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

TUESDAY, SEPTEMBER 29, 2015

House of Representatives,

Subcommittee on Oversight and Investigations

Committee on Energy and Commerce

Washington, D.C.

The Subcommittee met, pursuant to call, at 10:07 a.m., in Room 2123 of the Rayburn House Office Building, Hon. Tim Murphy [Chairman of the Subcommittee] presiding.

Members present: Representatives Murphy, Blackburn, Griffith, Bucshon, Flores, Brooks, Mullin, Collins, Cramer, Upton (ex officio), DeGette, Castor, Tonko, Yarmuth, Kennedy,

Green, Welch, and Pallone (ex officio).

Also present: Representatives Capps, Matsui, and Walden.

Staff present: Noelle Clemente, Press Secretary; Jessica Donlon, Counsel, Oversight and Investigations; Brittany Havens, Oversight Associate, Oversight and Investigations; Charles Ingebretson, Chief Counsel, Oversight and Investigations; Emily Martin, Counsel, Oversight and Investigations; Jessica Wilkerson, Oversight Associate, Oversight and Investigations; Christine Brennan, Press Secretary; Jeff Carroll, Staff Director; Ryan Gottschall, GAO Detailee; Tiffany Guarascio, Deputy Staff Director and Chief Health Advisor; Ashley Jones, Director of Communications, Members Services, and Outreach; Chris Knauer, Oversight Staff Director; Una Lee, Chief Oversight Counsel; Elizabeth Letter, Professional Staff Member; and Arielle Woronoff, Health Counsel.

Mr. {Murphy.} Good morning. The Subcommittee on Oversight and Investigation convenes this hearing today to examine the state health insurance marketplaces established under the Affordable Care Act.

We seek to understand the sustainability challenges these state exchanges continue to face. The Centers for Medicaid and Medicare Services has awarded $5.51 billion to the states to help them establish their exchanges. Let me repeat that. The states received 5.51 billion in federal taxpayer dollars to set up their own exchanges. Yet the ACA had no specific definition of what a state exchange was supposed to do, or more importantly, what it was not supposed to do. This is compensation without limitation.

Since the funding for these exchanges came from the entitlement side of the budget, there was no oversight throughout the appropriations process. There was no budget for state exchanges; rather grant money flowed freely and rewarded bureaucratic ``innovation.'' Of course, no one bothered to ensure that more money and more innovation didn't wind up creating more government bloat.

In fact, the states represented on our panel today--California, Connecticut, Hawaii, Massachusetts, Minnesota, and Oregon--were awarded over $2 billion of federal grant dollars. Notably, Oregon has already pulled the plug on its state exchange, and Hawaii is in the process of doing so.

The faucet of establishment grant money finally turned off at the end of 2014, when the states' exchanges were supposed to be self-sustaining. Despite this enormous taxpayer investment, state exchanges are still struggling. They continue to face IT problems, lower-than-expected enrollment numbers, and growing maintenance costs.

Here are just a few more recent headlines from news articles on the state exchanges: ``Obamacare Exchanges Are a Model of Failure,'' ``Nearly Half of Obamacare Exchanges Face Financial Woes,'' and another one, ``Obamacare's Failed State Exchanges.''

The alarm bells are not only being sounded in the media. Earlier this year, the Department of Health and Human Services Office of Inspector General alerted CMS Acting Administrator Andy Slavitt that the state exchanges may be using federal establishment grant funds for operational

expenses, which is prohibited by law. HHS OIG urged Administrator Slavitt to develop and issue clear guidance to the state exchanges on the appropriate use of establishment grant funds.

The guidance that followed, however, was still vague, permissive and lacked real-world examples. In fact, CMS has seemed more focused on doling out taxpayer dollars rather than overseeing how those dollars are spent.

The U.S. Government Accountability Office just issued a report demanding CMS conduct more oversight over states' health insurance marketplace IT projects. GAO found that CMS did not clearly document, define, or communicate its oversight roles and responsibilities to the states. Further, CMS often did not involve relevant senior executives to approve federal funding for states' IT marketplace projects, and although CMS established a process for testing state marketplace systems, these systems were not always fully tested.

We have a panel of witnesses today representing state exchanges, each with its own set of challenges and circumstances. The State of Hawaii was awarded $205 million,

but this past June, the Governor announced that its Hawaii Health Connector does not generate ``sufficient revenues to sustain operations'' and will shut down.

The Commonwealth of Massachusetts accepted $234 million for its Health Connector, but enrolled only 13 percent of its goal the first year, temporarily placed individuals in Medicaid because it couldn't determine eligibility, and cost Massachusetts an estimated $1 billion in additional funds.

The State of Minnesota initially received $155 million to launch its state exchange. Its exchange received an additional $34 million from CMS, in part to fund ongoing fixes to the IT system. Despite this infusion of funds, Minnesota has announced that it would revert to an old system next year for MinnesotaCare premiums because of the continued exchange problems.

The State of California received over $1 billion in federal grant dollars to establish its exchange, Covered California, the most of any state. Despite call center and Web site woes, California had the highest enrollment in 2014, but only retained 65 percent of its 2014 enrollees. This year, California's enrollment numbers reached 1.4 million,

falling 300,000 short of expectations.

CMS awarded the State of Connecticut approximately $176 million in federal establishment grants, and as of September 2015, approximately 96,000 individuals were enrolled in a plan. Only 50 percent of enrollees were previously uninsured.

The State of Oregon received $305 million in federal grant dollars exchange called Cover Oregon. Despite this heavy investment, Cover Oregon was dissolved early this year and transferred its responsibilities to the Department of Consumer and Business Services. The state is currently operating as a Federally Supported state-based Marketplace and relies on healthcare.gov.

So we are here today to understand the challenges these state exchanges face. Why are they struggling to become self-sustaining, especially given the extraordinary taxpayer investment? Is it a lack of accountability or oversight? Where has CMS been during this whole process, and is CMS encouraging fiscal restraint, or instead, taking a hands-off approach, which has allowed money to be spent uncontrollably? And where an exchange has decided to shut down, has CMS tried

to recoup any of the federal grant dollars? Lastly, are the exchanges doomed to fail? Hopefully, we will get answers to these important questions.

So I thank all the witnesses for testifying today.

[The prepared statement of Chairman Murphy follows:]

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Mr. {Murphy.} And I now recognize the Ranking Member from Colorado, Ms. DeGette, for 5 minutes.

Ms. {DeGette.} Thank you, Mr. Chairman.

I think we can all stipulate that some states have struggled with the technological hurdles of setting up their own marketplaces. We all knew that the Affordable Care Act would face challenges in some aspects of implementation, and I have been saying for a long time that it is this committee's role to conduct oversight and to improve that process, and so I am glad that we are having this hearing today, and I hope we have that goal in mind. I hope we are not hoping that the state exchanges fail. I hope we are hoping that we can improve it and we can make it better.

I think that despite the fact that we had a rough start in many places, the ACA is working and has greatly improved access to affordable, high-quality health insurance coverage.

In the last 5 years, we have made tremendous progress in helping millions of Americans throughout the country gain access to quality healthcare. Here are some notable statistics.

Since passage of the law more than 5 years ago, 17.6 million previously uninsured individuals have gained health coverage through the ACA's various provisions. Nearly 10 million consumers have enrolled in state and Federally Facilitated Exchanges. About 2.7 million of those individuals use state exchanges to select private plans. According to newly released data, the uninsured rate fell from 13.3 percent to 10.4 percent from 2013 to 2014, representing the largest single year reduction in the uninsured rate since 1987.

In 2014, hospital uncompensated care costs were $7.4 billion lower than 2013 levels as a result of exchange coverage and Medicaid expansion. The ACA also improved healthcare delivery systems, hospital readmissions are down, and indicators of patient safety like hospital-acquired conditions have improved significantly.

All of the states before us today have taken significant steps to improve health coverage for their residents. Their uninsured rates have plummeted due to their efforts to implement the Affordable Care Act.

Despite the technical and financial challenges that

confronted Hawaii's exchange, for example, its uninsurance rate has fallen and it now stands at only 5.2 percent. In just a few years since 2013, Minnesota has reduced the number of people without health insurance by more than 50 percent. Their uninsurance rate is now one of the Nation's lowest at 4.6 percent. Massachusetts, which already had one of the Nation's lowest uninsurance rates in the country, is down to just 3 percent in 2015, which is a 38 percent decrease since 2013. Connecticut, which now has a robust state-based marketplace, cut its uninsurance rate by more than 60 percent since 2012. In Connecticut, the uninsurance rate is 5 percent. And California, which also had one of the highest uninsurance rates in the country--it was 21.6 percent--has also managed to drop its rate by 45 percent since 2013. Now the uninsurance rate in California is 11.8 percent. And finally, Oregon, which had one of the Nation's highest uninsurance rates of 20 percent in 2013, also reduced its uninsurance rate by 55 percent to 8.8 percent today.

How did this all happen? How did states manage to insure so many millions of people? The Affordable Care Act has really provided these tools.

So as we discuss call centers, Web-based portals, and all these other things, let's not forget that the Affordable Care Act is really working to achieve its goals, and let's work together to try to make it better.

I want to thank you for having this hearing. I want to thank our Californians for joining us, Mr. Chairman, and I want to yield the balance of my time to Ms. Matsui from California.

[The prepared statement of Ms. DeGette follows:]

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Ms. {Matsui.} Thank you very much for yielding.

Peter Lee, thank you for coming here to testify today. And let me reiterate, the Affordable Care Act is working. California is an early adopter in so many areas, not the least of which is healthcare.

We have embraced the opportunities provided by the ACA to move our system from paying for volume to paying for value, and to reform our system to ensure that everyone has access to quality, affordable healthcare. Covered California has been an integral part of that, and I am happy to say that as of the most recently released census data, over 41,000 in my district of Sacramento and nearly 2 million Californians obtained health coverage from 2012 to 2014. That is an average of 5 percent reduction in the rate of uninsured. In Sacramento in 2012, 18 percent of the population was uninsured. In 2014, it was down to 12 percent. That rate is likely to be lower in 2015.

We need to continue to work to bring those numbers of uninsured down by supporting the advancements made by Covered California and other exchanges, not by moving backward.

Thank you, and I yield back.

[The prepared statement of Ms. Matsui follows:]

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Mr. {Murphy.} The gentlelady yield back.

And now on our side, if any members want to speak, I know Mr. Walden, who is not a member of this committee who wanted to sit in on this hearing, has the right to do so if you would like to be recognized for 2 minutes. Or first a member first and then you can yield to Mr. Walden for 2 minutes. Thank you.

Mr. {Bucshon.} Hi. I was a practicing physician before, and I want to just talk about the focus on insurance rates, people getting insurance. Coverage does not guarantee access to healthcare.

Deductibles are up. Premiums are up. The cost is being shifted to the people. The uninsurance rate may be down but the access, I would argue, has not improved dramatically. If you are a schoolteacher, a factory worker or other middle-class employee, if you have a $5,000 family deductible, maybe as high as $10,000, do you have affordable health insurance? I would argue that you do not.

In many states, physicians aren't taking new Medicaid patients. I know this because I am a physician and I talk to

physicians all the time. In fact, many physicians aren't taking new Medicare patients, let along Medicaid patients, so I just wanted to clarify that in focusing only on uninsurance rates is not the only parameter to look at when you are looking at the ability of our citizens to access quality, affordable healthcare, and I yield to Mr. Walden.

[The prepared statement of Mr. Bucshon follows:]

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Mr. {Walden.} I thank the gentleman, and I thank the committee for letting me participate in this hearing.

When I was in the state legislature, the Oregon Health Plan itself was passed, and when I became Majority Leader, we realized there had to be a lot of work done to implement the Oregon Health Plan, and I put together a select committee that did that, and I chaired it, so I concur with those who think we need to do more to reform delivery of healthcare and access to it. I have a pretty good record on doing both.

Mr. Chairman, I want to thank you for holding this hearing on this issue, though. Mr. Allen, thank you for coming out from Oregon to attend, and as you know, Oregon received $305 million in federal grants to build Cover Oregon. Only California and New York, states with about nine and four times the population, respectively, received more. So we have got a lot of money out there.

The exchange was launched with much fanfare. As an Oregonian, I heard the sort of kitschy ``Long Live Oregon'' jingle to encourage Oregonians to sign up. The problem was, when the lights came on and the curtain went up on Cover

Oregon, it failed to sign up a single person online in one sitting. Not one person was able to sign up that way. Oregonians were forced to sign up using paper applications. The state then decided to abandon the state-run exchange IT platform and move on to healthcare.gov, the federal exchange. Eventually, the legislature voted to shut down the entire program, which it did on June 30th. Hundreds of millions of taxpayer dollars apparently down the drain.

