

AN OVERDUE CHECKUP PART II: EXAMINING THE ACA'S STATE INSURANCE MARKETPLACES

HEARING BEFORE THE SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS OF THE COMMITTEE ON ENERGY AND COMMERCE HOUSE OF REPRESENTATIVES ONE HUNDRED FOURTEENTH CONGRESS

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AN OVERDUE CHECKUP PART II: EXAMINING THE ACA'S STATE INSURANCE MARKET- PLACES

TUESDAY, DECEMBER 8, 2015

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 10:02 a.m., in room 2322, Rayburn House Office Building, Hon. Tim Murphy (chairman of the subcommittee) presiding.

Members present: Representatives Murphy, McKinley, Burgess, Blackburn, Griffith, Bucshon, Flores, Brooks, Mullin, Collins, Cramer, Upton (ex officio), DeGette, Castor, Tonko, Yarmuth, Clarke, Kennedy, Green, Welch, and Pallone (ex officio).

Staff present: Jessica Donlon, Counsel, Oversight and Investigations; Emily Felder, Counsel, Oversight and Investigations; Brittany Havens, Legislative Associate, Oversight; Charles Ingebretson, Chief Counsel, Oversight and Investigations; Chris Santini, Policy Coordinator, Oversight and Investigations; Dylan Vorbach, Legislative Clerk; Christine Brennan, Democratic Press Secretary; Jeff Carroll, Democratic Staff Director; Ryan Gottschall, Democratic GAO Detailee; Christopher Knauer, Democratic Oversight Staff Director; Una Lee, Democratic Chief Oversight Counsel; and Elizabeth Letter, Democratic Professional Staff Member.

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

Mr. MURPHY. Good morning. This subcommittee will now convene, the Oversight and Investigations Subcommittee of Energy and Commerce. And this hearing today is to continue examination of the State health insurance marketplace established under the Affordable Care Act, the ACA.

On September 29 the committee heard from a panel of witnesses representing six State exchanges. While attempting to paint a rosy picture, it is claimed that there are serious short-term and long-term problems with State exchanges. One of our main concerns we will address today is how Centers for Medicare and Medicaid Services, or CMS, is conducting oversight over the billions of taxpayer dollars invested in establishing the State exchanges. Today, we expect direct and honest answers from CMS Acting Administrator Andy Slavitt. And welcome back, sir.

Today, CMS has handed up \$5.51 billion to the States to help them establish insurance exchanges. Despite this whopping investment of taxpayer dollars, four States' exchanges have been turned entirely over to the Federal exchange, while countless others are struggling to become self-sustaining. As the Federal dollars run dry and enrollment numbers appear far below administration projections, all State exchanges face significant budget shortfalls.

By law, State exchanges were supposed to be self-sustaining by January 1 of 2015, at which point Federal establishment grant money could not be used to operate the exchanges, not be used. Yet, CMS has been issuing no-cost extensions to State exchanges, allowing them to use the remainder of their Federal grants through 2015 and in some cases 2016 against intent and letter of the law. Federal funds still cannot be used for operational costs, but because of lax oversight and weak guidance, we don't know whether or not State exchanges have actually spent this Federal money appropriately. We intend to get clear answers today.

In the over 5 years since the ACA was enacted, CMS has issued only two guidance documents to inform State exchanges on the permissible ways to spend Federal establishment funds. The first guidance, issued in March 2014, was less than a page. The second guidance came only after the HHS Office of Inspector General issued an alert to Acting Administrator Andy Slavitt highlighting with urgency that State exchanges maybe using grant funds for operational expenses, which is not allowed. In fact, the OIG had discovered, based on budget documents, the Washington Health Benefit Exchange might have used \$10 million in the establishment grant funds to support operations such as printing, postage, and bank fees, again, not allowed.

HHS OIG urged Acting Administrator Slavitt to develop and issue clear guidance to the State exchanges on the appropriate use of establishment grant funds. What followed was a vague 2-page guidance document bereft of concrete examples. Based on these "guidances," one wonders if CMS is encouraging the State exchanges to spend Federal dollars in any way possible against the stated purposes of the law to keep these State exchanges limping along.

Through the committee's investigation, we have learned of instances where State exchanges may have used establishment grant dollars to cover operational costs or even transition costs when a State exchange shuts down and moves to the Federal platform. It hasn't been always easy to discern, however, because these funds have been co-mingled, and expenses and costs have been redefined. For example, rent, which is an operational cost by any definition, suddenly becomes business development costs. The system seems to be convoluted by design.

In spite of, or perhaps because of, CMS's hands-off approach, the State exchanges are struggling to become self-sustaining. They continue to face IT problems, lower-than-expected enrollment numbers, and growing maintenance costs. And as the HHS OIG pointed out in its alert, State exchanges are facing uncertainties in revenue. Four State exchanges—Hawaii, Nevada, New Mexico, and Oregon—have already shut down their State exchanges, and these four States alone receive \$733 million in Federal establishment

grants. The taxpayers' return on investment appears minimal at best.

Further, there was little indication that CMS has attempted to recoup any of this money. It is our hope that Acting Administrator Slavitt commits to and lays out a blueprint for recouping these lost Federal dollars so that the American people are not footing the tab for yet another ACA failure.

To better understand the challenges these State exchanges face to ensure more tax dollars aren't wasted, this committee has a number of questions. Why are State exchanges struggling to become self-sustaining, especially given the extraordinary taxpayer investment? Is it lack of CMS accountability or oversight? Is CMS encouraging fiscal restraint or instead taking a hands-off approach, which has allowed money to be spent uncontrollably, unwisely, and maybe even impermissibly? And where in exchange has decided to shut down has CMS sought to recoup any of the Federal grant dollars? Lastly, are the exchanges doomed to fail?

In my estimation, CMS oversight has been woefully sloppy at best and willfully ignorant at worst, but with obvious spending abuses, costing taxpayers millions and counting from the States. We hope that CMS will be forthright in answering the committee's many outstanding questions on its failure in overseeing the ACA State exchanges, as well as provide Members a blueprint on how the administration will recoup lost taxpayer dollars moving forward. Right now, the situation is a mess, and taxpayers are on the losing side, and that is simply unacceptable.

This hearing comes at a time when premiums for low-cost plans are on the rise, major insurers are publicly questioning their decisions to join the exchanges, co-ops are failing at an alarming rate, and State exchanges are expressing doubts about their ability to exist long term. Mounting evidence suggests that the ACA faces insurmountable problems in 2016, and today, we have an opportunity to ask CMS top official if and when the administration will finally address these concerns in a meaningful way.

So I thank Acting Administrator Andy Slavitt for testifying today and look forward to hearing answers to our questions, not more questions.

[The prepared statement of Mr. Murphy follows:]

PREPARED STATEMENT OF HON. TIM MURPHY

On September 29th, the committee heard from a panel of witnesses representing six State exchanges. While attempting to paint a rosy picture, it is clear there are serious short-term and long-term problems with State exchanges. One of our main concerns we will address today is how Centers for Medicare and Medicaid Services (CMS) is conducting oversight over the billions of taxpayer dollars invested in establishing the State exchanges. Today, we expect direct and honest answers from CMS Acting Administrator Andy Slavitt.

To date, CMS has handed out \$5.51 billion to the States to help them establish insurance exchanges. Despite this whopping investment of taxpayer dollars, four States exchanges have been turned entirely over to the Federal exchange while countless others are struggling to become self-sustaining. As the Federal dollars run dry and enrollment numbers appear far below administration projections, all State exchanges face significant budget shortfalls. By law, State exchanges were supposed to be self-sustaining by January 1, 2015, at which point, Federal establishment grant money could not be used to operate the exchanges. Yet CMS has been issuing No Cost Extensions to State exchanges, allowing them to use the remainder of their Federal grants through 2015 and, in some cases, 2016 against intent and letter of

the law. Federal funds still cannot be used for operational costs. But because of lax oversight and weak guidance, we don't know whether or not State exchanges have actually spent this Federal money appropriately. We intend to get clear answers today.

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In spite of—or perhaps because of—CMS' hands-off approach, the State exchanges are struggling to become self-sustaining. They continue to face IT problems, lower than expected enrollment numbers, and growing maintenance costs. And as the HHS OIG pointed out in its alert, State exchanges are facing uncertainties in revenue. Four State exchanges—Hawaii, Nevada, New Mexico, and Oregon—have already shut down their State exchanges. These four states alone received \$733 million in Federal establishment grants. The taxpayer's return on investment appears minimal at best. Further, there is little indication that CMS has attempted to recoup any of this money. It is our hope that Acting Administrator Slavitt commits to, and lays out, a blueprint for recouping these lost Federal dollars so that the American people are not footing the tab for yet another ACA failure.

To better understand the challenges these State exchanges face and to ensure more tax dollars aren't wasted, this committee has a number of questions: Why are State exchanges struggling to become self-sustaining, especially given the extraordinary taxpayer investment? Is it a lack of CMS accountability or oversight? Is CMS encouraging fiscal restraint, or instead, taking a hands-off approach, which has allowed money to be spent uncontrollably, unwisely and maybe even impermissibly? And where an exchange has decided to shut down, has CMS sought to recoup any of the Federal grant dollars? Lastly, are the exchanges doomed to fail?

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This hearing comes at a time when premiums for low-cost plans are on the rise, major insurers are publicly questioning their decisions to join the exchanges, CO-OPs are failing at an alarming rate, and State exchanges are expressing doubts about their ability to exist long-term.

Mounting evidence suggests the ACA faces insurmountable problems in 2016. Today we have an opportunity to ask CMS's top official if and when the administration will finally address these concerns in a meaningful way.

Mr. MURPHY. I now recognize Ranking Member Ms. DeGette for 5 minutes.

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

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

While today we are having yet another hearing on the Affordable Care Act, as usual, Mr. Chairman, I am disappointed that here we are having another hearing focused on undermining the law rather than focusing our efforts on trying to make the law work better.

And I know with respect to the topic of this hearing today, CMS is trying to implement efforts to make the law work better, and I think that we should be using our time today to see how we can partner to make that happen.

Since the ACA was passed over 5 years ago, this committee has held dozens of oversight hearings on the law. Not one of them has been focused on ways to make the law work better. Not one of them has presented a balanced view of the law's benefits. But despite that, we have gotten a lot of good news out of these hearings about the number of Americans that the law is helping and about what the agencies are trying to do to improve coverage, despite some of the bumps in the road.

But, you know, even more disturbingly to me, though, it has been really an uphill climb to try to implement this legislation because some of our colleagues, both here in Congress and around the country, have intentionally placed roadblocks to implementation that actually make it harder for their own constituents to access care.

Some of the Governors, when the law was passed, refused to implement the Medicaid expansion, which would give healthcare coverage to millions of lower-income Americans. One Republican presidential candidate, who also happens to be a U.S. Senator, recently bragged that he killed Obamacare by limiting risk quarter payments.

I have got two things to say in response to that. First, I think it is really disappointing that Members of Congress would brag about taking health care away from vulnerable Americans. Secondly, I think people are wrong on the facts. The Affordable Care Act is not going anywhere. Despite countless attempts to repeal, undermine, defund, and defame the law, the Affordable Care Act is making comprehensive health care a reality for American families. It is saving lives.

Since passage of the law more than 5 years ago, an estimated 17.6 million Americans have gained health coverage through the ACA's various provisions. According to the recent CDC data, the uninsured rate has dropped to historic low of 9 percent down from 16 percent in 2010.

I just ran into my Colorado folks yesterday at the airport coming out here, and they told me, despite the failure of the Colorado cop just a month or two ago, they are expecting, because of the revisions and innovations they are making Colorado, they may be up to 95 percent coverage in Colorado pretty soon. That is extraordinary for the health care of our constituents. And that is what we should be working to achieve.

I have got an article from the New York Times entitled "Rise in Cervical Cancer Detection Is Linked to Affordable Healthcare," Mr. Chairman. According to researchers from the American Cancer So-

ciety, more women are receiving an early diagnosis of cervical cancer due to an increase in health insurance coverage under the ACA, and I would like to ask unanimous consent to put that in the record.

Mr. MURPHY. Without objection, so ordered.

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

Ms. DEGETTE. Early diagnosis of cervical cancer improves women's prospects for survival of the disease, and it also bolsters their hope to preserve fertility during treatment. And women with health insurance are far more likely to get a screening that can identify cervical cancer early.

You know, I know that it is hard to make this specific about constituents. It is hard sometimes for my colleagues on the other side of the aisle to acknowledge that actual people are being helped by this law. But millions of Americans are benefitting from it, and a lot of people like me think we could be making it even better.

The reason I am talking about this this morning is because on the House Floor we will be likely voting this week on a reconciliation bill to repeal key parts of the Affordable Care Act. This would be, by our calculation, the 62nd attempted to eliminate or repeal key provisions of the ACA. If enacted, virtually all of the historic gains in health coverage we have made in the last 5 years would be lost. This would be a tragedy for the American people and a gross failure of leadership.

You know, we have done so much good this year in this subcommittee. We did bipartisan work on pandemic flu. We did bipartisan work on the Volkswagen investigation and many other things. I think this could be the committee where we had these hearings and then we sat down to think about how to improve rather than to undermine the Affordable Care Act. I hope that is what we will do in the next year, but frankly, I don't hold out a lot of hope.

I yield back.

Mr. MURPHY. The gentlelady yields back. Before I introduce the next presenter, I want to welcome today—we have several members here from the National Democratic Institute in support of the House Democracy Partnership. This is a peer-to-peer exchange and co-chaired by Representative Peter Roskam and Representative David Price.

And we have guests with us from Kenya and Peru. Welcome here. Just to let you know, this is a love fest among us. We all like each other. So take back to your country, sometimes we may argue, but in the end we still are in here for the same cause, so I hope this is valuable—

Ms. DEGETTE. If the chairman will yield?

Mr. MURPHY. Yes.

Ms. DEGETTE. We might disagree, but we disagree in a civil way.

Mr. MURPHY. Watch that seat.

Ms. DEGETTE. That is going too far.

Mr. MURPHY. Thank you. I now recognize Mr. Upton for 5 minutes.

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

Mr. UPTON. Well, I thank the good chairman.

Today, we continue our oversight into the Obama State health insurance marketplaces. Hard-working taxpayers invested some \$5.5 billion to establish these State exchanges, yet they still continue to struggle, as we know. Exchanges are struggling to sign up new customers, struggling to cover operational costs, struggling to fix ongoing IT systems problems, and ultimately struggling to become self-sustaining.

We welcome the CMS Acting Administrator Mr. Slavitt today, and we appreciate his testimony on this very important issue.

As the State exchanges struggle to survive, we seek to understand CMS' role in overseeing them. The Government's robust investment of Federal funds into State exchanges should be accompanied by equally robust accountability by these stewards of taxpayer dollars. Yet the committee's oversight has revealed that CMS took a hands-off approach to the State exchanges. For example, CMS rubber-stamped a no-cost extension request, issued permissive and vague guidelines, and welcomed failed State exchanges to the Federal platform with no questions asked. This is not acceptable.

We want to hear directly how CMS plans to improve its oversight over the State exchanges to ensure that they are spending all grant dollars legally and wisely.

We also must understand the long-term sustainability of the State exchanges, especially against the backdrop of rising premiums, failing co-ops, and insurance companies doubting their participation in the exchanges next year. The writing is on the wall that we very well could see yet another big taxpayer investment spiral down the drain.

So it is critical that we all understand the short- and long-term challenges that State exchanges are facing, as well as what CMS is doing to help the exchanges confront the challenges. Regardless of one's views of the President's health law, the law and its implementation demand oversight. As we continue to see today, billions of dollars are certainly at stake.

[The prepared statement of Mr. Upton follows:]

PREPARED STATEMENT OF HON. FRED UPTON

Today we continue our oversight into the Obamacare State health insurance marketplaces. Hard-working taxpayers invested over \$5.5 billion to establish these State exchanges, yet they still continue to struggle. The exchanges are struggling to sign up new customers, struggling to cover operational costs, struggling to fix ongoing IT systems problems, and ultimately, struggling to become self-sustaining.

We welcome the Centers for Medicare and Medicaid Services' Acting Administrator Andy Slavitt today and appreciate his testimony on this important issue. As the State exchanges struggle to survive, we seek to understand CMS' role in overseeing them. The Government's robust investment of Federal funds into State exchanges should have been accompanied by equally robust accountability by these stewards of taxpayer dollars.

Yet, the committee's oversight has revealed that CMS took a hands-off approach to the state exchanges. For example, CMS rubber-stamped No Cost Extension requests, issued permissive and vague guidance, and welcomed failed State exchanges to the Federal platform with no questions asked. This is unacceptable. We want to hear directly how CMS plans to improve its oversight over the State exchanges, to ensure that they are spending grant dollars legally and wisely.

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Regardless of one's view of the President's health law, the law and its implementation demand oversight. As we continue to see today, billions of dollars are at stake.

Mr. UPTON. And I yield the balance of my time to Vice Chair Blackburn.

Mrs. BLACKBURN. And thank you, Mr. Chairman. Mr. Slavitt, welcome. We appreciate that you are here.

You know, shopping on the Federal exchange was supposed to be as simple as shopping for insurance on Kayak or Esurance, and that absolutely has not happened. And what we continue to hear from our constituents is that this insurance, the Obamacare insurance product, is too expensive to use once they do get it because of the copays, the deductibles, and the premiums that are there. It is a very expensive product.

