PPACA PULSE CHECK: PART 2

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRTEENTH CONGRESS

FIRST SESSION

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C O N T E N T S

PPACA PULSE CHECK: PART 2

TUESDAY, SEPTEMBER 10, 2013

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 10:15 a.m., in room 2322 of the Rayburn House Office Building, Hon. Joe Pitts (chairman of the subcommittee) presiding.

Members present: Representatives Pitts, Burgess, Murphy, Blackburn, Gingrey, Lance, Cassidy, Guthrie, Griffith, Bilirakis, Ellmers, Pallone, Dingell, Matheson, Green, Butterfield, Christensen, Castor, Sarbanes, DeGette, and Waxman (ex officio).

Staff present: Clay Alspach, Chief Counsel, Health; Matt Bravo, Professional Staff Member; Karen Christian, Chief Counsel, Oversight and Investigations; Noelle Clemente, Press Secretary; Paul Edattel, Professional Staff Member, Health; Julie Goon, Health Policy Advisor; Brad Grantz, Policy Coordinator, Oversight and Investigations; Sydne Harwick, Legislative Clerk; Sean Hayes, Counsel, Oversight and Investigations; Katie Novaria, Professional Staff Member, Health; Andrew Powaleny, Deputy Press Secretary; Heidi Stirrup, Health Policy Coordinator; Ziky Ababiya, Democratic Staff Assistant; Brian Cohen, Democratic Staff Director, Oversight and Investigations, and Senior Policy Advisor; Hannah Green, Democratic Staff Assistant; Elizabeth Letter, Democratic Assistant Press Secretary; Karen Lightfoot, Democratic Communications Director and Senior Policy Advisor; Karen Nelson, Democratic Deputy Committee Staff Director, Health; Stephen Salsbury, Democratic Special Assistant; and Matt Siegler, Democratic Counsel.

Mr. PITTS. This subcommittee will come to order. The Chair will recognize himself for an opening statement.

OPENING STATEMENT OF HON. JOSEPH R. PITTS, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

On August 1st, CMS Administrator Marilyn Tavenner testified before the full committee on implementation of the Affordable Care Act. She assured us that despite numerous delays, including a one-year delay of the employee choice provision of the SHOP exchanges, the employer mandate, and verification of eligibility for insurance subsidies, that the exchanges would be ready on October 1st to begin enrolling Americans in new health plans and that implementation of the law's other provisions was on track.

Since that hearing, we have learned of several troubling developments. On August 13, The New York Times reported that it had discovered a delay in the implementation of the law's out-of-pocket caps buried in a list of 137 frequently Asked questions posted on the Department of Labor's Web site on February 20, 2013. On August 27, CMS announced that instead of finalizing contracts with health plans set to participate in exchanges between September 5 and September 9, as had been expected, final contracts would not be signed until mid-September.

The Affordable Care Act's implementation involves a litany of Federal and State agencies, and my constituents are understandably confused about what is happening with the exchanges, enrollment and premiums. Considering the administration's track record on deadlines and delays, reassurances from CMS officials are not comforting.

In our previous hearing, Administrator Tavenner also made an extraordinary remark that she had only heard of "isolated incidents" of the ACA having burdensome or negative impact on Americans.

I would briefly like to share the experiences of some of my constituents who are being harmed by the law. In April of this year, Eastern Lancaster County School District and Penn Manor School District in Lancaster, Pennsylvania, both announced that they were outsourcing some employees to avoid the costs of complying with the ACA's employer mandate. Elanco will outsource approximately 90 food service workers and classroom aides, and Penn Manor is shifting more than 95 special-education classroom aides off its payroll. The affected employees work over 30 hours a week, thus triggering the employer mandate, and the school districts simply cannot afford to pay for the additional expenses of covering these individuals.

Dairy farmers in my district, members of the Mt. Joy Farmers Cooperative Association, which is affiliated with Dairylea Cooperative, currently enjoy a negotiated plan characterized by a low-risk pool and shared savings. As of January 1, 2014, they will lose this unique risk pool and be forced on to the exchanges.

A father from my district wrote me, distraught, about his daughter's work hours being cut to 28 hours a week, because her employer could not absorb the cost of providing her with health insurance. He is among dozens of people who have told me that their hours have been cut, and they have been moved from full-time to part-time as a direct result of the ACA. Dozens more have expressed shock at the staggering premium increases they that face in 2014. These are not isolated incidents.

With that, I would like to welcome all of our witnesses here today, and I look forward to their testimony.

[The prepared statement of Mr. Pitts follows:]

PREPARED STATEMENT OF HON. JOSEPH R. PITTS

The subcommittee will come to order.

The Chair will recognize himself for an opening statement.

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verification of eligibility for insurance subsidies—that the exchanges would be ready on October 1 to begin enrolling Americans in new health plans and that implementation of the law's other provisions was on track.

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In April of this year, Eastern Lancaster County (Elanco) School District and Penn Manor School District in Lancaster, PA, both announced that they were "outsourcing" some employees to avoid the costs of complying with the ACA's employer mandate.

Elanco will outsource approximately 90 food service workers and classroom aides, and Penn Manor is shifting more than 95 special-education classroom aides off its payroll. The affected employees work over 30 hours a week, thus triggering the employer mandate, and the school districts simply cannot afford to pay for the additional expenses of covering these individuals.

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Dozens more have expressed shock at the staggering premium increases they face in 2014.

These are not "isolated incidents."

I would like to welcome all of our witnesses here today, and I look forward to their testimony.

I yield back.

Mr. PITTS. I yield the balance of my time to the gentleman from Georgia, Dr. Gingrey.

OPENING STATEMENT OF HON. PHIL GINGREY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Mr. GINGREY. Thank you, Mr. Chairman.

We are now 3 weeks from the beginning of open enrollment for Obamacare exchanges. It is fitting that we have before us today the vendors who are charged with running the exchanges. While I am sure that these companies are working as best they can to meet the deadlines, the reality is that most were awarded contracts within the past few months and the complex system has yet to be fully tested. How can taxpayers expect to feel secure with their personal information in the exchange when they have not had adequate security checks to determine its effectiveness.

Mr. Chairman, Obamacare will saddle taxpayers with higher premiums, fewer choices and the potential for employment disruption.

We must work to ensure that our citizens will not face fraud and identity theft from the law as well, and with that, I yield back and I thank you for the time.

Mr. PITTS. The Chair thanks the gentleman.

At this time I would like to request unanimous consent for Representative DeGette to participate in the subcommittee hearing. Without objection, so ordered.

And the Chair recognizes the ranking member, Mr. Pallone, for 5 minutes for an opening statement.

OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. Thank you, Chairman Pitts, and a special thanks to our witnesses for taking the time to be here today. I know you are right in the middle of gearing up for the October 1st start of open enrollment for the health care exchanges and that your time is valuable.

I must say that I am extremely troubled by the Republicans' repeated tactics to try to slow the progress of all those individuals and organizations working so hard to implement the Affordable Care Act. In particular, the oversight letter that committee Republicans sent to 51 groups, primarily community organizations that receive grants to serve as navigators to help the uninsured sign up for benefits under the ACA I think is despicable. This is an egregious abuse of the committee process and an attempt by Republicans to intimidate community organizations and overwhelm them with information requests at a critical period so that they don't implement the program.

I have been working with organizations in my district such as the Food Bank of Monmouth in Ocean County, who have taken on the responsibility of being navigators for the community and make sure that they know their rights under the committee rules, but even more so, I am encouraging them to remain committed to the critical work they are doing and not be detracted from their laudable goals of helping uninsured people gain coverage.

It is time that the Republicans stop trying to obstruct the law. Health care reform is undeniably moving forward. It is hypocritical that Republicans are holding this hearing today so say that the health exchanges are not ready and that the administration doesn't have enough staff or resources when the Republicans are the ones who refuse to adequately fund the law and are out advocating for it to be defunded. But despite this, I think what we will hear today from our witnesses is that the contractors, community organizations and States are ready for October 1st.

It is going to be a challenge, that is for sure. Will the rollout be flawless? No. Will there likely be some hiccups along the way as with any major program rollout? Yes. But these groups have been working day and night to make sure that they are ready for enrollment so that Americans can start receiving the benefits of health insurance, and starting October 1st, millions of people will gain access to health care coverage they didn't have before. Individuals in every State will have access to a health exchange where they can select coverage from an array of qualified health plans. Every

health plan will offer essential health benefits including preventative services such as screenings and vaccines, mental health services, trips to the emergency room, outpatient care, care before and after your baby is born, prescription drugs, lab tests and pediatric services including dental care and vision care for kids.

Now, one area where more progress is needed is State expansion of Medicaid. An important tool included in the ACA was the strengthening of Medicaid by allowing States to expand coverage to individuals and families who did not previously qualify for the program but also did not have the resources to access affordable, quality care through the private insurance market. Not only is this beneficial for low-income Americans, it is an advantageous fiscal arrangement for States, and I am disappointed that a number of States still have not chosen to expand Medicaid coverage, and anticipate we will hear from Ms. Kraus from the Pennsylvania Health Access Network today about how the continued refusal of States to accept Federal funding and expand Medicaid will hurt low-income families as well as State economies.

So implementing the ACA is a huge undertaking. It involves the coordination of a number of complicated provisions. We can't expect everything to go perfectly but we can support the administration, the contractors, the community partners and the States in their efforts so that the American people can access health care as intended on October 1st and receive the assistance they need to sign up for health insurance. I just hope that my Republican colleagues will realize this and stop trying to impede the law and those working to implement it.

I yield back, Mr. Chairman.

Mr. PITTS. The Chair thanks the gentleman and now recognizes the vice chair of the subcommittee, Dr. Burgess, 5 minutes for opening statement.

OPENING STATEMENT OF HON. MICHAEL C. BURGESS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. BURGESS. I thank the chairman for yielding, and let me just say in reply to my friend from New Jersey that it is the oversight function of this committee and its subcommittees that really has been one of the cherished functions in the Congress in the United States, and certainly under both Democratic and Republican committee leadership, the oversight function is one that other Members of Congress look to. They look to the oversight function of this committee. So now we are in a new situations where self-attestation is going to be the launch word for people who show up and sign up for benefits. Why we wouldn't have questions about the vast sums of money that have been pushed out the door relatively hostility to these navigator groups? Why wouldn't we have questions as to their credentials, as to their ability to provide what they've been required to provide, and why wouldn't we have questions that other Members of Congress would like answered as well. So really, it is the function of this committee to provide that oversight function, and I for one, Mr. Chairman, am grateful that those letters did go out, and certainly in support of the fact that we are trying to simply get the information that the administration for whatever reason does not want to give to the Congress.

Mr. PALLONE. Would the gentleman yield?

Mr. BURGESS. No, I will not. I have got some things to say. If I have time at the end, you may be welcome to it.

We have 3 weeks, 3 short weeks, 21 days, ready or not, October 1st, the health exchanges including the Federally Facilitated Marketplaces run by the Obama administration will open while the White House, Treasury and Health and Human Services continue to report that everything will be ready, everything is fine. We have only seen missed deadlines, delays and really an overall lack of information.

The most significant function for the operation of the exchanges as it turns out is not in the hands of the administration but has been outsourced. It has been contracted to organizations, and many of those witnesses are before us today and we appreciate your participation. The Federal hub will be the centerpiece of the exchanges, coordinating data from other five Federal agencies, millions of individuals, hundreds of insurance carriers and in all 50 States. Not surprisingly, the complexity involving coordinating the exchange has led several States, notably Oregon and California, to indicate that they will likely need to delay access to their online marketplaces. States have begun making contingency plans but the administration continues the same refrain: we will be ready.

Instead of communicating with Congress, the administration has decided just to open the door to eligibility errors and fraud and inappropriate payments by removing verification requirements and allowing consumers to simply use self-attestation. Because the agency is silent, because Health and Human Services will not speak on this, we must go to the source—the contractors who have to live in a world. Your world is comprised of contingencies and possibilities, deadlines and an ever-shifting environment. You know you deal with contingencies all the time.

The President's health care law continues to create more chaos, more uncertainty for Americans. Since the administration won't admit the enormity and complexity of the task they have undertaken, we have our witnesses today, and I hope that we will hear from them, from these people who are actually preparing the systems will be able to tell us the real status of the implementation of the Affordable Care Act.

Let me then yield to the chairman of the Oversight Subcommittee, Mr. Murphy.

OPENING STATEMENT OF HON. TIM MURPHY, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. MURPHY. Thank you very much, Doctor.

You know, it is kind of a preposterous thing the gentleman from New Jersey says, as if the Oversight and Investigations Committee has no business having oversight and investigation.

When we had multiple hearings, we heard from people from the administration that everything was fine for business rollout, only to say well, it wasn't ready and they had to slip in little unknown statements they were going to delay it for a year. They said the exchanges actually were supposed to start their training August 1. They didn't even start hiring until lately. Also, we saw the admin-

istration had to waive some of the rules for caps on copayments and deductible. Labor has to take out full-page expensive ads to get the attention of CMS, who wasn't talking to them. Treasury came before us and said they haven't heard any concerns from individuals. And by law and by design, the way the bill was written, the navigators have to be people who are inexperienced with selling insurance by law.

So we have every right to ask questions on behalf of the American people. That is what oversight is supposed to do. Quite frankly, I am puzzled by people who are trying to say that we are trying to delay this. No, I think the delays have been there because the administration, even though they have had a few years to do this, simply is not ready to bring this forward upon the American people. So we will continue to ask questions about how this program is going. If everything is fine, people will have nothing to be afraid of, but quite frankly, I think we have a lot to be afraid of, and that is why things aren't fine. Thank you.

Mr. PITTS. The Chair thanks the gentleman and now recognizes the ranking member of the full committee, Mr. Waxman, 5 minutes for an opening statement.

OPENING STATEMENT OF HON. HENRY A. WAXMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. WAXMAN. Thank you, Mr. Chairman.

It is an interesting example today of the Republicans ignoring their own oversight findings. They started this investigation in August. They did interviews. They got documents. They learned that the contractors were doing everything right and they were on target to meet the deadlines. Rather than talk about that, they are attacking the law which they have attacked from the very beginning. They want to portray health reform as an impossibly complex, inevitably doomed enterprise, and that is what we are hearing again today.

We have four private-sector contractors who are actually in the trenches with the administration implementing this law. Today's witnesses are not political. They will tell us that the administration is making steady, step-by-step progress. Their testimony will deflate the overheated Republican rhetoric of a coming health care apocalypse.

Last month, the committee launched an extensive investigation into these contractors. They peppered them with questions and they scoured the documents for signs of impropriety. What they found can be summarized in one word: nothing. The facts don't measure up to their doom-and-gloom talk. That is why they have said virtually nothing about their own investigation.

To fill this void, the Democratic staff is releasing a supplemental memo outlining what we learned from the oversight investigation. The key findings are as follows. One, the contractors and CMS have numerous systems in place to secure the privacy of consumer information; two, the contractors are on track to complete their remaining tasks by October 1; three, CMS's management of the program is sound; and four, these contractors are creating thousands of jobs throughout the country.

In my view, the timing of the committee's investigation is under suspicion. Burdensome demands came during the most critical phase of these contractors' work. The committee is taking the same approach in its investigation of the health care navigators. But having launched the investigation and received extensive responses, we should not ignore what we have learned. That is why I ask unanimous consent that this memorandum that I referred to be made part of the record.

Mr. PITTS. Without objection, so ordered.

[The information follows:]

FRED UPTON, MICHIGAN
CHAIRMAN

HENRY A. WAXMAN, CALIFORNIA
RANKING MEMBER

ONE HUNDRED THIRTEENTH CONGRESS
Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
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MEMORANDUM

September 10, 2013

To: Committee on Energy and Commerce Democratic Members and Staff

Fr: Committee on Energy and Commerce Democratic Staff

Re: Committee Investigation of Affordable Care Act Contractors

I. EXECUTIVE SUMMARY

On August 6, 2013, Chairman Fred Upton and other Republican members of the Committee on Energy and Commerce issued a letter requesting briefings and documents from six contractors involved in implementing the Affordable Care Act (ACA): Booz Allen, CGI, eHealthInsurance, Equifax Workforce Solutions, Serco, and QSSI.[1] According to the letters, the interviews and document requests were conducted "in order to better understand the work you have contracted to do, and the status of that work in light of the scheduled open enrollment period beginning October 1, 2013."[2]

All six of these contractors were interviewed by and provided documents to the Committee staff, and four of them will be testifying before the Subcommittee on Health today. This memorandum summarizes the information that the Committee received during this investigation.

During the investigation, the contractors told the Committee that they (1) have numerous measures in place to secure the privacy of consumers' personal financial and health information; (2) are on track to have any remaining tasks completed for October 1, the opening date of the law's health insurance marketplaces; (3) are satisfied with the management of their contracts by the Centers for Medicare and Medicaid Services (CMS); and (4) are creating jobs across the country through their work to implement this law.

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[1] Letters to Booz Allen, CGI, eHealthInsurance, Equifax Workforce Solutions, Serco, and QSSI, from Reps. Upton, Barton, Pitts, Blackburn, and Burgess (Aug. 6, 2013).

[2] *Id.*

II. ACA CONTRACTORS ARE PROTECTING CONSUMERS' PERSONAL DATA

Safeguarding consumers' personal information is a critical component of the implementation of the ACA. The contractors contacted by the Committee appear to be taking this responsibility seriously.

The contractors told the Committee they will comply with applicable federal privacy laws, including the Health Insurance Portability and Accountability Act (HIPAA) and the Federal Information Security Management Act. They also said they will have to meet the Minimum Acceptable Risk Standards for Exchanges (MARS-E) and other security standards, as specified in their contracts with CMS.[3]

Several of the contractors described additional steps they are taking. At Serco, which has the contract to process paper applications submitted to federally facilitated marketplaces (FFM), employees will be subject to background checks, receive training on handling personal information, and be blocked from accessing the Internet and using mobile devices at their desks while processing applications, in addition to other security measures.[4] Additionally, the three-page applications that these employees process will not contain any personal health information, unlike the lengthy forms that many consumers must fill out to obtain private health insurance today.

CGI Federal, the contractor designing the Healthcare.gov website, said it has incorporated specific CMS-approved security measures into its software design. It also stated that the company is using third-party experts to independently test system security.[5] eHealthInsurance informed the Committee that its contract was updated to improve privacy and security provisions in July 2013.[6]

Some of the concerns about security in the ACA's health insurance marketplaces have focused on the data hub that will connect with the Social Security Administration, Internal Revenue Service, other government agencies, and select outside contractors to verify information for the FFM. QSSI, the main contractor building this data hub, informed the Committee that the hub would not store any personal data, instead allowing information to pass only from one entity to another.[7] Additionally, Michael Finkel, the Executive Vice President for Program Delivery at

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[3] Briefing by CGI to House Committee on Energy and Commerce Staff (Aug. 19, 2013); Briefing by eHealthInsurance to House Committee on Energy and Commerce Staff (Aug. 14, 2013); Briefing by Equifax Workforce Solutions to House Committee on Energy and Commerce Committee Staff (Aug. 14, 2013); Briefing by Serco to House Committee on Energy and Commerce Staff (Aug. 22, 2013).

[4] Briefing by Serco to House Committee on Energy and Commerce Staff (Sept. 3, 2013).

[5] Briefing by CGI to House Committee on Energy and Commerce Staff (Aug. 19, 2013).

[6] Briefing by eHealthInsurance to House Committee on Energy and Commerce Staff (Aug. 14, 2013).

[7] Briefing by QSSI to House Committee on Energy and Commerce Staff (Sept. 4, 2013).

QSSI, told the Committee that QSSI had received the preliminary results of an outside security assessment on August 30, 2013.[8] This review found no major security issues with the data hub.[9] Mr. Finkel also said that CMS will put in place on-going security monitoring systems once the data hub is operational on October 1.[10]

Several of the contractors responsible for obtaining and using personal information under the ACA also told the Committee that they already have extensive experience collecting and protecting such information. For example, eHealthInsurance has an existing marketplace for insurance that collects such information, while Equifax maintains detailed credit profiles on millions of Americans and collects and uses payroll information to determine eligibility for Medicaid and S-CHIP.[11]

III. ACA CONTRACTORS INFORMED COMMITTEE STAFF THAT TASKS ARE BEING COMPLETED IN A TIMELY FASHION

Republican leaders have raised concerns about the readiness of CMS and its contractors for the October 1 rollout of the Affordable Care Act marketplaces. However, information provided to the Committee by the contractors that were interviewed indicates that key portions of the marketplace systems are being completed in a timely fashion.

CGI indicated that it was on schedule for designing and developing software for the Healthcare.gov website, had met all major deadlines, and was conducting appropriate testing internally and with outside parties.[12]

Similarly eHealthInsurance reported that it was on schedule to set up its website so that consumers in states using the FFM could compare and buy approved health insurance plans.[13]

Equifax reported that it had already completed key "end to end" tests of their income verification systems; Serco reported that it had hit or beaten all key deadlines.[14]

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[8] *Id.*

[9] *Id.*

[10] *Id.*

[11] Briefing by eHealthInsurance to House Committee on Energy and Commerce Staff (Aug. 14, 2013); Briefing by Equifax Workforce Solutions to House Committee on Energy and Commerce Committee Staff (Aug. 14, 2013).

[12] Briefing by CGI to House Committee on Energy and Commerce Staff (Aug. 19, 2013).

[13] Briefing by eHealthInsurance to House Committee on Energy and Commerce Staff (Aug. 14, 2013).

[14] Briefing by Equifax Workforce Solutions to House Committee on Energy and Commerce Committee Staff (Aug. 14, 2013); Briefing by Serco to House Committee on Energy and Commerce Staff (Aug. 22, 2013).

IV. ACA CONTRACTORS ARE SATISFIED WITH CMS'S CONTRACT MANAGEMENT

Every contractor asked by the Committee staff indicated confidence and satisfaction with CMS's contract management process. Booz Allen told the Committee that it had a "very pleasant experience" with CMS and that the agency was responsive to its questions.[15] John Lau, the Program Director for Serco, also described CMS's management as "perfectly competent."[16] Richard Martin, Vice President of Healthcare for CGI, told the Committee that CMS was "passionate about getting this right – not just done, but right."[17]

V. ACA CONTRACTORS ARE CREATING JOBS

Documents provided to the Committee and interviews with ACA contractors indicate that ACA contracts will create thousands of jobs. To process paper applications under the ACA, Serco will employ 1,954 individuals in the company's program management office and at production centers in Kentucky, Arkansas, and Missouri.[18] CGI has approximately 300 employees and subcontractor personnel working on its contract to design the software for the FFM.[19] QSSI has employed approximately 160 full-time equivalent employees as part of its contract to build the data hub; these are high-skill jobs including website developers, business analysts, managers, and other similar positions.[20] Booz Allen employed 42 individuals to work on three of the company's ACA-related contracts.[21]

VI. CONCLUSION

Republican leaders have expressed concerns about many aspects of the Affordable Care Act, including CMS and contractor preparedness for the October 1 opening of the health care marketplaces and the ability of CMS and its contractors to adequately protect consumers' private financial and health information. In order to investigate these and other concerns, the Committee requested voluminous information and briefings from key CMS contractors. The documents provided to the Committee by these contractors and the briefings that they provided to the Committee did not support the Republicans' concerns. The contractors reported that they are

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[15] Briefing by Booz Allen to House Committee on Energy and Commerce Staff (Aug. 23, 2013).

[16] Briefing by Serco to House Committee on Energy and Commerce Staff (Aug. 22, 2013).

[17] Briefing by CGI to House Committee on Energy and Commerce Staff (Aug. 19, 2013).

[18] Briefing by Serco to House Committee on Energy and Commerce Staff (Aug. 22, 2013).

[19] E-mail from CGI to Democratic Committee Staff (Sept. 9, 2013).

[20] Briefing by QSSI to House Committee on Energy and Commerce Staff (Sept. 4, 2013).

[21] Briefing by Booz Allen to House Committee on Energy and Commerce Staff (Aug. 23, 2013).

completing tasks in a timely fashion, that they are taking numerous steps to ensure that consumer privacy is protected, and that CMS is effectively managing these contracts.

Mr. WAXMAN. I want to make just a couple of points before I yield. Inevitably, there will be some glitches and hiccups in implementation of this law, and I expect every time they find any hiccup, the Republicans here in Washington will make a hue and cry about it. I believe we should keep our eyes on the bigger picture: problems that arise will be fixed, and we are on a steady path to offering every American quality, affordable health coverage and making our health care system more sensible, efficient and fair.

It is also important to remember that most of the implementation problems are likely to come from Republican State leaders who are openly obstructing the goals of the law. Antoinette Kraus of Pennsylvania Health Action has firsthand knowledge of what this senseless intransigence means to the hardworking Americans caught in the middle.

I am now going to yield 2 minutes to my colleague and friend, Mr. Butterfield.

OPENING STATEMENT OF HON. G.K. BUTTERFIELD, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NORTH CAROLINA

Mr. BUTTERFIELD. Thank you very much, Mr. Waxman, for yielding time. Mr. Waxman, I want to associate myself completely with your statement and that of Mr. Pallone.

Mr. Chairman, I am absolutely outraged that the chairmen of the full committee and Subcommittees on Health and Oversight as well as other Republican members of this committee sent a 3-page investigatory letter to 51 grant recipients demanding that they answer questions giving them only 2 weeks to provide detailed descriptions of the anticipated scope of wrong, among other very specific questions, to provide all documentation and communications related to their grant. My question to my staff and to you, my friends: how can 15 members of this committee simply get together and send a letter without committee action? Wasn't the vast majority of the information being sought by Chairmen Upton and Pitts and Murphy included in the navigator's application to CMS?

These grant recipients only received word they were selected to receive the grant on August 15th. Might I remind my colleagues that the marketplace goes live on October 1st, less than one month away? The majority is forcing these recipients away from their important work of getting ready on October 1st and diverting their limited resources to entertain its fishing expedition. Yes, that is what I am calling it, a fishing expedition, that will surely come back empty-handed. There is no evidence of any kind that any navigator grantees have misappropriated or misused grant funds in any way whatsoever. This is a gross misuse of the company's investigative authority and just another way this majority is attempting to derail the Affordable Care Act.

I am outraged by your actions. I want you to tell me when these letters came back what you have discovered. I believe you will come back empty-handed.

Thank you. I yield back to Mr. Waxman.

Mr. WAXMAN. I yield back my time.

Mr. PITTS. The Chair thanks the gentleman.

That concludes the——

Mr. BUTTERFIELD. May I ask unanimous consent to include in the record a copy of Mr. Waxman's letter dated August 30th? Mr. Waxman's letter to Mr. Upton dated August 30th, may I include this in the record?

Mr. PITTS. Without objection, so ordered.

Mr. BUTTERFIELD. Thank you, Mr. Chairman.

[The information follows:]

FRED UPTON, MICHIGAN
CHAIRMAN

HENRY A. WAXMAN, CALIFORNIA
RANKING MEMBER

ONE HUNDRED THIRTEENTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON ENERGY AND COMMERCE

2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515–6115
Majority (202) 225–2927
Minority (202) 225–3641

August 30, 2013

The Honorable Fred Upton
Chairman
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Upton:

I am writing regarding letters you sent yesterday to 51 groups that received grants to serve as Navigators to help the uninsured sign up for benefits under the new health care law. There is no legitimate predicate for these letters and no evidence of any malfeasance from any of the organizations. It is an abuse of your oversight authority to launch groundless investigations into civic organizations that are trying to make health reform a success.

You have opened investigations of every group that received Navigator grants in 11 states. You have asked these organizations to respond to extensive and time-consuming requests for information. You are demanding that the groups provide "all documents and communications related to your Navigator grant." And you are requesting that they provide briefings and answer a long list of questions on organization budgets and employee training, education, monitoring, review, and supervision.

