Obamacare Oversight: 112th to 114th Congress

March 2017
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“Health Care Issues Involving the Center for Consumer Information and Insurance Oversight,” Subcommittee on Oversight and Investigations, February 16, 2011.


II. Executive Summary

Concerned about the vast bureaucratic scope, immense government overreach and high costs associated with the Patient Protection and Affordable Care Act, also known as Obamacare, the House Committee on Energy and Commerce, through the Subcommittee on Oversight and Investigations and the Subcommittee on Health, has investigated and uncovered endless amounts of waste, fraud, and abuse associated with the implementation and funding of Obamacare.

Since its passage in 2010, the committee has convened 31 oversight hearings on Obamacare and performed systematic and methodical oversight to examine how the administration implemented the most critical components of Obamacare. In these hearings, 107 witnesses testified before the committee, culminating in hundreds of hours of testimony. Of those witnesses, 38 have been administration officials.

The committee’s most notable oversight includes:

- The administration’s decision to fund the Cost Sharing Reduction (CSR) program and the Basic Health Program (BHP) without a lawful appropriation;
- The failed launch of Healthcare.gov and mismanagement of the information technology systems by HHS and its component agencies;
- The failure of four out of 17 state-based exchanges, and the misuse of federal grant money in the creation and operation of the state-based exchanges;
- The closure of 18 out of 23 CO-OPs (Consumer Operated and Oriented Plans), and the associated loss of $2 billion taxpayer dollars; and
- The administration’s decision to divert payments from the U.S. Treasury to insurance companies through the Transitional Reinsurance Program.

The committee has also released reports detailing the committee’s oversight actions, highlighting the committee’s findings, and issuing recommendations for executive action. The committee released five investigative reports in the 114th Congress. Within these five reports, the committee published 59 findings and 9 recommendations.

While the committee’s Democrat members have long criticized the number of oversight hearings and investigations on Obamacare conducted by the committee, these methodical investigations and thoughtful hearings have created a record documenting the serious problems and deficiencies that exist in Obamacare and its implementation. The committee’s oversight has shown a lack of foresight by the drafters of Obamacare, such as the unlimited funding provided to state-based exchanges, contributing to duplicative federal IT systems and misuse of federal funds. The committee’s oversight has also exposed defects in the implementation of Obamacare, such as the administration’s decisions to fund the CSR program and BHP without a lawful appropriation from Congress.

The committee’s oversight over the last six years, compiled here in its entirety for the first time, has exposed serious deficiencies in Obamacare that have harmed the American people and wasted taxpayer dollars. These oversight hearings and reports have paved the way to legislation that can repeal this harmful law.
III. Hearings and Reports from the 114th Congress

A. Hearings


- “Unlawful Reinsurance Payments: CMS Diverting $3.5 Billion from Taxpayers to Pay Insurance Companies,” Subcommittee on Oversight and Investigations, April 15, 2016.


“An Overdue Checkup: Examining the ACA’s State Insurance Marketplaces”

Subcommittee on Oversight and Investigations
September 25, 2015

Witnesses
- Peter V. Lee, Executive Director, Covered California, State of California
- Jim Wadleigh, Jr., Chief Executive Officer, Access Health CT, State of Connecticut
- Jeff M. Kissel, Executive Director, Hawaii Health Connector, State of Hawaii
- Louis Gutierrez, Executive Director, Massachusetts Health Connector, Commonwealth of Massachusetts
- Allison O’Toole, Interim Chief Executive Officer, MNsure, State of Minnesota
- Patrick Allen, Director, Department of Consumer and Business Services, State of Oregon

Summary
The purpose of this hearing was to understand the sustainability challenges that State-Based Exchanges (SBEs) faced under the implementation of Obamacare, almost two years after open enrollment began. The federal government granted states roughly $5 billion to help “establish” and set up exchanges. But the exchanges were supposed to be self-sustaining—that is, have a funding source other than federal grant dollars—by January 1, 2015.¹ Despite this multi-billion-dollar investment, many SBEs struggled to become self-sustaining. The hearing included representatives from six different state exchanges to discuss these concerns.

Findings
- Many SBEs faced significant financial troubles in the first years of implementation. Oregon’s state exchange closed on June 30, 2015, and Hawaii was in the process of closing during this hearing.²
- As state exchanges failed and shuttered, taxpayers lost the money spent to establish those exchanges. States further spent additional money to switch from an SBE to Healthcare.gov, and to re-enroll every individual onto the federal marketplace.³
- Funding from the federal government to exchanges lacked any meaningful oversight, contributing to the widespread confusion among states. When HHS OIG urged CMS to issue clear guidelines on appropriate use of establishment grant funds, the resulting guidance was vague and lacked real-world examples.⁴
- At this hearing, the committee found that Hawaii did not use federal grants for the intended purpose. Hawaii planned to use $5 to $7 million in establishment grant funds to decommission or shut down its system, and to encourage enrollment on Healthcare.gov.⁵

² Id. at 4.
³ Id. at 124-125.
⁴ The Centers for Medicare and Medicare Services, FAQs on the Clarification of the Use of 1311 Funds for Establishment Activities (June 8, 2015).
“Reviewing the Accuracy of Medicaid and Exchange Eligibility Determinations”

Subcommittee on Health
October 23, 2015

Witnesses

- Seto Bagdoyan, Director, Audit Services, Forensic and Investigative Service, Government Accountability Office
- Carolyn Yocom, Director, Health Care, U.S. Government Accountability Office (GAO)

Summary

The hearing reviewed preliminary results from GAO reports that raised serious concerns about the eligibility verification systems related to Healthcare.gov and state-based exchanges, and sought to determine if these same failures may have been imported into Medicaid. Obamacare allowed states to vastly expand their Medicaid programs and required a coordinated eligibility process for Medicaid and the exchanges. According to an August 2015 HHS OIG report, the internal controls of Healthcare.gov did not effectively ensure that only eligible individuals are enrolled in Medicaid, and that State expenditures are correctly matched by the Federal Government. As a result, CMS could not identify erroneous expenditures due to incorrect eligibility determinations.

Findings

- Individuals who receive coverage from either Medicaid or the exchanges may switch between programs some time during the year, presenting the potential for duplicate coverage.
- According to GAO, CMS did not verify Medicaid eligibility at the federal level, “[creating] a gap in efforts to ensure that only eligible individuals are enrolled in Medicaid, and that State expenditures are correctly matched by the Federal Government.” As a result, CMS could not identify erroneous expenditures due to incorrect eligibility determinations.
- GAO observed no improvements in the federal marketplace’s controls from the 2014 coverage year tests, and “found similar control vulnerabilities in the State marketplaces.”
- In undercover testing, GAO obtained subsidized coverage with private or Medicaid plans for 17 out of 18 fictitious applicants that used simple workarounds such as making phone calls or self-attesting to circumvent any controls encountered, totaling $41,000 in subsidies.
- When undercover testing applicants submitted clearly falsified supporting documents to receive subsidized Qualified Health Plans—such as social security numbers with more than 9 digits—the federal or state marketplace approved coverage in all 10 instances.

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6 Gov’t Accountability Office, Not All of the Federally Facilitated Marketplace’s Internal Controls Were Effective in Ensuring That Individuals Were Properly Determined Eligible For Qualified Health Plans and Insurance Affordability Programs (2015).
8 Id. at 8-9.
9 Id. at 20.
10 Id. at 20.
11 Id. at 20-21.
“Examining the Costly Failures of Obamacare’s CO-OP Insurance Loans”

Subcommittee on Oversight and Investigations
November 5, 2015

Witnesses
- The Honorable Ben Sasse, Senator, State of Nebraska
- Julie McPeak, Insurance Commissioner, State of Tennessee
- James Donelon, Insurance Commissioner, State of Louisiana
- Peter Beilenson, Board of Directors, National Alliance of State Health CO-OPS
- John Morrison, Vice Chair, Montana Health CO-OP
- Mandy Cohen, Chief of Staff, Centers for Medicare and Medicaid Services
- Gloria L. Jarmon, Deputy Inspector General for Audit Services, Office of Inspector General, U.S. Department of Health and Human Services

Summary
The hearing examined the Obamacare CO-OPs that failed by this date, the factors that contributed to these failures, CMS’ oversight—or lack thereof—of the CO-OPs, and how the CO-OPs’ closures affected consumers and taxpayers who footed the bill for the $2.4 billion in loans ultimately awarded to the CO-OPs. Members sought to determine whether CO-OPs would be able to pay back their start-up and solvency loans.

Findings
- Even before HHS implemented the CO-OP program, both HHS and the Office of Management and Budget (OMB) projected significant loss of taxpayer dollars through this program. HHS estimated that approximately one-third of CO-OPs would fail to repay their loans, and OMB projected taxpayers would lose over 40 percent of loans.  
- The OIG audit warned that CO-OPs were at risk of exhausting all start-up funding before becoming fully operational if certain circumstances occurred, such as low enrollment, uncertainty about operations of the marketplaces, and a state’s denial of licensure.
- The closure of CO-OPs had real consequences for people who enrolled in health insurance through them—many were kicked off their plans and given very little time to find alternatives for coverage of their families, causing disruption and confusion.
- In some cases, CMS allowed CO-OPs to convert (or re-characterize) start-up loans into surplus notes, as if to make it appear that CO-OPs had more capital and were more financially stable than they actually were.