Last February, Chairman Upton, Chairman Pitts, Chairman Murphy and I requested an independent federal investigation into the failure of Cover Oregon. While the GAO did some good work on state exchanges generally, many questions about Oregon remain unanswered. How did this happen? Who was in charge? What could be done to make sure this never happens again anywhere in the country? We are still awaiting the answers, frankly.

Moving forward, the move to federal exchange poses a whole new set of questions. Mr. Allen, I understand you weren't there running this thing so, you know, we are not here to point fingers; we are here to get answers to how this happened and what we do now and how we are going to fund the

next phase of this. I still don't have a clear understanding what happened to $305 million establishment grants, and did CMS even try to recoup this? What was the role of CMS in all this to observe how this money, taxpayer money, was being spent? Did they do their due diligence?

In spite of your repeated assurances that the Oregon exchange is financially self-sustaining, I think there are still questions over how the state will pay the Federal Government for using healthcare.gov when it is required to do so in 2017. There are also concerns with significant insurance rate increases. I know in your testimony you state the rate increases are a result of market rebalancing itself. Whether or not it is rebalance or whether it is indicative of future rate hikes, I think remains to be seen.

The collapse of Cover Oregon, though, is clearly an epic disaster for Oregonians and for taxpayers across the United States. Frankly, the aftermath hasn't inspired additional confidence in our state government or CMS. I am deeply disturbed about the role of the former Governor, who has had to resign, and the role of his campaign consultants in calling the shots.

So I hope the hearing will help us learn more about what happened, why it happened, and what steps can be taken to make sure that this sort of debacle never happens again.

Thank you, Mr. Chairman. I yield back the balance of my time.

[The prepared statement of Mr. Walden follows:]

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Mr. {Bucshon.} I yield back.

Mr. {Murphy.} The gentlemen yield back.

I now recognize the Ranking Member of the full committee, Mr. Pallone, for 5 minutes.

Mr. {Pallone.} Thank you, Mr. Chairman.

Over 5 years ago, we passed the Affordable Care Act and fundamentally changed the health care system in this country. We expanded access to healthcare for millions of Americans and ensured that no individual could be denied coverage for arbitrary or discriminatory reasons. We guaranteed that insurance companies were in the business of making our citizens healthier, not just making a profit. And we strengthened Medicare and put the program on sounder financial footing to preserve and protect it for generations of Americans to come.

Today, my Republican colleagues will tell a different story. We will hear a lot about technical glitches, inefficiencies, and broken IT systems. If we just listen to the Republicans' side, we are led to believe we have poured money down the drain and seen no benefit.

The reforms of the Affordable Care Act are a complex undertaking and no doubt there are lessons to be learned from its implementation, and we should learn those lessons and use them to improve going forward. But that doesn't mean we should lose sight of the bigger picture.

Make no mistake: the Affordable Care Act is working. We are seeing its successes throughout the country, and the data is there to prove it. Recent census data shows that the uninsured rate has significantly declined in every state. Seventeen point six million Americans who didn't have coverage before the law went into effect now have insurance. States that chose to embrace the full measure of the law and expand their Medicaid programs and establish state-based marketplaces have seen the greatest gains for their citizens, and this success is true for the six states we have joining us here today.

Despite early technological challenges in some of these states, everyone here today has expanded access to care and significantly lowered their numbers of uninsured.

Now, it is of course also important that we look at how state-based marketplaces could be run more efficiently and

effectively, and how we can continue to enhance the health care delivery system in this country. But let's do this with an eye for improvement. Let's not use this hearing merely as an opportunity to score political points. Let's have a discussion about how to reach our remaining uninsured, how to continue to improve the consumer experience in year three of exchange enrollment, and how to best address the challenges that remain.

With that, I would like to yield my remaining time to split between Congressman Kennedy and Representative Capps. I will initially yield to Mr. Kennedy.

[The prepared statement of Mr. Pallone follows:]

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Mr. {Kennedy.} I want to thank the Ranking Member for yielding.

It is always nice to see a familiar face amongst our witnesses at hearings, and I am pleased to have a chance to welcome Louis Gutierrez this morning. Mr. Gutierrez throughout his career has championed the use of technology to help government do its job better, smarter and more efficiently whether it is as our Commonwealth's Chief Information Officer, Principal of the Exeter Group, or now as the Executive Director of the Massachusetts Health Connector. He has pursued innovative strategies to improve the delivery of critical services to people who need them most, particularly when it comes to health care.

In his latest role, he has worked diligently to ensure that Massachusetts maintains its proud status as a state with one of the lowest uninsured rates in the country. As our Nation's uninsured rate continues to fall nearing single digits, thanks to the Affordable Care Act, I believe it is critical that we replicate the successes we have seen in our Commonwealth across the country.

I am looking forward to hearing more about your efforts to make our system more effective and more efficient, sir, as well as any best practices that you have encountered that could be applied across this country.

Thanks very much for being here. Yield back.

[The prepared statement of Mr. Kennedy follows:]

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Mr. {Pallone.} I yield the remaining time to Mrs. Capps.

Mrs. {Capps.} Thank you to the Ranking Member for yielding and also letting me waive on to this subcommittee today for what I know to be a very important discussion.

I wanted to come and personally welcome Mr. Lee, the Executive Director of Covered California, which is my state's health insurance marketplace, which has helped connect so many of my constituents with health insurance. California made a conscious decision to be an active player with the Affordable Care Act implementation, and when there are problems, they have been responsive, holding insurance companies accountable and focused on making Covered California a national leader. Thanks to their efforts, we have cut our state's uninsurance rate by 28 percent, pretty remarkable, in my opinion.

California shows that when a state is invested and buys into the goals of the Affordable Care Act, prices can be held under control, and quality plans can be made available for purchasers.

I look forward to hearing more about how Covered California could perhaps serve as a role model for other states looking to get the best value for their residents while promoting high-quality care, and I'll yield back to the Ranking Member.

[The prepared statement of Mrs. Capps follows:]

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Mr. {Pallone.} I yield back.

Mr. {Murphy.} Thank you. The gentlelady yields back.

I now ask unanimous consent that written opening statements of members of the subcommittee will be introduced into the record. I know Mr. Upton will have something. We will leave it open for other members if they wish to do so. So without objection, the documents will be entered for the record.

[The information follows:]

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Mr. {Murphy.} To our witnesses, you are aware that the committee is holding an investigative hearing, and when doing so has the practice of taking testimony under oath. Do any of you have any objections to testifying under oath? All the witnesses say no.

The Chair then advises you that under the rules of the House and the rules of the committee, you are entitled to be advised by counsel. Do any of the witnesses desire to be advised by counsel today? And all he witnesses declined.

In that case, would you all please rise, raise your right hand, and I will swear you in.

[Witnesses sworn.]

Mr. {Murphy.} You are now under oath and subject to the penalties set forth in Title XVIII, section 1001 of the United States Code. We will have you each give a 1-minute-- or excuse me, a 5-minute summary of your statement. We are not trying to rush you.

We will begin with Mr. Allen. You are recognized for 5 minutes. Please make sure your microphone is on. Pull it very close to you so we can hear you. Thank you.

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^TESTIMONY OF PATRICK ALLEN, DIRECTOR, OREGON DEPARTMENT OF CONSUMER AND BUSINESS SERVICES, STATE OF OREGON; ALLISON O'TOOLE, INTERIM CHIEF EXECUTIVE OFFICER, MINNESOTA HEALTH EXCHANGE, STATE OF MINNESOTA; LOUIS GUTIERREZ, EXECUTIVE DIRECTOR, MASSACHUSETTS HEALTH CONNECTOR, STATE OF MASSACHUSETTS; JEFFREY M. KISSEL, CHIEF EXECUTIVE OFFICER, HAWAII HEALTH CONNECTOR, STATE OF HAWAII; PETER LEE, CHIEF EXECUTIVE OFFICER, COVERED CALIFORNIA, STATE OF CALIFORNIA; AND JAMES R. WADLEIGH, SR., CHIEF EXECUTIVE OFFICER, ACCESS HEALTH CT, STATE OF CONNECTICUT

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^TESTIMONY OF PATRICK ALLEN

} Mr. {Allen.} Thank you, Chairman Murphy, Ranking Member DeGette, members of the subcommittee. My name is Patrick Allen, and I'm the Director of the Oregon Department of Consumer and Business Services. We're the state's largest consumer protection and business regulatory agency. Our mission it to serve and protect consumers and workers in Oregon while supportive a positive business climate in the

state. My agency is responsible for regulating the financial services industry including banks, credit unions, mortgage lenders, and other non-depository programs; all aspects of insurance including life, health, property and casualty; our system of worker health and safety including Oregon OSHA and the state system of workers' compensation insurance; as well as statewide construction standards.

As of 90 days ago, after a brief transitional period, the department assumed responsibility for Oregon state-based health insurance marketplace. I appreciate the opportunity to be here today and to talk to you about the marketplace services in Oregon and my agency's plans going forward.

You have my written statement so I will just briefly summarize with three points. First, Oregon's marketplace is successful. Nearly 70,000 Oregonians enrolled in coverage during open enrollment for 2014 despite needing to navigate a hybrid paper and automated system. Using healthcare.gov, that number increased to over 100,000 for 2015 open enrollment. Between those private health insurance results and expansion of the Oregon Health Plan, our state's Medicaid program, the rate of uninsured in Oregon declined from over

14 percent to under 9 percent, one of the largest decreases in the country.

Second, Oregon's health insurance marketplace is healthy, competitive, and sustainable. For 2016, 11 companies will over Oregonians 120 individual plans at various coverage levels. Oregon's individual insurance market was one of the lowest priced in the Nation in 2015. We're in the process of rebalancing that market to ensure its long-term sustainability, and while the percentage increases in rates have been significant, the resultant rates are very comparable to those available in neighboring markets in California and Washington and remain very affordable.

Third, the marketplace as run by the State of Oregon is efficient, financially sustainable, and subject to ongoing oversight. Because of economies of scale and other efficiencies, we as a state agency are able to operate the marketplace with about 60 percent fewer staff than the previous organization. We're completely financed by an assessment on participating insurers with no state taxpayer or federal grant funding involved. While we have access to the federal platform currently at no direct cost for the 2015

and 2016 plan years, we have adequate financial capacity to pay a reasonable technology cost to the Federal Government, another state in a partnership arrangement, or to a private vendor should that be necessary.

I'd be happy to answers questions that you might have. Thank you very much.

[The prepared statement of Mr. Allen follows:]

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Mr. {Murphy.} Thank you.

Now, Ms. O'Toole, you are recognized. I am sorry I didn't introduce you before, Mr. Allen, the Department of Consumer and Business Services, the State of Oregon, but this is Allison O'Toole, the Interim Chief Executive Officer for MNsure, State of Minnesota. You are recognized for 5 minutes. You know the drill with the microphone.

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^TESTIMONY OF ALLISON O'TOOLE

} Ms. {O'Toole.} Thank you. Good morning, Chairman Murphy, Ranking Member DeGette, and distinguished members of the subcommittee. My name is Allison O'Toole, and I'm the interim CEO of MNsure, which is Minnesota's online health insurance marketplace. Thank you for inviting me here today. I'm honored to have this chance to share with you some of the success we're seeing in Minnesota.

Let me begin with an update on how MNsure is positively impacting Minnesotans. Building the MNsure marketplace was no easy task. However, we've made tremendous progress providing hundreds of thousands of Minnesotans with affordable, comprehensive coverage.

For the purposes of background, I want to provide the committee with a full picture of where we are today. Since October 1st of 2013, more than 500,000 Minnesotans have used MNsure to shop, compare and enroll in quality, affordable coverage. As a result, Minnesota has the lowest rate of uninsured in state history. In our first year, the state's

uninsured rate dropped by a whopping 40 percent, and now, nearly 95 percent of Minnesotans are covered, and they're saving money, more than $31 million in premium payments through tax credits in 2014 alone.

And I'm pleased to report that MNsure is financially sustainable. We have a balanced, conservative, sustainable budget that's based on real numbers and real experience.

And we've come a long way since our launch 2 years ago. The last 18 months have brought measurable progress along with a deep commitment to transparency and accountability. And most importantly, we're making a difference in the lives and the health of Minnesotans, Minnesotans like Richard Handeen, a cattle farmer in rural Minnesota, who with his newly purchased coverage through MNsure went to the doctor for the first time in years, discovered he had cancer, and was able to successfully treat it. Today, Richard's cancer free. And Minnesotans like Jake Sanders. Jake is a small business owner. He and his wife have three small children, one who's had a preexisting condition since birth. MNsure allowed Jake to find a lower-cost policy for his family, and today he knows his son will be covered.