We want to look at the GAO report from September. Today, we want to go through this with you. As both Chairman Upton and Chairman Murphy have said, it is very difficult for our constituents, and basically what it appears is that this has been a false promise that was given to people, that they would have healthcare access because they were going to have insurance, and that has not come about.

So we are very concerned about the dollars that have been spent on these State exchanges. We are concerned about the quality of the product.

And I yield the balance of my time to Dr. Burgess.

Mr. BURGESS. Well, thank you for yielding.

Look, the administration has invested billions of dollars in an experiment, the experiment that did not include the necessary safeguards, and in fact ignored successful models in the private market. The health benefit exchanges are one such experiment. Billions of taxpayer dollars have been pumped into reinventing the wheel, and millions of Americans, myself included, have been forced to rely on exchanges to purchase healthcare coverage.

My experience as a consumer on HealthCare.gov has been extremely frustrating, and my experience as a Member of Congress and a member of this committee and this subcommittee has been just as frustrating.

I know there are those who want to accuse us of trying to undermine the law. That in fact is not the case. The law should work, and we as members of the subcommittee, we as members of this full committee, we as Members of Congress have a constitutional obligation for oversight as to how those Federal dollars are spent. It has been extremely difficult getting questions answered. It has been extremely difficult getting information. That needs to change.

And I hope in this last year of the administration we perhaps can at least now admit to each other that there are serious problems with the law as it stands, and there are serious actions that we could take to fix those.

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

Mr. MURPHY. Thank you. The gentleman yields back.

I now recognize the ranking member of the full committee, the gentleman from New Jersey, Mr. Pallone, for 5 minutes.

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

Mr. PALLONE. Thank you, Mr. Chairman.

We are here today for yet another hearing to attack the Affordable Care Act. Since the August recess, the majority of the subcommittee's hearings have been dedicated to undermining the law. The majority has called on the State exchanges and CMS to criticize them, and they have burdened them with massive document requests in the middle of the open enrollment.

I do not mean to suggest that we should not be doing oversight of the implementation of the ACA, but what we are seeing from my Republican colleagues is not balanced oversight designed to improve the law. Instead, the majority's efforts are simply designed to hamper implementation and undermine the Affordable Care Act, regardless of the facts.

Frankly, it is incredibly frustrating to sit here time and time again listening to my Republican colleagues lay into the administration's witnesses, criticize the efforts of their departments without any sense of perspective on the historic gains in coverage that have been achieved. I would have hope that by this point nearly 6 years after the passage of the law we could add a balanced perspective on where implementation of the law faces challenges, but just as importantly, where it is helping Americans lead better lives and become more productive citizens.

We should be talking about ideas to advance the mission of the law to provide quality affordable care to all of our constituents or even make key fixes where appropriate. We should be holding hearings about ways to target the remaining uninsured.

As CMS will testify today, the ACA is clearly making a huge difference in the lives of millions of Americans. It is making families stronger. It is making States stronger. It is making America stronger. The law has faced challenges, but we have had many more successes that you never hear about from my colleagues on the other side of the aisle. So I am just going to take a moment to ensure that we hear some of these successes in today's hearing.

Because of the Affordable Care Act, 17.6 million uninsured people have gained coverage through the law's various coverage provisions. Since the start of this year's open enrollment period on November 1, 2 million Americans have selected plans through the federally facilitated exchange. More and more States are making the right decision on Medicaid expansion, which is benefiting the most vulnerable citizens, as well as saving billions of dollars. Preexisting conditions can no longer preclude individuals from gaining health insurance. Consumers do not have to worry about losing coverage if their employment changes. Reductions in the uninsured rate mean that doctors and hospitals provide less uncompensated care, which means fewer costs are being passed along to consumers and employers who pay premiums for health coverage.

Instead of acknowledging any of these successes, my Republican colleagues insist on holding more hearings and debating more bills to undermine the law. And what is worse, they are actively trying to take health insurance away from those who now have it.

This week, the House may be voting on a reconciliation bill to repeal key parts of the Affordable Care Act. This is the House Republicans' 62nd attempt to repeal or undermine key provisions of the law. The Republican bill eliminates subsidies for individuals purchasing coverage through the exchanges and eliminates the Medicaid expansion. According to the Congressional Budget Office, the GOP bill would increase the number of uninsured Americans by at least 22 million by 2018. The Republican bill would undo many of the historic gains in health coverage we have made in the past 5 years, while offering nothing to help those who will lose coverage or to make health care more affordable and available for all Americans.

As for a viable Republican alternative to the Affordable Care Act, which Republicans have said they would offer for several years now, let me just say this: I will believe it when I see it because I haven't seen it.

Let's actually work in a productive bipartisan way to make the Affordable Care Act work better instead of taking empty, meaningless votes to repeal it and take insurance coverage away from our constituents.

And I yield back.

[The prepared statement of Mr. Pallone follows:]

PREPARED STATEMENT OF HON. FRANK PALLONE, JR.

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I do not mean to suggest that we should not be doing oversight of the implementation of the Affordable Care Act. But what we are seeing from my Republican colleagues is not balanced oversight designed to improve the law. Instead, the majority's efforts are simply designed to hamper implementation and undermine the Affordable Care Act regardless of the facts.

Frankly, it's incredibly frustrating to sit here time and time again listening to my Republican colleagues lay into the administration witnesses and criticize the efforts of their departments without any sense of perspective on the historic gains in coverage that have been achieved.

I would have hoped that by this point, nearly 6 years after the passage of the law, we could add a balanced perspective on where implementation of the law faces challenges, but just as importantly, where it is helping Americans lead better lives and become more productive citizens.

We should be talking about ideas to advance the mission of the law, to provide quality, affordable care to all of our constituents, or even make key fixes where appropriate. We should be holding hearings about ways to target the remaining uninsured.

As CMS will testify today, the ACA is clearly making a huge difference in the lives of millions of Americans. It is making families stronger. It is making States stronger. It is making America stronger. Yes, the law has faced challenges, but we have had many more successes that you never hear about from my colleagues on the other side of the aisle.

So I will take a moment to ensure that we hear about some of them in today's hearing.

Because of the Affordable Care Act, 17.6 million uninsured people have gained coverage through the law's various coverage provisions. Since the start of this year's open enrollment period on November 1, two million Americans have selected plans

through the federally facilitated exchange. More and more States are making the right decision on Medicaid expansion, which is benefitting their most vulnerable citizens as well as saving billions of dollars.

Pre-existing conditions can no longer preclude individuals from gaining health insurance. Consumers do not have to worry about losing coverage if their employment changes. Reductions in the uninsured rate mean that doctors and hospitals provides less uncompensated care, which means fewer costs are being passed along to consumers and employers who pay premiums for health coverage.

Instead of acknowledging any of these successes, my Republican colleagues insist on holding more hearings and debating more bills to undermine the law. And what's worse, they are actively trying to take health insurance away from those who now have it.

This week, the House will be voting on a reconciliation bill to repeal key parts of the Affordable Care Act. This is the House Republicans' 62nd attempt to repeal or undermine key provisions of the law.

The bill eliminates subsidies for individuals purchasing coverage through the exchanges and eliminates the Medicaid expansion. According to the Congressional Budget Office, the bill would increase the number of uninsured Americans by at least 22 million by 2018.

This bill would undo many of the historic gains in health coverage we've made in the past 5 years, while offering nothing to help those who will lose coverage, or to make healthcare more affordable and available for all Americans. As for a viable Republican alternative to the Affordable Care Act, which the Republicans have said they would offer for several years now, let me just say this—I'll believe it when I see it.

Let us actually work in a productive, bipartisan way to make the Affordable Care Act work better instead of taking empty, meaningless votes to repeal it and take insurance coverage away from our constituents.

I yield back.

Mr. MURPHY. I ask unanimous consent that Members with written opening statements be introduced into the record, and without objection, documents will be entered in the record.

Mr. Slavitt, as you are aware, the committee is holding an investigative hearing, and when doing so, has the practice of taking testimony under oath. Do you have any objections to testifying under oath?

Mr. SLAVITT. I do not.

Mr. MURPHY. And the Chair then advises you that under the rules of the House and rules of the committee, you are entitled to be advised by counsel. Do you desired to be advised by counsel during the hearing today?

Mr. SLAVITT. I do not.

Mr. MURPHY. Thank you. In that case, would you please rise and raise your right hand? I will swear you in.

[Witness sworn.]

Mr. MURPHY. Thank you. Let the record show that the witness has said yes.

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.

**STATEMENT OF ANDY SLAVITT, ACTING ADMINISTRATOR,
CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES**

Mr. SLAVITT. Thank you. Chairman Murphy, Ranking Member DeGette, and members of the subcommittee, thank you for the invitation to discuss State-based health insurance marketplaces. I'm Andy Slavitt, the Acting Administrator of the Centers for Medicare & Medicaid Services.

CMS is working hard for the American healthcare consumer and American taxpayer to provide access to affordable quality healthcare coverage. Marketplaces, whether offered through States or through Federally Facilitated Marketplaces, allow individuals and families access to information, tools, personal help, consumer protections, and an array of health plan options from private sector health plans.

Setting up and managing State marketplaces is a significant task, and I would like to talk now about how we provide oversight and assistance to the marketplaces but also watch over the American taxpayers' dollars.

In considering our oversight role, it is important to understand all the responsibilities of a State-based marketplace. States must establish the infrastructure to review and qualify health plan offerings, develop online and call center capabilities to provide eligibility and enrollment services, interface with State Medicaid systems, develop cybersecurity capabilities, outreach and education functions, and dozens of other activities.

We've seen significant successes as States have innovated to meet the needs of their populations and are successfully serving their populations today, having insured millions of people.

Every State has also had its share of challenges during the start-up phase, including five who have had more significant IT challenges. And IT typically represents 30 to 50 percent of a State's development budget, given their other responsibilities.

In discussing now our three key oversight priorities, I want to focus in particular on those situations where States have had more significant challenges. Our first priority is to be good stewards of the Federal taxpayers' dollars. This means returning unspent dollars to the Treasury and closing grants, collecting improperly spent dollars, and preventing more from going out the door. Over \$200 million of the original grant awards have already been returned to the Federal Government, and we're now in the process of collecting and returning more. This also means no new money to fix IT problems was given or will be given to any of the five States or any other State that ran into difficulties. We should not pay twice for the same result.

Second, our job is to manage every dollar tightly. I have always been a big believer in preventing problems so we can spend less time recovering from them. Every State-based marketplace has external funding sufficient to run their operations. Federal money may not be used for regular operations. We do a line-item review of the expenditures a State proposes to ensure compliance with the law and conduct audits to make sure there's a full accounting of all Federal dollars. Important to our approach, we maintain control of the purse strings, and 69 times this year we've denied use of Federal funds. We also make adjustments through readiness reviews, detailed reporting, regular audits, and site visits.

Third, and perhaps most important, we assist the State in getting a return on their investment, as measured by the value they provide to their State. For all the challenges they've had, their ingenuity, their persistence, and their commitment to State residents has paid off for millions of Americans. As of June 30, State-based marketplaces provided coverage to approximately 2.9 million peo-

ple, and private health plans have helped millions access Medicaid, and the uninsured rates in these States have declined an average of 47 percent since 2013 to under 10 percent.

Now, I've worked in health care in the private sector since the early 1990s and joined the Government only last year. Among other things, I founded a company that assisted people who were un- and under-insured, and we had a large-scale data and analytics and healthcare consulting organization touching virtually every part of the healthcare system.

I can just tell you from my perspective what a significant advancement has been made for American families in a short time by giving people access to care and helping alleviate the financial worries that come from not being able to protect one's own family. Having done it many times, I can also tell you how difficult it is and how difficult it can be to launch and operate any new enterprise of this scale.

In conclusion, I have the privilege of serving as Acting Administrator while we are celebrating the 50th anniversary of Medicare and Medicaid. The perspective this offers is that at this early stage of the marketplace there are millions still to educate and enroll, and State health leaders and the private sector are continuing to find the best, most efficient ways of meeting their needs of these populations.

CMS's oversight responsibilities are also critical in this equation. CMS must not only be accountable for these responsibilities, but we must take every opportunity to find ways to improve how we do our job, including taking outside input so we can best fulfill our dual mission of providing access to affordable healthcare coverage for consumers and protecting the investment by taxpayers.

We do appreciate this subcommittee's interest in this area, and I am happy to answer your questions.

[The prepared statement of Mr. Slavitt follows:]

STATEMENT OF

ANDY SLAVITT

ACTING ADMINISTRATOR

CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

STATE-BASED HEALTH INSURANCE MARKETPLACES

BEFORE THE

UNITED STATES HOUSE COMMITTEE ON ENERGY & COMMERCE

SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS

DECEMBER 8, 2015

State-Based Health Insurance Marketplaces
U.S. House Committee on Energy & Commerce,
Subcommittee on Oversight & Investigations
December 8, 2015

Chairman Murphy, Ranking Member DeGette, and members of the Subcommittee, thank you for the invitation to discuss the Affordable Care Act's State-based Health Insurance Marketplaces (SBMs). The Centers for Medicare & Medicaid Services (CMS) serves both Marketplace consumers and the American taxpayers by providing oversight of and access to high-quality, affordable health insurance coverage.

Because of the Affordable Care Act, 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, they can purchase affordable coverage through the Marketplaces—regardless of their personal health histories. As the Affordable Care Act has taken effect, we've covered 17.6 million Americans. Since 2010, the uninsured rate (for those aged 18-64) has decreased by 45 percent. And for the first time, more than 90 percent of Americans are covered.¹ The reduction in the uninsured benefits Americans no matter how they get their health insurance, as reductions in the uninsured rate generally mean that doctors and hospitals provide less uncompensated care, the costs of which are often passed along to consumers and employers who pay premiums for health coverage.²

The Health Insurance Marketplaces bring private-sector health plans together to compete to meet consumer needs and help people shop for and afford health care coverage. In the past, when consumers shopped for health insurance, they had to read a patchwork of non-uniform and intricate disclosures about important matters, such as what benefits are covered under what conditions and the cost sharing associated with those benefits. The process was inefficient, difficult, and time-consuming. Because of the difficulty in obtaining comparable information across and within health insurance markets, consumers had trouble finding and choosing the coverage that best met their health and financial needs, as well as the needs of their families or their employees. Along with employer-sponsored coverage, Medicare, and Medicaid, private

¹ <http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201511.pdf>

² http://aspe.hhs.gov/sites/default/files/pdf/83961/ib_UncompensatedCare.pdf

insurance purchased through Health Insurance Marketplaces is now a reliable option for consumers to get the care they need at essential times in their lives. To help consumers shop for coverage, the Marketplaces allow consumers to compare health insurance plans based on key factors, such as covered services, providers, and importantly, price.

CMS's goal with the Health Insurance Marketplaces is to provide people in every state access to quality, affordable health care coverage and a fully functional Marketplace in which to purchase such coverage—whether their state chooses to have a Federally-facilitated Marketplace (FFM) or a SBM. SBMs have played a critical role in the success of the Affordable Care Act by enrolling consumers across the country into affordable, high-quality, private health insurance plans, while allowing states the option to offer local control over key Marketplace functions. Since the ACA was enacted in 2010, CMS has provided states with the information, guidance, and tools needed to make informed decisions about which type of Marketplace would meet the needs of their citizens.

SBMs are Tailoring their Work to Meet the Needs of their States

Across the country, a diverse set of states have chosen to implement an SBM to provide coverage to their residents, educate consumers about the importance of health insurance, and enroll them in high-quality, affordable health insurance coverage.

States that choose to establish and operate their own Marketplace must meet certain requirements and responsibilities set by the Affordable Care Act. Section 1311 of the Affordable Care Act outlines Federal requirements for establishing SBMs and makes available grant funding to states to meet those responsibilities. These requirements include, but are not limited to, establishing a governance structure, developing and implementing consumer assistance functions and resources (including a Navigator program and call center), and certifying qualified health plans (QHPs).

The Affordable Care Act provides significant flexibility to states to design and operate Marketplaces to meet the unique needs of their citizens. SBMs have taken different innovative approaches to their Marketplace consistent with their local needs. In California, Covered California employs an active purchasing strategy related to QHP certification and rigorously

reviews health insurance companies to determine whether they meet specific standards of quality, affordability, and accountability. These efforts helped improve consumers' options and contributed to a significant decrease in the uninsured rate in California. Approximately 1.7 million more Californians had insurance coverage in 2014 than in 2013.³ During this Open Enrollment, residents in California will have at least two carriers to choose from, and 99.6 percent will have three carriers to choose from.⁴ Covered California is working with 68 community-based Navigators and over 30,000 Certified Insurance Agents, Certified Application Counselors and other representatives across the state to enroll consumers in health insurance coverage during Open Enrollment this year.⁵

Massachusetts' Marketplace, the Health Connector, has significantly expanded its customer service for this year's Open Enrollment period, by providing additional customer service hours, creating four new walk-in centers, and expanding on-line capabilities which allow consumers to update their applications and make changes without calling a call center.⁶ Kentucky and Connecticut use a retail store format to educate and enroll consumers in coverage and have implemented on-line decision support tools for consumers and a mobile application and as of June 30, 2015, over 88,000 residents of Kentucky and over 92,000 residents of Connecticut were enrolled in high-quality, affordable health insurance coverage through their State-based Marketplaces.⁷

CMS facilitates and encourages the sharing of best practices between states, including the replication of successful models. For example, for the second year of Open Enrollment Maryland adopted Connecticut's Marketplace system for eligibility and enrollment functions.⁸

CMS Provides Oversight and Technical Assistance to the SBMs

CMS is responsible for the financial integrity and cost-effectiveness of the award and administration of grants to states to establish SBMs. CMS used HHS' established grant oversight

³ <http://www.census.gov/content/dam/Census/library/publications/2015/demo/p60-253.pdf>

⁴ <http://docs.house.gov/meetings/IF/IF02/20150929/103791/HHRG-114-IF02-Wstate-LeeP-20150929.pdf>

⁵ <http://news.coveredca.com/2015/10/covered-california-is-launching-its.html>

⁶ <http://docs.house.gov/meetings/IF/IF02/20150929/103791/HHRG-114-IF02-Wstate-GutierrezL-20150929.pdf>

⁷ <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-09-08.html>

⁸ <http://www.baltimoresun.com/health/health-care/bs-hs-exchange-board-vote-20140401-story.html>

process to safeguard taxpayer funds, which includes a competitive grant award process, budget negotiations, ongoing monitoring and oversight, funding release restrictions, and corrective actions for grantees that are in non-compliance with the terms and conditions of the grant, including the repayment of grant funds.