15 Id. at 82.
Witness

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

Summary

The hearing examined the same questions put forth during the September 25, 2015 hearing on Obamacare’s State Insurance Marketplaces, from the perspective of CMS. The hearing addressed CMS’ oversight of the billions of taxpayer dollars invested in establishing the state exchanges. Issues of particular interest included: (1) determining if state exchanges had remaining federal establishment grant dollars, and how CMS was monitoring whether states used those establishment funds appropriately (i.e. not spent on operational expenses); and (2) how CMS managed state exchanges that were forced to, or opted to, abandon their own infrastructure and instead use the Healthcare.gov platform.

Findings

- At the time of the hearing, four state exchanges had closed and turned operations over to the federal exchange. Others struggled to become self-sustaining, with enrollment metrics falling well below administration projections in addition to significant budget shortfalls. The four closed exchanges alone received $733 million in federal establishment grant dollars.\(^\text{16}\)

- Although Obamacare required state exchanges to be self-sustaining by January 1, 2015 (at which point federal establishment grant money could not be used), CMS issued no-cost extensions to state exchanges, allowing them to use the remainder of their federal grants through 2015 and, in some cases, 2016, against the intent of the law.\(^\text{17}\)

- In the five years since the enactment of Obamacare, CMS issued only two guidance documents to inform state exchanges of the permissible ways to spend federal establishment funds, one of which came only after HHS OIG alerted CMS that exchanges may have been using grant funds for operational expenses.\(^\text{18}\)

- The OIG discovered, based on budget documents, that the Washington Health Benefit Exchange might have used $10 million of the establishment grant funds to support operations such as printing, postage, and bank fees. Using establishment grant funds on such operational expenses was not allowed under the law.\(^\text{19}\) Mr. Slavitt acknowledged that some of the $10 million may have been used improperly, but that CMS had not recouped any funds at the time of this hearing.\(^\text{20}\)

\(^\text{17}\) Id. at 25-26.
\(^\text{18}\) Id. at 2.
\(^\text{19}\) Id. at 22.
\(^\text{20}\) Id.
“Unlawful Reinsurance Payments: CMS Diverting $3.5 Billion from Taxpayers to Pay Insurance Companies”

Subcommittee on Oversight and Investigations
April 15, 2016

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

Summary
The hearing examined why CMS diverted billions of dollars from the Treasury to health insurers. Section 1341, which established the transitional reinsurance program, specifically states that a portion of the contributions “shall be deposited into the general fund of the Treasury of the United States and may not be used for the [reinsurance] program.”

Initially, HHS obeyed the statute. According to HHS’ final rule issued on March 11, 2014, and similar to its 2013 rule, CMS planned to allocate contributions to the reinsurance program among the health insurers, the U.S. Treasury, and administrative costs. Ten days later, HHS issued a different proposed rule, completely reversing course. HHS’ March 21, 2014 proposed rule prioritized contributions to the health insurers; CMS would make payments to the U.S. Treasury only after health insurers received their full payments.

Findings
- The non-partisan Congressional Research Service issued a memorandum finding that the HHS rule diverting funds from the Treasury was not consistent with the clear language of the law. Mr. Slavitt testified that CMS disagreed with these findings.
- Mr. Slavitt implied that the rule changed because CMS had not contemplated what to do in the event of a shortfall in funds. However, HHS’ earlier rule did, in fact, contemplate this scenario. In the March 11, 2014, final rule, HHS stated, if “the total amount of contributions collected is less than or equal to $8.025 billion, we will allocate approximately…24.9 percent of the reinsurance contributions collected to the U.S. Treasury.”
- When asked about the unambiguity of the statute, Mr. Slavitt stated that there was simply “a difference of opinion.”

21 42 U.S.C § 18061(b)(4).
26 Id. at 26.
27 Id. at 59.
“The ACA’s Cost Sharing Reduction Program: Ramifications of the Administration’s Decision on the Source of Funding for the CSR Program”

Subcommittee on Oversight and Investigations
July 8, 2016

Witnesses
- Doug Badger, Senior Fellow, Galen Institute
- Simon Lazarus, Senior Counsel, The Constitutional Accountability Center
- Tom Miller, Resident Fellow, American Enterprise Institute
- Morton Rosenberg, Legislative Consultant

Summary
The hearing examined the consequences of the administration’s decision to fund Obamacare’s CSR Program through the permanent appropriation for tax refunds and credits. The committee, along with the House Committee on Ways and Means, undertook a multi-year investigation to understand the facts surrounding the administration’s decision on the source of funding and its response to the committee’s subsequent investigation. Members questioned witnesses about the implications of the administration’s decision and response to the congressional investigation in three areas: (1) on federal appropriations law and principles; (2) on Obamacare; and (3) on the congressional oversight process.

Findings
- Obamacare created the CSR program, but did not fund it. The administration therefore requested an annual appropriation for the CSR program in the president's fiscal year 2014 budget request. Congress subsequently denied that request. The committee’s investigation found that the administration, in fact, withdrew its request for an annual appropriation and proceeded to fund the program through the permanent appropriations for tax refunds and credits, an action which violated appropriations law.
- In testimony before Ways and Means, a senior Treasury official claimed that Congress could pass a law saying not to appropriate monies in this way if Congress did not want the Executive Branch to fund the CSR program through the permanent appropriation. Such a statement is contrary to the Constitution and appropriations laws and principles.
- The administration’s implementation of the CSR program has been irresponsible, unaccountable, and potentially unlawful. The decision to fund the CSR payments without a lawful appropriation put the entire program in legal jeopardy.

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30 The ACA’s Cost Sharing Reduction Program: Ramifications of the Administration’s Decision on the Source of Funding for the CSR Program: Hearing Before the H. Comm. on Energy & Commerce, Preliminary Transcript, 114th Cong. 6-7 (July 8, 2016) (discussing testimony before the Committee on Ways and Means).
“The Affordable Care Act on Shaky Ground: Outlook and Oversight”

Subcommittee on Oversight and Investigations
Subcommittee on Health
September 14, 2016

Witnesses

- Andy Slavitt, Acting Administrator, Centers for Medicare and Medicaid Services
- Gloria L. Jarmon, Deputy Inspector General for Audit Services, Office of Inspector General, U.S. Department of Health and Human Services
- Seto J. Bagdoyan, Director, Audit Services, Forensic Audits and Investigative Service, U.S. Government Accountability Office

Summary

The hearing examined the state of the implementation of Obamacare and the stability of the current exchange markets and CO-OPs through findings and recommendations from oversight work conducted by GAO, HHS OIG, and the committee. Members also questioned CMS on steps the agency had already taken, or planned to take, to enhance their oversight of the SBE and CO-OP programs.

Findings

- Obamacare required state exchanges to be financially self-sustaining by January 1, 2015, yet at the time of this hearing, state exchanges still used federal grant money.\(^3^1\)
- State exchanges faced lower than expected enrollment and larger, unpredictable operational costs.\(^3^2\)
- CMS recouped only $21.5 million of the approximately $4.6 billion in establishment grant dollars awarded to the 17 state-based exchanges – less than half of one percent of the total awards.\(^3^3\)
- The 23 CO-OPs originally established received $2.4 billion in taxpayer-backed loans, yet only six CO-OPs remained open at the time of the hearing.\(^3^4\) Failed CO-OPs had cost the taxpayers nearly $2 billion.\(^3^5\)
- Some of the nation’s most significant health insurers, including United Health, Aetna, and Humana, opted out of Obamacare’s health insurance exchanges.\(^3^6\)

\(^{32}\) Id. at 4.
\(^{33}\) Centers for Medicare & Medicaid Serv., 1311 Deobligations and Spending (on file with Committee).
\(^{34}\) A fifth state-based exchange, Kentucky, had announced its intention to close starting in 2017.
\(^{36}\) Id. at 4.
B. Reports


“Misleading Congress: CMS Acting Administrator Offers False Testimony to Congress on State Exchanges”

Majority Staff Report
May 9, 2016

Summary
CMS is the federal agency charged with overseeing the SBEs established under Obamacare. The exchanges offer health care insurance plans to individuals through websites independently established and maintained by the states. As part of its oversight of the exchanges, CMS must ensure the $4.6 million federal grant dollars awarded to 17 SBEs are legally and appropriately spent. Only 16 states and the District of Columbia set up SBEs. Four of the 17 original SBEs failed and subsequently joined the federal platform, Healthcare.gov.

When asked under oath about the status of American taxpayer dollars invested in the SBEs, Acting Administrator Andy Slavitt testified before the Committee on Energy and Commerce’s Subcommittee on Oversight and Investigations in December 2015 that SBEs returned over $200 million in grant dollars to the federal government. After the hearing, it was widely reported by the media that CMS recouped over $200 million from failed state exchanges. The committee requested CMS provide documents and information supporting Mr. Slavitt’s $200 million figure. Information and documents CMS provided to the committee failed to corroborate Mr. Slavitt’s testimony and raised significant questions regarding the truthfulness of his statements. Neither Mr. Slavitt nor CMS attempted to correct the record with the committee or amend his inaccurate statement to the news media.