Covering more Minnesotans has always been our foundational goal since day one, and MNsure's technology performance has improved dramatically since then. After lots of hard work, there is a night-and-day difference between the first and second open enrollment periods. Call center wait times dropped dramatically in year two. Minnesotans were able to complete the enrollment process with relative ease, and our dedication to improving MNsure continues today.

This is important to us because we think no one should struggle to find a health insurance plan that fits their needs. It's also part of making sure that Minnesotans can live their lives and focus on the important things like going to work, taking care of their families, and starting a business instead of worrying about how they're going to pay for big medical bills.

As we approach MNsure's third open enrollment period, there's plenty of work ahead. Our IT teams are hard at work adding functionality, improving Web site performance, and ensuring a positive consumer experience. There is also a strong focus on improving MNsure's functionality for Medical Assistance and Minnesota Care.

One final point that sets us apart. In Minnesota, our state created a 29-person bipartisan healthcare task force of healthcare and community leaders will help address questions like access to care and financing. Minnesota is taking oversight and accountability seriously, and I am thankful to these people for their thoughtful approach to addressing many tough questions that remain for our healthcare programs.

Thank you again for inviting me here today. As MNsure's Interim CEO, my eyes are squarely focused on preparing for the third open enrollment period, improving the customer experience for Minnesotans, setting and implementing a smart budget, and making sure as many people as possible take advantage of the products MNsure has to offer. We want to see people like Richard and Jake and their families get the care they need and deserve. I look forward to your questions, and thank you again for having me.

[The prepared statement of Ms. O'Toole follows:]

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Mr. {Murphy.} Thank you, Ms. O'Toole.

And now we recognize Mr. Louis Gutierrez, Executive Director of Massachusetts Health Connector from the State of Massachusetts. You are recognized for 5 minutes.

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^TESTIMONY OF LOUIS GUTIERREZ

} Mr. {Gutierrez.} Chairman Murphy, Ranking Member DeGette, and distinguished members of the subcommittee, good morning. Thank you for the opportunity to testify regarding the Massachusetts Health Connector Authority, our state-based marketplace. My name is Louis Gutierrez and I have served as the Executive Director of the Health Connector since February of this year following the election of Massachusetts Governor Charlie Baker.

As the new State Administration took office this year, Massachusetts was partway through a second attempt to implement a health insurance eligibility and enrollment system to enable Affordable Care Act access to our residents.

While a proficient eligibility determination front-end was completed for this year's open enrollment, a range of back-office enrollment functions remained under development. Much of this year has been devoted to stabilizing operations and completing the system foundations to support Massachusetts' state-based marketplace.

Upon taking office, the Baker Administration moved to effect several substantial changes in approach to the Connector Authority. First, it altered the governance structure, placing its Secretary for Health and Human Services as chair of the Health Connector Board of Directors. The Secretary for Health and Human Services also oversees the state's Medicaid organization, and this change reflects the importance of successful coordination between the exchange and the state Medicaid agency. Second, it replaced executive management at the Health Connector, hiring for experience in large-scale systems implementations along with a new Chief Operating Officer, a woman distinguished in Massachusetts payer operations. Third, it appointed an outstanding program management lead to lead the combined health insurance exchange/Medicaid integrated eligibility systems implementation effort. Fourth, because the health insurance exchange and integrated eligibility initiative is shared between the Health Connector and the state's Medicaid organization, it reestablished a formal governance structure for the project, led by the state Medicaid agency, the Health Connector, and the state's central Information Technology

Division. Fifth, it undertook a 6-week intensive examination of operational processes to assess the state of Health Connector operations, and to lay a path for resolving existing problems; and finally, it completed the process for transferring individuals from temporary coverage where they had been placed in 2014 to appropriate placement in either Qualified Health Plans or Medicaid.

The Health Connector is now better situated to service the needs of the residents of Massachusetts. For 2016, we have 11 insurers presenting 83 Qualified Health Plans on the Connector and 25 plans across five insurers with Qualified Dental Plans. Our enrollment totals over 175,000 Qualified Health Plan enrollees, and 40,000 Qualified Dental Plan enrollees. Massachusetts, as noted earlier, is one of five states with less than 5 percent underinsured. We have significantly expanded customer service components for this fall's open enrollment period, with 200 additional customer service hours, including later evenings, Saturdays and Sundays, four additional walk-in centers, and new access to online customer self-service so that users may update their applications and make changes to their accounts without

needing to call the call center.

Massachusetts believes that states need flexibility to continue to innovate in healthcare reform and meet local needs. We could not continue to provide Massachusetts-specific benefits to low-income populations without the flexibility of a state marketplace. For example, our ConnectorCare program, which adds subsidies for individuals earning less than 300 percent of the federal poverty level. We desire the ability to recognize local market conditions and the definition of small business size.

Going forward, there are potentially more seamless ways to integrate Medicaid and exchange eligibility and subsidies. It is important that states be offered that chance to make this law work better for everyone. Massachusetts remains committed to making sure that those who need health insurance can obtain it both now and in the future with the state-based marketplace as one component of that strategy. Thank you.

[The prepared statement of Mr. Gutierrez follows:]

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Mr. {Murphy.} Thank you, Mr. Gutierrez.

We now turn towards Mr. Jeff Kissel, the Executive Director of the Hawaii Health Connector from the State of Hawaii. You are recognized for 5 minutes.

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^TESTIMONY OF JEFFREY M. KISSEL

} Mr. {Kissel.} Thank you. Good morning, Chairman Murphy, Ranking Member DeGette, honorable members of the Oversight and Investigations Subcommittee. It's a pleasure to come before you to report on the activities of the exchange, but before doing so, I'd like to explain the healthcare environment in Hawaii to help you understand the context of my remarks.

Yes, Hawaii has among the lowest insurance rates in the Nation. This is, however, because of the passage of the Hawaii Prepaid Healthcare Act of 1974. At that point the state undertook as a matter of policy the responsibility for providing access to healthcare and wellness resources for virtually every employed resident of our state. Over the past half-century, both Democratic and Republican administrations in Hawaii have not only supported the provisions of the Act, they've developed substantial resources and focused on leading the insurance and healthcare industry to actually delivering these services to an ever-

increasing percentage of our population.

The evidence of our success is clear. Hawaii is not ranked among the states with the lowest rates of diabetes, obesity, infant mortality, and other critical public health metrics, our population, however, enjoys a longer lifespan, and, by any measure, healthier outcomes from the diseases and other health issues faced by a diverse ethnic and cultural mix. I believe that this is a direct result of our community's ability to develop excellent healthcare access and secure its viability through our Prepaid Healthcare Act with its employer mandate to provide insurance.

In this context, the passage of the Affordable Care Act was widely viewed as an opportunity to extend access to healthcare and wellness resources to even more of Hawaii's population. For the most part that effort has been successful. Taken together, the expanded Medicaid program and the Affordable Care Act insurance policies have reduced the Hawaii uninsured rate, already low, by more than half.

Unfortunately, however, a lack of planning, unclear business process design, and utterly inadequate program management as the technology systems were implemented,

resulted in both excessive spending and delays in delivering these important services to the people who most needed it in our state. Since I became Executive Director, however, the team at the Hawaii Health Connector have come a very long way toward achieving the goal of harmonizing the benefits of Hawaii's forward-thinking Prepaid Healthcare Act with the provisions of the Affordable Care Act.

Our business processes now utilize technology to support a well-trained outreach team of workers as they assist our customers with the enrollment process. This change in approach converted our computer systems to a resource rather than a barrier to entry.

In December of 2014, we produced a comprehensive 10-year strategic and business plan, a copy of which is attached to this testimony. It detailed a report on our condition, the activities, and sustainability required by both the Affordable Care Act and state enabling legislation. It also presented both the advantages and the challenges as the Exchange commenced its second full year of operations. In that plan we explained to CMS and our State Administration how we would meet the sustainability and other important

requirements of the Affordable Care Act. We recommended a financial approach that relied on debt financing and generating enrollment--revenue from about 70,000 enrollees at the rate of about $12 million a year.

I'm pleased to say that our enrollment in 2014 and 2015 increased by more than 400 percent. It is nearly now 40,000. Moreover, the Hawaii Health Connector was able to add thousands of individuals to the expanded Medicaid program, further reducing the impact of uncompensated costs in our community.

Even though we were able to overcome first-year technology challenges, it became clear to all of us that the cost of maintaining, upgrading and ultimately replacing the technology had the potential to exceed its initial cost. While the Federal Government funded the initial costs, the people of Hawaii are responsible for the ongoing costs. After consulting with CMS, our State Administration elected to migrate to healthcare.gov as a supported state-based exchange to assure continued access to Qualified Health Plans for our residents. I fully understand the basis for that decision as the risks of operating independently are greatly

mitigated by the assistance of Healthcare.gov technology and support from CMS.

We're continuing to work to harmonize the provisions of the Affordable Care Act with Hawaii's legislative framework to continue to provide outstanding access to healthcare and wellness resources to virtually every resident and, when necessary, any of the many millions of visitors we welcome to our state each year.

Honorable members, we thank you for your time, dedication and your interest in improving the quality of life in our country by addressing this important issue before the people of the United States. I look forward to any questions you might have.

[The prepared statement of Mr. Kissel follows:]

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Mr. {Murphy.} Thank you.

I now recognize Mr. Peter Lee, the Executive Director of Covered California from the State of California. Mr. Lee, you are recognized for 5 minutes.

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817 ^TESTIMONY OF PETER LEE

818 } Mr. {Lee.} Good morning, Chairman Murphy, Ranking
819 Member DeGette, and distinguished members of the committee,
820 and the members from California, Matsui and Capps, who were
821 able to join you. It's an honor for me to be here in front
822 of you before the subcommittee to speak about the success
823 we've had in California in implementing the Affordable Care
824 Act.
825 This landmark legislation has dramatically changed
826 healthcare in California and the Nation by expanding needed
827 coverage but also by putting in place new protections that
828 benefit all Americans. Today I'm pleased to address how
829 Covered California is working, what we consider to be the
830 keys to our success, and how we are actively working to
831 improve what we are doing in California.
832 First, let me note that California is a state that
833 embraced the Affordable Care Act from day one. We were the
834 first state to establish legislation to establish a state-
835 based exchange. That legislation was passed with a

Republican Governor and a Democratic legislator--legislature.

Since then, some of the tools we put in place to build on are being an active purchaser. Covered California chooses which plans to participate. We negotiate with them to make sure the rates, their quality, their networks provide the best value to consumers.

Second, we provide standard benefit designs. Covered California sets the benefits so they benefit consumers. In California, in the individual market, you will not see consumers surprised by not getting access to primary care because they need to pay a deductible first. That's a standard that we have in place that primary care access is not subject to a deductible for any Californians at Silver and above. We have tools, but that also means that the health plans are competing on an apples-to-apples basis.

Third, California has expanded its Medicaid program. Under Governor Jerry Brown and our legislature, deciding to expand Medicaid has meant that millions of Californians have had the benefit of coverage they would not otherwise have.

So in California, the Affordable Care Act is working. Covered California is working. Sixty-eight percent of

California's voters recognize that and say that they've seen the Affordable Care Act working in our state. First and foremost, that's because of strong enrollment. Today we have over 1.3 million Californians covered by Covered California but there's an additional 500,000 that had coverage in the last year and a half that aren't covered today. That's not because they're uninsured. They're now with employer-based coverage or Medicaid or Medicare coverage. But exchanges across the Nation are providing a safety net and a way station of individuals moving into the employer-based coverage with other options they did not have before. This is part of why all of us will have about a one-third of our population turn over every year. We are now the glue that is holding together the employer-based system and public programs.

In California, insurance rates are under control. For 2016, the average rate increase in California will be 4 percent. In 2015, the average rate increase was 4.2 percent. Two years in a row, we've proven the naysayers wrong. This comes on the heels of years of double-digit rate increases in the individual market.

Now, let me make clear that in California, the beneficiaries of those low rates are not just those in Covered California but the entire individual market. We have about 1 million individuals that buy insurance not through Covered California. They benefit from our negotiating on behalf of consumers.

How did we get there? We have a good risk mix. We have a young mix, a diverse mix that reflects the population of California, and we take that data and we meet with our health plans to the tune of $300 million of premium savings by showing the plans the data that there's a good risk mix. They've demonstrated that in the rates they've put before Californians.