All funds for the establishment of SBMs have been allocated following HHS Grants Policy and applicable Federal statutes and regulation. States applied for funding through a competitive grant opportunity, and were required to meet the criteria established in the Funding Opportunity Announcement.⁹ Proposals were reviewed by an objective review panel, made up of non-Federal staff with content expertise in such areas as information technology (IT), operations, Medicaid, provider issues, and health care financing. Simultaneously, CMS conducted a thorough review of the applications and engaged the grant applicants in a thorough budget negotiation process, which several times resulted in a reduction of the requested award amount.

Each state that received a section 1311 grant is subject to a post-award, ongoing monitoring process to enforce the grant's terms and conditions and to identify issues to be corrected or mitigated. SBMs are required to submit semi-annual progress reports, quarterly financial reports, and monthly budget reports. CMS also restricts the release of the states' grant funding for IT development. Prior to having access to IT funding for any deliverable, states are required to submit information justifying their requests, including details on the proposed spending. CMS reviews and assesses the requests to release funds submitted by grantees for reasonableness of the request and soundness of the technical approach. CMS often requires states to submit revised requests with more detail before granting a release of IT funds. If a state's request is determined to be unreasonable, unsound, or duplicative of previously-funded activities, CMS denies the SBMs' request for the release of grant funds.

The grant recipients were subject to establishment reviews where CMS and state grantees met face-to-face to assess progress or identify risks and issues during the planning, design, development, and implementation phases of their projects. If issues were identified during this review, CMS required states to implement mitigation strategies or workarounds in order to be

⁹ [https://www.cms.gov/cciio/resources/Funding-Opportunities/index.html#Health Insurance Marketplaces](https://www.cms.gov/cciio/resources/Funding-Opportunities/index.html#Health%20Insurance%20Marketplaces)

able to meet functional requirements by the time of open enrollment. CMS also required a state to develop and submit a Corrective Action Plan (CAP) when significant issues were identified. For example, in December 2013, CMS required Massachusetts to develop a CAP to address system deficiencies that impacted the state's ability to enroll consumers through the online Marketplace. The CAP outlined the steps Massachusetts was required to take to achieve compliance with the ACA's online eligibility and enrollment requirements. CMS established a series of milestones and due dates for key areas such as governance, organization and resource management, schedule, business capability, and engineering views. Massachusetts provided CMS with an updated program schedule weekly and regular demonstrations on the IT development. As a result of this oversight, Massachusetts successfully launched a new individual enrollment and eligibility system for the second open enrollment period. As states move from the establishment of the SBMs to the operation of the SBMs, CMS continues to oversee and monitor each SBM's performance through ongoing and regular consultations and Open Enrollment readiness review.

The Affordable Care Act requires that beginning January 1, 2015, SBMs must be financially self-sustaining by having a source of funding - other than section 1311 funds - in place for ongoing operations. After January 1, 2015, section 1311 funds may not be used for ongoing SBM operations. No new section 1311 grants were awarded after January 1, 2015, consistent with the statute. Under established HHS Grant Policy, states may request a time-limited No Cost Extension (NCE) to use existing establishment funding, where the grantee reasonably requires additional time to complete the design, development, and implementation of establishment activities that were part of the SBM's establishment work plan. Requests for an NCE must include a monthly budget and spend plan that identifies non-section 1311 funds that will support ongoing operations and to demonstrate that an SBM has internal controls to ensure that section 1311 funding and other funding sources are properly separated and documented. CMS reviews each request to assure the request is appropriate, meets allocation parameters, and reasonableness of costs based on section 1311 and existing HHS grant rules and policies. NCE requests may be granted after CMS reviews and determines that expenditures associated with the funding request meet previously approved funding proposals. CMS conducts careful oversight of states' compliance with these requirements.

To ensure the appropriate use of section 1311 grants, CMS provides extensive technical assistance to clarify the difference between operational and establishment costs, including through webinars and phone conferences tailored to individual SBMs. CMS posted written guidance on section 1311 grants in March and September 2014.¹⁰ In June 2015, consistent with the recommendation of the HHS Office of the Inspector General (OIG), CMS issued additional guidance on the difference between operational and establishment costs, including specific examples for states to consider.¹¹ Following this policy, in September 2015, CMS found through our routine oversight of state Marketplaces that the Arkansas SBM spent approximately \$1 million of the state's section 1311 funding for activities that are not allowed under regulations. CMS notified the state, and it is working cooperatively to return the funds to the Federal Government.

Additionally, CMS conducts reviews of the SBMs to enforce the sustainability requirements established in the statute. SBMs are required to submit a five-year budget that includes non-Federal funding sources and amounts. CMS reviews budgets and funding sources, and evaluates the SBMs' reserve funding, projected revenues, and the management structure and organizational stability of the SBM. These reviews enable CMS to identify SBMs that may not comply with sustainability requirements. On May 29, 2015, CMS notified Rhode Island's Marketplace, HealthSourceRI that it must identify and obtain a funding source other than section 1311 grant funds or it would be out of compliance. On July 1, 2015, Rhode Island enacted a new state budget¹², which included a 3.5 percent assessment on health plans sold through HealthSourceRI, which brought the Marketplace into compliance with the Affordable Care Act.

CMS provides analysis and tools for the SBMs to assess financial self-sustainability and forums for SBMs to share and discuss strategies and best practices regarding their administrative costs and finances. In July 2015, CMS hosted an in-person workshop that was attended by SBM

¹⁰ <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/no-cost-extension-faqs-3-14-14.pdf>

¹¹ <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FINAL-1311-FAQ-06-08-15.pdf>

¹² <http://www.ri.gov/press/view/25187>

leadership from across the country, and included discussions regarding strategies and best practices toward achieving sustainability.

Conclusion

The Health Insurance Marketplaces are designed to assist consumers with accessing affordable health care by connecting them to coverage, and making it easier to shop for private-sector health care options. Millions of Americans have taken advantage of the choice, competition, and affordability provided by these Marketplaces – both State-based and Federal – since they first launched in 2014. SBMs have used innovative approaches appropriate to their state-specific needs and conditions. Together, SBMs have provided health care coverage to millions across the country. While there has been a historic decrease in the number of uninsured in the United States, those states that have established and operated their own Marketplace have had on average, a larger decrease in the uninsured.¹³ CMS is equally committed to strong ongoing oversight of SBMs that protects taxpayer funds. As part of this work, CMS provides support in the form of technical assistance and oversight to steward the use of Federal dollars and compliance with applicable laws. CMS is committed to protecting the investment made in SBMs through ongoing monitoring and oversight and recovers misspent funds in accordance with HHS' established grants oversight process. As the needs of consumers and states continue to evolve, CMS will continue to support states as they consider their options with support and oversight. We appreciate the Subcommittee's interest and I am happy to answer your questions.

¹³ <http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201511.pdf>

Mr. MURPHY. Thank you, Mr. Slavitt. I will now recognize myself for 5 minutes of questions.

The HHS Office of Inspector General alert found that Washington State's exchange had budgeted 10 million Federal grant dollars for operational expenses, including printing, postage, and bank fees from July of this year through December 31 of this year. These expenses are prohibited, but CMS had approved them in Washington's grant application.

Now, I know you just said you screen these things, so how did CMS miss that Washington State exchange was spending Federal establishment dollars on operational costs?

Mr. SLAVITT. So I believe if I'm correct that the early alert stated that there was a potential that there may have been misspent funds, but I don't think the OIG made that conclusion. And we conducted an investigation and looked through all their funds. There were a few adjustments made, but we currently believe that the State of Washington, by and large, is spending its money and categorizing it properly. We do have one small collection that we are undertaking with the State of Washington, but that's in process.

Mr. MURPHY. But the OIG did say that that was occurring, so you are saying there was since then an adjustment that you have made in discussing with the OIG?

Mr. SLAVITT. There's been plenty of adjustments with the States. We have, just by background, hundreds of interactions with the States. We review all their line items, review their budgets monthly. So at any point in time they may have found that they thought something may have been classified improperly, and we take advantage of the work of the OIG and we go conduct further investigation ourselves. I don't think we believe that all of those 10 million were properly classified. I think we did find there was some, however.

Mr. MURPHY. Could you make sure you get us details of that, and would you have found these if the OIG had not pointed these out?

Mr. SLAVITT. I wouldn't represent that our team finds everything. I would say we have multiple pieces of the process, most important being prevention because, once the dollar goes out the door, you have to spend effort to collect it, so we spent a lot of effort preventing things from being misclassified.

We do, however, find things and collect them, and I think OIG also finds things that we don't find. And when they do, we have a period of time that extends 3 years past when the grant periods end, which haven't even—the clock hadn't started ticking yet. So we will make sure we collect anything that gets uncovered.

Mr. MURPHY. With that, do you then post what your findings are in the OIG to say this is all in the inappropriate categories and notify States if you have spent money in these categories like you just reviewed the State of Washington so States know that you are going to ask them to return that money? Have you been posting that?

Mr. SLAVITT. Yes. States are all quite aware.

Mr. MURPHY. Would you make sure you share that with us in writing, too? That would be helpful.

Mr. SLAVITT. Yes.

Mr. MURPHY. Is it appropriate for State exchanges to transition HealthCare.gov after spending hundreds of millions of taxpayers' dollars on their own sites? And shouldn't there be other consequences for that? I mean they have failed but they spent all this money and then later said, gee, sorry it didn't work out. Does that seem appropriate?

Mr. SLAVITT. Well, I think it is important for us to recognize States have the right under the law to decide whether they want to be a State-based exchange, a Federal exchange, or to be a State-based exchange and use our platform. They have a right to change their mind for a variety of reasons, including technical or otherwise. So we think that's important.

What is also important is that if we find that any money has either been misspent or we have granted money that we believe the State no longer needs, we control the purse strings and have the right to collect money back. And we've in fact done that. We have collected money from recently the State of Maryland in a similar situation.

Mr. MURPHY. But my concern is with regard to the States trying to get into the insurance business and it didn't work out for many States, but there is no real consequence if they were able to take the money, say, toss their hands up and say, well, it turns out it didn't work out. We will just go to the Federal exchange. And this is where my concern is, and many of us have a concern that under those circumstances, if there were no consequences, then that is hardly a lesson.

So this is where I want to know, do you have any plan or intention to gather back, to recoup the Federal funds that have been provided to States to set up their exchanges only to then shift into HealthCare.gov?

Mr. SLAVITT. So there's the five States that I think have had the most significant IT challenges. Two of them maintained their role as State exchanges. Three of them are now using the Federal exchange platform but are still State-based exchanges. And each of those cases is slightly different. In one of those cases we have recovered money. In another case, the State is—two of the other cases, I should say, the State is in the process of trying to recover money, of which we will they go after our Federal share. And in one of the other States we are in the process of also closing down and collecting some money.

So it really varies by State, but I would think it's important to point out that even though States had challenges, they were by every measure able to enroll people, they had contingency plans, and eventually were able to set up a system that worked, which extends, as I said earlier, beyond technology—

Mr. MURPHY. I understand that, but it was after a lot of failure and a lot of wasted money. And I would like it if you could give something in writing of what your specific plan is with regard to recouping these Federal lost dollars. I yield now—

Mr. SLAVITT. Happy to do that.

Mr. MURPHY [continuing]. To Ms. DeGette for 5 minutes. Thank you.

Ms. DEGETTE. Thank you, Mr. Chairman. Mr. Chairman, I am assuming that you are referring to this GAO report from September 2015 to Congress—

Mr. MURPHY. Yes.

Ms. DEGETTE [continuing]. In these questions? I would ask unanimous consent to make that report a part of the record as well.

Mr. MURPHY. Yes.¹

Ms. DEGETTE. Thank you.

So, Administrator Slavitt, I just wanted to ask you, have you also reviewed this GAO report—

Mr. SLAVITT. Yes, I have.

Ms. DEGETTE [continuing]. That the chairman was asking you about? And one of the things that they said, it was their finding that CMS had established a framework for oversight but it wasn't always effectively executed. Did you see that finding?

Mr. SLAVITT. Yes, I did.

Ms. DEGETTE. And what is CMS's response to that finding?

Mr. SLAVITT. Yes, I believe we concurred with that finding. You know, from our perspective we are overseeing a lot of grants, so engaging the OIG, which we have worked in partnership with, as well as reports from GAO, are very helpful to us, and we take action when we get those findings.

Ms. DEGETTE. And so did you take action as a result of that concurrence?

Mr. SLAVITT. Yes. Yes, we have.

Ms. DEGETTE. What did you do, briefly?

Mr. SLAVITT. We built a tool which allows and monitors all of the funding before it occurs, and so we were able to stop money from going out the door that shouldn't.

Ms. DEGETTE. And I think this hooks onto the question the chairman was asking you. If you could supplement your responses by letting us know the policies that you have implemented, I think that would be great.

Mr. SLAVITT. Yes.

Ms. DEGETTE. Now, can you tell me about CMS's interactions with SBM officials like weekly check-in calls and site visits?

Mr. SLAVITT. Yes. I think we have dozens if not hundreds of interactions. They relate, as you say, from weekly check-in calls to monthly financials to site visits to audits.

[Audio malfunction in hearing room.]

Ms. DEGETTE. There. Administrator, what types of reporting are required from CMS establishment grant recipients, and how are they used by CMS?

Mr. SLAVITT. So, you know, we conducted an OMB A-123 financial audit. We have a smart program audit. There's an external security audit. The States have their own OIG and GAO audits, many State Legislature audits. So these numbers get pored over pretty aggressively.

Ms. DEGETTE. And then how do you use them?

¹The information has been retained in committee files and also is available at <http://docs.house.gov/meetings/IF/IF02/20151208/104256/HHRG-114-IF02-20151208-SD003.pdf>.

Mr. SLAVITT. Well, if we find that money's been improperly classified either as a cost allocation or an operating expense when it wasn't, we go collect it.

Ms. DEGETTE. And what types of independent assessments and audits are required?

Mr. SLAVITT. Well, there's the OMB audit, there are the OIG and GAO audits, there are State audits. There is a large variety of audits that follow these monies.

Ms. DEGETTE. And so sometimes, I think you said before, States do misclassify or misuse the grants. So what steps does CMS take then to bring the State back into compliance?

Mr. SLAVITT. So to give you an example, we have found that, in the case of Arkansas, roughly \$1 million and we notified them and we're in the process of collecting that. There's three other States that have amounts of money that we thought were misclassified. But I'd also emphasize, Congresswoman, we do a lot more to prevent these from happening—

Ms. DEGETTE. Well, that was my next question, yes.

Mr. SLAVITT. OK.

Ms. DEGETTE. Go ahead.

Mr. SLAVITT. Yes. I mean, I think 69 times this year we have caught in a request something that was to be used for generally an operating purpose that we didn't believe was an operating purpose. We believed for a development purpose, we believed it was an actual operating purpose and we denied the funding to begin with. And I think the committee—

Ms. DEGETTE. In reviewing the original application?

Mr. SLAVITT. In reviewing the original request.

Ms. DEGETTE. And what types of review or evaluation does CMS conduct on no-cost extension requests?

Mr. SLAVITT. Pretty extensive requests, you know. And if someone's going to get a no-cost extension, it really needs to be to fulfill what's part of their work plan that they have set up and that they just need more time to establish. I think we all know that these things are taking a little more time to implement than people originally thought.

Ms. DEGETTE. Now, I just want to shift my questioning for a second to talk about some of the things the ACA is doing. The most recent data from the CDC and Census Bureau found that the uninsured rate has fallen to 9 percent from 16 percent in 2010. I am wondering is this a new historic low in the uninsured rate?

Mr. SLAVITT. I believe it is.

Ms. DEGETTE. Do you believe that the Medicaid expansion has played a significant role in these reductions?

Mr. SLAVITT. It has.

Ms. DEGETTE. Why do you say that?

Mr. SLAVITT. Because we see millions of people in the States that have expanded Medicaid who now have access to coverage largely for the first time in many cases.

Ms. DEGETTE. They didn't have insurance before?

Mr. SLAVITT. Didn't have insurance before.

Ms. DEGETTE. And for these vulnerable citizens, can you talk about how the Medicaid expansion has impacted them?

Mr. SLAVITT. Yes, certainly. I think, very briefly, Congresswoman, when you see families get access to health care for the first time, it changes their participation in the community in many profound ways, but it keeps them healthier. And I think that also reduces costs for the long term.

Ms. DEGETTE. Thank you very much.

Thank you, Mr. Chairman.

