 63 times I think we would have a much better law.

And having been on this committee when we were first drafting this law, I know that there are many different, you know, opinions and there are many things that I and others thought should have been put into the bill that were not put into the bill because we took the Senate-based bill and we thought we would be able to negotiate it, and then through circumstances we couldn't do it.

So I would just say that I think, they say if it ain't broke, don't fix it. Well, it is a little bit broken and it can be fixed and we should fix it instead of trying to kill it. So to echo Mr. Pallone, I am mystified by Republican attempts to paint a rosy picture of the insurance market prior to the passage of the Affordable Care Act.

Let's go back and let's remember what it was like denying insurance to people with preexisting conditions, forcing certain populations to pay outrageous rates, applying lifetime limits to care. Before the ACA this was standard operating procedure in the individual insurance marketplace and it was incredibly harmful to our families, friends and constituents. And again not to mention some popular things like keeping your child on having insurance on your policy until he or she is 26 years old.

So we have come a long way. An estimated 20 million Americans have gained health insurance through the ACA. My state of New York, there are some problems but basically it is going very, very well and we can rest easier knowing that a sudden illness won't wreak havoc on our finances. And 129 million Americans with pre-existing conditions like asthma or diabetes can no longer be turned away or charged more on account of their health status. More than 39 million seniors on Medicare have received free preventive services without copays thanks to the Affordable Care Act's preventive services benefit.

And like any major legislation, as I said, it is not perfect but we have made a world of difference for millions of Americans who were once denied coverage or who could not afford it. So, you know, I just think that we should do right by the American people and stop trying to turn this into a partisan issue. There are a lot of good ideas on both sides of the aisle. You know, when I go back to my district I hear people telling me, can't you guys get along? Can't you guys work together? The American people want to see us work together, not lurch from one thing to another.

So let me ask Mr. Slavitt—thank you for being here today. I think as I mentioned before New York provides a good example of what is possible when the federal government has a willing and enthusiastic partner in ACA implementation. Every county in New York has seen its uninsured rate decline, and on average individual premium rates for qualified health plans are almost 50 percent lower than they were before ACA implementation.

So would you talk about what your experience has been in states that have obstructed efforts to implement the ACA versus your experience in states that have been good partners like New York?

Mr. SLAVITT. Yes. So I think there's a fairly well documented difference in the uninsured rate now and Congresswoman DeGette, I think, referred to this, where states that have expanded Medicaid have lower rates of uninsured and number of benefits than the other states.

I might also just comment, Congressman Engel, on your earlier comment about working together, you know, my understanding of the history of Medicare very much falls in line with what you said, which is that there were a number of efforts that were required after Medicare Advantage passed to find the things that weren't working as well as they should and to amend them.

And as a result I think we have one of the most popular, long-standing bedrock programs today in our country in Medicare. And so I think we have the same opportunity without a doubt here to not just do what we've done but continue to do better. And we look forward to working with the Congress on this.

Mr. ENGEL. If I might, thank you. You noted during your testimony that CMS, and I quote you, has learned more about what kinds of outreach are most effective as you seek to reach out to the remaining Americans who are uninsured and eligible to enroll in marketplace coverage. So I am pleased to hear that CMS is drawing upon lessons learned to reach Americans who remain uninsured.

Can you talk about why targeted outreach is so important and how might we expect these efforts to affect the risk pool of enrollees?

Mr. PITTS. The gentleman's time is expired.

Mr. ENGEL. OK. I will take it in writing.

Mr. PITTS. Please respond in writing.

Mr. SLAVITT. I'll be happy to do that.

Mr. ENGEL. Thank you, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman and now recognizes the gentlelady from North Carolina, Mrs. Ellmers, 5 minutes for questions.

Mrs. ELLMERS. Thank you, Mr. Chairman. I thank the panel for being here today.

Mr. Slavitt, I would like to go back to some of the issues with premium increases that are projected for 2017. There has been some discussion here today about the projected cost increases for 2017 when it comes to the premiums, and I would just like to shed some clarity on it. And I know that you feel as strongly as we in Congress do about transparency and making sure that information to consumers is readily available.

In North Carolina, one of the top insurers has projected that there may need to be about a little less than 20 percent increase in their premiums, and I have heard from some of my colleagues here substantially larger increases in premiums. And I really do believe that this is something that even though we in Congress understand it because we have the ability to go to the, you know, to get that information and our staff are able to do that, the average person, the average American really doesn't.

So I would like to understand what that process is. For instance, in the discussion about the Oklahoma increases you had basically said that you weren't sure that that had been determined yet. At

what point will Oklahoma's increases be determined and how will the rest of America know each state's premium increases?

Mr. SLAVITT. Yes, thank you, Congresswoman. So right now, you know, and each state is on a slightly different schedule, states are going through a rate review process and each state does it a little bit differently which is why it's hard to generalize. And they're in the process of reviewing the rates and then they'll finalize and approve them.

