

**STATEMENT OF**

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**ON**

**A CHANGED APPROACH TO HEALTHCARE.GOV**

**BEFORE THE**

**U. S. HOUSE COMMITTEE ON ENERGY & COMMERCE  
SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS**

**JULY 31, 2014**

**U.S. House Committee on Energy & Commerce,  
Subcommittee on Oversight & Investigations  
A Changed Approach to HealthCare.gov  
July 31, 2014**

Good morning, Chairman Murphy, Ranking Member DeGette, and members of the Subcommittee. I'm Andy Slavitt, Principal Deputy Administrator of CMS. I joined CMS three weeks ago from the private sector, where I spent the last 20 years principally working with physicians, hospitals, health plans, and employers on solutions to problems of health care cost, quality, access and improving the patient experience. In the private sector, I have experience both starting my own health care technology business and operating larger-scale operations with more than 30,000 people. Until late October of last year, I had only peripheral involvement with the Affordable Care Act implementation, when I joined the CMS team as a contractor to help oversee the turnaround effort of the Health Insurance Marketplace.

While new to the Federal Government, I joined CMS to help oversee the implementation of the Affordable Care Act that is critical to delivering the promise of better affordability, better access and better quality to the American people. I am closely involved in working across the agency to provide the Center for Consumer Information and Insurance Oversight (CCIIO) and CMS entities the resources, capabilities and management needed to achieve a successful second year of operation.

As we plan for a second year of Open Enrollment, we are focused on building on the advances made for consumers during the first year. Our focus is on providing consumers more choices for coverage and affordable options, assisting them with selecting the options that are right for them, and educating first-time and newly insured consumers about their benefits, their eligibility requirements, and their financial protections.

At the same time we are keenly aware of the challenges of Year Two in a new program of this scale, particularly one that faced significant challenges in its first year. We are still working with brand new processes and technology, we are still establishing an understanding of unique consumer behavior and needs, and we are reacting to and solving new problems for the first time. It is thanks to the work of a very committed team of public servants and contractors and heeding

the lessons of the last year that we will continue to build on the success of the first year of state and Federally-facilitated Marketplaces.

### **Affordable Care Act Implementation: Building on Progress in Affordability, Access and Quality**

Evidence confirms that the Affordable Care Act is working as intended, making a difference in the lives of millions of Americans. Health care is becoming more affordable, with greater access and assurance of continuous coverage, and with improvements to quality and choice.

In the first full year, Americans have taken to a new way to purchase health insurance, as millions of Americans have selected a private insurance plan through their state or Federally-facilitated Health Insurance Marketplace. Millions more have retained coverage on their parents' policies and have qualified for Medicaid or CHIP.

In addition, recent years have seen historically low growth in overall health spending, and a variety of recent data show that very slow growth in health care costs has continued into 2014.<sup>1,2</sup> Preventive benefits, including wellness visits for women and screenings with no cost sharing for Medicare beneficiaries, as well as new incentives to pay doctors and hospitals for improving outcomes, are aimed at improving the quality of the health care that Americans receive.

#### *Reductions in the Uninsured Rate*

With the initial Marketplace open enrollment period now over, several recent reports make clear that the Affordable Care Act is reducing the uninsured rate. A study published in the New England Journal of Medicine found that, as compared with the baseline trend, the non-elderly uninsured rate declined by 5.2 percentage points by the second quarter of 2014, a 26 percent relative decline from the 2012–2013 period corresponding to 10.3 million adults gaining

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<sup>1</sup> Council of Economic Advisers. 2014. “Recent Trends in Health Care Costs, Their Impact on the Economy, and the Role of the Affordable Care Act.” *Economic Report of the President*, [http://www.whitehouse.gov/sites/default/files/docs/erp\\_2014\\_references\\_0.pdf](http://www.whitehouse.gov/sites/default/files/docs/erp_2014_references_0.pdf).

<sup>2</sup> Jason Furman and Matthew Fiedler. “Alongside Expanded Coverage, Underlying Slow Growth in Health Costs Is Continuing,” <http://www.whitehouse.gov/blog/2014/05/27/alongside-expanded-coverage-underlying-slow-growth-health-costs-continuing>.

coverage.<sup>3</sup> Using the same underlying data, Gallup found that the adult uninsured rate in the United States fell to 13.4 percent in the second quarter of 2014, representing the lowest quarterly recorded average since the survey began tracking the uninsured rate. According to Gallup, more than half of the newly-insured got their new coverage through the Marketplace.<sup>4</sup> The Urban Institute's Health Reform Monitoring Survey found a 4.0 percentage-point drop in the uninsurance rate for non-elderly adults between September 2013 and June 2014. The drop corresponds to a 22.3 percent reduction in the uninsurance rate, or a net gain in coverage of approximately 8 million adults.<sup>5</sup> Similarly, a Commonwealth Fund survey found that following the Affordable Care Act's first open enrollment period, the uninsured rate for non-elderly adults declined from 20 percent in July to September, 2013 to 15 percent in April to June, 2014, or an estimated 9.5 million fewer uninsured adults.<sup>6,7</sup> These independent surveys all point to the same overarching trend—the success of the Affordable Care Act in lowering the number of uninsured Americans.