Findings
● Mr. Slavitt’s testimony that “over $200 million” had been returned to the federal government was not supported by any CMS documents, including a chart created by the CMS staff and produced to the Committee.37
● Mr. Slavitt’s testimony greatly overstated the sum returned to the Treasury from SBEs—by nearly $180 million. CMS “recouped” only $21.5 million from the 16 states and the District of Columbia that established SBEs.38
● CMS does not appear to have made an effort to correct the record when it was widely reported that “over $200 million” was returned to the Treasury because of improper spending and CMS’ oversight efforts. Despite Mr. Slavitt’s implication otherwise, CMS did not recover any of the funds due to improper spending. Instead of recouping funds from the exchanges, CMS simply “de-obligated” these funds because the time for the grant had expired or the funds were no longer needed.39

37 STAFF OF H. COMM. ON ENERGY & COMM., 114TH CONGRESS, CONGRESSIONAL INVESTIGATIVE REPORT INTO MISLEADING CONGRESS: CMS ACTING ADMINISTRATOR OFFERS FALSE TESTIMONY TO CONGRESS ON STATE EXCHANGES 11 (MAY 2016).
38 Id. at 12.
39 Id. at 13.
Summary
The CSR program requires health insurance companies that offer qualified health plans to reduce co-payments, deductibles, and other out-of-pocket expenses for eligible beneficiaries. Nothing in the ACA provides an appropriation or a source of funding for the CSR program. Thus, the program needed to be funded through the annual appropriations process. Nevertheless, beginning in January 2014, the administration funded the CSR program payments through a permanent appropriation without Congress’ authorization.

The Committee on Energy and Commerce and the Committee on Ways and Means launched a joint investigation to understand the rationale behind the administration’s decision to fund the CSR program through the permanent appropriation.

The committees faced unprecedented obstruction from the Executive branch in the course of this investigation, as documented in the July report. Among other tactics, the administration refused to comply with subpoenas issued by the two committees and instructed federal employees not to provide relevant information to the committees during interviews.

Findings
- The administration knew it needed an annual appropriation from Congress to fund the CSR program, and took multiple steps after passage of Obamacare indicating that it understood this.\(^{40}\)
- The administration requested an annual appropriation for the CSR program, in the President’s fiscal year 2014 budget request but, shortly thereafter, informally withdrew the request.\(^{41}\)
- The administration developed a new—albeit illegal—path forward to pay for the CSR program using the permanent appropriation for tax refunds and credits found at 31 U.S.C. § 1324.\(^{42}\)
- High-level officials, including former Attorney General Eric Holder, were involved in the decision to fund the CSR program from the permanent appropriation.\(^{43}\)
- Senior IRS officials raised concerns about the source of funding for the CSR program.\(^{44}\)
- Secretary Lew signed an unusual Action Memorandum authorizing the IRS to administer the CSR payments in the same manner as the advanced premium tax credit payments.\(^{45}\)
- Administration officials based their decision to fund the CSR program on a flawed legal analysis.

\(^{40}\) STAFF OF H. COMM. ON ENERGY & COMM. AND H. COMM. ON WAYS & MEANS, 114TH CONGRESS, JOINT CONGRESSIONAL INVESTIGATIVE REPORT INTO THE SOURCE OF FUNDING FOR THE ACA’S COST SHARING REDUCTION PROGRAM 23-29 (July 2016).
\(^{41}\) Id. at 39-51.
\(^{42}\) Id. at 52-61.
\(^{43}\) Id.
\(^{44}\) Id. at 62-76.
\(^{45}\) Id. at 76-82.
“Addendum to Joint Congressional Investigative Report into the Source of Funding for the ACA’s Cost Sharing Reduction Program”

Majority Staff Report
December 22, 2016

Summary
In July 2016, the Committee on Energy and Commerce and the Committee on Ways and Means held two hearings and issued a joint staff report detailing the committees’ investigation into the source of funding for the CSR program. At a hearing before Ways and Means’ Subcommittee on Oversight, a senior Treasury official testified, “If Congress doesn’t want the moneys appropriated, they could pass a law that specifically said, do not appropriate moneys from that account.”

Spurred by this testimony that Congress should appropriate in the negative—a statement that directly contradicts the Constitution—and the number of questions still unanswered, the committees continued the investigation. The committees continued to press the administration to produce documents responsive to the multiple subpoenas issued over the course of the investigation, and the administration finally caved and made documents available. Staff of the two committees subsequently reviewed thousands of pages of documents about the source of funding decision.

Key information revealed for the first time in the Addendum included:

- HHS included a request for an advance appropriation to cover one month of payments for the CSR program in its FY 2013 budget submission to OMB. The request appears to have been denied by OMB. This new information—that HHS requested an appropriation for the CSR program not once, but twice—further indicates that HHS believed it required an annual appropriation to fund the program.46
- Just weeks after the administration informally withdrew the request for funding, senior officials at HHS, Treasury, OMB, and the White House discussed via email funding the CSR program from the permanent appropriation for tax credits and refunds. Moreover, these officials discussed the permanent appropriation as a source of funds for the CSR program in the context of the potential impact of sequestration on the program.47
- Senior IRS officials raised concerns not only to the IRS’ legal department, but also to the Office of the General Counsel and other senior Treasury officials. Given their concerns about the legality of the source of funding, IRS officials insisted on having the January 2014 Action Memorandum in hand before proceeding beyond organizational discussions with CMS.48
- The OMB legal memorandum justifying the source of funding for the CSR program did not provide a cognizable legal basis for using the permanent appropriation to fund the program.49

47 Id. at 17-20.
48 Id. at 20-29.
49 Id. at 29-30.
“Implementing Obamacare: A Review of CMS’ Management of State-Based Exchanges”

Majority Staff Report
September 13, 2016

Summary
Section 1311 provided funding assistance to the states to help them establish their own health insurance exchanges. HHS awarded 17 SBEs close to $5 billion in federal grant money, but four SBEs have since failed and the rest still depend on federal money, despite the statutory requirement that each SBE must be self-funded by January 1, 2015.

Rather than protecting the federal investment by utilizing their oversight authorities and ensuring that the states become self-sustaining through lawful means, CMS instead continued to funnel federal dollars to the states through permissive grant policies and “no cost extensions.” Further, CMS conducted little oversight of the states’ use of these federal grants. CMS indicated in both hearings and letters that it identified and recouped some misspent grant dollars, but failed to recover additional misspent dollars identified by the committee and the HHS Office of the Inspector General.

Findings
- CMS was not confident that the remaining SBEs would be sustainable in the long term.\(^{50}\)
- As of September 2016, every SBE relied upon federal establishment grant funds—20 months after Obamacare required SBEs to be self-sustaining.\(^{51}\)
- CMS was aware that SBEs misspent grant dollars, but failed to recoup misspent funds.\(^{52}\)
- CMS recovered only $1.6 million in misspent federal funds from three SBEs. Nearly $1 million was for impermissible construction costs that CMS did not detect for over a year.\(^{53}\)

Recommendations
- Require SBEs to pay the same user fee as other states.\(^{54}\)
- Recoup establishment grant funds from SBEs that shut down.\(^{55}\)
- Enforce the requirement that all SBEs publish the costs of the exchange publicly on the Internet.\(^{56}\)
- Require that SBEs publish and cite the source of the number of monies lost to waste, fraud, and abuse.\(^{57}\)
- Increase oversight of the current and past expenditures of federal grants for SBEs.\(^{58}\)

\(^{51}\) Id. at 33.
\(^{52}\) Id. at 46-52.
\(^{53}\) Id. at 51-52.
\(^{54}\) Id. at 62.
\(^{55}\) Id.
\(^{56}\) Id.
\(^{57}\) Id.
\(^{58}\) Id.

Majority Staff Report
September 13, 2016

Summary
Under Obamacare, HHS spent $2 billion in taxpayer-backed loans to establish non-profit insurers called CO-OPs. Intended to increase choice and create competition among insurers, these CO-OPs were structurally flawed and financially risky from the start. Closures of the CO-OPs—particularly ones that occurred outside of the open enrollment period—left consumers scrambling to find health care insurance in order to maintain their coverage. These closures left consumers with fewer and more expensive choices for health insurance. At the time of the issuance of this report, over two-thirds of the 23 CO-OPs had closed, and none of them had paid back their loans.

Several CO-OPs—both ones still open and ones that have closed—have filed lawsuits against the federal government regarding Obamacare’s flawed premium stabilization programs which contributed to the CO-OPs’ financial insolvency. The committee issued this report chronicling the overwhelming failures of the CO-OP program, including CMS’ poor management of the program.