The timing of these letters is particularly suspect. You are insisting on voluminous document productions by September 13, just when these groups need to be focused on their mission of helping uninsured Americans enroll for coverage. Indeed, it appears that these requests may have been sent solely to divert the resources of small, local community groups, just as they are needed to help with the new health care law. Certainly, there is no explanation of what legitimate purpose is served by the Committee making such invasive requests of small, non-partisan, and community-based organizations like Arizona's Campesinos Sin Fronteras, Inc. (recipient of a $71,386 grant), Louisiana's Martin Luther King Health Center, Inc. (recipient of an $81,086 grant), and New Jersey's Food Bank of Monmouth and Ocean Counties, Inc. (recipient of a $137,217 grant).

Unfortunately, these are not the only investigations you are conducting that are draining resources from entities doing important and time-sensitive work to implement the health care law and deterring others from working with these groups or the Administration. In May, you sent letters to HHS, Enroll America, and 15 other entities seeking detailed information and

documents regarding their work to inform the public about new benefits. Earlier this month, with no public notice, you sent letters to six HHS Affordable Care Act contractors, seeking briefings and documents from these entities. These investigations appear to be little more than fishing expeditions.

As you know, I am a strong believer in the congressional oversight process. Done right, oversight can prevent abuses, ensure laws are implemented correctly, and save taxpayer money. But your investigations of the implementation of the Affordable Care Act do not appear to be designed to achieve these goals. Their impact is not to enlighten the Committee, but to intimidate and divert resources from the effort to implement the law.

I urge you to reconsider these misguided investigations.

Sincerely,

Henry A. Waxman
Ranking Minority Member
House Energy and Commerce Committee

Mr. PITTS. All right. We have one panel, seven witnesses today. First, we have Mr. Brett Graham, Partner and Director of exchange Programs, Leavitt Partners. We have Ms. Antoinette Kraus, Director of Pennsylvania Health Access Network; Mr. Edward Lenz, Senior Counsel, American Staffing Association, testifying on behalf of the Employers for Flexibility in Health Care Coalition; Ms. Cheryl Campbell, Senior Vice President of CGI Federal; Mr. John Lau, Program Director of Serco; Ms. Lynn Spellecy, Corporate Counsel, Equifax Workforce Solutions; and Mr. Michael Finkel, Executive Vice President of Program Delivery, QSSI.

Thank you for coming today. You have 5 minutes to summary your testimony. Your written testimony will be placed in the record.

At this point I will recognize Mr. Graham for 5 minutes for his summary.

STATEMENTS OF W. BRETT GRAHAM, MANAGING PARTNER, LEAVITT PARTNERS; ANTOINETTE KRAUS, EXECUTIVE DIRECTOR, PENNSYLVANIA HEALTH ACCESS NETWORK; EDWARD A. LENZ, SENIOR COUNSEL, AMERICAN STAFFING ASSOCIATION, ON BEHALF OF THE EMPLOYERS FOR FLEXIBILITY IN HEALTH CARE COALITION; CHERYL CAMPBELL, SENIOR VICE PRESIDENT, CGI FEDERAL, INC.; JOHN LAU, PROGRAM DIRECTOR, SERCO, INC.; LYNN SPELLECY, CORPORATE COUNSEL, EQUIFAX WORKFORCE SOLUTIONS; AND MICHAEL FINKEL, EXECUTIVE VICE PRESIDENT FOR PROGRAM DELIVERY, QUALITY SOFTWARE SERVICES, INC.

STATEMENT OF W. BRETT GRAHAM

Mr. GRAHAM. Good morning, Chairman Pitts, members of the subcommittee. Thank you for the opportunity to testify today about the ACA as well as State readiness around State health insurance exchanges. I am the Managing Director of Leavitt Partners Center for Health Care Intelligence around health insurance exchanges. We advise clients on the health insurance exchange landscape. Several of my colleagues have been very involved in both the design and development of insurance exchanges both in the private sector as well as publicly. Leavitt Partners has also been very involved in advising clients on implementation and being ready for that implementation.

First, let me say that it has been very impressive all the work that States have done to be ready for the open enrollment season, which is just 3 weeks away. What they have done has been impressive. That being said, today where we stand, there is not a single State that is completely ready for open enrollment 3 weeks away. In an ideal world, States would be well into their outreach and education campaigns with all of the exchange operations and functionality fully tested and completed. In the current situation, however, uncertainty and doubt still surrounds how functional these systems will be on October 1st.

The bottom line is that while Leavitt Partners believes that a very baseline functionality of State-based exchanges will be up and running on October 1st, it can be expected that most, if not all, exchanges will experience a rocky enrollment period as they work to

overcome both known and unanticipated challenges that arise. Today I would like to focus on four critical challenges that States are facing as they work towards implementation in the short term.

The first challenge States are facing is the complexity of an exchange's architecture itself. The establishment of these health insurance exchanges is one of the most aggressive and complex IT projects the Federal Government has ever undertaken, certainly in the health care space. Coupling the complexity of these challenges with the informational delays has clearly strained States' capacity to complete their exchanges both on time and as originally scoped. In fact, as States are making final preparations for open enrollment, many have had to de-scope the capabilities they planned in order to be up and running on October 1st. While this is the right thing to do from a management perspective, it will certainly have an impact on consumers as they go to the exchanges.

The second challenge that is facing States is data verification and integration with the Federal Data Services Hub. Our surveillance of the exchange landscape shows that while some States have completed testing, others are working through the final testing phases despite still being in the building stage of development. This is problematic. Several States have expressed to us concern about using the Federal Data Services hub and where possible are planning to use their own data resources for verification.

The third challenge is privacy and security. In addition to integration challenges, there are also serious concerns regarding security of the hub's data. The Office of the Inspector General recently stated that any additional delays in completing the security authorization package would result in an incomplete assessment of system risks and needed security controls.

The fourth challenge should not be underestimated. It is achieving optimal enrollment. Because of the compressed timeline, States have not been able to devote the necessary resources to outreach and education. Tens of thousands of consumers, if not hundreds of thousands of consumers, will come to these exchanges with little or no prior exposure to health insurance coverage. They will need comprehensive assistance to be able to make these very important decisions. A lack of information and a high potential for misinformation will increase the likelihood for error, increase the possibility consumers will select suboptimal products and possibly result in a delayed enrollment.

In conclusion, Mr. Chairman, let me restate that although Leavitt Partners believes that baseline functionality of State-based exchanges will be up and running in 3 weeks, it can be expected that due to the challenges associated with, number one, the complexity of the IT exchange infrastructure and architecture, number two, the Federal Data Services Hub, three, privacy and security, and finally, four, the necessary arrangements and outreach associated with achieving optimal enrollment. Very few States will have a comprehensive working exchange on October 1st. This will result in a rocky enrollment period. Thank you.

[The prepared statement of Mr. Graham follows:]

Testimony of W. Brett Graham, Partner & Managing Director, Leavitt Partners

Hearing on PPACA Pulse Check: Part 2
United States House of Representatives Committee on Energy and Commerce
September 10, 2013

Based on our surveillance and understanding of the health insurance exchange landscape, Leavitt Partners believes that while baseline functionality of state-based exchanges will be up and running on October 1, it can be expected that most, if not all, exchanges will experience a rocky enrollment period as they work to overcome both known and unknown operational challenges. This statement focuses on four critical challenges that states are currently facing and how these challenges will impede effective exchange operations in the short term.

The first challenge states are facing is the complexity of an exchange's architecture itself. The establishment of health insurance exchanges is one of the most complex IT projects ever initiated by the federal government. Coupling the complexity of the project with informational delays has clearly strained states' capacities to complete their exchanges on time and as originally scoped. In fact, as states are making final preparations for open enrollment, many have had to de-scope the capabilities they planned to have available to consumers during the initial weeks of operation. While such downgrading is necessary to achieve basic functionality by October 1, the changes will impact the ability of both consumers and stakeholders to effectively access the system.

The second challenge is data verification and integration with the federal data services hub. Our surveillance of the exchange landscape shows that while some states have completed basic testing with the hub, others are working through the final testing phases despite still being in the building stages of development. Several states have expressed concern to us about using the federal data services hub and, where possible, are planning on using their own data sources for verification.

The third challenge is privacy and security. In addition to integration challenges, there are also serious concerns regarding the security of the hub's data. The Office of Inspector General recently stated that any additional delays in completing the security authorization package would result in an incomplete assessment of system risks and needed security controls.

The fourth challenge is achieving optimal enrollment. Because of compressed timelines, states have not been able to devote necessary resources to outreach and education. Tens of thousands of consumers, who have had no prior exposure to health insurance coverage, will need comprehensive assistance navigating the system. A lack of information, and a high potential for misinformation, will increase the likelihood for error, increase the possibility that consumers will select sub-optimal products, or delay enrollment.

Until these challenges are properly addressed, they could reduce usability of the system and impact the user-experience. More importantly, these challenges could diminish exchanges' success in increasing consumer choice and access to appropriate health insurance coverage.

Testimony of W. Brett Graham

Partner & Managing Director, Center for Exchange Intelligence
Leavitt Partners

hearing on

PPACA Pulse Check: Part 2

before the

United States House of Representatives Committee on Energy and Commerce

Subcommittee on Health

September 10, 2013

Testimony of W. Brett Graham
Partner & Managing Director, Center for Exchange Intelligence
Leavitt Partners

Good morning Chairman Pitts, Ranking Member Pallone, and members of the Subcommittee. Thank you for the opportunity to testify today on the ACA and health insurance exchange readiness, specifically the challenges that states are facing in exchange implementation. I am the Managing Director of Leavitt Partners Center for Health Insurance Exchange Intelligence, which advises clients on the rapidly evolving public and private exchange environment. In addition to tracking state and national exchange progress, Leavitt Partners has been involved in the design and development of exchanges in a number of states and provides guidance on exchange implementation to both public and private entities.

First of all, I'd like to acknowledge the amount of work that has been completed by states is impressive. It is important to note though, that at this moment, not a single state appears to be completely ready for open enrollment, which begins a short three weeks from today on October 1. In an ideal situation, the fourteen states and the District of Columbia that elected to operate state-based exchanges would be well into their outreach and education campaigns, with all exchange operations and functionality thoroughly tested and completed.

In the current situation, however, uncertainty and doubt remains as to how functional systems will be on October 1. Although most of these states have awarded consumer assistance grants and have announced which insurance carriers will be participating on their exchange, many of the states have only recently begun to test their systems with federal eligibility verification and premium administration systems.

The bottom line is that while Leavitt Partners believes that baseline functionality of state-based exchanges will be up and running on October 1, it can be expected that most, if not all, exchanges will experience a rocky enrollment period as they work to overcome both known and unknown operational challenges.

My remarks today will focus on four critical challenges that states are currently facing, how these challenges will impede effective exchange operations in the short term, and what lessons can be learned from Medicare Part D. Challenges I will discuss include:

- The complexity of an exchange's architecture
- Data verification and the federal data services hub
- Privacy and security
- Achieving optimal enrollment

Until properly addressed, these challenges could reduce usability of the system, impact the user-experience, and diminish the success of exchanges in increasing consumer choice and access to appropriate health insurance coverage.

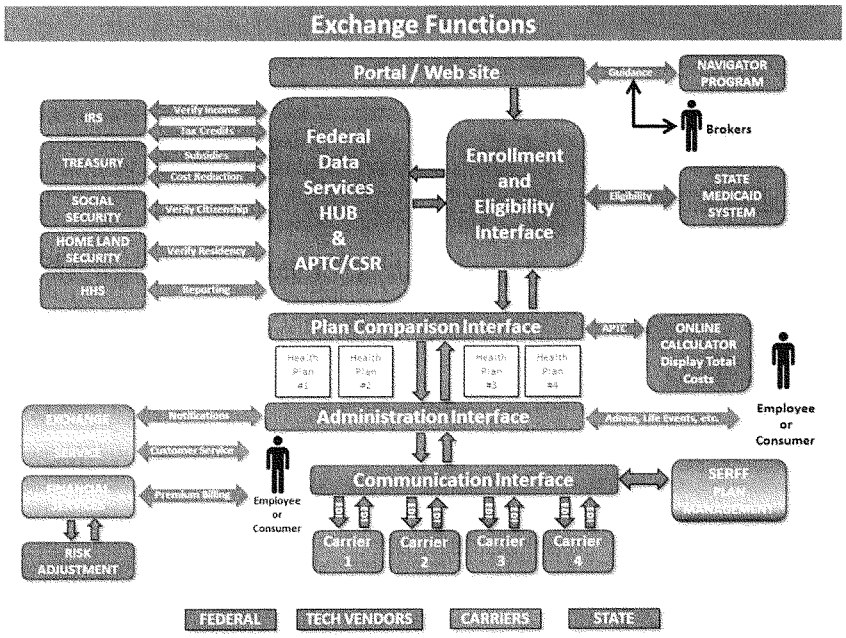
The complexity of an exchange's architecture

The establishment of health insurance exchanges is one of the most complex IT projects ever initiated by the federal government (see figure 1). Coupling the complexity of the project with a tight implementation timeline and informational delays has clearly strained states' capacities to complete their exchanges on time and as originally scoped.

In fact, as states are making final preparations for open enrollment, many have had to prioritize the capabilities that they planned to have available to consumers during the initial

weeks of operation, knowing that there is insufficient time to complete everything. Some of the de-scoping solutions that we have witnessed include: 1) a limited release for initial website access;[1] 2) manual processing for complex issues;[2] 3) removing online chat functions for consumer assistance;[3] and 4) limited accommodations for foreign languages.[4] While such de-scoping is necessary to achieve basic functionality by October 1, the changes will impact the ability of both consumers and stakeholders to effectively access the system.

Figure 1



Tight implementation timelines and informational delays have also left states with inadequate time to test their systems before exchanges open for enrollment, which means the functional capabilities of exchanges remain largely unproven. For example, while most state-based exchanges are leveraging private-sector technologies for their exchange architecture and functionality, integrating these technologies with existing Medicaid and other state systems is proving to be a significant challenge. Some states are currently in the process of implementing a comprehensive CMS 90/10 Medicaid modernization project, which means they have to test and integrate two new systems, while other states are dealing with the connectivity and integration challenges associated with an older system. Problems with this integration will slow the enrollment process, delay eligibility determinations, and increase the potential for errors, fraud, and abuse.

System testing between exchanges and participating stakeholders has also been slow to occur. Many of our clients are indicating that a lack of adequate testing of technical integrations between exchanges and stakeholder platforms is an area of major concern. This, and a lack of clarity on rules and requirements between states and stakeholders, is forcing clients to develop contingency plans for all possible scenarios.

Data verification and the federal data services hub

States are also facing challenges integrating with the federal data services hub, which is used to verify applicant information for income, citizenship, immigration status, and access to minimum essential coverage. The hub will provide one connection to common federal data sources such as the IRS, Social Security, and Homeland Security. Our surveillance of the

exchange landscape shows that while some states have completed basic testing with the hub, others are working through the final testing phases despite still being in the building stages of development. Several states have expressed concern to us about using the federal data services hub and, where possible, are planning on using their own data sources for verification. Some states mentioned they would like HHS to provide a waiver from hub use for the first year as technical issues are fixed and integration processes are refined.

As such, it is questionable as to whether states have had an adequate amount of time to complete the testing needed for their systems to efficiently operate on October 1. Inaccurate or untimely information will reduce usability of the system and impact the user-experience.

Privacy and security

In addition to integration challenges, there are also concerns regarding the security of the hub's data. The Office of Inspector General stated in a recent report, "If there are additional delays in completing the security authorization package, the CMS CIO may not have a full assessment of system risks and security controls needed for the security authorization decision by the initial opening enrollment period."[5]

Achieving optimal enrollment

Because states have been so focused on completing the technical infrastructure of exchanges in a compressed timeline, they have not been able to devote necessary resources to outreach and education. While several states are in the process of developing comprehensive outreach campaigns, recent surveys show that many Americans still don't understand the law,

exchanges, or what options are available to them in 2014.[6] It is expected that most states will have a difficult time engaging eligible populations and raising awareness of available subsidies, increased Medicaid eligibility, and other ACA provisions.

It is also expected that consumers will face challenges in understanding how to use the exchange system. Tens of thousands of individuals who will be utilizing exchanges will have had no prior exposure to health insurance or coverage options. These are very complex products and many individuals will need comprehensive assistance throughout the entire enrollment process. In many cases, however, Navigators are still being selected and trained, and their ability to penetrate a community and facilitate enrollment remains largely untested. Application Programming Interfaces will also not be available in most state-based exchanges, limiting the role web-based brokers will be able to play in optimizing access and enrollment.

Many of our clients are indicating that there is little clarity on when, where, and how consumers will be educated on exchange processes and receive enrollment assistance. A lack of information, and a high potential for misinformation, will increase the likelihood for error, increase the possibility that consumers will select sub-optimal products, or delay enrollment.

Lessons learned from Medicare Part D

It is important to note that an IT project of this size and scope is going to have issues regardless of the amount of time available for implementation. Technical issues are inherent with any IT project big or small. But when time is significantly limited, the probability of experiencing larger issues grows. Our company Founder and CEO, former Secretary of Health and Human Services Michael Leavitt, experienced a similar situation with the roll-out of

Medicare Part D. Technical glitches caused delays, insufficient testing led to system errors, and detailed outreach campaigns were needed to educate seniors about the new program.

Even with these challenges, the Department of Health and Human Services was arguably more prepared for implementing the smaller-scale Part D program in 2006 than the current administration is for implementing the much larger-scale ACA today. And with open enrollment starting in only 21 days, serious questions remain as to how effective exchanges will be.

Conclusion

In conclusion Mr. Chairman, although Leavitt Partners believes that baseline functionality of state-based exchanges will be up and running in three weeks, it can be expected that due to the challenges outlined in this statement, very few states will have a comprehensive working exchange on October 1. It is also expected that exchanges will experience a problematic enrollment period as states and the federal government work to overcome both known and unknown challenges.

Unfortunately, this means that most consumers will experience frustration as they complete the exchange enrollment and eligibility process. There will be technical issues that will impede a consumer's ability to enroll in a seamless and timely manner. There will be challenges to consumers understanding the system and getting necessary assistance. Until properly addressed, these challenges could reduce usability of the system and impact the user-experience. More importantly, these challenges could diminish exchanges' success in increasing consumer choice and access to appropriate health insurance coverage.

[1] Cover Oregon (2013). August 8, 2013 Board Documents. Available from http://www.coveroregon.com/wp-content/uploads/2013/08/8_8_13_board_documents.pdf.

[2] Access Health CT (June 26, 2013). Board of Directors Meeting Masterdeck. Available from http://www.ct.gov/hix/lib/hix/062613_Board_of_Directors_Meeting_Master_Deck_II.pdf.

[3] Washington Health Benefit Exchange (July 24, 2013). Operational Readiness Presentation. Available from http://www.wahbexchange.org/files/8313/7427/3849/HBE_EB_130724_Operational_Readiness_Presentation.pdf.

[4] S. Kliff & S. Somashekhar (August 24, 2013). States scramble to get health-care law's insurance marketplaces up and running. *Washington Post*. Available from http://articles.washingtonpost.com/.

[5] Department of Health and Human Services (August 2013), Office of Inspector General, Observations Noted During the OIG Review of CMS's Implementation of the Health Insurance Exchange—Data Services Hub. Available from http://oig.hhs.gov/oas/reports/region1/181330070.pdf.

[6] Kaiser Family Foundation Health Tracking Poll (conducted April 15-20, 2013). Available from http://kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-april-2013/.

Mr. PITTS. The Chair thanks the gentleman and recognizes Ms. Kraus 5 minutes for an opening statement.

STATEMENT OF ANTOINETTE KRAUS

Ms. KRAUS. Mr. Chairman and members of the committee, thank you for the opportunity to speak on the implementation of the Affordable Care Act in Pennsylvania.

I am the Director of the Pennsylvania Health Access Network. We are a statewide coalition representing over 60 organizations and 1 million Pennsylvanian consumers. Some of our partners include local health centers, physician groups, churches, retiree associations and community groups. Our mission is to make sure every Pennsylvanian has access to quality, affordable health care. In my work, I meet people from all walks of life: working moms and dads, retirees, young adults, laid-off workers and small business owners. They come from different backgrounds and live in different places, but their fears and anxieties over health care are the same: How do I find coverage? Can I afford to keep it? What do I do now that I have been denied because of a preexisting condition? Thankfully, we have the opportunity to address these fears and relieve the anxiety that so many of our neighbors, and your constituents, live with daily. We can do that by moving forward to fully implement the Affordable Care Act in Pennsylvania.

We can often get caught up in talking about the mechanics of implementing this law, but we should never lose sight of what this means for working families. Already in Pennsylvania, the Affordable Care Act has brought 177,000 children with preexisting conditions freedom from no longer being denied coverage; a boost for the bottom line of 160,000 small businesses, who are eligible for tax credits; stability for 91,000 young adults who have been able to stay covered on their parents' insurance; and soon in just 21 days, all Pennsylvanians will enjoy the freedom and feel the security that comes from knowing that affordable health care is within reach no matter where you work, how much you earn or if you have been sick in the past.

I want to tell you about two of these folks. Karen and Gary Capanello, they live in Waterford, which is a small town in Erie County. Karen and Gary own their own small business, a commercial cleaning company. For the last 2 years, Karen and Gary have been uninsured. The couple makes too much to qualify for Medicaid but nowhere near enough to afford the prices charged to people with preexisting conditions. Gary has heart problems and Karen has a torn tendon in her foot. Karen worries every day about Gary and all the things he is forced to put off. She is scared that if the couple continues to delay treatment, they might not be around to see their youngest son Tony graduate from high school. That is a fear no mom should have, especially one who works as hard as Karen. Thankfully, Karen and Gary won't have to live with fear much longer. On October 1st, they will be able to start looking for coverage in the Health Insurance Marketplace. They will choose from the same plans as all of you. They will have quality options that will cover the services Karen needs to fix her foot and the preventative care Gary needs to keep his heart healthy.

We are less than a month away from the day the door opens to 1.2 million Pennsylvanians who are sitting where Karen and Gary are today on the outside of our health care system looking it, hoping, praying, waiting to get in and to get the care they need. The Affordable Care Act opened that door. Political posturing, partisanship and delays threaten to keep it slammed shut.

Unfortunately, in Pennsylvania, we have seen our Governor, Tom Corbett, work to block 1.2 million uninsured Pennsylvanians from feeling the full benefit of the Affordable Care Act. While the new law gave each State the flexibility and tools to create a marketplace that fosters real competition, offers family and small businesses the best quality choices and ensures rates are reasonable, Pennsylvania, like several other States, chose to reject this opportunity and relinquish its responsibilities to the Federal Government. Instead of working in the best interest of our Commonwealth, Pennsylvania officials have been slow to implement the Affordable Care Act, delaying and defaulting on key provisions of the law.

I want to be very clear about what it is at stake for Pennsylvania and its decision over Medicaid expansion. The choice Governor Corbett and State House leaders make will determine whether or not our Commonwealth brings in $43 billion in new Federal funding over the next decade, whether or not we create up to 40,000 family-sustaining jobs, whether we continue to burden taxpayers with $1 billion in uncompensated care, and whether or not we leave 400,000 Pennsylvanians shut out from getting affordable coverage. Too many hardworking Pennsylvanians are forced to gamble every day with their lives and their likelihoods. They are counting down the days until they can sign up for coverage in the marketplace and they are praying that Governor Corbett will move forward with Medicaid expansion. They are looking forward to secure coverage no matter what the economic situation is.

There is a fundamental opportunity in the Affordable Care Act: the chance to make our future secure, the chance for us and working families and small business owners to be in control. We know there will be bumps along the way as there always are with any new major piece of legislation. Medicare and Social Security didn't enjoy a perfect rollout. There were challenges, tweaks and changes along the way but we worked together to make those laws work for the American people. That is what we need to do today.

The Affordable Care Act has already made the lives of millions of Pennsylvanians better, and if we get out of the way and let it work, this will open the door to stable, quality, affordable health care for 1.2 million of our uninsured neighbors. Too many lives and too many likelihoods are on the line to keep that door shut.

Thank you for allowing me today, and I look forward to your questions.

[The prepared statement of Ms. Kraus follows:]

Statement for the Record by
Antoinette Kraus, Executive Director, Pennsylvania Health Access Network

House Committee on Energy and Commerce
Subcommittee on Health

Implementation of the Affordable Care Act in Pennsylvania

Tuesday, September 10, 2013

Mr. Chairman and Members of the Committee:

Thank you for the opportunity to speak today on the implementation of the Affordable Care Act in Pennsylvania. The Pennsylvania Health Access Network is a statewide coalition of over 60 organizations representing over one million Pennsylvanians. Some of our partners include local health centers, physicians' groups, churches, retiree associations, and community groups. Our mission is to make sure every Pennsylvanian has access to quality, affordable health care.

In my work, I meet people from all walks of life – working moms and dads, retirees, young adults, laid-off workers and small business owners. They come from different backgrounds and live in different places, but their fears and anxieties over health care are the same:

How do I find coverage? Can I afford to keep it? What do I do now that I've been denied because of a pre-existing condition? My rates just went up again, but my paycheck didn't – what should I do now? Where do I turn?

These are the questions I hear, from folks across the Commonwealth. And it's no surprise, given the recent trends with health insurance in Pennsylvania:

Between 2000 and 2009, insurance premiums in Pennsylvania increased by 95%,[1] while wages increased by just 17.5%. Health insurance has become less affordable for individuals and small businesses, and, as a result, job-based coverage is on the decline. Between 2001 and 2009, 876,484 Pennsylvanians lost coverage from an employer, faster than only 2 other states in the nation.[2]

As the ranks of the uninsured swell, so does the burden on family budgets, Pennsylvania's safety-net providers, and our local hospitals who continue to absorb millions of dollars each year in "uncompensated care" that's provided to those without insurance, who end up in the emergency room needing care that they're unable to fully pay for.

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[1] Kaiser Family Foundation, Paper #7951: "Health Care and the Middle Class: More Costs and Less Coverage." Available at: http://www.kff.org/healthreform/upload/7951.pdf.

[2] Economic Policy Institute Report: "Employer-sponsored health insurance erosion continues." Available at: http://www.epi.org/publication/bp247/.

Thankfully, we have the opportunity to reverse these trends and relieve the anxiety that so many of our neighbors – and your constituents – live with daily. We can do that by moving forward to fully implement the Affordable Care Act in Pennsylvania. We can often get caught up in talking about the mechanics of implementing this law, but we should never lose sight of what this means for working families.

Already in Pennsylvania, the Affordable Care Act has brought:

- Security and peace of mind to the families of 177,000 children with pre-existing conditions[3] like asthma and leukemia, who no longer have to fear being denied coverage over a pre-existing condition;
- A boost for the bottom line of 160,000 small businesses,[4] who are newly-eligible for tax credits to reduce their cost of providing health insurance to their employees, if they choose to do so;
- Stability for 91,000 young adults,[5] who have been able to stay covered on their parents' insurance up to age 26;
- Much-needed relief for 222,703 seniors who, in 2012, saved an average of $753[6] on prescription medications in the "donut hole" coverage gap last year. Since the Affordable Care Act put these discounts in place, Pennsylvania seniors have saved over $393 million. That helps seniors on fixed incomes, but also our local economies as those freed-up dollars can be spent in the Main Street businesses in cities and towns across the state.
- More money in the pockets of over 675,000 hardworking families and small business owners to whom more than $58 million in rebates[7] was returned from their insurance companies since 2011. Before the new law, insurers could take the money we paid them in premiums to provide us coverage and use it on things like advertising, lobbying, and CEO perks – things that have nothing to do with the quality or value of our coverage. Thanks to the new law, Pennsylvanians are getting more bang for our buck, with at least 80% of our premium dollars going toward our medical care rather than overhead and excess.
- Freedom for 4.5 million Pennsylvanians – including 1.7 million women and 1.1 million children – who no longer have to fear restrictive and arbitrary lifetime and annual caps

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[3] U.S. Department of Health and Human Services: "How the Health Care Law is Making a Difference for the People of Pennsylvania." Available at: http://www.hhs.gov/healthcare/facts/bystate/pa.html.

