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HEARING ON THE STATUS OF THE AFFORDABLE CARE ACT IMPLEMENTATION

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRTEENTH CONGRESS

SECOND SESSION

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HEARING ON THE STATUS OF THE AFFORDABLE CARE ACT IMPLEMENTATION

WEDNESDAY, SEPTEMBER 10, 2014

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The subcommittee met, pursuant to call, at 10:06 a.m., in Room 1100, Longworth House Office Building, the Honorable Kevin Brady [chairman of the subcommittee] presiding. Advisory

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
Wednesday, September 3, 2014
No. No. HL-15

CONTACT: (202) 225–3625

Chairman Brady Announces Hearing on Status of the Affordable Care Act Implementation

House Committee on Ways and Means Subcommittee on Health Chairman Kevin Brady (R-TX) today announced that the Subcommittee will hold a hearing on the Administration's continued efforts to implement and administer the Affordable Care Act (ACA). The Committee will hear testimony from Andy Slavitt, Deputy Principal Administrator of the Centers for Medicare & Medicaid Services (CMS) at the U.S. Department of Health and Human Services (HHS), and John Koskinen, Commissioner of the Internal Revenue Service. CMS is the federal agency that oversees the operation of the Exchanges through the Center for Consumer Information and Insurance Oversight (CCIIO), and the IRS oversees the distribution and verification of the subsidies in the ACA. **The hearing will take place on Wednesday, September 10, 2014, in 1100 Longworth House Office Building, beginning at 10:00 A.M.**

In view of the limited time available to hear from the witnesses, oral testimony at this hearing will be from the invited witness only. However, any individual or organization not scheduled for an appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

As the ACA's Exchanges approach the second enrollment period, beginning on November 15, 2014, CMS and the IRS continue to implement new policies to address on-going problems including: the delay of the employer mandate; the back log in resolving eligibility inconsistencies; the failure to complete the back-end systems for the Exchanges; and the numerous exemptions to the individual mandate. Many of these challenges were identified at a Health Subcommittee hearing on December 4, 2013, and remain unresolved.

The ACA provides for an income-based premium tax credit for certain individuals who purchase health insurance through the new Exchanges. The accuracy and availability of these tax credits, which began with coverage on January 1, 2014, depends on multiple pieces of data, including an individual's income and eligibility for affordable employer-sponsored insurance. The Administration's 2013 decision to delay employer-reporting requirements continues to complicate the government's ability to verify an offer of ″affordable employer-sponsored insurance.″

The accuracy of these tax credits, which are paid directly to insurance companies, cannot be guaranteed without accurate income and insurance information. As a result of the failure to provide complete and accurate information, the government may overpay and be forced to rely on the IRS to recover overly generous tax credits from individuals during the 2015 tax-filing season.

On January 1, 2014, Health and Human Services Secretary Kathleen Sebelius certified the ability of HHS to verify the income and eligibility of enrollees on the Exchanges and healthcare.gov, as she was required to do so by law. The Continuing Appropriations Act, 2014 required that ″prior to making such credits and reductions available, the Secretary shall certify to the Congress that the Exchanges verify such eligibility consistent with the requirements of such Act.″ Despite the Secretary's cer-

tification, a June 2014 HHS Office of Inspector General report noted that CMS had yet to verify nearly 1 million income inconsistencies potentially putting at risk millions in taxpayer dollars through inappropriate subsidies/1/.

In announcing the hearing, Chairman Brady stated, ″**This White House continues to rewrite the President's health care law because the law is unworkable. The growing number of American families losing the health insurance they have and like is not something that can be glossed over. The White House must come clean with the American public and tell us how they will fix this mess before the beginning of Open Enrollment in November. More delay and confusion will only result in more mistrust and more families losing access to the health insurance that works for them and their families. The Centers for Medicaid and Medicare Services and the IRS need to do more to protect American families and taxpayers.**″

FOCUS OF THE HEARING:

The hearing will focus on the status of the Obama Administration's implementation and oversight of the Affordable Care Act.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, *http://waysandmeans.house.gov,* select ″Hearings.″ Select the hearing for which you would like to submit, and click on the link entitled, ″Click here to provide a submission for the record.″ Once you have followed the online instructions, submit all requested information. ATTACH your submission as a Word document, in compliance with the formatting requirements listed below, by the close of business on Wednesday,“ *http://oig.hhs.gov/oei/reports/oei* 01 14 00180.pdf”September 24, 2014. Finally, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225-1721 or (202) 225-3625.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be provided in Word format and MUST NOT exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, telephone, and fax numbers of each witness.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202-225-1721 or 202-226-3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Note: All Committee advisories and news releases are available on the World Wide Web at *http://www.waysandmeans.house.gov/*.

The subcommittee met, pursuant to call, at 10:06 a.m., in Room 1100, Longworth House Office Building, the Honorable Kevin Brady [chairman of the subcommittee] presiding.

Chairman BRADY. Committee will come to order. The Affordable Care Act has changed how Americans receive their healthcare. There has been ample debate over the last 4 years about the ACA and what impact it will have. Today we have the chance to look in the rearview mirror and judge results rather than the rhetoric and promises, and we have the opportunity to look forward to next year to see what other changes and surprises may lay ahead for the American people.

It is no surprise that I and many of my colleagues on this side of the aisle were very concerned about what would happen with the rollout of the ACA and HealthCare.Gov. Unfortunately, for the American people, many of those concerns came true. The ACA has helped some Americans, no doubt, but has hurt many more. Millions of families lost their doctor and their healthcare plan. Millions more saw their premium spike because of new taxes and regulations that provide them with no additional coverage, just more costs, and many more workers saw their hours cut as businesses prepare for further mandates.

But worst of all, many Americans have lost trust in our government when it comes to being honest about its healthcare promises. Many patients fear what may be in store for them next. They have lost their health care they have and like, lost their doctor and are seeing their premiums soar. And for those that end up in the government exchanges, the ones that the law was supposed to help, they were subjected to a disastrous rollout of HealthCare.Gov, delays as paperwork went missing, and the ongoing reality that they may owe thousands of dollars back to the IRS for subsidies they are not eligible for. Not because they did anything wrong, but because the ACA income verification system was not and still is not working.

But the administration assures us next year its smooth sailing. Unfortunately, the answer to that is "no." Open enrollment has been delayed until November 15. I am worried that individuals won't enroll. The Centers for Medicare and Medicaid Services recently announced that if individuals don't select a new plan by December 15, they will be auto enrolled in their old plan.

The problem with that, however, is that their premium tax credit, if they get one, will be based on the one they are receiving today, whether accurate or not. If a person wants to accurately know how much of a subsidy they will receive for 2015, they need to go through HealthCare.Gov again. Yes, the HealthCare.Gov that was just hacked, carries the risk of putting Americans' sensitive, personal information at risk.

In plain English, it means that working families will have to wait that much longer or work that much harder to find out how much their health care will cost next year. It is not right for those trying to put together their family budgets right now. What is also

not right is the fact that the ACA's income verification is still not working.

Despite Secretary Sebelius' certifying to Congress on January 1st of this year that a working verification system was in place, the HHS inspector general found that there were nearly 1 million income inconsistencies on exchange applications. Because individuals were able to self-attest to their income levels, there was little data before taxpayers' subsidies were sent out the door. And if the data is wrong, thanks to the horrible poor implementation of the bill, hundreds of thousands of Americans could be hit with a nasty surprise when they do their taxes next year. They could be forced to pay back hundreds or even thousands of dollars.

Recently, the Treasury Department spokesperson suggests that the ineligible subsidy that someone owes back to taxpayers could be capped. That is not how the law is written. Individuals who are not eligible, either because of improper income data or coverage from another source must repay the entire amount. The ACA tried to invent a system that would collect that information to prevent things like this from happening and improper subsidy, but guess what? It has proven so far to be too complicated and too burdensome.

The administration has admitted time and time again, the law doesn't work, delaying one provision after another or exempting special interests or politically-favored friends from the most onerous parts of the law. And while the mandate on local businesses is not being enforced, for 2014, the mandate on individuals to buy government-approved health care or pay a tax is. That certainly doesn't sound fair to me. And that is why this White House has lost, in my view, the trust of the American people.

Today's hearing is an opportunity for CMS and IRS to begin an open and honest conversation with the citizens of the great country about their health care. And before I recognize Ranking Member Dr. McDermott for the purposes of an opening statement, I ask unanimous consent that all members' written statement be included in the record. Without objection, so ordered.

And I will recognize the Ranking Member Dr. McDermott for 5 minutes for the purpose of his opening statement.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

Mr. Koskinen and Administrator Slavitt, welcome to a tale of two cities. Before we enacted the ACA 4 years ago, America's healthcare system was dysfunctional and deadly. Forty-six million people were uninsured, and every year 45,000 Americans died because they lacked coverage. Many Americans who had insurance weren't getting a good deal. Their health security was tenuous at best and prospect of bankruptcy due to medical bills was a real threat for far too many families. Insurance companies could hike up plan rates with impunity and without accountability. Insurance companies could refuse to cover people with preexisting conditions, and benefits dropped away from people who were most sick and needed health care the most.

Meanwhile, Medicare costs were increasing at unjustifiable high rates, in part because the Federal Government was overpaying private insurance companies tens of billions of dollars through the Medicare Advantage program. Waste, fraud, abuse continued to

chip away at the trust fund as fraudsters and other questionable actors built beneficiaries. And the American taxpayer, while law enforcement like the tools to crack down on, fraud, in fact, had existed. Millions of seniors were falling into the Medicare prescription donut hole where coverage evaporated just when they needed it.

Today, things are different. There is a real health security for millions of Americans due to ACA. Marketplaces across the country are backed up, running, ready for business. Eight million Americans signed up for coverage during the first open enrollment period, and the number of uninsured Americans has dropped by almost 10 million. Six million Americans have gotten tax credits and subsidies to help offset their healthcare costs.

In addition, smart States have expanded Medicaid, which has increased coverage to millions more of the most vulnerable Americans. Thanks to the ACA, hardworking Americans have no longer been denied coverage because they have preexisting conditions, and their rates cannot be arbitrarily raised when they get sick. We are cracking down on fraud, waste and abuse, instead of targeting fraud after the fact. Federal regulators are increasingly preventing violations on the front end.

Thanks to vigorous enforcement and the tools provided by the ACA, the administration has recovered more than $19 billion over the past 5 years. Payments to private insurance companies have been reduced to more appropriately reflect the cost of delivering Medicare while Medicare benefits have actually been increased. With free preventive care and coverage in the donut hole, millions of seniors have saved billions of dollars since the ACA was enacted.

Now, have there been a few hiccups? Yes, there have been a few hiccups. You start something big, you always have a few hiccups. Talk to the Boeing Company. Implementations of the ACA have suffered due to Republican propaganda designed to confuse and scare the public, senseless repeal votes and harmful budgets cuts. And as the Commissioner from the IRS has testified in the past, the IRS is seriously understaffed making it harder for the agency to implement key parts of the ACA.

Similarly, CMS has been denied needed resources, yet despite the Republican's best effort at sabotage, the ACA is working. The law is saving money and lives. And my belief is that we are on a pace to guarantee health security for 32 million more Americans in the coming years and Medicare spending is at its lowest per-person growth in history.

In light of the ACA's success, I look forward to the day when Republicans do an about-face to accept their share of the responsibility in guaranteeing health security for all Americans. That means ending this senseless mission of sabotage and repeal. That means working with the Democrats to ensure all of our constituents benefit from all the ACA has to offer.

And we look forward to your testimony. Thank you.

Chairman BRADY. Thank you, Ranking Member Dr. McDermott.

Today, we will hear from witnesses on two panels. John Koskinen, Commissioner of the Internal Revenue Service, and Andy Slavitt, Principal Deputy Administrator for the Centers for Medicare and Medicaid Services.

Commissioner Koskinen, you are recognized for 5 minutes.

Mr. KOSKINEN. Thank you, Chairman Brady, Ranking Member McDermott and Members of the Subcommittee, thank you for the opportunity to appear before you today to update you on the work that the IRS is doing to fulfill our responsibilities under the Affordable Care Act. My testimony will focus on the significant efforts the IRS has been making to prepare for the 2015 filing season in relation to the premium tax credit and the individual shared responsibility provision under the Act.

The IRS has already implemented a number of tax provisions under the Act, including the branded prescription drug fee, the tanning tax and the medical device excise tax. It should be noted at the outset that the vast majority of taxpayers will need to do nothing more next year under the Affordable Care Act than check a box on their tax returns because they have health coverage from one source or another.

People who buy insurance through the marketplace and who qualify for the premium tax credit will have an extra calculation to make when they file. Most of them chose to have an advanced payment sent to their insurer during the year based on their family situation and estimated income for 2014. They will have to reconcile this advance payment on their return. We have already issued a draft of the new form they will use for this purpose, Form 8962.

If anyone paid for the insurance up front and claims to be eligible for the premium tax credit, they will calculate the amount of the credit they are entitled to and claim it on their tax return. The IRS has also developed the Form 1095–A and instructions. Beginning with the coverage purchased in 2014, the marketplace must issue the Form 1095–A to those who bought a policy through the marketplace. The data on this statement will verify the fact of marketplace coverage and facilitate the reconciliation process for the premium tax credit.

The data will also be sent to the IRS and it will help us make sure that only people who qualify for the premium tax credit receive it. We are in the process of conducting tests with the Federal and State marketplaces to ensure that our systems can accept this data and will be ready to operate as planned when filing season opens next year.

The work being done to prepare for filing season also involves the individual shared responsibility provision. This requires people to have insurance coverage for each month of the year, have an exemption or make a shared responsibility payment. A number of individuals will be exempt from this provision.

For example, a person could be exempt for hardship reasons or if a gap in their coverage during the year was less than 3 consecutive months. Those who qualify for an exemption will provide information about it on a new form we have developed, Form 8965. The IRS has also been working to make sure that people understand how these two major ACA provisions may affect them at tax time. In helping people understand how the ACA might affect them, our primary goal is to make it as easy as possible for people to file their taxes next year. By providing this information in advance, we are also trying to answer as many questions as possible before the

filing season to limit the number of people who need to call us for help.

For example, our Web site, IRS.gov, has a new section devoted to the ACA. We have also issued 16 healthcare tax tips and nine YouTube videos on ACA topics so far this year, with more on the way. And we have increased our use of social media, including Tumblr and Twitter to help get the word out. And yet, we still anticipate an increase in calls next filing season from taxpayers seeking assistance in regard to the ACA.

We are concerned about our ability to meet this demand because of ongoing budget constraints and because of the possibility of additional increase in calls if Congress passes tax extender legislation later this year. We hope that Congress will pass any extenders as early as possible this year with as few changes as possible.

I would note that the various ACA implementation efforts I have just described were accomplished in the absence of appropriated dollars requested for this effort. For fiscal year 2014, the administration requested $430 million for the IRS to implement these tax-related provisions. Of that total, 300 million was needed for building and improving information technology systems and processes. No portion of the request was funded. Nonetheless, the IRS continues to deliver on this mandate given to us by Congress by refocusing the needed funding from other IT and agency priorities.

Our concern with fiscal year 2015 budget request of about $400 million for additional taxpayer services, if we had the funding, we would hire enough full-time equivalents to end up with a level of service at 80 percent. Without the funding, we expect that our taxpayer level of service may drop to as low as below 50 percent, which would mean that almost half of the people calling will not be able to reach a live assistant. We continue to work, as I said, to ensure that taxpayers in advance have as much information as possible to limit that load on our call-in system, but it is going to be one of our major challenges.

This concludes my testimony, and I would be happy to take your questions.

[The prepared statement of Mr. Koskinen follows:]

WRITTEN TESTIMONY OF
JOHN A. KOSKINEN
COMMISSIONER
INTERNAL REVENUE SERVICE
BEFORE THE
HOUSE WAYS AND MEANS COMMITTEE
SUBCOMMITTEE ON HEALTH
ON IMPLEMENTATION OF THE AFFORDABLE CARE ACT
SEPTEMBER 10, 2014

Chairman Brady, Ranking Member McDermott and Members of the Subcommittee, thank you for the opportunity to appear before you today to update you on the work the Internal Revenue Service (IRS) is doing to fulfill our responsibilities under the Affordable Care Act (ACA).

The IRS has been charged with implementing the numerous tax-related provisions of the ACA. This testimony will focus on two major provisions taking effect this year, the premium tax credit and the individual shared responsibility provision, as well as the substantial work being done to prepare IRS business processes and systems to facilitate return filing and compliance with these two provisions beginning with the 2015 filing season. This work includes the significant effort we are making to ensure that taxpayers know how these two provisions may affect them.

IRS' work in relation to the ACA started soon after the legislation was signed into law in March 2010, as the agency moved quickly to implement a number of tax-related provisions that became effective immediately. These provisions included: the Small Business Health Care Tax Credit; the tax credit available under the Qualifying Therapeutic Discovery Project Program; the expansion of the tax exclusion for student loan forgiveness for health care professionals working in underserved areas; and the Indoor Tanning Services Excise Tax. Other tax-related ACA provisions implemented by the IRS since 2010 include the Branded Prescription Drug Fee and the Health Insurer Provider Fee.

Another ACA implementation effort by the IRS has involved providing information to facilitate the delivery of advance payments of premium tax credits that are designed to help millions of American families obtain affordable health insurance coverage through the Federal and state Health Insurance Marketplaces. The operation of these Marketplaces is overseen by the Department of Health and Human Services (HHS). The IRS's limited role in the operation of the Marketplaces is to provide Marketplaces with data and computational services for use in their determinations about eligibility for financial assistance.

The IRS provides support to the process that each Marketplace goes through when an individual seeking to purchase insurance through the Marketplace also seeks financial assistance: that is, the Marketplace must determine what assistance, if any, the applicant may qualify for, such as the advance payment of the premium tax credit, or Medicaid. As part of assembling data for that determination, the Marketplace requests Federal taxpayer return data. In response to such a request, the IRS securely provides certain limited tax data from the applicant's most recent Federal income tax return, as specifically authorized by the Affordable Care Act. State Medicaid and Children's Health Insurance Program agencies may also choose to request the tax data for their eligibility determinations.

Separate from the process of providing limited tax return data to the Marketplace for eligibility determinations, the IRS also supports the Marketplace by providing an optional computational service, known as the Premium Tax Credit Computation Engine.

This computational service is used if an applicant, instead of paying for the insurance up front and claiming the premium tax credit later on their tax return, chooses to have an advance payment of the credit sent straight to the insurer, on a monthly basis throughout the year. After the Marketplace determines a predicted 2014 income figure, and without identifying the applicant, the Marketplace submits a few data elements – such as a Marketplace-determined income figure and family size, and the Marketplace benchmark plan premium – to the IRS' optional computational service. The Marketplace then receives back a single figure: the maximum advance premium tax credit for which an individual may be eligible based on those data inputs.

The systems and processes the IRS developed to support enrollment in the Marketplaces were launched on schedule in October 2013, and they continue to work as planned. We have handled the information requests received via the HHS Federal Data Services Hub, and we have processed the transactions as intended. This conclusion is supported by the Treasury Inspector General for Tax Administration (TIGTA), which issued a report in July 2014 on the IRS' performance in regard to the more than 27 million requests for federal taxpayer return data and the more than 11 million computational requests received between October 1, 2013 and March 31, 2014. TIGTA determined that the IRS provided accurate responses for 99.97 percent of the requests for return data and 100 percent of the computational requests that TIGTA reviewed.

Let me turn now to the work the IRS is doing to prepare for the 2015 filing season.

In regard to the premium tax credit, as noted above, eligible individuals can choose to have their insurer receive advance payment of the tax credit, the amount of which is based on a determination made by the Marketplace. At the

end of the coverage year, taxpayers who opted for advance payment of the credit will reconcile the payment on their 2014 tax returns filed in 2015.

When filing tax returns, these taxpayers will calculate the actual credit they qualified for based on their actual 2014 income. If the actual premium tax credit is larger than the sum of advance payments made during the year, the individual will be entitled to an additional credit amount. If the actual credit is smaller than the sum of the advance payments, the individual's refund will be reduced or the amount of tax owed will be increased, subject to a statutory sliding scale of income-based repayment caps. The IRS recently issued a draft of new Form 8962, *Premium Tax Credit,* which taxpayers will use to make these calculations and will file with their income tax return.

The IRS has also developed the Form 1095-A, *Health Insurance Marketplace Statement*, to facilitate the reconciliation process for the premium tax credit. Beginning with coverage purchased in 2014, each Marketplace will issue the 1095-A to individuals who purchased a policy through the Marketplace. The IRS recently issued a draft version of the form and its accompanying instructions.

The transactional information contained in the 1095-A issued by the Marketplace will include not only the fact and cost of coverage, but also information on any advance payments of the premium tax credit made during the coverage year to the taxpayer's insurance company on his or her behalf. This information will also be supplied to the IRS. We are in a testing phase with the Federal and state Marketplaces, to ensure that our systems will be ready to operate as planned when filing season opens in early 2015. The Marketplaces, including state-based Marketplaces, are responsible for reporting this information accurately and on time.

