

FRAUD, WASTE, AND ABUSE UNDER THE AFFORDABLE CARE ACT

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH CARE,
BENEFITS AND ADMINISTRATIVE RULES

OF THE

COMMITTEE ON OVERSIGHT
AND GOVERNMENT REFORM
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FRAUD, WASTE, AND ABUSE UNDER THE AFFORDABLE CARE ACT

Tuesday, January 31, 2017

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH CARE, BENEFITS AND
ADMINISTRATIVE RULES
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM,
Washington, D.C.

The subcommittee met, pursuant to call, at 2:00 p.m., in Room 2247, Rayburn House Office Building, Hon. Jim Jordan [chairman of the subcommittee] presiding.

Present: Representatives Jordan, Walker, Issa, Meadows, Grothman, Mitchell, Krishnamoorthi, Lawrence, and Norton.

Also Present: Representative Cummings.

Mr. JORDAN. The Subcommittee on Health Care, Benefits, and Administrative Rules will come to order.

Without objection, the chair is authorized to declare a recess at any time.

It is my understanding that the Democrat Caucus has not designated who all the members are. We know the ranking member, and we're pleased to have Mr. K here and Ms. Lawrence as well, but I understand we don't know for sure who all is on this committee. So we need to do a unanimous consent that all members of the Committee on Oversight and Government Reform be allowed to fully participate in today's subcommittee hearing.

Without objection, so ordered.

Welcome to the new Congress.

And, Mr. Krishnamoorthi—

Mr. KRISHNAMOORTHI. Yes, sir.

Mr. JORDAN. —we appreciate you being here and being the ranking member. And if you'd like to—we have Mr. Mitchell, and I know a number of other new members to the Oversight Committee will be joining us from potentially the Democrat side as well. So we want to welcome Mr. Mitchell to the committee this afternoon.

Let's start with opening statements and then get right to our witnesses. And we appreciate our witnesses being here today, talking about this important subject.

Health insurance premiums are soaring. President Obama and the administration promised multiple times that the Affordable Care Act would lower health insurance premiums by \$2,500. American families are still waiting to see those reductions. Instead, the health insurance premiums have skyrocketed under the Affordable Care Act. There has been about a 25-percent average increase in premiums just this year. Some Americans have experienced even

higher premium increases and had to drop coverage because it became just too darn expensive.

Under the Affordable Care Act, there are not just rising premiums; many Americans have also seen massive increases in the cost of their deductible. Healthcare costs are one of the top concerns for families, and even people with insurance oftentimes can't afford to use it, especially individuals enrolled in high-deductible health plans under the ACA.

There were promises from the administration about increased competition. In fact, though, in most parts of the country, there are only one or two insurers participating in the health insurance exchange in 2017. Insurers are seeing unprecedented losses on the exchanges. Losses on the exchanges are reaching into the billions of dollars for the health insurance industry. As a result, several large insurers are pulling out of the exchanges.

According to the Heritage Foundation, before the ACA was implemented, there were 12 insurers participating in the individual market in North Carolina. Today, only two insurers are participating in the exchanges in that State. In many areas of North Carolina, there is only one insurer selling coverage on the exchange.

And, finally, of course, we cannot forget the Affordable Care Act was sold on one of the biggest political misleading statements of all time: If you like your plan, you can keep it; if you like your doctor, you can keep your doctor. Even the President had to apologize for that one.

As we examine healthcare reform proposals, it is important to keep these realities in mind. While millions of individuals receive health coverage under the Affordable Care Act, many more are being harmed by the skyrocketing healthcare costs.

Today, I want to hear from the Health and Human Services Inspector General and the GAO on implementation of the Affordable Care Act and their recent and ongoing work in this area. Both of these agencies have done excellent work reviewing the Affordable Care Act programs and activities, and I want to hear their recommendations on how we can use lessons learned from the implementation of some of these programs to improve future programs.

The work of HHS OIG is critical to ensuring the integrity of Health and Human Services programs, and I am constantly impressed with the great work that comes out of their office. I look forward to hearing about the OIG's work relating to the Affordable Care Act.

Thank you, Mrs. Robinson, for testifying on behalf of OIG's office today.

The General Accountability Office has also done great work examining the early impact of the Affordable Care Act on private health insurance markets, and I look forward to learning more about their findings.

So thank you, Mr. Dicken, for testifying on behalf of GAO today.

And we are also pleased to have Mr. Jonathan Siegel here with us today to hear about his experiences under the ACA.

Thank you again for your willingness to be here and to testify.

I look forward to the discussion today. Congress needs to find a way to help make sure Americans have access to affordable health insurance and can choose among a variety of plans.

With that, I would now yield to our ranking member for his opening statement, and then we'll get right to our witnesses and our hearing.

The gentleman from Illinois is recognized.

Mr. KRISHNAMOORTHY. Thank you, Mr. Chairman.

And thank you to our witnesses for joining us today.

Millions of people now have high-quality, affordable health care as a result of the Affordable Care Act. One of my constituents wrote this to me, and I quote: "We are so grateful for the changes brought about the ACA in our situation. They have truly been life-changing for us. For the first time, our family has access to dental coverage. This means we actually go to the dentist. Before, this was a rare thing and only when in pain. For the first time, our preventative care is covered. This means my children are up to date on their vaccines and physicals because it is not costing me hundreds of dollars out of pocket. For the first time, we have hope that we may be able to dig out of the mountain of medical debt we have accumulated through a \$10,000-a-year deductible plan that we were locked into because of preexisting conditions because we now can get reasonable coverage through the marketplace."

Mr. Chairman, there are millions of people with similar stories all across the country, and all of our offices are being flooded by correspondence relating the same.

In addition, as a former small-businessman, I know that the ACA has allowed entrepreneurs to flourish because they don't have to worry that starting a new business means they can't afford health care. When people have high-quality, affordable health care, they can afford to follow their dreams, their talents, become entrepreneurs like myself, start businesses, create jobs, and grow the economy. When they are fearful about losing their health insurance or are buried under medical debt, none of those things are possible.

The Affordable Care Act empowered millions of people. One of them is a witness today, Mr. Jonathan Siegel.

And thank you, sir, for joining us.

He will testify that the guarantee of affordable coverage under the ACA enabled him to start a new business.

But there is a lot of fear in the country that those gains will be taken away by House Republicans if and when they repeal the Affordable Care Act. In fact, today, House Republicans have not offered an alternative to replace the ACA that offers the same coverage at a similar or lower cost. Let me repeat that: Today, House Republicans have not offered an alternative to replace the ACA that offers the same coverage at a similar or lower cost.

The consequences will be seriously harmful to Americans. First, a recent CBO and Joint Committee on Taxation analysis estimates that 18 million Americans would lose their health insurance in just the first year following a repeal without replacement. Second, the CBO and Joint Committee on Taxation estimates that premiums would increase by 20 to 25 percent more than currently projected in the first plan year following repeal.

These consequences are not limited to those who bought their health care on exchanges. ACA protections apply to all health plans, including those that many Americans get through their employer. Employer-provided insurance plans would no longer be required to offer the same level of care that they do today. Employees with preexisting conditions would have restrictions placed on their care. The lifetime cap on out-of-pocket expenses would disappear. And we'd return to the days when parents could no longer have young-adult children under 26 on their plans. Removing these protections will hurt businesses, workers, and families in my district and across the country.

Third and finally, the economic consequences of repeal without replace would be catastrophic. My home State of Illinois stands to lose over 100,000 jobs and \$13 billion in gross State output. My district alone would lose 4,000 jobs. Ohio, your home State, sir, could lose up to 126,000 jobs.

Repealing without replacing is foolhardy and reckless. What House Republicans have proposed so far inspires little trust that their plans will actually help Americans. We will not sit idly by while the ACA is torn down without any replacement. We need a replacement that offers coverage at similar or lower costs.

I yield the balance of my time.

Mr. JORDAN. I thank the gentleman.

We have three goals, I think, for today's hearing. One, we want to review the impact of the ACA on the health insurance market, including its impact on affordability, quality, choice, and access. Two, we want to understand the Federal Government's implementation of the ACA and how taxpayer dollars were spent, if there was any waste, any fraud, any abuse in those areas. And, three, as I think the ranking member was getting to in his comments, we have a big debate going on here in Congress, and we want to gather as much information as we can as we are debating the repeal, something I think should happen, of the Affordable Care Act. So those are our three goals.

We'll hold the record open for 5 legislative days for any members who would like to submit a written statement.

And I want to recognize Mr. Grothman for being here. It's the first time he's been a part of this subcommittee.

And I recognize, if he would like a short opening statement, our new vice chair, Mr. Walker from North Carolina.

Mr. WALKER. Jim, I thank you for your work as the chairman and hope that we are able to really fulfill our promises to the American people in getting to the bottom of some of the issues and concerns that we have with the ACA as a whole.

I've been privileged to work with you the last couple years. I know your heart is to work with all communities, and you have a record of that. And we look forward to seeing what we can get done. Thanks. I'm privileged to be part of it.

Mr. JORDAN. Thank you.

Ms. Vicki Robinson, Senior Counselor for Policy for the Office of the Inspector General at the U.S. Department of Health and Human Services, is with us today, as well as Mr. John Dicken, Director of Health Care at the United States Government Accountability Office, and Mr. Jonathan Siegel from Rochester, New York.

Welcome to you all.

Pursuant to committee rules, all witnesses will be sworn in before they testify, so please rise and raise your right hands, if you would, please.

Do you solemnly swear or affirm that the testimony you're about to give will be the truth, the whole truth, and nothing but the truth, so help you God?

Let the record show that each witness answered in the affirmative.

You guys are way ahead of me. You've done this before. You're already seated. So let's start with our first witness.

Ms. Robinson, you get to go first. And you know how it works. You get 5 minutes, give or take a few seconds, and then we'll go to the next one.

WITNESS STATEMENTS

STATEMENT OF VICKI ROBINSON

Ms. ROBINSON. Well, good afternoon, Chairman Jordan, Ranking Member Krishnamoorthi, and other distinguished members of the subcommittee. Thank you for the opportunity to discuss our work overseeing the Federal and State health insurance marketplaces established under the Affordable Care Act.

We are committed to combating fraud, waste, and abuse and promoting integrity, efficiency, and effectiveness in the programs run by the Department of Health and Human Services. Our work looks retrospectively to determine whether programs have worked as they should and prospectively to identify weaknesses to avoid and best practices to replicate in the future.

To oversee the marketplaces, we examined core program integrity questions: Are taxpayer funds being expended correctly for their intended uses? Are the right people getting the right benefits? Is the Department managing and administering the programs effectively and efficiently?

We identified three types of vulnerabilities: one, the need for tighter payment controls to prevent wasteful spending; two, the need for more reliable processes to ensure accurate eligibility determinations for applicants; and, three, the need for improved management.

Our findings and recommendations are detailed in my written testimony and in our reports. Let me offer some examples, starting with our payment accuracy work.

CMS was hampered in its administration of the Advanced Premium Tax Credit that provides subsidies to help consumers afford insurance. At the start of the program, CMS used a manual financial process that did not collect data on enrollee-by-enrollee policy-level payments. Rather, CMS collected only aggregated payment data from insurers. As a result, we found that CMS was not able to verify the accuracy of the payments to insurers, nor that enrollees benefiting from these payments had paid their portion of the premium as required.

We also found deficiencies in the administration of the establishment grant program that provided Federal funding to States to set up marketplaces. Most States we examined failed to allocate costs

properly between their establishment grant funding and funding for other programs that shared systems with the marketplaces, such as Medicaid. This resulted in States over-claiming Federal establishment grant funding.

Further, we found vulnerabilities in eligibility verification processes at both the Federal and State marketplaces. For example, we found that the marketplaces did not always properly verify Social Security numbers, citizenship, and household income.

Finally, we identified weaknesses in management of the Federal marketplace, including poor oversight of the many contractors engaged to build it. For example, CMS waited far too long to hire a systems integrator to coordinate the work of the contractors.

We examined CMS's management of the Federal marketplace across a 5-year period. We identified many missteps that contributed to the poor launch of the healthcare.gov website. We also identified better management practices that contributed to its subsequent improvement. These included, for example, assigning clear project leadership and fully integrating technical and policy staff. Our work offers important lessons to inform the management of complex policy and technology projects now and in the future.

To close, protecting taxpayer investments and consumers requires vigilance and sustained focus. Program integrity should remain a priority for the design and operation of current and future programs. Preventing, detecting, and remediating problems is our collective mission.

Thank you again for inviting me to appear today, and I look forward to answering your questions.

[Prepared statement of Ms. Robinson follows:]

Testimony of:
Vicki L. Robinson
Senior Counselor for Policy
Office of Inspector General, U.S. Department of Health and Human Services

Good afternoon, Chairman Jordan, Ranking Member Krishnamoorthi, and other distinguished Members of the Subcommittee. I am Vicki Robinson, Senior Counselor for Policy in the Office of Inspector General (OIG), U.S. Department of Health and Human Services (HHS or the Department). Thank you for the opportunity to appear before you today to discuss findings and recommendations from OIG's oversight of the Federal and State-based marketplaces established under the Patient Protection and Affordable Care Act (ACA).

Created by statute in 1976, OIG remains a nonpartisan body of evaluators, auditors, and investigators deployed across the Nation to help assess and protect the integrity of Federal health and human services programs enacted by Congress. We are committed to working with our stakeholders to protect taxpayer-funded programs and patients from fraud, waste, and abuse and to promote efficient and effective program operations. We focus on prevention, detection, and enforcement to fight fraud, waste, and abuse; promote quality, safety, and value; and foster sound financial stewardship of HHS programs. When we identify misconduct, we take appropriate enforcement action and make recommendations to address vulnerabilities and improve Department programs and operations.

OIG's Oversight of ACA Marketplaces

ACA established health insurance exchanges (commonly referred to as "marketplaces") to allow individuals and small businesses to shop for health insurance in all 50 States and the District of Columbia. States could choose to operate their own State marketplace or the Department would operate a Federal marketplace for residents of States without a State marketplace. ACA provided funding assistance, known as establishment grants, to States for planning and establishing their own marketplaces. In addition, ACA provided funding to assist eligible consumers. This assistance consists of subsidies in the form of tax credits and cost-sharing reductions. ACA also provided funding for health insurance issuers in the form of premium stabilization programs, such as the reinsurance and risk adjustment programs. The marketplaces presented complex regulatory, operational, and technological challenges for the Department and for States.