[4] Small Business Majority and Families USA: "A Helping Hand for Small Businesses: Health Insurance Tax Credits." Available at: http://www.familiesusa.org/assets/pdfs/health-reform/Helping-Small-Businesses.pdf.

[5] U.S. Department of Health and Human Services: Estimate of the number of uninsured young adults who are eligible to remain on their parents' plan is from interim final rules for the dependent coverage provision (May 13, 2010), distributed across the states based upon the proportion of all uninsured young adults (ages 19-25) in the U.S. living in the state. Available at: http://www.hhs.gov/healthcare/facts/bystate/pa.html.

[6] U.S. Department of Health and Human Services, Center for Medicare and Medicaid Services (CMS) Report: "The Affordable Care Act: A Stronger Medicare Program." Available at: http://www.cms.gov/apps/files/Medicarereport2012.pdf.

[7] The Center for Consumer Information & Oversight (CCIIO), Centers for Medicare & Medicaid Services (CMS). "2012 MLR Rebates by State and Market." Available at: http://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2012-mlr-rebates-by-state-and-market.pdf.

shutting off their coverage or forcing a choice between stopping treatment or declaring bankruptcy over medical costs.[8]

And soon – in just 112 days – all Pennsylvanians will enjoy the freedom and feel the security that comes with knowing that affordable health care is within reach, no matter where you work, how much you earn, or if you've been sick in the past.

I want to tell you about two of those folks now. Karen and Gary Carpinello live in Waterford, a small town in Erie County. They've been married for 33 years, and have 3 children and 6 grandchildren. They call their youngest son, Tony, who'll turn 11 next year their "little surprise God blessed us with." Karen and Gary run their own small business – a commercial cleaning company. For the last two years, Karen, at age 52, and Gary, at age 62, have been uninsured.

The couple makes too much money to qualify for Medicaid, but nowhere near enough to afford the prices charged to people with pre-existing conditions. They had been covered through a state health insurance option for people who don't have access to job-based coverage, called adultBasic, but unfortunately, that was one of the first cuts the new Corbett administration chose to make soon after taking office in 2011.

In addition to high blood pressure, Karen has a torn tibial tendon in her right foot; it's an incredibly painful injury that requires surgery and up to a year of rehabilitative care to fix. Karen works hard every day, in pain, and sometimes breaks down in tears at the end of the night because the pain is so bad.

Gary has been battling some heart problems that doctors had been regularly monitoring with stress tests – something that he's now putting off, because the couple can't afford to pay out of pocket.

Karen worries every day about Gary and all the things he's forced to put off. She's scared that if the couple continues to delay treatment, they might not be around to see their young son Tony graduate from high school.

That's a fear no mom should have, especially one who works as hard as Karen. Thankfully, Karen and Gary won't have to live in fear much longer. On October 1st, they'll be able to start looking for coverage in the Health Insurance Marketplace.[9] They'll choose from the same plans as all of you. They'll have quality options that will cover the rehabilitative services that Karen needs to fix her foot, and the preventive care Gary needs to keep his heart healthy. They'll get a break on costs from new tax credits and cost-sharing reductions. Their coverage will be secure, thanks to new consumer protections that ensure we all get good value for our health care dollars, and that we can count on our coverage being there when we need it.

We are less than a month away from the day the door opens to 1.2 million Pennsylvanians who are sitting where Karen and Gary are today – on the outside of our health care system, looking

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[8] U.S. Department of Health and Human Services, Center for Medicare and Medicaid Services (CMS) analysis of U.S. Census Data. http://www.hhs.gov/healthcare/facts/bystate/pa.html.

[9] The Health Insurance Marketplace is accessible online at: www.healthcare.gov or by phone, 24/7 at: 1-800-318-2596. A special resource line for Small Businesses is available Monday – Friday, 9am – 5pm at: 1-800-706-7915.

in; hoping, praying, waiting to get in. The Affordable Care Act opens that door. Political posturing, partisanship and delays threaten to keep it slammed shut.

Unfortunately, in Pennsylvania, we've seen our Governor, Tom Corbett, work to keep that door slammed shut, and block 1.2 million uninsured Pennsylvanians from feeling the full benefit of the Affordable Care Act.

While the new law gave each state the flexibility and tools to create a marketplace that fosters real competition, offers families and small businesses the best quality choices, and ensures rates are reasonable, Pennsylvania, like several other states chose to reject this opportunity and relinquish its responsibilities to the federal government. Instead of working in the best interest of our Commonwealth, Pennsylvania officials have been slow to implement the Affordable Care Act, delaying and defaulting on key provisions of the law.

Pennsylvania was the 48th state to submit our plan to integrate our IT systems and submitted it after the deadline had passed.[10] We had to have HHS step in and review rate hikes above 10 %, until we finally addressed the issue – enacting legislation that fails to adequately protect small business owners and individuals buying coverage in the small group market from unjustified, excessive rate increases.[11] We defaulted on designing an Essential Health Benefits package that would best meet the unique needs of families in our state. All of these decisions have slowed down our ability to best implement the Affordable Care Act in Pennsylvania.

However, the most striking example of Pennsylvania's obstruction of the new law, and the one that carries the most serious consequences – not just for low-income families, but also our state's hospitals and our economy – is Governor Corbett's continued opposition to accepting federal funding to expand Medicaid.

As you know, the Affordable Care Act worked to provide health insurance to individuals earning up to 138% of the federal poverty level[12] by requiring states to expand Medicaid coverage, drawing upon 100% federal funding in the first three years, and 90% after 2019. The Supreme Court ruling, however, derailed those plans, making Medicaid Expansion optional for states. As of today – despite a strong showing of bipartisan support for expanding coverage in our State Senate[13] chamber, and among states with Republican Governors across the country – Governor Corbett and State House leadership have failed to move forward with Medicaid Expansion.

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[10] Getting into Gear for 2014: Briefing, Survey Examine 2013 Data From 50-State Survey of Medicaid and CHIP Eligibility and Enrollment Policies: http://kff.org/medicaid/event/getting-into-gear-for-2014-briefing-survey-examine-2013-data-from-50-state-survey-of-medicaid-and-chip-eligibility-and-enrollment-policies

[11] Advocates question Pa. bills to review rise in health-insurance rates: http://articles.philly.com/2011-12-07/business/30486335_1_state-insurers-insurance-department-rate-increases

[12] The Patient Protection and Affordable Care Act, signed into law March 2010, allows for Medicaid to be expanded to childless adults making up to 133% of the FPL as in section 1396 a(a)(10)(A)(i)(VIII), but there is a 5% income disregard and so the eligibility guidelines are essentially increased to 138% of the FPL.

[13] On June 30th, 17 Republicans joined with 23 Democrats in Pennsylvania's State Senate in voting to advance Medicaid Expansion by amending the Welfare Code through House Bill 1075. The roll call vote can be viewed here: http://www.legis.state.pa.us/cfdocs/legis/RC/Public/rc_view_action2.cfm?sess_yr=2013&sess_ind=0&rc_body=S&rc_nbr=232.

I want to be very clear about what's at stake for Pennsylvania in this decision over Medicaid Expansion. The choice Governor Corbett and State House leaders make will determine whether or not our Commonwealth brings in $43 billion in new federal funding[14] over the next decade; whether or not we create up to 40,000 new, family-sustaining jobs[15] in every region across the state; whether we save money for state taxpayers, or add to the burden of continuing to foot the bill for a broken system that piles nearly $1 billion in "uncompensated care" onto our community hospitals;[16] and, most seriously – whether or not we leave over 400,000 Pennsylvanians shut out from getting affordable coverage.

Three independent fiscal studies, conducted by the RAND Corporation, the Economy League, and Pennsylvania's Independent Fiscal Office – our state's version of the Congressional Budget Office[17] – confirmed the positive economic impact that accepting new federal funding and moving forward with Medicaid Expansion would have on our state.

Each study shows that even after adjusting for state costs,[18] Medicaid Expansion would result in a net fiscal gain to our state, generating more than $3 billion in new economic activity each year[19] and saving the state budget dollars we're currently spending on a patchwork system of state-funded insurance programs that leave out nearly half-a-million low-income Pennsylvanians.

There is a steep cost associated with a failure to bring Medicaid Expansion to Pennsylvania. Most glaringly, Pennsylvania taxpayers will be forced to forfeit the opportunity to put the federal tax dollars we've already paid as part of the Affordable Care Act – a law, which, as you all know, has been scored by the Congressional Budget Office as reducing our federal deficit – to work in our state.

Without Medicaid Expansion, there will be no influx of federal dollars into our economy, no new jobs created, no relief for taxpayers, who will continue to foot the bill for a broken system, and no hope for over 400,000 uninsured Pennsylvanians, who are forced to gamble every day with their lives and with their livelihoods.[20]

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[14] Between 2013 - 2022. The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis. John Holahan, Matthew Buettgens, Caitlin Carroll, Stan Dorn The Urban Institute. Full report available at:

http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8384.pdf.

[15] THE ECONOMIC AND FISCAL IMPACT OF MEDICAID EXPANSION IN PENNSYLVANIA. Pennsylvania Economy League, Inc., Econsult Solutions, Inc. April 2013. Full report available at:
http://economyleague.org/files/PEL_MEDICAID_EXPANSION_REPORT_FINAL.pdf.

[16] Hospital and Healthsystem Association of Pennsylvania, April 2013: The Economic Impact of Medicaid Expansion on Pennsylvania

Executive Summary of RAND Health Research Report. Available at:
http://www.haponline.org/downloads/HAP_Executive_Summary_of_RAND_Health_Research_Report_April2013.pdf.

[17] An Analysis of Medicaid Expansion in Pennsylvania. The Independent Fiscal Office (IFO) of Pennsylvania. The IFO provides revenue projections for use in the state budget process along with impartial and timely analysis of fiscal, economic and budgetary issues to assist Commonwealth residents and the General Assembly in their evaluation of policy decisions. May 2013. Full report available at:
http://www.ifo.state.pa.us/resources/PDF/Medicaid_Expansion_Report_%20May_13.pdf.

[18] The Economic Impact of Medicaid Expansion on Pennsylvania. Carter C. Price, Julie M. Donohue, Evan Saltzman, Dulani Woods, Christine Eibner for the RAND Health, a division of the RAND Corporation. Full report available at.
http://www.haponline.org/downloads/HAP_RAND_Health_The_Economic_Impact_of_Medicaid_Expansion_on_Pennsylvania_Research_Report_March2013.pdf.

[19] The Economic Impact of Medicaid Expansion on Pennsylvania - RAND Corporation.

[20] Kaiser Family Foundation, The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis.

Cheryl Gannon is a health care worker from Washington County, who knows what it's like to roll those dice. She does it every day, even though she works full-time and provides critical services to people with disabilities. Cheryl works as a homecare attendant and makes around $13,000 a year. The work she does allows her consumer, Ronald, to live independently and with dignity. It is hard work – physically and emotionally demanding – that takes a special person to do.

Unfortunately, Cheryl's employer does not offer insurance. Cheryl worries about what might happen if she gets sick. She can't afford to miss work, and can't afford to get treated. She, like thousands of other working Pennsylvanians, has seen how quickly an accident or illness can bring on financial catastrophe. Last year, Cheryl fell and broke her ribs – an injury that left her unable to work for a month, and facing thousands of dollars in medical debt. Cheryl still doesn't know how or when she'll be able to pay those bills.

Cheryl's fate, like nearly half-a-million Pennsylvanians, is uncertain. Her income of $13,000 a year barely puts over 100% of the federal poverty level – the line at which tax credits start to help folks afford coverage in the Marketplace. If Cheryl's hours are decreased or if she loses her job and drops below 100% FPL, she won't be able to qualify for Medicaid in Pennsylvania and she won't get any financial help to afford coverage in the Marketplace. She won't face a tax penalty for going uninsured – as the Obama Administration has said that low-income folks in states that don't expand Medicaid won't be penalized if they're unable to afford coverage – but she'll once again be forced to gamble with her health and her livelihood.

For now, Cheryl is counting down the days until she can enroll in a plan in the Marketplace and praying that Governor Corbett and State House leaders will move forward with Medicaid Expansion, so her coverage will be secure, no matter what her economic situation is.

This is the fundamental opportunity in the Affordable Care Act: the chance to make our future secure; the chance for us as working families and small business owners to be in control. We know there will be bumps along the way, as there always are with any new, major piece of legislation. Medicare and Social Security didn't enjoy a perfect roll-out; there were challenges, tweaks and changes along the way. But overall, we all worked together to make those laws work for the American people. That's what we need to do today.

The Affordable Care Act has already made the lives of millions of Pennsylvanians better, and, if we get out of the way and let it work, this law will open the door to stable, quality, affordable health care for 1.2 million of our uninsured neighbors. Too many lives and too many livelihoods are on the line to keep that door shut. Thank you for hearing our concerns and allowing us to testify today.

Mr. PITTS. The Chair thanks the gentlelady and now recognizes Mr. Lenz 5 minutes for your opening statement.

STATEMENT OF EDWARD A. LENZ

Mr. LENZ. Good morning, Mr. Chairman and members of the subcommittee. I am Senior Counsel of the American Staffing Association, which is a founding member of the Employers for Flexibility in Health Care Coalition, which is called E–FLEX, and I am appearing today on behalf of the coalition.

E–FLEX represents leading trade associations and businesses in the retail, restaurant, hospitality, construction, temporary staffing, supermarket and other service-related industries. It also represents employer-sponsored health plans that insure millions of American workers. The coalition strongly supports employer-sponsored coverage, and we have been working to ensure that it remains a vibrant and competitive option under the ACA. Our members employ a major portion of the U.S. workforce each year, upwards of 30 million people. We offer flexible work opportunities, and the jobs we create are leading the jobs recovery.

But the high turnover rates and the fluctuating work schedules of our employees pose unique challenges in offering ACA-compliant health coverage, and we have been working with the administration to address those challenges in a way that does not impose unnecessary operational complexity that could disrupt our workforces or the labor markets. To that end, proposed regulations issued earlier in the year would a look-back measurement period to determine the full-time status of so-called variable-hour employees for purposes of offering coverage, but offering coverage is only part of the equation.

Many other issues affecting employers, which are integrally related to the employer mandate and the offer of coverage, have not been resolved, for example, the processes for determining employee eligibility for premium tax assistance and the employer reporting requirements, and for that reason, E–FLEX members supported the administration's 1-year delay in enforcement of the employer mandate.

As you know, the administration issued proposed employer reporting rules just last week. We have not fully evaluated the proposal but our initial reaction is that they do not take the holistic approach that we have been urging that takes into account all of the processes affecting employers' coverage obligations, especially the process for determining eligibility for subsidies and the interaction between employers, health insurance exchanges and the multiple Federal agencies involved in making those determinations. Given that our members' software and other systems must be in place by January 1st of this coming year to start tracking employees' hours in order to get ready for 2015, the absence of final reporting rules creates major uncertainty for employers as they head into the coming year.

I would like to touch briefly on three other major issues of concern to E–FLEX. First is the definition of full-time employee under the ACA. Full-time, as you know, is defined as 30 hours per week. It is below what most employers consider to be full time, and unfortunately, it is creating perverse economic incentives to reduce em-

ployee hours. We think that increasing hours to 35 or 40 would benefit employees by increasing their take-home pay, allowing employers to offer better coverage, allowing for more flexible employee work schedules, and interestingly, also because of how the Medicaid and ACA tax credit eligibility rules work, increasing the hours would actually allow more lower-income employees to be eligible for those benefits.

The 30-hour definition is already having an adverse impact in the market. We see that. And once those changes occur, employees won't be able to recapture the lost wages, the flexible hours or the better benefits that they might otherwise have had. So we strongly encourage Congress to act now to bring the definition of full-time employee more in line with current workforce practices.

Another key issue is the definition of large employer. The ACA defines a large employer as one having 50 or more full-time employees including full-time-equivalent employees. Full-time equivalence, the inclusion of full-time equivalence, greatly expands the scope of the law to cover many smaller businesses, and our concern is that this will stifle their ability to manage their workforces and in some cases may even discourage them from expanding their businesses or offering health coverage.

Finally, we remain concerned about the law's requirement that large employers enroll full-time employees into coverage automatically if an employee does not make an election. We think it is inappropriate to enroll employees in coverage they didn't select and may not want or need. It would impose a major administrative employer on employers and would result in unexpected and certainly undesired payroll deductions for many employees.

We greatly appreciate the opportunity to present the views of E–FLEX and we look forward to continuing to work with you and the administration to resolve the many outstanding issues that remain to be addressed. Thank you.

[The prepared statement of Mr. Lenz follows:]

Statement of the
E-FLEX COALITION

on the

Patient Protection and Affordable Care Act

By

Edward A. Lenz
Senior Counsel
American Staffing Association

Before the

United States House of Representatives

Energy & Commerce Committee
Subcommittee on Health

PPACA Pulse Check: Part 2

September 10, 2013

Statement of E-FLEX Coalition
PPACA Pulse Check: Part 2
September 10, 2013

Summary of Major Points

- Employers with high employee turnover rates and fluctuating work schedules face unique challenges in complying with the Affordable Care Act; this requires unique solutions to avoid disruption of their work forces and the labor markets.

- The ACA's definition of "full time" as 30 hours of service per week is below what most employers consider full-time and is creating perverse economic incentives to reduce employee hours. Congress should act to bring the definition in line with current work force practices.

- The ACA defines "large employer" as 50 or more full-time employees, including "full-time equivalents." Including "full-time equivalents" will stifle smaller employers' ability to manage their workforces and could discourage business expansion and offering of health coverage.

- Proposed regulations would allow a "look-back measurement period" to determine the full-time status of "variable hour" employees for purposes of the employer mandate—but other issues integrally related to the mandate, including employer reporting rules, have not been resolved.

- The just-issued proposed employer reporting rules fail to take a holistic view of employers' obligations under the law. Employers thus face major uncertainty regarding the software and other systems they must develop and implement *now* to be ready for 2015.

- The ACA provision requiring large employers to auto-enroll full-time employees into coverage is inappropriate; it would impose a major administrative burden on employers and result in unexpected payroll deductions for many employees who do not want or need coverage.

About E-FLEX

Employers for Flexibility in Health Care ("E-FLEX") is a coalition of leading trade associations and businesses representing retail, restaurant, hospitality, construction, temporary staffing, supermarket, and other service-related industries, as well as employer-sponsored health plans insuring millions of American workers. Coalition members strongly support employer-sponsored coverage—the backbone of the U.S. health care system—and have been working to ensure that such coverage remains a vibrant and competitive option under the PPACA ("ACA").

E-FLEX coalition members collectively employ a significant percentage of the U.S. work force each year—upwards of 30 million people. The jobs we create offer employees flexible work opportunities and are a leading contributor to the nation's economic job recovery. But those jobs are also characterized by high turnover rates and fluctuating work schedules. Therefore, a primary coalition goal is to ensure our members' ability to offer ACA-compliant health insurance coverage to our "variable hour" employees without unnecessary operational complexity that could disrupt our work forces or the labor markets.[1]

The Administration has addressed one major issue of concern to E-FLEX members that addresses the challenges presented in offering health coverage to variable hour employees—by allowing a "look-back measurement period" to determine the full-time status of those employees for purposes of the employer shared responsibility provisions under IRC §4980H. But many other issues affecting employers integrally related to those provisions have not been resolved—including the procedures for determining employee eligibility for premium tax

[1] Temporary staffing firms offer a striking example of the "variable hour" nature of the work forces of E-FLEX coalition members. In 2012, staffing firms employed an average of almost 3 million temporary and contract workers on any given day. But over the course of the year, they employed 11.5 million people— an annual turnover rate of almost 300%.

assistance, and the employer reporting requirements under IRC §§6055 and 6056. For that reason, E-FLEX members supported the Administration's one-year delay in enforcement of IRC §4980H.

Key Issues of Concern to E-FLEX Members

Definition of Full-Time Employee: The ACA's definition of "full time" as 30 hours of service per week is significantly below what most employers consider to be full-time and is creating perverse economic incentives to reduce employee hours. The E-FLEX coalition supports increasing the weekly hours required for full-time status. This would significantly benefit employees and employers by:

- Increasing employee take-home pay
- Allowing employers to offer more generous and affordable health coverage,
- Giving lower-income employees access to more affordable coverage options,[2] and
- Allowing for more flexible employee work schedules.

Because the law requires employers to measure their workforces in 2014 to comply in 2015, the 30-hour definition is already having an adverse impact. Once the labor market shifts, employees won't be able to recapture lost wages, flexible hours, or more generous benefits. The E-FLEX coalition strongly encourages Congress to act now to bring the definition more line with current workforce practices.

Definition of "Large Employer": The definition of a large employer under the ACA is based on whether an employer has 50 or more full-time employees. In making this calculation, employers must include "full-time equivalent" employees, thus significantly expanding the scope of the law to cover many smaller employers with large numbers of variable hour

[2]For example, in states that don't expand Medicaid, a single employee working 30 hours per week at the federal minimum wage would fall below 100% of the federal poverty level and thus be ineligible for either Medicaid or premium tax credits under ACA. But at 35 or 40 hours, the employee's income would exceed 100% of FPL which would qualify for tax credits. Increasing the hours also would benefit employees by reducing the top hourly wage rate at which they would be eligible for credits. For example, at 30 hours, an employee earning $29.46 per hour (400% of FPL) would be eligible. But at 35 or 40 hours, the top wage would drop to $25.25 (35 hours) and $22.10 (40 hours). The lowest hourly wage, of course, could not fall below the federal minimum wage of $7.25 per hour.

employees whose connection with the workplace, or with the employer, is tenuous or intermittent. The E-FLEX coalition is concerned that including "full-time equivalents" in the definition of large employer will stifle the ability of smaller employers to manage their workforces and, in some cases, may discourage them from expanding their businesses or offering health coverage.

Absence of Final Employer Reporting Rules

Also of pressing concern to E-FLEX members is the absence of definitive guidance on the employer information reporting requirements under IRC §§6055 and 6056. The one-year delay of the §4980H requirements means employers will not have penalty exposure until 2015. But they still must have their information technology and human resources systems in place by Jan. 1, 2014 in order to track employees' hours of service in 2014 and comply with their ACA coverage obligations on Jan. 1, 2015.

Without clear guidance on what IRC §§6055 and 6056 require, employers face major uncertainty regarding the software and other systems they must develop and implement now. The employer reporting rules were issued in proposed form just last week (Sept. 5) and contain substantial new reporting obligations that include data elements beyond those prescribed in statute. The proposed rules are narrowly focused on the IRS's role in verifying compliance with the individual and employer mandates and fail to take a holistic view of the role that employers play in providing coverage to individuals and the myriad reporting requirements they are already subject to.

To address the reporting issues holistically, the E-FLEX coalition has, since 2011, been urging a number of approaches to mitigate the recordkeeping and reporting burdens on employers. These recommendations were most recently detailed in an Aug. 5 letter to the Secretaries of Treasury, Health and Human Services, and Labor, a copy of which is attached to this statement for inclusion in the record. The key recommendations can be summarized as follows:

- Enhance the accuracy of determinations of eligibility for premium assistance tax credits by giving employers flexibility to provide information to employees and health exchanges regarding the employer health coverage offered *on a prospective basis*. This would have the major benefits of reducing the number of retroactive "claw-backs" of tax credits previously granted to individuals and allowing employers to more accurately determine their potential exposure to penalties.
- Simplify end-of-year employer reporting for purposes of verifying compliance and assessing tax penalties—for example, by minimizing the number of reporting fields and allowing "safe harbor" exceptions for employers that meet certain *prima facie* compliance criteria or that have a *de minimis* number of employees receiving tax credits.

Auto-enrollment: The ACA requires large employers to enroll full-time employees into coverage automatically if an employee does not make an election. The E-FLEX coalition believes that enrolling employees in coverage they did not select, and may not want or need, is inappropriate. It would impose a major administrative burden on employers and result in unexpected (and undesired) payroll deductions for many employees.

We greatly appreciate the opportunity to present the views of the E-FLEX coalition and look forward to continuing to work with the Administration and Congress to resolve the many outstanding issues that remain to be addressed.

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Employers for Flexibility in Health Care

August 5, 2013

The Honorable Jacob J. Lew
Secretary
Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, DC 20220

The Honorable Kathleen Sebelius
Secretary
Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

The Honorable Thomas E. Perez
Secretary
Department of Labor
200 Constitution Avenue NW
Washington, DC 20210

Dear Secretaries Lew, Sebelius and Perez:

We are writing on behalf of the Employers for Flexibility in Health Care (E-FLEX) Coalition to express our sincere appreciation for the Administration's decision to provide a year of transition relief to employers for information reporting requirements under IRC §§6055 and 6056 and excise taxes under IRC §4980H under the Affordable Care Act. This critical recognition by the Administration that employers need more time to implement complex new rules brings much-needed relief to employers across the nation and acknowledges the inextricable link among the employer coverage requirements, the information reporting requirements and other employer provisions of the law.

The E-FLEX Coalition is a group of leading trade associations and businesses in the retail, restaurant, supermarket, hospitality, health care, construction, temporary staffing and other service-related industries, that provide employer-sponsored plans insuring millions of American workers. Members of E-FLEX are strong supporters of employer-sponsored coverage and have appreciated the opportunity to work closely with the Administration to ensure that employer-sponsored coverage remains a competitive option for all employees, whether full-time, part-time, temporary or seasonal.

For the past two years, the E-FLEX Coalition has urged the Administration to provide transition relief to allow employers sufficient time to plan, budget and implement these new rules, especially those related to information reporting. The Administration's willingness to act upon the concerns of employers is the kind of flexibility we need in the implementation of a complex law to ensure that employers can continue to offer affordable coverage to their workers. Many members of the

E-FLEX Coalition will use the 2014 transition period as a "practice year" to build their tracking and compliance systems while working to voluntarily comply with the law's employer requirements.

We will continue to work with the Administration to develop the rules on reporting requirements under IRC §§6055 and 6056. We welcome an opportunity to review the recommendations we have submitted on streamlining and improving information reporting processes, including our comments in response to Notices 2012-31, 2012-32 and 2012-33 and the HHS Bulletin on Verification of Access to Employer-Sponsored Coverage.

In addition, we would like to call attention to several issues that have arisen as a result of Notice 2013-45, which provided official notice of the transition period in 2014.

Application of Transition Rules in 2015. Notice 2013-45 raises additional questions about how transitional rules that were provided for 2014 as part of the Treasury Department's proposed rule under IRC §4980H will operate in 2015. Given that 2015 will now be the first year in which employers could face excise taxes under IRC §4980H, employers need clarification regarding whether such transition relief will be extended into 2015. We urge the Administration to issue further guidance about the status of several transitional policies, including:

- Transition rules for non-calendar year plans that begin during the 2015 calendar year;
- Measurement periods for stability periods that start in 2015; and
- Minimum number of months an employer may use to determine applicable large employer status in 2015 and applicability of the coverage provisions under IRC §4980H.

Timely clarification around the application of these and other transition rules in 2015 will minimize confusion for employers working towards compliance with the law in 2014 and 2015.