Coming forward in 2016, there's going to be more plan choices. We're going to be expanding from the 10 plans we have today to 12 health plans. We're adding Oscar and UnitedHealthcare. This means that for virtually every Californian, they will have at least three health plans to choose, and the vast majority will have four, five, six plans to choose. But we don't think more is always better. We pick plans. We make sure that they're delivering value and

they're building on the platform that Congresswoman Matsui noted of making sure that we're changing the delivery system and lowering costs for everybody over the long term. That's the future that we all need to be looking for of building a delivery system that puts patients first, that makes sure that care is delivered when they need it. Covered California is delivering on that promise.

We still have work to do, and I look forward to taking your questions as we talk about our path forward in the future.

Thank you very much.

[The prepared statement of Mr. Lee follows:]

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Mr. {Murphy.} Thank you, Mr. Lee.

And now, finally, we turn to Mr. Jim Wadleigh. Am I pronouncing that correctly?

Mr. {Wadleigh.} Yes, you are, sir.

Mr. {Murphy.} The Executive Director--Chief Executive Officer--excuse me--of Access Health Connecticut for the State of Connecticut. You are now recognized for 5 minutes.

|

^TESTIMONY OF JAMES R. WADLEIGH, JR.

} Mr. {Wadleigh.} Good morning, Chairman Murphy, Ranking Member DeGette, and members of the subcommittee. Thank you for this opportunity to offer testimony as you examine the condition of several state-based health insurance marketplaces.

My name is Jim Wadleigh, and I'm the Chief Executive Officer of Access Health Connecticut, one of the Nation's best and healthiest state marketplaces.

Access Health Connecticut was established in 2012 by Governor Malloy, Lieutenant Governor Wyman, and the Connecticut General Assembly to expand access to health insurance. Their leadership, and the support of our Board of Directors and many public and private partners, has been critical to our success. So, too, has the commitment of the Access Health Connecticut team.

Since we launched our state-based marketplace 2 years ago, we've worked together to meet the unique needs of our citizens while staying focused on innovation, collaboration

and expanded coverage.

Today, I am pleased to report that 760,000 state residents and small business owners have used the exchange to enroll in qualified health plans and Medicaid. We have exceeded federal enrollment goals by more than 200 percent. We've cut Connecticut's uninsured rate in half, from 8 percent to less than 4 percent. That's 128,000 people who are now more likely to go to a doctor.

We've have worked with Connecticut's Insurance Commissioner to keep costs down. Rates for our most affordable plans have remained flat for the last 2 years. We have become a self-sustaining exchange well ahead of next year's deadline, and we no longer use state or federal funding for our operating costs.

How did we achieve this success? We heeded the old adage: ``An ounce of prevention is worth a pound of cure.'' From the very beginning, we kept things simple and stayed true to our mission. Our exchange is considered a national model because of its straightforward design and ease of use. Over 96 percent of Access Health Connecticut customers say they are satisfied. The development of this stable, user-

friendly Web site was overseen by an executive leadership team with a passion for health care and decades of experience in the industry. We set priorities, established clear business requirements, and tightly managed the scope of this project.

To reduce the number of uninsured residents, we conducted extensive research and partnered with numerous state- and community-based organizations. This helped us better understand and reach those individuals and families most in need. We used creative, award-winning marketing tactics, while sticking to a simple enrollment message.

In addition to putting feet on the street, we opened a store on Main Street. It's actually one of two brick-and-mortar storefronts we operate. Taking a page from Apple's customer service playbook, we provide free, professional guidance and a personal touch to help consumers navigate the complexities of health insurance.

The success of these stores has exceeded expectations. Not even the blizzard of 2015, which dumped two and a half feet of snow across the state, could keep people away. Our year-over-year foot traffic in the month of January more than

doubled.

Access Health Connecticut is the first state-based exchange to implement a mobile platform that integrates closely with our backend systems. This nationally recognized, award-winning mobile app allows customers to create accounts, comparison shop, submit documentation, and purchase plans all from the palm of their hand.

Our ability to collaborate across boundaries and streamline the enrollment process for both health insurance and state human services has also been recognized by our peers. Last year, Access Health Connecticut and the Connecticut Department of Social Services were honored for creating a multi-channel, ``no wrong door'' experience for consumers.

Solid technology and a commitment to exceptional customer service have made Access Health Connecticut a model for other states. As one Forbes columnist wrote, ``Connecticut isn't just ahead of every other state; it's in its own league entirely.''

We intend to strengthen and grow that league. We will continue to collaborate with other state-based exchanges, as

we did with Maryland, to share our expertise, business practices, and technology. We will continue to innovate and develop new strategies that expand access to health care, promote health and wellness, and eliminate health disparities. We will continue to explore new opportunities to reduce costs, safeguard our long-term financial stability, and keep premiums affordable for all consumers.

And we will never lose sight of why we do this. It's for hardworking people like Walter Gualteri, who operates a small tailoring and dry cleaning shop in Newington, Connecticut. Once Walter hit 50 and developed a chronic health issue, his insurance company began raising his rates on a regular basis. Month after month, year after year, Walter lived in fear of losing his coverage. Through Access Health Connecticut, Walter found a cheaper plan that lets him keep his own doctors and afford his prescriptions. Today, at age 60, Walter says he's living the American dream and has the peace of mind that comes with knowing he can't be dropped because of age or preexisting condition.

Thank you for the privilege of appearing before this subcommittee. I welcome the opportunity to answer any

questions you may have.

[The prepared statement of Mr. Wadleigh follows:]

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Mr. {Murphy.} Thank you, Mr. Wadleigh.

I now recognize myself for 5 minutes of questions. I'm going to ask a number of questions, so please answer them quickly if you could.

First, I want to ask each of you if your state has spent any federal establishment grant dollars on operational costs this year for your state exchange.

Mr. Allen?

Mr. {Allen.} We do not believe so.

Mr. {Murphy.} Ms. O'Toole?

Ms. {O'Toole.} No.

Mr. {Murphy.} Mr. Gutierrez?

Mr. {Gutierrez.} We have--

Mr. {Murphy.} Microphone, please.

Mr. {Gutierrez.} We have not spent outside any written authority from CMS.

Mr. {Murphy.} Mr. Kissel?

Mr. {Kissel.} We have one item that we are trying to reconcile with our auditors before engaging in spending it. It's in a segregated account.

Mr. {Murphy.} Mr. Lee?

Mr. {Lee.} We are spending establishment funds to continue the final establishment of our exchange, federal dollars but no operational funds.

Mr. {Murphy.} Mr. Wadleigh?

Mr. {Wadleigh.} No.

Mr. {Murphy.} Can I ask each of you what your operational costs are this year for the exchange?

Mr. Allen?

Mr. {Allen.} For the current state fiscal year, which began July 1st, our operational costs are about $12 million.

Mr. {Murphy.} Ms. O'Toole?

Ms. {O'Toole.} Thank you, Mr. Chair. Sorry, I'm having trouble with the microphone.

Mr. {Murphy.} Okay.

Ms. {O'Toole.} We are about the same, and I'm happy to provide the committee with full balance sheet on the project.

Mr. {Murphy.} Thank you. We'll get that.

Mr. Gutierrez?

Mr. {Gutierrez.} We are still in very much a build year. Our operation and build expenses within the Connector

are on the order of about $65 million.

Mr. {Murphy.} Mr. Kissel?

Mr. {Kissel.} A little over $8-1/2 million.

Mr. {Murphy.} Thank you.

Mr. Lee?

Mr. {Lee.} Our current fiscal year total budget is about $330 million. Segregating which part of that is operational versus establishment, I don't have off the top of my head.

Mr. {Murphy.} And Mr. Wadleigh, would you know?

Mr. {Wadleigh.} Our total operation--our total budget for the year is $28 million, and roughly $18 million of that is dedicated to operational costs.

Mr. {Murphy.} So with all this--and I would appreciate--this committee would appreciate if we got more detailed audited information in terms of what your costs are for establishment and operational.

I am curious. Have any of your states worked out what its costs per enrollee, which you have done in terms of operation and establishment.

Mr. Allen, do you know?

Mr. {Allen.} Yes. Our exchange is funded entirely through an assessment on--

Mr. {Murphy.} No, I mean in terms of how many enrollees does your state have now?

Mr. {Allen.} Yeah, I was--oh, right now we have about 107,000.

Mr. {Murphy.} A hundred and seven thousand, and how much have you spent so far for operational and establishment expenses, state and federal money?

Mr. {Allen.} Are you referring to since the beginning of the program?

Mr. {Murphy.} Yes.

Mr. {Allen.} I believe that's on the record at $305 million--

Mr. {Murphy.} And Ms. O'Toole?

Mr. {Allen.} --in federal grants, and there's a bit more now in the assessment--

Mr. {Murphy.} If you added state to that as well, you could--

Mr. {Allen.} I would have to add state to that as well.

Mr. {Murphy.} You could get that information for us?

Mr. {Allen.} We can.

Mr. {Murphy.} Ms. O'Toole, do you know?

Ms. {O'Toole.} Thank you, Mr. Chairman.

Mr. {Murphy.} You have to keep your microphone on. It's okay.

Ms. {O'Toole.} I'm very sorry.

Mr. Chairman, I'm happy to provide you a balance sheet. We can email--send that to the committee right away.

Mr. {Murphy.} Mr. Gutierrez, would you know what you spent for establishment and operational costs per enrollee? How many enrollees?

Mr. {Gutierrez.} Not offhand. We'd be happy to provide that in written response.

Mr. {Murphy.} Mr. Kissel, do you know?

Mr. {Kissel.} I do. It's a very large number. It's over $50,000. But I want to point out with respect, Chairman Murphy, it's like saying that the first year's use of a freeway is only for the people--the cost of the entire freeway is only for the people who use for the first year versus a--

Mr. {Murphy.} I got that.

Mr. Lee?

Mr. {Lee.} We have not done a per-enrollee cost but I note that we have managed over $10 billion of premiums in the first year and a half and we anticipate over $7 billion in premiums next year, and the $1 billion received from the Federal Government have established the infrastructure--

Mr. {Murphy.} Right. So I need to know in terms of your establishment operational costs and per enrollee. Do you know that number offhand?

Mr. {Lee.} No, I do not.

Mr. {Murphy.} Mr. Wadleigh?

Mr. {Wadleigh.} No, I do not.

Mr. {Murphy.} But if you could get that information for us--and I understand different costs up front but now, of your states, who is keeping it and who is turning it over to the federal? Who is turning it over to--who is maintaining your state exchange? Oregon, you are getting rid of yours, right?

Mr. {Allen.} We're operating the marketplace in Oregon and using the federal platform as--

Mr. {Murphy.} You are using the federal platform?

Ms. O'Toole, are you using the federal or are you keeping Minnesota?

Ms. {O'Toole.} We're keeping Minnesota.

Mr. {Gutierrez.} Retaining Massachusetts.

Mr. {Murphy.} Retaining?

Mr. {Kissel.} Moving to healthcare.gov.

Mr. {Murphy.} Okay. So you're switching.

Mr. Lee?

Mr. {Lee.} California is managing our systems in all facets.

Mr. {Murphy.} And Mr. Wadleigh?

Mr. {Wadleigh.} Connecticut is keeping our system.

Mr. {Murphy.} But over time, what happens is, you are getting less and less federal subsidy, right? So that will mean more and more to the states, and so that's going to continue on.

Mr. Kissel, I want to ask you, in your testimony, you were critical of project management of Hawaii Health Connector. Can you be a little more specific?

Mr. {Kissel.} Yes. When I joined the Health Connector in October 2014, I examined the project which had had a

miserable track record, and I admit that, and I looked at the project management tracking tools, and they were virtually nonexistent. The project was not tracked with a project plan that had a critical path. It didn't have hours tracked. It didn't really define what the end game and goals were, and I was very disappointed because I came out of the infrastructure business, and I worked for companies that built projects. We built roads, bridges, bases of bombs for the Departments of Transportation and the Department of Defense, and these departments had extensive resources for tracking, monitoring and verifying project progress.

Mr. {Murphy.} I just want to say, and I read the GAO report on this too, clearly there were a lot of problems. I mean, from some of the testimony, it sounds like it is all rainbows and unicorns. And look, one of the things this committee thrives on is just honest testimony. It is not rainbows and uniforms. There was a mess, and Mr. Kissel, I appreciate your honestly.

Mr. Gutierrez, the Governor came in. He made some substantial changes. I appreciate that too. That is what we want to hear.

There was some mess-ups here, some big ones that cost taxpayers billions of dollars, and we would much rather hear from people that say yeah, let me tell you the problems and here is how we addressed it. That helps us a great deal.

I know yield to Ms. DeGette for 5 minutes.