Testimony Before the United States House of Representatives
Committee on Oversight and Government Reform
Subcommittee on Health Care, Benefits, and Administrative Rules

January 31, 2017

Beginning in 2012, OIG identified implementation, operation, and oversight of the health insurance marketplaces as among the most significant management challenges facing the Department. Our marketplace oversight work has focused on key program integrity questions, including:

- Are taxpayer funds being expended correctly for their intended purposes?
- Are the right people getting the right benefits?
- Is the Department managing and administering the marketplace programs effectively and efficiently?

Since 2013, we have issued 38 audits and evaluations regarding the Federal and State-based marketplaces and related programs.¹ In addition to this oversight work, OIG has established relationships with its law enforcement partners to investigate fraud and closely monitor activities and concerns. We work with the Department to help identify potential fraud and ensure that allegations of fraud are investigated appropriately.

Today, I will summarize findings and recommendations from our oversight work with respect to payment accuracy, eligibility determinations, and the Department's management of the Federal marketplace. My testimony will highlight challenges and lessons learned that can inform the Department and policymakers as they consider HHS programs going forward.

OIG's Findings and Recommendations

OIG's work identified several challenges that potentially hampered the operation of the marketplaces. These challenges generally fall into three categories: insufficient payment controls that could lead to wasteful spending, vulnerabilities in ensuring accurate eligibility determinations at the Federal and State-based marketplaces, and challenges for Departmental management. For example, we found weaknesses in the Centers for Medicare & Medicaid Services' (CMS) financial management systems as well as deficiencies in States' management of establishment grants. In addition, CMS's contract monitoring and administration needed improvement. Finally, OIG identified broader lessons through our review of CMS's development and administration of HealthCare.gov (the website consumers use to access the Federal marketplace), including the poor launch and subsequent improvement of the site. OIG has recommended various improvements to address these challenges and vulnerabilities.

¹ A complete list of OIG reports related to ACA is on OIG's website at <http://oig.hhs.gov/reports-and-publications/aca/>.

Insufficient Payment Controls That Could Lead to Wasteful Spending

Ensuring sound expenditure of taxpayer funds for financial assistance payments and other marketplace purposes posed a substantial management challenge. OIG identified deficiencies that put Federal funds at risk of being misused or wasted due to ineffective internal controls in the financial management systems at both the Federal and State-based marketplaces.

For example, OIG identified the following deficiencies in CMS's financial management systems related to advance premium tax credits (APTC) and cost-sharing reductions made available under ACA:

- CMS lacked controls to ensure that financial assistance payments were correctly calculated. Specifically, CMS had limited ability to ensure that payments were made accurately to health insurance issuers because CMS obtained payment data from issuers on an aggregate basis, rather than by enrollee. As a result, CMS could not verify the accuracy of the nearly \$2.8 billion it authorized for financial assistance payments for the first four months of 2014. We recommended that CMS implement computerized systems for the Federal and State-based marketplaces to maintain individual enrollee and payment information.
- CMS lacked controls to ensure effectively that APTC payments were made only for enrollees who paid their monthly premiums. CMS relied on health insurance issuers to verify that enrollees paid their monthly premiums to the issuers. CMS did not obtain APTC payment information from the issuers on an enrollee-by-enrollee basis and thus could not verify whether individual enrollees had paid premiums. We recommended that CMS establish policies and procedures to ensure that APTC payments are made only on behalf of enrollees who have paid their premiums.

OIG identified establishment grants awarded to State-based marketplaces as a risk for potential misspent funds because of the complex requirements related to implementation and the potential overlap with other programs. OIG has issued seven reports that review establishment grants. The following deficiencies were identified in these reports:

- Four of the State-based marketplaces misallocated costs between establishment grant funding designated for marketplaces and funding for other programs that shared marketplace systems, such as Medicaid. We found that this misallocation occurred because these States used outdated or flawed information when better data were available. Generally, States allocated more costs to the establishment grant than they should have under Federal grant rules. For example, one State misallocated \$28.4 million in costs to the establishment grant. A portion of those costs may be claimed through the

State's Medicaid program, which would require the State to pay for a percentage of those costs using State funds. We recommended that States refund misallocated costs, update or amend cost allocation methodologies to make use of better data, and develop written policies to ensure that costs are allocated appropriately.

- In our most recent report, the State-based marketplace charged the establishment grant for \$4.5 million in unallowable costs, including prepaid operational expenses. OIG found that costs were unallowable because the marketplace used establishment grant funds to pay for operational support and maintenance services provided after December 31, 2014. Establishment grant funds were not available for such purposes after this date. In addition, the marketplace had other deficiencies, resulting in an additional \$5.2 million not being expended in accordance with Federal requirements. We recommended that the marketplace refund \$9.7 million and develop, finalize, and implement policies and procedures to ensure that it expends Federal grant funds in accordance with applicable requirements.

OIG also identified a risk related to insufficient CMS guidance regarding the particular types of operational costs that State-based marketplaces could charge against an establishment grant. We were concerned that, absent better guidance, States might incorrectly charge the establishment grant funds for prohibited costs, such as rent, software maintenance, telecommunications, and utilities. To help prevent potential waste of establishment grant funds, we issued an alert to CMS. As a result, CMS published updated guidance to clarify which costs States could not charge against the grants.

Vulnerabilities in Ensuring Accurate Eligibility Determinations

Accurate eligibility determinations ensure that only qualifying consumers can enroll in qualified health plans and receive financial assistance. OIG found vulnerabilities in CMS's eligibility verification and enrollment processes, as well as CMS's resolution of data inconsistencies. In three separate reviews of the Federal marketplace, OIG identified deficiencies related to the Federal marketplace's internal controls, including the following:

- Social Security numbers were not always validated with the Social Security Administration.
- Citizenship was not always verified in accordance with Federal requirements.
- Household income was not always verified properly.
- Inconsistencies between applicants' self-attested information and data received through the Federal data hub or from other data sources related to certain eligibility requirements, most commonly citizenship and income, were not resolved properly.

These deficiencies may have limited the Federal marketplace's ability to prevent inaccurate or fraudulent information from being used to determine eligibility of applicants.

OIG also reviewed internal controls on eligibility determinations at seven State-based marketplaces. We determined that certain internal controls were effective at the State-based marketplaces. However, we found that most of the State-based marketplaces had some ineffective internal controls for ensuring that individuals were enrolled in a qualified health plan in accordance with Federal requirements. Common deficiencies we identified included:

- Six State-based marketplaces did not always use existing data sources to verify whether applicants were eligible for health insurance through an employer or through other sources, such as Medicare or the Federal Employees Health Benefits Program.
- Four State-based marketplaces did not always properly verify annual household income.
- Six State-based marketplaces did not always resolve inconsistencies or notify applicants of inconsistencies.
- Four State-based marketplaces did not always properly maintain data or accurate records.

We recommended that both the Federal and State-based marketplaces improve their internal controls and redetermine eligibility for the applicants in our sample whose eligibility verifications did not meet Federal requirements.

Challenges That Impede Effective Department Management

Effective Department management and administration are critical to meeting program objectives and providing sound stewardship of Federal resources. OIG conducted several reviews focused on CMS's management of marketplace programs. For example, we examined CMS' acquisition planning and procurement of contracts to implement the Federal marketplace. CMS awarded 60 contracts across 33 companies to support the development and operation of the Federal marketplace. We identified vulnerabilities and offered recommendations related to contract monitoring and administration of payments for contracts related to the marketplaces. For example, we found:

- CMS did not always manage and oversee contractor performance in accordance with Federal requirements and contract terms. For example, CMS was unable to identify contractor delays and performance issues in all instances and was unable to identify when a contractor incurred \$ 28 million in unauthorized costs that increased the cost of the contract. OIG recommended that CMS direct its acquisition personnel to refrain from authorizing additional work on contracts, absent proper approval and funding. In response, CMS updated its internal guidance to delineate clearly that only the contracting

officer could make changes to the terms and conditions of a contract or direct a contractor to perform work or make deliveries not specifically required under the contract.

- CMS did not accurately identify all obligations and expenditures for six contracts we reviewed related to the Federal marketplace. CMS recorded \$24.3 million of obligations and \$22.9 million of expenditures, but it did not identify them as being related to the Federal marketplace. Consequently, CMS was unable to account accurately for and report to interested stakeholders the amount spent on the development, implementation, and operation of the Federal marketplace. We recommended that CMS include all relevant contract costs when it identifies total obligations and expenditures related to the design, development, and operation of the Federal marketplace.
- CMS missed the opportunity to plan for a lead systems integrator to coordinate the efforts of multiple contractors for the Federal marketplace. CMS did not identify a systems integrator until after the October 2013 launch of the Federal marketplace. The many companies that were awarded Federal marketplace contracts had individual tasks to support the implementation of the Federal marketplace. Yet there was no single point of contact with responsibility for integrating contractors' efforts and communicating the common project goals to all companies.

OIG also examined CMS's overall management and administration of HealthCare.gov. In 2016, OIG published a case study detailing the implementation of the website and identifying organizational factors that contributed to the website's poor launch and subsequent improvement. This work highlights lessons that can inform not just the management and administration of the marketplaces, but also other complex Department programs and operations now and in the future. These lessons learned will become increasingly important as Government programs become more dependent on the effective intersection of policy, technology, and management.

In the case study, OIG found that HHS and CMS made many avoidable missteps in developing HealthCare.gov that contributed to the poor website launch. For example:

- Lack of clear project leadership led to fragmentation and poor coordination, causing delays in making policy decisions and confusion about goals and objectives.
- Mismanagement of information technology contracts resulted in inefficient use of resources, problematic technological decisions, and limited oversight of contractor performance.
- Poor communication, particularly between policy and technical staff, hampered efforts to identify and correct problems, leading to a compressed timeframe for completing the

website build and a failure to recognize the magnitude of problems as the project deteriorated.

Following the poor launch, CMS changed its management approach to improve operations, including:

- hiring a systems integrator to coordinate the work of multiple contractors, simplify processes, and increase accountability;
- integrating the policy and technical teams of employed and contracted staff into a single, “badgeless” team that fosters innovation, problem solving, and communication; and
- practicing what CMS officials called “ruthless prioritization” of tasks to target the most urgent needs and align goals with available resources.

These strategies led to broader organizational changes focused on leadership, a deeper integration of policy and technology, and more active communication among partners, such as other Federal agencies, States, contractors, and insurers.

Conclusion

OIG is committed to fighting fraud, waste, and abuse in HHS programs and promoting their economy, efficiency, and effectiveness. OIG’s marketplace oversight work highlights challenges and lessons learned with respect to payment systems, eligibility determinations, and management and administration of complex programs. Ensuring program integrity requires vigilance and sustained focus on preventing problems from occurring in the first place, detecting problems promptly when they occur, and rapidly remediating detected problems through investigations, enforcement, and corrective actions. Program integrity is central to OIG’s mission and should be a priority for current and future HHS programs.

Thank you, again, for inviting me to speak with the Committee today to discuss our oversight of ACA marketplaces.

Mr. JORDAN. Thank you, Ms. Robinson.
Mr. Dicken, you're recognized for 5 minutes.

STATEMENT OF JOHN DICKEN

Mr. DICKEN. Thank you.

Chairman Jordan, Ranking Member Krishnamoorthi, and members of the subcommittee, I'm pleased to be here today as the subcommittee discusses the Patient Protection and Affordable Care Act.

Ms. Robinson highlighted some of the Inspector General's findings related to program integrity. My comments focus on the Affordable Care Act in relation to health insurance markets, highlighting findings from recent GAO reports on insurer availability, variation in premiums, and enrollee satisfaction.

The Affordable Care Act contained provisions that affect how issuers determine health insurance coverage and premiums and how they market their plans. Many of these provisions took effect in 2014.

For example, the act prohibits issuers from denying coverage or varying premiums based on health status or gender. The law also requires health plans be marketed based on metal tiers—bronze, silver, gold, and platinum—to help consumers compare the relative value of each plan.

It also required the establishment of health insurance exchanges in each State through which consumers select from among participating health plans. About 11 million individuals purchased health plans through the exchanges in 2016.

Given the act's reliance on the participation of private health plans, the law required GAO to report on competition and concentration in health insurance markets. In a 2016 report, we found out health insurance markets were concentrated among a small number of issuers in most States from 2010 through 2014, where the three largest issuers had at least 80 percent of enrollment. In 2014, enrollment in exchange plans during their first year was generally more concentrated among a few issuers than was true for the overall markets.

GAO has also reported on consumers' access to health plans offered through the exchanges. In 38 States for which GAO had sufficiently reliable data, we found most consumers had six or more bronze-, silver-, and gold-tier plans available through the exchanges in 2014 and 2015. For example, 94 percent of counties had at least six silver-tier plans available in 2015.

Since GAO issued the report, HHS has reported a decline in the number of issuers participating in the federally facilitated exchanges in 2017. According to HHS, all consumers continue to have multiple plan options, but for about 21 percent of them the options were limited to plans offered by a single issuer.

GAO also reported on the considerable variation in health insurance premiums available to consumers in 2014 and 2015. First example, in Arizona in 2015, the lowest-cost silver plan for a 30-year-old consumer was \$147 per month, but in Maine the lowest-cost silver plan for a 30-year-old was \$237 per month.

The range of premiums also varied considerably by State. While the lowest-cost silver plan for a 30-year-old in Arizona was \$147

per month, the highest-cost silver plan in 2015 was \$545 per month, a difference of 270 percent. In contrast, in Rhode Island, 2015 premiums for silver plans available to a 30-year-old range from \$217 to \$285 per month, a difference of just 32 percent.

More recent analyses by HHS found that premiums for exchange plans increased more in 2017 than in earlier years, an average of 25 percent from 2016 to 2017 for the second-lowest-cost silver plans in States that use the federally facilitated exchange. In comparison, average premiums for these plans increased 2 percent from 2014 to 2015 and 7 percent from 2015 to 2016.

Finally, let me close with key findings from a 2016 GAO report on enrollees' experiences in health plans offered through the exchanges.

Most exchange enrollees report being satisfied overall with their plans in 2014 through 2016, according to three national surveys. This report satisfaction was either somewhat lower than or similar to that of enrollees in employer-sponsored plans.

While most enrollees expressed overall satisfaction, concerns about enrollees' experiences with exchanges plans were revealed in other information GAO collected from stakeholders and literature. Often, these were consistent with longstanding consumers' concerns about private health insurance generally, such as affordability of out-of-pocket expenses and difficulties understanding coverage terminology.

Mr. Chairman, this concludes my statement. I would be glad to answer any question to you or the members of the subcommittee may have.