Mr. MURPHY. I now recognize Mrs. Blackburn for 5 minutes.

Mrs. BLACKBURN. Thank you, Mr. Chairman.

Mr. Slavitt, let's go to page 86 of the GAO report and take a look at that if you don't mind.

Mr. SLAVITT. I don't have it in front of me but I'm—if someone could provide to me—

Mrs. BLACKBURN. OK.

Mr. SLAVITT [continuing]. I'm happy to—

Mrs. BLACKBURN. All right. Well, on page 86 what you find is the grants that have gone out, and the pool of money, which was \$4.5 billion, and you have sent about \$1.3 billion out the door. So what we want to know is where is the balance of money? Where is it currently sitting?

Mr. SLAVITT. Yes.

Mrs. BLACKBURN. Do you have a proper accounting of that?

Mr. SLAVITT. Yes, we do. In fact, we can provide you with an accounting of every dollar that's been spent, every dollar that hasn't been spent but we still have control of, and we're in the process in many cases of pulling that money back.

Mrs. BLACKBURN. OK. Then do provide us—

Mr. SLAVITT. We will.

Mrs. BLACKBURN [continuing]. With that accounting because we will need to see that. And, you know, if there is money that you are—let's go to the Arkansas situation.

Mr. SLAVITT. OK.

Mrs. BLACKBURN. I know you had said there was \$1 million there for unallowable. So tying back into what the chairman was asking you, when you have a situation, do you give them a plan of action and a timeline for returning that money—

Mr. SLAVITT. Yes.

Mrs. BLACKBURN [continuing]. To the Treasury? OK.

Mr. SLAVITT. Sometimes there's a little negotiation at first, but then we do that, yes.

Mrs. BLACKBURN. OK. It seems interesting there would be negotiation if they used it for something that was not allowed.

Mr. SLAVITT. Well, I think really this is all a matter of us explaining to them why we believed it was unallowable, their reviewing it, reviewing with their lawyers. It takes—

Mrs. BLACKBURN. OK.

Mr. SLAVITT [continuing]. A little bit of time and then—

Mrs. BLACKBURN. All right. How many other States have utilized funds for unallowables?

Mr. SLAVITT. For unallowables, I can think of at least three that we're in the process of—

Mrs. BLACKBURN. OK.

Mr. SLAVITT [continuing]. We're in the process of working—

Mrs. BLACKBURN. And you plan to get all of that money back?

Mr. SLAVITT. We do.

Mrs. BLACKBURN. OK. Excellent. That sounds good. Also in the GAO report one of the things that is of concern to me is they say none, zero, nobody, not one of these exchanges are meeting the desired operational outcomes in all functional categories envisioned by CMS. So at this stage of the process, doesn't this demonstrate that the systems are incomplete and incapable of functioning properly?

Mr. SLAVITT. What I can tell you today is that all of the exchanges are functioning—serving the members in their States, in their communities. And all of them have run into their share of challenges. None of this was easy, some of them bigger challenges than others, but there have been some that are very successful, and I think the experimentation model of States doing this on their own has had some merit.

Mrs. BLACKBURN. OK. Then how do you answer the GAO's assessment that none are meeting the desired functional outcomes?

Mr. SLAVITT. I think at any given point in time there have been challenges, been things that have been delayed, have been contingency plans. And so these—

Mrs. BLACKBURN. But nobody is meeting the desired outcomes. We continue to get complaints about these exchanges. We hear from people that—you know, the dissatisfaction is rampant. It costs too much, it is too expensive to use, the exchanges don't work, and then you get a GAO report that says nobody is hitting the metrics. So why do you continue to put money in on this if they are not meeting the functional outcomes, the desired outcomes? Why are you continuing to put money into this?

Mr. SLAVITT. So I understand the question, and it's an important question, of course. You know, 2.9 million people have been covered. I think that's the primary job of these exchanges. I think they are reaching the needs of populations that have never been covered before, and I think they're rising to those challenges—

Mrs. BLACKBURN. So we have spent 4.5—or could spend \$4.5 billion to get access to 2.9 million people?

Mr. SLAVITT. You know—

Mrs. BLACKBURN. That is what you are saying?

Mr. SLAVITT. I'm saying the States have reduced their uninsured rate, the States that have State-based marketplaces, to under 10 percent, and they're still in the establishment phase. It's still early on. They're still working at building. And if we believe that there's money that's been either improperly spent or is money that's been part of a grant is no longer needed, we have every ability to collect that money and we'll bring it back. And so I think my—

Mrs. BLACKBURN. So if you are in the private sector and you were 5 years into a rollout and you still weren't functional, would you give yourself an A or an F?

Mr. SLAVITT. You know, I wouldn't agree with the characterization that they're not functional at this point.

Mrs. BLACKBURN. Well, the GAO says they are not. So then you are disagreeing with the GAO report?

Mr. SLAVITT. I would say that at this point in time the States are all functional. Are they perfect and—

Mrs. BLACKBURN. OK. So you disagree. Then if the GAO says not any of them have hit the desired operational outcomes in all functional categories, Mr. Slavitt, that means it isn't working.

Mr. SLAVITT. Well, let me take a look at the language they use and let me get back to you on the representation of their report.

Mrs. BLACKBURN. Well, I would think that you would have known that answer, if you are functional or not, before you came to us. I yield back.

Mr. MURPHY. The gentlelady yields back. I now recognize Mr. Pallone for 5 minutes.

Mr. PALLONE. Thank you, Mr. Chairman.

Despite countless attempts by the Republicans to repeal and undermine and defund the Affordable Care Act, it is making affordable, comprehensive health coverage a reality for American families. According to recent CDC data, the uninsured rate has dropped to a historic low of 9 percent down from 16 percent in 2010, and for the first time, more than 90 percent of all Americans have health insurance.

So I want to ask Administrator Slavitt, can you put this in historic perspective? How significant is this drop in the uninsured rate? And can you comment on how the different coverage provisions of the ACA have operated to result in these gains in insurance coverage?

Mr. SLAVITT. Well, since at least I've been in health care in the early 1990s there's really been very little progress up until 2013 in seeing the uninsured rate improve. So these strike me as fairly significant improvements. I think they've come both from Medicaid expansion, as well as the offering of qualified health plans through the exchange.

Mr. PALLONE. And you have said, of course, that these gains really are historic, and I want to thank you for all your contributions to making health insurance more affordable and available to millions of Americans.

But looking to the future, it is my understanding that this open enrollment season that we are in and future seasons are going to be more challenging because the most motivated individuals have already signed up and the remaining individuals who are eligible are harder to reach. Is that correct?

Mr. SLAVITT. I think that's a fair characterization.

Mr. PALLONE. And 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 I just wanted to ask you a couple questions about that. How is CMS recalibrating its outreach and enrollment strategy in order to communicate with these harder-to-reach populations?

Mr. SLAVITT. You know, I think everybody in the marketplace needs to figure out how to continue to simplify not only the messages but also how health care works and how health insurance works so that people can understand which doctors are in which networks, which drugs are in which formularies, how things like deductibles work, building tools for those things. These are very, very important challenges and opportunities for all of us.

Mr. PALLONE. And then am I correct in stating that nearly 80 percent of the uninsured who are eligible for marketplace coverage

may be eligible for tax credits to purchase subsidized insurance in 2016?

Mr. SLAVITT. That's correct.

Mr. PALLONE. So I mean these people are all—I mean, there are obvious advantages if they are made aware. What is CMS doing to communicate so that they understand that they may be eligible for the subsidies? I don't know if you answered that, but I would like to know more specifically if you could.

Mr. SLAVITT. So I think, for us, it's really a function of, exactly as you said, Congressman, making sure people are aware that there are subsidies, that there are plenty of choices available for under \$100 and premiums for most people, under \$75 for many people, and continuing to take that message to where people live and where they work in their communities. I have to remind myself all the time that these are people, many of whom have not had health insurance for a long time, and so they're not as connected to the process as people who've been engaged so far.

Mr. PALLONE. You know, my own experience, when you began the open enrollment I guess was, what, in the early part of November? Is that when it began?

Mr. SLAVITT. November 1.

Mr. PALLONE. And we had a couple of events at, you know, the centers that were being set up, and there was a lot of, you know, outreach that was done not so much in the traditional way, you know, with ads or, you know, media-type things but more, you know, just with people going around, you know, with flyers and, you know, knocking on doors and that type of thing. And we did get a lot of people actually show up, you know, even that first day.

And, you know, it is hard. I mean a lot of times you have to, you know, figure out exactly where your placement center is, you know, operate on weekends, you know, do things that are not easy to be honest just to get people.

And I just think that, you know, I know that a very good job is being done right now, you know, during this period to try to get to the people, but it is hard. You know, even when I talk to people one-on-one I explain to them that, you know, they can get help with their premium, they are kind of shocked by it, which to me, you know, is surprising 6 years after, you know, we voted on this that, you know, people still don't understand that they can get help with their premium. But that is the reality.

Mr. SLAVITT. And this is one of the successes of State-based marketplaces because they understand their local populations better than anyone could here in Washington, DC, and I think they do a nice job of that.

Mr. PALLONE. Thank you.

Mr. MURPHY. I thank you and now recognize Mr. McKinley for 5 minutes.

Mr. MCKINLEY. Thank you, Mr. Chairman. And thank you for appearing before us, Mr. Slavitt.

Several comments, one, I think in your opening remarks you touched on some of your mission statement of providing oversight and assistance, but what was missing, I thought, and maybe because of my hearing loss I might have missed something, but I didn't hear about accountability, trying to give some guidance to

the people not only on your own staff but those affected parties with it. And the chairman talked a little bit about accountability. And I know coming from the private sector, there is accountability.

Just a quick grab this morning of things here with a person that, because he had committed fraud, he is going to spend 30 months in prison. Here was another one that paid \$7 million in restitution to NIH. Here is another individual who is going to serve 27 months for \$335,000 in fraudulent documentation. And here is another person who is going to spend 364 days in a county jail for \$31,900 in inappropriate expenditures.

So what I am wondering about here a little bit is what are we doing? Are we just checking the box that you are providing guidance, or are you holding people accountable either in your department or at the effective—like Arkansas? Is anyone going to be held accountable?

Mr. SLAVITT. We are accountable for making sure that the Federal tax dollars are getting spent properly, and we're accountable and have been collecting Federal tax dollars when they have been misused or not—they're not—

Mr. MCKINLEY. OK. Could you tell me, has anyone lost their job?

Mr. SLAVITT. In the State?

Mr. MCKINLEY. In the State or in your own department if you caught—they have given inappropriate advice. These people all have gone to prison as a result of doing something wrong.

Mr. SLAVITT. I can't speak to what's happening in the States, but I would tell you that just because a State misclassified information doesn't necessarily mean that they did it with intent. And each case, as you know, it's case by case.

Mr. MCKINLEY. Well, I keep looking for a good analogy and a quick term, and I guess you seem to be like a policeman or a State trooper along the road trying to keep people and guide and keep them under control, but when they speed, they are ticketed; they are fined. I am just wondering what you are doing—

Mr. SLAVITT. All—

Mr. MCKINLEY [continuing]. Your accountability for that. If they abuse it, then they should be paying for it.

Mr. SLAVITT. Well, we're certainly willing to make all of these things a matter of public record, as we have.

Mr. MCKINLEY. But you don't have anyone who has been held accountable for anything going on?

Mr. SLAVITT. I'm sure there's been people throughout exchanges who've lost their jobs—

Mr. MCKINLEY. Can you share that back with me, names of any—just give me a handful of names because surely during this process, as convoluted as it has been, that someone should be held accountable for it.

And just in closing, you had mentioned about the affordability. I would—with all due respect, I have a little problem because in West Virginia we only have one exchange representing the majority of the State, and their costs are going to be increasing 19.7 percent if their rate is approved. That is not affordable. What should be done? What can we do in West Virginia, almost a 20 percent hike in premiums?

Mr. SLAVITT. Yes, so I believe West Virginia has seen its uninsured rate move from 17.6 percent down to 8.3 percent. I think we are—

Mr. MCKINLEY. No, that is not the question. My question is about affordability.

Mr. SLAVITT. Yes. I'll—

Mr. MCKINLEY. That is part of the title here of this bill, is the Affordable Care Act, but under the entitlement, they can't afford it.

Mr. SLAVITT. Sure. I'll be happy to get back with you on specifics around the State of West Virginia. What I can tell you is for the majority of the residents, they still have opportunities to get covered for less than \$100 a month. No doubt we take affordability seriously and there is a lot of work to do there, and I'm happy to visit with you about the State specifically.

Mr. MCKINLEY. I would love to hear it, and I just want to, again—going to close again with just—

Mr. SLAVITT. Of course.

Mr. MCKINLEY [continuing]. I want accountability. And that is what we started with. Who is going to be responsible for what is happening out here all in Federal Government? That may be just in yours right now is over this Affordable Care Act? Who is being held accountable? I look forward to talking to you.

Mr. SLAVITT. OK.

Mr. MCKINLEY. Thank you. I yield back my time.

Mr. MURPHY. Mr. McKinley, when you referred to the affordability, are you referring to the premiums—

Mr. MCKINLEY. Yes.

Mr. MURPHY [continuing]. Deductibles—

Mr. MCKINLEY. Just—

Mr. MURPHY [continuing]. Who pays all the—

Mr. MCKINLEY. I am talking about the premiums themselves were 19.7 percent increase.

Mr. MURPHY. I understand, but I think there is also concern for the deductible, so if you could also get that information, that would be helpful.

Mr. SLAVITT. OK.

Mr. MURPHY. I now recognize from Florida, Ms. Castor, recognized for 5 minutes.

Ms. CASTOR. Thank you, Mr. Chairman. And good morning, Mr. Slavitt.

Mr. SLAVITT. Good morning.

Ms. CASTOR. Survey after survey published by Government and nongovernment sources over the past year all confirm that the percentage of uninsured Americans has declined substantially due to both the Affordable Care Act exchanges and marketplaces and also due to the expansion of Medicaid in many States. In fact, the census data from September found that the uninsured rate dropped in each and every State, and this is a wonderful accomplishment. It was one of the overriding goals to ensure that our neighbors have that very basic fundamental access to affordable health care.

Although all States saw reduction in the uninsured rate, States that setup their own State-based marketplaces and expanded Medicaid saw the greatest gains. For example, according to the census data—and Mr. Yarmuth will like this—from 2013 to 2014 Ken-

tucky showed an over 40-percent drop in the uninsured rate. Oregon's rate dropped 34 percent, and Minnesota's rate dropped 28 percent. And further declines in uninsured rates are likely to continue into the next year.

Now, Florida, my home State, doesn't have a State-based marketplace, but we are going gangbusters on the number of my neighbors now that have access to an affordable plan. And it was announced just last week that, as my neighbors enroll and renew coverage, we are approaching over half-a-million so far just over the past 4 weeks. That is out of the 2 million all across the country that are renewing in the Federal marketplaces.

And if you all are looking for a holiday gift for a loved one, for your son or daughter or niece or nephew, be sure to get them enrolled by December 15 because then they can start their coverage on January 1.

We are very fortunate in the Tampa Bay area the average cost of our standard exchange insurance plan is actually dropping this year, and so it is very helpful to have that competition. In areas where we have that competition, the costs of plans are actually going down.

But back to the State-based exchanges, Administrator Slavitt, what did these declines in the uninsured rate tell us about the State-based marketplaces? Do you think that they are succeeding overall?

Mr. SLAVITT. Yes, Congresswoman, I think they are. I think the State-based market places are on average doing even better than the Federal marketplace reductions in the uninsured.

Ms. CASTOR. And do you have a sense of how many people have enrolled in coverage through the State-based marketplaces so far?

Mr. SLAVITT. As of June 30, I think the number was roughly 2.9 million people.

Ms. CASTOR. And what role have the premium support played in that, and who receives the premium support? Who is it available to?

Mr. SLAVITT. Sure. So the cost-sharing reductions and the tax credits that are available through the Affordable Care Act really are allowing people to afford their coverage for the first time in many of these places. So it's been a big impact.

Ms. CASTOR. And what we found in Florida is, you know, it is kind of complicated for folks who have never had the ability to afford health care before. The navigators are playing a very important role because they will sit down with you and go through all of the options and what makes sense for you or your family. And you have seen this same thing across the country?

Mr. SLAVITT. Absolutely. Absolutely. I was just at a community center and saw the exact same thing.

Ms. CASTOR. And what more can we do to continue to lower the uninsured rates even further?

Mr. SLAVITT. So we are willing to work with any State that hasn't yet expanded Medicaid that has an interest in having a conversation about—

Ms. CASTOR. Yes, that is my State. Boy, we have thousands and thousands of my neighbors, and it has just been—Governor Scott has been so intransigent while it shows that it would lower costs.

The chamber, businesses, hospitals are behind it. OK, you are willing to work, but what happens when you run into this brick wall of unreasonableness and unwillingness to expand Medicaid?

Mr. SLAVITT. Exactly. Well, we're willing to work with any State. We know the States have their own sets of local circumstances and concerns, and we're willing to entertain them on their terms. We are open for business for States that are interested.

Ms. CASTOR. I know you are still willing to talk to Florida. I hope we can put the coalition together again to do it. And even though we have those challenges in certain States on Medicaid and there are going to be glitches and audit reports that are not so favorable in some ways, it is still important to remember the purpose of these exchanges and the grants that support them is to provide affordable health coverage. And it is great to see that the Affordable Care Act is providing that lifeline to affordable coverage and consumer protections and the State and Federal exchanges are achieving those goals. So thank you very much.