Findings
- CO-OPs either failed to meet enrollment targets or surpassed enrollment capacity. Both scenarios created financial insolvency.59
- HHS and Congress designed the Risk Corridor program to be budget neutral.60
- CMS issued Corrective Action Plans in response to oversight conducted not by CMS, but rather by state regulators and the HHS OIG.61
- CMS issued Corrective Actions Plans that contained obvious errors and outdated information.62

Recommendations
- Monitor CMS’ oversight of the remaining CO-OPs.63
- Exempt individuals from the individual mandate penalty if their coverage under a plan offered by a CO-OP is terminated due to the failure of the CO-OP.64
- Alter the risk adjustment formula by imposing limits on risk adjustment payables.65
- Require transparency from CMS for risk corridor transfer payment availability.66

60 Id. at 18.
61 Id. at 29.
62 Id. at 31.
63 Id. at 52.
64 Id.
65 Id.
66 Id.
IV. Hearings from the 113th Congress


- “The Center for Consumer Information and Insurance Oversight and the Implementation of the Patient Protection and Affordable Care Act,” Subcommittee on Oversight and Investigations, April 24, 2013.


“Unaffordable: Impact of Obamacare on Americans’ Health Insurance Premiums”

Subcommittee on Health
March 15, 2013

Witnesses
- Douglas Holtz-Eakin, Former Director, Congressional Budget Office (CBO)
- Christopher Carlson, Actuarial Principal, Oliver Wyman
- Wendell Potter, Senior Analyst, The Center for Public Integrity

Summary
The hearing examined studies and analyses from the Congressional Budget Office, independent actuaries, State insurance commissioners, health insurance plans and health benefit consultants that projected the impact of Obamacare on health insurance premiums in the individual and small group market, as well as the price of coverage in the exchanges. While estimates vary, the general consensus was that the law would increase premiums in state insurance markets.

Findings
- Younger and healthier workers in the small-group market would face an average premium increase of roughly 149 percent. In the individual market, young healthy workers would face an average premium increase of around 189 percent.\(^\text{67}\)
- States with the highest uninsured and unemployment rates in the Nation, and individuals under the age of 40, will see their premiums increase the most.\(^\text{68}\)
- The report released by Oliver Wyman found that health insurer taxes would be passed on directly to consumers and that the age rating of plans would not result in net savings, though it would have the effect of increasing costs for younger enrollees and decreasing costs for older enrollees.\(^\text{69}\)
- Obamacare incentivizes employers whose employees are under [133 percent] of the federal poverty line to stop offering insurance and send employees to the federal exchanges. Employers in this situation would be able to save money even after factoring in the penalty, and they could even afford to increase employee salaries to help subsidize their coverage. In the long run, this would cost the federal government more than anticipated on subsidizing coverage.\(^\text{70}\)

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\(^\text{68}\) Id. at 6.
\(^\text{69}\) Id. at 29-30.
\(^\text{70}\) Id. at 70.
The hearing continued the committee’s oversight of the Center for Consumer Information and Insurance Oversight (CCIIO), the government agency responsible for the implementation of the Obamacare provisions related to private health insurance. CCIIO defined its areas of emphasis as: (1) ensuring compliance with the new market rules in Obamacare and helping states review insurance rate increases and overseeing new Medical Loss Ratio Rules; (2) providing oversight of the state health insurance exchanges and compiling data for Healthcare.gov; and (3) administering various programs in Obamacare, such as the program that administered waivers to the prohibition on annual or lifetime limits in insurance plans.

Findings

- Facing Obamacare implementation, some employers found their insurance plans to be ineligible under new Obamacare regulations. For example, Whole Foods, which employs 30,000 people, was satisfied with their plan but then realized it would be ineligible under Obamacare.  

- One Committee member heard from a company in the member’s district that planned to drop employer coverage or consider lay-offs to get under 50 employees and/or reduce part-time employee hours to below 29 hours per week to avoid increased costs and penalties.

- Many early aspects of Obamacare already faced failures or delays. The Pre-Existing Conditions Insurance Plan (PCIP) and the Early Retiree Reinsurance Program needed to be scaled back, and options were delayed for the Small Business Health Options Program (SHOP). The 1099 requirement had been repealed on a bipartisan basis.

- The Administration used funds allotted to the Prevention for the Public Health Fund for initiatives such as a pet neutering project and lobbying efforts for soda taxes.
“Health Insurance Premiums Under the Patient Protection and Affordable Care Act”

Subcommittee on Oversight and Investigations
May 20, 2013

Witnesses
- Cori E. Uccello, Senior Health Fellow, American Academy of Actuaries
- Chris Carlson, Actuarial Principal, Oliver Wyman Group
- Daniel T. Durham, Executive Vice President, Policy and Regulatory Affairs, America’s Health Insurance Plans
- Topher Spiro, Vice President, Health Policy, Center for American Progress

Summary
At this hearing, actuaries and health care industry professionals provided testimony on the impact that Obamacare would have on nationwide health insurance premiums. Members discussed specific policies that would impact premiums, industry’s preparation for those policies, and how premium changes under Obamacare would differ by market and state. In advance of the hearing, the committee sent letters to 17 insurance companies requesting information estimating Obamacare’s effect on premiums. The responses all predicted massive premium increases across the majority of states.

Findings
- Rate increases were predicted to vary widely based on an individual’s state of residence and current plan.\(^75\)
- The impact of young, healthy Americans not purchasing health insurance would cause premiums to increase among those who remain in the risk pool, creating a compounding effect over time of increasing premiums and decreasing amounts of young, healthy enrollees. Additionally, the guaranteed issue provision in Obamacare was expected to bring more high-cost enrollees into the program.\(^76\)
- The cost to taxpayers of providing the insurance subsidies was unknown.\(^77\)

\(^{76}\) Id. at 84-85.
\(^{77}\) Id. at 87-88.
“Challenges Facing America’s Businesses Under the Patient Protection and Affordable Care Act”

Subcommittee on Oversight and Investigations
June 26, 2013

Witnesses

- Hugh Morrow, President, Ruby Falls, LLC
- Jeffrey S. Kelly, CEO, Hamill Manufacturing Company
- Steve Lozinsky, Vice President, Sparkle and Shine Cleaning Services, Inc.
- Michael Brey, Owner, Hobby Works
- Neil Trautwein, Vice President and Employee Benefits Policy Counsel, National Retail Federation
- Katie Mahoney, Executive Director, Health Policy, U.S. Chamber of Commerce
- Michelle Neblett, Director of Labor and Workforce Policy, National Restaurant Association
- Bill Daley, Legislative and Policy Director, Main Street Alliance

Summary

The hearing examined the impact of Obamacare on American businesses. Specific challenges for businesses included difficulties for those that relied on part-time or seasonal employees, and the feasibility of providing health insurance for low-wage employees. The hearing also examined the law’s impact on the cost to companies of providing health insurance for employees, and whether the law has led companies to reduce hours or fire workers.

Findings

- At the time, 41 percent of small business had frozen hiring according to a Gallup poll. One fifth of American small business had reduced employment as a result of Obamacare. One witness, an owner of a business with over 200 employees, was left with the choice to fire employees, reduce hours to 30 per week, or face bankruptcy.\(^{78}\)
- Because the employer mandate did not apply to registered provisional immigrants, it could disadvantage companies that employ American citizens.\(^{79}\)
- Employers that provided health care insurance coverage for their employees were concerned that premium increases would necessitate employers to pass on some of the costs to their employees.\(^{80}\)
- The administration did not adequately consult the small business community during the development of the law.\(^{81}\)
- The complexity of the law makes it difficult for small business owners to comply.\(^{82}\)

\(^{78}\) Challenges Facing America’s Businesses Under the Patient Protection and Affordable Care Act: Hearing before the H. Comm. on Energy & Commerce, 113th Cong. 75 (June 26, 2013).
\(^{79}\) Id. at 36-37.
\(^{80}\) Id. at 40.
\(^{81}\) Id. at 73-74.
\(^{82}\) Id. at 19.
“Patient Protection and Affordable Care Act: Implementation in the Wake of Administrative Delay”

Subcommittee on Oversight and Investigations
July 18, 2013

Witness
- J. Mark Iwry, Senior Advisor to the Secretary, Deputy Assistant Secretary for Retirement and Health Policy, U.S. Department of Treasury

Summary
The hearing focused on the Department of the Treasury’s decision to delay implementation of the employer mandate by one year. The administration made this decision after receiving input from stakeholders to allow Treasury to consider ways to simplify the new reporting requirements and provide time to adapt health coverage and reporting systems. Members raised questions about the stakeholders that Treasury engaged with before making this decision, the concerns those stakeholders raised, whether any of the requirements will remain under the delay, and how the administration would guarantee Obamacare would not be subject to waste, fraud, or abuse.

Findings
- Treasury decided to provide relief from the employer mandate, but not the individual mandate, despite the disruption that resulted from the individual mandate.  
- Administration officials had previously testified to Congress that implementation of the employer mandate was on track. This delay came suddenly and unexpectedly, over 3 years after the enactment of the law.
- The announcement of the delay originally appeared on White House Senior Advisor Valerie Jarrett’s blog, suggesting the White House’s direct involvement in the decision to delay the rule. Mr. Iwry confirmed the White House’s involvement in the decision in his testimony.