Reliance on existing guidance and proposed rules in 2015. Notice 2012-58, which outlined guidance on determining full-time employees, provided much-needed flexibility for employers with variable hour workforces, including the look-back measurement/stability period and affordability safe harbors. The Notice provided employers certainty that they could rely on the guidance through at least the end of 2014. Similarly, proposed rules on IRC §4980H noted that employers may rely on the proposed regulations for guidance "pending the issuance of final regulations or other applicable guidance." Given the voluntary compliance approach the Administration has decided to take for 2014 with respect to reporting requirements and employer penalties, we urge the Administration to consider extending through 2015 the certainty with which employers can rely on guidance in Notice 2012-58 and the proposed rules in IRC §4980H. As many of our members will use 2014 as a practice year to voluntarily comply with the law, we will continue to work with the Administration to make refinements to the proposed rules as we learn about their practical applicability in 2014.

Information reporting under IRC §§6055 and 6056. The E-FLEX Coalition looks forward to working with the Administration as it develops rules on reporting requirements under IRC §§6055 and 6056. In light of the time needed to implement the necessary reporting systems, we urge the Administration to issue proposed rules on IRC §§6055 and 6056 as soon as possible so that employers can build and implement the necessary systems.

Since 2011, members of the E-FLEX Coalition have taken a holistic view of the law, having recognized that the employer requirements under the law are inextricably linked. How the reporting process is structured among employers, insurance Exchanges, and the federal agencies – and the timing and frequency of these interactions – will have a major impact on our business decisions about how to implement the law and our administrative processes and costs.

Minimizing the number of inaccurate determinations of individual eligibility for premium assistance tax credits to purchase Exchange coverage is a major priority of the E-FLEX Coalition. It is in all of our interests to avoid our employees having to repay tax credits when employer-sponsored coverage that meets the law's affordability and minimum value standards is available to them. As such, we are exploring the options the Administration has provided for employers to communicate with employees about the coverage they offer via the Department of Labor's model notice to employees about Exchanges under the Fair Labor Standards Act and the Department of Health and Human Services' employer pre-enrollment template as part of the model application for Exchange coverage.

The E-FLEX Coalition hopes to work with the Administration to find ways that employers can certify to IRS prospectively certain data elements under IRC §6056 about coverage available to employees to improve the accuracy of Exchanges' determinations of eligibility for advance payment of premium tax credits. This stands as the best path forward given that -- as HHS recognized in its July 5 final rule that addressed Exchange eligibility processes and other issues -- there currently is no comprehensive data source of eligibility for employer-sponsored coverage. In addition, given that HHS has confirmed that data from IRS, the Social Security Administration and the Department of Homeland Security "should be available every day" via the data hub (*See* CMS-2234-F), the Administration would not need to develop a separate data source of eligibility for employer-sponsored coverage if it can collaborate with the employer community to develop flexible options for reporting under IRC §§6055 and 6056 throughout the year.

The E-FLEX Coalition is committed to working with the Administration to simplify and streamline the employer information reporting requirements under the law in part by continuing to offer employers of different sizes and structures flexibility and options to comply with the law's requirements. In order to assist with the upfront determination of individual eligibility for tax credits and the availability of employer-sponsored coverage, we continue to explore options under the employer reporting requirements that would allow employers to report prospectively to the IRS general information about the coverage offered to employees (e.g., availability of minimum value plans and affordability based on employee wage bands). By giving employers the flexibility to report required data elements to the IRS on timeframes that coordinate with the

enrollment process, the Administration could use the federal data hub to provide Exchanges with access to more timely information about individuals' access to employer-sponsored coverage. In addition, we are exploring options to streamline end of year reporting for purposes of certifying compliance with the law and assessing tax penalties such as minimizing reporting fields, exceptions-based reporting based on limited number of employees receiving tax credits, and safe harbors for employers who are able to demonstrate compliance with the law.

We would like to thank you again for the opportunity to share our comments with the Administration on provisions of the ACA that affect employers, and we appreciate the constructive way in which the Administration has engaged with the employer community in developing regulatory guidance. The E-FLEX Coalition looks forward to working with the Administration to address issues that preserve employer-sponsored coverage and smooth the implementation process for employers and employees.

For questions related to this letter, please contact Anne Phelps, Principal, Washington Council Ernst & Young, Ernst & Young LLP, at 202-467-8416, on behalf of the Employers for Flexibility in Health Care Coalition.

Sincerely,

Employers for Flexibility in Health Care

Enclosure

cc: The Honorable Max Baucus
The Honorable Orrin Hatch
The Honorable Tom Harkin
The Honorable Lamar Alexander
The Honorable Dave Camp
The Honorable Sander Levin
The Honorable Fred Upton
The Honorable Henry Waxman
The Honorable John Kline
The Honorable George Miller

Mr. PITTS. The Chair thanks the gentleman and now recognizes Ms. Campbell 5 minutes for an opening statement.

STATEMENT OF CHERYL CAMPBELL

Ms. CAMPBELL. Good morning, Chairman Pitts, Congressman Pallone, members of the committee. Thank you very much for the opportunity to appear before you today. My name is Cheryl Campbell. I am the Senior Vice President at CGI Federal, a company that has provided information technology services to the Federal Government for more than 36 years. In my role, I lead CGI Federal's Health and Compliance Business Unit. I am responsible for all projects at the Department of Health and Human Services and several other Federal agencies. It is my pleasure to appear today to discuss CGI Federal's role as the contractor designing and developing the IT application known as the Federally Facilitated Marketplace, which I will call the marketplace. This application is one of several components being developed that will allow citizens, health insurance issuers, CMS and many States to participate in the marketplace for health insurance mandated by the Patient Protection and Affordable Care Act.

CMS conducted a competitive procurement, and on September 30, 2011, selected CGI Federal to design and develop the marketplace consistent with requirements established by CMS. At the time of contract award, most of these requirements were not fully defined. For that reason, the contract was issued as a cost reimbursement-type contract, and the project's original scope was defined broadly. During the course of performance, CMS has modified the contract on several occasions generally in response to more detailed requirements.

CGI Federal's scope of work includes the following three work streams: architecting and developing a marketplace that may be used by any State that opts out of building and operating its own; second, designing an IT solution that is adaptable and modular to accommodate the implementation of additional functional requirements and services; and third, participating in a collaborative environment and relationship in support of coordination between CMS and its primary partners.

When open enrollment begins on October 1, 2013, the marketplace will have three key functions to assist citizens in comparing, selecting and enrolling in qualified health plans. First, eligibility and enrollment, which serves as the front door for consumers to determine eligibility for and enroll in a qualified plan; second, plan management which serves as the entry point for health insurers to submit their plans for CMS certification as qualified health plans; and third, financial management, which allows CMS to manage financial transactions with issuers.

The IT solution developed by CGI Federal has been structured to support CMS as it provides pre-implementation models to the States. The Federally Facilitated Marketplace, the State Partnership Marketplace and the State-Based Marketplace. To date, the marketplace implementation has achieved all of its key milestones from the initial architecture review in October 2011 to project baseline review in March 2012, and most recently, the operational readiness review in September 2013. Additionally, in April 2013, health

insurers began submitting their plans to the system for review by CMS. Starting in August 2013, consumers were able to go into the system and register their counts. At this time, CGI Federal is confident that it will deliver the functionality that CMS has directed to enable qualified individuals to begin enrolling in coverage when the initial enrollment period begins in October 1, 2013.

Moving forward, CGI Federal is confident in its ability to deliver successfully on its contract and remains committed to the success of the marketplace as a mechanism for providing health insurance coverage by the statutory deadline of January 1, 2014.

I appreciate the opportunity to appear before you today and would be pleased to answer any questions that you may have. Thank you.

[The prepared statement of Ms. Campbell follows:]

Written Testimony of Cheryl Campbell
Senior Vice President
CGI Federal Inc.

Prepared for

The House Committee on Energy and Commerce
Subcommittee on Health

September 10, 2013

Chairman Pitts, Congressman Pallone, Members of the Committee, thank you very much for the opportunity to appear before you today. My name is Cheryl Campbell and I am a Senior Vice President at CGI Federal Inc. (CGI Federal), a company that has provided information technology (IT) and business process services to the federal government for more than 36 years. In my role, I lead CGI Federal's Health and Compliance Programs Business Unit, including responsibility for all of its projects at the Department of Health and Human Services (HHS) and several other federal agencies. It is my pleasure to appear today before you at this hearing to discuss CGI Federal's role as the contractor designing and developing the complex, IT application known as the Federally-Facilitated Marketplace (FFM), formerly known as the Federal-Facilitated Exchange. The FFM application, one of several components being developed in a multi-stakeholder environment, will allow citizens, health insurance issuers, the Centers for Medicare and Medicaid Services (CMS), and many States to participate in the marketplace for affordable health insurance mandated by the Patient Protection and Affordable Care Act (PPACA).

On September 30, 2011, CMS conducted a competitive procurement and selected CGI Federal to design and develop the FFM. CMS issued CGI Federal a task order for this work under CGI Federal's Enterprise Systems Development, Indefinite-Delivery, Indefinite-Quantity type contract. Currently, the task order includes: a 29-month Base Period for design, development, and implementation; one (1) 6-month and two (2) one-year Option Periods for operations and maintenance; and a 6-month Transition Out Period.

The task order directs CGI Federal to design and develop a FFM that will perform the functions and business processes that CMS has identified in regulations and guidance issued pursuant to the PPACA. At the time of task order award, most of these regulations and guidance were still being finalized and the associated system requirements defined fully. For that reason, the FFM task order was issued as a cost-reimbursement type task order and the project's original scope was defined broadly with deliverable dates to be determined by CMS. During the course of performance, CMS has modified the task order on several occasions, generally in response to more detailed requirements regarding system functionality as regulations and policy were better defined.

Generally, CGI Federal's scope of work includes the following three (3) work streams:

1) Architecting and developing a FFM that may be used by any State that opts out of building and operating its own marketplace;

2) Designing an IT solution that is adaptable and modular to accommodate the implementation of additional functional requirements and services; and

3) Participating in a collaborative environment and relationship in support of the coordination between CMS and its primary partners.

When open enrollment begins on October 1, 2013, the FFM will have three (3) key functions to assist citizens in comparing, selecting, and enrolling in qualified health plans in States that have chosen not to build their own marketplace. These three (3) key operational functions include:

1) Eligibility & Enrollment. The FFM will serve as the "front door" for consumers to fill out an online health insurance application, determine their eligibility for health insurance, and enroll in a qualified health plan. Among other things, the FFM will interface with a Data Services Hub being developed by a contractor under another contract to access income, citizenship, and the information necessary to determine an individual's eligibility for health insurance, and whether that individual also is eligible for subsidies or credits. The FFM also will allow citizens to view, compare, select, and enroll in health plans available through the exchange.

2) Plan Management. The FFM will serve as the entry point for health insurers to submit plans for CMS certification as qualified health plans. CMS will use the FFM to acquire, certify, and manage issuers offering qualified health plans through the FFM. CMS also will coordinate plan management activities with States, including monitoring and oversight, account management, and recertification. Health insurers began submitting their plans to the system in April 2013.

3) Financial Management. The FFM will allow CMS to manage financial transactions with issuers, including calculating reinsurance payments, risk adjustments and corridors, and premium processing.

Under CGI Federal's task order, CMS is responsible for establishing the business processes and general requirements for the FFM system and CGI is tasked with designing and developing an IT architecture to achieve these requirements. The business processes and general requirements come from the PPACA and regulations, policy, and guidance issued by CMS, CMS' requirements contractor, and other Federal agencies and are influenced by the diverse approaches individual States have adopted to implement the law. To that end, the IT solution has been structured to support CMS as it provides three (3) implementation model options to the States. In the most basic terms, these three (3) options are:

1) Federally Facilitated Marketplace – HHS operates the marketplace for a State;

2) State Partnership Marketplace – A State operates plan management or customer support or both and HHS operates the remainder of the marketplace for that State; and

3) State-Based Marketplace – A State operates the entire marketplace, but has the option to use HHS Support for certain activities.

To date, the FFM implementation has achieved all of its key milestones from the initial Architecture Review in October 2011 to Project Baseline Review in March 2012 and, most recently, the Operational Readiness Review in September 2013. Additionally, in April 2013, health insurers began submitting their plans to the system for review by CMS. Starting in August 2013, consumers were able to go into the system and register their accounts.

At this time, CGI Federal is confident that it will deliver the functionality that CMS has directed to enable qualified individuals to begin enrolling in coverage when the initial enrollment period begins on October

1, 2013. Moving forward, CGI Federal also is confident in its ability to deliver successfully on its task order and remains committed to the success of the FFM as a key mechanism for providing health care coverage by the statutory deadline of January 1, 2014. I appreciate the opportunity to appear before you today and would be pleased to answer any questions that you may have.

Mr. PITTS. The Chair thanks the gentlelady and now recognizes Mr. Lau 5 minutes for an opening statement.

STATEMENT OF JOHN LAU

Mr. LAU. Good morning, Mr. Chairman, Congressman Pallone, other members of the subcommittee. My name is John Lau. I represent Serco Inc., and I am the Program Director for CMS contract. Thank you for the opportunity to appear today to discuss Serco's role in this program. For the next several minutes, I will provide you with an overview of Serco, my background, the contract we have been awarded, and the status of our work to date.

Serco is a U.S. company based in Reston, Virginia, and we employ over 8,000 Americans across 45 States. We provide professional, technology and management services, primarily to the U.S. government and our customers include every branch of the U.S. military, numerous Federal civilian agencies, and the intelligence community. We are a wholly owned subsidiary of Serco Group PLC headquartered in the U.K. However, Serco Inc. maintains a separate board of directors and separate management under the terms of a special security agreement with the Department of Defense.

Serco has decades of award-winning experience in government-related records management and processing support programs. Examples of this experience include processing large volumes of visa applications for the Department of State, patent application processing and classification for the U.S. Commerce's Patent and Trademark Office, records management and application and petition processing for the Department of Homeland Security, and records management services at the U.S. Citizenship and Immigration Services National Benefits Center. Personally, I have over 30 years of experience specializing in implementation and management of large Health and Human Services programs such as Medicaid and other public assistance programs. I have been responsible for overseeing eligibility and enrollment support programs for up to 30 million citizens involving 50 million or more transactions per year, and those experiences include the California State Children's Health Insurance Program, the Texas Eligibility Support System for Medicaid, Children's Health Insurance Program, food stamps, and at the time, Temporary Assistance for Needy Families. This experience gives me the confidence to say that our team is dedicated and equipped to deliver on our contractual commitments.

Under the CMS contract, which was awarded to us on July 1, we will provide support services in the determination of eligibility for the Federally Facilitated Marketplace and the State-Based Marketplace for the eligibility support tasks under the Affordable Care Act. The contract tasks include intake, routing, review, troubleshooting of applications submitted for enrollment into a qualified health plan, and for insurance affordable programs including but not limited to advanced payment of premium tax credits, cost-sharing reductions, Medicaid Children's Health Insurance Program, and the Basic Health Program were applicable beginning on October 1, 2013. It includes 10 base tasks and potentially three optional tasks, and in my written testimony, I have a lot more detail on those tasks, which I think it is best in the interest of time to review there.

The funded base year of the contract totals $114 million, and our role is to support a process that is as efficient, accurate and protective of personal privacy as is technologically possible. I will just in full disclosure, there are two pending modifications to our contract, which may change some of the scope that we currently have. However, we are prepared to manage the estimated 6.2 million paper applications representing about 30 percent of the total applications projected to be received between October 1st and March 31, 2014. We don't do recruitment of Americans to submit applications nor are we involved in eligibility or enrollment decisions.

We are on schedule to deliver all requirements for our contract, and I look forward and am happy to answer any questions you might have.

[The prepared statement of Mr. Lau follows:]

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Summary of Testimony of John Lau
Serco Program Director for CMS contract HHSM-500-2013-00118C
"PPACA Pulse Check: Part 2"
Before the Energy and Commerce Subcommittee on Health,
U.S. House of Representatives
September 10, 2013

Serco Inc. Overview
Serco Inc., a U.S. company based in Reston, Virgnia, employs over 8,000 Americans. We provide professional, technology and management services primarily to the U.S. Federal government including every branch of the U.S. military, numerous federal civilian agencies and the intelligence community. Today we provide support in 45 states across the country.

CMS Program
Contract Overview
In July 2013, Serco was awarded the Centers for Medicare & Medicaid Services (CMS) contract to process and verify applications for a qualified healthcare plan as it pertains to the Patient Protection and Affordable Care Act (ACA). The funded base year tasks total $114,307,266. Serco is prepared to manage the estimated 6.2 million paper applications which are to be received between October 1, 2013 and March 31, 2014.

CMS-ES Information Security and PII/PHI Protection
Serco is dedicated to protecting the privacy of consumers through the paper application process. The company is committed to applying and enforcing a strong information security program and strict controls. Serco is implementing and maintaining information security management, operational, and technical controls for CMS-ES, as per the requirements of the CMS Information Security Framework and FISMA for the protection of Personally Identifiable Information (PII) and Personal Health Information (PHI).

Team and Staffing
Serco has comprised a team of experienced and new employees, and large and small businesses to deliver on the CMS contract commitments. The Program Director has over 30 years of experience specializing in the implementation and management of large scale health programs.

Facilities
Serco has set up three locations in Arkansas, Kentucky and Missouri to support the program.

Contract Deliverables
Serco is on schedule to deliver all requirements for the CMS contract to support open enrollment beginning on October 1, 2013.

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Summary of Testimony of John Lau

Serco Program Director for CMS contract HHSM-500-2013-00118C

"PPACA Pulse Check: Part 2"

Before the Energy and Commerce Subcommittee on Health,

U.S. House of Representatives

September 10, 2013

Serco Overview

Serco Inc., a U.S. company based in Reston, Virginia, employs more than 8,000 people, with reported annual revenue of $1.2 billion last year. We provide professional, technology and management services primarily to the U.S. Federal government. Our customers include every branch of the U.S. military, numerous federal civilian agencies and the intelligence community.

Serco Inc. was incorporated in the United States in 1988 and over the last 25 years we have assisted our government customers with their need to respond to new mandates and expand the scope of their missions. From the west coast, where we have over 400 employees in San Diego, California, providing command, control, communications, and computer intelligence services to the U.S. Navy, to the east coast where we have 450 employees in Portsmouth, New Hampshire, providing records management services to the Department of State, we have a track record of providing service excellence and exceeding expectations across the country.

To elaborate on records management services, which are critical capabilities in performing work under our CMS contract, we have extensive experience in this area for the U.S. government. Some of our major programs include patent application processing and classification for the U.S. Patent and Trademark Office; records management and application and petition processing for the U.S. Citizenship and Immigration Services' Service Centers; visa application processing at the State Department's National Visa Center and Kentucky Consular Center; and, records management services at the U.S. Citizenship and Immigration Services' National Benefits Center. These experiences have helped Serco develop and refine best practices which are already being incorporated into the CMS work.

These programs also highlight our robust experience in working with the Federal government. At Serco, we embrace our customer's mission, and make it our passion. It is this mindset that has earned us the trust of our government, military and intelligence customers. For example, we have:

- Assisted 2 million Soldiers and their family members with personnel and career transition support;
- Managed 63 air traffic control towers in 11 states;
- Managed 62 million active records at several U.S. Department of Homeland Security facilities; and,
- Managed 32 million immigrant and non-immigrant Visa transactions last year.

Serco Inc. is a wholly-owned subsidiary of Serco Group plc, headquartered in the United Kingdom. As a cleared U.S. company delivering solutions to the U.S. Federal government, we operate under a Special Security Agreement (SSA), ensuring that we are insulated from influence by our non-U.S. parent company. This protective security measure is overseen by the Department of Defense, Defense Security Service (DSS). We have a dedicated security team, along with a Serco Inc. Board of Directors separate from our parent company and a special committee of the board which oversees the SSA requirements and ensure that we are in good standing with DSS. Since our SSA was granted in April 1998, we have successfully passed all evaluations, with the most recent assessment resulting in four consecutive "Superior" ratings. In July of this year, Serco was one of 24 recipients out of 13,500 defense contractors who received the James S. Cogswell Outstanding Industrial Achievement Award from DSS.

Contract Overview

Serco was awarded the Centers for Medicare & Medicaid Services (CMS) contract to provide support services in the determination of eligibility for the Federally-Facilitated Marketplace (FFM) and the State-Based Marketplace (SBM) for the Eligibility Support tasks under the Patient Protection and Affordable Care Act (ACA). The contract is HHSM-500-2013-00118C and became effective on July 1, 2013.

The contract tasks include the intake, routing, review, and troubleshooting of applications submitted for enrollment into a Qualified Health Plan and for insurance affordability programs including, but not limited to, Advance Payment of Premium Tax Credits, Cost-Sharing Reductions, Medicaid, Children's Health Insurance Program, and the Basic Health Program, where applicable, beginning on October 1, 2013.

Our role is to support a process that is as efficient, accurate and protective of personal privacy as is technologically possible. We are prepared to manage the estimated 6.2 million paper applications, which is 30 percent of the total applications, to be received between October 1, 2013 and March 31, 2014 (based on a May 2013 CBO Estimate). Serco is not responsible for the recruitment of Americans to submit an application, the eligibility decisions, nor the online enrollment system and its software.

This contract was awarded as a Cost-Plus-Fixed-Fee type contract with a 12-month base period and four (4) 12-month option periods. At present, only base year required tasks are funded for $114,307,266. There are four optional years and three optional tasks, and if fully exercised, this

would bring the total contract price to $1,248,871,357. We are on schedule to deliver all requirements for the CMS contract, which has ten baseline and three optional tasks, as described below:

- Baseline Task 1 is on paper intake and forms processing. Our mailroom will sort, classify, and route postal mail, inter-office correspondence, courier mail, and related documents received throughout the day based on document category and CMS standard operating procedures. We will use an automated solution built around Rapid Opening and Extraction Desks for high-volume opening and extraction of mail. We will also manage the mail triage to sort incoming mail by document category, form number, or other criteria. We will then prepare all forms and correspondence prior to imaging. For Image Paper Documents, our approach is threefold: 1) Scan Quality Control – ensuring the images accurately represent the original documents; 2) Indexing and Validation – associating scanned images with index metadata to store/search/retrieve the images; and 3) Post Index and Image Processing – resulting in a cross-reference table that links images to coded records based on document number.

- Baseline Task 2 is to support processing of paper applications. Our leadership team has decades of award-winning experience in records management, including processing large volumes of visa applications for the Department of State, the Department of Homeland Security, and the Department of Commerce, as well as applications for Medicaid and public assistance programs for the Department of Health and Human Services. Lesson learned from these similar projects will accelerate our work. We will support the

processing of all paper applications for Enrollment in a Qualified Health Plan (QHP) and for Insurance Affordability Programs (IAP), Employer and Employee Applications for Small Business Health Options Program (SHOP) and Applications for Exemptions (beginning with the 2014 tax year).

- Baseline Task 3 is to support verification of the information. Once application information is entered in Federal Marketplace Processing System (FMPS), our workflow addresses eligibility verification. While many verification sources may be standard, our team will handle State-specific verification requirements using the approved standard operating procedures.

- Baseline Task 4 is on complex issue resolution. We have substantial experience in providing health insurance eligibility support and the expertise required to address the complexities of ACA and related programs. We have established a knowledge base of eligibility scenarios that will enable us to address the most complicated issues.

- Baseline Task 5 is on limited telephone support. We will establish, operate, and maintain phone support facilities for CMS to address clarifications for calls escalated from the call center contractor. We will organize the facility, the teams, call distribution, call handling, service delivery, and management along general Information Technology Infrastructure Library (ITIL) guidelines for service delivery standards and best practices.

- Baseline Task 6 is on mass changes. There are times when regulatory changes, workarounds for system or clerical issues, or recommendations made based on findings, research and analysis discovered during the operations of Eligibility Support Services (ESS) will require changes to enrollment or eligibility data affecting many individuals, and employers in FMPS. We will work collaboratively with CMS and the FMPS contractor to provide research, analysis, code development, and test support, and when directed, implement changes to FMPS with respect to enrollment and eligibility data issues. We built and maintain many complex data record and processing solutions and can readily support mass change needs to FMPS whether they be on demand, in batch, or of a more complex nature.

- Baseline Task 7 is on maintenance of standard operating procedures. We will establish a configuration library from which we will structure the usage and maintenance of program policies, standard operating procedures, and workflow tasks accessible to the entire program staff. We will manage the standard operating procedures using our defined configuration management process and a Change Control Board. Recommended standard operating procedure changes will be submitted to CMS for review and approval. We understand that operating environments are dynamic and as we move forward, we plan on recommending workflow and SOP changes reflecting process improvements.

- Baseline Task 8 is on training and coordination. Our training concept of operations is a planned progression of training and full integration with quality and performance measurement: startup, new hire, job-specific, refresher, remedial, and continuous learning

training. We will draw on our existing training practices on similar programs; our capability to do so is critical to rapidly develop a complete, effective, and timely training program.

- Baseline Task 9 is on performance, quality assurance and data analytics. Serco's dashboard tool and methodology provides comprehensive visibility and control over the performance indicators that matter. In our customized outcome-based approach, stakeholders share views of what the mission is, how the business fits together to support it, and where and why value is created. Incorporating data and metrics from existing performance management system data sources, the dashboard gives a clear line of sight between the program's activities resources and outcomes. It allows the Program Director and Site Managers at all levels to share perspectives, see cause-and-effect relationships, and understand the impact of decisions.

- Baseline Task 10 is on program management. To provide CMS with a low-risk solution for managing all tasks under this contract, we will draw on our collective best practices to support and implement eligibility support operations. Our Program Management Organization (PMO) is designed to provide outstanding quality, services, and products in a timely fashion. It will provide cohesive management of our large document-processing centers and multiple business partners, expertise to exceed program performance metrics, and support for the rapid implementation of value-added, cost-saving innovations throughout the life of the ESS contract.

Our three optional tasks:

- Task 11 is on the development of a standard operating procedure. We have readymade templates for developing SOPs. We will develop any new SOPs in CMS format. The templates ensure all applicable SOP structural components are considered for incorporation, making for a complete process document. Serco will maintain these optional task SOPs with process improvements in the same manner as described previously in Task 7.

- Task 12 is on an increase in volume of exchange participation. From a personnel perspective, our Project Managers will use forecasting models driven by performance history to provide a baseline against which to assess the operational impact of unanticipated volume changes on personnel staffing levels. From a facility perspective, we have proven strategies for managing increased staff size without increasing the facility footprint through effective use of multiple and expanded shifts in multiple sites without requiring overtime. From an IT perspective, we propose using virtual machines that operate on blade servers. Our servers and network will be ready for surge and heavier workloads with little cost impact to the infrastructure. We are prepared to accomplish any associated subtasks necessary to seamlessly address these optional task volume requirements, such as training and coordination.

- Task 13 is on an increased volume of appeals requests. As in Optional Task 12, we have the capability to accommodate unanticipated volume changes in Appeals Requests. We

will develop a workforce expansion/contraction plan and implementation timeline for CMS to consider.

On August 21, 2013, Serco received a request from CMS for a proposal to modify the contract due to changes in the government's estimates on workload. In addition, CMS requested that Serco include translation and interpreter services, and to include pricing on performing employee background checks for all project staff members. We provided these to them on September 3 and September 5, 2013, respectively.

CMS-ES Information Security and PII/PHI Protection

Protecting the privacy of consumers through the paper application process is top priority for Serco and CMS. We are committed to applying and enforcing a strong information security program and strict controls across all of our contracts and operations.