Mr. MURPHY. The gentlelady yields back. I now recognize Dr. Burgess for 5 minutes.

Mr. BURGESS. Thank you, Mr. Chairman.

Mr. Slavitt, I am going to depart a little bit from the stated purpose of the hearing. It is so rare that we get the CMS Administrator in here. I think it's been 2 or 3 years, so there are some things that I feel like I need to ask you since I have the opportunity to do so.

But first, I just want to offer to colleagues on the other side of the dais complaints that no one on the Republican side is trying to improve anything in health care, I have a bill out there, have had for some time, H.R. 1196, which would allow the bronze- and silver-level plans to be each considered as an HSA-compatible plan by definition.

One of the mainstays of the Affordable Care Act is you have got high-deductible, high-cost insurance. In the old days when I had an HSA I bought for a lower premium, I had a higher deductible and I could put some of that money away to use for that high deductible. We have made it very, very difficult for people who have these high deductible policies, but again, I encourage people on the other side of the dais to look at H.R. 1196. If you can suggest improvements to it, perhaps we have something to talk about.

But the basis is that every bronze or silver plan would be, by definition, HSA-compatible. You wouldn't have to look, you wouldn't have to fight, you wouldn't have to try to find one that was HSA-compatible. They all are or they all would be.

And then the other thing is really pretty straightforward. Currently, I have a health savings account. I am capped at \$3,400 a year that I can contribute, but my deductible is \$6,000 on a bronze plan and the PPO, so why not make those two amounts equal? And if the deductible is \$6,000 in a bronze- or silver-level plan, let that be the cap on the amount that could be put away into the health savings account.

Now, as I sit here and I listen to discussion on both sides of the dais, you know, I feel like I am stuck in a Dickens novel. It is the best of times, it is the worst of times. So, I mean, I think a fair observation is that the Affordable Care Act has never had, never

had even a plurality of positivity. It is about a 52 to 53 percent negative right now when you look at the polling numbers. You have to ask yourself you are giving something away, why aren't people liking it more? And the answer is because even though you are giving something away, it is still really expensive to live under the Affordable Care Act.

Now, my personal experience, I rejected the special deal for a Member of Congress and I just took a bronze plan, and the HealthCare.gov, one of the most miserable experiences that I have ever been through with trying to get signed up for the darn thing, but look, I have got an insurance premium that is higher than I have ever paid in my life. I have a deductible that, quite honestly, leaves me, at least in my consideration, functionally uninsured. People have asked me, well, is your doctor even on the list of providers you even go to? I don't know because I am not going to look because I am not going to go to the doctor. If I can't fix it myself, then, OK, that is that, but I am not going to spend \$6,000 on an office call or an ER visit. And most people actually fall into that category.

So once again, even though you have people with insurance, you have people who are financing a lot of their day-to-day healthcare needs out of cash flow, which is exactly the way it was before. The only difference was you could in fact buy an affordable policy before. Now, you simply cannot. And oh, by the way, we are going to fine you if you don't do that.

I also have a question about some of the implementation on the Affordable Care Act, and I apologize for doing this to you without warning you before, but section 1311(h), subsection (B), which deals with—of course, this is talking about the exchanges, (h) deals with quality improvement, enhancing patient safety. It talks about (A) a hospital with greater than 50 beds, the next paragraph is (B) a healthcare provider. And here, our healthcare provider can work in the exchange only if a provider implements such mechanisms to improve healthcare quality as the Secretary, by regulation, may require. And the start date for that was January of this year.

So I guess my question to you is have the rules been written on 1311(h) when my provider friends ask me where is this in the rule-making process? Has that in fact happened? Are people going to be excluded from the exchanges because they don't meet the Secretary's definition of quality? And has the Secretary defined quality? And are those definitions likely to change?

Mr. SLAVITT. Yes. Thanks. So I think your question is relative to how we're implementing the quality provisions in the Affordable Care Act relative to exchanges. I could spend more time with you either here or in another setting kind of taking you through the quality steps. We're introducing a whole series of quality reporting measures that are going to be coming with the exchange shortly. If I think I understand your—

Mr. BURGESS. Have you excluded a provider based on quality?

Mr. SLAVITT. Yes. I'm not sure I understand your question correctly. I want to make sure that I study that particular subsection. You know, we do reviews, and I think we do reviews based on the network adequacy. I'm not sure that we've yet excluded any provider for quality purpose at this point, but I will get back to you.

Mr. BURGESS. Thank you.

Mr. SLAVITT. Thank you.

Mr. MURPHY. Thank you. I now recognize Mr. Tonko for 5 minutes.

Mr. TONKO. Thank you, Mr. Chairman. Welcome, Administrator.

Administrator Slavitt, as you mentioned in your opening testimony, we need to keep in perspective that the Affordable Care Act is working, and it is working best in States that have embraced the law and taken advantage of the tools that the Affordable Care Act provides.

When States take ownership of the law and its benefits, the residents of that State see better outcomes. Let me use as an example my home State of New York. We expanded Medicaid. We set up our own exchange, the New York State of Health. And this year, we are one of the first States to utilize the basic health plan option known in New York as the Essential Plan. The Essential Plan will help people toward the lower end of the income spectrum but above the Medicaid eligibility line to gain access to quality health insurance for as little as \$20 per month.

Because New York has taken a proactive approach to healthcare reform, the citizens in our State have reaped the benefits. More than 2 million New Yorkers have enrolled in coverage because of the Affordable Care Act.

Certainly, with that in mind and across the board States have pursued the State-based marketplace models. And they are serving as laboratories for innovation, testing new models for enrollment, insurance market oversight, and consumer protection. And they are tailoring the ACA to their own given citizens.

With that in mind, Administrator, California has been a leader in the active purchaser model. Can you explain what this is and how this has helped cover California ensure access to high-quality affordable health insurance coverage?

Mr. SLAVITT. Yes, thank you for the question. Yes, I think this is an example of a State innovation where California has really been, as the description says, actively involved in defining the benefit offerings for the residents of their State, and I think quite successfully given—I think both the number of people that have been covered but also the management of the rate of costs has been, I think, quite good, and they've done a very nice job.

Mr. TONKO. Now, are other States taking similar approaches that you know of—

Mr. SLAVITT. Yes.

Mr. TONKO [continuing]. To certify, you know, qualified health plans?

Mr. SLAVITT. I believe there are several others, yes.

Mr. TONKO. OK. Any number that you have in mind of how many States?

Mr. SLAVITT. Yes, let me get back to you on the exact number—

Mr. TONKO. OK. Thank you. And what other steps are the SBMs taking to improve the quality of care to transform the healthcare delivery system?

Mr. SLAVITT. So I got back from a tour of several States, and, you know, they're each doing unique, innovative things. Some are

health fairs, some are, you know, reaching out into communities where they've got specific needs. But again, I think this is a benefit of the model of a State operating their own exchanges. It gives them more control to be able to tailor things to the needs of their population.

Mr. TONKO. And as we move forward, does CMS plan to encourage States to set up and operate their own exchanges? What Federal support will exist out there, will remain for our other States to plan to continue to operate their own exchanges?

Mr. SLAVITT. Well, of course, there is no more new grant funding, and of course the law provides every State the flexibility to make their own decision, but we will of course support any State that wants to set up a State-based marketplace. And, you know, today, if a State wants to do this, they get the benefit of all the best practices and lessons learned that the States that originally did it didn't have access to.

Mr. TONKO. Right. Do you hear from residents of these given States that have not expanded Medicaid, Medicaid for example or establish their own exchanges? Do you hear from any of the consumers?

Mr. SLAVITT. We do. We do frequently.

Mr. TONKO. And what is that dialogue like? Is it one of concern, frustration?

Mr. SLAVITT. You know, I think anybody who doesn't have coverage has to manage their own personal family situation very differently than the rest of us do. You know, they don't do things typically like let their kids play a sport in school because they might get hurt or injured. So there's a whole set of things that, you know, in the insecurity of people's lives that, you know, those of us that have insurance don't have to deal with every day.

Mr. TONKO. OK. Well, I certainly appreciate the work that you are doing. I know that it takes a lot of focus and concerted effort to move us and to transition us to a new era of healthcare delivery, and we thank you for the work that you are doing at the agency.

With that, Mr. Chair, I yield back.

Mr. MURPHY. The gentleman yields back.

I now recognize the gentleman from Texas, Mr. Flores, for 5 minutes.

Mr. FLORES. Thank you, Mr. Chairman. I thank the witness for joining us today.

The ACA required the State-based exchanges be self-sustaining on or after January 1 of 2015, at which point, according to CMS, States could no longer use grant funds to cover maintenance and operating costs. And yes, as you heard earlier today, according to the GAO report, the greatest challenges that States with State-based marketplaces are 1) inadequate staff and 2) inadequate funding.

And you answered a question earlier, and in that question you said this: You said State-based exchanges are doing better than Federal exchanges. So given that the GAO report says that the State-based exchanges are having problems, that doesn't foretell good news for the Federal exchange.

Continuing, according to the GAO, none of the State-based exchanges were fully operational on all the required functional cat-

egories as of February 2015. You heard that from Mrs. Blackburn's question. Four State-based exchanges have already transitioned to the Federally Facilitated Marketplace because they failed to be self-sustaining. So my question is this: How many more State exchanges do you expect to fail and make the transition to the Federal exchange?

Mr. SLAVITT. I believe what I said earlier was that States have been even more successful at reducing the uninsured rate. The national average has been about 45 percent. States that have State-based exchanges have done about 47 percent. So I think both are successful, States even more so. All the States have——

Mr. FLORES. OK. Let's go to my question.

Mr. SLAVITT. OK.

Mr. FLORES. So do you expect more State exchanges to fail and make the transition to the Federal exchange?

Mr. SLAVITT. So all the States have access to a source of their own funding either through an assessment that they have on the health insurers in their State or——

Mr. FLORES. So are you saying no State exchanges are going to fail?

Mr. SLAVITT. I'm saying all States currently have sources of funding now. Because it's a dynamic world, we do an evaluation at least twice a year——

Mr. FLORES. OK. Based on those evaluations, how many State exchanges do you expect to be unsustainable and to fail and move to the Federal system?

Mr. SLAVITT. Well, I can't predict who's going to come into the Federal exchange in large part because there's a lot of factors, including——

Mr. FLORES. OK.

Mr. SLAVITT [continuing]. Their own decision about whether or not they want to——

Mr. FLORES. So let me continue. Given this trend, do you think the self-sustainability is and always has been a serious situation facing these exchanges, the State exchanges?

Mr. SLAVITT. So, as I said, as of today, all of the States are sustainable. Whether they will be in the future, I'm not willing to predict. But——

Mr. FLORES. OK.

Mr. SLAVITT [continuing]. As of today they are.

Mr. FLORES. Well, I don't think the—the underlying economics of the ACA have not changed since its inception. Now, was there any work that CMS did that could have predicted that these State exchanges would fail? I mean, did you know in advance that any of the State exchanges would fail because of sustainability?

Mr. SLAVITT. So a lot of this comes before my time, but I wouldn't——

Mr. FLORES. OK.

Mr. SLAVITT [continuing]. Classify a challenge as a failure. I think every State has had challenges, but every State today is successfully enrolling individuals in their State, and every State has sources of funds sufficient to run their operations. So I would measure that as a success.

Mr. FLORES. When CMS awarded \$5.5 million in Federal marketplace grants for States to set up State-based exchanges, how could it have expected States like Hawaii or Nevada to sustain their own exchanges?

Mr. SLAVITT. So, again, these are decisions that were made before my time, so I can't speak to what was being thought of at the time. I can tell you that it's an ongoing process for States to make that evaluation, and as I think you're aware, the States of Nevada and Hawaii have decided it would be more efficient for them to operate maintaining the State-based exchange—

Mr. FLORES. Well—

Mr. SLAVITT [continuing]. But use our platform.

Mr. FLORES. It would be more efficient because they are broken, they couldn't afford to sustain themselves.

You have had us ask questions in the past how much has been recovered. I would ask for granularity on that from which States and how much each States still owes that they have not repaid back the Federal Government.

And the last question is this: How will you ensure the States have not used and will not use grant funds for operating expenses after January 1 of 2015?

Mr. SLAVITT. So, yes, I will provide that information that you requested.

And we do this through several steps. Most importantly is to prevent them from spending the money improperly in the first place. And I think, as I said, this year, 2015, on 69 occasions we have rejected a State's request to spend the money improperly. Now, if it turns out that they have for some reason, we conduct an audit and we go back and then we go through a collection process, as I've said. The first several States that we've begun the collection process for have begun to refund money, and we take that very seriously.

Mr. FLORES. OK. Thank you. I yield back the balance of my time.

Mr. MURPHY. The gentleman yields back. I now recognize another gentleman from Texas, Mr. Green, for 5 minutes.

Mr. GREEN. Thank you, Mr. Chairman. Mr. Slavitt, thank you for being here and thanks to CMS for working with us on something other than the GAO report.

Blue Cross Blue Shield recently announced that they would no longer be offering a PPO plan in the national exchange in Texas and also the individual market. This would mean there are no PPO plans on the individual and exchanges policies. As a result, specialty hospitals like M.D. Anderson in Houston and Texas Children's Hospital will be out of network on individual plans for that. Group plans are not under the same decision, so they will still—they have PPOs.

Blue Cross and Blue Cross Blue Shield Texas pulled the PPO plans citing that it is no longer financially feasible, that they cannot raise rates for PPOs without raising the rates for all the plans. This problem is not just limited to the Texas example because we are a national exchange and not a State exchange but, as reported, it is an issue in other exchanges across the country.

What can CMS do to address the issue of network adequacy that ensure that plans with premier and specialty hospital in network are available to consumers in the original market?

Mr. SLAVITT. Thank you for the question.

So we have just released a proposed rule around network adequacy. The National Association of Insurance Commissioners has also done some work in this area. But let me also say that this is an early stage of a market, and consumers are in the process of communicating, through what plans they choose, what things they're willing to pay for and what things they value and what things they don't.

And the health plans, I think, are in the process of trying to figure out how to create offerings that are affordable and meet the needs of individuals. So I do need to recognize this is still in year 3 of an early set of offerings, and I think if consumers suggest that they will want certain things in their networks, then my suspicion is that the health plans in those States will begin to make those things available.

Mr. GREEN. OK. Well, the Houston market, if you don't have Texas Children's or M.D. Anderson or a major full-purpose hospital that is in our medical center, you know, that is going to limit their opportunities for even using, whether it is under the Affordable Care Act or the individual market that I know we don't have an impact on. From your perspective, are there any actions that Congress can take to address this issue?

Mr. SLAVITT. You know, I think all of us should continue to listen to residents and make sure that we adjust and adapt, whatever our regulations are or however we are, you know, viewing this in the context of making sure that people are getting their basic sets of needs met. And we make sure that there's sufficient network adequacy and we do a review prior to allowing the State to go onto the exchange. And if we hear of problems, we'd like your office to let us know of specific instances.

Mr. GREEN. OK. We will be glad to.

Let me talk a little bit about the open enrollment for 2016. November 1 marked the beginning while open enrollment continues to the end of January. I mentioned about hearing how things are going. I realize you may not be able to speak to the Federal marketplace in terms of early data, but how are things going with the current open enrollment period, and how many folks are shopping for and signing up for some of the plans?

Mr. SLAVITT. So as of November 28, I think we've had 3.5 million applications this year during the open enrollment season, and there have been about 2 million plan selections, of which I believe 1.3 million have been to renew coverage and 700,000 have been to get new coverage. And of course we are now just beginning what has been a very big ramp-up period between now and December 15. People tend to be deadline-driven, and this week we are seeing that acceleration that we expect to continue on through the middle of December.

Mr. GREEN. Having done events in our district in an urban area in Houston, both with the original sign-up and the second time, you are right, we all procrastinate. What types of indications are you

receiving from the States on their enrollment? Any information on how enrollment is going in States that have their own plans?

Mr. SLAVITT. I've seen some preliminary data. It looks to be pretty close to on track to what they expected so far.

Mr. GREEN. OK. I understand several State-based marketplaces, as well as HealthCare.gov, are offering enhanced shop-and-compare tools that enable consumers to make smarter choices regarding their coverage option. Administrator, could you elaborate on these efforts and what type of tools are State marketplaces offering consumers, and why are such innovations important?

Mr. SLAVITT. Sure. You know, I think this allows me to speak to the question that was raised earlier about deductibles, and I think one thing that's very important for consumers to know is 80 percent of consumers—I believe is the right number—have access to plans that offer services like primary care visits and prescription drugs outside of the deductible. In other words, they don't need to meet their deductible before they hit them.

And the tools that you're describing allow people to understand whether or not a physician is in their network, whether or not a drug is covered in a specific plan, and of course how to make the tradeoffs sometimes that exist between coinsurance and premium levels, which I think is a complicated thing for people. So State-based exchanges, as well as the Federal exchange, all have those types of tools. And I shouldn't say all, many of them, and certainly the Federal marketplace, have those tools available.

Mr. GREEN. OK. Thank you. Thank you, Mr. Chairman.

Mr. MURPHY. Thank you. I now recognize the gentleman from Oklahoma, Mr. Mullin. You are recognized for 5 minutes.

Mr. MULLIN. Thank you, Mr. Chairman. And, sir, thanks for being here today. I know that sometimes that seat must get uncomfortable. But there are real questions and real concerns, and I don't want people to get caught up thinking that this is a partisan issue because really this is about taxpayer dollars, and what has been going on with it, and if they are being misused.