Most of the states, I can't think of one that doesn't, but most of the states make that information public immediately within their states as that happens and then they get reported in a number of studies. So I think they've been quite visible, but I can get back to you if you have any specific questions about states.

Mrs. ELLMERS. Well, I am concerned and I am wondering if CMS, if you actually at some point post this information, you know, so that it is readily available. And as far as a date, I know that you said that the process is being played out right now. Correct me if I am wrong, you said November 1st is the beginning of the enrollment period for the Affordable Care Act, so will these numbers be known by November 1st?

Mr. SLAVITT. Yes. Consumers will have access to this, the information beforehand. What we typically do is we open the Web site up early so that even before November 1st consumers can get a sense of what things cost and as a result the general public also has access to that information.

Mrs. ELLMERS. OK. So just for clarification purposes, any American who is ready to sign up or start looking at insurance for next year they can know that CMS is going to have that information by November 1st.

Mr. SLAVITT. Yes. That's what we've done historically, yes.

Mrs. ELLMERS. In the past, OK. And I just, you know, for the purposes of making sure this information is readily available, I have dropped a bill, 5960, which is basically the Consumer Healthcare Insurance Transparency Act, to make sure that we are making that message known to CMS that we would love for that information to be out there for consumers by November 1st. And I would like to see that happen and I hope that we will be able to do that again for those same purposes that you believe in which is consumer transparency.

In the remaining time that I have I would like to ask, for the insurance companies that have come forward who have, I mean, you know, three major insurance companies have said that they are backing out of the Affordable Care plan or limiting the number, the most recent being Humana, and others who have discussed the possibility of this, what do you say to that? I mean, if this is working within a manner where only minor tweaks need to be made which, you know, my colleagues, Democrat colleagues continue to say that we just need to make it better, this really doesn't seem like it is getting better. So what do you say to that?

Mr. SLAVITT. Yes. Well, I think one thing we all have to recognize is that it's not only change for us, it's not only change for consumers, it's change for these insurance companies as well. The business model is different in the way that they historically oper-

ated where they would essentially be able to assess people's health before they would write policies has gone away.

And so, you know, insurance companies are adjusting and I think they're all—it's hard to generalize, all adjusting differently. Many, many companies are doing that well and doing it successfully. Many, as it's been public as you pointed out Congresswoman, have retrenched. Even those that have retrenched a little bit are still committing hundreds of millions of dollars of capital to do so, but they're doing it at different paces. And I think that's just an acknowledgment of the kind of transformation that I think everyone has to go through.

Mrs. ELLMERS. Thank you so much, and I yield back.

Mr. PITTS. The chair thanks the gentlelady and now recognizes the gentlelady from Indiana, Mrs. Brooks, 5 minutes for questions.

Mrs. BROOKS. Thank you, Mr. Chairman. Administrator Slavitt, when you came before the Oversight Committee on December 8, 2015, you came to testify about the sustainability of the state-based exchanges. And at that hearing you testify, and I quote, over 200 million of the original grant awards have already been returned to the federal government and we are in the process of collecting and returning more, end of quote.

And in fact, there was significant media attention that went out that day indicating that CMS had recouped, recouped over 200 million from failed state exchanges. The committee then issued a report in May, and following the release of that report you responded to the committee stating that in fact the CMS had recouped \$1.6 million from the 17 state-based exchanges, not the 200 million initially stated during the hearing. And you clarified that it was simply an estimate of funds that CMS had de-obligated from states that didn't establish the exchanges.

But could you please explain how CMS arrived at that estimate initially when you came to testify in December, because it is a pretty significant discrepancy.

Mr. SLAVITT. So I believe that the transcript shows that I was asked a question about 5 billion-plus of funds that were sent out total, and at that time I estimated that of those 5 point, I think it was 5 billion, 200 million or so was being covered. In fact that number is now over 300 million.

Since that time I've got a letter from the subcommittee chair who said that wasn't, in fact, the question he thought he was asking. He thought he was asking something different. So we clarified that he was in fact asking about something different. And I certainly will take responsibility for making sure that I'm clear, because when I come before these committees whether the news is good or bad my job is to tell it straight. And if I don't do that then I need to do better, and I will.

But, so there was a miscommunication. I will say that as for actual numbers, you know, we just, I believe, received a check for about \$14.2 million on funds recovered from a state that did have trouble, so it's actually, it's more updated than the 1.2 million and so that continues ongoing. And we do keep the committee updated. I'm happy to continue to do that.

Mrs. BROOKS. And so the discrepancy was with respect to characterization of recouping versus de-obligating; is that correct?

Mr. SLAVITT. I think that's right.

Mrs. BROOKS. And so the recoupment was actually 1.6 million at that time?

Mr. SLAVITT. It's greater than that today.

Mrs. BROOKS. And can you tell me today, and thank you. That was my next question. Can you please talk to me about an update on the amount recouped from the 17 state-based exchanges today?

Mr. SLAVITT. I don't have the exact figures with me, but I know that it's at least higher by about \$14 million because we just received a check back from one of the states for over \$14 million. So, but I can get you a complete accounting.