Ms. {DeGette.} Thank you, Mr. Chairman.

Mr. Allen, yes or no. Are you denying that your exchange had problems?

Mr. {Allen.} No.

Ms. {DeGette.} Ms. O'Toole?

Ms. {O'Toole.} No, I'm not.

Ms. {DeGette.} Mr. Gutierrez?

Mr. {Gutierrez.} No, I am not.

Ms. {DeGette.} Certainly not you, Mr. Kissel.

Mr. Lee, did your exchange have problems?

Mr. {Lee.} Absolutely. Our exchange had some problems along the way.

Ms. {DeGette.} Now, Mr. Wadleigh, I don't know, it might be rainbows and unicorns for you but have even you had problems?

Mr. {Wadleigh.} Yes, we did.

Ms. {DeGette.} Everybody has had problems. What we are thinking about here is how did we recognize those problems and then move forward to try to fix it, and so I guess I would start with you since you are our model student, Mr. Wadleigh. If you want to talk about what Access Health Connecticut very briefly, what problems you saw and what you have done to move through those, I think that would be very instructive for us.

Mr. {Wadleigh.} Thank you for the question. So I think as we looked at the challenges from the onset of this very large project, which it really was, we saw some of the challenges being tight timelines. We saw some of the challenges being management of scope, could we deliver everything that we needed to deliver for me in a 10-month period? No, the answer was we couldn't. And so we went back to the drawing board a number of times to review everything that we needed to implement for the October 1st, 2013, time frame and deferred functionality out to later months for us that we knew would not impact our customers, and ultimately that came back around as some of our key decisions that we made. Unbeknownst to us, that's really where we--

Ms. {DeGette.} And are you continuing to try to refine and improve the efficiencies in your system?

Mr. {Wadleigh.} Every day we look to do that.

Ms. {DeGette.} Thank you.

Mr. Lee, I only have 2 minutes and 57 seconds left so could you answer the same question?

Mr. {Lee.} Yes, very briefly. First, very tight timelines for a big IT build that we addressed by being focused on--

Ms. {DeGette.} Timelines were a big issue, weren't they?

Mr. {Lee.} Absolutely, a huge issue.

Ms. {DeGette.} Were they a big issue for everybody else?

Ms. {O'Toole.} Yes.

Ms. {DeGette.} Mr. Allen?

Mr. {Allen.} Yes.

Ms. {DeGette.} Mr. Gutierrez?

Mr. {Gutierrez.} I was not there but it's my understanding, yes.

Ms. {DeGette.} Okay.

Mr. {Lee.} The other big that I know we all had to address is consumer misinformation and disinformation. Is it the fact of the availability of affordable subsidies that makes care affordable is a huge challenge, one that we are continuing to address because many Californians are now informed but some still are not, and so this is an educational message. I think it's a huge challenge. We're working with literally 12,000 insurance agents, faith-based groups, clinics, but that outreach challenge is something we address but it continues to be a challenge.

Ms. {DeGette.} That is true in my State of Colorado too, by the way.

Now, Mr. Kissel, you have been there, what, about a year now?

Mr. {Kissel.} Yes.

Ms. {DeGette.} And what did you do before that?

Mr. {Kissel.} I was in the infrastructure business. Most recently I ran the gas utility in Hawaii.

Ms. {DeGette.} So have you ever seen a utility or a system like this that didn't have issues that continually had to be addressed and updated?

Mr. {Kissel.} Absolutely not, and the way you do it is, you take the Connecticut model and perhaps the California model and you roll it out gradually. You increase functionality.

When we first started to make airline reservations, we couldn't even get a seat assignment online. Today we can order everything down to an umbrella in our drinks.

Ms. {DeGette.} It costs extra for those umbrella, I just want to tell you.

Mr. Gutierrez, your state had a lot of issues. What are you doing to remedy those issues and move forward?

Mr. {Gutierrez.} Partly because of my background, I have a belief that large IT projects really need strong governance, and we really tried to address governance not just for the project but for the overall business.

Ms. {DeGette.} Ms. O'Toole?

Ms. {O'Toole.} Thank you. Some of the same things that you've heard already. We actually in Minnesota early on took on two self-evaluations of ourselves to make sure we identified problems and could focus resources where they needed to be, and we have made tremendous progress in 2

years, and hundreds of thousands of Minnesotans have enrolled with relative ease now.

We also put in a much stronger governance process and procedure in place.

Ms. {DeGette.} Mr. Allen?

Mr. {Allen.} Thank you. As I mentioned earlier and as Congress Walden observed, I've had direct responsibility for the exchange functions in Oregon for about 90 days, and--

Ms. {DeGette.} So you fixed the whole thing?

Mr. {Allen.} Right.

Ms. {DeGette.} Perfect.

Mr. {Allen.} Really, the assignment of those functions, transferring them from a public corporation to a state agency was, I think, the single most significant step policymakers in Oregon did to put this on a different path. We're now laser-focused on delivering marketplace services in an efficient and functional way and moving forward that way.

Ms. {DeGette.} Thank you.

Thank you very much, Mr. Chairman. I yield back.

Mr. {Murphy.} Mr. Griffith, you are recognized for 5 minutes.

Mr. {Griffith.} Thank you, Mr. Chairman. I appreciate it. I know we are talking about state exchanges today. About this time 2 years ago, we were arguing whether the federal system was ready to be unrolled with its plan and so forth, and I noted with some interest, Mr. Kissel, in your written testimony, I quote: ``I'm pleased to say that as of June 2015, according to Turning Point, our independent validation and verification contractor, we were the only state-based exchange to have successfully passed its IT blueprint testing scenarios providing third-party validation that we have a working IT system.''

Mr. Chairman, we might want to get the federal folks in here and see if they can pass that same kind of test, and I do think it is interesting that Hawaii is the one that has passed it.

Notwithstanding that success, notwithstanding a 10-year plan to get the finances in order in June, the Governor decided to shut down Hawaii Health Connector and also notwithstanding, I should note, $205 million in federal establishment grant dollars. Now, for folks back home who may not have been paying attention to the whole hearing, that

is the money that gets started on the program. Isn't that correct, the state health exchange?

Mr. {Kissel.} That is correct. Now, we've committed or spent only $140 million of that and don't have plans to spend the full $205 million, of course.

Mr. {Griffith.} Okay. So as of June, you had spent about $140 million of the 205?

Mr. {Kissel.} That is correct.

Mr. {Griffith.} And you are not going to spend the rest of it on establishment. Where does the money go? Does it go back to the Federal Government?

Mr. {Kissel.} Some of it we don't plan to spend. About $5 million to $7 million will be spent in decommissioning and shutting down the system, and then we'll spend some additional money on new enrollments for policy year 2016.

Mr. {Griffith.} For enrollment?

Mr. {Kissel.} It's establishment, the outreach for establishment to greater increase the enrollment as we use healthcare.gov.

Mr. {Griffith.} And how much do you anticipate that will be?

Mr. {Kissel.} That's--I'll provide the exact amount, but it's about $7 million.

Mr. {Griffith.} Okay. So you are going to have tens of millions leftover. What happens to that money? Does that come back to the Federal Government or the State of Hawaii?

Mr. {Kissel.} That remains unspent. It's not drawn from the Federal Government.

Mr. {Griffith.} It's not drawn from the Federal Government? All right. I appreciate that. Thank you very much.

Is Hawaii undergoing a rate increase for health insurance plans?

Mr. {Kissel.} Yes, they are. The two main providers, the Blue Cross Blue Shield provider has announced a rate increase for Qualified Health Plans of about 46 percent.

Mr. {Griffith.} Wow.

Mr. {Kissel.} And Kaiser has announced an 8 percent increase.

Mr. {Griffith.} So one has a 40 percent and one has got an 8 percent. Which one is dominant in the market?

Mr. {Kissel.} Blue Cross Blue Shield has about an 85

percent market share.

Mr. {Griffith.} And do they cover the entire state?

Mr. {Kissel.} Yes.

Mr. {Griffith.} Does Kaiser cover the entire state?

Mr. {Kissel.} Virtually the entire state. Some of the rural areas, they don't.

Mr. {Griffith.} And do you have any other players in your marketplace? Because we have had previous testimony that except for some rural areas, and I guess Hawaii would qualify as a rural area for most of it, there just aren't that many players.

Mr. {Kissel.} That's correct. Now, the Medicare Advantage people are all there, but for the normal health plan for the average working person, it's those two players.

Mr. {Griffith.} Do you know of any states that are having a higher than--or have people higher than a 46 percent increase?

Mr. {Kissel.} I do not, but the reason for this is, we have a really well-balanced insurance community and it's been 40 years in the making, and when the Affordable Care Act policies were introduced, the insurance companies experienced

a lot of negative selection. The sickest people enrolled first. We're a tiny little state with a very fragile economy. Many of our businesses--and we don't have national players in Hawaii--need that extra protection to provide the safety net that we have against SARS outbreaks and other--you know, the swine flu and other kinds of things that are devastating to a small economy like ours.

Mr. {Griffith.} I appreciate that.

I noticed in the testimony, I believe Mr. Wadleigh, that you had indicated that the rates for our most affordable plans have remained flat, and that raises a question in my mind as a former practicing attorney, if your most affordable plans had remained flat and you don't tell me about the others, does that mean everybody else is getting a big increase?

Mr. {Wadleigh.} So all of our plans both on and off the exchange are--have to have the same rates so the benefit the state-based marketplace has created has allowed for the off-exchange plans to fall in line and have to be more competitive as well.

Mr. {Griffith.} Okay. So your affordable plans have

remained flat but you have some other plans that have not remained flat? Is that what I'm reading? Because that's the way I read that.

Mr. {Wadleigh.} Sure, sure. So there are always going to be plans when you get into the Platinum Group that are much richer.

Mr. {Griffith.} And I see--and I apologize, because I see that my time is up, but I will note that you are not claiming that the plans went down $2,500 from what people were paying before.

I yield back.

Mr. {Murphy.} The gentleman yields back.

I now recognize Mr. Yarmuth for 5 minutes.

Mr. {Yarmuth.} Thank you very much, Mr. Chairman, and I thank all the witnesses for their testimony.

I am not going to talk about rainbows and unicorns. In Kentucky, we prefer to talk about thoroughbreds. So I am going to talk about rainbows and thoroughbreds because Kentucky has had one of the truly successful and mostly problem-free experiences with the Affordable Care Act and our exchange called Kynect, and our Governor, Steve Basheer, and

his team deserve an awful lot of credit.

We had a glitch the first morning of the operation of the exchange for about 2 hours, and access was limited. Beyond that, we have been pretty much problem-free. And our experience is that we have insured now more than 500,000 people under the Affordable Care Act through our exchange and expansion of Medicaid in the 2 years of operation, and that's in a state of 4.4 million. We have reduced the uninsured rate by 50 percent statewide. In my district, we have reduced the uninsured rate by 81 percent. There are only slightly less than 20,000 uninsured citizens in my community of 750,000, which is a little less than 3 percent uninsured rate.

So how has that happened? It is because of the outreach that we all talked about. Kynect had people at every county fair and every neighborhood association meeting, at the community health centers, you name it, where people gathered. They were there explaining and helping people enroll.

So I am very proud of that. As a matter of fact, it has been so successful in Kentucky that one Republican state Senator has suggested that we try to expand the exchange to

other states. So we may be coming after your business pretty soon.

Additionally, just since I get to act like a witness here and talk about our experience. We do have this year three new insurance companies coming in to the exchange, which is positive. Now our consumers will have, I think, either six or seven choices of providers. There are three new insurance companies in the private marketplace so the market is actually expanding in a lot of ways.

And I think most importantly, earlier this year our Governor commissioned the Deloitte firm to do an assessment of what the economic impact of the Affordable Care Act would be over the next 5 years, and Deloitte came back and said that over the next 5 years, the Affordable Care Act would create 40,000 new jobs in Kentucky, would have created additional economic activity of $32 billion, and have a positive impact on the state budget of over $800 million.

So I think in virtually every sense of the word, the Kynect operation and our experience in Kentucky has been very, very positive. We are getting an incredible increase in preventive medicine. We have had screenings for breast

cancer increase by 111 percent, cervical cancer screenings by 88 percent, colorectal cancer screenings 108 percent, and physical exams are up 187 percent.