You know, if we remember back, this was supposed to be budget-neutral, and that hasn't taken place, and so now the American taxpayers are on the hook for it. And what has happened with the dollars? Where are they going? What is the accountability process? So I kind of want to maybe go down a different path with you. My understanding is that States operate on the Federal exchange receive a 3.5 percent user fee for the platform. Is that correct?

Mr. SLAVITT. The health plans have a user fee, not the States.

Mr. MULLIN. The States—or the health plan does?

Mr. SLAVITT. Yes.

Mr. MULLIN. So what happens to the 3.5 percent user fee? Where does that go?

Mr. SLAVITT. The 3.5 percent user fee goes to fund State exchange operations.

Mr. MULLIN. So who pays that? Does the State pay that or does the—

Mr. SLAVITT. The health insurance company.

Mr. MULLIN. The company does?

Mr. SLAVITT. Yes.

Mr. MULLIN. So the user, the insurer pays it?

Mr. SLAVITT. Insurer, yes.

Mr. MULLIN. All right. So it gets passed down to them. If a State closes its marketplace and transitions into the HealthCare.gov, is it required to charge the 3.5 percent?

Mr. SLAVITT. If a State continues to operate as a State-based marketplace—

Mr. MULLIN. Right.

Mr. SLAVITT [continuing]. But uses the Federal platform, we just have a rule that was proposed last month, that's proposed so it's still open for comment period, on what the fee would be, and the fee that's proposed is 3 percent for the use of the Federal—

Mr. MULLIN. The States that are currently on it, though, do they pay it? Does the insurers that participate in the fee States such as Oklahoma—

Mr. SLAVITT. It's proposed—I'm sorry, the States that are—

Mr. MULLIN. Well, we have some States that have obviously closed down and they have gone now, if I am not mistaken here, they have gone into the marketplace or they transition out of the marketplace into HealthCare.gov. Are they currently having to pay the 3.5 percent to participate in HealthCare.gov—

Mr. SLAVITT. I don't—

Mr. MULLIN [continuing]. Such other States that were already in it?

Mr. SLAVITT. Again, the States don't make the payments—

Mr. MULLIN. OK.

Mr. SLAVITT [continuing]. The plans do.

Mr. MULLIN. The plans do, but they are operating inside the State.

Mr. SLAVITT. The plans that—yes. And the proposed rule is for 2017. It would begin in January 2017.

Mr. MULLIN. So Oregon, Nevada, and Hawaii that recently came out—

Mr. SLAVITT. Yes.

Mr. MULLIN [continuing]. Their users inside the State, the insurers inside the State, are they required to pay the 3.5 percent?

Mr. SLAVITT. No, they make a payment to the State.

Mr. MULLIN. OK. The current individuals—

Mr. SLAVITT. Right.

Mr. MULLIN [continuing]. The current States that are in it, are they paying the 3.5 percent?

Mr. SLAVITT. The three you just mentioned?

Mr. MULLIN. No, they just came into it.

Mr. SLAVITT. Right.

Mr. MULLIN. The current States that are already operating inside the HealthCare.gov.

Mr. SLAVITT. Yes.

Mr. MULLIN. They are paying it but the States that are coming out aren't?

Mr. SLAVITT. Yes.

Mr. MULLIN. OK. Why?

Mr. SLAVITT. Well, the law didn't contemplate a splitting of duties. One of the things that—

Mr. MULLIN. Well, the law didn't contemplate a lot of things. I mean, it didn't anticipate a lot of this. We get that. But if one State

is—the users inside the State is required to pay for it and the other one isn't, then where is the offset coming from?

Mr. SLAVITT. So the first thing we had to do is determine how much is the appropriate amount to pay, given that the State maintains a lot of responsibilities. Remember, IT is just 30 to 50 percent on average of all of the responsibilities relative to a State budget. So once that's done, we are now setting the fee for 2017, contemplating the fact that they have had that year that you've described. So we'll set it to make sure that we've essentially evened up the tables.

Mr. MULLIN. But the first year they've been waived?

Mr. SLAVITT. The first year they've been waived but the second-year fee contemplates the fact that they didn't pay for 1 year.

Mr. MULLIN. So the next year they are going to go to 7 percent?

Mr. SLAVITT. No, it's not 7 percent.

Mr. MULLIN. Well, so if you are making up for the loss year, then where does it come from?

Mr. SLAVITT. The States have their own—another set of duties. So the calculation is not as simple as 3.5 percent. The calculation is based upon what portion of the service that they're going to get from the Federal Government—

Mr. MULLIN. There are a lot of complications inside this bill, and we understand that.

Mr. SLAVITT. Yes.

Mr. MULLIN. There is a lot of figuring that we can't get to. I am literally trying to figure it out. If they are trying to make up for—simple math is if you waived it this year and they are trying to make up for it next year, then a 3.5 percent and adding an additional year to make up for it would be 7 percent.

Mr. SLAVITT. Tell you what, that's not how the math works and I'm happy to go sit down with you and walk you through how—

Mr. MULLIN. Well, obviously, because I am confused in it, too. And I am really not trying to be difficult. I am just trying to figure out is Oklahoma making up for the lost fee? If they are missing it, the States already on it, are we having to pay for—the taxpayers inside Oklahoma, are they having to pay for the poor exchanges that were already set up and the failures of the taxpayers that they have already paid, on top of what they have having to—

Mr. SLAVITT. You know, I completely understand the question. It's a very fair question. I'll be happy to sit down and walk you through the math. The thing I want to just make sure is clear is that the States that are using the Federal exchange are still running call centers and 1095(a) collections and many, many other activities. So it's not as simple as just taking the whole fee and moving it.

Mr. MULLIN. And I will yield back in just one second. If you can set down with me, please put it on paper because I would like to share it with the committee because I think all of us need to figure this out.

Mr. SLAVITT. Yes, and as I mentioned, this is part of a proposed rule, so there are certain legal restrictions we have in terms of this, but I'm happy to do that.

Mr. MULLIN. Thank you.

Mr. SLAVITT. Thank you.

Mr. MURPHY. The gentleman's time is expired. I now recognize Mr. Yarmuth of Kentucky for 5 minutes.

Mr. YARMUTH. Thank you very much, Mr. Chairman. And thanks to you, Administrator Slavitt, for being here and your work on this issue.

As far as I am concerned, this is a very timely hearing because as we are sitting here, the inaugural events are underway for our new Kentucky Governor Matt Bevin, and he and I have very different perspectives on the Affordable Care Act in Kentucky. He has proposed as one of his campaign priorities to dismantle our State-based exchange, which is called Kynect.

And I am very proud to represent Louisville and proud of the work of our outgoing Governor Steve Beshear in implementing the Affordable Care Act. With the expansion of Medicaid in our State and the successful launch of Kynect, we have seen more than 500,000 Kentuckians gain access to quality, affordable health care, and the uninsured rate in the Commonwealth has dropped by more than half, and in my district, by 81 percent—

Mr. SLAVITT. Wow.

Mr. YARMUTH [continuing]. Which is pretty astounding. In my opinion, obviously, rolling back these successes would be shortsighted. It would jeopardize the health of a half-million Kentuckians, waste millions of taxpayer dollars, cost us jobs, hurt us economically.

And I would like to ask you, Administrator, a few questions about what it would mean to undermine our successful exchange Kynect? I believe I am correct that about \$280 million was spent in setting up Kentucky's exchange. Is that correct?

Mr. SLAVITT. Yes, the ballpark.

Mr. YARMUTH. Pretty substantial investment. And is it true that if we were to dismantle Kynect and move into the Federal exchange that Kentucky taxpayers would have to pay about \$23 million?

Mr. SLAVITT. I've seen secondhand a similar number, but it's true that there'd be some expense to the State.

Mr. YARMUTH. Yes. So millions of dollars would be spent to shut down what most healthcare policy experts consider to be a hugely successful exchange. As a matter of fact, one Republican State Senator Ralph Alvarado, who is also a physician, has proposed marketing our exchange to other States because it has been so successful. Would you, on behalf of CMS, consider Kentucky's exchange a success?

Mr. SLAVITT. I would congratulate Kentucky and the State and everyone involved that Kentucky's been a terrific success.

Mr. YARMUTH. Now, segueing on Congressman Mullin's questioning, we know now that the Federal exchange would be—it would be a 3 percent roughly charge, which would be passed down to consumers in Kentucky. It is 1 percent. That is what insurance company plans pay in Kentucky. So clearly, if we moved to the Federal exchange, consumers would have to pay more for their policies, all apples and apples, is that correct?

Mr. SLAVITT. I think that's correct.

Mr. YARMUTH. And would it be reasonable to assume—again reasonable to assume that they would be passed on—

Mr. SLAVITT. I think that's reasonable.

Mr. YARMUTH [continuing]. Those costs. So shutting down Kynect will either raise health insurance premiums or drive insurers out of the market, cost taxpayers more than \$20 million, eliminating hundreds of jobs, and harming the Kentucky economy. Administrator, is there any way that you can think of that Kentucky consumers would benefit from shutting down the Kynect, our State-based exchange, and moving to the Federal exchange?

Mr. SLAVITT. Well, of course, by law these are State decisions, and we're willing to cooperate and support the State in any way we can. But it feels like Kentucky has done such a great job and it's been so successful that it feels like it's going to be a good course for consumers to stay where we are.

Mr. YARMUTH. But knowing what you know about it, is there any way which consumers would benefit from that kind of switch?

Mr. SLAVITT. Not that I'm aware.

Mr. YARMUTH. Thank you for that. Just before I close, one of the things that I think is important to recognize is that while some premiums have still gone up, why we still have issues with deductibles, and I am very glad that you gave that explanation in the last session about the reality of deductibles, that what we really need to focus on is figuring out how to deal with the high costs of health care. And we have seen incident after incident of pharmaceutical costs skyrocketing by several hundred percent or even 1,000 percent, and that's really something that Congress has not done a very good job in addressing. Would you say that is accurate? I know CMS tries to address much of that, but isn't that still the biggest problem we face in health care?

Mr. SLAVITT. It is one of the critical issues that we all have to address.

Mr. YARMUTH. Right. I thank you for that and I yield back.

Mr. MURPHY. Thank you. The gentleman yields back. I now recognize Mrs. Brooks for 5 minutes.

Mrs. BROOKS. Thank you, Mr. Chairman.

I have been very surprised actually that the other side of the aisle seems to have focused on the uninsured rate, Medicaid expansion, other things that really haven't been relevant, I don't think, to the oversight of today's hearing. I think it is our duty to provide that oversight because billions of dollars have been spent and are at stake. And I am very concerned about ensuring that our taxpayer dollars are spent effectively and efficiently, as I know you are, Administrator Slavitt.

And I am concerned because you have indicated that the States—in Congressman Flores' testimony you indicated that the States have their own funding at some point, that the States have their own source of funding, and so I am curious if you would expand on those States with the exchanges, when the Federal dollars run out, what is the source of funding you are referring to?

Mr. SLAVITT. Sure. Thank you for the question.

So most of the States, all but I think two, have some type of assessment that they assess the health plans that operate in the marketplace. In some cases it's a percentage, in some cases it's a percentage plus a flat fee, and in some cases it's based on how

many members are enrolled. There are a few States that fund it directly out of their State budget as well.

Mrs. BROOKS. And because there are all of these different mechanisms and different ways States have decided to fund it, what confidence do you have that the different methods they have all chosen will be adequate so that the States will not be coming back to the Federal Government for more funding?

Mr. SLAVITT. Well, I have enough confidence that I need to make sure we check twice a year because things change with State budgets, things change with the membership, things change with enrollments, and sometimes we have to have difficult conversations with States to say to them, look, we don't think this looks like a very good future. Can you help explain to us why this makes sense? And in some cases there's a little bit of tough love, which results in some of the changes in the course that you've seen.

Mrs. BROOKS. Can you give us idea how many tough love discussions are you having?

Mr. SLAVITT. Well, an example of a tough love conversation might be Hawaii, which has been in—and it was in the process last year—of trying to decide what was the best course for themselves. And we had conversations where we made up numbers for them, and I think that made their decision to come to the Federal exchange.

Mrs. BROOKS. But how many States are you actually having discussions with about self-sustaining going forward in the future?

Mr. SLAVITT. So we're having discussions with all of the States. I wouldn't tell you we're concerned about all of the States but I would tell you that, you know, as a general rule, the smaller the State is, the greater the amount of effort we need to focus on them to make sure that they have a plan that's sustaining them.

Mrs. BROOKS. So do you have a chart that shows how many are you are confident they have got it, we are not going to have any problems with them? We are concerned or we are really very, very concerned that they are not going to make it? And how many people are in those different buckets?

Mr. SLAVITT. Ma'am, you—

Mrs. BROOKS. Or States—

Mr. SLAVITT. Congresswoman, you must know me well. I have hundreds of chart. And—

Mrs. BROOKS. I could tell.

Mr. SLAVITT. Yes. So, you know, I think I'd say that at this point in time we are confident that all the States are sustainable for the period of time that they need to be sustainable for.

Mrs. BROOKS. How long is that?

Mr. SLAVITT. Well, as I say, we look at least every 6 months because of budget cycles, because of membership cycles, because of costs, because of other factors, and all I can tell you is that at any point in time if we believe a State is nearing the point when we think they may not be sustainable, we talk to them.

I'll give you another example. We talked to Rhode Island, which is obviously a smaller State, and this was last year or earlier in the year, and told them they needed to increase their sources of funding. And they did that. But they did that because we had this kind of dialogue with them. So we try to get out in front of the

problem and prevent it from becoming a problem along with the States, and the States have the same interests.

Mrs. BROOKS. Well, I appreciate that. And I am very concerned about the sustainability, particularly if we are only doing them in 6-month increments.

In my brief time remaining, UnitedHealth has recently announced that it may leave the exchanges for next year. Could you please comment upon your thoughts about this announcement, what that might do to the exchanges and impact the sustainability of State exchanges if UnitedHealth, which is in my district, pulls out from all of these different exchanges because it has been a bad—"it was a bad decision for us" per UnitedHealth?

Mr. SLAVITT. So, tell you what, I won't comment on any one specific health plan. I think the majority of health plans that have made statements in the last few weeks have been very positive about their involvement in the exchanges. I think the vast majority of people in this country have access to at least three plan choices. There are literally hundreds of insurers with thousands of plans, and at any given time there's going to be people entering the market and people exiting the market. Some will have good strategies, some will have not-so-good strategies. That's just how marketplaces will work as we interact with the private sector.

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

Mr. MURPHY. The gentlelady yields back. I now recognize the gentleman from New York, Mr. Collins, for 5 minutes.

Mr. COLLINS. Thank you, Mr. Chairman.

Mr. Slavitt, in late September HHS ordered that the New York State co-op set up by the Affordable Care Act—Health Republic—to shut down. This past year, Health Republic insured about 20 percent of the individuals on the New York State health insurance exchange. So far, Health Republic's failure has cost taxpayers over \$265 million and 155,000 New Yorkers were kicked off their current insurance plan last week.

While other insurers in the marketplace picked up the displaced beneficiaries and honored the deductibles, there remains heavy concerns about Health Republic's outstanding liabilities to providers. Doctors have been calling my office complaining that their checks from Health Republic are bouncing. And I have seen estimates that hospitals in the State are owed at least \$160 million.

So into the questions, I understand that CMS reviewed Health Republic's financial filings and conferred with State regulators and co-op leaders during the setup and operation. I am assuming that is a correct statement?

Mr. SLAVITT. That's correct, Congressman.

Mr. COLLINS. So I am curious, can you walk me through the decision-making process. Our concerns are why was the co-op Health Republic, with the largest taxpayer losses in the country, allowed to continue as long as it did, which was up until a week ago?

Mr. SLAVITT. So I would say we grew concerned about the financial situation of the co-ops with each consecutive financial report that they submitted, conducted our own audit, sent up our own people, and worked very closely with the Department of Insurance in the State.

You know, I will tell you that in situations like this the most important thing from my perspective—and you mentioned it—is making sure we get as smooth a transition as possible for all of this—for all of the co-op consumers. So having a transition on December 1 all seamlessly—plans that honor the deductible was important and I think was great work from the Department of Insurance and the State. And I think that was very important.

Your other points relative to—the ultimate collection of payments, I think, is more a matter of State policy regarding State guarantee funds and other potential avenues and tools. We stand ready to assist both consumers and that State in any way we possibly can.

Mr. COLLINS. So, a simple question: Will the providers, for instance, 160 million of the hospitals and many doctors where the checks are bouncing, are they going to be paid with 100 percent assurance?

Mr. SLAVITT. Again, that's a question that's better directed at the State because that's based on State policy.

Mr. COLLINS. So the answer is no, they may not get paid?

Mr. SLAVITT. Again, you'd have to ask the State, but we'd be glad to cooperate in any way we can.

Mr. COLLINS. I guess I live in a world if the answer is not yes, it must be no?

Mr. SLAVITT. The answer is I'm not going to speak for the State—

Mr. COLLINS. OK. Well—

Mr. SLAVITT [continuing]. With all due respect.

Mr. COLLINS [continuing]. I will take the lack of an affirmative as—if I am a doctor, I am going to start worrying come Christmas on my bounced checks because we don't have any assurance from you certainly at the Federal level they are going to be paid, and I think we all know how New York State does things.

So now, you spoke to a smooth transition and that importance. Well, I will disagree with you on one thing. I believe taxpayer money is more important than a smooth transition when it comes to \$265 million in losses adding to our debt.