Having data from the Marketplaces will allow the IRS to efficiently sort for the basic qualification and computational elements of the premium tax credit. While the IRS does not share publicly all of the tools and techniques used for detecting noncompliance, it can be noted that the IRS will, for example, be able to determine:

- Whether there is a record of anyone on the return having enrolled at a Marketplace (a basic requirement to claim the credit);
- Whether any advance payments made directly to the insurance company have been properly netted against the credit calculation; and
- If the tax return reports inaccurately high premium costs or inaccurately low advance payments as compared to the Marketplace data.

The IRS' preparations for the upcoming filing season in regard to the ACA also involve the individual shared responsibility provision. Under this provision, individuals are required to have qualifying health insurance coverage for each month of the year, have an exemption, or make an individual shared responsibility payment. I would note that the vast majority of taxpayers will have

health coverage from one source or another – such as the individual's workplace, the Marketplace, Medicare or Medicaid – and so will have to do nothing more than check a box on their tax return.

There are a number of individuals who will be exempt from the individual shared responsibility provision. An exemption will apply for individuals who:

- Have no affordable coverage options because the minimum amount they must pay for the annual premiums is more than eight percent of their household income;
- Have a gap in coverage for less than three consecutive months; or
- Qualify for an exemption for one of several other reasons, including, but not limited to, having a hardship that prevents them from obtaining coverage.

Most individuals who qualify for an exemption and otherwise need to file a tax return will provide the exemption information with their returns. The IRS recently issued a draft of new Form 8965, *Health Coverage Exemptions*, which taxpayers will use to claim an exemption from the coverage requirement and will file with their tax return.

The small minority of individuals who do not have coverage and do not qualify for an exemption will need to make an individual shared responsibility payment. A worksheet will be provided for the calculation of the shared responsibility payment, but the worksheet will not be required to be attached to the tax return.

In general, the payment amount is either a percentage of the individual's income or a flat dollar amount, whichever is greater. The amount owed is 1/12th of the annual payment for each month that a person or the person's dependents are not covered and are not exempt. For 2014, the payment amount is the greater of:

- 1 percent of the person's household income that is above the tax return threshold for their filing status; or
- A flat dollar amount, which is $95 per adult and $47.50 per child, limited to a maximum of $285.

The individual shared responsibility payment is capped at the cost of the national average premium for the bronze level health plan available through the Marketplace in 2014.

Along with building and improving our processes and systems, and developing and issuing new forms and accompanying instructions in advance of the filing season, a major component of the IRS' preparations involves making sure taxpayers know how these two major ACA provisions may affect them at tax time.

The IRS has taken – and continues to take – a number of steps to provide information to taxpayers about these changes. For example:

- Our website, IRS.gov, has a section devoted to the Affordable Care Act (www.irs.gov/aca), which contains answers to many questions about the tax provisions, as well as links that will take persons to online ACA resources of other federal agencies. There already have been more than 2.5 million visits to this section;
- The IRS has issued 16 plain-language Health Care Tax Tips so far this year, and more are planned. These and other IRS Tax Tips are sent to more than 500,000 email subscribers in the tax and legal community as well as partner groups. These tips and other ACA information have been picked up widely by the media as well as on the web;
- Nine YouTube videos on ACA issues have been posted so far, including a series of question-and-answer sessions covering common taxpayer questions. We will continue to add to these videos, which also include videos in Spanish and American Sign Language;
- IRS officials have provided outreach to key groups such as the software community, and have presented information at numerous events, including this summer's five IRS Nationwide Tax Forums for tax return preparers. More than 10,000 tax professionals attended this year's Tax Forums, where key parts of the ACA were highlighted prominently during these three-day events, which in total provided more than 40 different tax law seminars on health care; and
- The agency has increased its use of social media to help people learn about the major ACA tax-related provisions. For example, a recent series of five Tumblr posts promoted the Health Care Tax Tips mentioned above, as well as the Premium Tax Credit and the Small Business Health Care Tax Credit. The IRS has also made use of Twitter, with more than 160 tweets promoting these and other ACA-related topics.

Providing information to individuals with regard to the premium tax credit has been a high priority. Throughout 2014, we have been making substantial efforts to ensure that individuals who opted for advance payment of the premium tax credit understand that a change in their circumstances during the year can make a big difference between the Marketplace's initial determination of how much credit a person qualifies for and the final premium tax credit amount.

Changes in circumstances during the year that should prompt individuals to update their information with the Marketplace include, but are not limited to: an increase or decrease in the individual's income; marriage or divorce; the birth or adoption of a child; starting a job with health insurance; gaining or losing eligibility for other health care coverage; and a change in residence.

Individuals receiving advance payments of the premium tax credit are required to notify the Marketplace of any changes in circumstances during the year as soon as possible, so their information can be updated and the amount of the advance payment adjusted if necessary. The IRS urges individuals to comply with this requirement, so the total advance payments made for the year will be the same

as or closely match the final premium tax credit amount on the individual's tax return.

The IRS' goal in its ACA-related communication efforts is to help people understand the law, which in turn will make their return filing experience easier next year. By providing this information in advance, we are attempting to anticipate and answer as many questions as possible before the filing season, to limit the number of people who would need to call us for help. The IRS adopted this approach because we have had success in steering potential callers to online resources in other areas. For example, one of the most popular features on IRS.gov is the "Where's My Refund?" electronic tracking tool, which taxpayers used more than 200 million times last year and more than 187 million times so far this year to find out about the status of their tax refund.

Notwithstanding our efforts to reach taxpayers in advance of filing season through all the channels described above, we still anticipate an increase in calls to our toll-free help lines in the 2015 filing season from taxpayers seeking assistance in regard to the ACA. Our ability to meet this demand may be strained due to ongoing budget constraints and the possibility of an additional increase in call volume related to the impact of tax extender legislation that may be passed later this year.

During the 2014 filing season, phone service outperformed our projections, notwithstanding our significant funding limitations. In addition to the diligent efforts of our employees, we attributed this improvement to our increased ability to provide information on IRS.gov, as well as to the lack of major tax legislation in 2013.

Now that filing season is over, we no longer have extra seasonal employees and thus have fewer people answering the phones. For this reason, we expect that our overall FY 2014 level of phone service will drop below our performance during the 2014 filing season.

The work being done to implement the major tax-related provisions of the ACA has occurred in the absence of appropriated dollars that had been requested for this effort. Nonetheless, the IRS continues to deliver on its Congressionally-mandated duties under the ACA by refocusing the needed funding from other priorities.

Addressing phone service waits, as well as the various operational and staffing shortages across the IRS, begins with the Administration's FY 2015 Budget request. Within this request there is new IRS funding, including the amount provided in the Opportunity, Growth, and Security Initiative, that would go towards taxpayer service programs. We estimate this would allow us to hire enough additional employees to answer 12 million more taxpayer calls. This increase in calls answered would amount to a level of phone service of more than 80 percent, which would be a significant improvement over the FY 2013

level. The additional calls answered would include calls from those seeking help with the tax-related provisions of the ACA as well as the expected tax extender legislation.

If we do not receive the requested funding and cannot hire the additional personnel necessary to handle our call volume, we estimate our level of phone service next year would decline significantly.

We will be watching developments in the budget process closely, in the hopes that Congress will ultimately provide adequate resources for the IRS for the next fiscal year. I stand ready to work with this Committee, the Senate Finance Committee and the Appropriations Committees to further explain the need to improve our current budget situation.

This concludes my testimony, and I would be happy to take your questions.

Chairman BRADY. Thank you, Commissioner.
Mr. Slavitt, welcome.

Mr. SLAVITT. Good morning, Chairman Brady, Ranking Member McDermott, Members of the Subcommittee. I am Andy Slavitt, Principal Deputy Administrator of CMS. I joined CMS 2 months 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 healthcare costs, quality and access. During that time, I have been both an entrepreneur and have run a major division of one of America's largest healthcare companies.

In late October of last year, I began my involvement with the Affordable Care Act implementation when I joined the group of people helping the CMS team on the turnaround effort of the health insurance marketplace. I am pleased to appear before you today. Before answering your questions, I will briefly walk you through some of the progress of the Affordable Care Act to date and talk about our priorities for the coming period.

There is growing evidence that the Affordable Care Act is working to make higher quality healthcare more affordable and accessible for millions of Americans. During the first open enrollment, millions of Americans selected a private insurance plan through their State or Federal health insurance marketplace and millions more have retained coverage on their parents' policies or have newly qualified for Medicaid or CHIP.

According to Gallup, the adult uninsured rate fell to 13.4 percent for the second quarter of 2014, a record low. In addition, we are seeing historically low growth and overall health spending measured at both the consumer level and the national level. This success is not being achieved by government policy alone, but in partnership with the private sector as insurers grow by competing to provide better quality and affordable services. Now, as we continue through the first year of marketplace implementation, we must build on that progress that is underway and continue to approve our execution based on the lessons from the last year.

First, we are focusing on increasing the value consumers get when they come to the marketplace. Early evidence from States that have already published this information is indicating consumers will have more options and more competitive rates. According to a recent survey conducted across 16 major cities, premiums for the benchmark marketplace plan will actually decrease on average in the coming year.

This is good news for consumers who are typically paying less than $100 a month for premiums for a policy in the marketplace. Most important is that this gives many families access to affordable, quality health care for the first time. According to a Commonwealth Foundation survey, two out of three newly-covered adults are saying they are now taking medicine and seeing doctors they couldn't afford before. When you get underneath all the statistics about the uninsured rate dropping and rates remaining competitive, this is what counts.

Next, we have heightened our focus on execution. Even as we continue to learn about new consumer needs, we are building out further automation and are working to improve interaction points with consumers and health plans. High on our agenda is making it easier for consumers to enroll and renew their coverage, pro-

viding scale to handle greater volumes of people, and completing back office functionality.

How we execute has been a major area of focus from the Secretary on down. Our operating principles are straightforward: Clear accountability with a new marketplace CEO and clearer structure; ruthless prioritization, which has meant we haven't done everything everyone has wanted, but have, instead, built in more time to test what we build; and transparency, even when things happen that we don't plan on.

The team at CMS is hard at work on implementation. This coming year will be one of visible and continued improvement but not perfection. We are in the early stages of the program newly serving millions of consumers and are still learning about the best ways to support their unique needs. We are making the right progress to have a successful open enrollment and continue to deliver on the promise of the Affordable Care Act to improve healthcare access, cost and quality for all Americans.

Thank you, and I look forward to your questions.

Chairman BRADY. Thank you, Mr. Slavitt.

Commissioner Koskinen and Mr. Slavitt, I want to return to the theme I mentioned in my opening statement and that is trust. I think, my view, the American people have lost trust in the IRS for a number of reasons, including health care. And I think the disastrous rollout of HealthCare.Gov has created a lack of trust among the American people, as well as promises not kept.

I do appreciate the work, Mr. Slavitt, you are doing, and there is a lot of it, to try to bring that site up to speed, more importantly, making sure we get the back end completed and right. Problems, obviously, remain with this. There are going to be more problems going forward into the second year.

So my question to both of you, and it really isn't a gotcha question, but in spite of all these problems, you know, how do you expect to, again, regain the trust of the American people when it comes to their health care? The ACA, in my view, through heavy subsidies is reducing the cost for some, but it is increasing the cost for others. And there is real concern back home from patients, providers and businesses about the Affordable Care Act.

So what are you doing to make sure the second year of the ACA is not like the first year in that steps will be taken to regain the trust of the American people regardless of what party they are, that are just simply concerned about their health care? Commissioner.

Mr. KOSKINEN. Well, we take, as I hope everyone knows, seriously the obligation to, as I say, try to make it as clear and straightforward and as easy as possible for people to determine what they owe and to be able to make those payments. As I have said on numerous occasions, we distinguish between the willing to pay and the unwilling to pay. And those willing to pay, even if they have difficulties, as I have said, don't have to hire somebody off late night TV to come talk to the IRS.

If you are willing to pay, trying to become compliant, we are anxious to work with you. We have installment agreement possibilities, we have ways of creating offers and compromise. With a focus on ACA, our role and the front-end rollout to providing income

verification data went very smoothly. The Inspector General said that it was virtually perfect. But we understand that there are going to be challenges with the first filing season, and that is why we are spending as much time as we are, starting last spring, trying to explain to the American people how the ACA affects them and what they need to do for filing.

And as I said, one of the most important things for the public to understand is the vast majority of those filing next year out of the 150 million expected individual returns, 120, 125 million of them will simply check a box that they have coverage and that is all they will have to do. The other people filing, those who are either reconciling premium tax credits, seeking a credit, filing an exemption or dealing with the shared individual responsibility payment will have additional responsibilities when they file, and we are doing everything we can to get them that information. We have had tax preparer forms across the country with 10,000 tax preparers focusing on the ACA.

But we take very seriously that, again, compliance with the Internal Revenue Code is a critical part of the tax system in the United States. We have a very compliant population. Our compliance rate is among one of the highest in the world. But to maintain that compliance rate, your point is well taken, people have to have trust and confidence in the system. They have to be confident they are going to get treated fairly no matter who they are.

As I have said, one of my highest priorities is to try to make sure that people understand, when they hear from the IRS, it is not because of who they are, what organization they belong to, who they voted for in the last election, if they hear from us, it is about an issue in their tax return. And if somebody else had that issue, they would hear from us, as well.

Chairman BRADY. There are questions about that. But let me ask you this: The IRS has three main tasks right now. One is to confirm income verification to those who are getting subsidies today; secondly, on January 1, delivering to American people Form 1095–A that tells them what they need to do to file their taxes; and then to prevent having verification income placed before the second year premiums and subsidies are released. Where are you on each of those three?

Mr. KOSKINEN. As I noted, last year in the rollout, we provided income verification information to 27 million inquiries. The inspector general reviewed it and said we were 100 percent accurate on the information we provided. It was primarily information about tax return information for 2012.

Chairman BRADY. Of those you have the information for, but the inspector general said roughly 1 million of them had inconsistencies, were not complete applications. What has been going on with those?

Mr. KOSKINEN. That was the review of HHS's and CMS's rollout. But in terms of the information provided by the IRS, the inspector general found that 100 percent of it was accurate. It was accurate to——

Chairman BRADY. So all the income from the IRS standpoint, everyone who is receiving subsidies today, their income has been fully verified?

Mr. KOSKINEN. Our role is to provide the data when the inquiry was made. We don't play a role in terms of what they do with the data. We will have a significant role when people file——

Chairman BRADY. The IRS has a roll of income verification?

Mr. KOSKINEN. When they file, we will obviously verify income as we do for the 150 million people who file, and that will determine the calculation that the taxpayer makes. It will determine whether they are eligible for the premium credit, how much of the advance payment they got and what reconciliation they have to make.

Chairman BRADY. So again, today, of those receiving subsidies through the ACA that are helping them with their health care, the IRS says you can assure us all of those incomes have been verified at this time?

Mr. KOSKINEN. We provided income verification when requested last year in the rollout. We will do it again in this year's rollout. We have been advising taxpayers since last spring that whatever determination they made with the marketplace is about their circumstances. If there is any change in those circumstances, either in their family size or their income, they need to go back to the marketplace, because our concern is that everybody makes an estimate when you file your W–2s and your withholding. You are estimating what your income will be, obviously, for most people it changes to some extent.

Chairman BRADY. Sure.

Mr. KOSKINEN. So we are focused on and concerned that we don't want people to have either gotten too small an advanced payment or too large of an advanced payment.

Chairman BRADY. What I didn't hear was a "yes" there. And I am hopeful we can get to the day where you can say yes, we have verified them.

The 1095–A due in January, have you completed testing on that? Can the American public be assured when they are ready to do their taxes and get their refunds, that that form will be there in January?

Mr. KOSKINEN. Right. We don't provide that form. That form is provided by the marketplace.

Chairman BRADY. But you provide the information for it?

Mr. KOSKINEN. Happy to turn it over to my colleague.

Chairman BRADY. Okay. How about preventing income verification to prevent eligible subsidies, ineligible subsidies in the future?

Mr. KOSKINEN. As I said, in this rollout period for the second year, we will continue to provide income information to our system marketplaces and determine eligibility. But I would stress in the filing season, we will check, as we always do with everybody who files, their income will be verified. As I say, we have a very compliant population. They provide information about their income as it actually happened. What we are providing in the rollout is income information that can be used for verification for a previous tax year.

But, again, that is what your, in this year's rollout, it will be what your tax income information was for 2013, but it'll be used for eligibility for 2015. And again, when you file for your 2015

taxes, you will have a different number almost no matter who you are as opposed to what you estimated.

Chairman BRADY. Sure. What is the process for collecting overpaid subsidies to those who are not eligible? Do you have that process in place?

Mr. KOSKINEN. That process will be our normal process in the sense that to the extent that your subsidy was too small, you will get a credit for that. For a lot of people in this income range it will be a refund. To the extent that your advance payment was too large, there will be a deduction either from your refund or an increase in the tax owing.

Chairman BRADY. Sure. Now, I know how that process works. Is it fully in place to do that?

Mr. KOSKINEN. It is, at this point, we are about to test our own systems. But I am assured, I have been meeting every 2 weeks since January with the IT people, with the program people and the business people, looking at exactly what we have to do to make that happen, and thus far, I have been assured that, while it is a challenge, we are on track to be able to do that.

Chairman BRADY. Sure. For someone who, through no fault of their own, received a subsidy they weren't eligible for, about what month in next year will they get the bad news that they owe taxes back to Uncle Sam?

Mr. KOSKINEN. They will get that news whenever—shortly after——

Chairman BRADY. It would be bad news. They will get that news.

Mr. KOSKINEN. They will get that news when they file, in the normal course. In other words, that news would be no different than any other bad news you might get if you turn out to owe taxes. So you will file a return. You will actually make your own calculation off the 1095 you get. You will determine whether you got too much and you owe additional tax or have a smaller refund. You will make that determination and you will file it with your return. Some people file in January. Some people file in April, and obviously, some extend their return into October.

Chairman BRADY. So they may start the repayment as early as January of the coming year?

Mr. KOSKINEN. It will all depend when they file.

Chairman BRADY. Sure.

Mr. Slavitt, can you address the issue, again, I know the serious work you are doing, both to address the problems in the past and try to both get the site working right and the back end right. There is no question about that seriousness. Can you address the trust issue at this point?

Mr. SLAVITT. Sure. Mr. Chairman, thank you for the question. I have actually thought a little bit about this question. As I mentioned, I have worked for the government for 2 months, and interestingly——

Chairman BRADY. You are an old man.

Mr. SLAVITT. I am an old man. Well, interestingly, the people that I work with at CMS and at the Department and across the government, the career people have been some of the most trustworthy people I have ever worked with, yet, coming from the pri-

vate sector, as you have said, there is a trust gap. And, you know, the way I understand that trust gap to be closed is the following ways: One is with transparency. Even when the news is bad, we need to be clear about what that news is, and I think this summer you have seen we have put out numbers, even worse-case numbers when there are challenges to help people with inconsistencies and so forth, rather putting those numbers out than other numbers and waiting for them to get better.

Second, is accountability. That means being here, and my first several months I have been here as frequently as I need to be. It also means owning up to mistakes. I don't think people expect us to be perfect. I do think people expect us to fix things when they don't work and be very candid about them and be very accountable.

And the third is straight talk. As much as possible, that means giving a direct and clear response when people are asking us very fair questions. It means saying "I don't know" when we don't know, even when we want to struggle to get back to people. There is no question that this implementation has a lot of pieces. It requires a lot of cooperation, and I think we can gain trust, I believe, in the work we are doing across government if we are clear in those categories.

Chairman BRADY. Thank you, Mr. Slavitt. Again, I think you are trying to implement a poorly-designed, poorly-written, unworkable law; nonetheless, I think that approach of openness, transparency and straight talk will go a long way, frankly, towards restoring that trust. So thank you very much.

Dr. McDermott.

Mr. MCDERMOTT. Thank you, Mr. Chairman. I would like to enter in the record the tax inspector general's for tax administration's report, "Affordable Care Act: Accuracy of Responses to Exchange Requests," dated 3 July, 2014. I ask unanimous consent.

Chairman BRADY. Without objection.

[The Honorable Jim McDermott]

TREASURY INSPECTOR GENERAL FOR TAX ADMINISTRATION

Affordable Care Act: Accuracy of Responses to Exchange Requests for Income and Family Size Verification Information and Maximum Advance Premium Tax Credit Calculation

July 3, 2014

Reference Number: 2014-43-044

This report has cleared the Treasury Inspector General for Tax Administration disclosure review process and information determined to be restricted from public release has been redacted from this document.

Redaction Legend:
2 = Risk Circumvention of Agency Regulation or Statute

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HIGHLIGHTS

AFFORDABLE CARE ACT: ACCURACY OF RESPONSES TO EXCHANGE REQUESTS FOR INCOME AND FAMILY SIZE VERIFICATION INFORMATION AND MAXIMUM ADVANCE PREMIUM TAX CREDIT CALCULATION

Highlights

Final Report issued on July 3, 2014

Highlights of Reference Number: 2014-43-044 to the Internal Revenue Service Chief Technology Officer and the Director, Affordable Care Act Office.

IMPACT ON TAXPAYERS

Beginning January 1, 2014, most individuals must obtain health insurance that meets minimum requirements. The Health Insurance Exchanges (also referred to as Marketplaces), established by the U.S. Department of Health and Human Services and the States, are intended to provide a place for Americans to shop for health insurance in a competitive environment. Eligible individuals who purchase health insurance through an Exchange may qualify for and request a refundable tax credit, referred to as the Premium Tax Credit, to assist with paying their health insurance premium. The credit can be paid directly to an individual's health insurance provider as a partial payment for their monthly premiums (referred to as the Advance Premium Tax Credit or (APTC)).