Mrs. BROOKS. And which state is that?

Mr. SLAVITT. The state of Maryland.

Mrs. BROOKS. So State of Maryland just wrote a check back for 14 million in addition to the 1.6 million, and at the time the 1.6 million, do you have any idea how many states that had come from, the 1.6 million?

Mr. SLAVITT. I'm not sure exactly. It's three or four, something like that.

Mrs. BROOKS. OK. And so the other, then, you know, 12 or so states, can you talk with us about what is being done with respect to the recoupment of the funds?

Mr. SLAVITT. Recoupment of which funds?

Mrs. BROOKS. The recoupment that we initially began talking about. Are you expecting to receive additional funds from other states?

Mr. SLAVITT. So we expect to recover funds that are improperly spent and that we can document are improperly spent. We, with the help of the OIG who's been very helpful in providing analytics, you know, go out and look for and assess when funds have been improperly spent. But, and those funds we do recover when, and we also, I should say, review many funds before they are spent. And so we don't need to go through a collection process if we required an approval process which we put in place as well.

Mrs. BROOKS. And the 14 million that Maryland just returned, was that for improperly spent funds?

Mr. SLAVITT. So that was for their technology vendor, was essentially the state got into a dispute with them for overcharging them or wasting technology spending. They settled the lawsuit and the 14 million was the down payment on the federal share of that funding. I think the total that will come in from Maryland is 32 million based on that specific thing.

Mrs. BROOKS. Thank you, my time is up. However, I would be interested in the committee receiving a report on the status of where the recoupment of funds is today from all of the states.

Mr. SLAVITT. We will update you.

Mrs. BROOKS. Thank you. I yield back.

Mr. PITTS. The chair thanks the gentlelady. I would like to clarify that Mr. Slavitt made the \$200 million estimate in his opening statement not in response to a question.

That concludes the first round of questions of members present. We will go to one follow-up per side and I will start. I recognize myself 5 minutes for that purpose.

To follow up on Mr. Griffith's questions about risk corridors, Mr. Slavitt, you said that there is an obligation to make insurers whole. My question is how does CMS plan to pay for the risk corridor obligation to make insurers whole under that program because there are no appropriated funds to do so?

Mr. SLAVITT. I can't speak to that directly today, but I mean, this is as you know as I've said earlier the subject of a lawsuit, so I think we'll let that settle out.

Mr. PITTS. Well, this is not a question for DOJ because not all insurers are in the litigation. And so the question is how do you plan to pay for the obligation when there are not appropriated funds to do so?

Mr. SLAVITT. Well, I'll get back to you. I'll consult with OMB and get back to you.

Mr. PITTS. Thank you. Another question, Mr. Slavitt, the committee's investigation into the CO-OP failures examined the negative impact of the 17 CO-OP closures and what they had on individuals enrolled in health insurance plans and the closures created uncertainty as individuals were forced to find new health insurance coverage.

In some cases with mid-term shutdowns, individuals had to ask fast in order to avoid gaps in coverage. Based on this finding, one of the recommendations from the committee's report released today is that the individuals be exempt from the individual mandate penalty if their coverage under a plan offered by a CO-OP is terminated due to the failure of a CO-OP.

We believe this recommendation is common sense as we should not be punishing individuals who make a good faith effort to comply with the individual mandate as a result of their plan no longer being offered. Does CMS agree with this recommendation?

Mr. SLAVITT. Well, we didn't receive that report until late in the evening last night so I haven't had time to study it in detail, but we will.

Mr. PITTS. Will you please respond to that question once you view the report?

Mr. SLAVITT. Will do.

Mr. PITTS. Thank you. That is the only follow-up questions I had. The chair will recognize the ranking member, Mr. Green, for his follow-up.

Mr. GREEN. Thank you, Mr. Chairman, and I have two issues. One, my colleague from Denver, Colorado, earlier mentioned the GAO study. If you would listen to all the questions on the Republican side you would think the people are up in arms about how bad the Affordable Care Act. But the GAO study that she mentioned was that there were studies in Colorado, Indiana, Montana, North Carolina and Vermont, and consumers, sister shareholders concluded that most exchange customers are satisfied with their coverage despite longstanding issues of out-of-pocket expenses, health literacy and access.

Mr. Bagdoyan, is that something the GAO was going to comment on, that study that was released on Monday?

Mr. BAGDOYAN. In what sense, Mr. Green?

Mr. GREEN. Oh, just one, why you only did five states, because a lot of us would like to see the consumer feelings on the Affordable

Care Act. I mean, you know, of course we trust the GAO for your work.

Mr. BAGDOYAN. Unfortunately I was not responsible for running that engagement that resulted in that report, but we'll be happy to get back to you in writing with an answer as to why those—

Mr. GREEN. OK, I appreciate it.

Mr. BAGDOYAN. Sure.

Mr. GREEN. We wasted countless hours in this committee, and my Republican colleagues criticize provision after provision of the Affordable Care Act and root for its failure. We should instead be using this time to build the law's successes by improving quality affordable care now available to our constituents.