84 Id. at 6-7.
85 Id. at 30-31.
“PPACA Pulse Check”
Committee on Energy and Commerce
August 1, 2013

Witness

- Marilyn Tavenner, Administrator, Centers for Medicare and Medicaid Services

Summary

At the time of the hearing, full implementation of Obamacare was two months away. The hearing focused on the status of implementation, including system readiness, eligibility verification processes, and new taxes and penalties that would go into effect upon full implementation.

Findings

- A committee member expressed concerns that the law would harm labor unions’ ability to provide medical benefits packages; according to a Washington Post article, unions such as the Teamsters and the Brotherhood of Electrical Workers further believed that their concerns were not heard by HHS. They were especially concerned about Obamacare’s dismantling of multi-employer health plans.86
- Confirming this belief, Ms. Tavenner testified that she was not aware of the unions’ concerns at the time.87
- A committee member raised concerns from universities and colleges in his district that student work hours would have to be cut because of the employer mandate requiring employers to provide insurance to employees working over 29 hours per week, and students would consequently have fewer dollars with which to pay their tuition.88
- Obamacare required all states to use a single streamlined Medicaid application beginning on October 1, 2013, unless they received approval by CMS to use an alternative application. However, the proposed application was not expected to be made available by CMS until the end of August, giving states only a month to decide whether to use it or to create their own.89
- At an earlier hearing, Ms. Tavenner testified that she did not have concerns about the integrity of the employer verification system in the wake of Treasury’s delay of the employer mandate. However, CMS released a rule on January 22, 2013, which stated that reporting under the employer mandate “could greatly contribute to the integrity of the employer verification into the future.” In this rule, CMS acknowledged that enforcing the employer mandate had an impact on the employer verification system. Ms. Tavenner confirmed that she issued the rule in a later response.90

87 Id. at 113-114
88 Id. at 130
89 Id. at 132-133
90 Id. at 144-145, 208; 78 Fed. Reg. 4593.
“PPACA Pulse Check: Part 2”
Subcommittee on Health
September 10, 2013

Witnesses
- Lynn Spellecy, Corporate Counsel, Equifax Workforce Solutions
- John Lau, Program Director, Serco
- Cheryl Campbell, Senior Vice President, CGI Federal
- Michael Finkel, Executive Vice President of Program Delivery, QSSI
- Brett Graham, Partner, Leavitt Partners
- Edward A. Lenz, Senior Counsel, American Staffing Association
- Antoinette Kraus, Director, Pennsylvania Health Access Network

Summary
Obamacare implementation involves multiple government agencies and contractors. In addition, HHS has entered into contracts with organizations to assist with the creation and operation of such exchanges. At the time of the hearing, many issues related to readiness, testing, and functionality of exchanges remained. Missed deadlines, delays, and untimely guidance were expected to affect areas such as consumer assistance and experience, eligibility accuracy, integration with existing state programs, and interagency coordination. This hearing was held to examine the abovementioned issues from the perspective of contractors working on the marketplace as well as other stakeholders.

Findings
- According to Health Subcommittee Chairman Pitts’ opening statement, the New York Times reported discovering a delay in the implementation of Obamacare’s out-of-pocket caps buried in a list of frequently asked questions on the U.S. Department of Labor’s website.\(^91\)
- CMS announced on August 27, 2013 that instead of finalizing contracts with health plans set to participate on the exchanges before September 9\(^{th}\), final contracts would not be signed until mid-September.\(^92\)
- Given that Obamacare exchange enrollment verification includes roughly 20 separate steps, a committee member expressed skepticism that the process would be functional by the October 1, 2013 enrollment start date.\(^93\)
- The representative from the American Staffing Association testified that employers were not given adequate time to digest Obamacare’s reporting rules and begin compliance, and that his member companies, who are all temporary staffing agencies, have expressed anxiety about the uncertainty of the law.\(^94\)

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\(^92\) Id.
\(^93\) Id. at 97-98.
\(^94\) Id. at 104-105, 111.
“Two Weeks Until Enrollment: Questions for CCIIO”

Subcommittee on Oversight and Investigations
September 19, 2013

Witness

- Gary Cohen, Deputy Administrator and Director, Center for Consumer Information and Insurance Oversight, Centers for Medicare and Medicaid Services

Summary

CCIIO is the government agency responsible for the implementation of the provisions related to private health insurance in Obamacare. CCIIO ensures compliance with the new market rules, helps states review insurance rate increases, provides oversight of the exchanges, and administers several programs under Obamacare. The hearing focused on CCIIO’s actions leading up to the start of enrollment, including whether the exchanges would be fully operational in time for the January 1, 2014, deadline and how CCIIO dealt with the numerous new requirements, particularly around the Navigator grant program.

Findings

- At the time of the hearing, which took place less than two weeks before exchange enrollment was to begin, the administration had provided no publicly available information on insurance rates.\(^\text{95}\)
- Mr. Cohen, the director of the agency responsible for administering the Navigator program, did not know the criteria for obtaining a Navigator grant.\(^\text{96}\)
- Navigator grantees were not required to undergo criminal background checks by the federal government. While Navigators would have some access to applicants’ personally identifiable information, CMS had issued guidelines governing best practices for safeguarding that information.\(^\text{97}\)
- One approved Navigator application described providing gift cards to applicants in exchange for consumer feedback. Mr. Cohen testified that he did not see a problem with that arrangement, and did not consider it enticement for positive feedback from the applicants.\(^\text{98}\)
- A committee member expressed concern over a lack of competition in the new insurance marketplaces. He said that in his district, a number of rural counties only have one individual plan and one SHOP plan from which to choose.\(^\text{99}\)

\(^{95}\text{Two Weeks Until Enrollment: Questions for CCIIO: Hearing Before the H. Comm. on Energy & Commerce, 113th Cong. 30 (Sept. 19, 2013).}\)
\(^{96}\text{Id. at 43-44.}\)
\(^{97}\text{Id. at 39-40, 31-32.}\)
\(^{98}\text{Id. at 56-57.}\)
\(^{99}\text{Id. at 63-66.}\)
“PPACA Implementation Failures: Didn’t Know or Didn’t Disclose?”

Committee on Energy & Commerce
October 24, 2013

Witnesses
- Cheryl Campbell, Senior Vice President, CGI Federal
- Andrew Slavitt, Group Executive Vice President, Optum/QSSI
- Lynn Spellecy, Corporate Counsel, Equifax Workforce Solutions
- John Lau, Program Director, Serco

Summary
This hearing focused on the failures and issues surrounding the implementation of Obamacare’s health insurance exchanges. Prior to the open enrollment start date, Members raised many questions about the readiness, testing, and functionality of the exchanges. In June 2013, GAO issued a report raising key questions regarding the readiness of the FFM. GAO found that core functions of the FFM not been completed and concluded that CMS “has many key activities remaining to be completed across the core exchange functions…” Despite these issues, HHS officials repeatedly assured the public that implementation was progressing on time and as intended. Implementation involved multiple government agencies and contractors. In addition, HHS entered into contracts with organizations to assist with the creation and operation of such exchanges, including the FFM website. This hearing examined Obamacare implementation from the perspective of these companies, and focused on determining the cause of the failures and steps forward.

Findings
- Mr. Slavitt testified that Optum/QSSI shared readiness concerns with CMS before the launch, and that CMS did not fully address those concerns.100
- Mr. Lau testified that Serco did not test their product’s compatibility with the portal prior to the launch date.101
- Committee Members identified several concerns surrounding the HIPAA compliance of the exchanges, such as contractors having access to enrollment information.102
- A contractor testified that end-to-end testing of the exchange website did not occur until a few days before implementation. Multiple contractors testified that standard practice is to allow multiple months for end-to-end testing.103
- Ms. Campbell testified that CGI tested their system in the days leading up to the launch of the exchange. The system crashed during the test with only several hundred people accessing the system.104

101 Id.
102 Id. at 46-48, 50-51
103 Id. at 57, 64-65
104 Id. at 73-74
“PPACA Implementation Failures: Answers from HHS”
Committee on Energy and Commerce
October 30, 2013

Witness

- The Honorable Kathleen Sebelius, Secretary, U.S. Department of Health and Human Services

Summary

The hearing examined the failed launch of Healthcare.gov and other Obamacare implementation failures. Open enrollment on Obamacare exchanges began on October 1, 2013. Despite the prior statements of HHS and CMS officials that the online application process would be ready to go by October 1, the launch of Healthcare.gov—the federal exchange—was plagued with crashes, glitches, and system failures.