WHY TIGTA DID THE AUDIT

This audit was initiated to ensure that the IRS is providing accurate information to the Exchanges to assist in determining an individual's eligibility to use the Exchange and receive the APTC. The overall objective of this review was to assess the accuracy of responses to Exchange requests for Income and Family Size Verification (IFSV) information for the purposes of determining insurance eligibility and the maximum APTC the individual could receive each month.

WHAT TIGTA FOUND

As of March 31, 2014, the IRS received more than 27 million IFSV information requests and more than 11 million APTC requests. Our review of the IRS's response to 101,018 IFSV requests received by the IRS between October 1 and October 4, 2013, showed that the IRS, based on the information furnished by the Exchange, provided accurate responses for 100,985 (99.97 percent) of the 101,018 requests.

However, TIGTA identified 33 requests for which the IRS incorrectly notified the Exchange that it could not provide tax information for individuals for whom the Exchange was requesting information because the IRS was unable to match the name on the application to IRS data records. These responses were incorrect because the individual's name used on the application was in fact available in IRS data records. This resulted from a computer programming error in which IRS data used to provide information in response to Exchange requests did not always contain the most recent name information shown on the individual's tax account.

In addition, TIGTA reviewed the IRS's response to 120,824 APTC requests received between October 1 and October 14, 2013. This review showed that the IRS, based on information furnished by the Exchange, accurately calculated the maximum monthly APTC for all 120,824 requests.

WHAT TIGTA RECOMMENDED

TIGTA recommended that the Chief Technology Officer ensure that IRS data records used to provide responses to Exchange requests accurately reflect an individual's most recent name information contained in IRS tax data.

IRS management agreed with TIGTA's recommendation. The IRS has already implemented programming modifications so that name information fields are now consistent with the most recent name information shown on the individual's tax account.

TREASURY INSPECTOR GENERAL
FOR TAX ADMINISTRATION

DEPARTMENT OF THE TREASURY

WASHINGTON, D.C. 20220

July 3, 2014

MEMORANDUM FOR CHIEF TECHNOLOGY OFFICER AND
DIRECTOR, AFFORDABLE CARE ACT OFFICE

FROM: Michael E. McKenney
Acting Deputy Inspector General for Audit

SUBJECT: Final Audit Report – Affordable Care Act: Accuracy of Responses to Exchange Requests for Income and Family Size Verification Information and Maximum Advance Premium Tax Credit Calculation (Audit # 201340335)

This report presents the results of our review to assess the accuracy of responses to Health Insurance Exchange requests for Income and Family Size Verification information for the purposes of determining insurance eligibility and the maximum Advance Premium Tax Credit the individual could receive each month. Our review was limited to verifying the accuracy of the IRS's calculations during the eligibility and enrollment process. This audit was conducted as part of our Affordable Care Act strategy and is included in the Treasury Inspector General for Tax Administration's Fiscal Year 2014 Annual Audit Plan. This review addresses the major management challenge of Implementing the Affordable Care Act and Other Tax Law Changes.

Management's complete response to the draft report is included as Appendix IV.

Copies of this report are also being sent to the IRS managers affected by the report recommendation. If you have any questions, please contact me or Russell P. Martin, Acting Assistant Inspector General for Audit (Returns Processing and Account Services).

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Abbreviations

ACA	Affordable Care Act
AGI	Adjusted Gross Income
APTC	Advance Premium Tax Credit
CDR	Coverage Data Repository
FPL	Federal Poverty Level
IFSV	Income and Family Size Verification
IRS	Internal Revenue Service
PTC	Premium Tax Credit
SLCSP	Second Lowest Cost Silver Plan

Background

The Patient Protection and Affordable Care Act of 2010[1] and the Health Care and Education Reconciliation Act of 2010[2] (hereafter collectively referred to as the Affordable Care Act (ACA)) were both signed into law in March 2010. The ACA legislation seeks to provide more Americans with access to affordable health care by creating a new Health Insurance Exchange (hereafter referred to as the Exchange),[3] enforcing patient/consumer protections, and providing Government subsidies for people who cannot afford insurance. The Exchange simplifies an applicant's search for health coverage by providing multiple options in one place and comparing plans based on price, benefits, quality, and other important features that help consumers make a choice.

The Affordable Care Act seeks to provide more Americans with access to affordable health care.

Beginning January 1, 2014, most individuals were required to obtain health insurance coverage that contained essential health benefits including emergency services, maternity and newborn care, and preventative and wellness services. The Exchanges, established by the U.S. Department of Health and Human Services and the various States, are intended to provide a place for Americans to shop for health insurance in a competitive environment. The Exchanges offer insurance plans by private companies, and individuals can access qualified health plan information online, via a call center, or in person. The qualified health insurance plans offered through the Exchanges cover the same core set of essential health benefits, and no plan can turn an applicant away or charge more because of a preexisting illness or medical condition.

To enroll in health insurance coverage offered through an Exchange, individuals must complete an application and meet certain eligibility requirements defined by the ACA. Individuals began using the Exchanges on October 1, 2013, to purchase health insurance for Calendar Year 2014. Figure 1 provides a list of the States that use the Federally Facilitated Exchange, the States that use a State Partnership Exchange,[4] and the States (including the District of Columbia) that have developed their own Exchange as of May 14, 2014.

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[1] Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of the U.S. Code), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029.
[2] Pub. L. No. 111-152, 124 Stat. 1029. (See Affordable Care Act, *infra*).
[3] Also commonly referred to as the Marketplace.
[4] A State Partnership Exchange is a hybrid model in which the State makes key decisions and works with the Department of Health and Human Services to tailor the operation of the Federally Facilitated Exchange to meet the local needs and market conditions in their State.

Figure 1: Type of Exchanges Used by the States[5]

Federally Facilitated Exchanges	State Partnership Exchanges	State-Based Exchanges
Alabama	Arkansas	California
Alaska	Delaware	Colorado
Arizona	Illinois	Connecticut
Florida	Iowa	District of Columbia
Georgia	Kansas	Hawaii
Indiana	Maine	Idaho
Louisiana	Michigan	Kentucky
Mississippi	Montana	Maryland
Missouri	Nebraska	Massachusetts
New Jersey	New Hampshire	Minnesota
North Carolina	Ohio	Nevada
North Dakota	South Dakota	New Mexico
Oklahoma	Virginia	New York
Pennsylvania	West Virginia	Oregon
South Carolina		Rhode Island
Tennessee		Vermont
Texas		Washington
Utah		
Wisconsin		
Wyoming		

Source: Centers for Medicare and Medicaid Services as of May 14, 2014.

Eligible individuals who purchase health insurance through an Exchange may qualify for and request a refundable tax credit,[6] referred to as the Premium Tax Credit (PTC), to assist with paying their health insurance premium. Individuals may elect to have the PTC paid directly to their health insurance provider as partial payment for their monthly premiums (hereafter referred

[5] According to the Centers for Medicare and Medicaid Services, no changes have been made in the individual states' participation as either a Federally Facilitated, State Partnership, or State-Based Exchange since October 18, 2013.
[6] Any tax credit that is refundable can be used to reduce a taxpayer's tax liability to zero. Any excess of the credit beyond the tax liability can be refunded to the taxpayer.

to as the Advance Premium Tax Credit (APTC)) or receive the PTC as a lump-sum credit on their annual Federal tax return at the end of each coverage year beginning with the filing of their Tax Year[7] 2014 tax return. Because the PTC is a refundable credit, individuals who have little or no income tax liability can still benefit. Figure 2 lists the eligibility requirements individuals must meet to purchase insurance through an Exchange and to qualify for the PTC.

Figure 2: Eligibility Requirements to Purchase Insurance From an Exchange and to Qualify for the PTC

Exchange Eligibility Requirements	PTC Eligibility Requirements
Individuals must: • Live in the United States. • Be a U.S. citizen or national (or be lawfully present). • Not be currently incarcerated.	**Individuals must:** • Buy health insurance through the Exchange. • Be ineligible for health coverage through an employer or government plan. • Be within certain income limits.[8] • File a joint tax return, if married. • Not be claimed as a dependent by another person.

Source: IRS.gov and Healthcare.gov.

Starting in January 2015, individuals must include the amount of the APTC paid to an insurance provider on their behalf on their tax return and reconcile it to the allowable amount of the PTC.

The Exchange determines an applicant's eligibility to obtain health insurance and monthly financial assistance to pay for the health insurance

Individuals applying for financial assistance for insurance obtained through an Exchange must provide information regarding their income and family status, *e.g.*, marital status and number of dependents. The Exchange then obtains information from other sources, including other Federal agencies, to verify the applicant's information and determine eligibility to obtain coverage through the Exchange. The Exchange also uses the information obtained to predict what an individual's income and family status will be in the year for which health coverage is being requested. During the Exchange enrollment and APTC eligibility process, the following Federal agencies perform verifications and provide information:

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[7] A 12-month accounting period for keeping records on income and expenses used as the basis for calculating the annual taxes due. For most individual taxpayers, the tax year is synonymous with the calendar year.

[8] For example, in Calendar Year 2013, income between 100 percent to 400 percent of the Federal Poverty Level equated to $23,550 to $94,200 for a family of four. More information on the Federal Poverty Level can be found at https://www.healthcare.gov/glossary/federal-poverty-level-FPL/.

- The U.S. Social Security Administration verifies the applicant's Social Security Number, lawful presence in the United States, wage data, and prisoner status.
- The U.S. Department of Homeland Security verifies the applicant's legal immigration status.

The Internal Revenue Service (IRS) provides tax return information for applicants and their family members and computes the maximum APTC amount. For example, for those individuals applying for financial assistance for Calendar Year 2014, the Exchange uses Calendar Year 2012 tax information received from the IRS to predict an individuals' Calendar Year 2014 income. The Exchange uses this predicted income and family status to determine if an individual is eligible to receive an APTC.

Income and Family Size Verification (IFSV) information

The Exchanges submit requests to the IRS using the Department of Health and Human Services Data Hub[9] to obtain the applicant's IFSV information. The IFSV information consists of income, family size, and other identifying information for the individuals included on the application. As of March 31, 2014, the IRS had received more than 27 million IFSV information requests. The Exchange provides the IRS with the Social Security Number, full name, and relationship to the tax filer for all individuals on the application. Using the information furnished by the Exchange, the IRS provides the following information back to the Exchange via the Hub:

- *Adjusted Gross Income (AGI)*. The AGI is gross income minus adjustments to income that was reported on the tax return that the IRS used to obtain the IFSV information.
- *Applicable Response Codes*. If the IRS is unable to provide income and/or family size information for the applicant or a member of the applicant's family, the IRS provides the Exchange with a code describing why the information was not provided. Examples of issues that would prevent the IRS from being able to provide the requested information include the IRS having no tax return information for an individual, the IRS having indications of identity theft on the individual's tax account, or the spouse on the application not matching the spouse on the tax return.
- *Applicant's Social Security Number and Spouse's Social Security Number (if applicable)*. The applicant's Social Security Number is the one reported on the tax return. When there is a spouse on the application, the spouse's Social Security Number is also included with the information provided to the Exchange.

[9] The Hub provides a single point where the Exchanges may access data from different sources, primarily Federal agencies. The Hub does not store data; rather, it acts as a conduit for the Exchanges to access the data from where they are originally stored.

- The U.S. Social Security Administration verifies the applicant's Social Security Number, lawful presence in the United States, wage data, and prisoner status.
- The U.S. Department of Homeland Security verifies the applicant's legal immigration status.

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- *Adjusted Gross Income (AGI)*. The AGI is gross income minus adjustments to income that was reported on the tax return that the IRS used to obtain the IFSV information.
- *Applicable Response Codes*. If the IRS is unable to provide income and/or family size information for the applicant or a member of the applicant's family, the IRS provides the Exchange with a code describing why the information was not provided. Examples of issues that would prevent the IRS from being able to provide the requested information include the IRS having no tax return information for an individual, the IRS having indications of identity theft on the individual's tax account, or the spouse on the application not matching the spouse on the tax return.
- *Applicant's Social Security Number and Spouse's Social Security Number (if applicable)*. The applicant's Social Security Number is the one reported on the tax return. When there is a spouse on the application, the spouse's Social Security Number is also included with the information provided to the Exchange.

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[9] The Hub provides a single point where the Exchanges may access data from different sources, primarily Federal agencies. The Hub does not store data; rather, it acts as a conduit for the Exchanges to access the data from where they are originally stored.

- *Family Size*. Family size is defined as the number of exemptions reported on the tax return that the IRS used to obtain the IFSV information.
- *Filing Status*. The filing status is what was reported on the tax return that the IRS used to obtain the IFSV information.
- *Household Income*. Household income includes the applicant's income and the total income of the other individuals in the house that are included in the family size and are required to file a tax return. The IRS will provide the Exchange with the total of the AGI, nontaxable interest, and foreign income exclusion. When present, it will also provide the amount of taxable Social Security benefits. The Exchange will obtain the amount of total Social Security benefits from the Social Security Administration to determine the amount of nontaxable Social Security benefits to be included in modified AGI. The modified AGI is defined in the ACA as AGI plus nontaxable interest, nontaxable Social Security benefits, and the amount of foreign income exclusion.
- *Tax Year of the Tax Information Being Provided*. For requests received during the current enrollment season,[10] the IRS returned Tax Year 2012 or Tax Year 2011 tax information. The IRS would only provide Tax Year 2011 information if a tax return had not been filed for Tax Year 2012.

The IRS developed five external response codes to respond to Exchange requests. External response codes provide a generic description as to why the IRS is not returning tax information for the applicant. The IRS can return multiple external response codes in response to an IFSV information request. Figure 3 lists the external IFSV information response codes.

Figure 3: External IFSV Information Response Codes

External Response Code	Description
001	Systemic error.
002	Unable to provide data due to authentication issue.
003	Unable to provide income due to spouse mismatch.
004	Return information is unavailable.
008	No dependent filing requirement.

Source: The IRS's IFSV Internal and External Response Code document.

The IRS sends its response to the IFSV information request to the Exchange via the Data Hub. The Exchange uses the information provided to assist in predicting an applicant's income and family size for the requested health coverage period for which insurance is being obtained. It

[10] The current enrollment season to apply for insurance through an Exchange ran October 1, 2013, through March 31, 2014.

should be noted that the Exchange is not required to use the information the IRS provides as the Exchange has the sole discretion in this process.

The IRS also developed 19 internal response codes which contain more specific information regarding the reason information is not being returned to the Exchanges. Internal response codes are for IRS use only and are not provided to the Exchanges. Figure 4 lists the internal IFSV information response codes.

Figure 4: Internal IFSV Information Response Codes

Internal Response Code	Description
001	**********2********** [11] *******.
004	**********2**********.
005	**********2**********.
006	**********2**********.
007	**********2**********.
008	**********2**********.
009	**********2**********.
012	**********2**********.
013	**********2**********.
014	**********2**********.
015	**********2**********.
017	**********2**********.
018	**********2**********.
020	**********2**********.
021	**********2**********.
022	**********2**********.
023	**********2**********.
024	**********2**********.
025	**********2**********.

Source: The IRS's IFSV Internal and External Response Code document.

[11] **********2**********.

APTC Calculation

Once the Exchange has determined that an individual's predicted income and family size makes them eligible to receive the APTC, the Exchange will send a request to the IRS to compute the maximum amount of the APTC the individual could receive each month. The IRS has developed a "PTC Calculator" to respond to these requests. As of March 31, 2014, the IRS had received more than 11 million APTC requests.[12] The Exchange provides the IRS the following information for use in computing the maximum monthly APTC:

- *Coverage Year*. The year the health insurance will cover the applicant.
- *Household Income*. Household income is determined by the Exchange based on the individual's projected income for the year for which health insurance coverage will be obtained.
- *Income As a Percentage of the Federal Poverty Level (FPL)*. The FPL is a measure of income level issued annually by the Department of Health and Human Services. The FPL is used to determine eligibility for certain programs and benefits. Individuals' income must be between at least 100 percent but not more than 400 percent of the FPL to be eligible for the PTC.
- *The Adjusted Premium of the Applicable Second Lowest Cost Silver Plan (SLCSP)*. The SLCSP refers to the level of coverage provided by the health plan. Health plans offered by the Exchange will be categorized as Platinum, Gold, Silver, Bronze, or Catastrophic, depending on the share of costs covered. For example, a Bronze plan will have a higher deductible than a Silver plan, and the Platinum plan will have a lower deductible than the Silver plan. A Silver plan will provide benefits that are actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the plan. This means the plan will cover about 70 percent of the costs for covered medical services.

The IRS uses the information provided by the Exchange to estimate how much the applicant can afford to pay for health insurance (referred to as Household Contribution) each month. The IRS then compares the applicant's estimated monthly Household Contribution to the monthly premium for the SLCSP.[13] If the monthly SLCSP premium is greater than the estimated monthly Household Contribution, the applicant is eligible for the APTC. The maximum amount of the monthly APTC is the difference between the monthly Household Contribution and the monthly

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[12] The total number of APTC requests is lower than the number of IFSV information requests because an APTC request will not be made when the IFSV information shows the income is too high to qualify for the APTC.
[13] The IRS uses the premium associated with the SLCSP because the ACA requires the use of this amount. For example, there could be more than one plan in the Silver category and, as required, the IRS is using the premium of the Silver Plan that has the second lowest cost associated with it.

SLCSP premium. If the monthly SLCSP premium is less than the monthly Household Contribution, the applicant is not eligible for the APTC.[14] For example (hypothetical example):

> *Individual A has household income of $50,000, which is 325 percent of the FPL. The SLCSP cost is $375 per month. The IRS calculates Individual A's monthly Household Contribution as being $396. Because individual A's Household Contribution is greater than the cost of the SLCSP, Individual A is not entitled to receive any APTC.*
>
> *Individual B has household income of $30,000, which is 162 percent of the FPL. The SLCSP cost is $1,000 per month. The IRS calculates Individual B's monthly Household Contribution as being $114. Because Individual B's Household Contribution is less than the cost of the SLCSP, Individual B is entitled to receive a monthly APTC in the amount of $886 ($1,000 – $114).*

An individual can elect to receive the maximum monthly APTC, a portion of the maximum monthly APTC, or no APTC. Once an individual selects his or her insurance coverage and how he or she would like to receive the monthly APTC, the Exchange sends a request to the U.S. Department of the Treasury's Bureau of the Fiscal Service to issue monthly APTC payments to the individual's insurance provider. As of March 31, 2014, the Department of Health and Human Services reported that more than $1.45 billion in APTCs has been paid to insurers.

Reconciliation of APTC amounts received

During the 2015 Filing Season[15] (filing of Tax Year 2014 tax returns), individuals will reconcile the APTC on their Tax Year 2014 return. The individual will complete a Form 8962, *Premium Tax Credit Schedule*, to reconcile the amounts of the APTC paid to an individual's insurance provider and the amount of the PTC allowed based on actual income reported. If the amount of the APTC received during the tax year exceeds the actual PTC allowed, the amount paid in excess will be additional tax due on the tax return. This can occur if the individual's income reported on his or her Tax Year 2014 tax return is higher than what was estimated by the Exchange when determining the amount of the monthly APTC. The amount of additional tax an individual will have to repay is capped if the individual's income remains within 100 percent to 400 percent of the FPL. However, if the individual's income is more than 400 percent of the FPL, the individual will have to pay back the entire amount of the APTC received.

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[14] In this instance, the IRS would return a figure for the Remainder Benchmark Household Contribution to the Exchange. The Remainder Benchmark Household Contribution is used by the Exchange to determine the remaining amount a family can be expected to contribute toward a second or subsequent policy.

[15] The period from January through mid-April when most individual income tax returns are filed.

CDR

The CDR is the IRS's main data repository for ACA initiatives. The CDR houses taxpayer data from the Individual Master File,[16] the Individual Return Transaction File,[17] and the Data Master One[18] file. The CDR will store a maximum of two years of a taxpayer's data at any time. The CDR will contain current year and previous tax year information for all taxpayers. For example, for the 2014 enrollment period,[19] the CDR contains tax information for Tax Years 2011 and 2012 for all taxpayers. The IRS loaded the first extracts of taxpayer data obtained from the source databases into the CDR on September 7, 2013. The IRS updated the CDR information on November 2, 2013; November 29, 2013; and January 26, 2014, and plans to execute subsequent monthly updates.

The IRS uses the data contained in the CDR to respond to IFSV information requests from the Exchanges. The IRS relies on the most recent tax return information maintained in the CDR for the applicant and the applicant's listed family members to respond to the Exchange requests. In the future, the CDR will also house information received from the Exchange related to who obtained insurance coverage, the period for which they had coverage, and the amount of any APTC received.

This review was performed at the New Carrollton Federal Building in New Carrollton, Maryland, and was performed with information obtained from the Affordable Care Act Office Filing and Premium Tax Credit Strategy function and the Affordable Care Act Program Management Office in Washington, D.C., including the Income Verification and Information Services function in Farmers Branch, Texas, during the period of July 2013 through April 2014. We conducted this performance audit 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 objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective. Detailed information on our audit objective, scope, and methodology is presented in Appendix I. Major contributors to the report are listed in Appendix II.