Administrator Slavitt, I applaud CMS's diligent work to implement the law and I know your agency has taken steps where possible to make administrative fixes, but some of the fixes require legislative action. Unfortunately, my Republican colleagues are only interested in undermining, weakening or repealing the law.

Mr. Slavitt, what steps has the Administration taken to help ensure the long-term success of the ACA, but more importantly, I would like to ask if you know what steps should be taken by statute for Congress to do to help make the Affordable Care Act moving forward and to be more successful?

And again I don't think in the 2 or 3 minutes or so you have, but I would be glad if you could get back with us—

Mr. SLAVITT. OK.

Mr. GREEN [continuing]. And CMS could, one, list what CMS has done, but then also say these are issues that you have that Congress needs to act on them so we could fix it so we could cover more people.

Mr. SLAVITT. We'll be glad to do that. Thank you.

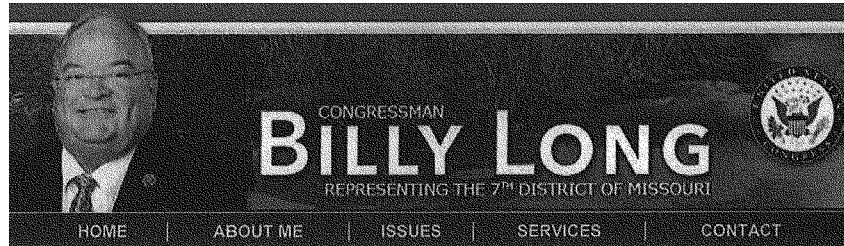
Mr. GREEN. OK. Mr. Chairman, I thank you and I yield back my time.

Mr. PITTS. The chair thanks the gentleman. That concludes the questions of the members present. We will have some follow-up questions in writing and other members who maybe were not able to attend may have questions in writing. We will provide those to you. We ask that you please respond promptly.

And members should, they have 10 business days to submit questions for the record, so members should submit their questions by the close of business on Wednesday, September 28. Another very informative and productive hearing, thank you very much for your expertise and without objection, the hearing stands adjourned.

[Whereupon, at 12:52 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]



September 9, 2016

Long's Short Report—Affordable Care Act's effects on education

By: U.S. Rep Billy Long

It's been six years since the Patient Protection and Affordable Care Act passed, which is also known as the Affordable Care Act or Obamacare. On Sept. 8 Gallup announced the results of a poll conducted Aug. 30-31 in which 51% of Americans disapprove of Obamacare while only 44% approve. During my time as a Congressman I have worked hard to dismantle this law, which has not lived up to its hyperbole and promises.

In August I visited and talked with many community leaders in the 7th District, but one stop in particular reminded me once again of the amount of stress this law places on schools and small businesses.

I had the opportunity to speak with members of the Nixa Public School's Board of Education and district administrators.

After speaking with them it confirmed again why I have been fighting to repeal this law that hurts schools and small businesses.

Two of their most pressing problems with the law were the 30-hour work week and the 26 week break for retired teachers.

The 30-hour work week, which is known as the employer mandate, requires all businesses or organizations with 50 or more employees to provide health insurance to their employees who work more than 30 hours a week. Nixa currently has 921 full-time staff.

The 26 week break is required for educational organizations that are unable to provide health insurance to faculty that recently retired. If ignored, that retired teacher would be seen as a "continuing employee," which would require them to offer health insurance.

Brenda Rantz, the Executive Director of Finance for the school district and Board of Education Treasurer, pointed out that this is a huge problem as children need consistency in working with teachers and the 30-hour work week prevents that.

Nixa already spends \$3.4 million a year on health care for their staff. Having to provide additional health care for substitute teachers who work more than 30 hours a week would add an additional

financial burden to the district.

In one year, Nixa can have anywhere between 30 to 40 long-term substitute teachers. With 921 employees already in the district, adding substitute teachers, both long-term and short-term, could increase the number of employees up to 1,200.

Not only does the lack of consistency with substitute teachers play into their predicament, but finding high quality substitute teachers is more challenging. The 26 week break for retired teachers prevents those same teachers from coming back in less than six months. Those are the same teachers who know the students, know the faculty and know how the school operates.

This isn't the first time I have heard a story like this. I have heard many across our district. These types of stories give me even more motivation to continue to push back against this law and that hurts not only individuals who need health care, but businesses and organizations that provide health care for their employees.

For more information on my activities in our district and in Washington I encourage you to follow my Facebook page at <https://www.facebook.com/Rep.Billy.Long> and my Twitter page at <https://twitter.com/USRepLong>. You can also subscribe to my weekly newsletter, "Long's Short Report", by visiting <https://longforms.house.gov/newsletter-and-email-updates-form>.