Findings

- Many plans on the individual market were cancelled as a result of Obamacare implementation, despite President Obama’s promises that Americans could keep their plans if they liked them.\(^{105}\)
- The website did not provide a guarantee of privacy to users. A line in the source code, not in language available to consumers, told users that the government may monitor and seize any communication or data stored on the website.\(^{106}\)
- When calculating initial quotes, the Healthcare.gov website gave anyone under the age of 50 pricing for a 27 year-old, and anyone above 50 received a quote for a 50 year-old.\(^{107}\)
- The website did not identify whether or not plans cover abortion services, and pro-life consumers had no way of identifying plans that do not cover abortion.\(^{108}\)
- Citing a *Washington Post* article, a committee member mentioned that a group of 10 insurers urged agency officials not to launch the website, but Ms. Sebelius testified that she was not aware of the recommendation.\(^{109}\)
- HHS sent a letter to GAO on June 6, 2013 saying CMS was in the final stages of finalizing and testing the IT infrastructure, and that HHS was extremely confident the marketplace would open on schedule. However, HHS actually only began the end-to-end testing of Healthcare.gov two weeks before the enrollment period opened. Moreover, HHS delayed this testing despite recommendations from contractors that HHS begin end-to-end testing two months before open enrollment began. Ms. Sebelius admitted the testing was not adequate.\(^{110}\)


\(^{106}\) *Id.* at 22-23.

\(^{107}\) *Id.* at 28-29.

\(^{108}\) *Id.* at 29.

\(^{109}\) *Id.* at 32.

\(^{110}\) *Id.* at 34-35.
Witnesses

- Henry Chao, Deputy Chief Information Officer and Deputy Director of the Office of Information Services, Centers for Medicare and Medicaid Services
- David Amsler, President and Chief Information Officer, Foreground Security, Inc.
- Maggie Bauer; Senior Vice President, Health Services; Creative Computing Solutions, Inc.
- Jason Providakes, Senior Vice President and General Manager, Center for Connected Government, MITRE Corporation

Summary of Hearing
The hearing continued the committee’s investigation into the failed launch of Healthcare.gov, focusing on the security of the website. The hearing featured testimony from CMS and contractors that worked with CMS to develop and validate the security controls and monitor system traffic. Members questioned the witnesses about CMS’ management and assessment of the security of Healthcare.gov, including the identification of vulnerabilities, and how the failure to complete end-to-end testing prior to the October 1, 2013 launch affected its security.

Findings

- Prior to the launch of Healthcare.gov, the Deputy Chief Information Officer of CMS expressed via email strong concerns about whether Healthcare.gov would be ready in time, but ultimately recommended that it was safe to launch on October 1. In the hearing, he confirmed sending the email.\textsuperscript{111}
- CMS hired McKinsey and Co. to audit the preparation for the launch of the federally facilitated marketplace. In March of 2013, McKinsey produced a report that identified serious concerns about the readiness of the exchange and briefed senior HHS and White House officials on the findings. Despite the concerns identified by the McKinsey report, HHS decided to press forward with the October 1, 2013 deadline.\textsuperscript{112}
- According to CMS testimony, 60 to 70 percent of the Federally Facilitated Marketplace still needed to be built at the time of the hearing.\textsuperscript{113}
- All security contractor witnesses testified that they were not aware whether or not the security controls they developed were incorporated into Healthcare.gov.\textsuperscript{114}

\textsuperscript{112} Id. at 28-30, 36-37.
\textsuperscript{113} Id. at 69.
\textsuperscript{114} Id. at 105-107.
“PPACA Implementation Failures: What’s Next?”

Subcommittee on Health
December 11, 2013

Witness

- The Honorable Kathleen Sebelius, Secretary, U.S. Department of Health and Human Services

Summary

The hearing examined problems with the implementation of Obamacare. Particularly, it examined narrow provider networks and quality of coverage under Obamacare and the impact it would have on the Medicaid program, particularly on current Medicaid enrollees and on states’ ability to properly administer their Medicaid programs. It also examined issues surrounding privacy, security, and fraud, which had arisen both within and outside of the federally facilitated marketplace’s website, Healthcare.gov.

Findings

- At the time of the hearing, CMS’ Office of the Actuary predicted that approximately five million Americans would move from employer-based insurance to Medicaid in the next four years.115
- Exchange plans provided more narrow coverage than most private plans with access to fewer providers.116
- Personally identifiable information for enrollees who signed up on the California state exchange was inadvertently released to insurance agents.117
- One member expressed concern that enrollees would mistakenly think that they were insured under exchange coverage because they would enroll on the website but subsequently fail to make the initial payment to insurers necessary to begin coverage.118

116 Id. at 58-59.
117 Id. at 25.
118 Id. at 33.
“2014: Seeking PPACA Answers”

Subcommittee on Oversight and Investigations
January 16, 2014

Witness

- Gary Cohen, Director, Center for Consumer Information and Insurance Oversight, Centers for Medicare and Medicaid Services

Summary

The hearing continued the committee’s oversight of the CCIIO. This hearing examined changes that had been made to Healthcare.gov since its launch, the performance of the exchanges, and the additional programs or policies that the public could expect from the administration in 2014.

Findings

- At the time of the hearing, the “back end” of the website was still not functional. Subsidies to insurance companies were being processed by hand on paper because the automated process was still under development.\(^\text{119}\)

- A committee member questioned whether the figure presented by HHS on the amount of people newly enrolled was overinflated by factoring in those who were removed from their previous insurance plan because of Obamacare, which is what happened with those enrolled in state-based high risk pools and later reenrolled in exchange coverage. The member also questioned whether exchange coverage would force patients into more narrow provider networks than those of the high risk pools.\(^\text{120}\)

- Although CMS issued instructions to Navigators prohibiting door-to-door solicitation, evidence suggested that Navigators were doing just that. Mr. Cohen said he was not aware of those instances but that he would investigate them.\(^\text{121}\)

- A Committee member discussed a Washington Post article which pointed out that the Administration’s claim that six million previously uninsured people had signed up for coverage was false. Mr. Cohen could not confirm whether the “newly covered” under Medicaid and exchange coverage were previously uninsured.\(^\text{122}\)


\(^\text{120}\) Id. at 42-44.

\(^\text{121}\) Id. at 33-34.

\(^\text{122}\) Id. at 46.
“PPACA Enrollment and the Insurance Industry”

Subcommittee on Oversight and Investigations
May 7, 2014

Witnesses

- Frank Coyne, Vice President of Operations, Chief Transformation Officer, Blue Cross and Blue Shield Association
- Mark Pratt, Senior Vice President of State Affairs, America’s Health Insurance Plans
- Paul Wingle, Executive Director of Individual Business and Public Exchange Operations and Strategy, Aetna
- Brian Evanko, President, Individual Segment, Cigna
- J. Darren Rodgers, Senior Vice President and Chief Marketing Officer, Health Care Service Corporation
- Dennis Matheis, President of Central Region and Exchange Strategy, Wellpoint, Inc.

Summary

The hearing examined the implementation of Obamacare and the status of enrollment and the marketplace from the perspective of insurance providers. Members asked questions about the industry’s experience with Healthcare.gov and other systems created by the administration; what patients could expect to experience in regard to future premiums, networks, and doctor choices; and whether states were facing unique risk pool or payment problems.

Findings

- Obamacare required insurers and providers to take on additional risks and administrative burdens. If enrollees who received subsidies did not pay their premiums, CMS awarded them a 90-day grace period before the insurer could cancel the insurance plan. If a provider submitted a bill for a non-paying patient during the latter 60 days of the grace period, the provider would be responsible for payment themselves.\(^\text{123}\)

- By May 2014, none of the insurers present had completed an internal analysis on the rate changes for exchange coverage for 2015, nor had any of the insurers present engaged in discussions with the administration about 2015 rates for exchange coverage.\(^\text{124}\)

- The Healthcare.gov website had a known issue causing some consumers to unintentionally enroll multiple times, causing confusion for insurers and enrollees.\(^\text{125}\)

- Insurers testified that providing coverage on the exchanges involved more manual processes than expected, and that problems with the “back end” of the system remained. These problems included CMS having to manually send Advanced Premium Tax Credit payments to the insurers, which was supposed to be an automated process.\(^\text{126}\)

\(^\text{124}\) Id. at 51-53.
\(^\text{125}\) Id. at 60.
\(^\text{126}\) Id. at 62-64.
“Failure to Verify: Concerns Regarding PPACA’s Eligibility System”

Subcommittee on Health
July 16, 2014

Witnesses

- Kay Daly, Assistant Inspector General, Office of Audit Services, Office of Inspector General, U.S. Department of Health and Human Services
- Joyce Greenleaf, Regional Inspector General, Office of Evaluation and Inspections, Office of Inspector General, U.S. Department of Health and Human Services

Summary
The hearing examined inaccuracies and inconsistencies in Obamacare’s eligibility verification program. Federal law requires that “prior to making such credits and reductions available, the secretary shall certify to the Congress that the Exchanges verify such eligibility consistent with the requirements of such Act.” However, documents released by the committee and by HHS OIG revealed a significant number of inconsistencies in health care applications. The hearing examined the lack of internal controls at HHS for verifying Social Security numbers, citizenship, and other sources of health coverage.