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[16] The Individual Master File is the IRS database that maintains transactions or records of individual tax accounts.
[17] The Individual Return Transaction File contains data transcribed from initial input of the original individual tax returns during return processing.
[18] The Data Master One is a database of name controls and Taxpayer Identification Numbers received from four sources: the Social Security Administration, IRS valid processing, the Individual Taxpayer Identification Number file, and the Adoptive Taxpayer Identification Number file.
[19] The 2014 Exchange enrollment period was from October 1, 2013, through March 31, 2014.

Results of Review

Responses to Exchange Requests for Income and Family Size Verification Information Are Mostly Accurate

Our review of the IRS's response to 101,018 IFSV information requests received by the IRS between October 1, 2013, and October 4, 2013, showed that the IRS provided accurate responses for 100,985 (99.97 percent) of the 101,018 requests based on the information furnished by the Exchange. We identified 33 requests for which the information contained in the CDR did not reflect the most current name control for an individual for whom the Exchange was requesting information from the IRS. A name control is the first four letters in an individual's last name, *e.g.*, the name control for Smith would be SMIT. As a result, the IRS incorrectly notified the Exchange that it could not provide tax information for these individuals because the IRS was unable to match the name on the application to name control information maintained in the CDR. Our analysis of taxpayer account information for the individuals in these 33 requests showed that there was not a mismatch between the name provided by the Exchange and the name information contained in the individual's tax account.

We raised this concern to the IRS on March 26, 2014. The IRS stated that it had recently identified an error with the computer programming used to capture the name control field from the Data Master One file.[20] This error occurred for individuals with more than five name controls associated with their tax account on the Data Master One file. The programming to capture the individual's current and past name controls from the Data Master One file pulled the individual's first five name controls from the file rather than the most recent five name controls. The IRS estimates that the name control information for approximately 2.8 million taxpayers (1 percent) of the more than 283 million taxpayers could be incorrect in the CDR.

While the IRS estimates this error affects approximately 2.8 million taxpayers for which information is contained in the CDR, the number of IFSV information requests received by the IRS that are affected by the inaccurate CDR information is likely significantly less. Not all individuals with tax information in the CDR are eligible to use the Exchange, and not all individuals who are eligible will use the Exchange to purchase insurance. The IRS indicated it has requested changes be made to the computer programming to correct the name control error for the next Exchange enrollment period in November 2014.

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[20] The data from the Data Master One file is loaded onto the Integrated Production Module. The Integrated Production Module provides the business operating divisions access to current and historical taxpayer data via one central data source to eliminate the need for multiple, often redundant, data sources. The data from the Integrated Production Module are loaded into the CDR.

External and internal IFSV information response codes accurately reflect information in the CDR

Our review verified that all five of the external response codes and 16 of the 19 internal response codes the IRS uses to respond to IFSV information requests accurately reflect information contained in the CDR. We were unable to verify the accuracy of three (codes 007, 013, and 015) of the 19 internal response codes because these codes were not applicable to the 101,018 IFSV information requests we reviewed.

Although the computer programming used to generate the internal and external response codes is accurate, we determined that inaccurate information in the CDR resulted in an incorrect response to 33 of the 2,613 IFSV information requests we reviewed for which the IRS generated an internal response code 018. Internal response code 018 indicates the *******2********* **********2********** ****2*****

Most Data received from the CDR matched data contained in source files

Our assessment of the tax account information contained in the CDR between October 1 and October 4, 2013, showed that most of the information from the CDR agreed with the information contained in source files including the Individual Return Transaction File, the Individual Master File, and the Data Master One file. As previously discussed, the CDR does not accurately reflect the prior names used by an individual when an individual has more than five prior names shown in the Data Master One file. The IRS is taking steps to correct the name information for these individuals for the next Exchange enrollment period beginning November 2014.

Recommendation

Recommendation 1: The Chief Technology Officer should ensure that the CDR accurately reflects an individual's most recent name controls contained in the Data Master One file.

> ***Management's Response:*** IRS management agreed with our recommendation. The IRS has already implemented programming modifications so that name control fields are now consistent with the Individual Master File.

Responses to Exchange Requests for Maximum Monthly Advance Premium Tax Credit Calculations Are Accurate

Our review of the IRS's response to 120,824 APTC requests received between October 1 and October 14, 2013, found that the IRS's calculation of the maximum monthly APTC using the information provided by the Exchanges was accurate for all 120,824 requests. As part of our analysis of the accuracy of the IRS's computation of the maximum monthly APTC, we reviewed the ACA and Treasury regulations in place at the time of our review. Treasury regulations

provide the official interpretation of the Internal Revenue Code by the Department of the Treasury.

Our review identified four responses with a discrepancy between the IRS's calculation of the maximum monthly APTC and the Treasury regulations in place at the time of our review. Specifically, the tables provided in the regulations indicate that the PTC, and as such the APTC, should be calculated for those applicants with incomes "less than 400%" of the FPL. For these four IRS responses, the applicant's income was exactly 400 percent of the FPL. We requested information regarding the legal guidance received by the IRS related to providing APTC calculations for applicants with income at 400 percent of the FPL on January 23, 2014. The IRS provided documentation that shows proposed changes to the Treasury regulations will clarify that the PTC as well as the APTC is available to individuals whose income is exactly 400 percent of the FPL.

Appendix I

Detailed Objective, Scope, and Methodology

Our overall objective was to assess the accuracy of responses to Exchange requests for Income and Family Size Verification information for the purposes of determining insurance eligibility and the maximum Advance Premium Tax Credit the individual could receive each month. Our review was limited to verifying the accuracy of the IRS's calculations during the eligibility and enrollment process. To accomplish our objective, we:

I. Determined if the IRS was accurately calculating the IFSV information during the eligibility and enrollment process.

   A. Obtained and reviewed the IFSV Project documentation and business requirements and reviewed the ACA legislation.

   B. Determined whether the IRS was accurately calculating the household income and family size information it provided to the Exchanges.

      1. Obtained an extract of 101,018 IFSV information requests received by the IRS between October 1 and October 4, 2013, and the IRS's response to the 101,018 requests. Beginning on October 1, 2013, the IRS captured IFSV information request and response data received during an off-peak window, *e.g.*, 2:00 a.m. to 4:00 a.m., until it had selected at least 100,000 IFSV information requests.[1] We validated the reliability of the data extracts by ensuring that the tax return data fields were supported by data contained in the IRS's Integrated Data Retrieval System[2] and by comparing information in the tables created by our Strategic Data Services to the source data provided by the IRS.[3]

      2. Using information contained in the IRS Individual Return Transaction File, the Individual Master File, and the Data Master One file, independently calculated the applicant's household income and family size for each request. We then compared our calculation to the IFSV information contained in the IRS's response.

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[1] The IRS opted to pull our requested data during the off-peak window rather than capturing the first 100,000 requests received because we asked that our request be performed in a way that would prevent negative effects to system performance.

[2] IRS computer system capable of retrieving or updating stored information. It works in conjunction with a taxpayer's account records.

[3] The IRS provided text files in Extensible Markup Language for the IFSV information and PTC transactions.

3. Using information contained in the IRS Individual Master File, the Individual Return Transaction File, and the Data Master One file, verified the accuracy of information contained in the CDR. We verified the accuracy of the information reflected in the internal CDR transactions associated with the 101,018 IFSV information requests we reviewed.

II. Determined if the IRS accurately calculated the APTC during the eligibility and enrollment process.[4]

A. Obtained and reviewed the IRS project documentation and business requirements relevant to the APTC and determined how the IRS calculates the APTC.

B. Reviewed the ACA legislation, the Internal Revenue Code, and Treasury regulations to determine how the APTC is to be computed.

C. Determined if the IRS accurately calculated the APTC in response to requests from the Exchanges.

1. Obtained an extract of 120,824 requests for an APTC calculation received by the IRS between October 1 and October 14, 2013, along with the IRS's response to each request. Beginning on October 1, 2013, the IRS captured APTC request data received during an off-peak window, *e.g.*, 2:00 a.m. to 4:00 a.m., until it had selected at least 100,000 APTC requests.[5] We validated the reliability of the data extracts by comparing information in the tables created by the Treasury Inspector General for Tax Administration's Strategic Data Services to the source data files provided by the IRS.

2. Using the information contained in the APTC request, independently computed the APTC for each request. We then compared our computation of the APTC to the APTC contained in IRS's response to the Exchange request.

Internal controls methodology

Internal controls relate to management's plans, methods, and procedures used to meet their mission, goals, and objectives. Internal controls include the processes and procedures for planning, organizing, directing, and controlling program operations. They include the systems for measuring, reporting, and monitoring program performance. We determined that the following internal controls were relevant to our audit objective: the IRS's policies and

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[4] If the amount the taxpayer could contribute was more than the cost of his or her insurance, the IRS will return a figure for the Remainder Benchmark Household Contribution to the Exchange. The Remainder Benchmark Household Contribution is used by the Exchange to determine the remaining amount a family can be expected to contribute toward a second or subsequent policy.

[5] The IRS opted to pull our requested data during the off-peak window rather than capturing the first 100,000 requests received because we asked that our request be performed in a way that would prevent negative effects to system performance.

procedures to document the programming of the IFSV information and PTC calculations and the processes the IRS developed to monitor the performance of the IFSV information and PTC processes. We evaluated these controls by interviewing management, obtaining data extracts of the IFSV information and APTC responses, and reviewing the related IFSV information and APTC calculations obtained in the responses.

Appendix II

Major Contributors to This Report

Russell P. Martin, Acting Assistant Inspector General for Audit (Returns Processing and Account Services)
Deann L. Baiza, Director
Sharla J. Robinson, Audit Manager
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Appendix III

Report Distribution List

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Office of Internal Control OS:CFO:CPIC:IC
Audit Liaison: Director, Affordable Care Act Office SE:ACA:ONE

Appendix IV

Management's Response to the Draft Report

DEPARTMENT OF THE TREASURY
INTERNAL REVENUE SERVICE
WASHINGTON, D.C. 20224

CHIEF TECHNOLOGY OFFICER

JUN 18 2014

MEMORANDUM FOR MICHAEL E. McKENNEY
ACTING DEPUTY INSPECTOR GENERAL FOR AUDIT

FROM: Terence V. Milholland
Chief Technology Officer

SUBJECT: Affordable Care Act: Review of the Accuracy of Responses to Marketplace Requests for Income and Family Size Verification Information and Maximum Advance Premium Tax Credit – Audit# 201340335 (e-trak #2014-55423)

Thank you for the opportunity to review your draft audit report and to discuss earlier draft report observations with the audit team. We take our responsibility to provide accurate Advance Premium Tax Credit (APTC) and Income and Family Size Verification (IFSV) responses to the marketplaces very seriously. I was pleased your report substantiated our efforts by showing 100 percent accuracy rate for our calculation of the monthly maximum APTC and an over 99 percent accuracy rate of IFSV responses to the marketplaces.

The Affordable Care Act (ACA) Program Management Office has put in place sound management practices that have been recognized by the Treasury Inspector General for Tax Administration (TIGTA) in earlier reviews. I am committed to continuously improving IRS information technology systems and processes, and the ACA IT Program Management Office has already taken steps to correct the few discrepancies identified in your report. I am also pleased to say that with the perseverance and commitment of our team, the corrective action specified within this audit has been corrected and completed.

We value your continued support and the assistance and guidance your team provides. Our corrective action plan for the recommendation is attached. If you have any questions, please contact me at (240) 613-9373, or a member of your staff may contact Lisa Starr, Program Oversight Coordination Manager, at (240) 613-4219.

Attachment

Affordable Care Act: Accuracy of Responses to Exchange Requests for Income and Family Size Verification Information and Maximum Advance Premium Tax Credit Calculation

Attachment

Draft Audit Report - Affordable Care Act: Review of the Accuracy of Responses to Marketplace Requests for Income and Family Size Verification Information and Maximum Advance Premium Tax Credit (Audit # 201340335) (e-trak# **2014-55423**)

RECOMMENDATION #1: The Chief Technology Officer should ensure the CDR accurately reflects an individual's most recent name controls contained in the Data Master One file.

CORRECTIVE ACTION #1: The IRS agrees and has already implemented programming modifications so that name controls fields changes are now consistent with the Individual Master File (IMF).

IMPLEMENTATION DATE: Completed (June 1, 2014)

RESPONSIBLE OFFICIAL: The Associate Chief Information Officer, Affordable Care Act PMO

CORRECTIVE ACTION MONITORING PLAN: Not Applicable

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Mr. MCDERMOTT. Both you gentlemen are listening to these questions, and I am trying—I am a physician, so I am thinking I have got a patient sitting in my office, and his name is John Smith and he has a wife named Mary, and their income is $70,000 between them. So that is their income last year. Do I understand that is the income that they bring forward, they say this is what I made last year, right?

Mr. KOSKINEN. That is correct. They provide that information to the marketplace.

Mr. MCDERMOTT. Now, if during the year John and Mary both have done good work and they get a pay increase, let's say they get $5,000 increase this year because the economy is recovering, so now they are making, not $70,000 together but $80,000, how does that affect their income verification from last year?

Mr. KOSKINEN. It won't change their verification. Their verification was made at the time they applied for the policy and if they applied and were eligible for the tax credit. So again, what I said in response to the chairman's question, one of our concerns has been since the spring trying to remind people, if you were in that fortunate situation and you now expect to earn more money than you originally expected with your income verification, you should report back to the marketplace and adjust any advance payment you are getting, because to the extent you qualified and the payment is going to the insurance company, if your income goes up, the amount of that payment will go down.

And if you can adjust it during the course of the year, it means you will be closer to the right number when you file a return. If you don't make the adjustment during the year, your premium tax credit will be higher than it should've been and you will have to actually make that adjustment on your tax return.

Mr. MCDERMOTT. So the individual, when they get a pay increase, has to go to their employer and say—or who do they go to and say, I want to adjust because I am now making $35,000 instead of $30,000 or whatever?

Mr. KOSKINEN. They go back to the marketplace where they purchased the policy.

Mr. MCDERMOTT. Back to the exchange?

Mr. KOSKINEN. Back to the exchange.

Mr. MCDERMOTT. Not to the insurance company but to the exchange?

Mr. KOSKINEN. To the exchange. The exchange is what determines how much of a premium payment, advance payment goes to the insurance company.

Mr. MCDERMOTT. And they have to do that if——

Mr. KOSKINEN. Mr. Slavitt, will correct me if I'm wrong.

Mr. SLAVITT. You got it right, Commissioner.

Mr. MCDERMOTT. If they get it anytime during the year, they have to make a correction that month to be able to take care of it at the end of the year or—I thought that was a fixed figure, that their income for this year is $70,000, and if they get an extra $10,000 that is next year's income.

Mr. KOSKINEN. No. What happens is the estimate was made last fall. We provided income verification for the tax year 2012.

Mr. MCDERMOTT. Which is $70,000 for this couple.

Mr. KOSKINEN. Assume that was $70,0000. Now we are in 2014 and they are going to make $80,000. The premium advance payment was made on the basis of the $70,000, but your tax return for this coming filing season will be based on what you actually earned in 2014 and what you actually earned in 2014 will be reconciled as to what your premium tax credit should be and what the advance payment should have been. So if your income goes up this

year, which is a terrific situation, your eligibility for the premium tax credit will decline to some extent.

Mr. MCDERMOTT. So anybody whose pay goes up this year and is getting subsidies will have a deduction or have a reduction in the subsidy at the end of the year?

Mr. KOSKINEN. Correct. When they make their reconciliation, they estimated they were going to make $70,000, turned out they made $80,000, on their calculation on the forms we provided they will calculate what their premium for 2014 premium tax credit should be, and if the advance payment turned out to be larger because their income had gone up, they will make an adjustment on their return.

Mr. MCDERMOTT. So how many people is this going to affect? How many people's income go up during the year?

Mr. KOSKINEN. I am not sure anybody knows. We expect of the 8 million people covered, we are probably going to have 3 million or 3.5 million returns because you have families in that 8 million. And of those 3 million, 3.5 million, any number of them are likely to have had a change in family circumstances, a change in income. The income may have gone up, it may have gone down. I don't think there is any way that I know off the top of my head to tell you what percentage will be affected.

Mr. MCDERMOTT. Suppose you have some problems—I guess my time is just about up—but if they have had some problems at the job and their income has now been reduced by $5,000 apiece, so they now are only making $60,000.

Mr. KOSKINEN. Again, if they go back to the marketplace during the year, their advance payment will be adjusted in light of the new estimate of what they are actually going to make during the year. If they don't go back to the marketplace, when they file next spring, they will do a calculation and it will show that their premium tax credit amount they are eligible for is actually larger than the sum of the advanced payments that went to the insurance company and they will have an increase in their refund.

So there is no penalty for not going back to the marketplace, but if you go back to the marketplace, it will be able to make an adjustment that gets you closer to what your actual tax return is going to look like next spring.

Mr. MCDERMOTT. Thank you.

Chairman BRADY. Thank you, Dr. McDermott.

Mr. Johnson is recognized.

Mr. JOHNSON. Thank you, Mr. Chairman.

Good morning, sir. You know, you all promised Americans under the Affordable Care Act that they could keep their health plan and their doctor at a lower cost. But as my constituents are seeing, those promises are just empty promises. They are outright lies. The reality is that millions of Americans have lost their health care and are being forced by this Act to get plans with higher out-of-pocket costs and fewer doctors.

And as you know, we are less than 4 months from the tax filing system, and unfortunately, Americans will face yet another hardship under Obamacare, because you can't file a simple tax form anymore. You've got to report your health care on it and you can't do that on a simple form. Is that true? In other words, will folks

who are forced to pay more for health care and lose their doctor now be forced to file a more complicated tax return?

Mr. KOSKINEN. Those who actually have gotten a premium tax credit will have a calculation they have to make for it. As I say, the vast majority of Americans are going to have, you know, we estimate 120 million, 125 million Americans are going to be affected by the Act by simply checking a box on their return. But anyone who actually has purchased a policy and is either claiming the premium tax credit or reconciling the advance payment they have already gotten, will have a more complicated process as they will have to make that calculation on their return.

Mr. JOHNSON. So they can't file a simple form?

Mr. KOSKINEN. So they will not be able to file the simple form.

Mr. JOHNSON. So that is a hardship on America, isn't it?

Mr. KOSKINEN. It's part of the obligation, if you have got premium tax credit advance payment, then you have to reconcile it at the end of the year.

Mr. JOHNSON. Okay. Mr. Slavitt, under President Obama our national debt has reached a record high of almost $18 trillion. So one of the most important things we can do here in Washington is get the fiscal House in order. In April, the CBO and the Joint Tax Commission estimated that the Federal Government will pay $17 billion in 2014 for health insurance subsidies and over $1 trillion from 2015 through 2024. The GAO testified in a July hearing that they had obtained numerous policies through the Federal exchange using false identities, including made up or nonexistent Social Security numbers.

Then the HHS Office of the Inspector General released a study of internal controls at select insurance exchanges, that report found that those exchanges were unable to validate the Social Security numbers and other eligibility requirements. Considering that nearly 87 percent of those who enroll in a plan through the Federal exchange receive a subsidy, that is a major concern.

Can you respond to these findings and tell us exactly what you are doing about it, and are you personally following that issue?

Mr. SLAVITT. Yes, Congressman Johnson. So there is a fairly extensive process when someone fills out an application to apply to the covered under insurance marketplace. For a typical family of four, they provide 21 pieces of information that we independently verify through our computer systems that link up to various government entities. If even one of those pieces of information, of those 21 pieces of information we cannot verify, for whatever reason, then it is our obligation to seek physical documentation from the individual to make sure that, in fact, what they are reporting, when this pertains to their income level, whether it pertains to their citizenship status or whatever the information happens to be, that we get verification.

We have been contacting people extensively, in many cases with 10 or more outreaches, to ask them to submit the documentation so that we can be sure that all the information is coming in as accurate. It is, as you can imagine, a fairly extensive process. It is our first year doing it. It's the first year consumers have had to do it, and we are being, I think, fairly open about the fact that there

are numbers of people who have inconsistent information that we have to match, and we are making that level of progress.

Mr. JOHNSON. Thank you.

Thank you, both, for being here.

Thank you, Mr. Chairman.

Chairman BRADY. Thank you.

Mr. Thompson, you are recognized.

Mr. THOMPSON. Thank you, Mr. Chairman.

Thank you, both, for being here.

Mr. Koskinen, I want to follow up on Mr. Johnson's question about the extra hoop that you have to jump through if you receive a subsidy. There isn't an easier way to do this? You have to elevate them to a completely different process for filing?

Mr. KOSKINEN. It is a calculation. In other words, they have applied, as I discussed earlier, they have applied based on an estimate of what their income will be for 2014, those who have gotten——

Mr. THOMPSON. So can this be an extra box to check or something on the short form?

Mr. KOSKINEN. No, because you actually, if you got the premium, advance payment has gone to your insurance company, you have gotten that benefit. And what we need to do at the end of the year is reconcile—you need to do as a taxpayer is reconcile how much of an advance payment have you gotten compared to what you are actually entitled to. And what determines what you are entitled to is how much you actually made this year as opposed to what you estimated when you enrolled.

Mr. THOMPSON. Let me ask a different way. Is this going to be an significant enough change to trigger some sort of elaborate filing, or is it something people can still do on their own?