So it goes back to 2014, Health Republic lost \$35 million. It is inconceivable to me what then happened. They were loaned an additional \$91 million. I mean, I suppose is that like doubling down on a stock that loses all its value so you go buy more? I don't know other than your smooth transition how we squandered another \$91 million, didn't ask any of the right questions, just said here is another \$91 million, and sure enough, it is flushed. So can you speak to that \$91 million after you knew they lost \$35 million?

Mr. SLAVITT. Sure. The way that we have set up co-ops is the vast majority of the funding is needed to even set up the co-op in the first place to have enough capital to write members. And of course nobody knew how many members they were going to write because this is the new year of open enrollment.

Mr. COLLINS. Sure. You know what, they were owed more than expected. Everyone else is complaining when they write—

Mr. SLAVITT. Right.

Mr. COLLINS [continuing]. Less than expected, oh my God, oh my God. Health Republic signed up more than expected.

Mr. SLAVITT. They did. They did. And, of course, the first time you have an understanding of the ability to match claims to the premiums they've collected isn't for some time because of the way claims come in and because of the way the financials work. So it really wasn't until the middle of 2015 that we really started to have data that would give us reason to be significantly concerned about the State and about their ability to play claims given the—

Mr. COLLINS. My time is expired but I can tell you the private sector we start worrying when someone says I just lost \$35 million. That is when I have them starting to report hourly, daily, weekly—

Mr. SLAVITT. Yes.

Mr. COLLINS [continuing]. Not just, hey, every quarter, "How did you do this quarter?" "Oh, we only lost \$30 million."

Mr. SLAVITT. That's not a fair characterization of how we worked with the co-op.

Mr. COLLINS. Well, it sure sounds like it to me. You lost another \$91 million. I yield back.

Mr. MURPHY. The gentleman yields back.

Mr. Slavitt, just a follow-up for Mrs. Brooks' question, and you had said you had some charts or things that relate to the State. Can you make sure you share this with this, too? I would love to see what—not all your charts. Apparently, you make charts of everything—

Mrs. BROOKS. Just the relevant ones.

Mr. MURPHY. The relevant ones to compare in the States. That would be helpful.

Mr. SLAVITT. Will do.

I now recognize the gentleman from Indiana, Dr. Bucshon, for 5 minutes.

Mr. BUCSHON. Thank you, Mr. Chairman.

I was a cardiovascular surgeon prior to coming to Congress, and I just want to say that, you know, I want everyone in our country to have access to quality, affordable health care.

And that said, I feel compelled to comment on the uninsured rate and that coverage doesn't necessarily equal access. And I think that is a point that maybe people that aren't in health care don't necessarily get, in fairness. And I am not implying you but others that made comments because the Medicaid program, for example, traditional Medicaid is a program that doesn't reimburse providers at a level that many will accept, and even though people may have Medicaid, it doesn't necessarily access them to anything more than the emergency room, which they had access to when they didn't have Medicaid. And the data shows that that is the truth.

In Indiana we are using Healthy Indiana Plan 2.0 to cover those citizens—and this is something that I support because it is a State-based way to manage Medicaid dollars more effectively and efficiently in my opinion, and it is HSA-based, which you have heard some comments about HSAs in the past, which does encourage more proper utilization of the healthcare system by the person who has the coverage because they actually have some of their own financial resources at risk if they don't.

My question will be about the plans offered under the exchanges. I mean most of my questions have been answered about the tech-

nical aspects of what is happening with these plans, but, I mean, many, including yourself, have commented about \$100 premiums. What percentage of people that are on the exchanges approximately are subsidized people? What percentage of people—or maybe the better question is that are getting coverage through the exchange don't get a subsidy?

Mr. SLAVITT. About 20 percent.

Mr. BUCSHON. So 20 percent don't get a subsidy?

Mr. SLAVITT. That's about right.

Mr. BUCSHON. And so the premiums for those folks, do you know what those are? I mean, what is the level of subsidy on average, for example, for a person on the exchange that is getting a subsidy?

Mr. SLAVITT. That's a tough question to answer. It depends on if they're silver, gold, bronze, and so forth, and the income levels and a variety of factors.

Mr. BUCSHON. OK. Because my constituents are complaining about the deductibles also. And again, the devil is in the details, right? If you pay \$100 for a premium and you are being subsidized, most likely you are being subsidized thousands of dollars for your premium or maybe hundreds of dollars. But your deductible is \$6,000 to \$10,000.

I would argue that better plans than that were available before the Affordable Care Act. You could do that on the individual and small group marketplace almost before the Affordable Care Act and do better with that lower deductible, better premiums. So I just don't see where, you know, we have created a huge advantage. The only thing we have done, as was pointed out, is we have mandated that people buy coverage.

So the question in my view is is if someone has a deductible—say you are a family of four and, you know, say only one parent is working, whether that is the man or the woman and they are a schoolteacher and they have a \$10,000 deductible for their family when they have maybe an annual income of \$55,000, \$60,000 a year, is that good health coverage?

Mr. SLAVITT. Well, you and I have both been in health care a long time.

Mr. BUCSHON. Yes.

Mr. SLAVITT. My reflection would be prior to the Affordable Care Act health plans had—if you could get it, meaning you didn't have a preexisting condition and you had no regulated out-of-pocket maximum, you had higher rates of increase, and you could be dropped at any time. Now, you have free programs and services—

Mr. BUCSHON. Well, those are things—yes, that is true—

Mr. SLAVITT [continuing]. And 80 percent of folks—

Mr. BUCSHON. That is not the cost.

Mr. SLAVITT [continuing]. Have coverage outside of the deductible, and there's a whole array of options and services today. So by my estimation and by the people that we interact with who are getting coverage, you know, their lives are better today, notwithstanding your points about we have an affordability crisis in this country and we have—and not everybody can afford all the services that they need. Those are very legitimate concerns and we share them.

Mr. BUCSHON. Fair enough. What I was trying to point out with my deductible question is you could have gotten a policy with these type of deductibles and these type of premiums before the Affordable Care Act without massive subsidies from the Federal taxpayers subsidizing the premium to keep the premium low. And I think that is a fair statement. Of course, you know, there are always exceptions to every rule.

But, again, the other concern I have with the exchange is—my time is up. I will make this brief comment and then I will yield—is what I am hearing from hospitals and providers, the number one area of accounts receivable that they are starting to see is from insured individuals because they can't meet their deductibles. They can't pay that. So we have created a different problem.

I yield back.

Mr. MURPHY. Thank you. The gentleman yields back.

I now recognize the gentleman from North Dakota, Mr. Cramer, for 5 minutes.

Mr. CRAMER. Thank you, Mr. Chairman. Thank you, Mr. Administrator, for being here and for your incredible access. I have appreciated that, as has my staff.

And I am going to shift gears a fair bit since I have this opportunity. And it might not surprise you that I want to ask you about a discussion we had previously that has since resulted in my dropping some legislation, and that is that last March when CMS released an interim final rule that gave authority to insurers that are offering plans on the exchange to denying nonprofit charities the opportunity to provide premium assistance. And since patients with rare diseases and catastrophic illnesses are oftentimes the utilizers of this kind of charity, this rule has really had the effect of pushing individuals with preexisting conditions of the health plans that they purchased in an exchange. So that really means fewer insured Americans and more patients with complex conditions in the Federal safety net.

Now, obviously, under the ACA the law provides Federal subsidies for health insurance, as we are discussing. Why then did the administration offer a rule to prevent Americans from doing the same amount of charity that the Government does now?

And, you know, since the release of the interim final rule, I think there is something like 30 or 31 States that have announced a prohibition. This seems to be completely counterproductive to the goals of the ACA. That is why I dropped the bill. It has already gotten very broad support. I could name names and you would go wow, that is a big swath. And most of us are between that swath.

So can you tell me something that would give me some encouragement that may not require the law or that you are going to support the law change?

Mr. SLAVITT. Well, we share the same goal of trying to get everybody covered, and I appreciate your efforts in this area as well. Because we have an interim proposed rule, I am limited in what I can comment on the rule, but we do appreciate your input.

Mr. CRAMER. With that, I think we will just keep pushing for co-sponsors of the bill and try and make it a law because it really is broadly supported both in Congress and certainly in the public.

So with that, I have nothing further and would yield back. Thank you.

Mr. SLAVITT. Thank you.

Mr. MURPHY. The gentleman yields back. Well, thank you.

In that case, Mr. Slavitt, I just want to note that in November 24 the committee sent a letter to CMS regarding the failure of 12 out of 23 co-ops or nonprofit insurers set up through the ACA. These 23 co-ops were funded by Government-backed loans to the tune of \$2 billion. CMS's response to the co-op letter is due today so I don't know if you have that in your briefcase. We would love to see that letter today. And you will be complying with that request then?

Mr. SLAVITT. We are working on your letter, absolutely. We have got a few of them to do, but we are—it is a high priority.

Mr. MURPHY. Thank you very much.

Mr. SLAVITT. We'll answer all your questions.

Mr. MURPHY. We appreciate it because we would like to, as you would, get some answers to this so we need to pursue that. And we will receive the other documents we requested. You have already stated that, so thank you.

In conclusion, I want to thank you for coming today and the Members who have participated in today's hearing. I remind Members they have 10 business days to submit other questions for the record, and I ask also, Mr. Slavitt, you agree to respond promptly to those questions.

And with that, this subcommittee is adjourned.

[Whereupon, at 11:53 a.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]



U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON ENERGY AND COMMERCE

December 4, 2015

TO: Members, Subcommittee on Oversight and Investigations

FROM: Committee Majority Staff

RE: Hearing entitled “An Overdue Checkup Part II: Examining the ACA’s State Insurance Marketplaces.”

On December 8, 2015, at 10:00 a.m. in 2322 Rayburn House Office Building, the Subcommittee on Oversight and Investigations will hold a hearing entitled “An Overdue Checkup Part II: Examining the ACA’s State Insurance Marketplaces.”

Section 1311 of the Affordable Care Act (ACA) provided funding assistance to the States to help them establish their own health insurance exchanges. The Federal government granted States at least \$5.51 billion toward this effort. By law, the State exchanges were supposed to be self-sustaining—that is, have a funding source other than Federal grant dollars—by January 1, 2015. Despite this multi-billion dollar investment, many are struggling to become self-sustaining. The Department of Health and Human Services (HHS) Office of Inspector General (OIG) alerted the Centers for Medicare and Medicaid Services (CMS) that these faltering State exchanges may be using establishment grants to help cover operational costs. With growing maintenance costs and lower than expected enrollment numbers, States are weighing their options, including shutting down their exchanges and migrating to the Federal system. The Subcommittee is conducting oversight to understand the sustainability challenges State exchanges are facing. The hearing also will examine how Federal establishment grant dollars were spent.

I. WITNESS

- Andy Slavitt, Acting Administrator, Centers for Medicare and Medicaid Services

II. BACKGROUND

Section 1311 of the Affordable Care Act

The Affordable Care Act established a private health insurance marketplace through health insurance exchanges in all 50 States and the District of Columbia.¹ Section 1311 of the

¹ Patient Protection and Affordable Care Act of 2010, § 1311 (2010).

Majority Memorandum for December 8, 2015, Subcommittee Oversight and Investigations Hearing
Page 2

ACA provides funding assistance to the States to help them plan and establish their marketplaces.² According to section 1311, “a State shall use amounts awarded under this subsection for activities (including planning activities) related to establishing an American Health Benefit Exchange.”³ No grant shall be awarded after January 1, 2015, for the purposes of establishing a State marketplace and a marketplace must be self-sustaining by January 1, 2015.⁴ In March 2014, CMS issued guidance that Federal funds may not be used to cover maintenance and operating costs after January 1, 2015.⁵ CMS, however, allows establishment grant funds to be used for non-operational costs after January 1, 2015, through No Cost Extensions (NCEs), including the complete design, development, and implementation activities of a marketplace.⁶

To date, over \$5.51 billion in Federal grants have been awarded to States in Federal marketplace grants to States.⁷ (See Appendix A, which demonstrates how much Federal grant dollars each State received.) December 2014 was the last month CMS could award establishment grant funding assistance. During that month alone, CMS awarded approximately \$420 million to State-based marketplaces and State partnership marketplaces.⁸

April HHS OIG Alert

On April 27, 2015, the HHS OIG alerted Andy Slavitt, Acting Administrator for CMS, that State exchanges may be using Federal establishment grant funds for operational expenses after January 1, 2015, which is prohibited by law.⁹ The OIG noted that both in media reports and its review of State exchanges’ budget information, some State exchanges face uncertain operating reviews for 2015 and beyond. Because of this uncertainty, the OIG acknowledged the risk that State exchanges might use establishment grant funds to cover operational costs. The OIG also noted that certain terms in section 1311—such as “operating expense” and “design, development, and implementation expenses”—lacked “meaningful distinction.”¹⁰

The OIG encouraged CMS to develop and issue clear guidance to State exchanges on the use of establishment grant funds. Specifically, the OIG encouraged CMS to clarify what “constitutes (1) operational costs and (2) design, development, and implementation costs to minimize the marketplaces’ improper use of establishing grant funding.” The OIG further encouraged CMS to review State exchange plans for using establishment grant funds to ensure that CMS’ guidance addresses real-world examples such as call centers, in-person assisters, bank

² *Id.*

³ *Id.*

⁴ *Id.*

⁵ The Centers for Medicare and Medicaid Services, FAQs on the Use of 1311 Funds and No Cost Extensions (Mar. 14, 2014).

⁶ *Id.*

⁷ U.S. Gov’t Accountability Office, State Health Insurance Marketplaces: CMS Should Improve Oversight of State Information Technology Projects (GAO-15-527) (September 2015), <http://www.gao.gov/assets/680/672565.pdf>.

⁸ Early Alert: Without Clearer Guidance, Marketplaces Might Use Federal Funding Assistance for Operational Costs When Prohibited by Law (A-01-14-02509) (Apr. 27, 2015), <http://oig.hhs.gov/oas/reports/region1/1402509.pdf>.

⁹ *Id.*

¹⁰ *Id.*

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Page 3

fees and printing and postage expenses. Lastly, the OIG encouraged CMS to actually monitor the State exchanges' use of establishment grant funds.¹¹

On June 8, 2015, CMS issued guidance intended to clarify how States can use establishment grant funds.¹² According to its guidance, States are permitted to use establishment grant funds for designing, developing, and testing information technology functions, setting up Federally compliant financial and program audit policies and procedures, outreach and education to boost enrollment, call center activities, and long-term capital planning. States also can use these funds to cover costs indirectly supporting establishment work such as salaries. Unallowable costs include, but are not limited to, rent, hardware/software maintenance and operations, telecommunications, and call center operations that do not constitute establishment activities.¹³ The guidance did not provide real-world examples to help clarify what constitutes operational costs.

III. STATE EXCHANGES

The ACA grants HHS the authority to fund establishment grants to States setting up “State-based” exchanges to sell health insurance.¹⁴ For States that did not establish exchanges, the ACA directs HHS to establish a “Federally facilitated” exchange within that State. HHS also developed two additional exchange models—“Federally-supported” and “State-partnership”—where States and the Federal government share responsibilities for the operation of those exchanges.

Thirteen States currently run and operate their own health care insurance exchanges. These “State-based” exchanges were initially funded by Federal establishment grants, and consumers in these States apply for and enroll in coverage through websites established and maintained by the States. These States are also responsible for performing all exchange functions, including health insurance plan management and consumer assistance and outreach. Four additional States originally set up State-based exchanges, but later switched to the Federal technology platform after each State was unable to maintain its exchange for various reasons. These States—Oregon, Hawaii, Nevada, and New Mexico—are known as “Federally-supported” exchanges, and perform all exchange functions. Consumers in these States, however, apply for and enroll in coverage through healthcare.gov.

Over half of the States did not elect to establish a State exchange. Instead, HHS set up “Federally-facilitated” exchanges in each of those 27 states. In these exchanges, HHS performs all of the exchange functions, and consumers apply for and enroll in coverage through healthcare.gov. Lastly, seven States participate in “State-partnership” exchanges, where States administer in-person consumer assistance functions and HHS performs the remaining exchange

¹¹ *Id.*

¹² The Centers for Medicare and Medicaid Services, FAQs on the Clarification of the Use of 1311 Funds for Establishment Activities (June 8, 2015).

¹³ *Id.*

¹⁴ Patient Protection and Affordable Care Act of 2010, § 1311 (2010).

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functions. Consumers in these States also apply for and enroll in coverage through healthcare.gov.

IV. ISSUES

The following issues are expected to be examined at the hearing:

- Are State exchanges on track to becoming self-sustaining?
- What are CMS' oversight mechanisms to monitor how States spend establishment grant dollars?
- Do States have remaining Federal establishment grant dollars? How does CMS ensure that States do not spend the dollars on operational costs?
- If a State exchange chooses to abandon its infrastructure and instead use the Healthcare.gov platform, what steps must a State exchange take before CMS permits the State to use Healthcare.gov?