Findings

- Between October 1 and December 31, 2013, OIG identified 2.9 million inconsistencies between applicants’ information in health care applications and data received through the Data Hub, which compiles personal data from seven federal agencies for verification purposes, or from other data sources. One-third of the inconsistencies were related to income, and thus potentially relevant to the cost to the federal government of the exchange coverage subsidies. These subsidies were forecasted to cost the federal government $1 billion over the first 10 years before accounting for inconsistencies.\textsuperscript{127}
- OIG reported that the federal marketplace could not resolve 2.6 million out of 2.9 million inconsistencies as of the first quarter of 2014 because the CMS eligibility system was not fully operational. This called into question Secretary Sebelius’ certification to Congress on January 1, 2014, that HHS had processes in place to verify applicant eligibility before paying subsidies. This certification is required by law.\textsuperscript{128}
- The Social Security Administration (SSA) did not always validate social security numbers provided by applicants.\textsuperscript{129} According to CMS data, SSA identified 167,861 inconsistencies as of April 28, 2014.\textsuperscript{130}
- At the time of the hearing, CMS still did not have an end-to-end verification process for applicant information in place.\textsuperscript{131}

\textsuperscript{127} Failure to Verify: Concerns Regarding PPACA’s Eligibility System: Hearing Before the H. Comm. on Energy & Commerce, 113th Cong. 6-7 (July 16, 2014).
\textsuperscript{128} Id. at 3, 6-7.
\textsuperscript{129} Id. at 17.
\textsuperscript{130} Id. at 60.
\textsuperscript{131} Id. at 26-27.
PPACA Implementation: Updates from CMS and GAO

Subcommittee on Oversight and Investigations
July 31, 2014

Witnesses

- Andy Slavitt, Principal Deputy Administrator, Centers for Medicare and Medicaid Services
- William Woods, Director of Acquisition and Sourcing Management, Government Accountability Office

Summary

The hearing examined the status of the federal exchange, Healthcare.gov, as well as other Obamacare implementation issues. Witnesses provided an update on the functionality of the exchange website, as well as testimony on whether the back end systems that handled payment processes for the federally facilitated exchange would be ready for the next open enrollment period. GAO testified about their independent review of CMS’ implementation of Obamacare, which assessed CMS’ oversight of the website and actions taken by the administration to identify and address contractor performance issues. The hearing also examined the expected impact of the upcoming implementation of the employer mandate and expectations for 2015 premium rates.

Findings

- GAO’s report on the contracting aspects of the development of the federally facilitated exchange found that, as of March 2013, the Administration had spent $840 million developing the exchange website, and development costs were still increasing at the time of the hearing.\textsuperscript{132}
- CMS had become increasingly frustrated with CGI, the main contractor, and declined to renew their contract. In January, CMS awarded Accenture a contract to continue work on the federal exchange for $91 million, but, according to GAO, the cost for the second contract ballooned to $175 million and was continuing to grow. CMS had not analyzed the cause of the cost increase.\textsuperscript{133}
- An operational readiness review scheduled for spring 2013 was moved to September 2013, weeks before the launch. Up until the launch, CMS officials testified before Congress that the exchange would be ready for launch.\textsuperscript{134}
- CMS testified that the back end of the exchange system responsible for paying plan issuers was not functional and that issuers were being paid based on estimation.\textsuperscript{135}
- GAO found 40 instances where individuals within CMS who did not have authority to change contract requirements did just that.\textsuperscript{136}

\textsuperscript{132} PPACA Implementation: Updates from CMS and GAO: Hearing Before the H. Comm. on Energy & Commerce, 113th Cong. 61 (July 31, 2014).
\textsuperscript{133} Id. at 77-79.
\textsuperscript{134} Id.
\textsuperscript{135} Id. at 60.
\textsuperscript{136} Id. at 71-72.
V.  Hearings from the 112th Congress

- “Health Care Issues Involving the Center for Consumer Information and Insurance Oversight,” Subcommittee on Oversight and Investigations, February 16, 2011.


“Health Care Issues Involving the Center for Consumer Information and Insurance”

Subcommittee on Oversight and Investigations
February 16, 2011

Witnesses
- Steve Larsen, Deputy Administrator and Director for the Center for Consumer Information and Insurance Oversight, Centers for Medicare and Medicaid Services
- Jay Angoff, Senior Advisor, Office of the Secretary of the Department of Health and Human Services, and former Director of the Office for Consumer Information and Insurance Oversight

Summary
The hearing examined the newly-created CCIIO. Members inquired about the justification for the creation of CCIIO, the responsibilities of CCIIO, and how it is funded. Members also sought explanations about Obamacare’s waiver program and how the law impacted existing state programs.

Findings
- The newly created CCIIO was responsible for overseeing new insurance market rules, the temporary PCIP, new medical loss ratio rules, and assisting states in complying with the new regulations imposed by Obamacare.\(^ {137}\)
- CCIIO provided waivers to roughly 900 health insurance plans, allowing them to delay compliance with Obamacare regulations. Otherwise, those health plans would have been forced to reduce benefits, raise costs to enrollees, or drop plans, because complying with Obamacare regulations would be too costly.\(^ {138}\)
- Some state programs that provided health care coverage to low-income individuals, such as CoverTN in Tennessee, were in danger of shutting down in 2014 because they needed a continuous waiver from CCIIO to continue operating. These programs needed this waiver because the plans did not meet all of the Obamacare requirements.\(^ {139}\)
- The number of individuals enrolled in the PCIP was far lower than expected. This was surprising because individuals previously unable to secure health insurance coverage because of pre-existing conditions were often cited as a reason to pass Obamacare. Congress appropriated $5 billion to fund the PCIP.\(^ {140}\)
- Only 12,000 individuals had enrolled in the PCIP by the end of 2010, although CMS’s Chief Actuary had previously predicted that 375,000 people would enroll. At the hearing, Mr. Angoff acknowledged that CMS’ prediction was inaccurate.\(^ {140}\)

\(^{138}\) Id. at 9.
\(^{139}\) Id. at 44.
\(^{140}\) Id. at 40.
“Waste, Fraud, and Abuse: A Continuing Threat to Medicare and Medicaid”

Subcommittee on Oversight and Investigations
March 2, 2011

Witnesses

- John Spiegel, Director of Medicare Program Integrity, Centers for Medicare and Medicaid Services
- Kathleen King, Director of the Health Care Division, U.S. Government Accountability Office
- Omar Perez, Assistant Special Agent in Charge, HHS Office of the Inspector General, Miami Regional Office
- The Honorable R. Alexander Acosta, former U.S. Attorney for the Southern District of Florida and current Dean of the Florida International University College of Law
- Craig H. Smith, former General Counsel of Florida’s Agency for Health Care Administration
- Sara Rosenbaum, Professor, The George Washington University School of Public Health and Health Services

Summary
The hearing examined waste, fraud, and abuse in the Medicare and Medicaid programs. Waste, fraud, and abuse in government programs is a persistent, bipartisan problem. Due to the immense scale of Medicare and Medicaid as a part of the budget, any percentage of wasted money is a large amount of money. Under the new authorities and extra resources provided to CMS under Obamacare, the amount of waste, fraud, and abuse of the Medicare and Medicaid programs should have dropped—but it did not. Both the prevention and screening mechanisms and the active pursuit of fraud detection and mitigation have been relatively ineffective.

Findings

- As Obamacare will increase the number of individuals on Medicaid coverage, members found it critical that the federal government address Medicaid and Medicare fraud. This is even more important considering Medicaid enrollees who are newly eligible under the law will receive a higher federal matching rate for funds spent on Medicaid coverage.141
- GAO issued a report in February 2009 indicating that Medicare continued to pay some home health agencies for services that were not medically necessary or not rendered. GAO made several recommendations to CMS in order to address this problem, but GAO testified at the hearing that CMS had not implemented any of them.142

142 Id. at 14.
“FY 2012 HHS Budget and the Implementation of Public Laws 111-148 and 111-152”

Subcommittee on Health
March 3, 2011

Witness

- The Honorable Kathleen Sebelius, Secretary, U.S. Department of Health and Human Services

Summary

The hearing examined HHS’ fiscal year 2012 budget request, with a particular focus on provisions related to Obamacare, and offered Members the opportunity to question Ms. Sebelius about the budgetary implications of the development, implementation, and administration of Obamacare. Several provisions of Obamacare provided mandatory funding for implementation of the law, meaning these funds were automatically available and not subject to the normal appropriations process. In addition, President Obama’s fiscal year 2012 budget request included several funding requests for administration of the new health care law.