Mr. KOSKINEN. This should be something that people can do. The form, is the usual form. It is simply a calculation of what you earned, what you are eligible for, what you actually received. You will have the 1095–A that will give you the information you need to fill out that form. The vast majority of Americans——

Mr. THOMPSON. Dr. McDermott had asked about individuals who either get a raise during the year or get a reduction in salary during the year and you explained—and it sounded to me like a pretty complicated process that these folks are going to have to go through. But are you doing something to educate people, to let them know that if they do have a change of income that they are going to have to proactively do something on their forms?

Mr. KOSKINEN. Yes. As I noted, we have been talking about this in our public releases since the spring. Our Affordable Care Act site on the Web site has this information highlighted. We have been trying to continually remind people to make that adjustment, although it is not a requirement. If they don't make the adjustment, they make more money. When they make the calculation it will be a simple calculation. This is what I was entitled to and this is what I got.

Mr. THOMPSON. I suspect that most folks after they sign up for health care aren't going back to review the Web site. They figure that they have done that and they are getting on with the other things in their life. So I don't know that merely putting something

on the Web site is going to be enough. And it seems to me there ought to be some way to better educate folks what they may have to face in this process.

Mr. KOSKINEN. Well, I am not a user of Twitter or Tumblr, so I can't tell you the reach of it, but we have YouTube videos, we have information that is going out on all the social networks and Web sites. As I say, we have talked to tax preparers across the country all year long about this.

Again, to the extent they go back to the marketplace and make the adjustment, it means they will be closer in their calculation. But one way or the other, whatever they do——

Mr. THOMPSON. Somebody ought to be thinking through this. I am not saying you are not. But somebody ought to be thinking through this, because when this hits, I don't think it is going to be enough to say I am not a user of Twitter or whatever. I think we need to figure out how to better educate folks going into this.

Mr. KOSKINEN. Right. We are continuing to do it. We are doing the best we can. We are open to other suggestions, as I say. We have got what I call a full court press trying to get full information out to people, not only about the adjustments, but about how the calculation is made when they file their returns.

Mr. THOMPSON. Mr. Slavitt, you have got pretty extensive private sector experience working in the technology industry, including working on components of HealthCare.Gov. And you now, in your current position, you are leading efforts related to marketplaces and other technology innovations. And given the issues that HealthCare.Gov experienced last year, which I add that you helped to fix, I am glad that you are there given your experience. It seems to me you probably know the right questions to ask.

Looking forward to November 15, the next enrollment period, what are the markers or the benchmarks you are looking for to prove the system is ready for open enrollment?

Mr. KOSKINEN. So Congressman, we are in a more favorable situation when we have a functioning Web site that is already up and running. Having said that, we have new functionality that needs to be added for open enrollment next year. So let me give you a little bit of a feel for how we are approaching that. First is, we are rolling out new functionality and adding it over the summer as opposed to all at once, and so that helps us ensure that we can put things into the marketplace and test them.

Second thing, and I know we are over time, is that we have built a much longer period of time in for testing, because when software is built, people need to use it and pound on it before it can be rolled out. We are more fortunate this year in that we have more time. Having said all of this, I am a realist and we will not get it perfect, but we have, I think, the right processes in place to make it as good as it should be.

Mr. THOMPSON. Thank you.

Chairman BRADY. Thank you.

Mr. Roskam, you are recognized.

Mr. ROSKAM. Thank you, Mr. Chairman.

Commissioner, the Congressional Budget Office estimates that there is going to be $1 trillion in Obamacare subsidies over the next 10 years, and that is just a huge pool of money, as you know.

You said that those who simply check a box are going to be free from a level of scrutiny, which suggests that there is going to be a significant number of people who are going to be subject to scrutiny in terms of income verification and so forth. And it seems to me like the IRS is just poised to go swimming in a huge pool of money.

So the question is, what are the things that are happening proactively to prevent the next Lois Lerner, Lois Lerner 2.0, from looking out of a landscape with a high level of discretion, to be able to say, you know what, we are going to make inquiries here and we are going to make inquiries there and we are not going to make inquiries over here. And you see where I am going.

Mr. KOSKINEN. Right.

Mr. ROSKAM. And there is a high level of suspicion.

And also, I mean, you said you are meeting with IT people every 2 weeks, and I accept at face value that you need to meet with IT people every 2 weeks, but are these the same IT people that can't find Lois Lerner's emails and can't deal with hard drives? And so what level of confidence does the American public have as they are looking out and they are saying to themselves, holy Moses. I mean, when this institution, the Internal Revenue Service, reaches its long arm into our lives and grabs somebody by the neck and shakes them up, it gets people's attention and it can be incredibly damaging.

Now, you know, the administration last year said we are basically going to do an honor system because it is too overwhelming. So what is the level of confidence that there is not an environment where Lois Lerner 2.0 is able to emerge?

Mr. KOSKINEN. You have asked a set of questions, and let me try to deal with all of them. First of all, and we are trying to remind everybody of this, the inspector general who filed a report about the use of improper criteria said, to fix the problem there were a series of nine recommendations that the IRS should adopt. We have adopted and implemented all of those recommendations. In our normal exam process, there is no way that any individual can single out any taxpayer for review.

Mr. ROSKAM. Why not?

Mr. KOSKINEN. Because there is a review process.

First of all, the first cut of the selection is made automatically by computer. To the extent, then, exams are decided, there are three people who meet and have to approve that; so that the system is designed and has been for some time so that no one can pick out an individual taxpayer for review. We have buttressed that with all of the recommendations the IG said we should do.

Mr. ROSKAM. Wasn't that true, though, in the (c)4 situation, where, I mean, look these are (c)4 applicants that rise to a level of scrutiny. They were presumably chosen by a computer by definition because they were (c)4 applicants, and then Lois Lerner makes decisions about, well, we are going here and we are going there. So you have got now another computer that is going to be deciding there is a threshold that the program presumably pops people up, and presumably those are people by your own definition who haven't checked the box.

Mr. KOSKINEN. Right.

Mr. ROSKAM. So now they are in open country.

What prevents an IRS employee from saying, I am going after you?

Mr. KOSKINEN. First of all, and I am waiting for the rest of the investigators to be completed, there is no evidence thus far that anybody picked an individual organization to be picked out. There were improper criteria to select an entire set of organizations. No individual organization was targeted.

Mr. ROSKAM. You are not defending Lois Lerner?

Mr. KOSKINEN. I don't know her, and I am not defending her.

Mr. ROSKAM. I wouldn't give her eye contact, but go ahead.

Mr. KOSKINEN. What I am trying to defend is that whatever the recommendations were the inspector general thought were necessary to fix the problem have been adopted, have been implemented, and I am confident that if people haven't learned any other lesson in the last year and a half they have learned this lesson, that we need to provide guarantees to the American public that they can be confident that whether it is the Affordable Care Act or any other part of the implementation of the Tax Code, if they hear from us, they are hearing from us for something in their return and that they have not been selected arbitrarily. If someone else had that same issue, they would hear from us as well.

Mr. ROSKAM. Commissioner, my time is waning. Let me just impress upon you one point, that I know you are understanding what I am saying, but just unambiguously, this committee has a high level of scrutiny and a high level of expectation that the administration by the Internal Revenue Service of all elements of the Tax Code are unbiased and impartial, and it is a huge background to overcome because the American public is burned, and they are not going to put up with it.

And so with that, I yield back. Thank you, Mr. Chairman.

Mr. KOSKINEN. I would just say, we share that view with you; that is, that the American public deserves and needs to be confident that the IRS is a tax administration agency without a political agenda, without political connections. And we stand ready to work with this committee and every one of the members of this committee to do whatever we can to make sure that that happens.

Chairman BRADY. Thank you.

Mr. Kind, you are recognized.

Mr. KIND. Thank you, Mr. Chairman.

I want to thank our guests here for your testimony. And I would like to just echo Mr. Roskam's sentiment, Mr. Commissioner. We do expect impartiality and fairness from the IRS. I feel more confident with you in the seat right now with the overview and following the recommendations of the IG report that you have followed up, and I commend you for those efforts. But naturally, there is some credibility that has to be restored right now and we look, you know, forward to working with you in order to do that.

Now, let's just back up and keep today's testimony a little bit in context. Commissioner Koskinen, you, again, in your opening testimony indicated that the vast majority of Americans were merely needed to just "check a box," and they are going to satisfy what they need to do as far as showing if they have got health insurance in their lives. Is that correct?

Mr. KOSKINEN. Correct.

Mr. KIND. And can you break that down as far as percentagewise, the number of Americans that are filing who just merely have to check the box and not do anything further?

Mr. KOSKINEN. Because it is the first year of filing, it is hard to know with precision, but our best estimate is that out of 150 million returns we will process, 125 million will simply check a box.

Mr. KIND. And that won't require a separate IRS form to do? It is built into the normal——

Mr. KOSKINEN. The normal 1040 will have a box. I have looked at the line.

Mr. KIND. If you are a recipient of some tax credit in the exchanges and that, there is a separate form for them to have to fill out in order to match up income verification for that purpose, right?

Mr. KOSKINEN. That is correct.

Mr. KIND. That won't be on a 1040–EZ; that requires a separate form?

Mr. KOSKINEN. That requires a separate form that we have already provided, and we are trying to educate preparers and everyone else about how to fill it out.

Mr. KIND. Mr. Slavitt, now, some of us had a recent meeting with Secretary Burwell, and she was trying to put the numbers in context, too. There is really two kind of reconciliations that are going on right now: One is income verification, but one is also citizenship verification, too. And she indicated that on the citizenship side there was initially 970,000 discrepancies or so, but that number has been drastically reduced to about 220,000. Does that sound right to you?

Mr. SLAVITT. Right. So I think, in August we had sent out about 310,000 letters informing people who we have had contact with on a number of occasions that we needed to receive documentation from them in order to maintain their policy in the marketplace. Since that time, and I believe the estimate that Secretary Burwell gave you was, since that time, as deadlines have tended to do for us, we have seen an influx from individuals, and so I think that that number has been dropping below 310,000 pretty meaningfully.

Mr. KIND. And probably safe to assume that number is going to continue to go down as more people respond to the inquiries sent to them. Is that right?

Mr. SLAVITT. That is right.

Mr. KIND. Now, some of this might be a little confusing for some. Is there a role for the navigators to play in order to help these individuals to send the proper documentation in order to satisfy the requirements?

Mr. SLAVITT. Well, we found in the first year that in-person assistance of a variety of types, navigators certainly, but also agents and brokers and others have a tremendous role to play in helping people through, whether it is that issue or even some of the issues that Commissioner Koskinen has addressed.

Mr. KIND. Now, is that going to be true for income verification, or are there some privacy concerns that attach to that?

Mr. SLAVITT. Regarding navigators, or regarding——

Mr. KIND. Yeah, the role of navigators, someone assisting the individual to get proper documentation.

Mr. SLAVITT. Yeah, I think that level of assistance is available to most people and they should take advantage of that. They also can call our call center directly and we can walk people through that process.

Mr. KIND. You indicated that on average, the typical individual is getting about ten touches from you in order to match up the data that you have with what they are submitting?

Mr. SLAVITT. That has been true for citizenship and immigration status, and for other categories it has been five or six.

Mr. KIND. And what form of information are the individuals getting? Is it more detailed? It is not just a letter saying, hey, something doesn't match up, or is it this is what you are missing? Can you——

Mr. SLAVITT. So we have tried reaching out to them with letters. We have also had the health plans directly reach out to them with some success, as well. And then where we haven't had success we have used the telephone, we have called them, and we have attempted to walk people through them. We understand that for a lot of people, this is their first time through a process like this, and sending information to some place that they are not familiar with isn't always the most comfortable thing.

Mr. KIND. Commissioner Koskinen, back to you again, the income verification information you are looking for is really no different from what a typical taxpayer may have to do. If something doesn't match up with their income that they are submitting through the W–2 form or whatever, such as if they are missing a 1099 or something, they will get a notification from the IRS saying, hey, something doesn't match up here. Is that right?

Mr. KOSKINEN. That is correct. Although, initially, we expect that, as with all tax returns, people will make that calculation themselves. As I say, when we all do our withholding, we make an estimate as to what we are going to end up owing and it always is a different number at the end and it is the same way here.

Mr. KIND. And that has been going on for years and we haven't seen the demise of western civilization with that practice, have we?

Mr. KOSKINEN. Not yet.

Mr. KIND. Okay. Thank you. Thank you, Mr. Chairman.

Chairman BRADY. Some would argue differently, Mr. Kind.

Dr. Price, you are recognized.

Mr. PRICE. Thank you, Mr. Chairman. I want to thank the witnesses as well for the information. I have found much of this fascinating.

Our friends on the other side of the aisle seem to be waking up to the fact that it is a complex program that it is requiring things of Americans and patients across this country that haven't been required before and may be significantly problematic. In fact, the CEO of H&R Block, Mr. Koskinen, says that Obamacare would add significant complexity to the tax system, and I think that the questions from Mr. McDermott and Mr. Thompson actually outlined that. And Mr. Kind put the punctuation point on it, and that is that anybody who fills out their form today, tax form today, 1040–EZ, simple form, good thing for consumers, good thing for citizens,

but if they have any change in their work status, any change in their income, will not be able to fill out the 1040–EZ. Is that correct?

Mr. KOSKINEN. No. That is an overstatement of the situation. They will not be able to use the 1040–EZ if they have received an advance payment on a premium tax credit. A lot of people use the 1040–EZ who are going to be part of that 125——

Mr. PRICE. But those 25 million that you estimate, I suspect is going to be greater than that, because millions, tens of millions, if not over 100 million Americans see some change in their income——

Mr. KOSKINEN. Right.

Mr. PRICE [continuing]. Throughout the course of the year. The fact of the matter is that they are not going to be able to use the form that they used before, they will be required to use another form.

Mr. KOSKINEN. That will be——

Mr. PRICE. In fact, if they go to the site that you identify, that is not even done automatically, right? If——

Mr. KOSKINEN. Right.

Mr. PRICE. If they go to the marketplace, as you call it, go to the exchange now and they say, my income just went up, is that automatic?

Mr. KOSKINEN. No. First of all, I would like to make it very clear: Millions of people use the 1040–EZ and they are going to continue to use the 1040–EZ. The people who are going to actually have to make a separate calculation are only those who actually get advanced premiums on the premium tax credit or are applying for the premium tax credit.

Mr. PRICE. Millions of folks. Is it automatic when they go on the site and identify that they have in—either increased their income or decreased? Isn't that a manual process now?

Mr. KOSKINEN. I don't know what happens on the Web site, so Mr. Slavitt would have to tell you.

Mr. PRICE. Is that a manual process at this point?

Mr. SLAVITT. If someone has a change in status of any variety, income, of several varieties, they have children, a divorce, a loss in the family, we ask them to come back to the Web site and update their information.

Mr. PRICE. Is that a manual process now or is that an automatic process?

Mr. SLAVITT. It is automated. Once they update it, it is automated.

Mr. PRICE. I know you have only been with them for 2 months now, and I won't hold you to account on that, but please go back and check.

Mr. SLAVITT. Okay.

Mr. PRICE. Let me get some basic information, Mr. Slavitt. How many folks are enrolled through the exchange?

Mr. SLAVITT. As of the end of the last open enrollment period, there were—I think the number was some 8 million people that had enrolled in coverage.

Mr. PRICE. How many?

Mr. SLAVITT. Some 8 million had enrolled in coverage.

Mr. PRICE. 8 million. How many of those folks had insurance coverage before?

Mr. SLAVITT. I don't know.

Mr. PRICE. You don't know.

Mr. SLAVITT. I don't.

Mr. PRICE. HHS doesn't know how many folks had coverage before but now were forced into the exchange?

Mr. SLAVITT. We do know that we have seen the uninsurance rate drop significantly in the second quarter. I think that tells us that there are a lot of people through the exchanges or through Medicaid——

Mr. PRICE. Wouldn't it be helpful to know how many had insurance before to see whether or not the system's working?

Mr. SLAVITT. Sure. We also—that is fair. We also don't want to overburden people by asking them needless questions when they are applying for insurance.

Mr. PRICE. Well, we ought to poll the American people as to whether or not you are asking them needless questions.

How many folks had coverage through the workplace before the Affordable Care Act went into effect?

Mr. SLAVITT. I don't know the exact number. I believe some 96 percent of people who have coverage have it through their workplace. I haven't seen——

Mr. PRICE. 159 million sound somewhere in the range?

Mr. SLAVITT. Sounds—sounds right.

Mr. PRICE. How many folks have coverage through the workplace now?

Mr. SLAVITT. I haven't seen an updated study.

Mr. PRICE. Well, I would urge you to look. Again, I know you have only been there for 2 months and it is a lot of numbers, but that number has gone down.

Mr. SLAVITT. We will do, Congressman.

Mr. PRICE. So the place where folks have been getting their coverage that has worked for them for years and years and years has decreased the numbers of individuals.

You talk about costs going down. In fact, costs are actually going up, by HHS's own admission. Average of 7 percent increase in premiums in the next year. With the higher deductibles that folks are having, paying—the deductibles for many people now are between $4,000 and $12,000 a year. Let me suggest to you that an individual making $50,000 a year, a family making $50,000 a year who has a $6,000 to $8,000 deductible, that is not a person who can afford a $6,000 to $8,000 deductible. That is how you have shoved everybody into these programs.

The increase in bad debt in physician's offices across this country in the exchange is up 60 percent, 60 percent. Those folks are going to have to figure out what to do, and it is not going to be able to continue to provide coverage for people.

I want to touch on identity theft. You all had a hacker break into the system, correct, in July?

Mr. SLAVITT. That is correct.

Mr. PRICE. When did you know that?

Mr. SLAVITT. August 25th.

Mr. PRICE. When did you notify the Federal authorities?

Mr. SLAVITT. I believe it was within 10 days or so of that.

Mr. PRICE. When did you notify the insurers that were participating in the exchange and covering those lines?

Mr. SLAVITT. At the very same time. There was no impact to the insurers, but at the very same time.

Mr. PRICE. The fact of the matter is, as you should know, is that the insurers found out about this through the press, through the press. If we are going to protect people's personal information, especially as it relates to health care, and not notify those individuals and not notify the insurers who are trying to protect as hard as they can the information that they have, this is unconscionable. This is what the American people are concerned about.

Mr. SLAVITT. Congressman——

Mr. PRICE. I think that we have underscored once again the challenges with this law, and urge you to get the facts, look objectively. You spent a significant amount of time in United Health Care and Optum. You—talk to those folks. I have talked to them recently. The fact of the matter is what CMS is doing right now, what HHS is doing right now with the ACA isn't working in the real world. I would urge you to talk to your former colleagues. They will shed a whole lot of light on what is going on.

Mr. SLAVITT. Congressman, thank you. You want you to know I did personally call a representative of the Insurance Association to inform them.

[The prepared statement of Mr. Slavitt follows:]

STATEMENT OF

ANDREW SLAVITT

PRINCIPAL DEPUTY ADMINISTRATOR,
CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

PREPARING FOR THE SECOND YEAR OF OPEN ENROLLMENT

BEFORE THE

U. S. HOUSE COMMITTEE ON WAYS & MEANS
SUBCOMMITTEE ON HEALTH

SEPTEMBER 10, 2014

House Committee on Ways and Means
Subcommittee on Health
Preparing for the Second Year of Open Enrollment
September 10, 2014

Good morning, Chairman Brady, Ranking Member McDermott, and members of the Subcommittee. I'm Andy Slavitt, Principal Deputy Administrator of CMS. I joined CMS in mid-July 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. As we prepare for the second year of Health Insurance Marketplace Open Enrollment, CMS is building on our successes and lessons we have learned. I appreciate the opportunity to update you on our progress and our continuing work.

A new wave of evidence points to the clear conclusion that the Affordable Care Act is working to make health care coverage more affordable, accessible and of a higher quality, for families, seniors, businesses, and taxpayers alike.

Thanks to the Affordable Care Act, consumers today enjoy better access to affordable health coverage, stronger protections in the case of illness or changes in employment, and a competitive Marketplace that allows them to choose from and enroll in insurance coverage that is right for them. Millions of people have obtained private insurance coverage in the Marketplace, over seven million children, families, and individuals have gained coverage through Medicaid and CHIP, and more than three million young adults have gained or retained insurance under the Affordable Care Act by staying on their parents' plan. The Marketplace is enrolling people every day and is available when people need it – currently consumers are getting coverage through the

Marketplace when they qualify for a special enrollment period, available to those that lose employer coverage, get married or have a baby, or have other qualifying life events.

As we plan for the second Open Enrollment, including the first opportunity for many consumers to re-enroll in coverage, 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 right plans 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 we face as a new program of this scale matures, particularly one that faced significant challenges in its first year. It is thanks to the work of a very committed team heeding the lessons of the last year that we will continue to build on the success of the first year of State-based and Federally-facilitated Marketplaces.

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

Recent years have seen historically low growth in overall health spending, and a variety of recent data show that slow growth in health care costs has continued into 2014.[1,2] 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.

Thanks to the Affordable Care Act, we are also taking important steps to improve the quality of care for Medicare beneficiaries, while improving Medicare's long-term solvency. More than 8.2 million seniors have saved more than $11.5 billion on prescription drugs since 2010. Medicare

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[1] 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_chapter_4.pdf.

[2] 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.