### *Consumer Protections and Affordable Coverage*

The Affordable Care Act benefits Americans broadly, not simply those who are newly insured. Over the past three years, Americans have benefitted from insurance reforms that have already gone into effect, such as allowing adult children up to age 26 to stay on their parents' insurance, eliminating lifetime dollar limits on essential health benefits, and prohibiting rescissions of insurance when someone gets sick.

Now, in 2014, pre-existing conditions no longer preclude individuals from gaining health insurance, and consumers have better access to comprehensive, affordable coverage. New

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<sup>3</sup> New England Journal of Medicine, Health Reform and Changes in Health Insurance Coverage in 2014.

<sup>4</sup>After Exchanges Close, 5% of Americans Are Newly Insured, <http://www.gallup.com/poll/171863/exchanges-close-americans-newly-insured.aspx>

<sup>5</sup> Urban Institute Health Policy Center: Health Reform Monitoring Survey: Quicktake: Number of Uninsured Adults Continues to Fall under the ACA: Down by 8.0 Million in June 2014, <http://hrms.urban.org/quicktakes/Number-of-Uninsured-Adults-Continues-to-Fall.html>

<sup>6</sup> The Commonwealth Fund: Tracking Trends in Health System Performance: Gaining Ground: Americans' Health Insurance Coverage and Access to Care After the Affordable Care Act's First Open Enrollment Period, July 2014, [http://www.commonwealthfund.org/~media/files/publications/issue-brief/2014/jul/1760\\_collins\\_gaining\\_ground\\_tracking\\_survey.pdf](http://www.commonwealthfund.org/~media/files/publications/issue-brief/2014/jul/1760_collins_gaining_ground_tracking_survey.pdf)

<sup>7</sup>After Exchanges Close, 5% of Americans Are Newly Insured, <http://www.gallup.com/poll/171863/exchanges-close-americans-newly-insured.aspx>

protections also ensure that consumers' premium dollars are spent primarily on medical care, rather than on administrative expenses. Since the program's inception in 2011, this protection has saved consumers an estimated \$9 billion.<sup>8</sup> And consumers now have the comfort of knowing that if their employment changes or they lose coverage for any reason, they can purchase affordable coverage through the Marketplace—regardless of their personal health history.

### *Benefits Felt Across the Health Care System*

These market reforms are effective because they have benefits across the health care system. Reductions in the uninsured rate should mean doctors and hospitals provide less uncompensated care, a cost that is often passed along to taxpayers as well as consumers and employers who pay premiums for health coverage. And new pools of people buying insurance means insurers have an opportunity to grow by competing to provide better access to quality, affordable choices, the benefits that consumers are used to in any competitive marketplace. The creation of a successful, viable health insurance market had benefits for all Americans no matter where they get their health insurance.

### **Affordable Care Act Implementation: Building on Progress and Lessons From Year One**

Our focus now is on several critical priorities to build on the progress from our first year of operations. First, we are focused on increasing the value to consumers by continuing to improve the information, plan options, and affordability of the shopping experience. Second, we need to continue to automate the back end systems of the Marketplace. Third, we are addressing the execution and technology lessons we learned during the first open enrollment period with a more disciplined, highly accountable and visible management structure.

### *Bringing More Value to Consumers in the Marketplace*

Like any marketplace, the Health Insurance Marketplace leverages technology to bring more value, better information and a better shopping experience to consumers. Driven by competition and the significant demand for health coverage, our goal is to expand health plan options with more affordable premiums for consumers.

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<sup>8</sup> [http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Final-MLR-Report\\_07-22-2014.pdf](http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Final-MLR-Report_07-22-2014.pdf)

Based on their experience in Year One, we are aiming for insurers to bring more options in more geographic markets, including in markets where consumers had limited options for coverage. While we are still reviewing the proposed plans to ensure they meet the requirements for participation in the Marketplace, we have seen an increase over last year in the number of applications from issuers for the 2015 plan year. With more choices in year two, consumers should have an even greater opportunity to find a quality health plan that best meets their needs.

Enhanced competition among insurers means that in year two, insurers will continue to compete on the basis of plan quality and value, as consumers are no longer charged different premiums because of health status or gender. Advance payments of the premium tax credits are significantly lowering many consumers' premiums for insurance coverage through the Marketplace, with seven in ten consumers paying \$100 or less after tax credits.<sup>9</sup>

CMS is also bringing more value to consumers in the coming year by ensuring better transparency for provider networks. We are doing so in two ways. First, CMS will hold insurers to a "reasonable access" standard for network adequacy and will identify provider networks that fail to provide access without unreasonable delay, especially in areas that have historically raised network adequacy concerns, such as hospital systems, mental health providers, oncology providers, and primary care.