V. STAFF CONTACTS

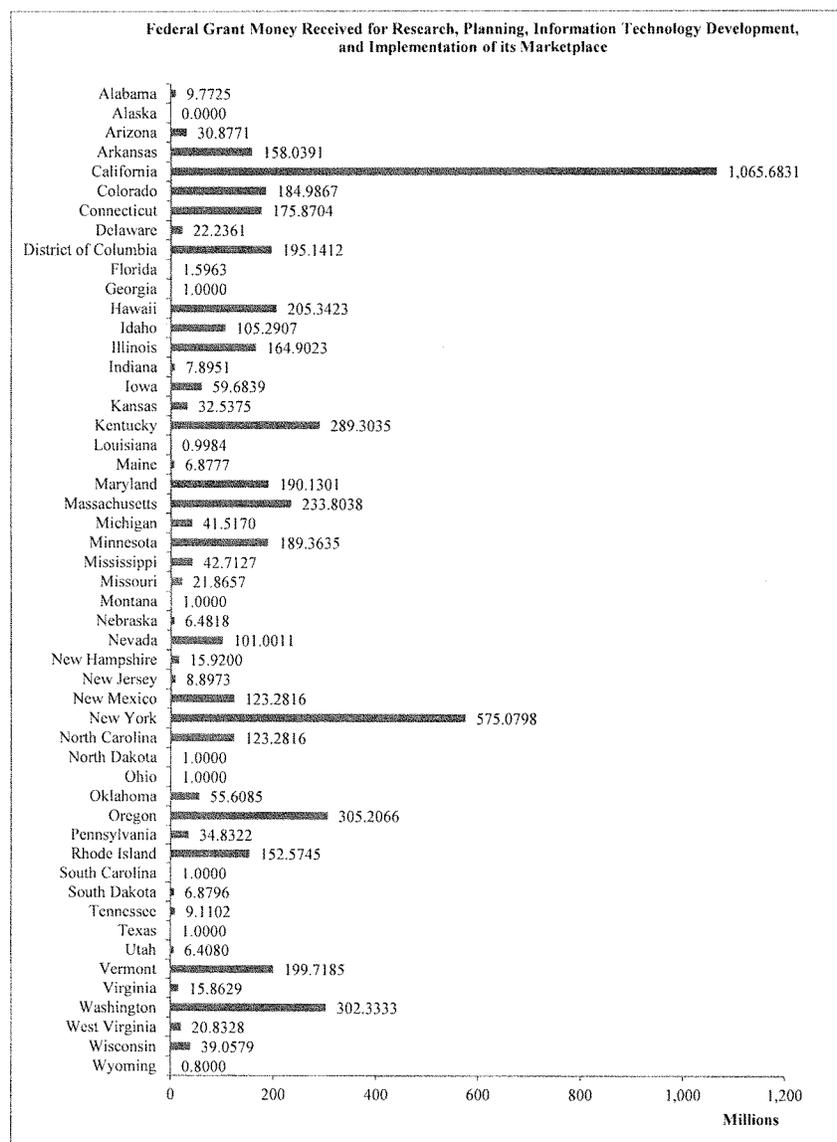
If you have any questions regarding this hearing, please contact Jessica Donlon, Emily Felder, or Brittany Havens of the Committee staff at (202) 225-2927.

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APPENDIX A

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(CHART NEXT PAGE)



Rise in Early Cervical Cancer Detection Is Linked to Affordable Care Act

By SABRINA TAVERNISENOV. 24, 2015



Alina Nurieva selected an insurance plan at the Mall of Americas in Miami this month. A growing number of early-stage cervical cancer diagnoses among young women may be related to higher insurance signups under the Affordable Care Act. Credit: Joe Raedle/Getty Images

WASHINGTON — Cancer researchers say there has been a substantial increase in women under the age of 26 who have received a diagnosis of early-stage cervical cancer, a pattern that they say is most likely an effect of the Affordable Care Act.

Starting in 2010, a provision of the health law allowed dependents to stay on their parents' health insurance until age 26. The number of uninsured young adults fell substantially in the years that followed. The share of 19- to 25-year-olds without health insurance declined to 21 percent in the first quarter of 2014 from 34 percent in 2010 — a decrease of about four million people, federal data show.

Researchers from the American Cancer Society wanted to examine whether the expansion of health insurance among young American women was leading to more early-stage diagnoses. Early diagnosis improves the prospects for survival because treatment is more effective and the chance of remission is higher. It also bolsters women's chances for preserving their fertility during treatment. And women with health insurance are far more likely to get a screening that can identify cancer early.

Researchers used the National Cancer Data Base, a hospital-based registry of about 70 percent of all cancer cases in the United States. They compared diagnoses for women ages 21 to 25 who had cervical cancer with those for women ages 26 to 34, before and after the health law provision began in 2010. Early-stage diagnoses rose substantially among the younger group — the one covered by the law — and stayed flat among the older group.

About 79 percent of the younger group had an early-stage diagnosis in 2011-12, up from about 71 percent in 2007-09. For the older group, the percentage dropped to 71 percent from 73 percent, a change that is not statistically meaningful.

The study, published in JAMA, was not aimed at proving that the change was a direct result of the law. But the size of the database, and the fact that the share of young women with health insurance had increased so substantially, led researchers to conclude that the law was having an effect. (Pap tests are a part of most routine medical checkups for young women.)

"It's a very remarkable finding, actually," said Dr. Ahmedin Jemal, one of the researchers. "You see the effect of the A.C.A. on the cancer outcomes."

The effect for younger women looked even stronger when analyzed by year. About 84 percent of the younger group had early-stage diagnoses in 2011, compared with 68 percent in 2009. Early-stage diagnoses dropped to 72 percent of the group in 2012, a drop that Dr. Jemal said was typical during increases in screenings, because many of the early-stage cases have already been detected.

For several years, researchers have been trying to test whether the law is working to improve health, but isolating its effects has been tricky. A study this spring found that the number of new diabetes cases identified among poor Americans had surged in states that embraced the Affordable Care Act, but not in states that had not.

Since November 2009, the American College of Obstetricians and Gynecologists has recommended that cervical cancer screening begin at age 21, the only cancer screening recommendation for that age group. Dr. Jemal said that change made it impossible to compare the total number of women who got screened before and after the health care law came into effect.

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

January 15, 2016

The Honorable Andy Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

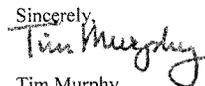
Dear Administrator Slavitt:

Thank you for appearing before the Subcommittee on Oversight and Investigations on Tuesday, December 8, 2015, to testify at the hearing entitled "An Overdue Checkup Part II: Examining the ACA's State Insurance Marketplaces."

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.

To facilitate the printing of the hearing record, please respond to these questions with a transmittal letter by the close of business on Friday, January 29, 2016. Your responses should be mailed to Dylan Vorbach, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to Dylan.Vorbach@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,


Tim Murphy
Chairman
Subcommittee on Oversight and Investigations

cc: The Honorable Diana DeGette, Ranking Member, Subcommittee on Oversight and Investigations
Attachment

Andy Slavitt's Hearing
"SBMs"
Before
Committee on Energy & Commerce, Subcommittee on Oversight & Investigations

December 8, 2015

Attachment - Additional Questions for the Record

The Honorable Tim Murphy

1. Mr. Slavitt, I'm concerned about CMS' ability to keep adequate track of Federal loan funds. As I requested during the hearing, please provide the subcommittee with CMS's conclusions regarding OIG's findings that funds were misspent by the Washington State exchange. How much was misspent, according to CMS? How does CMS's conclusion differ from OIG's?

Answer: Section 1311 of the Affordable Care Act provided for grants to states, not loans, for the planning and establishment of Exchanges. In April 2015, the OIG sent a memo to CMS stating that some SBMs, specifically Washington, were at risk of using establishment funds to support operations. In this memo, OIG recommended CMS to develop and publish clear guidance on operational costs in order to minimize marketplaces' improper use of establishment funding for operational expenses after January 1, 2015. CMS followed OIG's recommendation and issued clarifying guidance, detailing which activities are considered allowable establishment activities.¹

In addition, CMS conducted a line-by-line review of Washington's budget and determined all costs to be for allowable purposes.

2. In response to OIG conclusions regarding funds misspent by state exchanges, what plans have you put in place to recover Federal loan dollars? Have you changed CMS processes after the OIG alert to better find misuse of federal dollars by state exchanges? Please explain.

Answer: Section 1311 of the Affordable Care Act provided for grants to states, not loans, for the planning and establishment of Exchanges. In June 2015, consistent with the recommendation of the HHS Office of the Inspector General (OIG), CMS issued additional guidance on the difference between operational and establishment costs, including specific examples for states to consider.² In addition, CMS provides SBMs with technical assistance to clarify the difference between operational and establishment costs, including through webinars and phone conferences tailored to individual states. CMS also continues to monitor SBM use of establishment grant funds and take appropriate action, as OIG recommended, if any SBM uses grant funds for unallowable costs or for activities that are not authorized according to the terms of the grant. SBMs are required to provide budgets and justifications to spend grant awards, which CMS carefully reviews. CMS also conducts ongoing oversight through regular monitoring calls and site visits, SBM grant budget and performance reports, and by requiring SBMs to conduct annual financial audits. When misuse of 1311 funding is identified through these review and oversight activities, CMS takes appropriate action to recoup

¹ <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FINAL-1311-FAQ-06-08-15.pdf>

² <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FINAL-1311-FAQ-06-08-15.pdf>

funds that have been misspent.

3. During the hearing, you mentioned that CMS has produced a variety of visual representations of the state exchange program. Please provide the subcommittee with any charts relevant to state exchange financial sustainability.

Answer:

State	Sustainability Plan for 2016 (based on budget information reported by the SBMs)
CA	\$13.95 Per Member Per Month (PMPM) on individual QHPs, \$18.60 PMPM on SHOP QHPs, and \$0.83 PMPM on dental plans.
CO	3.5% user fee on plans sold through the Marketplace, \$1.80 PMPM marketwide assessment, premium tax credit donation by issuers, and private foundation grants.
CT	1.65% marketwide assessment on all health insurance carriers.
DC	1% marketwide assessment on all health insurance carriers.
HI	\$2 million state appropriation for FY2016 and 3.5% user fee on plans sold through the Marketplace
ID	1.9% user fee on plans sold through the Marketplace.
KY	1% PMPM marketwide assessment on all health insurance premiums and a stop-loss assessment
MA	Issuer assessment on all plans sold through Marketplace: 3% of premium for ConnectorCare (0-300% federal poverty level [FPL]) and stand-alone dental, 2.5% of premium for APTC only plans, subsidized non-group members, and small group members; and a state appropriation.
MD	State budget.
MN	3.5% PMPM on plans sold through the Marketplace.
NM	Marketwide assessment on all major carriers (% varies based on their market share) and a special carrier reserve assessment.
NV	3.15% PMPM on plans sold through the Marketplace.
NY	State budget.
OR	Issuer assessment on plans sold through the Marketplace: \$9.66 PMPM on QHPs and \$0.97 on QDPs.
RI	Marketwide premium assessment: average 2.86% on individual and 0.59% on small-business group plans; \$2.6 million state appropriation in FY2016.
VT	State budget.
WA	State budget (sources are: \$7.46 PMPM on QHPs sold on the Marketplace and a 2% PMPM marketwide assessment that is generated specifically by plans sold through the Marketplace.)

The Honorable David McKinley

1. **Mr. Slavitt, during the hearing, you expressed that you were sure some employees had lost their jobs during the failure of state exchanges. Please provide the subcommittee with all available names of those who have been held accountable for misallocated funds in the state exchange system.**

Answer: Many State Based Marketplaces have made leadership and staff changes, which have been widely reported. For example, officials have left positions in Oregon³, Massachusetts⁴, Minnesota⁵, Hawaii⁶, and Maryland.⁷

The Honorable Marsha Blackburn

1. **Mr. Slavitt, during the hearing, you told me that you have access to a full accounting of all Federal outlays to state exchanges, totaling \$4.5 billion. Please provide the subcommittee with these figures, including details on misallocated funds that are yet to be recovered.**

Answer: CMS has provided the Subcommittee staff with an accounting of 1311 Funding Grants obligations and deobligations. As of November 30, 2015, approximately \$319 million in grant funding awarded has been deobligated and returned to the federal government. This does not include the \$32.5 million that Maryland has agreed to return to the federal government due to their legal settlement with their contractor. CMS is in the process of collecting and returning more of the grant funds to the federal government through the grant closeout process, as well as through audits that identify any unallowable costs. CMS has identified unallowable costs from Arkansas, Minnesota, Oregon and Washington and we are working with states to recover this funding.

The Honorable Michael C. Burgess, M.D.

1. **Mr. Slavitt, during the hearing, we discussed the implementation of Sec. 1311-H of the Affordable Care Act, as it pertained to provider quality. Has CMS ever excluded a provider from accessing state exchanges based on quality? If yes, please explain the nature of each exclusion.**

Answer: Providers contract with individual insurance issuers, which are regulated by state Departments of Insurance. CMS reviews and approved the Qualified Health Plans (QHPs) offered by those issuers.

CMS has been phasing in implementation of Section 1311(h), which requires qualified health plans (QHPs) to only contract with hospitals with greater than 50 beds that use patient safety evaluation systems (PSES) and implement comprehensive hospital discharge programs. It also requires QHPs to contract with health care providers who implement health care quality improvement mechanisms.

³ http://www.oregonlive.com/health/index.ssf/2014/03/kitzhaber_cleans_house_announc.html

⁴ <http://boston.cbslocal.com/2015/02/25/gov-baker-calls-for-resignation-of-gruber-at-health-connector/>

⁵ <http://www.twincities.com/2013/12/16/under-fire-mnsures-executive-director-abruptly-resigns/>

⁶ <http://www.bizjournals.com/pacific/news/2016/01/13/hawaii-health-connector-board-members-resign.html>

⁷ <http://www.bizjournals.com/baltimore/news/2013/12/06/maryland-health-exchange-head-rebecca.html>

In the Notice of Benefit and Payment Parameters for 2015⁸, which we finalized after offering an opportunity for public comment, we established that for the initial two years beginning January 1, 2015, we would draw on Medicare standards and require that QHP issuer-contracted hospitals are:

- Medicare-certified or are Medicaid-only hospitals, and
- Are subject to Medicare Hospital Conditions of Participation (CoP) standards for a quality assessment and performance improvement program (QAPI) and for discharge planning.

In the Proposed Notice of Benefit and Payment Parameters for 2017⁹, which we have released for public comment, we propose to strengthen standards and align with current, effective patient safety interventions. We propose requiring QHPs to:

- Verify that their contracted hospitals, with more than 50 beds, have current agreements with Patient Safety Organizations (PSO); or
- Provide reasonable exceptions to the PSO requirement, including allowing QHPs to contract with hospitals that implement evidence-based initiatives to reduce all cause preventable harm, prevent hospital readmission, improve care coordination and improve health care quality through the collection, management and analysis of patient safety events.

CMS looks forward to reviewing comments received on the proposed notice.

The Honorable Bill Flores

I. Mr. Slavitt, what is the remaining balance on each state exchange's Federal loan?

Answer: Section 1311 of the Affordable Care Act provided for grants, not loans, to states for the planning and establishment of Exchanges. All funds for the establishment of SBMs have been allocated following HHS Grants Policy and applicable Federal statutes and regulation. States applied for funding through a competitive grant opportunity, and were required to meet the criteria established in the Funding Opportunity Announcement.¹⁰

CMS has provided the Subcommittee staff with an accounting of 1311 Funding Grants obligations and deobligations. As of November 30, 2015, approximately \$319 million of grant funding awarded has been deobligated and returned to the federal government. This does not include the \$32.5 million that Maryland has agreed to return to the federal government due to their legal settlement with their contractor. CMS is in the process of collecting and returning more of the grant funds to the federal government through the grant closeout process, as well as through audits that identify any unallowable costs.

The Honorable Markwayne Mullin

I. Mr. Slavitt, during the hearing, we discussed the math behind calculating state

⁸ <https://www.federalregister.gov/articles/2014/03/11/2014-05052/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2015>

⁹ <https://www.federalregister.gov/articles/2015/12/02/2015-29884/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2017>

¹⁰ [https://www.cms.gov/ccio/resources/Funding-Opportunities/index.html#Health Insurance Marketplaces](https://www.cms.gov/ccio/resources/Funding-Opportunities/index.html#Health%20Insurance%20Marketplaces)

exchanges' provider user fees. Please provide the subcommittee with a detailed description of the calculations CMS employed in arriving at the established user fees.

Answer: In the Proposed Notice of Benefit and Payment Parameters for 2017¹¹, which we released for public comment, CMS proposed to charge issuers offering QHPs through an SBM-FP a user fee rate of 3.0 percent of the monthly premium charged by the issuer for each policy under a plan offered through an SBM-FP. This fee will recover funding to support FFM operations incurred by the Federal government associated with providing the services that SBM-FPs have elected to leverage. CMS also stated that, for the 2017 benefit year, we would consider reducing the user fee rate by one half or one third (that is, to 1.5 or 2.0 percent) for the issuers in SBM-FPs, to provide these States additional time to integrate this user fee rate.

The proposed user fee rate was calculated based on the proportion of FFM costs that are associated with the FFM information technology infrastructure, the consumer call center, and eligibility and enrollment services, and allocating a share of those costs to issuers in the relevant SBM-FPs. A significant portion of expenditures for FFM services are associated with the information technology, call center infrastructure, and personnel who conduct eligibility determinations for enrollment in QHPs and other applicable State health subsidy programs as defined at section 1413(e) of the Affordable Care Act, and who perform the functions set forth in §155.400 to facilitate enrollment in QHPs. We intend to review the costs incurred to provide these special benefits each year, and revise the user fee rate for issuers in SBE-FPs accordingly in the annual HHS Notice of Benefit and Payment Parameters. Additional guidance on user fee collection processes will be provided in the future.

¹¹ <https://www.federalregister.gov/articles/2015/12/02/2015-29884/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2017>