<p>Washington Office 1541 Longworth HOB Washington, DC 20510 Phone: (202) 225-6536 Fax: (202) 225-5604</p>	<p>Springfield Office 3232 E. Ridgeview St. Springfield, MO 65804 Phone: (417) 889-1800 Fax: (417) 889-4915</p>	<p>Joplin Office 2727 E. 32nd St. Ste. 2 Joplin, MO 64804 Phone: (417) 781-1041 Fax: (417) 781-2832</p>
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Uncertainty surrounds whether newly Medicaid-eligible in Louisiana can keep their Obamacare plans if prefer them

• TED GRIGGS | THE ADVOCATE
 • JUL 3, 2016 - 12:15 AM



Advocate staff photo by BILL FEIG -- Gov. John Bel Edwards, third from right, and Dr. Rebekah Gee, DHH Secretary, second from right, discusses Medicaid expansion at an event. From left, Rodrick Perkins, BR council member Donna Collins-Lewis, Loretta Robillard, Originae Brown, Edwards, Gee and Linda Simms. The event is the first in a series from Gov. Edwards and Dr. Gee in the state on this topic. Gov. Edwards and Dr. Gee met with new enrollees of the Medicaid expansion program and made an announcement regarding the June 1 enrollment start date, including providing new information for the public.

This refrain may sound familiar: If you qualify for Medicaid but you like your Obamacare plan you can keep it Unless you can't.

That's the confusing and mixed message residents are getting from the state and insurance companies now that Louisiana has become the 31st state to expand Medicaid under the Affordable Care Act. About 375,000 people — mostly the working poor — are expected to get free health insurance coverage through the expanded program, which is mostly subsidized by the federal government.

Tens of thousands of those Louisiana residents — the total's not known — already have health insurance policies through what is called the federal marketplace, an Obamacare program that pays most of their insurance premiums.

The state says people who bought individual policies through the federal marketplace but now qualify for Medicaid under the state expansion can keep their Obamacare plans if they prefer them over Medicaid. They just have to keep paying their share of the premiums.

"There's no requirement that they move," said Ruth Kennedy, Louisiana Medicaid Expansion project director.

But Blue Cross and Blue Shield of Louisiana, the state's largest health insurer and carrier for the bulk of Obamacare policies, says that's not allowed under federal regulations.

Once Obamacare plan members become eligible for Medicaid they are no longer eligible for the federal subsidies that help them pay for the federal marketplace coverage, said Blue Cross spokesman John Maginnis.

The date of Medicaid eligibility is based on when the person is notified. The notification may come from the state or federal government or when the person checks his or her enrollment status online at Healthcare.gov.

Blue Cross expects 20,000 to 30,000 of its members — people who bought individual Obamacare coverage through Healthcare.gov and received subsidies — to become Medicaid-eligible with the program's expansion, Maginnis said. Those people will need to enroll in Medicaid and cancel their marketplace plans by calling Healthcare.gov.

"If they do not take steps to end their Blue Cross coverage, the government could charge them a tax penalty and bill them for any subsidy they get after becoming eligible for Medicaid," Maginnis said.

Other health industry experts have a different interpretation.

Brian Burton, program director for the Southwest Louisiana Area Health Education Center, said because the state expanded Medicaid in the middle of the year, Obamacare enrollees have the option to keep their private insurance through 2016.

But in 2017, people who earn less than 138 percent of the federal poverty level will have to move to Medicaid.

On Tuesday, Kennedy said Blue Cross and Burton were both incorrect. There's a lot of bad information out there, she said, including the mistaken belief that people must enroll in Medicaid if eligible. She based her opinions on discussions with federal Centers for Medicare & Medicaid Services officials.

On Friday, Kennedy was less certain about Burton's statement being incorrect. Kennedy said she hadn't been able to nail down the federal agency on what would be required of the newly Medicaid eligible after Dec. 1.

The Centers for Medicare & Medicaid Services declined comment on Blue Cross's assertions.

However, the agency did issue a statement saying CMS and state officials will send notifications to individuals who may now have additional coverage options to assist them with exploring those potential choices.

Kennedy said the only thing that will be a problem this year for Obamacare members who are also eligible for Medicaid is if they enroll in both at the same time.

That's happened in other states that expanded Medicaid, said Elizabeth Hagan, a senior policy analyst at Families USA, a health care consumer advocate.

"You do have to pay back those premium tax credits because you're only eligible for one or the other," Hagan said.

And that can be costly.

Close to 93 percent of the 184,400 Louisiana residents who got health insurance through Obamacare receive help to offset the costs, according to the U.S. Department of Health and Human Services. This year, the average monthly premium paid by Louisiana residents who get subsidies is \$86. The average subsidy is \$362 per month.

This means the vast majority of the premium is covered by the federal government, or taxpayers. It also means a new Medicaid enrollee who forgets to cancel his or her Obamacare plan could find himself on the hook for hundreds of dollars for each month the policy remains in place.

Hagan said the Centers for Medicare & Medicaid Services will try to prevent dual enrollment through a program known as periodic data matching.

In this process, information from the federal marketplace is checked against that of Medicaid. Consumers who enrolled in both programs receive a notice that they need to immediately cancel their Obamacare coverage.