[Prepared statement of Mr. Dicken follows:]

United States Government Accountability Office



Testimony
Before the Subcommittee on Health Care,
Benefits, and Administrative Rules,
Committee on Oversight and Government
Reform, House of Representatives

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PATIENT PROTECTION AND AFFORDABLE CARE ACT

Concentration, Plan Availability and Premiums, and Enrollee Experiences in Health Insurance Markets Since 2014

Statement of John E. Dicken
Director, Health Care

GAO Highlights

Highlights of GAO-17-383T, a testimony before the Subcommittee on Health Care, Benefits, and Administrative Rules, Committee on Oversight and Government Reform, House of Representatives

Why GAO Did This Study

PPACA contained provisions, many of which took effect in 2014, that could affect how issuers determine health insurance coverage and premiums and how they market their plans. For example, PPACA prohibits issuers from denying coverage or varying premiums based on consumer health status or gender. PPACA also requires health plans to generally be marketed based on metal tiers (bronze, silver, gold, and platinum), which allows consumers to compare the relative value of each plan. It also required the establishment of health insurance exchanges in each state, through which consumers can compare and select from among participating health plans.

This testimony describes (1) private health-insurance market concentration and issuer participation from 2011 through 2014, the year by which key PPACA provisions took effect, (2) health plans and premiums available to individuals in 2014 and 2015, and (3) the experience of enrollees that obtained coverage through the exchanges from 2014 through 2016. It is based on three GAO reports issued in 2015 and 2016. For these reports, GAO examined data from the Centers for Medicare & Medicaid Services (CMS); reviewed published research; and interviewed stakeholders, including experts and officials from CMS and five states—Colorado, Indiana, Montana, North Carolina, and Vermont—that varied in geography and whether the state or CMS offered the exchange.

View GAO-17-383T. For more information, contact John E. Dicken at (202) 512-7114 or dickenj@gao.gov.

January 2017

PATIENT PROTECTION AND AFFORDABLE CARE ACT

Concentration, Plan Availability and Premiums, and Enrollee Experiences in Health Insurance Markets Since 2014

What GAO Found

GAO issued three reports in 2015 and 2016 on the early impact of the Patient Protection and Affordable Care Act (PPACA) on private health insurance markets.

Market Concentration

- In a 2016 report, GAO examined enrollment in private health-insurance plans in the years leading up to and through 2014, the first year of the exchanges established by PPACA, and found that in all years analyzed, markets were concentrated among a small number of issuers in most states.
- Beginning in 2014, enrollment in PPACA exchange plans was generally more concentrated among a few issuers than was true for the overall markets.

Plan Availability and Premiums

- In a 2015 report, GAO examined the availability of health plans for individual market consumers and found that they generally had access to more health plans in 2015 than in 2014.
- In both years, most consumers in 28 states for which GAO had sufficiently reliable data had 6 or more plans from which to choose in three of the four health plan metal tiers (bronze, silver, and gold).
- The range of premiums available to consumers varied considerably by state, and in most states the costs for the minimum and median premiums for silver plans increased from 2014 to 2015. In both years, the lowest cost plans were typically available on an exchange.
- More recent analyses by the Department of Health and Human Services found that in 2017 all consumers continued to have multiple plan options, and that premiums for exchange plans increased more in 2017 compared to the annual increases for these plans since 2014.

Enrollee Experiences

- In a 2016 report, GAO examined national survey data to examine satisfaction of exchange enrollees. GAO found that, from 2014 through 2016, most enrollees who obtained their coverage through an exchange reported being satisfied overall with their plans.
- In 2015 and 2016, the satisfaction that exchange enrollees reported with their plans was either somewhat lower than or similar to that of enrollees in employer-sponsored plans.
- Exchange enrollees reported varying degrees of satisfaction with specific aspects of their plans, including coverage and plan affordability.
- Stakeholders GAO interviewed and literature GAO reviewed revealed some concerns about exchange enrollee experiences that were generally consistent with longstanding concerns in the private health insurance market—including concerns about affordability of out-of-pocket expenses and difficulties understanding coverage terminology.

Chairman Jordan, Ranking Member Krishnamoorthi, and Members of the Subcommittee:

I am pleased to be here today to discuss findings of several recent GAO reports on the effects of the Patient Protection and Affordable Care Act (PPACA) on health insurance markets, including insurer availability, variation in premiums, and enrollee satisfaction.¹

According to the most recently available Census Bureau estimates, over 189 million Americans under the age of 65 obtained health coverage from private health insurance plans in 2015.² Private health insurance is sold through individual and group markets. Group market participants generally obtain health insurance coverage through a group health plan, usually offered by an employer—small employers purchase insurance from the small-group market and large employers purchase from the large-group market.³ Americans without access to group health coverage, such as those with employers that do not offer health coverage, may choose to purchase it directly from an insurer through the individual market. All three markets (individual, small-group, and large-group) have historically been highly concentrated—that is, a small number of issuers in a market enrolled a significant portion of the people in that market.⁴

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

²Census Bureau, *Health Insurance Coverage in the United States: 2015* (Washington, D.C.: September 2016).

³For group health plan purposes, federal law defines a small employer as having an average of 1 to 50 employees on business days during the preceding calendar year and employing at least 1 employee on the first day of the plan year, however, states may instead elect to define the term as an employer having an average of 1 to 100 employees on business days during the preceding calendar year. See 42 U.S.C. §§ 300gg-91(e), 18024(b).

⁴GAO, *Private Health Insurance: Concentration of Enrollees among Individual, Small Group, and Large Group Insurers from 2010 through 2013*, GAO-15-101R (Washington, D.C.: Dec. 1, 2014).

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

As you know, PPACA contained a number of provisions that could affect private health insurance markets, many of which took effect for plan years beginning in 2014. For example, it changed how insurers determine health insurance coverage and premiums and how they market their plans, such as by prohibiting insurers from denying coverage to individuals and from varying premiums based on consumer health status or gender and established limits on premium variation based on age, geographic location, and other factors. In addition, PPACA established requirements for the benefits that must be covered by health plans—referred to as essential health benefits—and required insurers to market their plans according to defined categories based on the extent to which the plans would be expected to cover the costs of enrollees' medical care.

PPACA also required the establishment of health insurance exchanges in each state beginning in 2014—marketplaces through which consumers can compare and select health insurance coverage from among all the health plans participating in the state exchange. These plans are known as qualified health plans (QHP). Some states have established their own exchanges—referred to as state-based exchanges. In states that have not done so, consumers have access to a federally facilitated exchange (FFE). For 2017, 17 states were operating a state-based exchange and 34 states were using the FFE. In general, plans available on either type of exchange are also available for sale outside of the exchange, in that the consumer could work directly with an insurer to purchase a plan without using their state's exchange. However, PPACA provided incentives for many consumers to use the exchange instead of purchasing plans directly from an insurer. For example, certain consumers are eligible for tax credits to help them pay their premiums, but only if they purchase a QHP through the exchange. In addition, the exchanges are required to carry out certain consumer assistance functions that may facilitate individuals' selection of and enrollment in exchange coverage. The combination of all of these provisions allows consumers to use the exchanges to directly compare the health insurance plans available to them based on premium costs, benefits covered, and plan generosity.⁵ According to the Department of Health and Human Services (HHS), enrollments in the exchanges have increased every year since 2014, with about 11 million individuals having purchased health plans through the exchanges in 2016, up from about 7 million in 2014.

⁵We refer to the expected impact of the design of plan coverage on enrollee cost sharing as a plan's "generosity." A plan whose enrollees would incur lower out-of-pocket costs is more generous than one whose enrollees would incur higher costs.

This testimony describes (1) private health-insurance market concentration and issuer participation in the individual, small-group, and large-group markets from 2011 through 2014, the years leading up to and through the first year that key PPACA provisions took effect; (2) the numbers of health plans and ranges of health plan premiums available to individuals during the first 2 years of exchange operation (2014 and 2015); and (3) enrollee experiences with QHPs obtained through the exchanges during the first 3 years of exchange operation (2014 through 2016).

My comments are primarily based on three reports we issued in 2015 and 2016.⁶ For these reports, we primarily examined data from the Centers for Medicare & Medicaid Services (CMS), within HHS, and previously published research. For our 2016 report on private health-insurance market concentration and issuer participation, we analyzed data from 2011 through 2014, the first year of PPACA exchanges, to see how market concentration and issuer participation in 2014 compared to earlier years. We used 2011 through 2014 Medical Loss Ratio datasets and 2014 Unified Rate Review data that issuers are required to report annually to CMS. For our 2015 report on the numbers of health plans and ranges of health plan premiums available to individuals in 2014 and 2015, we also analyzed data from CMS. Comparisons across years were conducted at both the state and the county level for states that had sufficiently reliable data in both years—including comparisons of plans offered either on or off an exchange in 28 states (1,886 counties), and comparisons of plans offered only on an exchange for 38 states (2,613 counties). For our 2016 report on enrollee experiences with QHPs obtained through the exchanges during the first years of exchange operation, we performed a search of research databases to identify relevant literature published from January 1, 2014, through April 30, 2016. Among other things, we identified and reviewed the results of five national surveys of QHP enrollees who obtained their coverage through the exchanges. We interviewed stakeholders, including officials from CMS and five states—Colorado, Indiana, Montana, North Carolina, and Vermont—that varied geographically and by whether the state or CMS

⁶GAO, *Private Health Insurance: In Most States and New Exchanges, Enrollees Continued to be Concentrated among Few Issuers in 2014*, GAO-16-724 (Washington, D.C.: Sept. 6, 2016); GAO, *Private Health Insurance: The Range of Premiums and Plan Availability for Individuals in 2014 and 2015*, GAO-15-687 (Washington, D.C.: Aug. 10, 2015); and GAO, *Patient Protection and Affordable Care Act: Most Enrollees Reported Satisfaction with Their Health Plans, Although Some Concerns Exist*, GAO-16-761 (Washington, D.C.: Sept. 12, 2016).

offered the exchange. Each report includes a full description of our scope and methodology. For the purpose of this testimony, we also present more recent data on issuer participation, plan availability, and premium options in the exchanges that were published by HHS in 2016.⁷

We conducted the work upon which this statement is based in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

PPACA required the establishment of individual health insurance exchanges, as well as small business exchanges, within each state by 2014.⁸ PPACA does not require issuers to offer plans through these exchanges, but instead generally relies on market incentives to encourage issuer participation. Issuers seeking to offer a health plan in an individual exchange or small business exchange must first have that plan approved by the exchange in the state. We previously reported that most of the largest issuers holding the majority of the market in the 2012 individual and small-group markets participated in the 2014 exchanges, although most of the numerous smaller issuers in those markets did not.⁹ In addition, some issuers that participated in the 2014 individual or small business exchanges had not participated in that respective market in 2012. While some of these issuers had previously provided coverage in other markets in 2012, other issuers were newly established through the federally supported Consumer Oriented and Operated Plans (CO-OP) program.¹⁰

⁷HHS Office of the Assistant Secretary for Planning and Evaluation, *Health Plan Choice and Premiums in the 2017 Health Insurance Marketplace* (Washington, D.C.: Oct. 24, 2016).

⁸States may establish separate individual and small business exchanges or a single exchange to serve both individuals and small employers.

⁹GAO, *Patient Protection and Affordable Care Act: Largest Issuers of Health Coverage Participated in Most Exchanges, and Number of Plans Available Varied*, GAO-14-657 (Washington, D.C. Aug. 29, 2014).

¹⁰PPACA established a program to foster the creation of consumer-governed, not-for-profit issuers of health coverage—referred to as CO-OPs—that would provide additional coverage options in the individual and small-business exchanges. For 2014, 23 CO-OPs receiving federal loans offered coverage through the exchanges.

As I mentioned above, PPACA also changed, as of 2014, how insurers determine health insurance premiums and how consumers shop for health insurance plans. As part of this, PPACA required that health plans be marketed based on information that helps consumers compare the relative value of each plan. Specifically, plans must be marketed by specific categories—including four “metal” tiers of coverage (bronze, silver, gold, and platinum)—that reflect out-of-pocket costs that may be incurred by an enrollee.¹¹ These changes occurred at the same time that PPACA required the establishment of health insurance exchanges for each state, through which consumers could compare and select from among QHPs. Finally, beginning January 1, 2014, premium tax credits and cost-sharing subsidies became available under PPACA for qualified individuals who purchased QHPs sold through an exchange.¹²

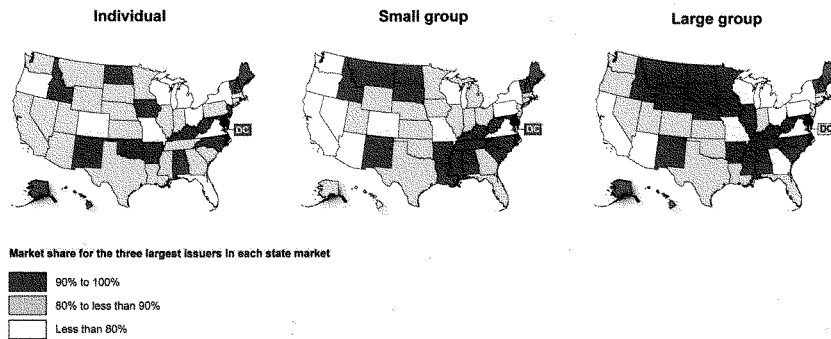
Health-Insurance Markets Remained Concentrated in Most States in 2014, While Issuer Participation Generally Decreased from the Prior Year

In 2016, we examined enrollment in private health-insurance plans in the years leading up to and through 2014, the first year of the exchanges established by PPACA, and found that in each year, markets were concentrated among a small number of issuers in most states. On average, in each state, 11 or more issuers participated in each of three types of markets—individual, small group, and large group—from 2011 through 2014. However, in most states, the 3 largest issuers in each market had at least an 80 percent share of the market during the period. (See fig. 1.) Not all issuers in the individual and small group markets participated in the exchanges in 2014, and several exchanges had fewer than 3 participating issuers. Enrollment through the exchanges was generally more concentrated among a few issuers than was true for the individual and small group markets overall in 2014.

¹¹The metal tier designation categorizes plans by their actuarial value, which reflects the amount out of pocket costs that may be incurred by an enrollee. Bronze plans (with an actuarial value of 60 percent) tend to have the lowest premiums but leave consumers subject to the highest out-of-pocket costs when they receive health care services, while platinum plans (with an actuarial value of 90 percent) tend to have the highest premiums and the lowest out-of-pocket costs. In addition to these metal tiers, catastrophic plans are available for certain individuals who are exempt from the requirement to have minimum essential coverage. Catastrophic plans’ actuarial value must be lower than that of a bronze plan.

¹²Premium tax credits may be used to reduce monthly premiums, and cost-sharing subsidies decrease out-of-pocket expenses such as deductibles and copays.