Part B premiums are projected by the Medicare Trustees to be the same in 2015 as they were in 2013 and 2014. Additionally, the Medicare Trustees recently projected that the trust fund that finances Medicare's hospital insurance coverage will remain solvent until 2030, four years beyond what was projected in last year's report. [3] Due in part to reforms in the Affordable Care Act, per capita spending is projected to continue to grow slower than the overall economy for the next several years. In addition, the Congressional Budget Office (CBO) recently released updated projections[4] providing further evidence that Medicare is stronger today than it was prior to the Affordable Care Act, including that the rate of growth in spending is expected to be slower than the rate of growth in beneficiaries in 2014.

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 because 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. 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. New protections also ensure that consumers' premium dollars are spent primarily on medical care, rather than on administrative expenses. Since the Medical Loss Ratio program's inception in 2011, its protections have saved consumers an estimated $9 billion. This year, families will receive an average rebate of $80 through the program.[5]

The market reforms are effective because they have benefits across the health care system. Reductions in the uninsured rate generally means that doctors and hospitals provide less

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[3] http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/downloads/tr2014.pdf
[4] http://cbo.gov/sites/default/files/cbofiles/attachments/45653-OutlookUpdate_2014_Aug.pdf
[5] http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Final-MLR-Report_07-22-2014.pdf

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 has benefits for all Americans no matter where they get their health insurance.

Reductions in the Uninsured Rate

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 coverage.[6] 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.[7] 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 eight million adults.[8] 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-September 2013 to 15 percent in April-June 2014, or an estimated 9.5 million fewer uninsured adults.[9,10] These

[6] New England Journal of Medicine, Health Reform and Changes in Health Insurance Coverage in 2014.
[7] After Exchanges Close, 5% of Americans Are Newly Insured, http://www.gallup.com/poll/171863/exchanges-close-americans-newly-insured.aspx
[8] 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
[9] 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
[10] After Exchanges Close, 5% of Americans Are Newly Insured, http://www.gallup.com/poll/171863/exchanges-close-americans-newly-insured.aspx

independent surveys all point to the same overarching trend—the success of the Affordable Care Act in lowering the number of uninsured Americans.

Consumers are finding affordable coverage options, a greater choice of plans, and coverage that meets their care needs. The vast majority of consumers who gained private insurance coverage through the Marketplace are paying $100 or less per month. In fact, nearly half – 46 percent – were able to get covered for $50 per month or less. For many it was the first time they had a real choice in health plans - during Open Enrollment for the 2014 plan year, consumers could choose from an average of over 40 Marketplace plans.[11] The Commonwealth Fund survey found that nearly two in three of newly covered consumers who went to the doctor or filled a prescription said they would not have been able to afford or access those services were it not for their new coverage, and more than three in four newly-insured consumers expressed satisfaction with their coverage.

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

As we embark on the second Open Enrollment period, CMS is concentrating now on several critical priorities to build on the progress from the first year of operations. We are focused on increasing the value to consumers by continuing to improve the information, plan options, and affordability of the shopping experience. We are working to ensure that consumers satisfied with their current Marketplace coverage can easily reenroll, while continuing our efforts to reach those who are eligible, but not yet enrolled in coverage. We are also 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 Marketplace leverages technology to bring more value, better information and a better shopping experience to consumers. Driven by competition and the

[11] ASPE Research Brief: Premium Affordability, Competition, and Choice in the Health Insurance Marketplace, 2014, http://aspe.hhs.gov/health/reports/2014/Premiums/2014MktPlacePremBrf.pdf

significant demand for health coverage, our goal is to expand health plan options with more affordable premiums for consumers.

The Affordable Care Act has increased competition in the market and offered more plan options to consumers. In the coming year we expect insurers to bring more options to more geographic markets, including in markets where consumers have historically 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 in the number of insurers seeking to participate in the Marketplace in the 2015 plan year. With more choices in year two, consumers should have an even greater opportunity to find quality health plans that best meets their needs.

As we work to bring greater choice to consumers, CMS is also bringing more value to consumers in the coming year by improving the transparency of provider networks. 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. Many health insurers are strengthening their networks, increasing inclusion of Essential Community Providers, and improving access to prescription drugs. We are also working to prevent cost sharing discrimination so that consumers have access to the appropriate services.

CMS is also continuing to monitor consumers' access to provider directories to help consumers more easily find network providers. Insurers are expected to 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 insurers to maintain these directories and that they 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.

While many are already utilizing their new coverage, we know that many consumers have received coverage for the first time in years – some for the first time ever, so they may need a little extra help in understanding their rights and their new coverage. Our From Coverage to Care initiative helps people with new health care coverage understand their benefits and connect to primary care and the preventive services that are right for them, so they can live a long and healthy life. The goal of the initiative is to help the newly insured navigate the healthcare system, improve their health and insurance literacy, promote patient engagement, and know what services are available in their local community.

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

While we know millions have signed up for new coverage, we know more work remains to reach out to those who are not yet covered, to educate them about the benefits of health insurance and to assist them in signing up for plans that fit their needs. We recognize these challenges cannot be managed from Washington alone. One of the lessons we learned over the past year was that one of the most effective ways to get people enrolled is through in-person help in their own communities. In a survey of Marketplace assister programs, including Navigators, in-person assisters, certified application counselors, and others, Kaiser Family Foundation found that assistor programs helped an estimated 10.6 million people during the first open enrollment period.[12] We've put a priority on recruiting more organizations to sign up to be Certified Application Counselors and recruiting more local leaders to be in-person assistors. We will also continue working with agents and brokers as they utilize their experience and existing relationships with consumers and small businesses to assist them in enrolling in coverage.

[12] http://kff.org/health-reform/report/survey-of-health-insurance-marketplace-assister-programs/

Adding Critical Functionality to Operate the Marketplace

Significant technological improvements are underway to support the operation of the Marketplace in a more automated fashion and to allow consumers to renew their coverage as seamlessly as possible this year. Building this functionality 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.

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 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 open enrollment. And we will continue to strengthen our privacy and security protocols to protect consumers' personally identifiable information. As we make these improvements, we are focused on managing our resources efficiently and are conscious of the limited time available for technology development this year.

We have created clear accountability for the leadership of this project. Earlier this year, Secretary Burwell announced a series of organizational changes designed to strengthen the implementation of the Affordable Care Act, including the recent addition of Kevin Counihan as Marketplace Chief Executive Officer, with responsibility and accountability for leading the federal Marketplace and, managing relationships with the state Marketplaces. Most recently, he served as Connecticut's Health Insurance Exchange CEO. Our 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, and we are building an operation better suited to identify and resolve them.

Conclusion

The Affordable Care Act is delivering on the promise of access to high quality, affordable health care coverage, while controlling the growth of health care costs. While the Marketplace is still at

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Chairman BRADY. Thank you, Dr. Price.

Mr. Pascrell, you are recognized.

Mr. PASCRELL. Thank you, Mr. Chairman, very much.

Look, Commissioner, you know what is going on here. If you can't shoot the dog, starve it. That is what this is all about. In the budget itself, in the budget itself, the House bill as amended for the appropriations, the total IRS funding in 2015 would be about $9.8 billion, which is 19 percent below 2010, when the ACA became the law of the land. So we are—in every manner, shape or form, in every hearing that we have had here, and I have a great respect for every Member of our side as well as the other side, but we know what it is: Starve it and it will go away, it will disappear, it will die.

I mean, there are some great things that are happening in the ACA, even to—its detractors know that. They won't admit it. They will not admit it.

So we know how many people we have enrolled, and we know how many people have received tax credits. We are trying to verify all of them, which is true. You want to know the mess we had 10 years ago on the prescription drug bill? Nobody wants to talk about that. This is half a story you get here, and there is a reason: We are going to starve the dog. We are not going to shoot it, because they haven't found the way to do that, either. And, again, 6 million more people are enrolled in Medicaid. Or the Children's Health Insurance Program, you don't want to talk about that, do you, what you have done to it?

So the United States uninsured rate continues to decline. It is about 13.4 percent now. Correct me if I am wrong, gentlemen.

Mr. SLAVITT. That is correct.

Mr. PASCRELL. Thank you. Before the ACA, many people were paying for plans that didn't provide them with the coverage they needed. Some of these people that have lost their coverage are better off now because they had to go into the exchange and they got better plans. Let's talk about that. And for those who are falling through the cracks, we have an obligation to them, too. Nobody's denying that.

I like to talk about this at town meetings. I hope you do, too. And I am sure you will be objective and tell the good with the bad.

Americans are denied coverage for pre-existing conditions and insurance companies arbitrarily increase their premiums to the point where they can't afford it. You talk about 7 percent increase. I will tell you what the increases were for each of the last 5 years.

My Republican colleagues refuse to acknowledge any benefits that have resulted from this law. And it is not a perfect law, Mr. Commissioner. We have never passed a perfect one, believe it or not.

Unlike the Part D Medicare prescription drug plan, where Democrats who voted against the bill came together and helped educate and enroll seniors, I voted against that, but I went back to my district to initiate those folks, the seniors, with what this plan was all about, they have done nothing to do that. They haven't cooperated in the least.

So my question to you is this, Mr. Commissioner. And thank you—I was here the last time you were grilled, and you handled it very, very well, you kept your cool. Continue to keep your cool, Mr. Commissioner.

My Republican colleagues are fond of attacking the Obama administration at every step of the Affordable Care Act's implementation. They have expressed outrage over the delays, but at the same time, refused to give the agencies the funding. That is a big cut, 20 percent. The House appropriations bill for fiscal year 2015 that would set the funding at 19 percent below what it was 4 years ago.

Mr. Commissioner, can you explain how budget cuts have affected your agency's ability to implement the ACA?

Mr. KOSKINEN. We view, as I have said on numerous occasions in the past, implementing the Foreign Account Tax Compliance Act, FATCA, and the Affordable Care Act are statutory mandates

that we have an obligation to implement, so whatever else it means we are not doing, we are going to implement both Acts this year in the filing season. As I noted, by not providing the $430 million for fiscal 2014 or the $450 million for fiscal 2015, it simply means that we have to take that money from the other places we have available.

Mr. PASCRELL. So therefore——

Mr. KOSKINEN. It is either enforcement, taxpayer services, or continued improvement in——

Mr. PASCRELL. So you are moving dollars around?

Mr. KOSKINEN. We have to move the dollars around.

Mr. PASCRELL. The Affordable Care Act, Mr. Chairman, so far has had little impact on the insurance people get through their jobs, with roughly the same share of employers offering coverage in 2014 as last year, to correct the record.

Chairman BRADY. Thank you, Mr. Pascrell.

Mr. PASCRELL. May I just finish my point?

Chairman BRADY. Very quickly.

Mr. PASCRELL. As you have allowed other folks to. I appreciate that.

Chairman BRADY. No. We have been—I tell you what, we have been very close to time on everybody. And certainly finish.

Mr. PASCRELL. And you have been very, very charitable in——

Chairman BRADY. Thank you, sir.

Mr. PASCRELL [continuing]. With all of us. Thank you.

The employer sponsored health insurance premiums were rising about 3 percent. I would like to enter this report from the Kaiser Family Foundation on employer health benefits since that seems to be of interest to my friends on the other side. Thank you, Mr. Chairman.

Chairman BRADY. Without objection.

[The information follows: The Honorable Bill Pascrell]

THE KAISER FAMILY FOUNDATION -AND- HEALTH RESEARCH & EDUCATIONAL TRUST

Employer Health Benefits

2014 Summary of Findings

Employer-sponsored insurance covers about 149 million nonelderly people.[1] To provide current information about employer-sponsored health benefits, the Kaiser Family Foundation (Kaiser) and the Health Research & Educational Trust (HRET) conduct an annual survey of private and nonfederal public employers with three or more workers. This is the sixteenth Kaiser/HRET survey and reflects employer-sponsored health benefits in 2014.

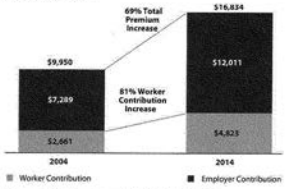
The key findings from the survey, conducted from January through May 2014, include a modest increase in the average premiums for family coverage (3%). Single coverage premiums are 2% higher than in 2013, but the difference is not statistically significant. Covered workers generally face similar premium contributions and cost-sharing requirements in 2014 as they did in 2013. The percentage of firms (55%) which offer health benefits to at least some of their employees and the percentage of workers covered at those firms (61%) are statistically unchanged from 2013. The percentage of covered workers enrolled in grandfathered health plans - those plans exempt from many provisions of the Affordable Care Act (ACA) - declined to 26% of covered workers from 36% in 2013. Perhaps in response to new provisions of the ACA, the average length of the waiting period decreased for those with a waiting period and the percentage with an out-of-pocket limit increased. Although employers continue to offer coverage to spouses, dependents and domestic partners, some employers are instituting incentives to influence workers' enrollment decisions, including nine percent of employers who attach restrictions for spouses' eligibility if they are offered coverage at another source, or nine percent of firms who provide additional compensation if employees do not enroll in health benefits.

HEALTH INSURANCE PREMIUMS AND WORKER CONTRIBUTIONS

In 2014, the average annual premiums for employer-sponsored health insurance are $6,025 for single coverage and $16,834 for family coverage. The average family premium rose 3% over the 2013 average premium. Single coverage premiums rose 2% in 2014 but are not statistically different than the 2013 average premium. During the same period, workers' wages increased 2.3% and inflation increased 2%. Over the last ten years, the average premium for family coverage has increased 69% (Exhibit A). Premiums have increased less quickly over the last five years (2009 to 2014), than the preceding five year period (2004 to 2009) (26% vs. 34%).

EXHIBIT A

Average Annual Health Insurance Premiums and Worker Contributions for Family Coverage, 2004–2014



SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2004–2014.

Average premiums for high-deductible health plans with a savings option (HDHP/SOs) are lower than the overall average for all plan types for both single and family coverage (Exhibit B), at $5,299 and $15,401, respectively. There are important differences in premiums by firm size: the average premium for family coverage is lower for covered workers in small firms (3–199 workers) than for workers in larger firms ($15,849 vs. $17,265).

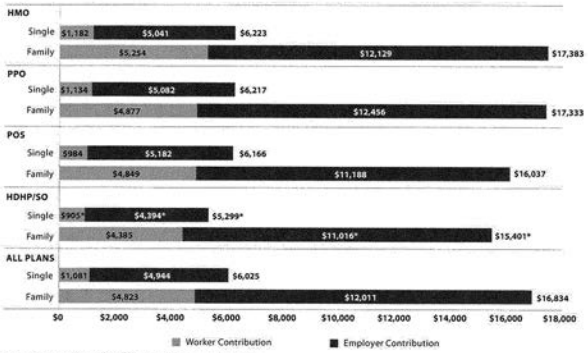
Premiums vary significantly around the averages for single and family coverage, resulting from differences in benefits, cost sharing, covered populations, and geographical location. Twenty percent of covered workers are in plans with an annual total premium for family coverage of at least $20,201 (120% of the average family premium), and 20% of covered workers are in plans where the family premium is less than $13,467 (80% of the average family premium). The distribution is similar around the average single premium (Exhibit C).

Most often, employers require that workers make a contribution towards the cost of the premium. Covered workers contribute on average 18% of the premium for single coverage and 29% of the premium for family coverage, the same percentages as 2013. Workers in small firms (3–199 workers) contribute a lower average percentage for single coverage compared to workers in larger firms (16% vs. 19%), but they contribute a higher average percentage for family coverage (35% vs. 27%). Workers in firms with a higher percentage of lower-wage workers (at least 35% of workers earn $23,000 or less) contribute higher percentages of the premium for single coverage (27% vs. 18%) and for family coverage (44% vs. 28%) than workers in firms with a smaller share of lower-wage workers.

As with total premiums, the share of the premium contributed by workers varies considerably among firms. For single coverage, 57% of covered workers are in plans that require them to make a contribution of less than or equal to a quarter of the total premium, 2% are in plans that require a contribution of more

EXHIBIT B

Average Annual Firm and Worker Premium Contributions and Total Premiums for Covered Workers for Single and Family Coverage, by Plan Type, 2014



* Estimate is statistically different from All Plans estimate by coverage type (p<.05).
SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2014.

than half of the premium, and 14% are in plans that require no contribution at all. For family coverage, 42% of covered workers are in plans that require them to make a contribution of less than or equal to a quarter of the total premium and 15% are in plans that require more than half of the premium, while only 5% are in plans that require no contribution at all for family coverage (Exhibit D).

Looking at the dollar amounts that workers contribute, the average annual premium contributions in 2014 are $1,081 for single coverage and $4,823 for family coverage. Covered workers' average dollar contribution to family coverage has increased 81% since 2004 and 37% since 2009 (Exhibit A). Workers in small firms (3–199 workers) have lower average contributions for single coverage than workers in larger firms ($902 vs. $1,160), but higher average contributions for family coverage ($5,508 vs. $4,523). Workers in firms with a higher percentage of lower-wage workers (at least 35% of workers earn $23,000 or less) have higher average contributions for family coverage ($6,472 vs. $4,693) than workers in firms with lower percentages of lower-wage workers.

PLAN ENROLLMENT

PPO plans remain the most common plan type, enrolling 58% of covered workers in 2014. Twenty percent of covered workers are enrolled in a high-deductible plan with a savings options (HDHP/SO), 13% in an HMO, 8% in a POS plan, and less than 1% in a conventional (also known as an indemnity plan) (Exhibit E). Enrollment in HDHP/SOs increased significantly between 2009 and 2011, from 8% to 17% of covered workers, but has plateaued since then (Exhibit E). In 2014, twenty-seven percent of firms offering health benefits offer a high-deductible health plan with a health reimbursement arrangement (HDHP/HRA) or a health savings account (HSA) qualified HDHP.

Enrollment distribution varies by firm size; for example, PPOs are relatively more popular for covered workers at large firms (200 or more workers) than smaller firms (63% vs. 46%) and POS plans are relatively more popular among smaller firms than large firms (17% vs. 4%).

EMPLOYEE COST SHARING

Most covered workers face additional out-of-pocket costs when they use health care services. Eighty percent of covered workers have a general annual deductible for single coverage that must be met before most services are reimbursed by the plan. Even workers without a general annual deductible often face other types of cost sharing when they use services, such as copayments or coinsurance for office visits and hospitalizations.

Among covered workers with a general annual deductible, the average deductible amount for single coverage is $1,217. The average annual deductible is unchanged from last year ($1,135), but has increased from $826 in 2009 (Exhibit F). Deductibles differ by firm size: for workers in plans with a deductible, the average deductible for single coverage is $1,797 in small firms (3–199 workers), compared to $971 for workers in larger firms. Covered workers in small firms are significantly more likely to have high general annual deductibles compared to those in larger firms. Sixty-one percent of covered workers in small firms are in a plan with a deductible of at least $1,000 for single coverage compared to 32% in larger firms; a similar pattern is seen for those in plans with a deductible of at least $2,000 (34% for small firms vs. 11% for larger firms) (Exhibit G).

EXHIBIT C

Distribution of Annual Premiums for Single and Family Coverage Relative to the Average Annual Single or Family Premium, 2014

NOTE: The average annual premium is $6,025 for single coverage and $16,834 for family coverage. The premium distribution is relative to the average single or family premium. For example, $4,820 is 80% of the average single premium, $5,423 is 90% of the average single premium, $6,628 is 110% of the average single premium, and $7,230 is 120% of the average single premium. The same break points relative to the average are used for the distribution for family coverage.

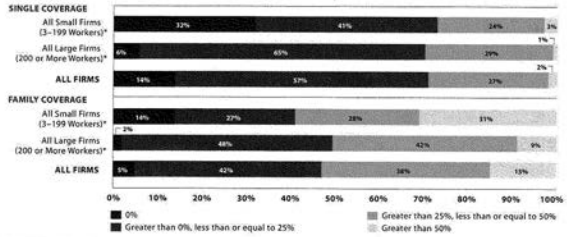
SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2014.

The large majority of workers also have to pay a portion of the cost of physician office visits. Almost three-in-four covered workers pay a copayment (a fixed dollar amount) for office visits with a primary care physician (73%) or a specialist physician (72%), in addition to any general annual deductible their plan may have. Smaller shares of workers pay coinsurance (a percentage of the covered amount) for primary care office visits (18%) or specialty care visits (21%). For in-network office visits, covered workers with a copayment pay an average of $24 for primary care and $36 for specialty care. For covered workers with coinsurance, the average coinsurance for office visits is 18% for primary and 19% for specialty care. While the survey collects information only on in-network cost sharing, it is generally understood that out-of-network cost sharing is higher.

The cost sharing that a person pays when they fill a prescription usually varies with the type of drug – for example whether it is a generic, brand-name, or specialty drug – and whether the drug is considered preferred or not on the plan's formulary. These factors result in each drug being assigned to a tier that represents a different level, or type, of cost sharing. Eighty percent of covered workers are in plans with three-or-more tiers of cost sharing. Copayments are the most common form of cost sharing for tiers one through three and coinsurance is the most common form of cost sharing for drugs on the fourth or higher tier of formularies. Among workers with three-or-more tier plans, the average copayments in these plans are $11 for first-tier drugs, $31 for second-tier drugs, $53 for third-tier drugs, and $83 for fourth-tier drugs. Apart from first-tier drugs, the average copayment amounts are similar to those reported last year. HDHP/SOs have a somewhat different cost-sharing pattern for prescription drugs than other plan types: just 62% of covered workers are enrolled in a plan with three-or-more tiers of cost sharing, while 15% are in plans that pay the full cost of prescriptions once

EXHIBIT D

Distribution of Percentage of Premium Paid by Covered Workers for Single and Family Coverage, by Firm Size, 2014



* Estimate is statistically different between All Small Firms and All Large Firms ($p<.05$).