But all of this is really not as important as the human impact, and as Ms. O'Toole mentioned, a couple of her clients. I would like to read a letter from one of my constituents, a woman named Kim Atkins, and she wrote, ``My daughter, Sarah Atkins, is one of the several young adults that are on our insurance policy until she is 26 years old. She is still unemployed and looking for employment. On January 9th, 2011, that bill, the ACA, saved her life. One of her kidneys shut down and almost went septic. If she wasn't on our insurance, she would have waited or not gone to the hospital at all. The doctor told her if she would have waited an hour later, she would have lost a kidney or died.'' And that is what this is all about. This is providing quality, affordable care to our citizens, and I think--I am very proud once again of Kentucky and the experience we have had there, the progress we have made, and I thank you for the work that you all are doing in your respective states as well because this is one of our, I think, can ultimately be one of

the true success stories of Congress and the Federal Government that we have created this new way to insure Americans.

So I thank you all for your work and your testimony, and I yield back.

Mr. {Murphy.} The gentleman yields back.

I now recognize Dr. Bucshon for 5 minutes.

Mr. {Bucshon.} First of all, I would like to thank all of you for doing what you can on behalf of the citizens in the state that you represent. I think all of us want everyone to have access to quality, affordable care. That is not in question.

And I also agree that states have should more flexibility. Indiana used Healthy Indiana plan as a way to cover our low-income Medicaid patients, and using a combination of federal funds as well as state funds from hospitals across the state that agreed to kick in so that we could expand coverage in a state-based program that is actually HSA-based that is working.

Mr. Allen, the State of Oregon was awarded $305 million in federal tax dollars, correct?

Mr. {Allen.} Yes.

Mr. {Bucshon.} And did they spend all the money?

Mr. {Allen.} A little bit less than the full amount but there was some unused grant funding at the end of Cover Oregon's term.

Mr. {Bucshon.} Okay. And all of that went for Cover Oregon? All the money spent went for Cover Oregon?

Mr. {Allen.} All of the money was used to establish the health insurance exchange in Oregon, which was actually--the grants were partially to Cover Oregon and partly to the Oregon Health Authority.

Mr. {Bucshon.} Okay. So none of the money was spent on anything else other than attempting to establish Cover Oregon?

Mr. {Allen.} Correct.

Mr. {Bucshon.} Okay. So could you provide us with an itemized accounting of all the expenditures, the $305 million that was spent? Is that possible?

Mr. {Allen.} I can.

Mr. {Bucshon.} So let it be noted, he has agreed to provide the committee with an itemization of expenditures,

and from past history frequently we get one page with people with about four things on there. We would like to have a really in-detail itemization of where the money went. That would be great.

Also, there are a lot of good things happening out there, and a lot of things that need to be changed.

Mr. Lee, what percentage of your people are on Silver plans or above, approximately?

Mr. {Lee.} About 75 percent.

Mr. {Bucshon.} Okay. So 75 percent of the people then have no deductible for primary care and 25 percent still have--

Mr. {Lee.} But even at the Bronze plan in California, everyone in Bronze, which is a 60 percent actuarial value, have three visits to primary care or specialty care starting in 2016 not subject to a deductible in addition to the preventive care, which is never subject to a deductible.

Mr. {Bucshon.} Okay. Thanks for that clarification because in your testimony, you said Silver and above, and so that was interesting.

And also, you know, I would like to point out that, you

know, I understand that the private sector plans, you know, are still there but, you know, federal subsidization of healthcare plans competing with the private sector makes it pretty hard for the private sector to compete. That is part of the issue.

Mr. Wadleigh, in May, the board of Connecticut's health insurance exchange approved a 22 percent hike in the fee it charges insurers to help fund its operations. Is that correct?

Mr. {Wadleigh.} Yes, it is.

Mr. {Bucshon.} Okay. So insurance companies got a higher fee.

Mr. Gutierrez, is it true that I guess at some point Massachusetts had to temporarily put 300,000 people on the Medicaid program and some--and are all those people still there when you were working to establish the exchange, that there was a template--your Web site had issues, and I am assuming all of that has been resolved and the people that went into Medicaid temporarily CMS approved are now out of that?

Mr. {Gutierrez.} All of those temporary Medicaid

members have been predetermined into either Qualified Health Plans or Medicaid.

Mr. {Bucshon.} Great.

And Ms. O'Toole, do you still have a backlog of about 180,000 public insurance renewals in the system?

Ms. {O'Toole.} Thank you for the question, Congressman. We do not. That has been resolved.

Mr. {Bucshon.} Okay. And it says despite additional funds, MNsure--you do continue to struggle some obviously, and again, I applaud all of you for what you are doing. We just--the goal of our committee is to find out where we can make improvements, right?

But Minnesota announced that they are going to revert to the old system for MinnesotaCare because of MNsure's problems. Is that true?

Ms. {O'Toole.} Congressman, that is true just for a short period of time and that is--we have prioritized that functionality for the very beginning of 2016.

Mr. {Bucshon.} Okay. Great.

And in Hawaii, I guess you have totally turned yours over to the federal exchange now because it says in the

information I have, you extended it until October of 2016. You originally announced Health Connector would shut down due to insufficient funds but recently has extended it through October 2016. Is that true or not true?

Mr. {Kissel.} The outreach will extend through open enrollment and then the corporate affairs of our independent nonprofit will wrap up and it'll take until October to do the accounting and the like.

Mr. {Bucshon.} Okay. Great.

Mr. Chairman, I yield back. Thank you.

Mr. {Murphy.} Mr. Tonko, you are recognized for 5 minutes.

Mr. {Tonko.} Thank you, Mr. Chair. And let me thank all of our witnesses for joining us today and presenting good information.

I know that some state-based marketplaces have faced challenges in building and managing their IT platforms. These challenges are well publicized. What is less well known perhaps is the efforts that state-based marketplaces have been implementing and tailoring the ACA to their own citizens. So I would like to ask our witnesses, what is your

state-based marketplace doing to ensure that consumers in your state are receiving culturally and linguistically appropriate outreach as well as healthcare?

Mr. Allen, we might start with you and we will go across the table.

Mr. {Allen.} Thank you for the question, Congressman. That's--in taking over responsibility for the marketplace, that was exactly the number one question that landed with us was, given the success we've had in Oregon in driving down the rate of uninsured, the remaining population is relatively small but relatively harder to reach, and so we have made the decision to move from a wide media broadcast advertising kind of an outreach approach to something that is much more tailored that works through community partners, organizations that work in communities of color, and other areas, much more targeted kinds of technology outreach to try to work hard to get to those geographic and demographic populations that are amongst the hardest to get insured.

Mr. {Tonko.} Thank you.

Ms. O'Toole, please?

Ms. {O'Toole.} Thank you, Congressman. I'm happy to

answer that. And we--what we've learned in Minnesota is that with the remaining uninsured like Mr. Allen said, they're harder to reach. We have 26 statewide grantees who work in every committee around Minnesota to help reach out to these populations and enroll them. We're really proud of that. And we pair them also with enrollment centers around the state that are sponsored by brokers and so we're trying to come at it from all angles and, you know, we've learned this is not an easy decision for people so they need help and they need in-person assistance, so we focused resources there.

Mr. {Tonko.} Thank you.

And Mr. Gutierrez?

Mr. {Gutierrez.} Three principal items. This year our media strategy is very focused on ethnic media dealing with the Hispanic, Portuguese and Asian communities and pockets throughout the state that are underinsured. Secondly, our selection of navigators and walk-in centers for this fall is specifically targeted towards underinsured communities. And thirdly, there's an innovative program where because Massachusetts has a state insurance mandate, our Department of Revenue knows who does not have insurance. Now, they

would never share data with us. That's out of bounds. But they are able on our behalf to notify uninsured residents of their opportunity to become insured through the state-based marketplace.

Mr. {Tonko.} Thank you very much.

Mr. Kissel?

Mr. {Kissel.} We changed our outreach model from a media-driven model to a personal model. We added marketplace assisters to speak the 15 or 20 languages and dialects of the people of the nations of the Pacific Rim in addition to the cultures of America. We went from a call center to a personal outreach, although we still operated the call center, and we went into the areas where, for example, there are people who've lost their homes due to economic conditions. We find that more than half of those families have one or two working members, and we help them enroll in coverage. We also moved forward with essentially what was a--I'm not a rocket scientist--with the Social Security model where you have multi layers of aid depending on the needs of the individual. You can call, you can--if you're sophisticated, you can log on to the computer, and if you

need help, we in fact make house calls. My telephone number personal contact information is on the Web site.

Mr. {Tonko.} Wonderful.

Mr. Lee?

Mr. {Lee.} From day one, we've done outreach which is anchored in local communities in a wide range of languages. We continue to do that. The other thing, I want to appreciate your question. It's not just about outreach. It's about making sure care is delivered that is culturally appropriate and addresses health equity. We have contract requirements in our negotiations with the plans to hold the plans to account. Three of our 12 plans are among nine nationally recognized by NCQA for providing culturally appropriate care. It's something we're going to hold our plans to account to.

Mr. {Tonko.} Thank you so much.

And finally, Mr. Wadleigh, please.

Mr. {Wadleigh.} Thank you for the question. We too have been focusing all of our outreach into our communities where we know that from--in Connecticut that our uninsured reside in basically 10 zip codes and so we can go right into

those communities and work with those residents.

Mr. {Tonko.} Thank you very much. I yield back.

Mr. {Murphy.} Thank you. The gentleman yields back.

I now recognized Mr. Flores for 5 minutes.

Mr. {Flores.} Thank you, Mr. Chairman. I just wish we had invited the D.C. exchange because it still shows I am ineligible for coverage.

Anyway, states continue to opt out of their tried to set up their state exchanges and they are migrating to the federal exchange, as we all know. We need to try to understand the impact on that. In order to do that, we need to know how sustainable the state exchanges are that are still in existence.

So Ms. O'Toole, would you tell me what taxpayers can expect from your state exchange over the next 5 to 10 years, and will it be sustainable somewhere during that time period?

Ms. {O'Toole.} Congressman, thank you for the question. I'm happy to answer it.

Like I said in my opening testimony, we are finally sustainable at this point. Our budget is balanced. It's based on real numbers and real experience, and the board of

directors in March of this year has passed a 3-year financial plan that looks out. So we keep a close eye on this. It's something we're concerned about. And, you know, our board and our team is committed to living within our means. So if we have to--you know, revenue has to match expenditures, and we have to make hard decisions, we will.

I also mentioned in my testimony that we have a task force, a bipartisan task force, in Minnesota that's looking into some of these issues that took it out of the legislator--legislative arena to have a more in-depth conversation throughout this fall, and we look forward to that work continuing.

Mr. {Flores.} Okay. Mr. Gutierrez?

Mr. {Gutierrez.} Our current expense profile, because it's still a buildout year, is high and we'll need to reduce it, making some hard choices along the way. But Massachusetts is fortunate in that the Connector Authority was initially instantiated with a reserve fund. It also has dedicated revenue sources from our cigarette tax and from the state insurance mandate penalties as well as the carrier administrative fees. So we have a very diverse set of

funding sources and bipartisan commitment to the effort.

Mr. {Flores.} Mr. Lee?

Mr. {Lee.} From day one, Covered California has been putting money in the bank from our plan assessments while we were going through establishment funds. We have over $200 million in the bank, a very strong balance sheet. We have a wholly sustainable model over the long term.

Mr. {Flores.} You talked about these assessments. What impact has that had on premiums in your state?

Mr. {Lee.} Well, it's actually--compared to what health plans were spending to enroll people in the individual market previously, we think it reduces overall effect on the premium dollars. It's about 3-1/2 percent of premium. But enrolling people in the individual market is very expensive, and prior to the exchange coming along, plans were spending as much as 12 percent on commissions and a whole range of acquisition. I like to think we're the cheapest date in town, Congressman.

Mr. {Flores.} Mr. Wadleigh?

Mr. {Wadleigh.} We too have a fully balanced budget that also right now we have about $12 to $15 million in reserves within our budget as well.

Mr. {Flores.} Okay. And what has the impact been on premiums in your state?

Mr. {Wadleigh.} The impact on our premiums related to the assessment has similar to California. We feel that it has allowed the marketplace to level off and compete evenly across the state.

Mr. {Flores.} Mr. Kissel, what has been the impact--excuse me, not Mr. Kissel. Mr. Gutierrez, what has been the impact on premiums in your state from the assessments?

Mr. {Kissel.} If I made a statement on that, I think I would be speaking without firsthand knowledge, so I'd like to respond to that more fully in writing.

Mr. {Flores.} That's fine. Okay.

Ms. O'Toole?

Ms. {O'Toole.} Thank you, Congressman. Last year we saw rate increases on average of about 4 percent. Our Department of Commerce in Minnesota reviews so that we don't--that's an independent review process aside from our organization. They have not released rates for this year. That happens later this week.

Mr. {Flores.} Okay. Would you advise us after that

happens?