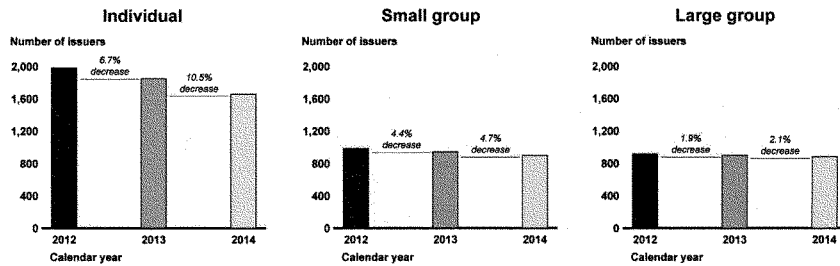
Figure 1: Market Share for the Three Largest Issuers, by Market in 2014



Sources: GAO analysis of data from the Centers for Medicare & Medicaid Services (data); Map Resources (map). | GAO-17-383T

For our examination of issuer participation in the first year of the exchanges, we reported that fewer issuers participated in most state health insurance markets in 2014 compared to 2013, though exiting issuers generally had small market shares in that prior year. Specifically, we found that from 2013 to 2014, the number of issuers participating in individual markets decreased in 46 states, while fewer states' small-group and large-group markets had decreased participation (28 and 22 states, respectively). (See fig. 2.) However, across the three types of markets, those issuers exiting each state market before 2014 generally had less than 1 percent of the market in the prior year. There were also issuers that newly entered state markets in 2014. Their market shares in 2014 varied across the three types of markets, with some newly entering issuers in the individual market capturing a market share of over 10 percent. Most newly entering issuers in 2014 participated in the exchanges and they generally had a larger share of the enrollment sold through the exchanges than through the overall markets. In addition, some newly entering issuers captured a majority of their exchange market, with CO-OPs having a higher proportion.

Figure 2: Total Number of Issuers Participating in the Individual, Small-Group, and Large-Group Markets across All States, 2012-2014



Source: GAO analysis of data from the Centers for Medicare & Medicaid Services. | GAO-17-383T

Since 2014, there have been additional changes to the number of issuers entering and exiting the individual and small group markets. For example, most of the CO-OPs that offered coverage in the exchanges in 2014 have since discontinued offering coverage.¹³ In addition, in an analysis of data from exchanges in states that used the FFE and state-based exchanges, where available, HHS has since reported that the number of issuers offering health plans through the exchanges decreased from 2016 to 2017, reflecting multi-state withdrawals by a few large insurers.¹⁴

¹³We found that as of January 2016, 12 of the 23 CO-OPs that offered coverage in 2014 had since discontinued offering coverage. For additional information on the CO-OPs, see GAO, *Private Health Insurance: Federal Oversight, Premiums, and Enrollment for Consumer Operated and Oriented Plans in 2015*, GAO-16-326 (Washington, D.C.: Mar. 10, 2016).

¹⁴HHS Office of the Assistant Secretary for Planning and Evaluation, *Health Plan Choice and Premiums in the 2017 Health Insurance Marketplace* (Washington, D.C.: Oct. 24, 2016).

Consumers in the Individual Market Had Access to More Plans in 2015 than 2014, with Varying Premiums in Both Years

In 2015, we reported that individual market consumers generally had access to more health plans in 2015—a year after the initial implementation of key PPACA provisions—than in 2014. Consumers in most of the counties analyzed in the 28 states for which we had sufficiently reliable data for plans offered either on or off an exchange had six or more plans from which to choose in three of the four health plan metal tiers (bronze, silver, and gold) in both 2014 and 2015. The percentage of counties with six or more plans in those metal tiers increased from 2014 to 2015. Specifically, in 2014, six or more bronze-, silver-, and gold-tier plans were available to consumers in the individual market (either on or off an exchange) in at least 95 percent of the 1,886 counties and were available on an exchange in at least 59 percent of the 2,613 of the counties for which we had sufficiently reliable data for plans offered on an exchange. In 2015, the percentage of these same counties with six or more bronze-, silver-, and gold-tier plans available in the individual market increased to 100 percent, and at least 71 percent had six or more of these plans available on an exchange. (See table 1.)¹⁵

Table 1: The Percentages of Counties in Which Various Numbers of Health Plans Were Offered to Individual Market Consumers, by Market Category and Metal Tier, 2014 and 2015

Market category	Metal tier	Percentage of counties in 2014			Percentage of counties in 2015		
		No plans available	Between 1 and 5 plans available	6 or more plans available	No plans available	Between 1 and 5 plans available	6 or more plans available
All plans (available on or off exchange) ^a	Bronze	0%	3%	97%	0%	0%	100%
	Silver	0	3	97	0	0	100
	Gold	0	5	95	0	0	100
	Platinum	9	31	60	1	15	84
Plans available on an exchange ^b	Bronze	0	20	80	0	12	88
	Silver	0	20	80	0	6	94
	Gold	0	41	59	0	29	71
	Platinum	46	48	7	31	63	6

Source: GAO analysis of Center for Consumer Information and Insurance Oversight data. | GAO-17-383T

Note: Figures may not total 100 across rows within each year due to rounding.

^aIncludes data for plans in the 1,886 counties in the 28 states for which we had sufficiently reliable data on plans whether or not they were sold through an exchange.

^bIncludes data for plans in the 2,613 counties in the 38 states for which we had sufficiently reliable data on plans sold through exchanges.

¹⁵Consumers had fewer options regarding platinum-tier plans, although the availability of platinum plans generally also increased from 2014 to 2015.

In our 2015 report, we also found that premiums varied among states and counties, the lowest cost plans were typically available on an exchange, and in most states premiums increased from 2014 to 2015. Specifically, we found that:

- The range of premiums available to consumers in 2014 and 2015 varied among the states and counties we analyzed. For example, in Arizona, the premium for the lowest-cost silver plan option for a 30-year-old in 2015 was \$147 per month, but in Maine, the lowest-cost silver plan for a 30-year-old in 2015 was \$237. We also found that the range of premiums—from the lowest to highest cost—differed considerably by state. For example, in Rhode Island, 2015 premiums for silver plans available to a 30-year-old either on or off an exchange ranged from a low of \$217 per month to a high of \$285 per month, a difference of 32 percent. By contrast, in Arizona, 2015 premiums for these plans ranged from a low of \$147 per month to a high of \$545 per month, a difference of 270 percent.
- The lowest cost plans were typically available on an exchange. Specifically, in both years, taking into account plans available through an exchange and those only available off an exchange, the lowest cost plans were available through an exchange in most of the 1,886 counties we analyzed in the 28 states.
- In most states, the costs for the minimum and median premiums for silver plans increased from 2014 to 2015. For example, in the 28 states included in our analysis, from 2014 to 2015 the minimum premiums for silver plans available to a 30-year-old increased in 18 states, decreased in 9 states, and remained unchanged in 1 state. At the county level, we found that premiums for the lowest cost silver option available for a 30-year-old increased by 5 percent or more in 51 percent of the counties in the 28 states.

While our 2015 report examining the numbers of health plans and ranges of health plan premiums available to individuals in 2014 and 2015 was our most recent examination of these two issues, HHS has examined more recent data.¹⁶ For example, in 2016, HHS reported that despite a decline in the number of issuers participating in the FFE from 2016 to 2017, all consumers were able to choose among various plan options for

¹⁶HHS Office of the Assistant Secretary for Planning and Evaluation, *Health Plan Choice and Premiums in the 2017 Health Insurance Marketplace* (Washington, D.C.: Oct. 24, 2016).

2017, although the options for about 21 percent of consumers were among choices of plans offered by a single insurer. HHS also conducted analyses focused on the premiums for the second-lowest cost silver plan in states that used the FFE and estimated that average premiums for these plans increased more between 2016 and 2017 (25 percent) than in previous years (2 percent between 2014 and 2015, and 7 percent between 2015 and 2016).¹⁷

Available Data Show That Most Early QHP Enrollees Expressed Satisfaction with Their Plans in 2014 through 2016, Despite Some Concerns

In 2016, we reported that most enrollees who obtained their coverage through the health insurance exchanges were satisfied overall with their QHP during the first few years that exchanges operated, according to national surveys of QHP enrollees. For example, most QHP enrollees who obtained their coverage through the exchanges reported overall satisfaction with their plans in 2014 through 2016, according to three national surveys that asked this question. One survey found that most 2015 enrollees re-enrolled in 2016 with the same insurer, and often with the same plan offered by that insurer, and another survey reported that most re-enrollees expressed satisfaction with their QHP. The surveys reported that QHP enrollees' satisfaction with their plans was either somewhat lower than, or was similar to, that of those enrolled in employer-sponsored health insurance in 2015 and 2016. To varying degrees, QHP enrollees expressed satisfaction with specific aspects of their plan, including their coverage and choice of providers, and with plan affordability.

We also interviewed stakeholders—including experts, state departments of insurance, and others—and reviewed literature for our 2016 report. These interviews and the literature revealed some concerns about QHP enrollee experiences that were similar to longstanding concerns in the private health insurance market. For example, according to these experts, some enrollees found it too expensive to pay for their out-of-pocket expenses before reaching their deductibles and have reported concerns about affording care or have been deterred from seeking care. Some enrollees have also faced difficulties understanding their QHP's coverage terminology and others have faced problems accessing care after enrollment, according to stakeholders and literature we reviewed.

¹⁷The second lowest-cost silver plan has significance because PPACA's premium tax credits are calculated based on the premiums for these plans.

Chairman Jordan, Ranking Member Krishnamoorthi, and Members of the Subcommittee, this concludes my statement. I look forward to answering any questions that you may have.

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Acknowledgments**

For questions about this statement, please contact John E. Dicken at (202) 512-7114 or dickenj@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement.

Individuals making key contributions to this statement include John E. Dicken, Director; Gerardine Brennan and William Hadley, Assistant Directors; and Kristen J. Anderson, LaKendra Beard, Sandra George, and Laurie Pachter.

Mr. JORDAN. Thank you, Mr. Dicken.
Mr. Siegel, you're recognized.

STATEMENT OF JONATHAN W. SIEGEL

Mr. SIEGEL. Thank you, Mr. Chairman, Mr. Ranking Member, members of the committee. It is a pleasure to be with you today. I come as a husband, a father, and an independent businessman, but, most of all, I come as a citizen of our beloved country.

Here is my story. In 2012, I was laid off. I was 56, with one child still in high school and the other just having graduated. I was lucky. I got a severance that provided the resources for me to continue my insurance through COBRA for the rest of 2012 and 2013.

A friend invited me to be a founding partner of a new market research agency. Most importantly, by the time we started the firm, the effective launch of the ACA was only a year away. Because of the ACA, I could start this business knowing that my family would continue to get affordable insurance no matter how the business did. Without the ACA, I would not have had the courage to launch my own business but would have sought the sanctuary of traditional employment.

We have purchased our insurance without subsidy, a gold plan, on the exchanges since the ACA began. Our premium is about \$1,360 a month, plus an additional \$60 a month for dental insurance—\$600 less a month than our COBRA plan was.

Because New York State took the Medicaid expansion, I know that, no matter what happens to me, my family will get affordable health care. Affordability is a big issue for us. My spouse of 30 years has MS. She is the bravest person I know, taking her shots for over 20 years. The cost of her medications is over \$30,000 a year at free-market prices. Yes, we do participate in a manufacturer's program that gives some people access to their meds without charge, but we don't know when it will end. Even so, there is the cost of ongoing doctor visits, MRIs, and other tests.

The ACA and the Medicaid expansion also protect my children, now 21 and 23. They are working at jobs that do not provide health insurance. We make sure they have it today. It is a great comfort to an aging parent to know that the ACA assures that they can continue to have affordable coverage when they turn 26 no matter their employment situation.

In all of these ways, the ACA enhances my security, reduces anxiety, and furthers freedom, not just for me but for all Americans who at any time may find that employer-based insurance just doesn't work or isn't available to them.

The possible replacement of the ACA with insurance options that are unwise, inadequate, and discriminatory threatens us. We may not receive subsidies, but we are not making much more than the cutoff point for subsidies. About 20 to 25 percent of our income today goes for medical and dental insurance and health care. I don't know what that percentage will be when purchase becomes voluntary and insurance can pedal anything they want, skimming away those lucky enough to be perfectly healthy.

What happens if, without the ACA, the cost of adequate insurance goes up to \$3,000 or more a month? How can anyone afford

that for years on end? My spouse is, after all, only 57 years old. What happens if no one will insure her at any price?

Some people say that high-risk pools are a solution. I've got to tell you, there are few words more frightening to me than those. The term is a misstatement. My spouse is not a high risk. It is the healthy who are high risk, because we do not know what illness will strike us or when. So these pools are really pools of high-cost citizens. That is a real complaint some people have about my spouse: She has the nerve to need expensive care to treat an illness.

Once it is clear that it is the cost, not the risk, that is a problem, it is obvious why so many of us fear high-risk pools. To work for the patient, you have to have clear rules for who gets put in them, you have to assure that they don't pay for more insurance than others would pay, and you need to assure that they get all the care they need.

I have yet to see a proposal that provides these protections. Instead, we have vague promises of Federal and State support. Without these protection, high-risk pools are not insurance or health care; they are just vicious cruelty to ordinary Americans who've worked hard, played by the rules, but have had a little bad luck.

A better name for high-risk pools without these protections is death pools. The goal of their advocates, in my view, is to shunt off to one side the folks who cost too much, whose fate is too hard, and let them die out of sight and out of mind. My spouse is not someone to shunt off, to cast away. She is a human being who has as much right to quality health insurance and care at a price she can afford as any of us.

I am also frightened by some proposed changes to Medicaid. The object of these proposals seems to be to reduce it by cutting what it covers or tightening eligibility. Paint it as you will, but the real goal seems to be punishing low-income people for the sin of being low-income. There is a good chance that will include my children. My children and all people with low income do not deserve this. They are children of God, just like the rest of us.

In closing, the story of the ACA is not just my story or the stories of millions of other people. It is first and foremost a story about democracy. Democracy is not just a set of rules about who gets power and under what conditions; democracy is also about assuring equal dignity to all citizens.

The argument over health care and health insurance is thus the latest battle in the unending struggle that Lincoln described many years ago, the struggle that to me defines the United States and the highest purpose of citizenship, the struggle to assure that government of the people, by the people, and for the people shall not perish from the Earth.

Thank you.

[Prepared statement of Mr. Siegel follows:]

Jonathan W. Siegel, Citizen

Testimony Prepared for the Hearing "Fraud, Waste and Abuse Under the Affordable Care Act"

Subcommittee on Health Care, Benefits, and Administrative Rules

January, 31, 2017

Thank You Mr. Chairman, Mr. Ranking Member, Members of the Committee:

It is a pleasure to be with you here today. I come not as an expert on healthcare but simply as a husband, a father and an independent businessman.