In the past, dual enrollees would continue to receive premium tax credits unless they cancelled their policies, Hagan said. But later this summer, the Centers for Medicare & Medicaid Services will actually shut off those credits, protecting consumers from learning at the end of the year that they have to pay back the subsidies.

The question, Hagan said, is this: Does Louisiana's expanded Medicaid program have the capacity to do the periodic data match? Louisiana has done so in the past, but it's possible the program won't be able to check the entirety of the newly expanded Medicaid population.

It's unclear how many Louisiana residents now covered by Obamacare will move to Medicaid.

Vantage Health Plan and Humana, the other insurers that offer coverage on the federal marketplace, did not have estimates. Vantage spokesman Billy Justice said several thousand could possibly be touched by the expansion.

Humana spokesman Mitch Lubitz said customers who ask about their Medicaid eligibility will be referred to the Centers for Medicare & Medicaid Services.

Justice said Vantage was instructed to let that agency and the state Department of Health handle the notifications.

People may be able to keep their Obamacare plans through the end of the year, Justice said. As far as he understands, the newly Medicaid-eligible have to switch when their Obamacare plans come up for renewal. If they don't, they could be penalized on their tax returns or be sent a bill by the IRS, but that could change.

Kennedy said some people will switch and some won't.

Moving to Medicaid offers some advantages. For one thing it's free to members, she said. Adults' maximum out-of-pocket costs are 50 cents to \$3 per prescription, and even that's not enforceable.

If a person doesn't have the ability to pay, he doesn't have to, Kennedy said.

Burton said his group, which helps people navigate the Obamacare enrollment process, is seeing a pretty even split on people keeping their private coverage versus moving to Medicaid.

“There are consumers who are saying, ‘I’m still having a hard time meeting the co-pays, so I’d like to drop the marketplace insurance and sign up for Medicaid.’ But then you’ve got half saying, ‘No, I’m going to ride this wave as long as I can. Because I’ve got a Blue Cross or Vantage or UnitedHealth plan, the network (of available doctors and medical facilities) is so much wider than with one of the Medicaid providers.’”

FRED UPTON, MICHIGAN
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

ONE HUNDRED FOURTEENTH CONGRESS
Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6115
Majority (202) 225-2927
Minority (202) 225-3641

October 11, 2016

Mr. Andy Slavitt
Acting Administrator
Centers for Medicare and Medicaid
7500 Security Boulevard
Baltimore, MD 21244

Dear Mr. Slavitt:

Thank you for appearing before the Subcommittee on Health and the Subcommittee on Oversight and Investigations on Wednesday, September 14, 2016, to testify at the hearing entitled "The Affordable Care Act on Shaky Ground: Outlook and Oversight."

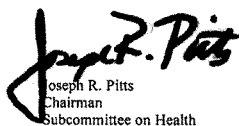
Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

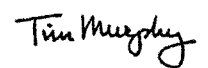
Also attached are Member requests made during the hearing. The format of your responses to these requests should follow the same format as your responses to the additional questions for the record.

To facilitate the printing of the hearing record, please respond to these questions and requests with a transmittal letter by the close of business on Tuesday, October 26, 2016. Your responses should be mailed to Elena Brennan, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, DC 20515 and e-mailed in Word format to Elena.Brennan@mail.house.gov.

Thank you again for your time and effort in preparing and delivering testimony before the Subcommittees.

Sincerely,


Joseph R. Pitts
Chairman
Subcommittee on Health


Tim Murphy
Chairman
Subcommittee on Oversight and
Investigations

cc: The Honorable Gene Green, Ranking Member, Subcommittee on Health
The Honorable Diana DeGette, Ranking Member, Subcommittee on Oversight and Investigations

Attachments

Attachment 1—Additional Questions for the RecordThe Honorable Joe Barton

1. Mr. Slavitt, late last year I was contacted by Mr. Ron Knott of Desoto, Texas, who told me that Blue Cross Blue Shield would no longer offer PPO plans on the Texas exchange. I was alarmed by this news and looked further into it, only to realize that insurance companies across the nation were doing the same thing. Now, here we are in 2016 and I see premium requests for as high as 62%. What will the health insurance market look like in five years or even ten years? What choices will consumers be left with in these state exchanges?
2. Mr. Slavitt, in your testimony, you say that premiums remain well below what CBO initially predicted, citing a 2010 CBO report. But in this same year, CBO said that premiums for the individual would increase 27 to 30 percent as a result of Obamacare. Right now, for the 17 states that have approved their rates, the average increase is 25.8 percent from 2015 alone. Do you think that a roughly 27 percent increase – before we've seen some of the traditionally more expensive states – is affordable?

The Honorable Michal C. Burgess, M.D.