Second, CMS is continuing to monitor and improve consumers' access to provider directories to help consumers more easily find network providers. Insurers must now provide links that connect consumers directly to provider directories specific to a given plan option without needing to log in, enter a policy number, or navigate through various websites. CMS expects that these directories will be kept up to date and will include location, contact information, specialty, medical group, institutional affiliations, and whether the provider is accepting new patients—information consumers need to make informed health plan decisions.

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<sup>9</sup> ASPE Research Brief: Premium Affordability, Competition, and Choice in the Health Insurance Marketplace, 2014, <http://aspe.hhs.gov/health/reports/2014/Premiums/2014MktPlacePremBrf.pdf>

CMS also plans to make the process of renewing coverage as simple as possible. We will encourage everyone to come back to the Marketplace to shop for the best coverage option that meets their needs and to update their eligibility information. But for those consumers who are satisfied with their current plan and don't want to change, we will follow the model used at most employers and in the Medicare Advantage and Part D programs, and allow people to automatically re-enroll in the same plan for the following year without doing anything.

### *Adding Critical Functionality to Operate the Marketplace*

There are significant new technological requirements to support the operation of the Marketplace in a more automated fashion and to allow consumers to renew their coverage as seamlessly as possible in a Year Two. Doing this successfully means ruthlessly prioritizing efforts to execute on critical capabilities, while setting the course for further improvement and development of new functionality in coming years. This level of discipline is vital in both the private and public sector in executing projects of this magnitude.

Critical focal areas include completing functionality that was targeted for the first year of development, but has not yet been completed, such as more automated back end functionality, case management tools to assist consumers with more complex eligibility situations, and launching an online exchange for small businesses and their employees. In addition, we are building the functionality required for renewing members and adding to the infrastructure to better support a shorter open enrollment period. We are also making a few key consumer improvements, including a streamlined application process for the majority of new consumers. And we will remain committed to ensuring that the Marketplace continues to adhere to the stringent privacy and security protocols necessary to protect consumers' personally identifiable information. Importantly, we are focused on managing our resources efficiently and are conscious of the limited time available for technology development this year. Given the large amount of required development, we are focused on executing on our priorities in a disciplined way and adding additional functionality in years to come.

### *Addressing Execution and Technology Lessons Learned from Year One Open Enrollment*

As part of the turnaround team, I experienced first-hand the challenges of the first year and at CMS, am helping to oversee a series of changes to improve the management of the Marketplace. We are building on our experiences of what worked during the first year of open enrollment. This year, we are making several critical changes to oversee the implementation of the Marketplace that align with best practices from the private sector.

First and foremost is the alignment of clear accountability for the leadership of the project. In June, Secretary Burwell announced a series of organizational changes designed to strengthen the implementation of the Affordable Care Act. The changes include the creation of two new roles to provide clear accountability and visibility for managing and delivering the technology necessary to strengthen implementation of the Marketplace. Those roles, with full support from me, the Administrator, and the Secretary, are designed to bring clear leadership, accountability and visibility into the delivery of this large and complex technology project.

This new leadership structure will improve the discipline and focus of the project, enhance communications, and identify risks throughout the project. Like any project of this size, there will always be ongoing challenges, but we are building an operation better suited to identify and resolve them. We will ensure that team members, regardless of their affiliation with CMS or with a private-sector contractor, are encouraged to bring attention to problems they encounter. From the top of the team to the bottom, our priority is on visibility into—and frank communication about—our daily progress.

This coming year will be one of continued improvement, but not perfection. We still have a lot to learn that will help us continue to improve the Marketplace. We are in the first year of a program newly serving millions of consumers, many with unique and complex needs and many of whom are gaining coverage for the first time. We are still learning about the best ways to support those needs and are setting up and testing new processes and new technologies along the way. From my experience, at this stage, businesses begin to see how closely their design matches the battle-tested needs of the market. Good organizations learn and adapt and continuously improve their operations and the services they provide. We are accountable to the American public for



delivering the best possible value as we implement the Affordable Care Act and will continue to monitor our progress and improve to fulfill this responsibility.

### **Conclusion**

CMS takes seriously its commitment to the American people—to provide each eligible consumer access to quality, affordable health coverage through private insurance, Medicaid, or CHIP.

While the Marketplace is still at an early stage, we are hard at work building on the successes and lessons learned from the first open enrollment, and look forward to meeting the needs of consumers and insurers as we continue to learn and improve for future years. The transition to a reformed health insurance market will take sustained effort, persistence, and focus from all stakeholders, but CMS is committed to continuing to deliver on the promise of the Affordable Care Act and improving health care access, cost, and quality for all Americans.