For the last 17 years my spouse and I and our two children, who are now young adults, have lived in Brighton, a suburb of Rochester, NY. For most of our time there we purchased insurance as most people do, through our employer, in my case Harris Interactive.

In 2012, I became one of the hundreds laid off by that company over a decade as it struggled and ultimately failed to survive. As part of the process for obtaining unemployment insurance, New York State informed me that I was very unlikely to find employment in my field in Rochester and that I should consider starting my own business. I was 56, with one child still in high school and the other just having graduated.

I was lucky. I got a decent severance package which provided the resources for me to continue my insurance through COBRA at about \$2,000 a month for the rest of 2012 and 2013. I also had a former colleague who was launching a small market research agency and invited me to be one of the founding partners. Most importantly, by the time we launched the firm, the effective launch of the ACA was only a year away. My COBRA insurance though expensive would get me to then.

Because of the ACA I could start this new business with the assurance that my family would continue to get affordable insurance no matter how the business did. Starting the business meant carefully watching our spending--we moved to a smaller house and cut back on other expenses--but thanks to the ACA we did not face financial ruin if something happened to our health. Without the ACA, I would not have had the courage to launch my own business, but would have instead sought the sanctuary of more traditional employment despite the view of New York State that the odds were against me.

We have purchased our insurance without subsidy, a gold plan through MVP, on the exchanges since then. The current premium is about \$1,360 a month, plus an additional \$60 or so a month for dental insurance, much less than I had paid under COBRA for insurance that is comparable. It is not just our ability to purchase quality insurance today that matters. New York State took the Medicaid expansion so now I know that no matter what happens to me, even should I die, that my family can get good affordable insurance.

This is a real issue for us. My spouse of 30 years has MS. She is one of the bravest people I know, taking her shots religiously for over 20 years and living with the uncertainties of this disease that results from

the rolling of G_d's dice. The cost of her medications is huge, over \$30,000 a year at free-market prices. Yes, we along with others have benefitted from a manufacturer's program that gives some people access to their meds without charge, though we never know when the program might end. Even so, there is the cost of ongoing doctor visits, MRIs and other tests. We know not what the future holds.

The ACA and the Medicaid expansion also protect my children, now 21 and 23. Like many young people, they are struggling to find themselves in this world. They are both working at jobs that do not provide health insurance and offer no job security. We make sure they have it today and the ACA assures that we can continue to do this until they are 27.

I cannot tell you how much of a comfort it is to an aging parent to know that under the ACA once they are 27 that they are assured of access to quality health insurance through Medicaid if they are not able to find an employer who provides insurance or do not make enough to purchase insurance through the ACA Marketplace. It means that there is at least one thing I don't need to worry about; they can get health insurance and healthcare no matter what happens to their mom or to me and no matter their employment situation.

The ACA has thus helped me go out and start my own business, protected my wife from the potential financial burdens of MS and assured me that my children, whatever else may happen to them or to us, need not go without health insurance or health care.

All of this is now in question because of the possible replacement of the ACA with insurance options that seem unwise, inadequate and discriminatory. I fear for my health insurance coverage, and even more for my spouse and my children.

We may not receive subsidies, but we are not making that much more than the cutoff point for subsidies. About 20%-25% of our gross income goes to pay for medical and dental insurance and health care (including deductibles and co-pays). What that percentage will go to if purchase becomes voluntary and insurers can peddle anything they want, skimming away those lucky enough for a short time to be perfectly healthy, G_d only knows; especially if you take away the power of New York State's insurance commissioner to approve plans.

What happens to us if the cost of adequate insurance goes up to \$3,000 or more a month? How can anyone afford that? For years on end? My spouse is, after all, only 57 years old. What happens if no one will insure her at any price? And what happens to her if my business fails or otherwise comes to an end?

Now, some people say that high risk pools are a solution to this problem. Just put folks like my spouse in those pools and the cost will come down for everyone else. And by some miracle she'll be covered.

There are few more frightening terms in this world than 'high risk pool'. It is, first, a miss-statement. My spouse is not a high risk. Doctors have a good feel for MS and how it progresses and the treatments that are available. It is in fact us, the healthy, who are high risk because we do not know what illness will strike us yet, though we know something will eventually. So these pools are really pools of 'current

high cost citizens'. And that is a clue to the real complaint some of you have about my spouse: she has the nerve to need expensive care to treat an illness.

Once it is clear that it is the cost, not the risk, that is the problem, it should also be obvious why so many of us distrust 'high risk pools'. To work for the patient, you have to have clear rules for who gets in them, you have to assure that they don't pay more for insurance than they would pay if they were not in the pool, and you need to assure that they get all the care they need.

So far, in all the discussion of high risk pools, I see no mechanism in anything that has been proposed that will do that. We have, instead, just vague promises that Federal and state governments will allocate money. The amounts we have heard such as \$25 billion over ten years from the Federal government, for instance, are laughably inadequate.

So, though it may sound harsh, it seems to me that a better name for 'high risk pools' is 'death pools'. The goal seems not to provide health insurance or health care but, rather, to shunt off to one side the folks who cost too much, whose fate is too hard, and let them die out of sight and out of mind. My spouse is not someone to shunt off, to cast away; she is a human being who has as much right to quality health insurance and care at a price she can afford as any of us.

So high risk pools are not insurance or healthcare. They are just vicious cruelty to ordinary Americans who've worked hard, played by the rules, but have had a little bad luck, bad luck that it is the purpose of insurance to cover. How anyone in public office can propose this is beyond me.

I am also frightened by some of the proposed changes to Medicaid. The thrust of most of these proposals seems to be to reduce Medicaid spending by reducing what it covers and tightening eligibility. Paint it as you will, but the real goal seems to be punishing low-income people for the simple sin of being low income. There's a good chance that will include my children. My children, and all people with low income, imperfect and struggling though they may be, do not deserve this; they are children of G_d just like the rest of us.

It is, I think, easy to misunderstand the importance of the ACA in two ways. One is to get so tangled up in the details of public policy that one loses sight of the people affected. I hope I have helped you avoid that problem. The other is to get so focused on individual stories that one misses what the debate about the ACA means for our country.

The story of the ACA is not just my story or the stories of millions of other people. It is first and foremost a story about democracy. Democracy is not just a set of rules about who gets power and under what conditions. Democracy at its core is about creating the assurance of equal dignity to all citizens. The ACA furthers this profound democratic goal. It liberates citizens from fear and ill health; enabling them to start a business, care for a parent, or help launch their children on their life voyage.

The argument about the ACA is thus the latest battle in the unending struggle that Lincoln so nobly declaimed about many years ago on a battlefield not far from here, the struggle that our forebears so willingly made the ultimate sacrifice to advance, the struggle that to me defines the United States and

the highest purpose of citizenship, the struggle to assure that "government of the people, by the people and for the people shall not perish from the earth."

Thank you.

Mr. JORDAN. I thank you, Mr. Siegel.

Real quick before we recognize the gentleman from North Carolina, I just wanted for clarification, because I wasn't sure I understood, you currently don't have a plan that is—you're not receiving a subsidy from the government in the form of a refundable tax credit or anything else under your—

Mr. SIEGEL. No. That's correct. No subsidy.

Mr. JORDAN. So you're paying for your insurance on your own.

Mr. SIEGEL. Entirely. Have since day one.

Mr. JORDAN. Okay. I just wanted to make that clear.

I want to welcome the ranking member of the full committee, Mr. Cummings, and would now recognize the gentleman from North Carolina.

Mr. WALKER. Thank you, Mr. Chairman.

Mr. Siegel, thank you for the courage you expressed today in sharing your story. I'm obviously impressed with how much you love your wife as well. You can tell she means a lot to you. Mine does as well, a nurse practitioner. We've been married 24 years.

Most of my career I've spent as a minister, a pastor. I worked in the refugee camps in Europe, visited many people. I've seen destitute and despair, health, the funerals, you name it, have been across the board.

I'm also concerned about the millions of people who have been damaged, even unintentional, by the Affordable Care Act. In fact, if you want to get down to raw numbers, we have 11 percent of North Carolinians who still don't have any insurance of any kind.

So I don't want to get into all the bits and pieces of the numbers, but, according to your most neutral polling, 25 percent of the population have been damaged by either higher premiums, lost insurance, or something along when it comes to dealing with ObamaCare or the Affordable Care Act.

In fact, even moving it from the individual aspect and even getting it to the business, it was President Clinton and the Minnesota Governor who recently talked about the damage the ACA has caused for small businesses. According to a Gallup poll not too long ago, 70-something percent believed it should be altered, overhauled, or completely repealed.

So where I want to dial down my questions today, after giving a little bit of a preface there, is specifically I would like to talk to Mr. Dicken about some questions that we have on some broken promises when it comes to the Treasury.

Under ObamaCare's reinsurance program, section 1341 directed the HHS to collect—let me make sure we get this number correctly—\$5 billion and send it directly to the United States Treasury to pay for ObamaCare's cost. HHS sent the money to insurance companies instead and disregarded the Treasury and the American people. As of 2015, HHS denied the Treasury and taxpayers now up to \$3.5 billion that they were owed.

So I really don't have a lot of questions, but just one major one here would be this, if you would answer it. Since September of last year, GAO issued a ruling concerning HHS's actions. What did GAO determine with this report?

Mr. DICKEN. Thank you, Congressman Walker.

And you're correct that last year GAO did issue a legal opinion looking at the payments under the program. As you indicated, the Affordable Care Act indicated that both the payments that were collected were to be provided some to the general Treasury, some in reinsurance payments to the payers.

In fact, the collections were less than the amount that HHS had fully intended to include in the reinsurance and paid all of that to the insurers instead. GAO's legal opinion indicated that, in fact, those payments should have also been to the general Treasury.

Mr. WALKER. Obviously, this is a pattern for the last 3 years. Can you share what the reasoning was, as far as disregarding the Treasury, which, as we know, is basically taxpayers' money? Why was it disregarded? Can you brief us on that?

Mr. DICKEN. Yeah, I would defer to—you know, I think, certainly, HHS's attorneys would be able to speak to the legal reasoning there, but that, in general, because the collections were less than the amount that are authorized, that was the priority that HHS made in giving the reinsurance to the insurers first without payments to the Treasury.

Mr. WALKER. Do you still—well, let me ask you this. Do you have any idea how much is still owed to the U.S. Treasury that the previous administration refused or denied to pay?

Mr. DICKEN. I don't have that at my fingertips but certainly can follow up.

Mr. WALKER. Do you have any kind of ballpark? Is it in the billions of dollars?

Mr. DICKEN. I think it indicated that the requirement was for several billion, Treasury. Some of those payments could still be made, because those collections for 2016 would actually be made in 2017. And so some of that is still being reconciled.

Mr. WALKER. Thank you, Mr. Dicken.

Mr. Chairman, I yield back.

Mr. JORDAN. I thank the gentleman and would now recognize the ranking member from Illinois for his 5 minutes.

Mr. KRISHNAMOORTHY. Thank you, sir. I would like to yield to the ranking member of the general committee to make a few comments, please.

Mr. CUMMINGS. Thank you very much.

I want to thank you, Mr. Chairman.

And I want to take an opportunity to officially welcome Congressman Krishnamoorthi to his first Oversight Committee hearing. We're very fortunate to have him on our committee. He brings a valuable perspective as a small-businessman and entrepreneur and as a lawyer and a public servant.

We also are fortunate that he has accepted the responsibility of serving as the ranking member on this very, very important Health Subcommittee. This subcommittee takes up some of the most important issues that come before our committee, not the least of which is the Affordable Care Act.

Recent polls have shown that the number-one issue, even beyond this, by the way, is another subject that he, I'm sure, will touch on at some point, and that is the cost of prescription drugs. That is the number-one issue with regard to independents, Democrats, and Republicans.

And in recent hearings we've had testimony about how, Mr. Chairman and Ranking Member, about how the cost of prescription drugs, these folks who are improperly and because of greed raising the prices of these drugs, that, too, is going into the cost of health care, and very significant.

And so we are truly at a crossroads with regard to the ACA. Congressional Republicans are moving forward to repeal this law without having an adequate replacement. As a matter of fact, they had a deadline, I think, of yesterday or today. They didn't meet the deadline. If they do this, it will be nothing short of disastrous for tens of millions of Americans who have gained coverage thanks to the ACA.

It will also be disastrous for Americans with employer-provided insurance who have benefited from the ACA's many consumer protections. People with employer-provided insurance no longer have caps on the annual and lifetime coverage benefits. They now have free preventive care like cholesterol screenings and mammograms. And there is no price that you can pay or put on prevention, no price that you can put on wellness. And so they cannot be treated any differently by their insurance company because of a preexisting condition.

Repealing the ACA would also have disastrous effects on our economy. Repeal would completely destabilize the insurance market, drive premiums up, and cost millions of jobs across our entire country. This is not what the American people want, and it is certainly not what they need.

All types of statistics have been cited with regard to people who want to repeal, but a lot of times when people—you need to dig into those numbers a little bit and discover that there are a whole group of people that want to expand the Affordable Care Act.

And so we've got a situation here where we have to keep in mind that health care should not be a privilege, it must be a right. When you have an unhealthy society, you have a society that cannot be all that God meant for it to be.

And so I am excited about our new ranking member. I know that he will bring much to this discussion. He is here for a reason, and that is to make a difference.

I would only say this. Mr. Ranking Member, you weren't here when we voted for the Affordable Care Act, but I've told my constituents many times that in my 14 years as a member of the Maryland legislature and my 21 years as a Member of this legislature there is nothing that I have done that has been more important than pulling that lever for the Affordable Care Act. Because I have absolutely, unequivocally no doubt that we have saved lives and we will continue to save lives. We can repair—there are things that probably need to be done, but we must make sure that the American people are healthy.

And, with that, I would thank the ranking member for yielding, and I yield back.

Mr. JORDAN. I thank the gentleman.

The ranking member is recognized.

Mr. KRISHNAMOORTHY. Thank you, Mr. Ranking Member. I agree with your comments that it appears to me that we should mend the ACA, not end it—mend, don't end it.

I have a couple questions. Thank you so much to the witnesses for coming today. I was heartened to learned from Mr. Dicken that the people on the ACA were about as satisfied, in terms of their satisfaction levels, as compared to those in employer plans.

Is that generally correct?

Mr. DICKEN. Yeah. The surveys we saw, there were generally satisfaction levels in the 70 or 80 percent overall satisfaction, which was similar to or somewhat lower than for employer-sponsored plans.

Mr. KRISHNAMOORTHY. Right. And I would surmise that their satisfaction levels would go down if they had no health coverage, if there was a repeal without replacement, correct?