Findings

- At the time of the hearing, a case was pending in federal court challenging the legality of Obamacare’s requirement that individuals enroll in health insurance coverage, known as the individual mandate. Ms. Sebelius declined to comment on whether HHS had done an impact assessment or made arrangements for if the Supreme Court declared the individual mandate unconstitutional.143
- A committee member expressed concerns with transparency around the CCIIO. The office was not authorized or mentioned in the law, yet President Obama’s fiscal year 2012 budget request included a $1 billion dollar increase that appeared to be intended for CCIIO.144
- Members questioned HHS’ decision to move CCIIO, the entity responsible for implementing Obamacare provisions related to private insurance, to be under the umbrella of CMS, which is responsible for public insurance.145
- Medium-sized businesses saw the costs of providing health insurance for employees rise as a result of new regulations imposed through Obamacare. Increasing benefits under Obamacare also increased the costs of insurance premiums paid by business-owners, and small business tax credits and waivers would not provide sufficient relief from higher costs.146

144 Id. at 2-3.
145 Id.
146 Id. at 118.
“True Cost of PPACA: Effects on the Budget and Jobs”

Subcommittee on Health
March 30, 2011

Witnesses
- Doug Elmendorf, Director, Congressional Budget Office
- Rick Foster, Chief Actuary, Centers for Medicare and Medicaid Services
- Douglas Holtz-Eakin, President, American Action Forum
- Larry Schuler, President, Schu’s Hospitality Group
- Philip K. Kennedy, President, Comanche Lumber Company
- David Cutler, Otto Eckstein Professor of Applied Economics, Harvard University
- Rick Poore, President, DesignWear/Velocitee

Summary
The hearing explored how Obamacare dramatically affected federal and state budgets by increasing federal and state health care spending through the creation of a new entitlement program and a large expansion of Medicaid. The hearing also sought to discover how new obligations from the law imposed on employers could have adverse consequences for both the cost of employer-provided health coverage and the labor market. Some of these employer obligations included a mandate to provide health coverage to employees, new disclosure and information obligations, and an expansion of tax-filing and administrative requirements.

Findings
- Administration officials claimed Obamacare’s $575 billion in Medicare cuts could both finance new entitlement spending and fund future Medicare benefits. However, as noted by the Congressional Budget Office, “[t]o describe the full amount of [Hospital Insurance Trust Fund] savings as both improving the government’s ability to pay future Medicare benefits and financing new spending outside of Medicare would essentially double-count a large share of those savings and thus overstate the improvement in the government’s fiscal position.”
- One of CMS’ actuaries provided evidence that Obamacare’s Medicare cuts were unsustainable—showing that 15 percent of Medicare-accepting hospitals, skilled nursing facilities, and home health agencies could be forced out of business because of Medicare-related requirements in the law.

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“The PPACA’s High Risk Pool Regime: High Cost, Low Participation”

Subcommittee on Oversight and Investigations
April 1, 2011

Witness
• Steve Larsen, Deputy Administrator and Director for the Center for Consumer Information and Insurance Oversight, Centers for Medicare and Medicaid Services

Summary
The hearing examined the PCIP created through Obamacare. Obamacare provided $5 billion in funding to provide health care coverage for individuals who had been locked out of the insurance market because of a pre-existing condition. The Chief Actuary of Medicare and Medicaid previously estimated that 375,000 people would enroll in the PCIP by the end of 2010, but only 12,000 actually enrolled by the end of 2010. Committee members questioned the source of the funding for advertising the program and the distribution of program funding across states.

Findings
• Not a single state projected that premium revenue would be near the cost of claims over the life of the PCIP.\textsuperscript{150} The transitional program ended on January 1, 2014, when Obamacare coverage began.
• California expected to accumulate $1 billion in claims over the lifetime of the program, with approximately 70 percent paid by the federal government.\textsuperscript{151}
• Alaska anticipated enrolling only 132 individuals, but anticipated spending $7 million over the life of the program—a cost of $56,000 plus per enrollee.\textsuperscript{152}
• \textit{The Washington Post} reported that “New Hampshire’s plan has only about 80 members, but they have actually spent nearly double the $650,000 that the state was allocated for this program. HHS agreed to give New Hampshire more money.” Mr. Larsen confirmed this.\textsuperscript{153}
• HHS used a Children’s Health Insurance Plan (CHIP) formula to allocate money between the states. The CHIP formula is used to determine the number of uninsured children in each state—not the number of uninsured children with pre-existing conditions.\textsuperscript{154}

\textsuperscript{151} Id.
\textsuperscript{152} Id. at 55-56.
\textsuperscript{153} Id. at 2, 55.
\textsuperscript{154} Id. at 1-2.

Subcommittee on Health

June 2, 2011

Witnesses

- Scott Harrington, Ph.D., Professor of Health Care Management and Insurance and Risk Management, Wharton School of the University of Pennsylvania
- Randi Reichel, Esq., Counsel, Mitchell, Williams, Selig, Gates & Woodyard, P.L.L.C., on behalf of America’s Health Insurance Plans
- Janet Trautwein, Chief Executive Officer, National Association of Health Underwriters
- Edward Fensholt, Senior Vice President, Lockton Benefit Group
- Katherine Hayes, Associate Research Professor, Department of Health Policy, George Washington University School of Public Health and Health Services
- Terry Gardiner, Vice President, Policy and Strategy, Small Business Majority
- Ethan Rome, Executive Director, Health Care for American Now
- Steve Larson, Director, Center for Consumer Information and Insurance Oversight, Centers for Medicare and Medicaid Services

Summary

The hearing examined the impact of major regulatory rules by HHS in implementing Obamacare and the Health Care and Education Reconciliation Act of 2010. Major portions of Obamacare required implementing regulations, with CMS largely responsible for developing and implementing these regulations. Members raised concerns that some of these regulations were duplicative, overbearing, and harmful to states and consumers.

Findings

- Obamacare created a federal rate review program, which not only duplicated what the states already did, but also provided the administration with authority to require health plans to justify rate increases, impose more paperwork and disclosure requirements, and empower the Secretary of HHS with continuing monitoring authority.155
- HHS issued rules imposing restrictions that health plans must comply with in order to keep their grandfathered status—making it harder for consumers to keep their existing health care plans.156
- The administration estimated that 49 to 80 percent of small-employer plans, 34 to 64 percent of large-employer plans, and 40 to 67 percent of individual plans would not be grandfathered by the end of 2013—meaning that Americans would, at that time, lose their grandfathered coverage and become subject to Obamacare’s costlier requirements.157

156 Interim Final Rules for Group Health Plans and Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act; Final Rule, 75 Fed. Reg. 34537 (June 17, 2010).
157 Id. at 34552.
“The Center for Consumer Information and Insurance Oversight and the Anniversary of the Patient Protection and Affordable Care Act”

Subcommittee on Oversight and Investigations
March 21, 2012

Witnesses
- Steve Larsen, Director, Center for Consumer Information and Insurance Oversight, Centers for Medicare and Medicaid Services
- The Honorable Ron Johnson, U.S. Senator, State of Wisconsin
- The Honorable Donna F. Edwards, U.S. Representative, State of Maryland

Summary
Members examined the costs of implementing Obamacare, both to individual consumers and to federal taxpayers. Members questioned the reasonableness of Congressional Budget Office projections for private plan coverage enrollment and costs, and examined the use of waivers. The hearing also explored the solvency of the Early Retiree Reinsurance Program, and the inaccurate enrollment projection for the PCIP.

Findings
- At the time of the hearing, over 1,700 companies, insurers and individuals had received waivers from HHS to delay implementing Obamacare regulations and avoid premium increases and loss of individual coverage.158
- As of February 2012, the Early Retiree Reinsurance Program spent $4.7 billion of its $5 billion budget, which was intended to last until 2014.159
- At the time of the hearing, only 50,000 individuals were enrolled in the temporary PCIP. Before the enactment of Obamacare, however, the CMS Chief Actuary had projected that 375,000 individuals would enroll in this program.160

159 Id. at 4.
160 Id. at 2.
“State of Uncertainty: Implementation of PPACA’s Exchanges and Medicaid Expansion”

Subcommittee on Health
December 13, 2012

Witnesses

- Gary Cohen, Director, Center for Consumer Information and Insurance Oversight, Centers for Medicare and Medicaid Services
- Cindy Mann, Deputy Administrator and Director, Center for Medicare and Medicaid Services
- Bruce D. Greenstein, Secretary, Department of Health and Hospitals, State of Louisiana
- Dennis G. Smith, Secretary, Department of Health and Human Services, State of Wisconsin
- Gary D. Alexander, Secretary, Department of Public Welfare, Commonwealth of Pennsylvania
- Joshua M. Sharfstein, M.D., Office of Secretary, Department of Health and Mental Hygiene, State of Maryland
- Andrew Allison, Ph.D., Director, Division of Medical Services, Department of Human Services, State of Arkansas

Summary

One-thousand days since President Obama signed Obamacare into law, and with less than 13 months before the full implementation of the law, states, governors, and the committee had yet to receive substantive responses from HHS or CMS regarding critical questions related to the policy and process of full implementation. States were left to seek guidance through the administration’s speeches and press reports. This hearing provided an opportunity for the administration to address these issues and hear the perspectives of state officials responsible for managing the consequences of Obamacare.

Findings

- Obamacare was expected to cost taxpayers $1.7 trillion and increase health care costs.\(^\text{161}\)
- Thirty-three months after the passage of Obamacare, states like Georgia had still not received any direction from HHS on the essential health benefits rule that went into effect the very next year—a rule necessary for operation of state exchanges.\(^\text{162}\)
- Uncertainty from the administration on how the thousands of provisions would be enacted made it difficult or, in some cases, impossible for states to successfully budget for the future.\(^\text{163}\)
- States were not only concerned about provider participation in Medicaid, but also that funding for other state programs like education and infrastructure would be reduced as health care costs consumed a greater portion of their overall budget.\(^\text{164}\)

\(^{162}\) Id. at 131.
\(^{163}\) Id. at 6.
\(^{164}\) Id. at 135.