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2014.

the plan deductible is met, and 17% are in a plan with the same cost sharing for all prescription drugs.

Most workers also face additional cost sharing for a hospital admission or an outpatient surgery episode. After any general annual deductible is met, 62% of covered workers have a coinsurance and 15% have a copayment for hospital admissions. Lower percentages have per day (per diem) payments (5%), a separate hospital deductible (3%), or both copayments and coinsurance (10%). The average coinsurance rate for hospital admissions is 19%, the average copayment is $280 per hospital admission, the average per diem charge is $297, and the average separate annual hospital deductible is $490. The cost-sharing provisions for outpatient surgery are similar to those for hospital admissions, as most covered workers have either coinsurance (64%) or copayments (16%). For covered workers with cost sharing for each outpatient surgery episode, the average coinsurance is 19% and the average copayment is $157.

Most plans limit the amount of cost sharing workers must pay each year, generally referred to as an out-of-pocket maximum. The ACA, requires that non-grandfathered health plans, with a plan year starting in 2014 have an out-of-pocket maximum of $6,350 or less for single coverage and $12,700 for family coverage or less. In 2014, 94% percent of covered workers have an out-of-pocket maximum for single coverage, significantly more than 88% in 2013. While most workers have out-of-pocket limits, the actual dollar limits differ considerably. For example, among covered workers in plans that have an out-of-pocket maximum for single coverage, 54% are in plans with an annual out-of-pocket maximum of $3,000 or more, and 10% are in plans with an out-of-pocket maximum of less than $1,500.

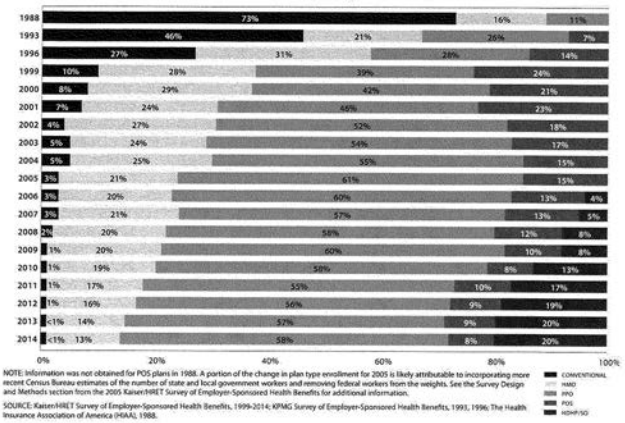
AVAILABILITY OF EMPLOYER-SPONSORED COVERAGE

Fifty-five percent of firms offer health benefits to their workers, statistically unchanged from 57% last year and 61% in 2012. The likelihood of offering health benefits differs significantly by size of firm, with only 44% of employers with 3 to 9 workers offering coverage, but virtually all employers with 1,000 or more workers offering coverage to at least some of their employees. Ninety percent of workers are in a firm that offers health benefits to at least some of its employees, similar to 2013 (90%). Offer rates also differ by other firm characteristics: 53% of firms with relatively fewer younger workers (less than 35% of the workers are age 26 or younger) offer health benefits compared to 30% of firms with a higher share of younger workers.

Even in firms that offer health benefits, not all workers are covered. Some workers are not eligible to enroll as a result of waiting periods or minimum work-hour rules. Other workers do not enroll in coverage offered to them because of the cost of coverage or because they are covered through a spouse. Among firms that offer coverage, an average of 77% of workers are eligible for the health benefits offered by their employer. Of those eligible, 80% take up their employer's coverage, resulting in 62% of workers in offering firms having coverage through their employer. Among both firms that offer and do not offer health benefits, 55% of workers are covered by health plans offered by their employer, similar to 2013 (56%).

EXHIBIT E

Distribution of Health Plan Enrollment for Covered Workers, by Plan Type, 1988–2014



NOTE: Information was not obtained for POS plans in 1988. A portion of the change in plan type enrollment for 2005 is likely attributable to incorporating more recent Census Bureau estimates of the number of state and local government workers and removing federal workers from the weights. See the Survey Design and Methods section from the 2005 Kaiser/HRET Survey of Employer-Sponsored Health Benefits for additional information.

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2014; KPMG Survey of Employer-Sponsored Health Benefits, 1993, 1996; The Health Insurance Association of America (HIAA), 1988.

RETIREE COVERAGE

Twenty-five percent of large firms (200 or more workers) that offer health benefits in 2014 also offer retiree health benefits, similar to the percentage (28%) in 2013 but down from 35% in 2004. Among large firms (200 or more workers) that offer retiree health benefits, 92% offer health benefits to early retirees (workers retiring before age 65), 72% offer health benefits to Medicare-age retirees, and 3% offer a plan that covers only prescription drugs. There may continue to be evolution in the way that employers structure and deliver retiree benefits. Among large firms offering health benefits, 25% of firms are considering changing the way they offer retiree coverage because of the new public health insurance exchanges established by the ACA. In addition to the public exchanges, there is considerable interest in exchange options offered by private firms. Four percent of large employers currently offer their retiree benefits through a private exchange.

WELLNESS, HEALTH RISK ASSEEMENTS AND BIOMETRIC SCREENINGS

Employers continue to offer programs in large numbers that help employees identify issues with their health and engage in healthier behavior. These include offering their employees the opportunity to complete a health risk assessment, and offering a variety of wellness programs that promote healthier lifestyles, including better diet and more exercise. Some employers collect biometric information from employees (e.g., cholesterol levels and body mass index) to use as part of their wellness and health promotion programs.

Almost one-third of employers (33%) offering health benefits provide employees with an opportunity to complete a health risk assessment. A health risk assessment includes questions about medical history, health status, and lifestyle, and is designed

EXHIBIT F

Among Covered Workers the Prevalence and Average Value of General Annual Health Plan Deductible for Single Coverage, 2006–2014

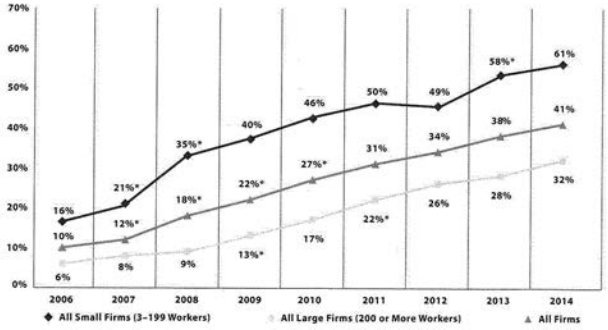
	2006	2007	2008	2009	2010	2011	2012	2013	2014
Percent of Covered Workers with A General Annual Deductible for Single Coverage	55%	59%*	59%	63%	70%*	74%	72%	78%*	80%
Average General Annual Deductible for Single Coverage	$584	$616	$735*	$826*	$917*	$991	$1,097*	$1,135	$1,217

* Estimates are significantly different from estimate for the previous year shown (p<.05).

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006–2014.

EXHIBIT G

Percentage of Covered Workers Enrolled in a Plan with a General Annual Deductible of $1,000 or More for Single Coverage, By Firm Size, 2006-2014



* Estimate is statistically different from estimate for the previous year shown (p<.05).

NOTE: These estimates include workers enrolled in HDHP/SO and other plan types. Average general annual health plan deductibles for PPOs, POS plans, and HDHP/SOs are for in-network services.

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2014.

to identify the health risks of the person being assessed. Large firms (200 or more workers) are more likely than smaller firms to ask employees to complete a health risk assessment (51% vs. 32%). Among these firms, 51% of large firms (200 or more workers) report that they provide a financial incentive to employees that complete the assessment. Thirty-six percent of firms with a financial incentive for completing a health risk assessment reported that the maximum value of the incentive is $500 or more.

Fifty-one percent of large firms (200 or more workers) and 26% of smaller firms offering health benefits report offering biometric screening to employees. A biometric screening is a health examination that measures an employee's risk factors, such as body weight, cholesterol, blood pressure, stress, and nutrition. Of these firms, one percent of large firms require employees to complete a biometric screening to enroll in the health plan; and 8% of large firms report that employees may be financially rewarded or penalized based on meeting biometric outcomes.

Virtually all large employers (200 or more workers) and most smaller employers offer at least one wellness program. Seventy-four percent of employers offering health benefits offer at least one of the following wellness programs in 2014: 1) *weight loss programs*, 2) *gym membership discounts or on-site exercise facilities*, 3) *biometric screening*, 4) *smoking cessation programs*, 5) *personal health coaching*, 6) *classes in nutrition or healthy living*, 7) *web-based resources for healthy living*, 8) *flu shots or vaccinations*, 9) *Employee Assistance Programs (EAP)*, or a 10) *wellness newsletter*. Large firms (200 or more workers) are more likely to offer one of these programs than smaller firms (98% vs. 73%). Of firms offering health benefits and a wellness program, 36% of large firms (200 or more workers) and 18% of smaller firms offer employees a financial incentive to ***participate*** in a wellness program, such as smaller premium contributions, smaller deductibles, higher HSA/HRA contributions or gift cards, travel, merchandise or cash. Among firms with an incentive to participate in wellness programs, only 12% of small firms and 33% of large firms believe that incentives are "very effective" at encouraging employees to participate. In lieu of or in addition to incentives for participating in wellness programs, 12% of large firms have an incentive for ***completing*** wellness programs.

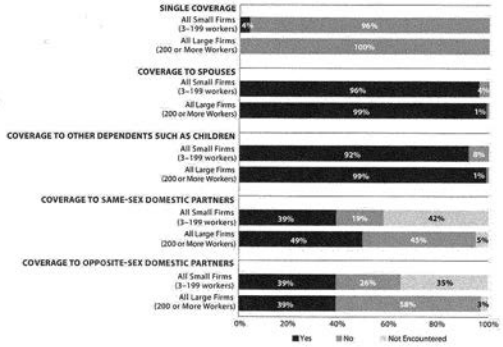
PROVIDER NETWORKS

High Performance or Tiered Networks. Nineteen percent of employers offering health benefits have high performance or tiered networks in their largest health plan. These programs identify providers that are more efficient or have higher quality care, and may provide financial or other incentives for enrollees to use the selected providers. Employers may use different criteria to determine which providers are in which tiers. Fifty-nine percent of firms whose largest plan includes a high performance or tiered provider network stated that the network tiers were determined both by providers' "quality and cost/efficiency", followed by 33% who selected "cost-efficiency".

Narrow Networks. Some employers are limiting their provider networks to reduce the cost. Six percent of employers with 50 or more employees reported that their plan eliminated hospitals to reduce cost and eight percent offer a plan considered a narrow network plan. Only six percent of employers with 50 or more workers offering health benefits stated that "narrow networks" are a very effective strategy to contain cost, less than other strategies such as "wellness program" (28%) and

EXHIBIT H

Among Firms Offering Benefits, Percent of Firms Which Offer Coverage to Spouses, Dependents and Domestic Partners, by Firm Size, 2014



NOTE: In 2008, we changed the response options to account for firms which had not encountered the issue because they have no workers in the category and have corporate policy. This response is distinguished from firms that report "no" since those firms have a set policy on the issue.

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2014.

"consumer drive health plans" (22%).

Retail Health Clinics. Fifty-seven percent of employers offering health benefits cover services provided by retail health clinics. These may be health clinics located in grocery stores or pharmacies to treat minor illnesses or provide preventive services, such as vaccines or flu shots. Among firms covering services in these settings, eight percent provide a financial incentive to receive services in a retail clinic instead of a physician's office.

EMPLOYEE AND DEPENDENT ELIGIBITY

Waiting Period. The ACA limits waiting periods to no more than 90 days for non-grandfathered plans with plan years beginning after January 1, 2014. The average length of waiting periods for covered workers who face a waiting period decreased from 2.3 months in 2013 to 2.1 months in 2014. Twenty-three percent of large firms and 10% of small firms with a waiting period indicated that they decreased the length of their waiting period during the last year. As more firms renew their plans in 2014 and lose grandfathering status more firms will be subject to this provision.

Dependent Coverage. The overwhelming majority of firms which offer coverage to at least some employees offer coverage to dependents (96%) (Exhibit H). Thirty-nine percent of firms offer coverage to same-sex domestic partners, the same percentage that offers coverage to opposite-sex domestic partners. Both percentages are similar to 2012, the last time the survey included this question. Some employers are requiring additional cost sharing (5%) or restricting eligibility for spouses (9%) to enroll if they have an offer of coverage from another source. Eighteen percent of large firms provide compensation or benefits to employees who do not enroll in coverage.

OTHER TOPICS

Grandfathered Health Plans. The ACA exempts "grandfathered" health plans from a number of its provisions, such as the requirements to cover preventive benefits without cost sharing or the new rules for small employers' premiums ratings and benefits. An employer-sponsored health plan can be grandfathered if it covered a worker when the ACA became law (March 23, 2010) and if the plan has not made significant changes that reduce benefits or increase employee costs. Thirty-seven percent of firms offering health benefits offer at least one grandfathered health plan in 2014, less than 54% in 2013. Looking at enrollment, 26% of covered workers are enrolled in a grandfathered health plan in 2014, down from 36% in 2013 (Exhibit I).

Self-Funding. Fifteen percent of covered workers at small firms (3–199 workers) and 81% of covered workers at larger firms are enrolled in plans which are either partially or completely self-funded. The percent of covered workers enrolled in self-funded plans has increased for large firms since 2004, but has remained stable for both large and small firms over the last couple of years.

Private Exchanges for Large Employers. While relatively few covered workers at large employers currently receive benefits through a private or corporate health insurance exchange (3%), many firms are looking at this option. Private exchanges allow employees to choose from several health benefits options offered on the exchange. A private exchange is created by a consulting company or insurer, rather than a governmental entity. Thirteen percent of large firms are considering offering benefits through a private exchange and 23% are considering using a defined contribution method. This interest may signal a significant change in the way that employers approach health benefits and the way employees get coverage.

CONCLUSION

The 2014 survey found considerable stability among employer-sponsored plans. Similar percentages of employers offered benefits to at least some employees and a similar percentage of workers at those firms were covered by benefits compared to last year. Family premiums increased at a modest rate and single premiums are not statistically different than those reported last year. On average, covered workers contribute the same percentage of the premium for single and family coverage as they did last year.

The relatively quiet period in 2014 may give way to bigger changes in 2015 as the employer shared-responsibility provision in the ACA takes effect for large employers. This provision requires firms with more than 100 full time equivalent employees (FTEs) in 2015 and more than 50 FTEs in 2016 to provide coverage to their full-time workers or possibly pay a penalty if workers seek subsidized coverage in health care exchanges. While most large employers provide coverage to workers, not all do, and not all cover all of their full-time workers. In addition, the coverage offered by these larger employers must meet a certain value and must be offered at an affordable amount to workers. We expect

EXHIBIT I

Grandfathering Under the Affordable Care Act (ACA), by Firm Size, 2011–2014

Percentage of Covered Workers in a Grandfathered Health Plan	2011	2012	2013	2014
All Small Firms (3–199 Workers)	63%	54%*	49%	35%*
All Large Firms (200 or More Workers)	53%	46%	30%*	22%*
ALL FIRMS	**56%**	**48%***	**36%***	**26%***

Percentage of Firms with At Least One Grandfathered Plan	2011	2012	2013	2014
All Small Firms (3–199 Workers)	72%	58%*	54%	37%*
All Large Firms (200 or More Workers)	61%	57%	43%*	34%*
ALL FIRMS	**72%**	**58%***	**54%**	**37%***

* Estimate is statistically different from estimate for the previous year shown ($p<.05$).

NOTE: For definitions of Grandfathered health plans, see the introduction to Section 13 at http://ehbs.kff.org.

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2011–2014.

some employers to revise eligibility and contributions for benefits in response to the new provisions.

The continued implementation of major reforms in the non-group market also may affect employer strategies going forward. For smaller firms not subject to the employer-responsibility requirement, the ability of their employees to receive subsidized nongroup coverage in health insurance exchanges may be an attractive alternative which would relieve the employer of the burden of sponsoring coverage. Small firms that have struggled to offer good coverage options may decide to stop offering now that other alternatives are available. In addition, a quarter of large firms offering retiree coverage to active workers indicated they were considering changes to the way they offered retiree coverage because of the implementation of the public exchanges. We may see shifts in the coverage options offered by some employers in response to these new options and new tax incentives.

Employer-sponsored coverage also will continue to evolve for reasons that are not related to the ACA. Employers and insurers continue to develop more integrated approaches to assessing individuals' personal health risks and offering programs to address them. Wellness programs present enrollees with opportunities and challenges, including the possibility of much higher out-of-pocket costs if their health profile is a potentially costly one. Narrow networks and provider networks and new tools like reference pricing can lower premiums but also require enrollees to have a more active role in ensuring that they have access to the providers they want to use. And the development of private marketplaces for larger employers, if it continues, may signal a new direction where individual employers are less engaged in plan design and management and where more decisions and economic responsibility is shifted to employees.

Finally, the continuing improvement in the economy is likely to put new cost pressure on employers and insurers. Costs grew at low levels while the economy struggled, but are likely to rebound if the growth in the economy is sustained. The potential of higher premiums may push employers and insurers to accelerate some of the changes we already are seeing.

METHODOLOGY

The Kaiser Family Foundation/Health Research & Educational Trust 2014 Annual Employer Health Benefits Survey (Kaiser/HRET) reports findings from a telephone survey of 2,052 randomly selected public and private employers with three or more workers. Researchers at the Health Research & Educational Trust, NORC at the University of Chicago, and the Kaiser Family Foundation designed and analyzed the survey. National Research, LLC conducted the fieldwork between January and May 2014. In 2014 the overall response rate is 46%, which includes firms that offer and do not offer health benefits. Among firms that offer health benefits, the survey's response rate is also 46%.

We ask all firms with which we made phone contact, even if the firm declined to participate in the survey: "Does your company offer a health insurance program as a benefit to any of your employees?" A total of 3,139 firms responded to this question (including the 2,052 who responded to the full survey and 1,087 who responded to this one question). Their responses are included in our estimates of the percentage of firms offering health coverage. The response rate for this question is 70%.

Since firms are selected randomly, it is possible to extrapolate from the sample to national, regional, industry, and firm size estimates using statistical weights. In calculating weights, we first determine the basic weight, then apply a nonresponse adjustment, and finally apply a post-stratification adjustment. We use the U.S. Census Bureau's Statistics of U.S. Businesses as the basis for the stratification and the post-stratification adjustment for firms in the private sector, and we use the Census of Governments as the basis for post-stratification for firms in the public sector. Some numbers in the exhibits in the report do not sum up to totals due to rounding effects, and, in a few cases, numbers from distribution exhibits referenced in the text may not add due to rounding effects. Unless otherwise noted, differences referred to in the text and exhibits use the 0.05 confidence level as the threshold for significance. In 2014 we adjusted the premiums for a small number of firms which gave a composite family/single amount.

For more information on the survey methodology, please visit the Survey Design and Methods Section at http://ehbs.kff.org/.

[1] Kaiser Commission on Medicaid and the Uninsured. The uninsured: a primer—key facts about health insurance on the eve of coverage expansions [Internet]. Washington (DC): The Commission; 2013 Oct 23 [cited 2014 Aug 5]. Available from: http://kff.org/uninsured/report/the-uninsured-a-primer-key-facts-about-health-insurance-on-the-eve-of-coverage-expansions/

[2] Kaiser/HRET surveys use the April-to-April time period, as do the sources in this and the following note. The inflation numbers are not seasonally adjusted. Bureau of Labor Statistics. Consumer Price Index - All Urban Consumers [Internet]. Washington (DC): Department of Labor; 2014 [cited 2014 June 6]. Available from: http://data.bls.gov/timeseries/CUUR0000SA0?output_view=pct_1mth. Wage data are from the Bureau of Labor Statistics and based on the change in total average hourly earnings of production and nonsupervisory employees. Employment, hours, and earnings from the Current Employment Statistics survey [Internet]. Washington (DC): Department of Labor; 2014 [cited 2014 June 6]. Available from: http://data.bls.gov/timeseries/CES0500000008

[3] *Federal Register*. Vol. 75, No 221, November 17, 2010, http://www.gpo.gov/fdsys/pkg/FR-2010-11-17/pdf/2010-28851.pdf.

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The full report of survey findings (#8625) is available on the Kaiser Family Foundation's website at www.kff.org.
This summary (#8626) is also available at www.kff.org.

Chairman BRADY. Mr. Buchanan, you are recognized.

Mr. BUCHANAN. Thank you, Mr. Chairman. I also want to thank our witnesses for taking their time to be here today.

Mr. Commissioner, let me just ask about subsidies people have brought up. One of my colleagues mentioned about getting a $5,000 increase, but what happens—at least in Florida, I see a lot where you have realtors that are independent contractors, you have a lot of people that have a minimal salary but they are on commission, or you have minimal salary where they get subsidies, but they

might get a year-end bonus. How do you address that? Or somebody, for example, that one year as a realtor where real estate hasn't been great for a period of time, but Florida is back now, was making $30,000 a year, now he might make $100,000 this year, the next year make $30,000. How do you deal with—you know, I would say that is a large percentage of people that are employed in America are in those circumstances where they don't have a fixed salary at $60,000 a year. They might earn $70,000, but it is based on how they do over the year——

Mr. KOSKINEN. Right.