For this program specifically, we are implementing and maintaining information security management, operational, and technical controls for CMS-ES, as per the requirements of the CMS Information Security Framework and FISMA for the protection of Personally Identifiable Information (PII) and Personal Health Information (PHI).

The ES operations includes security features and controls that include: dedicated secure facilities with physical access controls, monitoring, and guard force; background checks and vetting of all personnel; segmented and compartmented IT and computer networks, based on ES roles and operations; no access to outside Internet, email, wireless, and mobile devices for all ES

operations that process PII/PHI; and secure access to CMS Eligibility Support Desktop (ESD), where all information resides.

The Standard Operating Procedures describe and script the proper handling of PII and PHI across the entire flow of information through ES – from paper mail through digital processing and finally through destruction and/or returning of information to the consumer.

We are conducting initial and periodic Security Awareness and Training for all personnel, which will include: privacy laws, policies, guidance, and principles; our role and obligations in protecting PII/PHI and how we protect PII/PHI in all forms; privacy – how we recognize and respond to various threats; and, procedures to report a privacy incident or suspicion of information breach.

Team and Staffing

We recognize the essential role of timely and accurate eligibility determinations to achieve the program's elements. That is why we have a strong team of employees to help deliver on our commitments to the government, as well as the American people.

From a leadership perspective, I'll oversee the program as Program Director. I have over 30 years of experience specializing in the implementation and management of large scale HHS programs. I have been responsible for overseeing eligibility and enrollment support service programs for up to 30 million citizens and 50 million transactions per year, including the California State Children's Health Insurance Program and the Texas Eligibility Support system

for Medicaid, Children's Health Insurance Program, and Temporary Assistance for Needy Families. This experience gives me the confidence to say today that our team is dedicated and equipped to deliver on our contract commitments.

The Deputy Program Director is Francis Moody. Francis is a Vice President at Serco and has directed Serco's efforts at the Department of State's National Visa Center and Kentucky Consular Center (NVC/KCC) for more than 11 years with the processing of immigrant and non-immigrant visa applications. NVC/KCC processes in excess of 32 million transactions each year supported by a staff of over 800 employees.

To fulfill the CMS contract, we needed to hire over 1,500 new employees in three major groups – baseline staff utilized year round, contingent or on call employees available for unanticipated increases in volume during non-peak periods, and seasonal workers for peak volume periods associated with health plan enrollment opportunity windows. These employees will be responsible for project management, mail, file/case management, document scanning, analysis and quality control in support of eligibility determination to manage the healthcare insurance applications mandated under the ACA.

As of September 3, 2013, over 6,744 employment applications have been submitted. We hosted job fairs near the new Serco facilities and set up over 1,557 interviews for pre-screened applicants. We also accepted walk-ins and had computers available for people to apply online at the job fair sites. The executed job fairs ran smoothly and were well-received.

We have extended 1,194 offers for new Serco and subcontractor employees with each of them to go through background checks (noted in the job advertising and on applications). Starting on September 9, the new hires will be required to attend orientation, training, practice, and live testing sessions.

Five of the seven subcontractors under this contract are small businesses including veteran and women owned companies. We are proud to have them on our team. At Serco we know the important contributions small businesses can make as a member of our team, and the value-added services they provide in support of our customers. We have a proven track record of exceeding Small Business subcontracting goals and have seven mentor protégé programs; four recognized by DHS, and one each with the State Department, GSA and the FAA.

We are also proud of our efforts to hire military veterans. We recognize the incredible skill sets that these men and women bring to the workforce, and want to harness those skills while supporting the CMS contract. We are working with local workforce organizations and services that have specific veteran representatives to drive awareness of our available jobs. We are consistently active in helping veterans find jobs within our company and have veteran-specific resources on our website to match veterans with possible Serco careers. This type of dedication has led to us receiving the Virginia Valued Veterans certificate for our commitment to recruiting, hiring, training and retaining veterans.

The full CMS team – including Francis and myself – will be overseen by Serco's Executive Team. Our Executive Team brings a diverse background and has an average of over 28 years' experience in leadership and management positions in the Federal government market sector.

Facilities

We selected the locations for the new Serco facilities based on a variety of factors, including the competitive labor costs with higher unemployment rates so we can create a positive impact on the local economies. We selected three locations: London, Kentucky – opening October 1; Rogers, Arkansas– opening October 15; and, Wentzville, Missouri, near St. Louis – opening October 30.

These sites meet required task volume levels and are ready to be expanded to address optional task increases. We will handle required tasks with a single eight-hour shift and have the ability to expand to additional shifts and/or ten-hour shifts to meet optional tasks. We have found this to be an effective technique in our support of other Federal customers like DHS National Benefits Center where we use two 10-hour shifts and Saturday work hours when required.

Our technical solution puts the optimal workforce into a comfortable and effective work environment to promote employee satisfaction that fosters high productivity and quality service delivery. All facilities include administrative offices for site management and open office space for eligibility, outbound calls, and related functions.

Contract Deliverables

This program is divided into two phases – start-up/implementation and operations. The first phase is the start-up/implementation period, which began in July. This phase includes the coordinating of task schedules, frequent production of deliverables, employee hiring and on-boarding, employee orientation and training, pre- and live testing, and close monitoring of key milestone dates and events. The second phase is operations, which runs from the 'go-live" date through the complete lifecycle of operations. It includes performance under the baseline tasks described earlier with quantitative performance monitoring and enhancement through continuous quality improvement.

Serco is dedicated to delivering on our contract commitments. We have held kick-off meetings (July 11; July 31), developed plans for training (July 29), project management (August 8), business continuity (July 16) and quality assurance, improvement and control (August 16), created reports for project design (July 25) and the monthly status (August 15), drafted key performance indicators (August 9) and continue to hold weekly teleconference meetings with COR and other CMS contractors.

During the month of September for the Kentucky and Arkansas facilities, Serco is installing and testing networks and equipment, hiring and training new employees, conducting pretests of system, holding "dress rehearsals" with employees, and performing live tests of system. The Kentucky facility will go live October 1 and the Arkansas facility will go live on October 15. The Wentzville facility will follow a similar time line with a go live date of October 30.

As we continue to drive this program forward, we are keenly aware of the challenges placed in our hands, and prepared to devote every resource necessary to meet our obligations to our contracting agency – and to the American people.

Mr. PITTS. The Chair thanks the gentleman and now recognizes Ms. Spellecy 5 minutes for an opening statement.

STATEMENT OF LYNN SPELLECY

Ms. SPELLECY. Good morning, Chairman Pitts, Congressman Pallone and distinguished member of the subcommittee. My name is Lynn Spellecy, and I serve as Senior Director and Corporate Counsel for Equifax Workforce Solutions. In that role, I am the primary attorney responsible for the day-to-day legal operations of the business unit, and I provide guidance, advice and legal support. I appreciate the opportunity today to provide information related to the income verification services that Equifax Workforce Solutions will be providing to CMS to assist them in their benefit eligibility determination requirements under the Affordable Care Act.

Equifax Workforce Solutions is a wholly owned subsidiary of Equifax Incorporated. Workforce Solutions provides employers with various human resources-related services. We serve employer clients by providing services like unemployment claims management, W–2 processing, I–9 management and similar other functions.

One of the largest parts of our business is providing income verification on behalf of employers. Workforce Solutions responds to requests for employment and income information on behalf of our employer clients so that the employers do not have to devote resources to answering the phone and dealing with these requests, which typically come from lenders, social services agencies and any other entity that has the need to verify a consumer's employment or income information.

In order to provide this service for our employer clients, our clients send us a data feed every time they process their payroll so every couple of weeks usually. This feed contains information regarding their employees' salary information and employment history. We take that information and store it in a database that we call The Work Number. We then accept requests from verifier clients—the lenders, social services agencies and others mentioned previously—and provide consumer employment and income information in response to those verifier requests. The Work Number is a consumer recording database that is regulated by the Consumer Financial Protection Bureau and is subject to the Federal Fair Credit Reporting Act. Therefore, we credential all of our verifier clients to be sure that the entity making the request is entitled to receive the information that they are requesting. Subject to Federal laws, we make sure that the verifier client has a permissible purpose to access the data, and we require that the verifier obtain consumer consent before we release income information.

By providing automated access to employment and income information, we alleviate the need for employers to have human resources staff verifying income when their employees are seeking a loan, for example. On the verification side, we can give verifiers the information so that they can process loans more quickly and reliably. Similarly, the process benefits consumers because consumers can obtain more ready access to credit and to the services for which they have applied without the delays caused by having to manually obtain pay stubs and provide them to lenders and others.

Our contract with CMS is to provide the same services we provide to thousands of other social services agencies and lenders every day. In late November, CMS issued a request for proposals to provide automated income and employment verification to the CMS hub in order to enable CMS to make its determination of consumer eligibility for tax credits and then programs like Medicaid and CHIP. We responded to that RFP, and we were notified at the end of March of this year that we had won the RFP. We entered into a contract with CMS at the beginning of April. The contract is a 1-year contract renewable for up to 5 years. We will be doing verification similar to what we provide to other clients. CMS will provide us with information from a consumer who has requested qualification for Medicaid, CHIP or a tax subsidy or reduced cost sharing. CMS will obtain the consumer's consent to have their employment and income information verified. In response to CMS's request, we will provide CMS with income and employment information that we have stored in The Work Number database. CMS will use that information to enable a determination as to whether that individual is eligible for CHIP, Medicaid and a tax subsidy or reduced cost sharing.

Equifax Workforce Solutions is prepared to provide income verifications to CMS. We operate in a closely regulated environment in accordance with Federal law, and consumers provide their written consent to CMS before we verify their income. The configuration between Equifax Workforce Solutions and the CMS data hub has been tested, and we stand by our commitment to maintain the highest standards for information security and consumer data privacy.

Thank you for the opportunity to testify, and I welcome your questions.

[The prepared statement of Ms. Spellecy follows:]

One-Page Summary

Testimony of Lynn Spellecy
Corporate Counsel
Equifax Workforce Solutions

Before the Subcommittee on Health
Committee on Energy & Commerce
U.S. House of Representatives
September 10, 2013

Summary points:

- Equifax Workforce Solutions will be providing income verification services under a contract to the Centers for Medicare & Medicaid Services (CMS) to assist in their eligibility determinations for benefits under the Affordable Care Act (ACA).

- The services we will be performing for CMS are similar to those we currently provide to 30 states in their eligibility reviews for Medicaid and Children's Health Insurance Program (CHIP). Equifax Workforce Solutions provides over 10 million verifications annually to government entities including agencies in all fifty states. We also provide these services for many employers, including 75% of the Fortune 500 companies and many federal agencies, when their employees initiate transactions requiring income verification.

- Equifax Workforce Solutions income verification service delivers a streamlined, secure and timely transfer of information to government entities and employers. Equifax Workforce Solutions operates in a closely regulated environment in accordance with federal law, and consumers provide written consent before we verify their income. Our database has close to 54 million current employee payroll records.

- After a competitive bid process (including an ROI and RFP), CMS awarded a 5-year contract to Equifax Workforce Solutions in March of 2013 to provide real time verification of income to assist CMS in the verification of eligibility for Medicaid, CHIP, premium tax credits and reduced cost sharing. CMS will obtain written consent to verify the income from each applicant prior to sending the request to Equifax Workforce Solutions.

- Equifax Workforce Solutions is qualified to provide income and employment verifications (not benefit eligibility determinations) to CMS because we maintain the largest database of its kind and have been providing this service to government agencies and businesses since 1995.

Testimony of Lynn Spellecy

Corporate Counsel

Equifax Workforce Solutions

Before the

Subcommittee on Health

Committee on Energy & Commerce

U.S. House of Representatives

PPACA Pulse Check: Part 2

September 10, 2013

Good morning Chairman Pitts, Ranking Member Pallone, and distinguished Members of the Subcommittee. My name is Lynn Spellecy and I serve as Senior Director and Corporate Counsel for Equifax Workforce Solutions. I appreciate the opportunity to appear before you today and provide information related to the income verification services that Equifax Workforce Solutions will be providing to the Centers for Medicare & Medicaid Services (CMS) to assist in their administration of the benefit programs defined by the Affordable Care Act. Our services to CMS will be similar to the income verifications that we currently provide to 30 states in their review of Medicaid and Children's Health Insurance Program (CHIP) eligibility.

EQUIFAX WORKFORCE SOLUTIONS

When people hear the name Equifax, many think of us as the company that provides credit reports to their lenders when they apply for a new mortgage, refinance their current mortgage, buy a new car or try to obtain a new credit card. I am here to discuss Equifax Workforce Solutions - which is a subsidiary of Equifax, but is separate from the credit reporting business. This business unit is employed by over 8,200 human resources departments and is the leading income verification service in the country. Equifax Workforce Solutions provides human resource data, analytic services, and verifications of income and employment to both the public and private sector. We manage unemployment claims, tax matters, and employment and income verification services to over 75% of the Fortune 500 companies. We also provide other outsourced human resources functions, such as I-9 compliance and management, W-2 and payroll processing, workforce analytics and employee onboarding.

THE WORK NUMBER

Our automated employment and income verification service is provided through our proprietary database known as The Work Number®. The Work Number delivers a streamlined, secure and timely transfer of

information between employers and verifiers that ultimately benefits the consumer by accelerating the decision process on their loan or government benefit, while freeing the employer from the disruption of verification requests. Over 2,900 employers, including the majority of Fortune 500 businesses and most of the federal civilian contractors, contribute their payroll information to the database at each pay period, entrusting Equifax Workforce Solutions to provide critical human resources functions on their behalf. The Work Number database has close to 54 million current employee payroll records and is projected to grow to 78 million records by the year 2017. Equifax Workforce Solutions operates in a closely regulated environment in accordance with federal law and consumers provide written consent before we verify their income.

When a consumer seeks a loan for housing or auto, or fills out a credit card application, the lender often requests verification of the applicant's employment and income. Without The Work Number database, the lender or government agency would typically call the Human Resource department of the consumer's employer for that information – often suspending the consumer's financial transaction or government benefit until the necessary data was confirmed. The Work Number allows lenders and government agencies to verify employment and income without contacting the employer directly, speeding up the verification process and reducing the burden on the employer.

Additionally, The Work Number service is utilized by federal and state government agencies as they seek to verify eligibility for government public assistance benefits. Benefits such as the Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance to Needy Families (TANF), CHIP, and Medicaid or housing assistance require a social services agency to verify that a consumer meets the program's eligibility

requirements. The Work Number provides a streamlined, secure and timely solution for government agencies as they process applications for government benefits.

The Work Number database of employee payroll information is a completely separate operation from the division of Equifax that manages its credit bureau data. The two information sources are kept separate and data stewardship rules dictate how the information is handled within each organization. Both data sources, however, are compliant with the federal Fair Credit Reporting Act (FCRA) and both are protected by globally recognized standards for information security and data management.

FAIR CREDIT REPORTING ACT

Equifax Workforce Solutions is compliant with all applicable federal and state regulations. Equifax Workforce Solutions is a "consumer reporting agency"[1] as defined by the FCRA when it provides services that rely upon The Work Number database. Automated verifications of income and employment provided by Equifax Workforce Solutions through The Work Number are "consumer reports"[2] and regulated by the FCRA. The verification of a consumer's employment and income in determining a consumer's eligibility for benefits under the Affordable Care Act is a "permissible purpose" and is authorized under FCRA Section 604. This section of the law allows a consumer reporting agency to furnish a consumer report under the following relevant circumstances:

(a) (3) To a person which it has reason to believe –

(D) intends to use the information in connection with a determination of the consumer's eligibility for a license or other benefit granted by a governmental instrumentality required by law to consider an applicant's financial responsibility or status.

[1] *FCRA Section 603(f)*
[2] *FCRA Section 603(d)(1)*

As part of our FCRA compliance obligations, Equifax Workforce Solutions requires the credentialing of all verifier clients and we obtain certifications that The Work Number data will only be used for permissible purposes as allowed under the FCRA. Equifax Workforce Solutions also provides consumers the ability to obtain an annual free copy of their "Employment Data Report," our Workforce Solutions employment and income data file, and a process to dispute any inaccuracies they may find in their data within The Work Number.

In addition to the permissible purpose requirements contained within the FCRA, Equifax Workforce Solutions in most cases requires consumer consent in order for a verifier to receive income information from The Work Number. Verifiers are also subject to potential audits during which they are required to show proof of consumer consent.

GOVERNMENT EXPERIENCE

As I mentioned earlier, state and federal government agencies utilize Equifax Workforce Solutions to verify consumers' income and employment to help determine their eligibility for government benefit programs. In 2011, one in three Americans lived in households that received some kind of income-based government benefit[3]. Equifax Workforce Solutions provides over 10 million verifications annually to government entities including agencies in all fifty states. We help them review applications and verify income for various programs such as SNAP, TANF, Medicaid, child support enforcement, and for state and local housing subsidies. Government organizations that administer public assistance to low-income individuals and families use The Work Number to check applicant provided information, identify missing or incomplete data, and reduce program fraud.

[3] *United States Census Bureau*

Federal agencies such as the Social Security Administration (SSA) and the Department of Treasury also utilize The Work Number for verification services. The SSA contracts with Equifax Workforce Solutions for verifying past and current wages of individuals applying for or currently receiving Social Security Retirement, Survivors and Disability Insurance benefits and Supplemental Security Income benefits. The SSA uses The Work Number service to verify the wages of individuals applying for benefits and for those already receiving benefits.

The Department of Treasury recently contracted with Equifax Workforce Solutions to help the agency enforce H.R. 4053, the "Improper Payments Elimination and Recovery Improvement Act of 2012." Equifax Workforce Solutions provides access to The Work Number database for employment and income verifications in order for the Department of Treasury to facilitate the identification of improper payments by the agency.

The Commonwealth of Pennsylvania has worked with Equifax Workforce Solutions since 2010. Pennsylvania's Department of Public Welfare relies on Equifax Workforce Solutions to provide income verifications of applicants for the state's public welfare programs (SNAP, TANF and Medicaid) through the Office of Income Maintenance. These agencies access The Work Number through a secure web-based platform for real time information regarding an applicant's current employment status and payroll income. The Work Number also provides an "Alert" product to the state's Bureau of Child Support Enforcement (BCSE). This Alert service monitors over 725,000 social security numbers of liable parents on a weekly basis and informs BCSE of any significant changes in income that would impact an active case.

Another example of a state agency using The Work Number is the Michigan Higher Education Authority. This authority depends on income verifications through The Work Number for servicing student loan applications. Also in Michigan, The Department of Human Services and The Bureau of Adult and Family Services have utilized the Work Number income data since 2007 to help determine applicants' eligibility for SNAP, TANF and Medicaid programs.

Equifax Workforce Solutions requires its public sector verifier clients, other than child support enforcement agencies[4], to obtain the applicant's consent for the verification of his or her income. The consumer will typically sign his or her consent in the application documents. This consent policy goes beyond FCRA requirements and provides the consumer with increased transparency and awareness that their income will be further verified when applying for these government benefits.

CMS

The Affordable Care Act charged CMS with assisting millions of Americans to obtain health insurance through their employers and exchanges. After a competitive bid process that included a Request for Information and a Request for Proposal, CMS awarded a contract to Equifax Workforce Solutions in March of this year to provide real time verification of income and employment to the CMS Data Hub to facilitate the verification of eligibility for Medicaid and CHIP, as well as for eligibility for premium tax credits and reduced cost sharing.

As I mentioned earlier in my testimony, we have almost 54 million active employee payroll records and over 2,900 public and private sector employers contributing their payroll data to The Work Number every pay

[4] *See FCRA Section 604(a)(4)(5)*

period. The Work Number database includes payroll data on approximately one-third of the working population in the United States and reflects employees at all wage levels.

The Equifax Workforce Solutions contract with CMS has the potential to cover five years of service, but it is an annual contract renewable each year. Equifax Workforce Solutions is qualified to provide income and employment verifications to CMS because we maintain the largest database of its kind in the country and we have been providing similar income verification services to government agencies and businesses since 1995.

SOLUTION DELIVERY

Under the Equifax Workforce Solutions contract with CMS, CMS will obtain consent to verify the income from each applicant prior to sending the request to Equifax Workforce Solutions. CMS will also certify its FCRA permissible purpose for each request. Once an application is submitted and consent is obtained from the applicant filer, CMS will provide the applicant's name, date of birth, and social security number to the hub which in turn will send a request to The Work Number. If there is a match in The Work Number database, we will validate that the information matched is that of the applicant. If we are confident in the match, we will then evaluate the data in The Work Number database to determine if we have sufficient information to satisfy the CMS match requirements specified in our contract. If so, we will return to CMS the employer's name, federal Employment Identification Number and address, as well as the employee's employment status, pay data, gross earnings and net earnings.

Under Equifax Workforce Solutions' contract with CMS, the applicant will need to provide CMS the right to validate their income when filling out their application for insurance benefits and/or tax credits. Like other government verifier clients, CMS will be subject to Equifax Workforce Solutions audits during which CMS

will be required to show proof of consent for verifying an applicant's income or employment. For each verification request of an applicant's income, an inquiry will be posted on the consumer's Employment Data Report maintained by Equifax Workforce Solutions. The inquiry will neither appear on nor impact the consumer's credit report or credit score because The Work Number is managed by Equifax Workforce Solutions, a separate entity from Equifax's credit reporting business. As stated above, a consumer may request their Employment Data Report maintained by Equifax Workforce Solutions to review for accuracy and potentially dispute any errors.

TESTING

When Equifax Workforce Solutions partners with a new government verifier client, we develop appropriate integration technology on both sides to successfully deliver the verifications in a timely and secure manner. The Equifax Workforce Solutions integration with the CMS Data Hub has been successfully established. We have already performed end-to-end testing with both the hub and the state exchanges, and intend to test our data flow with the Federally Facilitated Marketplace next week.

From the inception of the project in April of 2013, Equifax Workforce Solutions has worked closely with CMS and its contractors to establish a progression plan of testing for the successful delivery of Equifax Workforce Solutions income verification solution. Our team first supported testing of the custom components of the solution that we developed to support the requirements for CMS. These tests included modifications and enhancements to our standard service to accept the data elements from CMS that will be used to match an applicant to one or more records in The Work Number database. The tests were conducted independent of the hub to allow us to isolate potential defects or issues and quickly resolve them. At the

completion of the initial test phase, we conducted an acceptance test with the CMS Contracting Officer Representative to validate completeness of our solution and its compliance with the requirements.

Second, we collaborated with CMS and the hub contracting vendor to initiate connectivity testing between the various CMS test environments and those implemented at Equifax Workforce Solutions to support our clients. Our connectivity testing uncovered some configuration issues with the gateway between our systems. Our team resolved these issues in July and we were successful in establishing an application connection between CMS and Equifax Workforce Solutions.

During the third phase of testing, we collaborated with CMS and the hub contracting vendor to conduct testing of our application through the gateway. The testing consisted of preparing, loading, and executing over 200 test cases between the hub and our service. Each test case resulted in either a match or non-match to simulate the different types of transactions anticipated when the system goes live on October 1, 2013. In all cases, a response was provided back to the hub and we determined that all tests were successfully executed.

Fourth, Equifax Workforce Solutions conducted volume testing to simulate the expected volumes identified in our contract during peak periods. Testing was conducted by our team independent of the hub to allow us to refine the performance of our solution and the dedicated infrastructure that was procured to support the CMS contract.

In the fifth test phase, Equifax Workforce Solutions prepared for and supported end-to-end testing of the state facilitated markets. This testing was initiated in late August and focused on supporting states in their

efforts to conduct testing of their state facilitated market applications. This testing will proceed through September 14, 2013, and our team will continue to support this testing as necessary.

The final phase of testing prior to production is scheduled for September 15, 2013, when we will initiate testing with the Federally Facilitated Marketplace. This testing is expected to be conducted in much the same way as we currently support our existing state customers that purchase our income verification solutions. From Equifax Workforce Solutions' standpoint, our technical interfaces are with the hub and we do not foresee any changes in our test results during this final phase.

SECURITY

Managing large amounts of highly confidential data and sensitive information is an extremely important responsibility. Equifax has the highest standards for information security and data privacy. The Equifax Global Security organization provides for the protection of every Equifax subsidiary, including Equifax Workforce Solutions, and ensures that their information and resources are in accordance with appropriate security policies, controls and applicable regulatory doctrine. Equifax Global Security protects data from a wide range of threats in all formats, during both transmission and storage. The goals of the security program are the preservation of:

1) Confidentiality – the securing of information so that is accessible only to those authorized to have access;
2) Integrity – safeguarding the accuracy and completeness of information and processing methods; and
3) Availability – providing authorized users with access to information and associated assets when required.

The Equifax Global Security program holds a global accreditation under ISO/IEC 27001: 2005. This standard, published by the International Standards Organization (ISO) and the International Electrotechnical

Commission (IEC), formally specifies a management system that is aligned with eleven specific domains of information security that are designed to ensure management control of an organization's information security program. ISO 27001 provides a holistic, risk-based approach to identifying and managing risks to key information systems and assets. ISO/ISE 27001 requires organizations to systematically examine their security risks; design and implement a comprehensive set of information security controls and other risk mitigation strategies (e.g., risk avoidance by limiting certain activities); and to adopt a management process that ensures that the information security controls continue to meet organizational needs in the evolving threat environment. The standard specifies the requirements for establishing, implementing, operating, monitoring, reviewing, maintaining and improving a documented Information Security Management System.

Equifax is formally audited and annually certified for compliance with ISO/IEC 27001. ISO/ISE 27001 forms the foundation on which Equifax builds compliance with various legal, regulatory and contractual security requirements that govern its data and activities. This allows Equifax to monitor its subsidiaries' compliance with multiple regulatory regimes, as each subsidiary, including Equifax Workforce Solutions, may operate across economic sectors and therefore be subject to multiple regulatory regimes, including the FCRA, the Financial Privacy and Safeguards Rules of the Gramm-Leach-Bliley Act, as well as other requirements.

As a federal contractor to CMS, Equifax Workforce Solutions must also comply with the Privacy Act of 1974, Federal Information Security Management Act (FISMA), the Health Insurance Portability and Accountability Act (HIPAA) and the privacy and security provisions of the Affordable Care Act.
The security controls required to meet FISMA are specific and detailed for information protection and availability. Real time auditing assures a high level of security and protection of our customer's data.

Equifax Global Security is constantly evaluating new threats and making adjustments as necessary to ensure the best protective measures are in place. Equifax is certified and accredited for FISMA to accept government data and has a history of protecting data for several large government customers. Equifax maintains an active FISMA Authority to Operate through the National Finance Center for information systems supporting the verification of income service.

To ensure security of the communications between Equifax Workforce Solutions and the hub, all messages will have transport level encryption and all contents of communications will be encrypted with private certificates that were exchanged between both Equifax and the hub contracting vendor.

CONCLUSION

Equifax Workforce Solutions is ready for the October 1, 2013 open enrollment date and the implementation of our income verification for applicants seeking financial assistance under the Affordable Care Act. With the experience we have gained from providing income verifications to 30 states for their similar reviews of consumer applications for Medicaid and CHIP benefits, Equifax Workforce Solutions is prepared to provide our services to CMS. We operate in a closely regulated environment in accordance with federal law and consumers provide their written consent before we verify their income. The configuration between Equifax Workforce Solutions and the CMS Data Hub has been successfully tested and Equifax Workforce Solutions stands by our commitment to maintain the highest standards for information security and consumer data privacy. Thank you for the opportunity to testify and I welcome your questions.

Mr. PITTS. The Chair thanks the gentlelady and now recognizes Mr. Finkel 5 minutes for his opening statement.