1. Do you believe it is appropriate for state exchanges to transition to HealthCare.gov after spending hundreds of millions of taxpayer dollars? Should there be consequences? Should the states be required to raise state revenue or user fees to keep their exchanges afloat, instead of spending more federal dollars?
 - a. Do you expect additional states to transition to HealthCare.gov?
 - b. Have any state exchanges approached you about transitioning to HealthCare.gov? Which ones?
2. When a state exchange—such as Hawaii, Nevada, New Mexico, or Oregon—decides to shut down its exchange, what happens to any remaining unspent establishment grant dollars?
 - a. Does CMS try to recoup any of the unspent establishment grant dollars? Why or why not?
 - b. Does CMS require the state exchange to return any of the establishment grant dollars—spent or unspent? Why or why not?
3. Does the federal government incur any additional costs when a state exchange migrates to HealthCare.gov? In other words, does the transition cost the federal government any additional money?
 - a. If so, how much? What were the specific costs?
 - b. Please provide a breakdown of the costs and how much was money that was already awarded to the state-exchange via establishment grants and how much was additional funding.

The Honorable Marsha Blackburn

Mr. Slavitt, the Health Subcommittee held a discussion on May 11, 2016 about solutions that are fair and move patients away from today's rigged health care system. We talked about ways to achieve stronger protections for pre-existing conditions, lower costs, increase choices, and market stability without mandates.

During this hearing, I spent the bulk of my time reviewing Special Enrollment Periods, or SEPs. Many observers and members of Congress believe that these are being abused, which is leading to an imbalance in the risk pools. I'd also like to add that I have a bill, H.R. 5589, the Plan Verification and Fairness Act that gets at this issue, and I would request that this administration support this measure.

1. I realize the administration has moved to improve the verification process. But the current confirmation process is post-enrollment. Do you believe that leniency for SEP verification has led to marketplace instability?
2. How many people have had their coverage retroactively ended because they did not provide adequate documentation?
3. If someone provides inadequate or false information after their plan has taken effect and they've already received a tax credit, what happens to that individual and the tax credit?

The Honorable Gus Bilirakis

Last December HHS' OIG issued a report titled, "CMS Could Not Effectively Ensure that Advance Premium Tax Credit Payments Made Under the Affordable Care Act Were Only for Enrollees Who Paid Their Premiums." In the report, OIG stated that CMS was paying advance premium tax credits based on the attestation of the insurance companies without verifying on an individual level if monthly premiums were being paid. The OIG recommended that CMS institute an automated policy-based payment process to verify premium payments on a monthly or real-time basis.

1. When did CMS institute the automated policy-based payment process with insurers for the federal marketplace?
2. Are the state-based exchanges using an automated policy-based payment process?
 - a. If not, what are they using to verify if premiums are paid?
 - b. Does CMS perform any verification on submitted state-exchange data?
 - c. Is there any penalty for not performing this verification by state-exchanges?
3. Does CMS have any plans of running the policy payment process against prior years to find individuals who may have improperly claimed cost sharing reductions or premium tax credits when they were not current on their payments?
 - a. If no, why not?

Does CMS have a legal obligation to recoup Advance Premium Tax Credits that were improperly claimed or paid by CMS?

- b. Please describe the duties and responsibilities of CMS for the Advance Premium Tax Credit under the Memorandum of Understanding signed with the Treasury/IRS.
- 4. Does CMS have a legal obligation to recoup Cost Sharing Reductions that were improperly claimed or paid by CMS?
- 5. In Secretary Burwell's testimony to E&C in February 2016, on the question of the automated payment process, the Secretary stated that the process was in place and, "we have seen the results in that the number of those enrolled in the marketplace actually is lower because we had more people come out." When CMS instituted this policy-based payment process for the federal marketplace, by how much did you find enrollment was reduced?

The OIG report recommended that CMS provide the IRS with Advance Premium Tax Credit payment data when payments are made throughout the year in order to allow the IRS to verify the data reported on each individual's tax forms.

- 6. Is CMS providing Advance Premium Tax Credit payment data to IRS for federal exchange enrollees?
 - a. Is CMS providing Advance Premium Tax Credit payment data to IRS for state exchange enrollees?
 - i. If not, who is responsible for providing this information to IRS?
 - ii. Is there any penalty for not providing this information?

The Honorable Billy Long

- 1. Mr. Slavitt, I am the sponsor for H.R. 815, the Access to Professional Health Insurance Advisors Act of 2015, a bill that would carve out agent commissions from the Medical Loss Ratio. Every Energy and Commerce Republican and several Committee Democrats have cosponsored the bill. Much of the success for enrollment in the exchanges has been due to agent involvement. Yet agent commissions are continuing to be cut due to the Medical Loss Ratio. In your testimony, you state that you are providing the carriers with some relief from the Medical Loss Ratio. I have no problem with that, but why not the same consideration for the agents?

The Honorable Bill Flores

- 1. In your testimony you paint a picture of a very utopian health care environment. One where my constituents are experiencing unprecedented access to care while being inundated with consumer choice and lower than expected costs. Also in your testimony you lead us to believe that CMS can fix what few problems do exist with lessons learned from a trial and error system that your agency has employed. Yet you seem to gloss over the fact that this utopian view accompanies an immense cost to the taxpayer. Fraud and failed state based exchanges and CO-OPs being the tip of the iceberg. Do you think that a trial and error system is fair to the hardworking taxpayer in my district that is footing the bill for CMS' mistakes and miscalculations?
- 2. In your testimony, you list a number of policy change fixes to build a stronger marketplace. The second action you point to is to "better reflect the risk associated with enrollees who are not enrolled for a full

12 months.” Do you believe that having patients participate for all 12 months is best for their care as well as for risk balance?