Ms. {O'Toole.} I'm happy to do so.

Mr. {Flores.} Okay. Thank you.

Given the short amount of time, I don't have time for another question so I will yield back the balance of my time. Thank you, Mr. Chairman.

Mr. {Murphy.} The gentleman yields back and I recognize Ms. Castor for 5 minutes.

Ms. {Castor.} Well, thank you, Mr. Chairman, for calling this hearing on the substantial reductions in the rate of uninsured Americans under the Affordable Care Act, and thank you to all the witnesses here today and what you are doing for families across the country.

When I think of the Affordable Care Act, I often think--I think it is helpful to break it up into its pieces. First, you have the consumer protections the Affordable Care Act brought. You have a piece on Medicare--we strengthen Medicare. And then you have the policies and strategies to reduce the rates of uninsured all across the country. So for consumer protections, the ACA is working. We no longer have discrimination based upon a preexisting condition like a

cancer condition or diabetes. That has been a godsend to families. The consumer protections that allow young adults to stay on their parents' policies, I've heard directly from many friends back home what a benefit that has been. And then insurance companies can no longer cancel you if you get sick, so that is--and there are others, but that is an important piece.

Then under Medicare, Medicare is stronger. We invested savings into lengthening the life of the Medicare Trust Fund. We also are closing the donut hole, put money back in the pockets of our parents and grandparents through less costly prescription drugs, and then Medicare is undergoing reform so that care is provided in a smarter way.

But then it comes to the rates of uninsured, and it is pretty remarkable, and this is important as well when you think about it for people who already have insurance because what the Affordable Care Act has done is helped people take personal responsibility for themselves and make insurance more affordable. That way you don't have this cost shifting to people that do have insurance.

So the recent Census Bureau report said that since the

passage of the Affordable Care Act 5 years ago, 17.6 million Americans have gained coverage, and that from 2013 to 2014, we have had the largest reduction in the uninsured rate in America in 25 years, and it is important to note that at the same time, the rate of employer-sponsored health insurance has remained constant because that was kind of a--that was a question mark going on, so, so far, so good.

And I would really like to thank you all for--I heard today a little healthy competition among the states, how proud you are of some of the things you have been able to do. I certainly heard it from my colleague, Mr. Yarmuth from Kentucky, where they have done a fantastic job.

Mr. Lee, congratulations. Since opening of the exchanges, California has provided a lifeline to so many families in California through Covered California, Medi-Cal. What has happened to the uninsured rate in California?

Mr. {Lee.} The uninsured rate, depending on census figures, has dropped to about 12 percent, a huge reduction, one of the fifth largest reductions in the Nation, but it's also, if many, Congresswoman, your note that it's also for people that have insurance are seeing the benefit of lower

rates. A million Californians in the individual market that don't buy through us benefit from our 2 years holding rates down, so I think your note on those benefits aren't just for the uninsured but it is also for insured people that are in jobs, that have insurance that have now rates kept in check.

Ms. {Castor.} Well, I am glad Mrs. Capps came in at this point so she can hear that directly after she worked so hard on the Affordable Care Act and passage.

How are you working to ensure that coverage remains affordable from this point forward and meaningful for families?

Mr. {Lee.} Well, one of the things we are doing at Covered California as an active purchaser, we are working with our 12 health plans to say how do we actually affect care where it's delivered. In the end, affordability is about delivering the right care at the right time every time, and the movement that we've seen in Congress, a common movement, a moving from volume to value is something we are working with all of our health plans to change payment to promote primary care to make sure people with chronic illnesses get the right care at the right time, and that

needs to be the focus I think all of around this table have is, as one of the other Congress people noted, it's not just about giving people an insurance card; it is making sure people get the right care and that right care is delivered at the right time, and that's going to be the key for all of us in reducing costs over the long term.

Ms. {Castor.} Thank you.

Mr. Wadleigh, on behalf of Access Health--you are here on behalf of Access Health Connecticut. Congratulations, and thank you for what you've done in lowering the rate of uninsured.

Tell us what has happened to the uninsured rate in Connecticut and what this has meant for your citizens.

Mr. {Wadleigh.} Thank you, Congresswoman. The uninsured rate in Connecticut has been cut in behalf just in the last 2 years. We see that it will continue to go lower, so that has been very exciting.

What I would also say is, our next--it's really what our next step, so similar to Mr. Lee had said, it really comes down to, how do we start working through health disparities, wellness, access to primary care physicians. Those are some

of the goals that we are working on right now as working with the residents of Connecticut.

Ms. {Castor.} Thank you very much, and I yield back.

Mr. {Murphy.} The gentlelady yields back.

We are in agreement that Mr. Walden will be able to go next, so without objection. Thank you, Mr. Walden.

Mr. {Walden.} I thank the chairman. I thank my colleagues for that.

I know Ms. DeGette asked each of you if there were trouble with your exchanges, and you all wisely answered ``yes'' because it is never easy to roll one of these out. I have just got to go to an Oregon-specific issue, though, but I am going to ask each of you to put a highlight on this. Did the Governors in your states use their paid campaign political advisors to craft official communication and management strategies for the rollout or the termination of your exchange? Yes or no.

Mr. Wadleigh?

Mr. {Wadleigh.} I don't know the answer if our Governor did that or not.

Mr. {Walden.} All right.

Mr. Lee?

Mr. {Lee.} I have no information about how my Governor uses his staff.

Mr. {Walden.} All right.

Mr. Kissel?

Mr. {Kissel.} Not to my knowledge, but the Governor has very courageously taken on the burden of this exchange by embedding it in all of the departments.

Mr. {Walden.} Mr. Gutierrez?

Mr. {Gutierrez.} Not under the current administration.

Mr. {Walden.} Ms. O'Toole?

Ms. {O'Toole.} Thank you, Congressman. I have no information about that.

Mr. {Walden.} I think Mr. Allen knows potentially the answer to this question in Oregon.

Mr. {Allen.} Well, Congressman, I was not directly involved in the management or operation of the exchange at that point and have no direct experience with that kind of involvement.

Mr. {Walden.} All right. Good answer on our part. However, I want to introduce into the record, Mr. Chairman, a

series of newspaper articles that were acquired, investigative reporting that was done that clearly indicate that our Governor at the time used his outside political campaign staff to manage and coordinate the messaging on Cover Oregon. It may be worse than that based on emails that have been made available from FOIA. I just think it is important for the committee to know as we investigate what happened to this money what happened in the behind the scenes apparently in our State of Oregon, and so Mr. Chairman, without objection, I'd like to have those entered into. I will be happy to provide them.

Mr. {Murphy.} Without objection.

[The information follows:]

********** COMMITTEE INSERT **********

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Mr. {Walden.} Mr. Allen, do you know how close to completion Cover Oregon was when they pulled the plug on it?

Mr. {Allen.} Congressman, I don't have direct knowledge of how close it was to completion. I do know on the--there is on the record a technology assessment report provided to the Cover Oregon Board at the time that the decision was made whether to move forward with that infrastructure or move to the federal marketplace that indicated that were they to choose to maintain the existing infrastructure, it was already failing to meet benchmarks necessary to be available for open enrollment in 2015.

Mr. {Walden.} So my understanding is, it was about 90 percent done.

Mr. {Allen.} I would have no knowledge of that.

Mr. {Walden.} You don't know? You haven't asked? Okay. How did Oregon inform CMS of its decision to migrate to healthcare.gov? Do you have any knowledge of that?

Mr. {Allen.} Sorry for this to be a theme, but I don't have direct knowledge. My understanding--

Mr. {Walden.} No, I know you have only been on it 90

days, but I assume at some point these--well, then, do you know who Oregon worked with or is currently working with at CMS either during this transition?

Mr. {Allen.} Sure. We've been in most close--mostly closely working with Myra Alvarez, who just recently departed CMS. I've been in close contact with Kevin Counihan as we've dealt with this transition issues, updating them on transition as well as dealing with site visits and those kinds of things.

Mr. {Walden.} And how did CMS--what did CMS require of Oregon before allowing it to migrate to healthcare.gov? Do you know that?

Mr. {Allen.} I don't know the answer to that.

Mr. {Walden.} Did CMS conduct any forensic analysis on Cover Oregon or are the now? Did they conduct an audit of their own?

Mr. {Allen.} We did recently have an audit on the ground by CMS about 3 months ago, and I should make a comment. In that context earlier, I said we have not used grant money for 2015 operations. There are actually two very minor elements that were identified in that audit that we are

working to resolve with them now. I would not be able to characterize anything that I'm aware of as forensic.

Mr. {Walden.} All right. And will that audit be made public by the state when it is completed or by CMS?

Mr. {Allen.} I believe it will be made public by CMS.

Mr. {Walden.} All right. I am sure the committee would like to have access to that either from CMS or Oregon.

Do you know if CMS required Oregon to return any of the $305 million originally awarded for the establishment of the--

Mr. {Allen.} Other than the potential couple of minor items I just mentioned that we're in discussions with them about, no, I'm not aware of that.

Mr. {Walden.} Okay, and did Oregon incur any additional costs when it migrated to healthcare.gov? Do you know that? Or do you want to get back to me?

Mr. {Allen.} I can get back to you on that.

Mr. {Walden.} I realize you have only been at that--but this has been going on a long time, and it has, as you know, dominated certainly on the minds of Oregonians out there.

Now that Oregon has elected to switch over to the

federal exchange, will there be an attempt to recoup any of the money that was granted to the state to establish the state exchange? Are you in any discussions about that?

Mr. {Allen.} To recoup from whom by whom? I'm not--

Mr. {Walden.} Well, the $305 million.

Mr. {Allen.} Well--

Mr. {Walden.} Is CMS going to come back on the state?

Mr. {Allen.} Yeah. What I am in a position to know is that we've been able to review the grant documents. The $300 million went for the entire operation of setting up a health insurance exchange. Technology is certainly a piece of that. I think you have a GAO report--

Mr. {Walden.} Right.

Mr. {Allen.} --that identifies $78 million of the $304 of that function. It is my understanding that we are in compliance with and have delivered the deliverables required under the terms of the grant for the 305--the various grants for the $305 million. So I don't there's discussion about a return because we've complied with the terms of the grant.

Mr. {Walden.} Wow. Even though the exchange never was functional or on--

Mr. {Allen.} Congressman, the technology didn't launch but we were able to cover 70,000 people in the first year despite that, 100,000 people most recently--

Mr. {Walden.} Did you actually use the exchange behind the curtain with paper input?

Mr. {Allen.} It was a hybrid paper-automated process.

Mr. {Walden.} I am sorry, Mr. Chairman. I have gone over time.

Mr. {Murphy.} I do want to know as a follow-up in terms of an audit, Mr. Allen, you said--I want to know, does HHS or CMS require an audit of any of you in terms of how you spent the money?

Mr. Allen?

Mr. {Allen.} We're required--

Mr. {Murphy.} You are required to report?

Ms. O'Toole? Is any of you required by the federal plans to do an audit of how you spent the money?

Mr. {Gutierrez.} It's my understanding that we are required in Massachusetts. We've had three straight years of clean, third-party audits--

Mr. {Murphy.} I am just curious. Are you required by

the state or the Federal Government? Is it the Federal Government?

Ms. O'Toole?

Ms. {O'Toole.} Congressman, we are subject to comprehensive oversight both in Minnesota by our state--

Mr. {Murphy.} No, no, I just want to know, yes or no.

Ms. {O'Toole.} --and the Federal Government.

Mr. {Murphy.} And Mr. Gutierrez, yes.

Mr. Kissel?

Mr. {Kissel.} It's a yes but there is detailed self-reporting and certification and auditing, but it relies on our records so that they don't go to the next level and look at our contractors' records to be sure that what we say has actually been done.

Mr. {Murphy.} There is limits to it.

Mr. Lee?

Mr. {Lee.} Yes, there's reviews both by CMS as well as by state level of our spending.

Mr. {Murphy.} Mr. Wadleigh?

Mr. {Wadleigh.} Same thing.

Mr. {Murphy.} Same thing. We will have to go those

records.

Mrs. Capps, you are recognized for 5 minutes.

Mrs. {Capps.} Thank you, Mr. Chairman.

States that created and run their own state-based marketplaces are testing new models for enrollment, insurance market oversight and consumer protection serving as Hubs of Innovation. The work being done there can serve as a model for other states and the Federal Government as the ACA continues to be implemented.

Mr. Lee, California has been a leader in the ``active purchaser model.'' Can you explain what this is and how that has helped Covered California ensure access to high-quality, affordable health insurance coverage?

Mr. {Lee.} Great. Thank you very much, Congresswoman Capps. Thanks for your leadership.