STATEMENT OF MICHAEL FINKEL

Mr. FINKEL. Good morning, Chairman Pitts, Ranking Member Pallone and members of the subcommittee. My name is Michael Finkel, and I am the Executive Vice President for Program Delivery at QSSI. My role is to ensure successful project delivery and implementation. I have worked in the IT field for 17 years, and manage the delivery of numerous government programs.

QSSI is a leading systems integrator that designs and builds custom IT systems, and we have been working with CMS since 2006. Currently, QSSI is one of several contractors developing systems at the direction of CMS that will support Health Insurance Marketplaces, commonly known as exchanges. While we do various work with CMS in this area, today I will focus on QSSI's role in developing the Data Services Hub on behalf of CMS.

Our job is to write the software code based on CMS approved specifications for the Data Services Hub. We expect the Data Services Hub will be ready for CMS to operate as planned on October 1st. In simple terms, the Data Services Hub will transfer data. It will facilitate the process of verifying applicant information by routing queries and responses between given marketplaces and various data sources. The Data Services Hub itself will not determine consumer eligibility, it will not determine which health plans are available in the marketplace, and it will not handle personal medical records.

Here is how it will work. A consumer will go to the Health Insurance Marketplace web portal to fill out enrollment forms and select health insurance plan. Certain information the consumer provides to the marketplace such as citizenship will have to be verified. The marketplace will direct a query to external information sources such as government databases. Those queries will be funneled through the Data Services Hub. Once the requested information is sent back, eligible consumers can then enroll in one of the available plans. The enrollment data, such as name, address and premium amount will be transferred through the Data Services Hub from the originating marketplace to the health plan chosen by the consumer.

It is important to keep in mind that CMS owns and will operate the hub. It is housed in the CMS secure cloud hosted at the Terremark Data Center. We are developing the hub within CMS's environment where it will remain.

Let me address the status of this work. I can report that our delivery milestones for the Data Services Hub are being met on time. We have completed software coding for the Data Services Hub for all functionality required for October 1st. We are continuing performance and integration testing. We have connected to the Data Services Hub to the databases at the key Federal agencies that will be used for verifying information. We have connected the Data Services Hub to the system that will transfer data to and from health plan issuers. We expect that data services functionality planned for October 1st to be ready.

Finally, let me turn to data security. As I said earlier, the Data Services Hub is located in the CMS secure cloud. CMS and its information security contractors will continually monitor the Data Services Hub. Government regulations require CMS to follow National Institute of Standards and Technology's security guidelines applicable to the Data Services Hub. The design and development of the Data Services Hub complies with these standards.

Additionally, the Data Services Hub has recently undergone an independent security risk assessment by CMS's security assessment contractor, the Mitre Corporation. Our understanding is that that assessment did not identify any issues that would prevent CMS from launching the Data Services Hub on October 1st. Once in production, CMS will enforce additional security controls to protect systems including controlling access and changes to the system. The Data Services Hub will continually be monitored by CMS and its information security contractors.

Thank you for the opportunity to testify today. I will be happy to answer any questions you might have.

[The prepared statement of Mr. Finkel follows:]

U.S. House Committee on Energy & Commerce Subcommittee on Health
Hearing on "PPACA Pulse Check: Part 2"
Testimony of Michael Finkel
Quality Software Services, Inc.
September 10, 2013

Chairman Pitts, Ranking Member Pallone, and Members of the Subcommittee, good morning. My name is Michael Finkel, and I am the Executive Vice President for Program Delivery of Quality Software Services, Inc., or QSSI. My role at QSSI is to oversee our project managers and staff, and ensure successful and efficient project delivery and implementations, with a particular focus on government IT projects. I have worked in IT for 17 years, concentrating on health care IT for the last nine years, and have successfully managed the delivery of numerous government programs during that time. I am pleased to be here this morning to introduce you to QSSI and discuss our work with the Centers for Medicare and Medicaid Services (CMS) on the federal Data Services Hub.

QSSI

QSSI was founded in Maryland in 1997, and we are a leading systems integrator. We work with customers in the public and private sectors to design and build custom IT systems, including security and privacy solutions, cloud-based applications, and data management systems.

QSSI has worked with Federal government agencies for nearly 15 years and with CMS since 2006. Currently, QSSI is one of several contractors working at the direction of CMS to develop systems that will support health insurance marketplaces, commonly referred to as Exchanges. While we do various work with CMS in this area, my testimony today focuses on QSSI's role in developing the Data Services Hub on behalf of CMS. Our job is to write the software code, based on CMS-approved specifications for the Data Services Hub. We expect the Data Services Hub will be ready for CMS to operate as planned on October 1st.

The Data Services Hub: What It Is, How It Works

Simply put, the Data Services Hub will transfer data. It will facilitate the process of verifying applicant information data, which is used by health insurance marketplaces to determine eligibility for qualified health plans and insurance programs, as well as for Medicaid and CHIP. The Hub's function will be to route queries and responses between a given marketplace and various data sources. The Data Services Hub itself will not determine consumer eligibility, nor will it determine which health plans are available in the marketplaces.

Here's more detail on how the Data Services Hub will work:

A consumer interested in purchasing health insurance online will go to a health insurance marketplace's web portal to fill out enrollment forms and select a plan. Certain information the consumer provides to the marketplace, such as citizenship, will have to be verified. The marketplace will direct a query to external information sources, such as government databases. Those queries will be funneled through the Data Services Hub.

Once the requested information is sent back, eligible consumers are then able to enroll in one of the available plans. The enrollment data, such as name, address, and premium amount, will then be transferred through the Data Services Hub from the originating marketplace to the health plan chosen by the consumer.

It's important to keep two characteristics of the Hub in mind. One, while the Data Services Hub will pass eligibility data from verification sources to the federal and state marketplaces and enrollment data from marketplaces to plan issuers, it will not handle personal medical records.

Second, CMS owns and will operate the Hub, and will house it in the CMS secure cloud hosted at the Terremark Data Center. We are developing the Hub within CMS' environment, where it will remain. Once the Hub is operational, QSSI's role will be to support CMS in ensuring proper system performance, including maintenance and the development of enhancements as requested by CMS, as systems integrators routinely do for their customers on the customers' systems.

Status of the Data Services Hub

Our delivery milestones for Data Services Hub completion are being met on time. We expect CMS' Data Services Hub will be ready as planned by October 1st.

At this point:

- We have completed software coding for the Data Services Hub for all its required October 1st functions.
- We are continuing performance and integration testing.
- We have connected the Data Services Hub to databases at the key federal agencies that will be used to verify information.
- We have connected the Data Services Hub to the system that will transfer data to and from the health plan issuers.

As with any large scale project, we continue to review and test the Data Services Hub and will do so until launch. Additionally, CMS' independent tester has been testing the Data Services

Hub. The results to date have been routine and have required, in some instances, modifications and improvements to the system that are being successfully completed.

Data Security

Lastly, let me turn to data security, which we know is a longstanding priority for this Committee. Under the Federal Information Security and Management Act, CMS is required to follow the National Institute of Standards and Technology's security standards and guidelines for federal IT systems. Accordingly, the design and development of the Data Services Hub complies with these standards. As an IT solution provider to many federal agencies for nearly 15 years, QSSI is experienced at developing systems that comply with these standards. The Data Services Hub recently underwent an independent Security Risk Assessment by CMS' security assessment contractor, the Mitre Corporation. Our understanding from the preliminary report is that the Security Risk Assessment did not identify any issues that would prevent CMS from launching the Data Services Hub on October 1st.

As I mentioned previously, the Data Services Hub code is being developed, will launch, and will operate from within the CMS secure cloud hosted at the Terremark Data Center. Once in production, CMS will enforce additional security controls to protect the system, including controlling access and changes to the system. The Data Services Hub will be monitored continually by CMS and its information security contractors.

Closing

Thank you for the opportunity to discuss QSSI and our work on the Data Services Hub.

I'm happy to answer any questions you might have.

Mr. PITTS. The Chair thanks the gentleman and thanks all the witnesses for your testimony, and we will now begin questioning and answering. I will begin the questioning, and recognize myself 5 minutes for that purpose.

Mr. Graham, in your testimony, you included a chart, and we will put it up on the screen, which displays the sheer complexity of the exchange, enrollment and subsidy eligibility process, and I would like to walk through this chart to help our constituents as to what they will face interacting with the exchange and what happens to the data provided on the application.

Mr. GRAHAM. Sure.

Mr. PITTS. I have a series of questions I would like to ask you. My constituents may apply for enrollment through a paper application. Is that correct?

Mr. GRAHAM. Yes.

Mr. PITTS. She could also apply online. Is that correct?

Mr. GRAHAM. Correct.

Mr. PITTS. It is also possible to apply by phone. Is that correct?

Mr. GRAHAM. Correct.

Mr. PITTS. A navigator or an in-person consumer could also be involved. Is that correct?

Mr. GRAHAM. That is correct.

Mr. PITTS. And so the navigators and others will have access to personal information included on the application such as Social Security number, date of birth, address and household income. Is that correct?

Mr. GRAHAM. That is my understanding.

Mr. PITTS. There would have to be a check on whether an individual is eligible for Medicaid, and the application information would then need to be transferred to the State. Is that correct?

Mr. GRAHAM. That is correct.

Mr. PITTS. The Federal Data Services Hub will have to route information to several agencies as well. Is that correct?

Mr. GRAHAM. That is correct.

Mr. PITTS. A check will occur with Homeland Security to verify residency as well. Is that correct?

Mr. GRAHAM. That is correct.

Mr. PITTS. The Social Security Administration will have to verify citizenship. Is that correct?

Mr. GRAHAM. Yes.

Mr. PITTS. The IRS will also check prior-year income. Is that right?

Mr. GRAHAM. Yes.

Mr. PITTS. If household income doesn't match, CMS will check income verification with a private contractor. Is that correct?

Mr. GRAHAM. Yes.

Mr. PITTS. If the private contractor does not have data on file, CMS claims they will conduct an audit to check for eligibility. Is that right?

Mr. GRAHAM. Yes.

Mr. PITTS. Individuals with affordable employer-sponsored coverage are not eligible for a subsidy. There may have to be a phone call to an applicant's employer to verify this. Is that correct?

Mr. GRAHAM. There would be verification needed, yes.

Mr. PITTS. The exchange interface will show approved plan options upon the entering of application information. Is that correct?

Mr. GRAHAM. Correct.

Mr. PITTS. Then the beneficiary premium will have to be calculated correctly after the household income and size is considered. Is that correct?

Mr. GRAHAM. Yes.

Mr. PITTS. Paper documentation verifying information on the application may or may not be asked of the beneficiary. Is that correct?

Mr. GRAHAM. Correct.

Mr. PITTS. Treasury will be responsible for making sure payment is then sent to the plan. Is that right?

Mr. GRAHAM. Correct.

Mr. PITTS. Based on the application's information, cost-sharing subsidies will be calculated based on actuarial value and payments will then be sent to plans accordingly. Is that correct?

Mr. GRAHAM. Correct.

Mr. PITTS. Overpayments and underpayments of subsidies will be dealt with during a reconciliation process, both for the plan. Is that correct?

Mr. GRAHAM. Correct. There will be a reconciliation process afterwards.

Mr. PITTS. Is there a similar reconciliation process for the beneficiary?

Mr. GRAHAM. The beneficiary? What do you mean by that?

Mr. PITTS. The tax credits for the individual.

Mr. GRAHAM. So if an individual receives too many tax credits because they have reported incorrect or their income status changes throughout the year, there would be a reconciliation process.

Mr. PITTS. And what happens if there is incorrect information?

Mr. GRAHAM. So it is projected that if an individual receives too much subsidy based upon either the information they submit or the change in income throughout the year, then they would owe the repayment of whatever additional subsidy they receive throughout the year.

Mr. PITTS. Would that clawback come back from the insurance companies or from the individual's income?

Mr. GRAHAM. It would come from the individual's income. They would owe it.

Mr. PITTS. Well, now, I don't have much time left. I have just gone through 20 steps of the complexities associated with the ACA exchange enrollment. I am a little skeptical the system can actually function as advertised on October 1st, given the myriad of missed deadlines by the administration, and I am afraid this Rube Goldberg experiment will not end well. Trillions of taxpayer dollars are at stake, and it is our duty to watch this closely as we approach open enrollment.

I wish I could go further but my time is up, and I will yield to the ranking member 5 minutes for questions.

Mr. PALLONE. Mr. Chairman, because I didn't have time before, I just wanted to respond to this notion that on the Republican part that somehow this letter that was sent out to navigators including

the Food Bank of Monmouth in Ocean County in my district was somehow an appropriate oversight function, which I don't think it is. First of all, you should understand, and I can use the Food Bank as an example, that they have just begun the process of trying to sign up people who are uninsured that happen to come to the Food Bank, and normally when we have oversight functions, it is after the program has actually been implemented, not before it even begins. My concern is that this letter is solely designed to cause delay and to basically take resources away from the outreach effort of an organization like the Food Bank, and there has been no evidence that there has been any mishandling of these funds, particularly since most of the funds haven't even been used.

So when I say that that oversight function is inappropriate, it is because it is not consistent with what we usually do in the committee. We don't usually start oversight and ask a myriad of questions before the program has even begun and before there is any indication that there is any kind of misuse of funds. So that is why I say strictly a delaying tactic and trying to intimidate these organizations such as the Food Bank from actually trying to sign up the uninsured.

I wanted to ask two questions. We hear all this over-the-top criticism of the ACA and the implementation process from my Republican colleagues, and as a supplemental memo the staff released today shows the contractors here today are working hard to do a good job. But I just wanted to down the line and ask the contractors whether they agree or disagree with my characterization, and I will start from the left. Granting that there may be hiccups and unanticipated issues, are you on track to deliver on your contract and have things up and running, or is this whole implementation effort doomed to failure? I know you have sort of answered this so maybe I will just ask yes or no whether you are on track to deliver and have things up and running or you think it is hopeful. If you could just answer quickly, I will run down the line starting with Mr. Graham.

Mr. GRAHAM. So Leavitt Partners is not——

Mr. PALLONE. You are not involved. OK. Ms. Kraus?

Ms. KRAUS. We are not a contractor.

Mr. PALLONE. OK. Then let us start with the contractors.

Ms. CAMPBELL. So I am the first one on the contractor side. The answer would be yes, we are prepared.

Mr. PALLONE. OK.

Mr. LAU. Yes, Serco is prepared.

Ms. SPELLECY. Equifax Workforce Solutions is prepared.

Mr. FINKEL. QSSI is on schedule.

Mr. PALLONE. All right. Thank you so much.

And this is the reality. It simply doesn't match up with my Republican colleagues' over-the-top rhetoric. Those working to implement this law are doing difficult but important work. Not everything is going to go perfectly but we have an obligation to work together to make this law work for the American people, and obviously those who are the contractors are not having a problem in terms of getting up and running.

So I want to ask a second question of Ms. Kraus, if I could. My Republican colleagues seem intent on using this hearing to argue

that the Affordable Care Act is not ready to be implemented. They are looking for the smallest missed deadline, using any indication of difficulty of this task to argue that implementation is failing, and I think again we need to put this in perspective. Whatever implementation hiccups or glitches we see from here, the negative effects will be nothing, in my opinion, compared to the harm governors around this Nation are doing to their citizens by rejecting the ACA's Medicaid expansion. So Ms. Kraus, can you put this in perspective for us? What can you tell us about the very harm your State's decision not to expand Medicaid is going to have and how does that compare to, say, a week's delay in testing IT readiness?

Ms. KRAUS. Thank you. So just to put it in perspective, so on October 1st, there will be approximately 400,000 Pennsylvanians that will not have access to health insurance. They will not be able to get tax credits on the exchange. They can't qualify for health insurance now. So they are going to continue to be forced to go to Pennsylvania's emergency rooms. Hospitals as part of the Affordable Care Act are facing cuts in uncompensated care, and in Pennsylvania, hospitals face about $1 billion a year in uncompensated care costs, and they are still going to have to pay for that. In addition, you know, the economic benefits to Pennsylvania by accepting Federal funding is huge. We are looking at, you know, $3 billion a year in increased economic activity. Our own independent fiscal office, which is a nonpartisan group, looked at it. We are looking at, you know, being able to create 40,000 jobs in Pennsylvania each year alone from Medicaid dollars and, you know, Pennsylvania taxpayers are going to continue to have to shoulder the costs of uncompensated care and paying for folks that end up in the emergency room. So as we look forward to October 1st, this is going to cause a big problem for 400,000 Pennsylvanians.

In terms of IT infrastructure, we have 1.2 million uninsured in Pennsylvania, about 1.1 million will qualify for the exchange, and Medicaid expansion, if we go down that road, these are folks that have been uninsured, you know, for a long time, have been shut out of the market because they have a preexisting condition, and these folks are just counting down the days until October 1st. Their survival counts on it. Right now they have to choose between, you know, feeding their family or figuring how to pay medical bills. We hear all the time from clients who, you know, have ended up in the emergency room. They don't have health insurance. They have huge bills. They don't know how they are going to pay them and they don't know where they are going to turn next. So on October 1st, they will be able to start the process of making sure they have financial security and nothing like this happens.

Mr. BURGESS. [Presiding] Great. Let us wrap it up there. The gentleman's time is expired and now recognize myself for 5 minutes for questions.

Mr. Lau, your contract was awarded on July 1st of this year. Is that correct?

Mr. LAU. Yes, Congressman.

Mr. BURGESS. So on July 2nd, things changed, didn't they, as far as the employer mandate was concerned?

Mr. LAU. Correct, yes.

Mr. BURGESS. So were you prepared for that contingency? Was this something that had been discussed as you were tendering that contract?

Mr. LAU. Well, at that stage, we were prepared because we hadn't—we were just really getting started then. So there was not a change of course that was required.

Mr. BURGESS. Had you been to the White House and talked to the administration about some of these changes that they were contemplating?

Mr. LAU. No, Congressman.

Mr. BURGESS. Ms. Campbell, let me ask you, at any point have you or CGI been to the White House to discuss the potential changes that were coming to the Affordable Care Act, the contingency plans that they were laying?

Ms. CAMPBELL. No, sir, we have not.

Mr. BURGESS. And Mr. Lenz, how about yourself?

Mr. LENZ. Well, we are not contractors, sir, so we have had discussions with the administration with respect to the employer mandate but not with respect to implementation of the infrastructure.

Mr. BURGESS. But in regards to the employer mandate, what were those discussions?

Mr. LENZ. Well, our group in particular had tremendous concern about implementation and specifically around the definition of who is a full-time employee, given the unique nature of our workforce—lots of people that come and go. Their work patterns are unpredictable and uncertain, and at least in that respect, the administration acknowledged that that posed significant problems, not just for employers but also for the administration of the program. So we were able to agree on a look-back rule. The administration was accommodating in that respect. But as I noted in my opening remarks, it is not the whole—it doesn't answer all of the questions. We still have lots of questions relating to reporting, how the premium tax credits will be administered and so on.

Mr. BURGESS. These meetings at the White House, when did they occur?

Mr. LENZ. Well, they were—I wouldn't say they were at the White House. They were with the agencies that are responsible for the development of the rules, primarily treasury.

Mr. BURGESS. Did you talk to them during the month of June?

Mr. LENZ. I can't recall whether we actually spoke to them in June. We had several meetings with them.

Mr. BURGESS. Mr. Lau, let me go back to you. Your contract is a cost-plus arrangement. Is that correct?

Mr. LAU. That is correct.

Mr. BURGESS. And because of the changes that have occurred, well, if I am doing the arithmetic correctly, this will represent about 10 percent of your business. Is that correct?

Mr. LAU. The employer postponement? Is that what you are——

Mr. BURGESS. No, no, just your contract.

Mr. LAU. Oh, with this—I don't know the exact percentage for Serco. You may well be correct.

Mr. BURGESS. You record a cost, or your contract price was $114 million.

Mr. LAU. Base year, yes, sir.

Mr. BURGESS. And your annual revenues are about $1.2 billion?
Mr. LAU. That is close to 10 percent, yes, sir.
Mr. BURGESS. So this is a big deal for you all?
Mr. LAU. It is certainly a big deal, yes.
Mr. BURGESS. And, I mean, does it concern you that as you—I mean, you are working through a highly complex set of circumstances. Does it concern you that things seem to be changing?
Mr. LAU. I think that things generally tend to change in complex programs like this. I have been doing these for 30 years. The company itself has lots of experience, and the one thing we know is that change is a constant, and sometimes the pace of that change increases as you get closer to the deadline.
Mr. BURGESS. See, and this is what——
Mr. LAU. We are prepared to accommodate and adjust to whatever changes.
Mr. BURGESS. But look, at the committee level, we invite members of the administration in. We expect to get answers to our questions, and the question about contingency plans, and what are you doing to deal with the complexity of this program, really, we get no answers, so your responses today are really the first that we have heard that the administration is in fact or the agency is in fact considering the fact that things may not be exactly as they think.
Mr. Graham, let me just ask you a question because you used a word that I had actually used in questioning Mr. Cohen from the Office of Consumer Information and Insurance Oversight. You used the word "de-scoping." Is that something that you have encountered in your study of this?
Mr. GRAHAM. Yes. In fact, many of the State-Based exchanges have been very public in their intent. Some of the earliest ones were messaging their plan to de-scope as early as April, so it is the right thing for them to do, given where they are.
Mr. BURGESS. Yes, I don't disagree with that, but again, Mr. Cohen, in response to a direct question at the end of April, said no de-scoping, no delay.
My time is expired. Let me recognize Mr. Green for 5 minutes for questions, please.
Mr. GREEN. Thank you, Mr. Chairman.
I appreciate our panel being here today because of our oversight effort on the law now, and coming from Texas, it is really important because we have a national plan. Our State decided not to participate.
One of the things I want to talk about is, the Affordable Care Act sets important nationwide standards on insurance plans and makes financial assistance available to those who need it, but the law preserves the State's primary role in regulating your insurance markets. The law was designed to be a floor and not a ceiling for consumer protections in the insurance market. It encourages States to set up their own health insurance marketplaces and tailor rules and regulations for them.
But many States, including my own, have decided to turn over control of their health insurance marketplace to the Federal Government. Handing the keys to the Federal Government seems to be a strange way to be pro-States' rights, but that is their option. In

contrast, States like Maryland and California have been running their own marketplaces and working to implement the law and have driven down insurance premiums, expanded options for small businesses and helped simplify cost sharing and deductibles.

Ms. Kraus, what benefits can States realize by taking a more active parting implementation and setting up their own marketplaces, and how would things look in your State if they were taking a more active role?

Ms. KRAUS. Thank you, and like Texas, Pennsylvania has decided to default to the Federal Government. In doing that, we have given up a lot of flexibility and we have really been slow to move forward. For example, we were the 40th State to submit our plans to integrate our IT. We submitted it after the deadline was passed, so that is slowing up the process in Pennsylvania. We have seen other States go above the Affordable Care Act standards. Oregon, for example, went above the requirements of the ACA in terms of rate review. This year they brought in $69 million from waste, fraud and abuse at looking at insurance plans in the marketplace in 2014. Other States have done things to strengthen their essential health benefits package. We defaulted to a larger small group plan. States have, you know, defined rehabilitative services, providing, you know, consumers with greater protection with disabilities. So we have really passed up the ability to be innovative and creative and really craft a marketplace that would work best for Pennsylvania.

Mr. GREEN. I want to ask you about fraud and subsidies. We have heard this the last few weeks—in fact, the House may be voting tomorrow on it—about a particularly offensive attack we heard recently on health reform that the health insurance subsidies will be rife with fraud. Marketplaces will have robust verification of consumers' income before they receive any financial assistance, and the IRS will make sure no one receives excess subsidies when taxes are filed at the end of the year. There are penalties for perjury for lying to get these benefits, and the ACA even added new penalties for providing false information on the application. And yet we still hear what I consider slander of the hardworking people who get a little help from these programs are really just fraudsters trying to get benefits they aren't eligible for.

Ms. Kraus, you worked with many folks who might need a little assistance from these important public programs. These people, are they just people looking for a free lunch or are they actually willing to commit fraud to get it?

Ms. KRAUS. No. I mean, look, the majority of folks that would qualify in Pennsylvania for Medicaid expansion, about 80 percent of them have one full-time worker in a job. They are just trying to get health insurance to protect them and their family. I think you pointed out, HHS has been very clear in setting up guidelines on protection against fraud and penalties for navigators that choose to not have security standards in place. If we look at how folks apply for health insurance today, you have to hand over an array of your health history, very private data. An insurance company can decide whether or not you have health insurance. Going forward, it is income, it is age and geographic location. So, you know, to me, that

is a lot safer than handing over very personal, detailed health insurance records.

Mr. GREEN. Well, as we know, October 1st, States like Pennsylvania and Texas, we are going to have a national plan with no State input. I am not familiar with Pennsylvania law but I know as a former State legislator in Texas, we tried to get, for example, 80 percent of the premium by statute. Does Pennsylvania have anything on a State level that requires a certain amount of premium to go back to benefits like the Affordable Care Act does?

Ms. KRAUS. No, we don't, so the Affordable Care Act actually makes sure that, you know, Pennsylvania consumers are protected, and I think in Pennsylvania, the average Pennsylvania consumer saw about $200 in a rebate this year from refunds from insurance companies that did not spend 80 percent on actual care.

Mr. GREEN. Well, I appreciate that because that is one of the things I hear from employers, particularly small businesses, by going to their exchanges and they can starting October 1st but they will be able to make sure that at least 80 percent of their premium dollar will come back to benefits.

Ms. KRAUS. Correct.

Mr. GREEN. Thank you, Mr. Chairman.

Mr. BURGESS. The gentleman yields back his time. The Chair now recognizes the gentlelady from Tennessee 5 minutes for questions, please.

Mrs. BLACKBURN. Thank you, Mr. Chairman, and thank you all for being here and for your testimony and allowing us to do the due diligence that our constituents expect from us.

Mr. Lenz, I would like to come to you, if I may, sir.

Mr. LENZ. Yes, ma'am.

Mrs. BLACKBURN. We have all been in our districts for 5 weeks, and I have to tell you, not a single day went by that I did not hear from employers or employees and hearing about changes, reductions in benefits, uncertainty, confusion, and you know, they say, well, the employer mandate, that delay for a year still doesn't take away that underlying requirement. We know that it is still there and it is going to be affecting jobs and job creators. All these mandates seem to just have a crushing effect. I met this morning with a group of business leaders from another State, and when I said our goal is to delay, defund, repeal, replace Obamacare and find something workable, they broke into applause because in their State, just like in mine, it is a huge problem.

So what I would like for you to do is take just a few seconds and expand on your testimony and kind of connect for us how the Obamacare requirements on employers are causing the job market to contract and not to grow.

Mr. LENZ. Well, thank you, Ms. Blackburn. We do represent a specific group of employers and a specific concern in regard to what we sometimes refer to as variable-hour employees, that is, temporary, part-time employees who work patterns are intermittent, unpredictable, short term and so on. They present unique challenges under the statute. We certainly recognize that there is general concern on the part of employers about implementation, and we have addressed some of that in our own testimony, but I would have to confine my comments to the unique circumstances of our

particular workforce, and there are lots of them. As I pointed out, there are upwards of 30 million employees that are in that category, and so we have made some progress, I think. We recognize that it is the law and that we are compelled to comply with it but we still have major concerns about implementation, the timing of it, and as you pointed out, the fact that the employer mandate has been delayed a year does not mean that we don't have to be ready now. In fact, we had to be ready yesterday and 6 months ago, and we weren't and couldn't in large because rules weren't out that we could rely on, in particular, regarding the reporting rules. Now, they just came out last week and we are scrambling to look at them and to digest them. We were somewhat disappointed to see that some of the suggestions that we had urged that had not been adopted for various reasons, and we understand that there is lots of complexity associated with it, but it doesn't relieve the fact that we have major concerns about implementation on January 1st of this coming year, not 2015, because all these software programs have to be in place, up and running, so that employers can begin to track hours now in order to know who they have to offer coverage to on January 1, 2015. So this has been an ongoing problem in trying to get certainty and answers as to how we need to operate in order to comply.