Mr. DICKEN. This was satisfaction with their health plan, so I can't speak to what satisfaction would be without the health plan.

Mr. KRISHNAMOORTHY. Sure.

And, Ms. Robinson, thank you so much for your testimony and investigating the issues related to the ACA.

I presume that you didn't look at waste, fraud, and abuse before the ACA was instituted, right?

Ms. ROBINSON. Thank you for that question.

We've done a lot of work looking at fraud, waste, and abuse in the Medicare and Medicaid and other HHS programs before the Affordable Care Act. But our jurisdiction is to look at programs of the Department, so if you're asking whether we looked at, sort of, private insurance before the Affordable Care Act, we did not.

Mr. KRISHNAMOORTHY. Right.

Now, Mr. Siegel, I want to sincerely thank you for appearing before the subcommittee today. I know you run a small business and are taking valuable time out of your small business to be here today. As a small-businessman, I know that that is a big sacrifice on your part.

I want to ask a few questions about your experience with the ACA. You testified that after you were laid off in 2012 you wouldn't have had the ability to start your own business had it not been for the ACA. Can you explain why that is?

Mr. SIEGEL. I wouldn't have had the courage. And the reason I wouldn't have had the courage is because the prospect of not having insurance, especially for my wife, is frightening.

You can spend tens of thousands of dollars a year on medication for MS, even if you don't have a problem with relapses and other problems, which we have been spared. And she was 53. She was 52 or 53, whatever it was. So that is at least 12 years till Medicare. I can't screw around with that. I can't take a chance. She has to have insurance.

And the private market in New York before the ACA, as I said, was incredibly expensive. It's cheaper under the ACA than it was before. That's not true of every State, but it's true of New York.

Mr. KRISHNAMOORTHY. You know, as a small-businessman myself, I understand the risks of going out on your own. We want more people to do what you did. We want people to go out on their own and create new businesses and new jobs. That's how we grow our economy. Worries about health insurance, whether it is affordable, whether it will cover preexisting conditions, can hold prospective entrepreneurs back.

And the economic effects of repeal are not just anecdotal. According to The Commonwealth Fund, repealing the ACA would lead to the loss of 2.6 million jobs in 2019 alone, mostly from the private sector.

Now, Mr. Siegel, can you tell the members of this committee directly about how the threat of repeal affects you and your family today?

Mr. SIEGEL. If the ACA is repealed, I'm not sure how I would get insurance and if I could get it for my wife. And my kids, I don't know, they are going to turn 26, 27 soon enough. And, you know, I'll pay for them as long as I can get them insurance, but I don't know. So it's about that simple.

Mr. KRISHNAMOORTHY. And what does that do to—you know, what are your anxiety levels right now?

Mr. SIEGEL. I have not slept very well since the election, to be honest with you.

Mr. KRISHNAMOORTHY. So it's affected your health.

Mr. SIEGEL. It's affected my anxiety. I don't know that it has affected anything else yet. We shall see. I hope not.

Mr. KRISHNAMOORTHY. Now, Mr. Siegel, can you tell us a little bit about your business and how it's grown since you started?

Mr. SIEGEL. Sure. We are a small market research firm. We do mainly survey research on product development. And we have grown from essentially nothing our first year to this year—I'm not going to tell how much we make because we're an LLC and that will tell you how much I make, but I made a good living this last year. Let me put it that way.

Mr. KRISHNAMOORTHY. Great.

Thank you.

Mr. JORDAN. I thank the gentleman from Illinois.

Ms. ROBINSON, in your opening statement, you talked about most States didn't have any type of accurate accounting for how ACA dollars were allocated and what they got from the Feds. Something to that effect you said in your opening statement.

Ms. ROBINSON. Thank you, Chairman.

I think you're referring to the work we did looking at the establishment grant program—

Mr. JORDAN. Yes.

Ms. ROBINSON. —which looked at cost allocation. So if you've got a marketplace in the States that's sharing a system, you need to allocate the costs between the funding for the establishment grant for the marketplace and other programs that may share the same system, such as the Medicaid eligibility—

Mr. JORDAN. And the States weren't accurately accounting for all that.

Ms. ROBINSON. Correct. In many of the situations we looked at, States were not accurately—

Mr. JORDAN. And was the inaccurate accounting, did it result in more Federal dollars coming to the State or less?

Ms. ROBINSON. What it resulted in, often, was too much establishment grant funding going to the State. In some—

Mr. JORDAN. Oh, imagine that. They got more. They erred on the side where they got more. Imagine that.

Ms. ROBINSON. In some cases, however, some of that funding could be allocated to the Medicaid program. So we did recommend that CMS and the States work together to—

Mr. JORDAN. In your report, you also said there were insufficient payment controls that led to wasteful spending. You said CMS lacked controls to ensure that financial assistance payments were correctly calculated. And you said CMS lacked controls to ensure effectively that APTC payments were made only for the enrollees who paid their monthly premiums.

It sounds like a lot of screwing up going on.

Ms. ROBINSON. Chairman, we did find a number of vulnerabilities and internal control weaknesses in our work, yes.

Mr. JORDAN. Yeah.

And the GAO, you guys did a little—it looks like a little experiment here, where you had 15 fictitious folks, right, fictitious people applied for coverage. And how many of those 15 got coverage and got the subsidy and got credit for it all, Mr. Dicken?

Mr. DICKEN. Right. So, for the open enrollment in 2016, we had 15 fictitious applicants. All of those initially received coverage that would've been subsidized—

Mr. JORDAN. Every single one?

Mr. DICKEN. Initially, yes.

Mr. JORDAN. Wow. So they didn't catch anybody who was trying to rig the game and mess with the system, did they?

Mr. DICKEN. There was some documentation that was requested over time. So, over time, you know, one was not retained; it was terminated. But, initially, we did receive all 15 approvals for—

Mr. JORDAN. Even though some fictitious documents were also sent along after the initial entry, right?

Mr. DICKEN. That's correct. We—

Mr. JORDAN. Wow. So they were batting 1,000 in ripping off the taxpayer.

Mr. Dicken, I'm just curious, not so much as GAO guy but as just a citizen who follows the press, are you familiar with the name Jonathan Gruber?

Mr. DICKEN. Familiar with him as a healthcare economist, yes.

Mr. JORDAN. Yeah. And do you remember, you know, some of the statements that he made back when this thing was—when they were passing this law and some of the statements that came from the administration? Do you remember some of those, for the promises that were made?

Mr. DICKEN. I've seen some of Dr. Gruber's research. I've—

Mr. JORDAN. Let me remind you of some of the things. I just want your comment if these actually turned out to be true.

Many folks said back when this was being debated and initially passed, they said, if you like your plan, you can keep your plan. Was that an accurate statement? Did that turn out to be accurate?

If you can give me some short answers, because I've got a lot of questions to ask you.

Mr. DICKEN. So, certainly, there are dynamic changes, and so many newly covered people were covered through the exchanges. Some people that were previously covered through plans—

Mr. JORDAN. You've got to give me shorter answers than that.

Mr. DICKEN. —did change to other plans.

Mr. JORDAN. Yeah, okay. That's what I thought.

And we also said, if you like your doctor, you can keep your doctor. Did that turn out to be true? Was that accurate for all Americans, like it was presented?

Mr. DICKEN. Certainly, to the extent that individuals changed plans at different networks—

Mr. JORDAN. Yeah. Lots of people had to get new doctors.

Did premiums go down, like we were promised? Have premiums gone down?

Mr. DICKEN. Well, we've seen that—you know, it's hard to compare premiums before and after. For a number of reasons, we've seen premium increases, I think as you mentioned—

Mr. JORDAN. Twenty-five percent.

Mr. DICKEN. —in the most recent year, of 25 percent in the exchange.

Mr. JORDAN. Yeah. So premiums didn't go down on average \$2,500 either, did they?

Mr. DICKEN. We've not compared before and after, but premiums in the most recent year have gone up 25 percent.

Mr. JORDAN. Do you remember when this thing was rolled out? Did the website work very well when this thing was first rolled out?

Mr. DICKEN. So, certainly, there were a number of technical challenges and problems that were widely known—

Mr. JORDAN. And was the website secure? All this information, private information, was it secure at the time it was rolled out? Do you remember that?

Mr. DICKEN. GAO has done work looking at and made a number of recommendations to try to improve the privacy and security—

Mr. JORDAN. Yeah, because it wasn't secured.

Have emergency room visits declined under the Affordable Care Act, as we were promised to do?

Mr. DICKEN. I don't believe GAO has evaluated, kind of, what—

Mr. JORDAN. I figured that was one you probably hadn't looked at, but they've went up dramatically.

And what about the co-ops, these co-ops that were created that were supposed to be, you know, just apple pie, wonderful, you know, be-all, end-all, save-all, 23 of them that were created, how have they done?

Mr. DICKEN. Yeah, so we've evaluated those. There are five that are still being offered in 2017.

Mr. JORDAN. Yeah. So 23 originally, and only 5 or so—another way of saying that is 18 have already went bankrupt, right?

Mr. DICKEN. And one is in the process of trying to transition, but—

Mr. JORDAN. So I count nine false statements: like your plan, keep your plan; like your doctor, keep your doctor; premiums are going to go down, they're going to go down on average \$2,500, website won't work, website's not secure, emergency room visits declined, co-ops have went—18 of 23 have went bankrupt even though they were promised—and deductibles have actually increased dramatically when they were said they were going to decline. So nine false statements.

And now we find out—so we were misled. And now we find out when the plan's actually put in place, most States don't have an accurate accounting of how the dollars are spent, inefficient payment controls that led to wasteful spending. CMS lacked controls to ensure financial assistance payments were correctly calculated. CMS lacked controls to ensure effectively that APTC payments were made only for enrollees who paid their monthly premiums. And when you guys ran a little experiment and had 15 fictitious people, 15 made-up folks who signed up for it, they all got the subsidy.

And yet we have people say, oh, this thing is wonderful, we've got to keep it. That's just amazing to me. This thing has got to go. And that's what we're going to be working on here over the next several weeks, to put in a plan—I start from the simple premise, health care gets better and costs less when ObamaCare is gone. And that, to me, seems to be the direction we have to go.

So, with that, I would yield to, if the gentlelady is ready, Ms. Norton.

Well, we can go to Mr. Cummings, and then we'll go to—

Mr. CUMMINGS. Would the gentleman yield?

Mr. JORDAN. Well, actually—yeah.

Mr. CUMMINGS. Let me ask you, President Trump has said that he is going to provide health care for everyone and that it would be cheaper. Can you tell us about that plan so that the American people will be aware? Are you aware of it, of how that's going to work? Mr. Chairman? Chairman, I yield—

Mr. JORDAN. I thought you were asking our—

Mr. JORDAN. I'm asking you.

Mr. JORDAN. I'm not sure what Mr. Trump had in mind. I don't know what you have in mind sometimes when you make statements, and I don't know what everyone has in mind when they make statements.

But what I do know is what I just outlined, the false statements that were made when the Affordable Care Act was presented to the American people and—

Mr. CUMMINGS. Well, I reclaim my time. I reclaim my time.

Mr. JORDAN. —all the fraud that the witness has said—

Mr. CUMMINGS. You're not answering the question. I reclaim my time. Thank you. I just wanted to know so that the general public would know what the President's talking about.

I'd like to take a few minutes to discuss what we can expect our healthcare system to look like under a Trump administration.

President Trump has claimed that his replacement to the ACA would provide, and I quote, "health care that is far less expensive and far better than the ACA," end of quote. But based on the actions of President Trump, actions taken so far, the only thing that TrumpCare seems to be doing is creating chaos in the insurance market and leaving millions of people uncertain about their health care.

On January 20th, President Trump issued an Executive order that directs Federal agencies to, quote, "waive, defer, and grant exemptions from or delay implementation of any provision of the act," end of quote.

What this will mean for people with the ACA insurance isn't entirely clear since the order is short on concrete details, but it does raise serious doubts about whether consumers, including those with employer-sponsored insurance, will continue to enjoy the benefits and protections they received under the ACA, such as no caps on annual and lifetime limits, free preventive care, and comprehensive coverage of essential health benefits.

Mr. Siegel, as a small-businessman and an ACA plan enrollee, how does all of this uncertainty impact you and your ability to run your business?

Mr. SIEGEL. As I said, I have not had slept well since the election. To the extent that I'm focused on that instead of focusing on our business, it takes time away.

How do I put this? I don't know that this new administration understands. And when people don't understand, it makes it very hard to plan for the future at all, because you don't know what they're going to do.

Mr. CUMMINGS. Yeah.

The uncertainty is also affecting insurance companies, Mr. Siegel. The Urban Institute recently released findings from interviews with executives from 13 insurance companies that offer coverage in the individual market in 28 States. Most of the executives interviewed warned that repealing the individual mandate would drive up premiums, up to 20 percent more than currently expected. And some insurers warned that they might leave the market altogether.

Now, Mr. Dicken, you have studied the individual insurance market closely, have you not?

Mr. DICKEN. Yes, GAO has.

Mr. CUMMINGS. And does it surprise you that insurers are wary of repealing fundamental aspects of the ACA without having a comparable replacement plan in place?

Mr. DICKEN. Well, certainly, insurers in the next few months will be setting benefits and premiums for 2018 and so certainly need to understand the Federal and State rules that they'll be working under.

Mr. CUMMINGS. And so, in addition to creating instability in the insurance market and uncertainty among consumers, it appears that the Trump administration is taking steps to actively prevent people from enrolling in coverage. According to a recent Politico article last week, the Trump administration canceled TV advertisements for open enrollment that had already been placed and paid for, even though the last day to enroll wasn't until today.

But, Ms. Robinson, as you've stated in your written testimony, the IG's central mission is to, quote, "protect the integrity," end of quote, of the ACA and other Federal health programs. Do you plan to look into this issue?

I think they reversed that now, right? In other words, they put the ads back up.

Ms. ROBINSON. Thank you for that question.

Mr. CUMMINGS. By the way, I was in my district on Monday telling my constituents to enroll.

But go ahead.

Ms. ROBINSON. Thank you for that question. I don't have that particular detail about this.

Mr. CUMMINGS. Okay.

Ms. ROBINSON. I've seen some of the same reports that others have seen.

Mr. CUMMINGS. Even if the money that has been wasted on the ads that never aired is somehow recovered, it is still deeply concerning that the Trump administration would intentionally sabotage the final week of open enrollment in this way, especially since we know that young and healthy people tend to wait until the last minute to enroll.

If this is any indication of the future of TrumpCare, we will need the IGs to remain vigilant in the oversight—in his oversight responsibilities, and, as the primary oversight body of the House, I hope that we will do the same.