Mr. BUCHANAN [continuing]. In terms of bonus, commissions or other things. How do you address that in terms of subsidies one year making $30,000 and the next year making $150,000 the following year making $30,000?

Mr. KOSKINEN. Those—it is a situation many people face. They face the same issue when they file their estimated taxes or make W–2 determinations. They make an estimate, their best judgment as to what they are going to owe in taxes. Everybody tries not to owe taxes at the end of the year, so over 80 percent of the people who file actually get refunds every year. And so they are going to make the same kind of judgment here. They have to make an estimate when they file for withholding or when they file estimated taxes, they have to make an estimate here if they are going to apply for the premium tax credit. At the end of the year when they file their tax return, much as when they reconcile their income generally on their overall taxes, they will make a reconciliation as to whether they got too much or too little on their premium tax credit in the advanced payment.

Our expectation is, just as people adjust their estimates for withholding, and they usually over withhold to make sure they take into that account, that we expect that a lot of people when they make their estimates, if they are fluctuating like that, will estimate on the low side, will have a lower——

Mr. BUCHANAN. Well, it sounds like you have got a pretty good handle on, you know, all these variations of possibilities.

Mr. KOSKINEN. Well, we expect them to kind of mirror the normal variations people make when they have to estimate how much to pay in estimated——

Mr. BUCHANAN. Thank you. I want to kind of move over to Mr. Slavitt real quick.

You have been in the healthcare-related industry for how many years?

Mr. SLAVITT. 20 years.

Mr. BUCHANAN. Yeah. Let me just tell you, as someone that has been in business before I got here 30 years and bought a lot of health care for a lot of employees, I think we have got quality health care, but it is—my biggest concern is cost. I think it is—everybody likes to talk about the middle class, I grew up in the middle class, but it is bankrupting the middle class, cost. It is not unusual in my area, I represent a part of Florida, but I am the only member in Florida, where you have someone between 50 and 65 years old, I do a lot of town halls, that are talking their costs for them or maybe their employees, but ideally for them and their family of four could be as high as $2,000 a month. That is not unusual,

$1,500 to $2,000. So I am very concerned about health care in general, and I see the costs continuing to go up. As someone that has employed a lot of people or I talk to a lot of people back in the district, they get a bill every year, even since the ACA, going up 10 to 20 percent a year, cost of living is 2 to 3 percent, and this has been going on for, it seems like, 10 or 15 years. It is one of the biggest concerns we have got, is health care. It is not that we don't have good providers, but the cost is bankrupting, in my opinion, the middle class. What do you say to that? Do you think—do you share that concern.

Mr. SLAVITT. Yes. Congressman, you are—you are exactly right. You know, affordability——

Mr. BUCHANAN. I don't use the term "bankruptcy"——

Mr. SLAVITT. Right.

Mr. BUCHANAN [continuing]. Lightly, I am an optimist, but it does concern me when people are paying $1,000 to $2,000 a month for health care along with all their other costs, and I don't see that changing.

Mr. SLAVITT. Yes.

Mr. BUCHANAN. Go ahead.

Mr. SLAVITT. Yes. Congressman, affordability is one of the three critical pillars of our implementation, along with quality and access. And I think there are a couple things that are, I think, highly encouraging, although early still: one is that the premium levels that people are paying are at much more affordable levels; second is I think those in business and those who are individual health plan members for some time are used to things like double digit rate increases. And I think, you know, the five or six States that have publicly put forward the rates that they are going to have for 2015 are all in the range of single digits. I think Arkansas was a couple percent, I think Delaware was a couple percent, I think California was 4 percent. So these are relatively——

Mr. BUCHANAN. I would take—just do me a favor and take a look at Florida. I have met with one of the largest providers in the State and did a lot of our stuff, one of the largest, met with the CEO for the State.

Mr. SLAVITT. Yep.

Mr. BUCHANAN. And, you know, they are talking—I don't know what they are going to be. It is going to 20, 40 percent. They are losing a lot of money, because they have got the sickest in Florida, a lot of them that are joining up and they are very concerned. They used to make tens of millions, now they are making zero. So I can see what is going to happen to—you know, from that standpoint, so I am very concerned about that.

Let me mention one other thing I wanted to bring up. The insurance companies in our State have been in to see me that they are looking to the Federal Government, because they were promised or felt they were promised that they would make a certain return or somehow the government would underwrite their losses. What is your sense of that? Is there any—are insurance companies going to have the opportunity to come back to the Federal Government and get subsidized somehow?

Mr. SLAVITT. So let me follow up in writing, given that I am out of time, but, no, that is—that is not going to be the case.

Mr. BUCHANAN. That is what they are looking for.

Chairman BRADY. Thank you. Time has expired.

Mr. Blumenauer is recognized.

Mr. BLUMENAUER. Thank you, Mr. Chairman.

Commissioner, I appreciate your coming back for another round.

Mr. MCDERMOTT. You might push your mike.

Mr. BLUMENAUER. My mike was on. It is not——

I will try Mr. Pascrell's, not that he needs a mike.

Chairman BRADY. It always seems to work.

Mr. BLUMENAUER. That is right.

Mr. MCDERMOTT. He turned that off.

Mr. BLUMENAUER. Mr. Commissioner, I appreciate your joining us for another round. I particularly appreciate the end of your testimony where you were talking about needing the resources to be able to meet the needs of people, not just with the Affordable Care Act provisions, but just the ongoing challenges of trying to administer an IRS Code that Congress repeatedly makes more complex. No IRS employees are complicating the Code. That is our job.

I had the occasion last month to just sit down in a large sort of brown bag discussion with your employees in Portland, and I was—I was struck by how frustrated they are. They don't want people on hold for 45 minutes. They want to be able to meet their needs. And I would just urge you to be relentless in driving this point home that we can't continue to cut the IRS budget, reduce staffing, make the Code more complex, and then beat up on the IRS and still expect that we are going to keep the highest compliance rate in the world for over 150 million taxpayers. I appreciate your forthrightness, and I would just encourage it.

And I would hope that individual members of this committee in particular could sit down in a shirtsleeve session off the record, no cameras, and just meet with the men and women who are trying to meet the needs of our constituents. I have found it instructive every time I do it, and I think maybe if more of our members did that, we might look at the budgeting a little different.

But I would just say, Mr. Chairman, I appreciate your ongoing efforts and your evenhandedness, even allowing us to slide over for a second or two, and your good humor. I also appreciate that you have been looking at a draft kind of tying together some elements that a number of us have co-sponsored on the committee, good work from Mr. Roskam, Mr. Gerlach.

I have indicated in the past that I hope we can shift gears and get to the point where we can actually have hearings on things that can pass and don't have anything to do with the Affordable Care Act. I would note the legislation I have with my good friend Dr. Roe helping make sure that end of life care has a value. And we put it in the Affordable Care Act. It somehow wasn't included in terms of reconciliation. But in terms of what we do with Medicare, card identification, the secure card, the Prime Act, Congresswoman Black and I have some legislation dealing with value-based insurance. There is a whole host of things that we could be making progress on. Put them on the floor. They will pass. They will make the system better. They are not going to make the nightly news, but collectively we will be doing our job. And I hope we can minimize hearings that are just beating up on people for things beyond

their control, that actually we kind of make their job harder, and that we get down to cases.

I appreciate the draft that you are circulating. I look forward to supporting it. And the other references that I have made of bipartisan legislation that will make a difference, that can be approved, they could—some of these could roll out before we adjourn for October, and certainly in the lame duck when we will be standing around trying to figure out what to do, waiting for the powers that be on the big stuff, we could get some good things going and give Congressman Gerlach a going-away present with important legislation that will make a difference.

Thank you, Mr. Chairman. Again, I appreciate your good humor and your evenhandedness, and I would respectfully request that maybe we could put that to work on some legislation that will pass before we adjourn for the year.

Chairman BRADY. Thank, Mr. Blumenauer. I want to—I share your belief that while we have very strong differences on the Affordable Care Act, and a hearing like today is really about finding out what our families and patients and taxpayers have to face in the second year, there are legitimate questions that need to be asked. But we are also trying to create a climate where we can take the good work that is being done by these committee members on all those areas that you have an interest in, I think we have a bipartisan interest in, in legislation and move that forward. So we have got some work to do in each of those areas. We are trying to work through these final points, for example, on the—our fraud, bipartisan fraud bill and some other issues as well. So look forward to working with you. Thank you.

Now, Mr. Smith, you are recognized.

Mr. SMITH. Thank you to our witnesses today for your time here and sharing your insight and expertise. I think between the two of you, you do have vast insight, perhaps Mr. Slavitt, you bring some objectivity as a relatively new employee over at CMS.

Let me start. Commissioner Koskinen, the waivers that are offered by HHS or CMS, does IRS keep track of those waivers?

Mr. KOSKINEN. Yes. We have got a very, I think, positive working relationship with HHS and CMS. And to the extent that exemptions or waivers are created, they get built into our system as well, and so we are—we need to be aware of those, because obviously when people file their taxes, that we have a form that allows them to identify the exemption that applies to them.

Mr. SMITH. What percentage of the American population files a Federal tax return?

Mr. KOSKINEN. Well, that is a very good—a good question, because if you are below a certain income level, you are not required to. We have 150 million returns that are filed every year, and it is obviously the vast majority. I would be happy to get back to you, because I have never actually asked that question as to how many people do not have to file a return.

Mr. SMITH. I mean, because we have heard earlier that, you know, there are so many great and wonderful things that have come about, and yet we know that the enforcement of and the benefits perhaps to some, benefits of the healthcare situation here are offered through the Tax Code. So are there concerns that perhaps

there might be some beneficiaries out there who would not see the benefits or the complications associated along the way?

Mr. KOSKINEN. Thus far, our experience has been, as a general matter, and there are a number of tax credits that have been written into the Tax Code that we administer, the vast majority of people take advantage of those credits. We do run the earned income tax credit program, and part of our goal there is to make sure everybody who is eligible for the credit knows about it and uses it. In that case, about 80 percent of the eligible people for the earned income tax credit actually take advantage of it. So I am sure if everything continues to go as it usually does, there will be some people who are eligible for the premium tax credit and support for health care who may not take advantage of it.

Mr. SMITH. Okay. Thank you.

Mr. Slavitt, let's talk about the individual mandate briefly. Can you give us an update on the individual mandate? Obviously the administration is choosing to stick with the individual mandate in contrast to delaying the employer mandate. Is that accurate?

Mr. SLAVITT. The individual mandate, yes, is law and we are—we are administering and implementing the law that way, yes.

Mr. SMITH. And what would you say is a rough, I am not expecting exact, but a rough compliance rate with the individual mandate?

Mr. SLAVITT. I don't think that will be known until after we get through the year and through tax season, but in any event, I don't have an estimation, and I would be happy to try to get one to you, if it is possible.

Mr. SMITH. So penalties being levied would take place when?

Mr. SLAVITT. I think through the Tax Code, is my understanding.

Mr. KOSKINEN. It would be—it would be this year. There is no——

Mr. SMITH. No. I know. That—that is the how; but the when.

Mr. SLAVITT. During the tax filing season.

Mr. KOSKINEN. It will be when you file your return, on the 1040–A, you will check either I have got coverage or I have a premium tax credit.

Mr. SMITH. Wait. We are through one tax-filing season where that question has been asked, correct?

Mr. KOSKINEN. No. It did not apply last year. So the 2014 filing season for tax year 2013 did not have any requirement for individual shared responsibility payment. The first time it will take effect——

Mr. SMITH. But the question was asked about health care, was it not?

Mr. KOSKINEN. No. In other words, the tax returns last year did not have Affordable Care information in them.

Mr. SMITH. Okay. So—but then in this next tax-filing season, it will.

Mr. KOSKINEN. This coming spring for the 2014 tax year, we call it filing season 2015, because——

Mr. SMITH. Okay. If someone marks "no," can you share what happens from that point forward?

Mr. KOSKINEN. Yes. If you mark on your return that—"no," and you don't—aren't eligible for an exemption or a waiver, and there is a form you can fill out, then what happens is you will do a calculation and you will have the responsibility, the additional tax for this year is the $95 per individual capped at $250, give or take a little, for a family.

Mr. SMITH. Would that be considered a penalty?

Mr. KOSKINEN. Well, it is an additional tax. You can call it, you know—you can call it a penalty. Whatever it is, you will owe that amount of money.

Mr. SMITH. It is avoidable, you are saying?

Mr. KOSKINEN. Pardon?

Mr. SMITH. It is avoidable?

Mr. KOSKINEN. It is not avoid—it is avoidable if you are eligible for an exemption, and there are a significant number of exemptions available for people who don't—who had short—lack of coverage for less than 3 months, people who have particular hardships can provide that information, some religious affiliations will be able to provide that information. There are a series of exemptions. So it is avoidable to that extent, but if you don't qualify for an exemption, then you will owe the additional tax.

Mr. SMITH. Thank you. I yield back.

Chairman BRADY. Thank you.

Ms. Black is recognized.

Ms. BLACK. Thank you, Mr. Chairman. Thank you for holding this very important hearing. I appreciate being a non-member of this committee and having an opportunity to be able to ask the witnesses questions. And thank you, by the way, for being here.

Commissioner, I want to go back to a line of questioning that my colleague from Florida was talking about in relation to income accuracy in the filing process. And I think that I have probably—I think I remember bringing this up the last time we had a hearing on the oversight, and that was the idea of the E–FLEX Coalition.

Mr. KOSKINEN. I am sorry. E–FLEX——

Ms. BLACK. The E–FLEX Coalition made a specific recommendation to make the administration of the tax credits more accurate. They suggested, and I quote, their suggestion is, "giving employers the option to prospectively file information with the IRS about the coverage available to employees through an annual certification process."

Their letter went on to say, we believe that it is in the collective best interests of individual Americans, the employers and the administration to ensure accuracy—which is what my colleague was talking about—on such upfront determinations to avoid the subjecting of individuals to unexpected payments of any credits for which the exchanges incorrectly deemed them to be eligible.

Now, the Treasury during the rule writing process rejected that recommendation. Do you believe, given what we are going to be seeing, as my colleague referenced, that sometimes the—especially for those that are in sales where their income may be here and the next year it might be down here, that it would be helpful to have that information prospectively?

Mr. KOSKINEN. Well, tax policy matters are determined by the Treasury Department and the Congress. We are just the tax administrators, so we follow whatever the rules are.

As I noted, every taxpayer makes an estimate in advance as to what their income is going to be in the following year and then they reconcile it when they file their tax return and they know exactly what they earned. Where taxpayers have variety and they have bonuses or they are on commissions, in the normal process of filing their taxes, they make estimates, and they generally make estimates trying to make sure that they don't owe any more tax than usual, which means that is why most people get a refund.

We expect that with regard to those who qualify for the premium tax credit and are applying for an advanced payment, they will adjust and make the same kinds of estimates that they make for their withholding purposes.

Ms. BLACK. But the system is more complicated when you are having to go back and figure out, okay, do taxes. Now, let's just say someone has earned more than what they anticipated. Will there be a call-back?

Mr. KOSKINEN. Not a call-back. If you have earned more than you anticipate and you have been getting you advanced payment——

Ms. BLACK. Right.

Mr. KOSKINEN [continuing]. Paid to your insurance company, the payment doesn't come to you, at the end of the year, if you, in effect, have claimed more of a credit that has gone to your insurance company, you will either have a smaller refund or more tax owed, yes.

Ms. BLACK. So it will just be withheld from them. That won't be—let's say that they don't owe—or they are not due a return. And so what will happen then, because you can't withhold something from someone who wasn't due a return? How will you retrieve the money that has been paid out for an advanced tax credit?

Mr. KOSKINEN. They would be treated the same way any tax collection process. We would match up, we would determine if there is an amount owed. The first thing we usually do is send people a letter saying we see a discrepancy in your return. Can you explain what the issue is.

In fact, I would just make a plug here. We are trying to make people understand. We contact taxpayers by letter first. So if you are hearing from us by phone for the first time, the chances are pretty good you are not hearing from us. There is a significant amount of tax scamming going on that we are concerned about.

But in any event, we would advise the taxpayer. And they would be treated the same way any taxpayer was who had an amount owing, or at least some apparent discrepancy in what they filed and what they owed.

Ms. BLACK. It seems so complicated. It seems to me it would almost be better for us to say, what was your income this year, and then having the filing date maybe 2 months after they know what their income is at the end of the year. So moving the signup to maybe February so they know what their income was last year and you can go on that, but it seems like a very complicated system.

Let me go to Mr. Slavitt on an issue that you did actually mention, and that was the end-to-end testing. And we know that the end-to-end testing is a critical step in preparing for that successful 2015 open enrollment. Last year the testing occurred far too late, and we know that there was not time to correct those problems. And so you did mention that there is a new functionality and you are going to be rolling that out over the summer. Does this include testing of the auto enrollment renewal transaction process as well?

Mr. SLAVITT. Yes, Congresswoman, that will be tested. I believe it is slated in October.

Ms. BLACK. Slated in October.

Mr. SLAVITT. Yeah.

Ms. BLACK. So that is—the——

Mr. SLAVITT. The auto——

Ms. BLACK [continuing]. Signups—okay. And the signups will begin when?

Mr. SLAVITT. So recall that the auto enrollment functionality will occur in December——

Ms. BLACK. In December. Okay.

Mr. SLAVITT [continuing]. Because that is when——

Ms. BLACK. You won't test it until November?

Mr. SLAVITT. We will be—so to give a quick overview of the process, and I know I am over time, people will have—the beginning of open enrollment is November 15th. People will have an opportunity to come back, shop, and select a plan. The functionality you are referring to is what do we do in the occasion when somebody is enrolled in a plan——

Ms. BLACK. Right.

Mr. SLAVITT [continuing]. But doesn't come back.

Ms. BLACK. Right.

Mr. SLAVITT. December 15th, we will automatically enroll them in their existing plan, presuming that that plan is still offered through the marketplace.

Ms. BLACK. But you are doing some testing on that as well?

Mr. SLAVITT. We will—we will test, we will test everything.

Ms. BLACK. Okay. So have you worked with the insurers on this testing?

Mr. SLAVITT. So our initial testing with insurers actually is beginning this week with a group of insurers we call alpha insurers, and then in early October, we will invite all the insurers to begin to do their testing, end-to-end testing with the goal to make sure that when someone comes through the process, at the end of it, they get an 834 and they can return one back to us.

Ms. BLACK. Okay. Thank you very much.

Thank you, Mr. Chairman.

Chairman BRADY. Thank you, Ms. Black.

Commissioner Koskinen, I just want to follow—I am not sure we got a clear answer on one part of Representative Black's questions. If your income changes or if some reason there is an overpayment of subsidies, there is a cap on your overpayment depending upon your income, but if you were given, for example, affordable—offered affordable insurance at work and you don't take it, you are not eligible period. The law is very clear that all of that must be repaid.

Will you be following—following the law in the collection of that in that instance in the ineligible subsidy?

Mr. KOSKINEN. Yes. If somebody is ineligible and has received a credit, they will be treated the way anybody else would be in our compliance process.

Chairman BRADY. No, no, no. The question was, the law in that case, there is not a cap. All of the subsidy must be repaid. Will you be following the law in that recapture?

Mr. KOSKINEN. Yes. Wherever we can, we follow the law.

Chairman BRADY. Whenever we can. I encourage you to follow the law——

Mr. KOSKINEN. Right.

Chairman BRADY [continuing]. In all instances. And I had so many things going through my mind at that point. Commissioner, thank you for being here.

Mr. Slavitt, I know my office has reached out to you as well from a letter that Ms. Black, myself and others sent to Ms. Tavenner in August regarding the issue of the abortion surcharge, if you recall from the law that was a sensitive issue. The resolution was that consumers could know which plans provided those services, to choose one or the other, and if they did, there would be a separate charge to that. That was very clear. We sent a letter asking for a written response from the agency. I would encourage you to encourage the agency to respond as soon as possible.

Mr. SLAVITT. Yes, chairman. We are—we have the letter.

Chairman BRADY. Great.

Mr. SLAVITT. We are working on it.

Chairman BRADY. Great. Thank you very much.

I want to thank the witnesses for being here today. There are still a lot of questions dealing with the law going forward, but we will work together on this.

I do want to recognize Dr. McDermott for a special notice.

Mr. MCDERMOTT. Thank you, Mr. Chairman. Before we close the hearing, I would like to say a few words about a departing staff member, Askia Suruma is leaving the committee after 21 years in Congress—or working for Congress. He is the staff director of the Democrats on the committee and the staff director on the Oversight Committee. Prior to coming to this committee, he was a staff director—senior staff director for the Rules Committee and worked with Martin Frost from Texas. He is leaving to go to George Washington University, and we are grateful for his time here and wish him all the best, and please join me in thanking him.

[Applause.]

Chairman BRADY. Thank you for all your hard work.

With that, the witnesses, members do have 14 days in which to submit questions. Encourage the witnesses to respond as quickly as possible. Again, thank you for being here today. Hearing is adjourned.

[Whereupon, at 11:45 a.m., the subcommittee was adjourned.]