Mrs. BLACKBURN. Thank you.

Mr. Lau, I want to talk with you a minute about Serco. You know, you are talking about the data you have got to start holding now in order to be ready on January 1, 2015, and then as you look at the amount of information on your employees. Well, one of the main problems that we hear about from our constituents, the main concern is the lack of privacy that they are going to have, and their lack of faith that people are going to be able to protect that personally identifying information and the fear that some of that could be used against them. So what kind of provisions are you putting in place?

Mr. LAU. Well, Serco has a very comprehensive privacy and security program beginning with security of the facility, thorough background checks on each and every employee that will work there, compartmentalization of the roles and functions of the employees, role-based security so that employees can only see certain parts of an applicant's record. We deal with no personal health information. None of that is there. It is PII mostly. We also have extensive training, a cultural background to instill in all of our workers respect for the information and the fact that it represents very personal information of people and citizens. In addition, there are a number of technological components as well in compliance with Federal information security standards and NIST standards and things like that so there are firewalls and other preventions. So the networks are not accessible to the Internet. They are point-to-point networks and so there is just layer after layer of security in place.

Mrs. BLACKBURN. Thank you. Yield back.

Mr. PITTS. The Chair thanks the gentlelady and now recognizes the gentlelady from the Virgin Islands, Dr. Christensen, for 5 minutes for questions.

Mrs. CHRISTENSEN. Thank you, Mr. Chairman, and thank the panelists for being here this morning.

I want to focus on some of the concerns that Mr. Butterfield raised earlier. Mr. Graham, in your testimony you described consumer outreach as being very important. As a matter of fact, it is one of your four key areas of concern. By consumer outreach, I assume you mean advertising, public events and the navigator program and similar efforts to inform the public about their new insurance options in the exchange. Is that correct?

Mr. GRAHAM. That is correct. When I say outreach, I mean just going out in the community and making consumers aware of their choices so that they might make the optimal choices for themselves.

Mrs. CHRISTENSEN. And is it also important to make sure that the largest number of young people and healthy people are also engaged, taking advantage of the exchange so that the cost might be lower?

Mr. GRAHAM. One of the changes that the ACA brought about was clearly how risk pools would be created, and as the risk pools are created, certainly, as with any insurance product, it is necessary to have a broad spectrum of individuals in that pool. And so if the exchanges were not able to attract those individuals, there would be problems in subsequent years.

Mrs. CHRISTENSEN. And so you would agree that States that are not doing the consumer outreach and education are likely to see higher costs than those who are more active?

Mr. GRAHAM. Well, when you say higher costs, higher costs overall or higher costs——

Mrs. CHRISTENSEN. Of the premiums.

Mr. GRAHAM. Of the premium? So they run the risk of having not attracted the right risk pool or everyone into that risk pool and so having premiums be higher in subsequent years.

Mrs. CHRISTENSEN. And Ms. Kraus, you agree also? I am sure that consumer education efforts are important to make this law work properly?

Ms. KRAUS. Yes, correct.

Mrs. CHRISTENSEN. You know, it is good to see that witnesses invited by both Democrats and Republicans agreeing on something this important. I think it is unfortunate that the Republicans are attacking the HHS for investing in efforts to inform the public, and it is even more unfortunate that they are working to undermine the civic and community groups that are going to be doing some of that consumer outreach, and I hope we can agree, just as President Bush did with Medicare Part D, a robust consumer outreach and education campaign for these new insurance options is important, and we should all get behind it.

I remember when we passed Medicare Part D. It was not the Democrats' version of the bill. It created a donut hole that didn't treat the territories equitably, and yet I went out across my community to do outreach to ensure that people understood the bill and engaged our foundation in doing a lot of outreach across the country. And, you know, I think that is that the we ought to go instead of trying to undermine the law and unfund the law that is already helping individuals across the country.

Ms. Kraus, I was in Pittsburgh about 2 weeks ago at a women's conference and heard firsthand and personal the issues of health

disparities and lack of insurance in that community, and it is extremely unfortunate that Medicaid expansion is not going to be accepted even, as you have said, when it creates jobs, helps the economy in Pittsburgh and of course provides services to many—this is a women's conference who are uninsured in the area.

I think, you know, that really was the question that I wanted to ask, Mr. Chairman, and I will yield back the balance of my time.

Mr. PITTS. The Chair thanks the gentlelady and recognizes the gentleman from New Jersey, Mr. Lance, 5 minutes for questions.

Mr. LANCE. Thank you, Mr. Chairman, and good morning to the panel.

Mr. Graham, as I understand it, under the law, States will be responsible for accepting application transfers from an exchange where Medicaid eligibility needs to be determined. There has been some systems testing of such transfers where in fact Medicaid eligibility is valid. However, testing has not been completed for cases where Medicaid eligibility cannot be determined for various reasons including an incomplete file. From your perspective, Mr. Graham, has there been sufficient testing with the States, and if not, what are some of the financial risks to the States?

Mr. GRAHAM. So the question about has there been sufficient testing, one of the key things here is that it is different in every State so that some States are further along in testing, and certainly more testing would be more beneficial. The risks of not having testing completed or if something doesn't work as plan is really delay: delay for the consumer and delay for enrollment. So in those instances where things cannot be done in an automated or electronic way, then physical documents have to be faxed in or brought in in some form or fashion and interaction has to occur with the consumer that delays the actual process to be able to become enrolled. So the risk is delay.

Mr. LANCE. And can you estimate how long that delay might be?

Mr. GRAHAM. We know that HHS is required to be able to actually, in instances where it goes to a manual system or has information brought in, it has a 90-day review period. So that is what the law requires. I can't estimate in terms of how long things might go out should there be challenges in Medicaid and HHS.

Mr. LANCE. It would be my suspicion at least that it will be longer than 90 days. Do you share that suspicion?

Mr. GRAHAM. I think delays tend to be longer than we originally expect.

Mr. LANCE. Can you tell us, perhaps you don't know this, which States have done a good jobs so far in this regard and which States need to do a better job?

Mr. GRAHAM. I would be happy do that offline for you in terms of getting into specifics with States.

Mr. LANCE. Thank you, Mr. Chairman, and am willing to yield my time to anyone who would like it. Dr. Burgess?

Mrs. BLACKBURN. If the gentleman would yield?

Mr. LANCE. Whatever time the gentlelady would like.

Mrs. BLACKBURN. Just a couple of minutes. Adding to your question, which I think was a great one on detailing the States, and you said you would talk with the Congressman offline. I wish that you

would submit that in writing so that it could be put into the record of the committee, and I yield back to Mr. Lance.

Mr. LANCE. Thank you. Is there any other member on our side who would like——

Mr. PITTS. If the gentleman would yield?

Mr. LANCE. Absolutely. I certainly will, Mr. Chairman.

Mr. PITTS. Mr. Lenz, I had another question. In my opening statement, I mentioned that Eastern Lancaster County School District, Penn Manor School District in Lancaster, Pa., both announced that they were outsourcing some employees to avoid the cost of complying with the ACA's employer mandate. The school districts simply cannot afford to pay for the additional expenses covering these individuals. Are you hearing similar stories or anecdotes like these from members of your coalition due to the ACA?

Mr. LENZ. Yes, we are hearing questions being raised as to whether businesses or entities that would otherwise be subject to the ACA would try to outsource some of their workers in order to avoid the rules. It is not clear how that is actually going to play out because the responsibility for employer coverage is going to be determined based on common law employer rules. So it really ultimately will be a legal question as to who the responsible employer is. We have addressed that at great length to our members of the American Staffing Association. I am not speaking on behalf of E–FLEX now but temporary staffing firms are in the business of supplying employees to other businesses that require temporary help or other contract help, and so there are questions in those so-called third-party employment relationships who is the actual employer. Our view is, if the temporary staffing firm, for example, is offering or providing compliant health care coverage, it shouldn't ultimately matter who technically the common-law employer is as long as the arrangement is not being used to circumvent the law. But those are technical questions. In some cases they raise thorny issues but they remain to be addressed as we go along.

Mr. PITTS. Thank you. The gentleman's time is expired. The Chair now recognizes the gentlelady from Florida, Ms. Castor, 5 minutes for questions.

Ms. CASTOR. Thank you, Mr. Chairman, and thank you to the panel. This is an important time in the enrollment, or in the implementation of the Affordable Care Act, particularly with the online marketplaces about to come online in the open enrollment period that will run October to March. In my home State of Florida, it is particularly important. The U.S. Census Bureau reported over the last couple of weeks that 25 percent of the population in the State of Florida is uninsured. That is about 3.8 million individuals. Now, most people have insurance, and if you have insurance, you want other people to have insurance because otherwise you are going to—part of your copayment and premiums is going to go to subsidize folks who do not have insurance, and if you have insurance today, you have already seen the benefits of the Affordable Care Act. In essence, you have new rights. You cannot be discriminated against for preexisting conditions. You cannot be kicked off your policy if you get sick. In the greater Tampa Bay area, we already have almost 50,000 young adults who have been able to stay on their parents' policies. That is very positive. Over 200,000 small

businesses in the State of Florida are eligible for the new tax credits. That is very meaningful in a State that has so many mom-and-pop small businesses.

One of my favorites for folks who have insurance today is the fact that just in the greater Tampa Bay area, over $47 million has come back into the pockets of families due to the new requirements that 80 to 85 percent of your premiums and copays have to go to health insurance. So rebates have come back to about a million people just in my greater community.

But what concerns me now is that we are not all working together to address the flaws and improve the Affordable Care Act. Instead, we continue to run into obstruction. Last month, Ranking Member Waxman and the Democrats on this committee released an analysis describing 10 ways that Republicans have acted to undermine and obstruct the Affordable Care Act. That in addition to the 40 repeal votes that have taken up precious time here in the House this session. That is a waste of time. We have got to be working together on this. And then when you look across at the States, Republicans Governors, including mine, some have refused to take the Medicare expansion in the State of Florida. That means that our hard-earned tax dollars that Floridians have paid are most going to come back to our State, $50 billion over the next 10 years. That is not smart. That is not in the public interest.

But I wanted to highlight to my colleagues today the one that takes the cake, the one that wins the ideology over the public interest award, and that is the fact that in the State of Florida, the Republican legislature passed a law to actually remove State oversight and regulation of insurance companies and their rates. When Secretary Sebelius was in Florida a few weeks ago, she said she knew of no other State that had gone this far. The States still have the authority to negotiate and regulate insurance rates. So in this effort to elevate ideology and obstruction over the best interests of my neighbors, they now have taken the cops off the beat to regulate insurance rates. I want to know if anyone on this panel thinks that that is in the best interest of our businesses and consumers. I didn't think so. I haven't heard of anyone outside of the Republican legislature and our Governor, even if they don't like Obamacare and the Affordable Care Act, that thinks it is reasonable for the State to put insurance companies in charge of where the rates go. I really think it is a shame, and like I said before, if you have insurance, you want other folks to have insurance.

Ms. Kraus, I would like to ask your perspective on these Republican efforts to undermine the law. What kind of impact are they having on the implementation in your State? I can tell you in my State, it is very problematic.

Ms. KRAUS. Yes, I mean, I just to emphasize this again and really hit this home. Medicaid expansion is huge, and when we have 400,000 people with health insurance, and that affects every single person. It affects, as you said, the folks that have health insurance, we are paying for that, and we are going to continue to have to pay for that. Like Florida, Pennsylvania's tax dollars are going to be thrown out the window to pay for health insurance coverage in other States. We are an island of no amongst other States. Our

neighbors, New Jersey, Ohio, Maryland, they are all moving forward with Medicaid expansion.

Ms. CASTOR. Thank you, and I yield back.

Mr. PITTS. The Chair thanks the gentlelady. The Chair now recognizes the gentleman from Louisiana, Dr. Cassidy, 5 minutes for questions.

Mr. CASSIDY. Thank you, Mr. Chairman.

Mr. Graham, earlier there was a question suggesting the possibility of fraud in this arrangement where there wouldn't be income verification was merely a straw horse—straw man. I understand that under the earned income tax credit, it is estimated that 21 to 25 percent of the payments are fraudulent, and that is when they totally integrated hub with the IRS. Now, are you as comfortable that in States like California where it is going to be self-attestation with no verification by the IRS that the level of fraud will be less, or what is your perspective as to what is going to happen?

Mr. GRAHAM. I am not an expert to project on what the fraud may or may not be. I will just say that in areas where the systems testing hasn't been completed or hasn't done to the full extent that it was originally intended to or needed, that the potential for fraud exists.

Mr. CASSIDY. And knowing that we are all sinners and fall short of the glory of God, it seems reasonable that there could be some fraud?

Mr. GRAHAM. That is a reasonable expectation.

Mr. CASSIDY. I mean, it is almost laughable to say that there won't be, and there is going to be a trillion dollars spent on the health insurance exchanges over the next 10 years. The Federal taxpayers are about to get whacked.

Ms. Campbell, you mentioned that everything is kind of going well as regards a baseline, but it is my understanding that the systems have not included foreign-language support, and yet I have already read that the hope to get the big numbers, the young men who currently are not insurance but will theoretically pay three times the market rate in order to participate in the exchange, will rely on people who are minorities, many of whom will not have English as a primary language. So that said, is it true—I mean, you tell me, I don't know—are the exchanges robust in terms of their ability to support folks for whom English is not a primary language?

Ms. CAMPBELL. So Spanish is part of the rollout for implementation.

Mr. CASSIDY. But is it ready? Is the Spanish—put it this way. If I was a primary Spanish speaker, would I be able to log on and have a seamless experience as regards my ability to interface with the forum?

Ms. CAMPBELL. For the online application, yes.

Mr. CASSIDY. And what about Vietnamese?

Ms. CAMPBELL. I don't have an answer for that but I can get back to you.

Mr. CASSIDY. That would be great. Chinese, Mandarin?

Ms. CAMPBELL. I have an answer for the Spanish version. I can get back to you with the other dialects.

Mr. CASSIDY. OK. So for these other folks who perhaps are not currently insured in Orange County, which I gather Orange County has the greatest concentration of Vietnamese outside of Vietnam may not be quite ready. Now, granted, a lot of those folks speak English, but still I am a little interested.

Mr. Lenz, I have heard the President's health care law described as one of the most significant anti-growth policies that have been passed by Congress. I am proud to say I voted against it. And that we continue to see a declining unemployment rate but only because people are dropping out of the job market. The total number of jobs is actually terrible. It is just that people are no longer looking for work.

Now, you described something along those lines. The businesses that you represent, do you say that they are encouraged to grow by this law or perhaps they are otherwise encouraged?

Mr. LENZ. Well, it is almost cliché to say that businesses don't respond well to uncertainty and higher costs have an impact on hiring. Those are just basic business truths. I think our members believe that. I think we are particularly concerned about the definition of full-time employee as we mentioned. The 30-hour definition we think is not working well and is having perverse economic impacts already.

Mr. CASSIDY. And if I may interrupt, also, when I speak to small business owners, she will tell me that she is spending so much thinking about this law, she is not actually thinking about how to expand her business. She is trying not to run afoul of the Federal Government as opposed to where do I next open up. Is that a fair statement?

Mr. LENZ. Well, let me just say on behalf of the American Staffing Association, which represents temporary staffing companies, the great majority of which are small business owners, we have lots of employees that come and go but most of them are small businesses by anybody's reckoning. There is tremendous anxiety about enforcement, very much confusion because of the complexity.

Mr. CASSIDY. So it is fair to say, if they are confused, conflicted, whatever, then it is fair to say that they are not thinking as much about expanding their business?

Mr. LENZ. I think that is a fair statement.

Mr. CASSIDY. Lastly, let me just make the point, Ms. Kraus, you have been very wonderful about how Pennsylvania is going to benefit from this, but let me just say that Pennsylvania's small group market has a projected 27 percent increase in their premiums, that Pennsylvania's individual market, one insurer predicted an average increase of 30 percent in the individual market, males facing premium increases of 11 to 63 percent. Heck, it doesn't seem as good for the law in Pennsylvania if you are that male getting a 63 percent in your premium.

Ms. KRAUS. Well, I mean, I think a couple of things. First, when we talk about small businesses, we have to remember that small businesses with 50 or fewer employees are exempt from having to offer health insurance coverage, and I think when you go out——

Mr. CASSIDY. So your only salvation is that you are exempt?

Ms. KRAUS. No, but I think when you go out and talk to small businesses, a large concern is, you know, the cost of health insur-

ance. We have seen health insurance costs rise astronomically over and over for years before the Affordable Care Act, and for the first time in history, insurance rates have slowed, and this year they only grew by 4 percent. So I think this is going to start to help small business owners that can now pull their power together and get coverage that is offered——

Mr. CASSIDY. Based on what the insurers say, it seems more an article of faith. It is a hope. It doesn't seem to be what the insurers are saying.

I am out of time. I yield back. Thank you.

Mr. PITTS. The Chair thanks the gentleman and now recognizes the ranking member of the full committee, Mr. Dingell, for 5 minutes for questions.

Mr. DINGELL. Thank you, Mr. Chairman, for holding this hearing, and thank you to our witnesses.

First of all, I welcome the opportunity to hear from our witnesses today about the progress of ACA implementation. One misconception that seems to be a big one is the data hub. These questions are for Mr. Finkel of Quality Software Services Inc. Mr. Finkel, these are yes or no questions. QSSI has a contract with CMS to work on what is known as the data hub. Is that correct? Yes or no.

Mr. FINKEL. Yes.

Mr. DINGELL. Now, Mr. Finkel, we have heard from some that the data hub will be this new government database with personal medical information. Is this an accurate characterization of the program? Yes or no.

Mr. FINKEL. No.

Mr. DINGELL. Would you submit for the record what is a correct representation of the circumstances, please?

Mr. FINKEL. Yes.

Mr. DINGELL. All right. Now, instead, is it fair to say the data hub is technological tool to help facilitate the transfer of data between government agencies? Yes or no.

Mr. FINKEL. Yes.

Mr. DINGELL. Now, will data hub handle personal medical records at all? Yes or no.

Mr. FINKEL. No.

Mr. DINGELL. Mr. Finkel, will the data hub be up and running 3 weeks from today on October 1? Yes or no.

Mr. FINKEL. Yes.

Mr. DINGELL. Could you please submit for the record a summary of the functions of data hub that may relate to an earlier question I asked? Could you do that for me, please, sir?

Mr. FINKEL. We will work with the committee on that.

Mr. DINGELL. Very good. Work with me. This committee might not be quite as helpful.

The next questions are for Mr. Lau of Serco. Mr. Lau, does Serco have experience in handling applications and records management for government agencies? Yes or no.

Mr. LAU. Yes.

Mr. DINGELL. CBO has estimated that 6.2 million paper applications will be submitted between October 1, 2013, and March 31, 2014. Does Serco have the capability to handle this large amount of paper application? Yes or no.

Mr. LAU. Yes.

Mr. DINGELL. Now, Mr. Lau, how many people has Serco hired to work on this CMS contract?

Mr. LAU. To date, 1,200. The plan is for about 2,000 by October 1st.

Mr. DINGELL. Now, if you want to submit for the record, it would be appreciated.

Now these questions are for Ms. Spellecy of Equifax. Ms. Spellecy, will Equifax get prior consent from a consumer before conducting an income verification report on that individual? Yes or no.

Ms. SPELLECY. CMS will obtain the consent first, yes.

Mr. DINGELL. Thank you. Now, does this practice go above and beyond what is required of Equifax under the Fair Credit Reporting Act? Yes or no.

Ms. SPELLECY. Yes.

Mr. DINGELL. Now, has Equifax done testing of your income verification systems with data hub and the State exchanges? Yes or no.

Ms. SPELLECY. Yes. Now, will income verification services provided by Equifax be ready in 3 weeks when the marketplaces are open or rather are available for open enrollment? Yes or no.

Ms. SPELLECY. Yes.

Mr. DINGELL. Now, I want to thank you all for your testimony. This is a critical time in our history. The American people are counting on us. When I was back home in Michigan just recently, my constituents weren't asking me political questions about the Affordable Care Act. They wanted to know where and how to sign up for quality, affordable health care that will help their families and their small businesses. We have only 3 weeks before the marketplaces open. The time for political games is over, and it is time for this body, the Congress, and the Senate, to quit playing games. It is also time for us to understand that we have to work together. The law is the law, and ACA is the law of the land, and frankly, we should all be working together to ensure that implementation goes smoothly as possible in the interest of seeing to it that we don't waste hundreds of millions or perhaps billions of dollars that has been spent so that and that we don't dissipate our opportunities to see to it that the American people can get a chance to see to it that health care is a matter of right, not a privilege just for those who are well-to-do, and I would observe that working men and women need this legislation. It is something which will help them to live a better quality of life and will improve medical care all across the board. I would also note that it is saving money for everybody in sight, and if we will just give it a chance and work together, I believe the country will be better off for it. I thank you, Mr. Chairman.

Mr. PITTS. The Chair thanks the gentleman and now recognizes the gentleman from Virginia, Mr. Griffith, 5 minutes for questions.

Mr. GRIFFITH. Thank you, Mr. Chairman, and I appreciate it very much. I appreciate all the witnesses being here. As you might gather, Mr. Dingell and I do not agree on this point although I respect him greatly and appreciate his contributions over the many decades to this committee, and obviously whenever you have a law

on the books, it is Congress's obligation to review it and make sure it makes sense, and each Congress has a separate obligation to do that, and we come to somewhat different conclusions.

Mr. Lenz, I noticed with some interest on your summary of major points, your very last point, you said it would impose a major administrative burden on employers and result—referring to the large employer auto-enroll requirement—and result in an unexpected payroll deduction for many employees who do not want it or need coverage. Am I to assume that you are referring to perhaps the husband whose wife has a much better plan with her employer and now he is going to be automatically enrolled, albeit his wife has a better plan and already has a family plan for them and their children? Is that the type of thing you are referencing?

Mr. LENZ. That would be one example.

Mr. GRIFFITH. And would another example be the one that a constituent came to me with last year or a similar situation where a student, full-time enrolled in college, also held a full-time job and through the Affordable Care Act was forced off of their parents' plan because they were eligible through their employer and then they ended up having to spend more money because obviously being part of a family plan with their parents, it was free, but now because they were doing what I hope my kids will have the fortitude to do, carry a full-time load at school and a full-time job, it ended up costing them several thousand dollars a year. Would that be another example of that kind of a problem that this Act is just not ready for?

Mr. LENZ. Yes, sir.

Mr. GRIFFITH. And I would ask the gentleman also, I noticed on page 5 of your testimony, you indicate that the 1-year delay of the employer requirements means employers will not have penalty exposure until 2015 but they must still have their information technology and human resources systems in place by January 1, 2014, in order to track employees' hours of service in 2014 and comply with the ACA coverage obligations on January 1, 2015, but I would ask you, Mr. Lenz, has your organization taken into consideration what happens if the courts determine that the President didn't have the authority—and I ask this question because I can't find where in the bill the President has the authority to delay the employer mandate. If a court finds oh, let us say, next September that the President didn't have that authority, you all have got the records, aren't your employers then responsible for going back in and reimbursing the costs of that health insurance to their employees that they thought they weren't mandated to provide but now they are if they hadn't provided something that would have been in compliance with ACA as of January 1, 2014?

Mr. LENZ. Well, that would be quite a conundrum.

Mr. GRIFFITH. And isn't it a possibility, understanding that there is nothing directly authorizing the President to delay the employer mandate and recognizing that we do live in a litigious society?

Mr. LENZ. We do indeed, sir.

Mr. GRIFFITH. And so this conundrum could be a great detriment to many employees in the United States, and isn't it also just one of the thousands of examples out there of why you are concerned

about employers not knowing what the rules are and what they have to do and what is coming next as a part of this Act?

Mr. LENZ. There are multiple opportunities for unforeseen consequences here.

Mr. GRIFFITH. There are indeed. There are indeed.

I would go back to Mr. Graham. I was reminded when you were talking about the fraud—and I know you don't want to get on record as to what percentages are fraud or whether it will be more or less, and I understand that, but a friend of mine once explained to me, and I thought it made good sense, that locks are just there to help keep the honest men and women honest, and that that is why you have locks because if there is somebody who really wants to get into your house or get into your car, they are going to figure out a way to get in. And so doesn't it cause you some concern that we don't have proper locks in place on fraud when it comes to this particular Act and the various requirements that you say what your income is or don't say what your income is?

Mr. GRAHAM. When I ride my bicycle to work, I lock it up.

Mr. GRIFFITH. Yes, sir. I appreciate your answer.

Mr. Chairman, unless somebody wants my last 30 seconds, I yield back.

Mr. PITTS. The Chair thanks the gentleman and now recognizes the gentleman from Florida, Mr. Bilirakis, 5 minutes for questions.

Mr. BILIRAKIS. Thank you so much. Thanks for holding this hearing. I apologize for being late. I was at the other hearing.

A question for Mr. Lau. Did CMS, in any of your conversations, state why they waited until July to issue the contract?

Mr. LAU. No, it was a competitive procurement, so I am not sure what——

Mr. BILIRAKIS. Well, did they not know that paper processing was required when the exchanges would go online? Do you usually get contracts affecting 6.2 million people 3 months before it occurs?

Mr. LAU. Well, this one was certainly more challenging that most in that regard in time spent.

Mr. BILIRAKIS. Thank you.

A question for Ms. Campbell. Ms. Campbell, can you talk about CGI's role in the exchange? Do you make all final decisions for yourself and the subcontractors?

Ms. CAMPBELL. I would be happy to discuss the role of CGI as our role on the exchanges. For us, I would like to equate it to sort of the face of the exchange. This is where an individual will be able to go into a portal, sign up, actually put in a profile, peruse the database or peruse the system to determine which plan is of interest to themselves. They will also be able to determine their eligibility through a series of questions, and then they will make their selection, and that is the portal that CGI is developing for the marketplace, or for the exchange.

Mr. BILIRAKIS. Next question. Ms. Campbell, who is ultimately considered the integrator, or quarterback, for making sure the exchange works properly?

Ms. CAMPBELL. That would be CMS.

Mr. BILIRAKIS. Thank you.

Next question for Mr. Finkel. Will QSSI be offering the Data Services Hub after open enrollment on October 1st through 2014?

Mr. FINKEL. No. As I stated, CMS will be operating the Data Services Hub once it goes live.

Mr. BILIRAKIS. Another question. According to the Inspector General Office's report, it says that CMS's Chief Information Officers expects to make a security authorization on September 30th. Is it responsible to make this decision so late in the process? The original timeline, as I understand, was September 4th, the decision would be made. Can you comment on that?

Mr. FINKEL. I cannot comment on CMS and what they will approve and when. I can tell you that the Data Services Hub has gone through a security risk assessment that was completed on August 30th and we have no reason to believe why CMS cannot sign off on the Data Services Hub.

Mr. BILIRAKIS. OK. Thank you very much, Mr. Chairman. I appreciate it. I yield back.

Mr. PITTS. The Chair thanks the gentleman. That concludes the first round of questions. We will have one follow-up on each side. So Dr. Burgess, you have 5 minutes for follow-up.

Mr. BURGESS. Thank you, Mr. Chairman.

Ms. Campbell, let me just ask you, in your testimony you referenced that your company has achieved all its milestones and the last one you referenced was the operational readiness review in September of 2013. Do I understand that correctly?

Ms. CAMPBELL. That is correct.