And so we will continue to look over this again. Health care in the great country called the United States should not be a privilege but a right.

And, with that, I yield back.

Mr. JORDAN. I thank the gentleman.

The gentleman from Michigan is recognized.

Mr. MITCHELL. Before I joined this esteemed body, I retired as the CEO of an education group. We had 650 employees. A fair number were part-time. Anybody who was scheduled more than 9 hours a week on a regularly scheduled basis had health care. They had health care for themselves, and they could buy health care for their family relatively inexpensively.

The Affordable Care Act, when that came into place and the requirements were finally rolled out by HHS, increased the cost for part-time employee health care by 50 percent year one for my company.

So my question for Ms. Robinson or Mr. Dicken: Did you do any analysis when you looked at the fraud, the waste, at the immediate impact on health insurance premiums, never mind copays and deductibles, for privately sponsored healthcare programs and what the impact was in the first few years?

Mr. DICKEN. We've not directly looked at the changes in employer-sponsored health premiums. There are some surveys that look at that by other organizations, but GAO has not reported on that.

Mr. MITCHELL. Did HHS look at this issue?

Ms. ROBINSON. We have not looked at that issue. Our focus is really on HHS dollars and the expenditure of HHS funds.

Mr. MITCHELL. Well, but as my constituents view it, whether their money that they paid for premiums, whether it's the employer paying for premiums, whether it's their tax dollars that they pay the Federal Government, it's all their money. So would it not make sense to look at waste as it's viewed in terms of the immediate and then long-term impact on healthcare costs in America by looking at what suddenly the change in costs were? As I indicated, for our company it was dramatic, and a number of others I know of.

Mr. DICKEN. Yeah, certainly, we're glad to work with the subcommittee on looking at healthcare costs and trends in the markets. Certainly, employers—there have been longstanding increases

overall in health insurance costs, even for—Federal employees have seen increases in healthcare costs in recent years.

Mr. MITCHELL. Let me change direction for a second question. There were concerns with those who are receiving subsidies or payments. Can you tell me how many people in year one received subsidies that were improper or determined to be inaccurate the first year?

Ms. ROBINSON. So that's a very important question. We don't have the number of folks, but what we did look at was the risk to the programs of potentially weak controls on eligibility. So our work—

Mr. MITCHELL. Let me ask you, why—I mean, we're subjected to audits as a company. Why would we not know how many people received subsidies that were found to be inappropriate and/or fraudulent, whatever term you want to put on it? How would we not investigate that and not know?

Ms. ROBINSON. So, Congressman, my office does investigate when we get allegations of an improper person being in the marketplace. Our work initially set out to figure out whether there were adequate safeguards to prevent fraudulent or improper information from impacting the eligibility determinations.

Mr. MITCHELL. So at this moment, we still don't have either year one or any year since any idea of an approximation of the number of people that receive payments that we—they should not have?

Ms. ROBINSON. My office does not have that information.

Mr. MITCHELL. Does HHS, in general, have that?

Ms. ROBINSON. I don't know.

Mr. MITCHELL. Do we—you lead me to believe, then, we don't know how much those inappropriate payments total up to be to the taxpayers. Is that correct?

Ms. ROBINSON. I do not have that information.

Mr. MITCHELL. Mr. Dicken, do you have that information?

Mr. DICKEN. No, but I will note that the GAO has recommended that HHS develop a fraud risk assessment to get at some of the questions that you are getting at, so they have an overall understanding of what the fraud risk potential is and how they can manage those risks.

Mr. MITCHELL. I readily admit, as I say, I'm subject to freshman hazing here as a freshman Member of Congress, but I spent 35 years in private business, and I have to say, Oh, my God. How is it that we don't have the means by which to figure out those that we didn't, and how much it has cost us here? We're analyzing fraud and abuse. How do we not think about it was a problem?

Ms. ROBINSON. Well, Congressman, I think you're raising a really important question about transparency in government. And one of the things that we have been recommending to CMS and the marketplace is to look at things like having the right kinds of data to be able to figure these things out. And so, for example, in our work looking at the accuracy of the subsidies, what we—

Mr. MITCHELL. Well, let me stop you and ask a question.

Ms. ROBINSON. Yeah.

Mr. MITCHELL. But if we're making a payment to a private carrier or somebody else, we certainly would insist on that kind of

transparency of them, and we would recover the money if it was improperly paid, wouldn't we?

Ms. ROBINSON. Yes, Congressman.

Mr. MITCHELL. So we fail to undertake a basic function of the department of government is to make sure we're not throwing money out of the window.

Ms. ROBINSON. Well, Congressman, that's why we've done the work. We've looked at the controls that CMS has on the accuracy of the payments, is to be able to make recommendations to strengthen those controls.

Mr. MITCHELL. Thank you very much. Thanks very much. I yield back.

Mr. JORDAN. I thank the gentleman. I think it's a great line of questioning. We can't get an answer to the number of individuals who got payment inappropriately, fraudulent payments, but we can probably conclude that anyone who attempted, who applied fraudulently, probably did get paid. And who can we conclude that? Because you all ran the experiment: 15 fictitious people, and you found that it wasn't one who got paid, it wasn't two, it wasn't 10, it wasn't 14; it was 15 out of 15. So Mr. Mitchell's question is entirely appropriate, and one we need to get—think about that. If everyone, based on the little experiment you all ran where you found it was—that we're batting 1,000, anyone who applied fraudulently may, in fact, have gotten money that they weren't entitled to. And that is a concern for the tech—not to mention all the other problems with the ACA that we've talked about, all of the misleading statements, all the false statements, all the lies told to the American people before this thing was passed. So we'd like to get that number as quickly as possible. And I appreciate the gentleman's questioning from Michigan.

I now recognize the gentlelady from the District of Columbia.

Ms. NORTON. Thank you, Mr. Chairman. I guess it's been reported that this is the last day to sign up for the Affordable Healthcare Act, and people have been signing up in huge numbers. People are afraid of a big structural change and what effects it will have, not only on those who are part of the ACA, but, of course, we're talking about a sixth of the economy, and how fooling with this aspect of it could have an effect on the economy itself.

And in my district, and I represent the District of Columbia, a lot of people already have health care because they work for the Federal Government, but 100,000 D.C. residents would lose their insurance if the Affordable Healthcare Act were repealed, and the estimated cost to D.C. would be \$1.1 billion. Now, that's a city of 700,000 people. Imagine what this means writ large across the country.

I'm interested in, Mr. Siegel, because I think when most people think of the health care, of the Affordable Healthcare Act, they may not think of enrollees like Mr. Siegel, but the largest segment of enrollees in the non-group market is self-employed. So I'd be interested in your views on what effect guaranteed access to private insurance has had on the security of your business as a business.

Mr. SIEGEL. I always had access. Affordable enrollment in coverage has made a huge difference, and the reason it makes—

Ms. NORTON. To your business?

Mr. SIEGEL. Yes.

Ms. NORTON. To your business itself?

Mr. SIEGEL. Well, I buy it on the exchange, so the business doesn't buy it. But for the business, it makes a big difference, because it would not have me as a participant if it was not for the ACA. And we started out with three partners, and our youngest partner died after 6 months, and you cannot run a market research business with one person. So our business would probably not exist right now. That's my guess.

Ms. NORTON. Without the Affordable Healthcare Act.

Mr. SIEGEL. That's my guess. It's counter-factual, right, so—

Ms. NORTON. So let's look at the potential effects of the repeal on your family's access, your business access, to affordable healthcare coverage.

Mr. SIEGEL. New York is a State that will do something. I don't know what. I do know that in New York, before the ACA, they had—private insurers had to take anybody, and that made our costs—but they—but you didn't have to buy, so only people who needed it bought it, and so it made it expensive. My fear is we'll go back to that, and that would—if I can get insurance at all, it will probably now be, and I don't know, but I'm guessing \$2,600, \$2,700, \$3,000 a month, because it was about \$2,000 a month before the ACA, and so you're going to see a pop back. And at that level, I'm going to have to find a job working for an employer. And I'm 61 years old, and in market research, that is not easy. And in any case, I'm tired of being a boss and I'm tired of having bosses. I love running a business with a partner I admire, serving clients that I like, and taking care of my family that way, and I don't want to go back.

Ms. NORTON. Mr. Siegel, finally, let me ask you about a plan that I read about in the Republican Study Committee Guide that would replace this long-standing tax exclusion for employer-based coverage with a standard tax deduction. Now, we know that would put health care out of the reach of lower brackets of Americans, but I don't see how it would account for geography or age or health status. Do you have any view on such a replacement?

Mr. SIEGEL. I don't have any view on the technical side of it. I can tell you now that health insurance and healthcare coverage, according to our accountant, are something I can deduct, but I also know that that is not as good as what—

Ms. NORTON. What about a standard tax deduction?

Mr. SIEGEL. I imagine I'd benefit from it, but I don't know that my kids would. But what I was going to say is, you know, employer plans get a much better deal. And so just having a deduction for the private side, I don't know what it would be. You make it as good as employers, maybe it has an effect, I don't know, but if you don't, definitely not. I'm not an expert on the tax system. I'm sorry.

Ms. NORTON. Well, no one's an expert on how this would work out, I can tell you that much.

Thank you very much, Mr. Chairman.

Mr. JORDAN. I thank the gentlelady. We'd now recognize the gentleman from Wisconsin.

Mr. GROTHMAN. Sure. Mr. Dicken, I notice in some of the information we have here and in your initial talk, you told us a little

bit about the number of options Americans have as the number of insurance companies involved has dropped. Could you recite the numbers again for the last couple of years and the number of options?

Mr. DICKEN. Sure. For plan options, that would be on the different metal tiers that are offered through the exchanges, to be silver or gold, we found that most consumers had six or more plan options. In the most recent years, the number of issuers that are offering plans have declined, and so we've seen that. HHS has reported that this year, 21 percent of consumers have plan options, but only from one issuer, one insurance company.

Mr. GROTHMAN. Okay. So at 21, in essence, you have a monopoly, correct, 21 percent?

Mr. DICKEN. For the exchanges that there will be different silver or gold plans, but just from the same insurer.

Mr. GROTHMAN. And at this rate, how many, we don't know yet, but how many plans do you think will be out there for 2018?

Mr. DICKEN. Yeah. I think there's a lot of uncertainty about what future years will bring. Certainly it's—insurance companies, it's been very concentrated, with many States having only one or two or three insurers having 80 percent of the market.

Mr. GROTHMAN. It shot up about—it shot up from, like, 5 percent to 21 percent in one year, correct?

Mr. DICKEN. I don't have the early numbers, but it has increased that more—

Mr. GROTHMAN. Dramatically.

Mr. DICKEN. —areas have only one issuer.

Mr. GROTHMAN. Is there any concern that some areas will soon have no issuers?

Mr. DICKEN. Certainly, you know, it would be important to make sure that consumers under the current system with the exchanges have plans that are available. You know, certainly, that's a local decision—local decisions by the insurers in those areas.

Mr. GROTHMAN. Right. But if we've gone down from three or four or five options to one option, it stands to reason that it's entirely possible soon we're going to have no options, right?

Mr. DICKEN. That has not yet been experienced, but certainly a concern.

Mr. GROTHMAN. Okay. And what effect on premiums has that had as the number of—as the competition is disappearing?

Mr. DICKEN. Yeah. In general, you would expect that less competition would mean less pressure on keeping low premiums.

Mr. GROTHMAN. And is that true, right?

Mr. DICKEN. You know, we've not done a causal study looking at that, but that certainly would be the expectation.

Mr. GROTHMAN. Premiums have shot up in this past year, correct?

Mr. DICKEN. On average, about 25 percent increase.

Mr. GROTHMAN. 25 percent, which is—and I would say one of the reasons they shot up may be is there is no competition, right?

Mr. DICKEN. A range of issues for that as the experience of the exchanges has led some insurers to increase the premiums.

Mr. GROTHMAN. Right. And can you tell us why the number of insurance companies keeps disappearing?

Mr. DICKEN. I think there's a variety of reasons, a couple that have been mentioned today. Some of the plans that were available, such as co-op plans, have terminated operations, some large national insurers have changed the markets that they're operating in, or left the exchanges.

Mr. GROTHMAN. Can you let us know why they've left? I mean, there must be some reason. You know, a few years ago, they were apparently gung-ho and thought they could make a go of it, and now they can't. What happened?

Mr. DICKEN. Yeah. I think those are business decisions by the insurers as they decide what markets and what their experience has been.

Mr. GROTHMAN. Well, they are businesses, but could you speculate for us why companies keep leaving the current market that was originally envisioned?

Mr. DICKEN. Yes. Certainly, as they've learned more about the cost of individuals that they're covering and their relative premiums in that market, some have made business decisions that they're not going to compete in that market.

Mr. GROTHMAN. So it would seem that over time, given the current framework, insurance companies cannot operate, correct, or they wouldn't keep pulling out? And no new insurance companies are jumping in, are they, largely?

Mr. DICKEN. There have been—we did look at new entrants and exits. We found that most of the exits were among smaller insurers. There were—there have been some new entrants into the market as well.

Mr. GROTHMAN. Okay. Ms. Robinson, you looked at the grant funds, and reviews by the inspector general identified money that need to be refunded to the Federal Government, because it's not spent in accordance to your requirements. What's the status of your recommendations that money that was misspent be refunded to the Federal Government?

Ms. ROBINSON. Thank you for your—that question. On the establishment grant funding, I believe most of those recommendations are still open and we are following up on that, but I think those are still open recommendations.

Mr. GROTHMAN. Are they refunding the money?

Ms. ROBINSON. Not as far as I know.

Mr. GROTHMAN. What efforts are they making to refund the money, or is this just considered par for the course now?

Ms. ROBINSON. So we worked with CMS to follow up on those recommendations. I don't have at my fingertips, but I'd be happy to follow up with you on any details about with respect to the specific amounts that we've identified.

Mr. GROTHMAN. Okay. And how many States does that include, do you know?

Ms. ROBINSON. We looked at—if you just give me one moment. We looked at establishment grants at six States that we had—that we looked at.

Mr. GROTHMAN. Okay. Were there problems in all six or—

Ms. ROBINSON. Yes. So we had problems in all six. We had one other that did not have any problems.

Mr. GROTHMAN. Okay. Well, six. One out of seven? Huh? Okay. Thank you.

Mr. JORDAN. I thank the gentleman.

The former chairman of the committee, we're glad to welcome. The gentleman from California is recognized.

Mr. ISSA. Thank you, Mr. Chairman.

Mr. Dixon—Dicken, you know, we're all watching the Affordable Care Act underperform, and we are all concerned that what it sought to achieve, one would say it at least partially achieved; there are millions of people on the plan, but let me go through a couple of comparisons, and they're a little outside your briefing, but I think they're well within your competence.