Three things that underscore about being an active purchaser. First, we don't take every plan that wants to knock on our doors and be part of the marketplace. We review them critically and make sure they have the networks in place, the system to deliver quality care. Second, we looked very closely at their rates and make sure that the rates

align with the quality of care we expect of them. And finally, we hold them to account for delivering quality care, and that's all in the context of what we have, which we think is critical, and some of my colleagues up here have similar things, which is standard benefit designs where right now in many parts of the Nation, consumers may buy the lowest-cost plan and then find out they need to spend a $3,000 deductible before they get care. That doesn't happen in California, and that's because standard benefit designs for both on and off exchange in the individual market, we're reshaping the market so benefit designs are designed for consumers, not for a health plan.

Mrs. {Capps.} Thank you.

Mr. Wadleigh, similar question. Does Access Connecticut have a standardized benefit package? How does it help consumers make informed purchasing decisions?

Mr. {Wadleigh.} We do. Thank you for the question. We have standard plan designs for all of our individual metal tiers, and what we have found is that it makes it easy for our residents to compare apples to apples whereas prior to this it was much more difficult to compare plans.

Mrs. {Capps.} Thank you.

One of the focuses of the ACA is to transform the delivery system and improve quality of care. As a nurse, I find this goal to be incredibly important, bottom line, really, especially as we reach the goal of transitioning from a sick care system to one that promotes wellness.

Mr. Lee, what efforts has Covered California taken to improve the quality of care through better coordination, payment reform or other initiatives?

Mr. {Lee.} Thank you very much for that question. When we released our rates this year, which were only a 4 percent increase, we didn't just release the rates, we released background on how our 12 plans are doing better coordinated care, using tele-health, addressing wellness and prevention, addressing health disparities and health equity. These are requirements in our contracts with our health plans. They aren't just putting products on the shelf and having people get insurance cards. They need to deliver on that promise of care, and we think that's something that all exchanges should be looking at to make sure it's not just a card in the pocket but actually people are getting access to care that's being

improved over the long term.

Mrs. {Capps.} Let me put that to each of you briefly. If you have something to add, just so we get it on the record, about initiatives going on in your individual states if you want to add, go ahead.

Ms. O'Toole?

Ms. {O'Toole.} Congresswoman, yes, thank you. A lot of this--a similar experience but one thing that we're doing differently in Minnesota this year is, we're adding a comparison tool. I think someone mentioned it earlier about, you know, premiums are just one part of the cost of care and so we're trying to give consumers a more robust picture of like out-of-pocket costs and other costs that go into their care so they make better choices for themselves, so that will be a new feature on our website for open enrollment this year.

Mrs. {Capps.} Great. And the other examples of initiatives?

Mr. {Allen.} I would just add very quickly, I mentioned that we have 120 different plan options available for consumers through 11 companies in a market as relatively

small as Oregon.

Mrs. {Capps.} Wow.

Mr. {Allen.} It's actually an incredible range of choice, which actually becomes a problem for consumers.

Mrs. {Capps.} Yes.

Mr. {Allen.} We're relying quite heavily on agents and assisters to actually help people through that decision-making process so that they don't just immediately go to the lowest price plan when in fact their own circumstances may really dictate that a higher monthly premium but lower deductibles or copays would be a better option for them.

Mrs. {Capps.} Are individuals opting to use those assisters?

Mr. {Allen.} Yes.

Mrs. {Capps.} Anything else?

Mr. {Wadleigh.} So I would say Connecticut very similar to the rest of my peers. We are doing something new this year working with all of our carriers. We've met with them to start collaborating on how we can help improve health literacy with all of our new customers who have previously been uninsured, and similarly, we have found that we needed a

comparison tool to help our customers pick the right metal tier versus the lowest price.

Mrs. {Capps.} In 17 seconds, Mr. Lee, what, if anything, has Covered California done to encourage this right care at the right time? That is such an important area.

Mr. {Lee.} The one thing that I'd highlight is, we have a partnership with all of our plans to promote what's called the Choosing Wisely Initiative, which is an initiative led by the clinician community to help make sure patients don't get unnecessary care but always get the right care, so that's the one that I'd highlight.

Mrs. {Capps.} Thank you.

Mr. {Lee.} Thank you.

Mrs. {Capps.} I yield back.

Mr. {Murphy.} Thank you.

I now recognized Mr. Collins for 5 minutes.

Mr. {Collins.} Thank you, Mr. Chairman.

I want to thank the witnesses too. It has been very educational. I think we all know that everything we are all working on is a work in progress, and with differing results, and not being from any of your states, it's interesting to

hear what you are saying.

I am from New York. We received $575 million to set up our state exchange, but somewhat disappointedly--well, quite--the Inspector General of HHS last week revealed that of a randomly selected number of applicants on our state exchange that it investigated 62 percent were either improperly granted subsidies or the application was deficient in some other meaningful way.

The most prevalent problems were inconsistencies in reporting their eligibility data and their income. The Web site didn't seem to question those, and applicants received subsidies that frankly they weren't entitled to.

So before I get back to some questions on that, we also just last week, an insurer called Health Republic of New York, which is a New York City-based insurance cooperative and a very significant player in our state exchange, especially up in western New York that I represent, was directed by state and federal officials to stop writing health plans, effectively shut down because they were not solvent, which means over 12,000 people in western New York, which I represent, are going to lose their health plans.

Here was the problem with Health Republic of New York. As a new insurer under the ACA, that company received government assistance to cover startup costs in return for providing more competition in the marketplace, but as you might suspect, their policies were not what the market could sustain. They cost too little and gave away too many benefits. These plans sucked in unsuspecting New Yorkers by wasting taxpayer money and distorting the health insurance marketplaces. These New Yorkers now have to find a new plan with staggering price increases that reflect the real rate of coverage for the ACA-mandated benefits.

So while I know none of you represent New York, I would like to know, have your state exchanges been audited like New York just was by HHS where we found this 62 percent error rate and again subsidies being given that were not based on eligibility or income, and if so, what did your states--I know, Mr. Allen, you may not--

Mr. {Allen.} We used the federal platform so we--

Mr. {Collins.} We will just skip you, all right? There we go. Sorry about that.

Ms. O'Toole?

Ms. {O'Toole.} Thank you, Congressman. Not to my knowledge. I did see that report so I'm generally familiar with what you're talking about. Not to my knowledge. I just want to note that we obviously take compliance very seriously. We have a robust team that's working on that, and making sure that only eligible Minnesotans are enrolled through MNsure. So it's a focus for us.

Mr. {Collins.} Well, that is what we would certainly hope for. Thank you.

Mr. Gutierrez?

Mr. {Gutierrez.} Not to my knowledge on the formal audit but we also have an in-depth validation program for our eligibility system.

Mr. {Collins.} I am glad to hear that as well.

Mr. Kissel?

Mr. {Kissel.} We have not been audited but we have-- we're a small community, and since everybody has my phone number, we're self-audited in that respect.

The inquiries to us went from the thousands in 2014 down to a few dozen in 2015. We did have a problem, and I think it has largely been resolved. The 1095 IRS reporting process

for us went very smoothly with fewer than 100 overall issues and fewer than two dozen financial issues.

Mr. {Collins.} Thank you.

Mr. Lee?

Mr. {Lee.} Covered California has been the subject of a range of both OIG, GAO, HHS audits and reviews of enrollment practices. Pretty much all of them will find options for improvement but by and large have found that we've been complying with the rules and setting them in place better and better each year.

Mr. {Collins.} I am glad to California is doing better than New York.

Mr. Wadleigh?

Mr. {Wadleigh.} Thank you for the question. We too have had multiple audits from the GAO, OIG, and we also take all those opportunities to improve our system.

Mr. {Collins.} Thank you. I don't think I have time for my other question, Mr. Chairman, so I yield back.

Mr. {Murphy.} The gentleman yields back.

So I recognized Mrs. Brooks for 5 minutes.

Mrs. {Brooks.} Thank you, Mr. Chairman. I apologize. I

was at another hearing.

Mr. Allen and Mr. Kissel, I guess I have a question for both of you. Do you know whether CMS permits establishment grant dollars to be spent on the transitional costs to healthcare.gov, and if you could tell me transitional costs are? Mr. Allen?

Mr. {Allen.} I do not know the answer to that directly. We need to respond directly to the committee later.

Mrs. {Brooks.} Mr. Kissel?

Mr. {Kissel.} Yes. We have submitted a transition budget, and it has--I've got to check on its status. I believe it has been approved. And these are for the enrollment of new members in healthcare.gov. It is for the decommissioning and archiving of our existing technology and certain other items including approximately $225,000 for the program management organization that the state has retained to manage the transition of our functions into both healthcare.gov and into the state departments, the operating departments.

Mrs. {Brooks.} And was this a written policy, if you know, that Hawaii is using--you are using your money,

correct, from establishment to transition?

Mr. {Kissel.} Correct.

Mrs. {Brooks.} Was this a written policy or was this something you negotiated?

Mr. {Kissel.} I don't know whether it is written but I do know that we agreed on with CMS.

Mrs. {Brooks.} And do you know what was the basis for that agreement? Why did CMS say that you could use your establishment dollars to transition, and what was the rationale?

Mr. {Kissel.} I can't speak for all of their decisions because it covered technology, it covered outreach, it covered a large number of issues. Insofar as outreach, it is only to enroll new members in healthcare.gov. We are bearing the cost of re-enrolling our 38,000 existing members into healthcare.gov. That's coming from internal state funds.

Mrs. {Brooks.} And do you believe that this should be permitted? Obviously it is beneficial to Hawaii, correct?

Mr. {Kissel.} Let me answer the question by saying in hindsight, we are learning an awful lot. Had the regulations relating to small business health options been in place then

that are in place now, Hawaii never would have had to undertake to build the exchange to support our Prepaid Healthcare Act and harmonize it with the Affordable Care Act. This is the kind of issue that I think this transition will be later.

Mrs. {Brooks.} And I apologize if these questions were asked, but why did your Governor choose to shut down the Hawaii Health Connector?

Mr. {Kissel.} He worked extensively with CMS Administrator Slavitt, and they came to the conclusion jointly that because we were an independent, reliable agency relying solely on issuer fees for revenue, we couldn't get to critical mass to be self-sustaining. The Governor decided to embed these functions into state departments--our Department of Labor, our Department of Human Services--and bear the cost of essentially the deficit because we were not financially sustainable. Administrator Slavitt encouraged us to do this so that we could maintain insurance for Qualified Health Plan recipients indefinitely in compliance with the Affordable Care Act.

Mrs. {Brooks.} Was that your role and was that--what

was your role in that decision?

Mr. {Kissel.} Because we're not a part of the administration, we're an independent corporation with separate board of directors, our role was to make the Hawaii Health Connector work, and we developed plans that did, we believe, make it work. We fixed the technology, and we went forward with a financing plan that we thought would be workable. CMS and the state decided that that had too high a risk for our small and fragile economy, and they decided it was better to continue on the basis of moving to healthcare.gov.

Mrs. {Brooks.} Was there a contractor involved in that transition?

Mr. {Kissel.} There are contractors involved in the transition on behalf of the Hawaii Health Connector, the state, and the Medicaid agency to build the interface with healthcare.gov.

Mrs. {Brooks.} So how many contractors are involved and how was that contract awarded--those contracts?

Mr. {Kissel.} We have two contractors involved, two principal contractors involved at the Hawaii Health

Connector, mostly in the archiving and decommissioning of the process. There are--there is a sole source contract with KPMG for building the interface. That's done in accordance with state procurement regulations.

Mrs. {Brooks.} Are there other contractors involved?

Mr. {Kissel.} Yes, there are. Health Management Associates is providing the PMO, the project management, for the transition.

Mrs. {Brooks.} And do you have any sense of the transition cost?

Mr. {Kissel.} I know that their initial contract is for $400,000. The state is going to have to spend its own money to embed these functions in the various departments.

Mrs. {Brooks.} Thank you. I yield back.

Mr. {Murphy.} The gentlelady yields back.

There will be other questions. I know, Mr. Kissel, you had just mentioned about other costs that have been identified for different departments. Your Governor directed the Department of Labor, you said--we will be sending other questions. I would love to know about other costs and how--what you anticipate future costs and how your states are

going to absorb those additional costs. It is important for us to know that.

So I want to thank to thank you all for being here today and participating. Members, I want to remind you, have 10 business days to get other questions for the record, and I ask all witnesses to agree to respond quickly and promptly to those questions.

And with that, this committee hearing is adjourned.

[Whereupon, at 12:03 p.m., the subcommittee was adjourned.]