- a. Is your agency actually negatively impacting patient care by allowing individuals to go three months without paying for their premiums before they lose coverage?
- b. Prior to the ACA, over 40 state individual markets had a roughly 30-day grace period. Why are you allowing exchange participants three times as much time before their plan is ended?
- c. You state that not having individuals enrolled for a full 12 months is problematic yet in one state as many as 50 percent of enrollees enter the grace period at some point during the benefit year. Given your statement, do you find that 50 percent number troubling?

The Honorable Chris Collins

3. The Committee’s report, “Implementing Obamacare: A Review of CMS’ Management of the Failed CO-OP Program,”¹ explains how several factors caused the CO-OPs to fail. One in particular was enrollment: that both low and high enrollment caused CO-OPs to become financially insolvent. Health Republic Insurance of New York had the highest enrollment numbers in the nation, yet, the CO-OP lost \$35 million in 2014, and \$52.7 million in the first half of 2015. Despite these and other warning signs, CMS decided not to place the CO-OP on a Corrective Action Plan. Why did CMS decide not to place Health Republic on a Corrective Action Plan?
4. Page 29 of the Committee’s CO-OP report discusses how CMS only placed two CO-OPs on Corrective Action Plans before HHS-OIG issued its July 2015 audit “Actual Enrollment and Profitability was lower than projections made by the Consumer Operated and Oriented Plans and might affect their ability to repay loans provided under the Affordable Care Act.” Both of these Corrective Action Plans were the direct result of state regulators finding that the CO-OPs violated state laws. Corrective Action Plans for the remaining CO-OPs were not imposed until after HHS-OIG cited warning signs in their report. It seems as if CMS simply followed the actions of other regulators, rather than conduct its own oversight to identify problems before the CO-OPs failed. Did CMS conduct any of its own oversight of the CO-OP programs? If so, did CMS conduct any of this oversight prior to HHS OIG’s July 2015 audit?
 - a. Did CMS issue any Corrective Action Plans that were not based on the work of other outside groups?

¹ *Implementing Obamacare: A Review of CMS’ Management of the Failed CO-OP Program*. U.S. House of Representatives, Committee on Energy and Commerce, Majority Staff, 13 Sept. 2016, available at: https://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/documents/114/analysis/20160913Review_of_CMS_Management_of_the_Failed_CO_OP-Program.pdf

Attachment 2—Member Requests for the Record

During the hearing, Members asked you to provide additional information for the record, and you indicated that you would provide that information. For your convenience, descriptions of the requested information are provided below.

The Honorable Joseph R. Pitts

1. Please provide the Committee with recommendations from the February 2016 GAO report that recommends CMS conduct a risk assessment of potential exchange fraud, application eligibility, and the enrollment process.
2. Does CMS support the Committee's recommendation in the CO-OP report, entitled, "Implementing Obamacare: A Review of CMS' Management of the Failed CO-OP Program," that individuals be exempt from the individual mandate penalty if their coverage under a plan offered by a CO-OP was terminated due to the failure/closure of the CO-OP?¹ Please explain.

The Honorable Brett Guthrie

1. Secretary Burwell said that CMS would check whether exchange enrollees with subsidies are also enrolled in Medicaid or CHIP. She also said that notices would be sent in May to consumers who are enrolled in both. Have any consumers actually been unenrolled in Medicaid or an exchange as a result of this?

The Honorable David McKinley

1. Please provide an update on the site-neutral deadline case for the hospital complex in West Virginia that I mentioned during the hearing.

The Honorable Morgan Griffith

1. Please provide the names of those at CMS who have spoken to the Justice Department about the Risk Corridor lawsuits.
2. Please provide a list of insurers that are suing or have indicated that they intend to sue CMS for Risk Corridor payments.

The Honorable Larry Bucshon

1. Please provide the Committee with an analysis of the Medicare Part B proposed rule that would force physicians and practices to send patients to hospitals to receive care, increasing costs for beneficiaries — particularly as it relates to increased costs due to shifting care to hospitals.

¹ *Implementing Obamacare: A Review of CMS' Management of the Failed CO-OP Program*. U.S. House of Representatives, Committee on Energy and Commerce, Majority Staff, 13 Sept. 2016, available at: https://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/documents/114/analysis/20160913Review_of_CMS_Management_of_the_Failed_CO_OP-Program.pdf

The Honorable Susan Brooks

1. At the hearing you indicated that the amount of funds recouped from the state-based exchanges is greater than the \$1.6 million previously reported to the Committee, and is in fact at least higher by about \$14 million. Please provide an update on the status of recouped funds from all state-based exchanges. Please provide this update with breakdowns of amounts by state and date of re-payment.