You're personally under FEHBP, right?

Mr. DICKEN. That's correct.

Mr. ISSA. And you're familiar with the programs that are offered, the 250-plus different options?

Mr. DICKEN. Nationwide, there are many, yes.

Mr. ISSA. So if we were to contrast the 11 million-plus people that are in FEHBP, they're Federal employees, retirees, and their families, contrast the options between what you expect to have in 2017 in the Affordable Care Act as it is, and what half the number of people, but the Federal workers and their families have.

Mr. DICKEN. Right. About 8 million people covered through the Federal employees program, as you mentioned, nationwide, over 200 plans offered. That includes some national plan offerings, mostly PPOs as well as local HMOs, that are available in specific markets.

Mr. ISSA. Right. To include Kaiser, Blue Cross, all the major names?

Mr. DICKEN. That's correct. And so—and throughout those markets, Federal employees, retirees, and dependents can choose either from those national plans, the largest by far of which is the Blue Cross standard and basic options, which covers about two-thirds of enrollees.

Mr. ISSA. And under the plan, if you go onto a COBRA because you leave the Federal workforce, you pay to whichever healthcare program you were in as you continue, right?

Mr. DICKEN. COBRA would have continuation coverage with the individual paying the full premium, a smaller—

Mr. ISSA. Right. Which means at least in some cases, the healthcare providers accept a check from an individual?

Mr. DICKEN. In the COBRA cases, yeah. I don't know the actual transfer of money, but it would be coming from the individual.

Mr. ISSA. But in all cases, essentially these are private companies who have made a decision to provide a program to whatever amount of people, if you will, any and all from the Federal workforce current or, in the case of COBRA, COBRA, that choose their plan, correct?

Mr. DICKEN. They are private plans, yes.

Mr. ISSA. And just going through a couple of points, they're not gender discriminate, right?

Mr. DICKEN. It's available to all Federal employees that—

Mr. ISSA. But, I mean, they change the same rate regardless of age?

Mr. DICKEN. Same premium nationwide.

Mr. ISSA. Right. So you take advantage of the pool, that you're not worrying about whether you're young or old, man or woman, the rate's the same?

Mr. DICKEN. It is one premium for all.

Mr. ISSA. Right. And your 26-year-old child can stay on it?

Mr. DICKEN. Up to age 26.

Mr. ISSA. Or 27th birthday, whatever.

Mr. DICKEN. It think it's 26th, but—

Mr. ISSA. 26th birthday. And there's no problem switching as a Federal worker from program to program on an annual basis, based on any preexisting conditions or any other discrimination?

Mr. DICKEN. Yeah. During the open enrollment period or for special reasons, they can change plans.

Mr. ISSA. Okay. So it's fair to say that FEHBP with 200 and some, my number is 250, but a great many plans more than the Affordable Care Act in most areas, in fact, offers all the same protections to the consumer that the ACA handles, right?

Mr. DICKEN. My understanding is that the plans meet the requirements of the Affordable Care Act.

Mr. ISSA. Okay. And they come in all levels, from relatively stripped down to essentially the equivalent, the very large plans like the Postal plan, which is a pretty good one, and so on, right?

Mr. DICKEN. They're all comprehensive medical. Some are high deductible offerings, and some are HMOs, yes.

Mr. ISSA. So I've taken you through this and taxed your expertise for a reason. Is there any reason that if the Affordable Care Act were to go away and a transition to enjoying the same programs offered to the Federal workforce to virtually everyone who now or has retired from the Federal workforce, is there any reason that that wouldn't be viable, considering these are insurance companies that want access to those 8 million-plus people they now insure, they bid for it every year, and if the number were increased, both for individuals and small or even not small businesses, is there any reason to believe that the program inherently wouldn't be able to serve the same purpose, especially considering at least a subset of FEHBP are, in fact, the same companies?

Mr. DICKEN. Yeah. We—GAO has not kind of evaluated expanding the Federal employees program to other plans or offerings. It is an employer-based plan based on the group of Federal employees, retirees, and that's kind of important for that risk pool, as there's not risk adjustment and other issues, and so—

Mr. ISSA. Well, there is risk adjustment, because they bid annually based on the risk, right?

Mr. DICKEN. It's based on their experience, yes, but not—if different plans end up with different risks, that's—

Mr. ISSA. Right. But if over time the Federal workforce gets older, sicker, whatever, they adjust?

Mr. DICKEN. Yes. So it would be placed based on that plan's experience.

Mr. ISSA. Okay. So last question, if I may, Chairman.

You know, it was not considered originally, but they are private programs, there are more plans, it enjoys all the same protections of the Affordable Care Act. So when people, and I'm not trying to

be partisan, I'm trying to be very open here against what do we do in the eventuality. There is no inherent reason that you couldn't have the Federal Government ensure through these national contracts with local and not local companies, there's no inherent reason that that couldn't be offered as a viable alternative, recognizing that there is a risk pool change, but these companies start off with an incredibly desirable 8-plus million people that they're not going to want to walk away from if others are allowed to join. Is that a fair question? And, again, we're taxing your expertise for an opinion.

Mr. DICKEN. It's certainly a fair question. We've not evaluated kind of what the effects could be, either for new entrants to that or for the Federal—existing Federal employees program; certainly a lot of considerations as to the risk pools, as to individuals involved. Some plans have left FEHBP over time as well. And so there would, again, be business decisions by the insurers whether or not to participate in that.

Mr. ISSA. Okay. Thank you, Mr. Chairman. I yield back.

Mr. JORDAN. I thank the gentleman. We can do maybe a quick question or two from—does the gentlelady from D.C. have additional questions?

How about the gentleman from Wisconsin? You want another minute or minute and a half?

Mr. GROTHMAN. Oh, absolutely.

Mr. JORDAN. Yeah. You've got another minute and a half.

Mr. GROTHMAN. Minute and a half, that's what I need.

Mr. JORDAN. And then we'll come back to the D side and then we'll finish up here.

Mr. GROTHMAN. Sure. Maybe if I can, I'll even take 2 minutes. If you give me one and a half, I'll take two.

Mr. JORDAN. All right.

Mr. GROTHMAN. Ms. Robinson, HHS, you've conducted several reviews of CMS' management of the health and insurance exchange programs and identified vulnerabilities related to Federal contracting and oversight in CMS's overall management and administration of the facilities.

Through those case studies of the management and administration, what lessons have been gathered?

Ms. ROBINSON. Well, thank you for the opportunity to talk about our case study work, where we did look across the management, and there were a number of lessons. Certainly the lesson around needing good acquisition strategies and good contract planning; lessons around needing clear leadership for projects; and a really important lesson that I think extends across, particularly for complex technological and policy projects, is really to integrate technology and policy staff and thinking and contractors and employed staff in working together without fragmentation and without silos. Certainly, when we saw that at CMS, it helped improve their management across the marketplace program.

Mr. GROTHMAN. Thank you.

One more question for Mr. Siegel. I know there's some areas in which there's robust competition, but there are other areas that we just heard that only 20—you know, 26 percent of America, you've only got one choice under ObamaCare. And given that this has fall-

en over time, like, maybe a few years earlier, they had three or four, now they have one, does it concern you for your fellow Americans, as the number of companies drop off, that it's possible, maybe as early as next year, that there'll be no options at all? Does that concern you on behalf of your fellow Americans as you watch under the current—

Mr. SIEGEL. Well, I only speak for myself. I don't pretend to speak for my fellow Americans, but of course it concerns me. I am not in the insurance industry, so I'm not going to speculate why there is only one company in some places. I can tell you that in New York, which has a long tradition of robust regulation of insurance markets, and a commitment, in many ways, to providing insurance to as many people as possible, we, by and large, have pretty robust choices. I had a choice this year. I'm trying to envision the thing they gave us. I had a choice, I would guess, of somewhere between 12 and 20 plans. I can't tell you exactly how many, because I can't remember the big, wide 8-1/2 by 11, 11-by-14 thing that I saw.

Mr. GROTHMAN. Okay. I'll come back to Mr. Dicken one more time. Again, there are some people, and I fought it and I think everybody else up here has fought it, who say we ought to let ObamaCare continue a few more years, because as companies continue to get out of these markets, the thing is going to collapse on its own. And when you already see 26 percent of the areas have one insurance company compared to where we were a couple of years ago, common sense will tell you that if we just let this thing go as it is, there might be some markets that have no plan at all, and others will just have one plan and they'll—and the rates will keep going up 25 or 26 percent, and we can just sit here and watch the train wreck and blame President Obama.

I think almost every Republican has stepped forward and said, no, we cannot allow this train wreck to happen to the American people. But I'll ask you again, if you could speculate, given the disappearance of insurance firms from the market, how much of America is only going to have one company, or maybe no company if we don't act by 2019 or 2020?

Mr. DICKEN. Yeah. Thank you. And I cannot speculate, but I will note that, you know, this is the fourth year, it has been dynamic in the exchanges, we saw some increases up to 2015 and then a decline in insurers, as you've noted. That's a concern for the private health insurance market as a whole. As our work, required by the Affordable Care Act, indicated insurance markets are very concentrated, with often only one, two, or three large insurers having the predominance of the market. And so a competitive market, whether it is the exchanges or the insurance market overall, that is a challenging consideration going forward.

Mr. JORDAN. Mr. Dicken, I think the gentleman's point is the trend lines aren't good, the pattern isn't good. 2 years ago, 23 co-ops started, today there are 5; 18 of them went bankrupt. Three years ago, most exchange areas had five plans that you could choose from, today it's down to one. You look at patterns, you look at the pattern you all did, 15 fictitious people apply, they all get subsidies. So all the trends, all the patterns in this law are terrible, and that's our point, and I think that's Mr. Grothman's point. So

I appreciate his questioning, even though it was his first hearing and it was sort of a filibuster there in the second round, but we have—I'm kidding you, Mr. Grothman. We appreciate that.

Mr. KRISHNAMOORTHI. Well, Mr. Chairman, can I have equal time, please?

Mr. JORDAN. Yes. You've got all the time you need.

Mr. KRISHNAMOORTHI. Great. Thank you so much.

Are you aware, Mr. Siegel, that 11.5 million people, as of December 24, had enrolled in the ACA, and we are on record-breaking pace for the number of enrollees in the ACA in the coming year?

Mr. SIEGEL. I was aware of that, yes.

Mr. KRISHNAMOORTHI. And in your opinion, do you think that the fact that there were almost 40 million uninsured folks before the ACA and now there—it's dramatically fallen is a positive trend line for America?

Mr. SIEGEL. I think it's a wonderful trend line for America.

Mr. KRISHNAMOORTHI. And, sir, would you agree with me that there hasn't been any contrary evidence presented today about the amount of waste, fraud, and abuse that existed in the private insurance market prior to the ACA? Isn't that right?

Mr. SIEGEL. I did not hear anything about private insurance fraud at all.

Mr. KRISHNAMOORTHI. And would you also agree with me, sir, that there hasn't been any contrary evidence presented that there would be millions of jobs lost if the ACA is repealed without a replacement, as my honorable colleagues on the other side propose to do?

Mr. SIEGEL. I did not hear discussion of job loss at all.

Mr. KRISHNAMOORTHI. And would you surmise that people in the employer market, who have today protections from discrimination against preexisting conditions and other similar protections, would lose those protections once the ACA is repealed?

Mr. SIEGEL. I don't know whether some States have protection, but if that was the end of Federal protection and your State didn't step up, yeah, I think you'd be screwed.

Mr. JORDAN. Term of art.

Mr. KRISHNAMOORTHI. Thank you for that colorful——

Mr. SIEGEL. Sorry. I apologize if that's a violation of etiquette. I didn't mean that. I don't do this every day, so——

Mr. KRISHNAMOORTHI. And that's why you're such a convincing witness.

Mr. Siegel, what would you like to say to the chairman when he says it's clear that the ACA has got to go?

Mr. SIEGEL. I would say that if you think about health insurance—Representative Cummings said it should be a right. I don't like "rights" talk, but I will tell you that I think it is a necessity in today's world for any person to have adequate, affordable health care available to them, and in our country, we do it through health insurance, and we must have that if you want people to be able to live lives where they reach their potential, and, therefore, contribute as much as they can as citizens, as taxpayers, as employees, as business owners to our society.

Mr. KRISHNAMOORTHI. The ACA has improved your life, correct?

Mr. SIEGEL. The ACA made the life I have today possible, yes.

Mr. KRISHNAMOORTHY. Now, sir, I need to ask you a question about the creation of small businesses because of the ACA. Are you aware of others in your friend circle, family circle who similarly benefited from the ACA?

Mr. SIEGEL. I don't—to be honest with you, I don't have a personal friend that I know of for sure started their business relying on the ACA for health insurance. I just don't know. I have some friends who get their health insurance through the ACA as well, but they are not necessarily in business.

Mr. KRISHNAMOORTHY. Got it.

Mr. SIEGEL. So, you know, the honest answer to that is I don't know.

Mr. KRISHNAMOORTHY. Got it. Well, sir, I just want to thank you so much for your testimony today.

Mr. SIEGEL. Okay. You're welcome.

Mr. JORDAN. I would just—just to close maybe say, look, I didn't say it wasn't a necessity. All I did was point out the facts. And the facts are there were all kinds of statements made to the American people 6 years ago about the Affordable Care Act that turned out to be false, turned out to be lies. And you don't have to take my word for it, you can take the architect of ObamaCare, Jonathan Gruber's word for it. He told us they misled the American people on all those statements, nine different statements.

And now we have the ACA come along, it's the law, and we see where things are going, as evidenced by what Mr. Issa and Mr. Grothman pointed out. We started off with five choices for consumers, we're now down to one in lots and lots of places. We started out with 23 co-ops, we're now down to five, because 18 of them went bankrupt. These guys didn't look at the private market, they looked at taxpayer dollars because, that's what's involved here. These guys took taxpayer money and lost it. And we have all kinds of fraud going on, as evidenced by the study that they undertook where it was 15 for 15.

Now, think about this: If you're down to one insurer in an area, that obviously is going to drive up costs, so that's a monopoly situation, and if you have fraud going on up there, that's even more cost to the taxpayers. That's the story of the ACA, not to mention the increased premiums, increased deductibles for families all across this country. And that's why we're looking to repeal this law, just like we told the voters we were going to do, just like we promised them that we would do, and just like they sent us here to do, and we need to do that. After all, there was an election where that was one of the most important issues.

So with that, I want to thank our witnesses for being here, thank our members for participating. And we are adjourned.

[Whereupon, at 3:30 p.m., the subcommittee was adjourned.]