Mr. BURGESS. Is that something you can make available to the subcommittee?

Ms. CAMPBELL. I can make available our report that we submitted to CMS.

Mr. BURGESS. Can you make that—have you made it available to the committee?

Ms. CAMPBELL. We have not made that available to the committee.

Mr. BURGESS. Well, then I would ask that if you would make that available to the committee. Mr. Chairman, when staff gets that, I would appreciate the opportunity to review it.

Mr. Graham, we talked just a little bit about de-scoping, and the reason this is important, and I am not just picking on this, but look, February 1st with the elysian fields of Obamacare still 11 months away, the window for application to the Federal preexisting program closed, and it closed rather suddenly without warning to the people who had been trying to go six months without health insurance to age into the program. So for almost a full year, the promise of coverage for preexisting conditions has been an empty, hollow promise. The caps on out-of-pocket expenditures was very quietly delayed for a year. Apparently the press picked it up here in the past month but it was something that actually happened much earlier in the year. Of course, we have had the discussions about the employer mandate being delayed. There have been other pieces of this apparatus that have sort of fallen into the barrage on the way to October 1st and January 1st. When you all talk together, when all of the smart minds who are in charge of the outsourced implementation, when you get together, are there things that you talk about and speculate about that may be the

next to go or the next shoe to drop as far as the pieces of the Affordable Care Act that may go by the wayside?

Mr. GRAHAM. With respect to the de-scoping, when we look at what capabilities each of the State-based exchanges will have and which ones will be live on October 1 and those that are not, how long they will take to come up, we project that as in many IT implementations, it will be 3 or 6 months for many of those things to go.

With respect to the law itself, there is a lot of talk about where that is. I don't know that I am the best to comment on that.

Mr. BURGESS. You are all I have got. You know, as we look at this group assembled in front of us, you are an impressive group, and there are some impressive contracts that go with the work that you sell to the Federal Government, and with all respect to the ranking member of the subcommittee, I mean, a local Meals on Wheels outfit being able to do what you all are doing and it has taken you months to do and hundreds of millions of dollars in some cases, is it really responsible to expect that some community organization is going to be able to accomplish what you all have been tasked to accomplish? I mean, anybody is free to answer that question. I should do like Chairman Dingell; I need a yes or no. I got no answer, so Mr. Chairman, I am going to assume that it is a no.

Let me yield back the balance of my time in the interest of other members of the committee. If someone wants to claim it, they may do so.

Mr. PITTS. Thank you. The Chair recognizes the ranking member for follow-up.

Mr. PALLONE. Thank you. I am glad Dr. Burgess brought up the navigators or, in my cases, the food bank issue. You know, again, I want to ask a question of Ms. Kraus, but I disagree totally in terms of who should be a navigator. I mean, I mentioned the Food Bank of Monmouth in Ocean County, which is one of a number of organizations or nonprofits in New Jersey that, you know, received a grant to act as a navigator and now has been subject to these what I consider intimidation tactics by the Republicans on the committee, but I totally disagree with Dr. Burgess.

The Food Bank of Monmouth in Ocean County, which I am very familiar with in my district, took on this responsibility because they just get I don't know how many hundreds or thousands of people that come to the food bank on a regular basis and obviously a lot of them are uninsured and a lot of them are probably people who may be afraid to even admit that they are uninsured or go to a place to try to find insurance. And so I think they are an excellent organization that would actually be charged with trying to deal with the uninsured and navigate them so that they get insurance, and I think that the whole purpose of these grants is to try to find somebody who can play that role in a significant way, even if they don't have extensive background doing that. I commend them for taking on the role.

But Ms. Kraus, my concern is that they may be intimidated, that resources are being taken away because they have to answer all these questions at the same time that there is no evidence of any wrongdoing or any predicate for this kind of time-consuming and burdensome investigation that the GOP on this committee are

going about, and, you know, these are small community-based groups. The timing, I think, was very suspicious, imposing a burden on these groups before the October 1st rollout. It is only a few weeks away.

So can you offer some perspective on the importance of these navigators and the impact on implementation of the law if the Republicans ' intimidation disrupts their efforts? I am not asking you to say they are being intimidated but I know that some have already suggested that they might just not proceed because of the questions and all the paperwork.

Ms. KRAUS. Yes, I mean, look, 75 percent of those that are eligible for coverage have no idea that this is coming. The majority of them have never had access to health care before so a fundamental piece of the Affordable Care Act was to place community organizations in these local communities to help folks that might need a little extra help. They are not building IT infrastructure; they are there to help people kind of walk through the process and understand what health insurance means. In Pennsylvania, there are community organizations that have been helping folks for year: the Federally Qualified Health Centers, which folks walk into their office every day and they help them enroll in public assistance programs. So we are not reinventing new community organizations, and we need to be assisting these organizations to make sure they have their resources and the tools they need to reach constituents where they are and make sure they take advantage of the Affordable Care Act.

Mr. PALLONE. I appreciate that. And the other thing that I would point out, you know, New Jersey is another State where the Governor, wrongly, in my opinion, decided not to set up a State exchange, and the outreach efforts for those State are very limited. The fact of the matter is, if you didn't set up your own State exchange, a lot of the Federal dollars that would have gone to help you do that in terms of outreach are just not made available, and so it is particularly important that these community organizations be out there in this time period trying to sign people up, and I just—again, I know I am beating a dead horse here but I just feel that it was very wrong on the part of the Republicans on this committee to use these kind of tactics right now when we are really trying to sign people up, and these are community-based organizations that really have no ax to grind, they are trying to help people.

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

Mr. PITTS. That concludes the questioning. I would like to thank the witnesses for your testimony, for answering all the questions. There may be follow-up questions. We will ask that you please respond promptly as members submit those. I remind members they have 10 business days to submit questions for the record, and those questions should be submitted by the close of business on Tuesday, September 24th. Very important hearing, very important information. Thank you for your courtesy and your patience.

Without objection, the subcommittee is adjourned.

[Whereupon, at 12:22 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

Opening Statement of Chairman Fred Upton
Health Subcommittee Hearing on "PPACA Pulse Check: Part 2"
September 10, 2013

Three weeks from today the Affordable Care Act's exchanges open for enrollment, but as October 1st fast approaches the American people continue to ask, "is the administration truly ready?"

On August 1st, CMS Administrator Tavenner testified before the Full Committee on the implementation of the health law. In her testimony, she assured the committee that despite numerous delays of the law, the exchanges were on schedule and the administration would be ready to enroll Americans in new health plans beginning October 1st. She was also confident that all other provisions of the law were on track. Yet a report published by an independent government watchdog the very next day revealed that security testing for the exchange data hubs was actually months behind.

We are now three weeks from the exchanges opening for enrollment, and questions and uncertainties continue to overwhelm. Issues related to readiness testing and functionality of the exchanges have yet to be addressed. Missed deadlines, delays, and untimely guidance will affect critical components of the exchanges, including eligibility determinations, integration with existing state programs, and coordination among agencies.

This uncertainty is also real for employers. The delay of the employer mandate may provide employers with more time, but it does not provide answers or eliminate burdens. Under the law, employers are still asked to provide government-approved coverage or pay a penalty, and the reporting requirements

have not been altered, only delayed. Guidance on how reporting requirements will be administered has not been made available, leaving employers in the dark on how to plan for 2015.

I have heard firsthand from Southwest Michigan employers like Lake Michigan Mailers and ServiceMaster on how the law's costly mandates and penalties are harming business operations and health care for their workers. In another case, Kalamazoo-based manufacturer Stryker Corporation has announced that it will reduce its global workforce by approximately 5 percent, or 1,000 employees, in order to absorb the law's new domestic medical device tax. Unfortunately, these are not isolated incidents as countless job creators across the country are facing similar scenarios.

This committee has conducted ongoing oversight on the health law's implementation, and since January 2011, we have held numerous hearings to ensure the American public has the information they need. Our work will continue well beyond October 1st but this hearing is another opportunity for us to get answers for our constituents and better understand what lies ahead in the coming weeks.

I thank the witnesses for coming today, and I look forward to your testimony.

FRED UPTON, MICHIGAN
CHAIRMAN

HENRY A. WAXMAN, CALIFORNIA
RANKING MEMBER

ONE HUNDRED THIRTEENTH CONGRESS

Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515–6115
Majority (202) 225–2927
Minority (202) 225–3641

September 26, 2013

Mr. Brett Graham
Director of Exchange Programs
Leavitt Partners
299 South Main Street, Suite 2300
Salt Lake City, UT 84111

Dear Mr. Graham:

Thank you for appearing before the Subcommittee on Health on Tuesday, September 10, 2013, to testify at the hearing entitled "PPACA Pulse Check: Part 2."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your response to that question in plain text.

Also attached are Member requests made during the hearing. The format of your responses to these requests should follow the same format as your responses to the additional questions for the record.

To facilitate the printing of the hearing record, please respond to these questions and requests by the close of business on Thursday, October 10, 2013. Your responses should be mailed to Sydne Harwick, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to **Sydne.Harwick@mail.house.gov**.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Frank Pallone, Jr., Ranking Member, Subcommittee on Health

Attachments

Response to Questions and Member Requests for the Record

October 09, 2013

W. Brett Graham, Partner & Managing Director, Leavitt Partners

Hearing on PPACA Pulse Check: Part 2
United States House of Representatives Committee on Energy and Commerce
on September 10, 2013

Additional Questions for the Record

The Honorable Gus Bilirakis

1. **One of the things that I have been concerned about is the difficulty in integrating Exchange systems, either federal or state run, with outside systems. One challenge is Medicaid eligibility check. To enroll in the Exchanges there is supposed to be a Medicaid eligibility check. However, many states may not have their systems online to make eligibility determinations under the new Medicaid eligibility formula. How will the system deal with a lack of information on these eligibility checks? What happens to the consumer or the state?**

   Integration between the exchange and state Medicaid systems is one of the most complex technological challenges associated with implementation of an exchange. Not only is it difficult to connect two large processing systems, but the challenge is exacerbated by the fact that some states are currently in the process of implementing a comprehensive Medicaid modernization project—which means they have to test and integrate two new systems—while other states are dealing with the connectivity and integration challenges associated with older legacy systems.

   To work around these challenges, some states are developing contingency plans that include performing these determinations manually and relying on self-attestation to make initial Medicaid or subsidy determinations (e.g., requiring consumers to provide documented proof of their income, residency, etc., rather than verifying it through the Federal Data Services Hub or other electronic verification systems). Processing Medicaid and subsidy determinations manually and relying on self-attestation will delay enrollment—increasing the potential that consumers won't receive coverage by January 1, 2014—as well as increase the possibility of unintentional errors, fraud, and abuse.

2. **What type of security standard are the states using that create their Exchange and/or use their own data portals? How does it compare to the FISMA standard that the federal exchange is using? Should CMS require a higher standard? Is CMS implementing this trillion dollar law on the cheap?**

   The guidance outlined in the Cooperative Agreement to Support Establishment of the Affordable Care Act's Health Insurance Exchanges requires the following of states with respect to the security and privacy standards of exchanges.

   - Per National Institute of Standards and Technology (NIST) publications, the design and implementation must take into account security standards and controls. (For details on NIST publications, see: http://csrc.nist.gov/publications/PubsSPs.html)
   - HIPAA: The HIPAA Privacy and Security Rules provide Federal protections for personal health information held by covered entities and give patients an array of rights with respect to that information. At the same time, the Privacy Rule is balanced so that it permits the disclosure of personal health information needed for patient care and other important purposes.
   - Security: The applicant shall address the Security requirements in Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers found in 45 CFR § 155.260, and other applicable Security requirements.
   - Federal Information Processing Standards (FIPS): Under the Information Technology Management Reform Act (ITMRA), Division E, National Defense Authorization Act for FY 1996 (P. L. 104-106), the Secretary of Commerce approves standards and guidelines that are developed by the National Institute of Standards and Technology (NIST) for Federal computer systems. These standards and guidelines are issued by NIST as Federal Information Processing Standards (FIPS) for use government-wide. NIST develops FIPS when there are compelling Federal government requirements such as for security and interoperability and there are no acceptable industry standards or solutions. See Recommendation 5.3 in Section 1561 recommendations for more details: http://healthit.hhs.gov/portal/server.pt?open=512&mode=2&objID=3161

   With respect to Federal Information Security Management Act (*FISMA*) (which applies to both federal and state-based exchanges), the Minimum Acceptable Risk Standards for Exchanges (MARS-E) requires health insurance exchanges and common program enrollment systems to meet certain federal legislation and regulations. The most significant federal laws to be met are FISMA and HIPAA.

   These requirements and standards are proven and, we believe, do provide a sufficient level of security and privacy (it is important to note that Leavitt Partners does not have direct expertise in information security, but can speak to it from a high level). If these standards are thoroughly tested and met during the implementation phases, requiring a higher standard of security is not necessary. The concern is that states simply have not had enough time to perform comprehensive testing to guarantee an adequate level of performance for the initial enrollment period. So, while CMS is ensuring the necessary security standards are used, it may not have provided sufficient time for states to test processes and policies in order to adequately meet FISMA and other standards.

Member Requests for the Record

The Honorable Leonard Lance

1. **Has there been sufficient testing with the States, and if not, what are some of the financial risks to the States? If there are to be any delays, do you believe they would be longer than 90 days? Which States have done a good job so far in this regard and which States need to do a better job?**

Due to markedly short timelines for implementation, very few states have had sufficient time to conduct comprehensive system testing. In fact, many states were simultaneously testing and building systems leading up to the October 1 go-live date—a less than ideal process for testing overall system effectiveness. For many states, exchange testing is expected to continue during the initial enrollment period, with much of the remaining testing to take place around the development of back-end systems for carrier interaction and the dispatch of enrollment information.

The lack of testing and short timelines increases the probability of exchanges experiencing unexpected problems that will need to be fixed during, rather than prior to implementation (which generally requires additional resources and costs). It is also expected that once exchanges get past the challenges associated with website functionality and the user-interface, they will move on to the next set of problems. For example, during the first week of the open enrollment period, state and federal exchanges experienced some significant challenges that impacted a consumer's ability to enroll. The concern is that if something as fundamental as creating a user account is causing problems, then what issues are consumers going to encounter when they start the more complicated enrollment and eligibility process for premium subsidies? Overcoming these challenges will require additional time and resources and may create a backlog of consumers waiting to complete the enrollment and eligibility process. Until these issues are fixed, many states are using inefficient manual workarounds, potentially resulting in unexpected costs and increasing the exchange's operating costs over time.

There is no precedence for determining a reasonable timeframe in which these manual determinations can or will be made. However, we do know that many of the state exchanges are attempting to process these issues in less than 90 days of receiving the consumer's application or dispute. Still, if the current exchange problems persist or the systems cannot achieve the desired functionality, it could be possible that an increased volume of manual determinations may force longer timelines for consumer enrollment and create delays past 90 days.

While every state would have preferred to implement additional capabilities if they had more time and resources, all state-based exchanges had to de-scope their plans in order to meet the October 1 launch. Still, during these first few days of operation, some states have offered a higher degree of functionality than others. If we were to develop two categories around state-based exchange readiness—those that had minor delays, but are capable of facilitating enrollment, and those that had significant delays and may need to delay enrollment—the number of states falling in each category would nearly be an even split.

While this underscores the lack of preparedness, there is a widely held expectation that exchange enrollment will be ramping up as we approach the coming 2014 benefit year. As a result, a major priority for exchanges over the next few weeks will be making necessary system refinements to allow consumers sufficient time to shop and enroll by the end of the year.

FRED UPTON, MICHIGAN
CHAIRMAN

HENRY A. WAXMAN, CALIFORNIA
RANKING MEMBER

ONE HUNDRED THIRTEENTH CONGRES

Congress of the United States
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Minority (202) 225-3641

September 26, 2013

Mr. Edward A. Lenz
Senior Counsel
American Staffing Association
277 S. Washington Street, Suite 200
Alexandria, VA 22314

Dear Mr. Lenz:

Thank you for appearing before the Subcommittee on Health on Tuesday, September 10, 2013, to testify at the hearing entitled "PPACA Pulse Check: Part 2."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions by the close of business on Thursday, October 10, 2013. Your responses should be mailed to Sydne Harwick, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to **Sydne.Harwick@mail.house.gov**.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Frank Pallone, Jr., Ranking Member, Subcommittee on Health

Attachment

Employers for Flexibility in Health Care

October 9, 2013

The Honorable Joseph R. Pitts
House of Representatives
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515-6115

Dear Chairman Pitts,

Thank you for the opportunity to appear before the Committee on Energy and Commerce Subcommittee on Health on September 10, 2013 on behalf of the Employers for Flexibility in Health Care Coalition (E-FLEX) and the American Staffing Association. Please find below responses to the Committee's questions for the record.

The Honorable Joseph R. Pitts

1. **At this time, what can employers do to be prepared for the enforcement of the employer mandate in January of 2015? What guidance do they need and when do they need it?**

   Employers across the country are working throughout 2013 and 2014 to prepare to comply with the employer mandate. Employers are analyzing their workforce, determining their employer size, reviewing their health plan designs, communicating with employees, and building new reporting and compliance systems. A major concern for employers is the lack of final reporting regulations under Internal Revenue Code sections 6055 and 6056. It will take many employers 12 to 18 months to budget, plan, build, program, and contract for new comprehensive reporting systems. The proposed rules are complex and unless modified may be costly for employers to implement and maintain.

2. **Has progress been made in revising the employer reporting requirements? Can you describe the burden this causes for employers in our district?**

   The IRS released proposed regulations on September 5, 2013. The proposed regulations would require employers to report to the IRS complex, detailed information about their workforce, employees, employees' dependents and coverage options. In an effort to streamline the process, the proposed regulations eliminated four data elements, but added 10 additional new elements deemed necessary to determine compliance the individual and employer mandates. The proposed regulations also proposed three partial reporting safe harbors that offer very limited relief. As proposed, the regulations will require costly system changes, data collection and burdensome reporting to individuals and the IRS.

Of additional concern to the Members of the E-FLEX coalition is the failure of the proposed regulations to address the need to minimize the number of inaccurate determinations of individual eligibility for premium assistance tax credits to purchase Exchange coverage. It is in all of our interests to avoid employees having to repay tax credits when employer-sponsored coverage that meets the law's affordability and minimum value standards is available to them.

The E-FLEX Coalition hopes that the IRS will work to find ways that employers can certify to IRS prospectively certain data elements under IRC §6056 about coverage available to employees to improve the accuracy of Exchanges' determinations of eligibility for advance payment of premium tax credits. This stands as the best path forward given that currently there is no comprehensive data source of eligibility for employer-sponsored coverage. In addition, given that HHS has confirmed that data from IRS, the Social Security Administration and the Department of Homeland Security "should be available every day" via the data hub (See CMS-2234-F), the Administration would not need to develop a separate data source of eligibility for employer-sponsored coverage if it can collaborate with the employer community to develop flexible options for reporting under IRC §§6055 and 6056 throughout the year.

3. **Job creation has been and continues to be a priority for me and my colleagues. Do you think PPACA's demands of employers is creating perverse economic incentives and discouraging businesses from expanding and creating jobs?**

The law contains new definitions that employers will need to consider when analyzing their workforce. Because these new definitions are linked with tax penalties, basic economic principles require employers to take these new definitions into account in structuring their workforce and employee benefits and in anticipating their annual tax liability. As noted in E-FLEX's statement and testimony, 30 hours is significantly below what many employers consider to be full-time and therefore the E-FLEX supports increasing the hours to bring the definition more in line with current workforce practices. A bipartisan effort is already underway to address this significant concern.

4. **Will you explain the "look back "period and explain what the absence of final reporting rules means for employers?**

The "look back" period is an essential tool for employers with high numbers of variable hour and seasonal employees that allows employers to look back over a longer period of time (3-12 months) to determine whether variable hour or seasonal employees are in-fact working on average 30 hours per week per month. PPACA defines an employee that works on average 30 hours per week per month as working full time. Employers that use a "look-back" period must offer health coverage to those employees that are determined during the look back to be full time for at least 6 months and no less than the length of the look-back.

Employers for Flexibility in Health Care

Absence of final reporting rules creates uncertainty for employers and will drive-up the cost of compliance for everyone seeking to comply in a compressed timeframe.

Thank you for the opportunity to testify on behalf of the Employers for Flexibility in Health Care Coalition. We look forward to continuing to work with you and the Committee.

Sincerely,

Edward A. Lenz
Senior Counsel
American Staffing Association

Cc: The Honorable Frank Pallone, Jr.

FRED UPTON, MICHIGAN
CHAIRMAN

HENRY A. WAXMAN, CALIFORNIA
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Minority (202) 225-3641

September 26, 2013

Ms. Cheryl Campbell
Senior Vice President
CGI Federal
12601 Fair Lakes Circle
Fairfax, VA 22033

Dear Ms. Campbell:

Thank you for appearing before the Subcommittee on Health on Tuesday, September 10, 2013, to testify at the hearing entitled "PPACA Pulse Check: Part 2."

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Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Frank Pallone, Jr., Ranking Member, Subcommittee on Health

Attachments

CGI Federal Responses to Attachment 1—Additional Questions for the Record

The Honorable Joseph R. Pitts

1. The Wall Street Journal reported on September 19, 2013, that "less than two weeks before the launch of insurance marketplaces created by the federal health overhaul, the government's software cannot reliably determine how much people need to pay for coverage." Was CGI involved in the creation of this software? If so, please provide a written description of your responsibilities, current status, and a description of any delays or problems encountered.

> **CGI Federal Response**: The calculator is a part of the Federally-Facilitated Marketplace (FFM) that CGI Federal is building at the direction of CMS. Under the contract with CMS, CGI Federal's responsibilities were to follow requirements as defined by CMS to determine the business logic behind calculations and determinations. CGI Federal worked with CMS to implement those requirements into a piece of software. The current status is that the software was deployed as part of the FFM that went live on October 1, 2013. There were no delays and the software appears to be functioning consistent with CMS' requirements.

2. If CGI has been party to any talks or discussions of the inability to reliably determine how much people need to pay for coverage, please provide a written description of all of these conversations or discussions.

> **CGI Federal Response**: CGI Federal's project team is in daily contact with both CMS and other stakeholders around all aspects of the FFM, including feedback related to the calculator. These conversations and discussions are all centered around making further improvements to system functionality based on business rules provided by CMS for eligibility and data from insurers.

3. Is CGI currently in possession of any documents discussing or related to the ability of exchange software to reliably determine how much people need to pay for coverage? If so, please provide a written description of these materials and summarize their contents.

> **CGI Federal Response**: CGI Federal has design documentation and logic flows related to this aspect of the FFM system. CGI Federal also provides monthly reports to CMS regarding project status, including updates regarding the calculator functionality.

The Honorable Gus Bilirakis

1. Will you talk about CGI's role in the exchange? Do you make all final decisions for yourself and subcontractors?

> **CGI Federal Response**: CMS directs the work of CGI Federal under the contract. CGI Federal is one of several contractors designing, developing, and implementing the Federal Exchange. CGI Federal is responsible for the FFM software application that individuals, employers, brokers, navigators, carriers, and Federal and State officials will

use to enable individuals to compare, select, and enroll in qualified health plans in States that have chosen not to build their own marketplace. The FFM has three key areas of functionality:

1) Eligibility & Enrollment. The FFM allows consumers to fill out an online health insurance application, determine their eligibility for health insurance through the Federal Exchange and enroll in a qualified health plan (QHP). Among other things, it interfaces with a Data Services Hub being developed by another contractor under another contract to access income, citizenship, and other information necessary to determine an individual's eligibility for health insurance and whether that individual also is eligible for subsidies or credits. It also allows citizens to view, compare, select, and enroll in health plans available through the Federal Exchange.

2) Plan Management. The FFM serves as the entry point for health insurers to submit plans for CMS certification as QHPs. CMS will use the application to acquire, certify, and manage issuers offering QHPs through the FFM. CMS also will coordinate plan management activities with States, including monitoring and oversight, account management, and recertification.

3) Financial Management. The FFM allows CMS to manage financial transactions with issuers, including calculating reinsurance payments, risk adjustments and corridors, and premium processing.

CGI Federal coordinates with many other contractors that also play critical roles in the Federal Exchange. For example, the FFM application that CGI Federal is responsible for will reside on hardware infrastructure that is maintained by Terremark Federal Group. Similarly, before individuals may access the FFM, they must first set up an account using the CMS Enterprise Identity Management system (EIDM), maintained by another contractor, Quality Software Services, Inc. (QSSI), under a separate contract vehicle. CGI Federal's FFM application also interfaces with the Federal Data Services Hub, maintained by QSSI. The Data Services Hub is responsible for providing electronic, near real-time access to Federal data, as well as access to State and third party data sources needed to verify consumer-eligibility information.

2. Who is ultimately considered the integrator, or quarterback, for making sure the exchange works properly?

CGI Federal Response: CMS is the systems integrator for the Federal Exchange.

3. The Federal Exchange is a complicated architecture which serves as a hub for everything. How will the Exchange operate when so much of it is dependent on the input from other groups and those groups may not be ready on October 1? For example, Medicaid eligibility: To enroll in the Exchanges there is supposed to be a Medicaid eligibility check. However, many states may not have their systems online to make eligibility determinations under the new Medicaid

eligibility formula. How will the system deal with a lack of information on these eligibility checks?

CGI Federal Response: The functions and issues described in this question are not performed by the FFM, but by the Data Services Hub. Thus, CGI Federal is not in a position to answer this question.

4. Has HHS, CMS, or another government agency come back to you and asked you to modify the initial contract? If so, what was changed? Did CMS state why they needed to make this change or why this was not included in the original bid?

CGI Federal Response: CMS has modified CGI Federal's task order seven (7) times since it was initially awarded. These modifications generally have been issued in response to more detailed requirements regarding system functionality as regulations and policy were better defined. When CMS originally awarded CGI Federal the task order award, most of the regulations and guidance implementing the Affordable Care Act had not yet been finalized. The following table summarizes the modifications to date:

Modification No. and Date	Description
Modification 1, 8/26/12	Modification to purchase the software and hardware requirements for the FFE (now known as FFM), as well as changes in the SOW.
Modification 2, 11/16/12	Modification reflecting administrative changes to the Task Order, including restatement of CLINs, update to contracting officer and contracting specialist information, and revision of the deliverable schedule.
Modification 3, 4/30/13	Modification to cover changes in SOW such as: • Additional eligibility and enrollment requirements; • Account transfer between Medicaid and FFE (now FFM); • Coverage of families and small businesses; • Integration with additional systems; • Re-work associated with changes from Paperwork Reduction Act (PRA) process, incorporation of Medicaid/CHIP account transfer and associated MAGI rules complexity; • Re-work associated with changing policy and requirements from final/published rules; and • Additional/expansion of User Interface functionality from prototyping and Consumer Testing.
Modification 4, 5/10/13	Modification to include Akamai for Content Delivery Network.
Modification 5,	Modification to:

Modification No. and Date	Description
signed 8/29/13 effective 9/1/13	• Add additional funding for the Base Year; • Reduce CLIN 0001AC, Travel; • Extend the period of performance for Base Year- CLIN 0001 to February 28, 2014; • Change the period of performance for Option Year CLIN 0002 from March 1, 2014 through September 1, 2014 so that Option Years 2 forward align with the current contract structure; • As a result of revised software pricing for Adobe, reduce the estimated cost for Option Year 1- CLIN 0002, Option Year2- CLIN 0003, and Option Year 3- CLIN 0004; • Revise key personnel for Chief Architect, who is now Keith Rubin; and • Include a revised Statement of Work dated August 28, 2013.
Modification 6, signed 9/19/13 effective 9/13/13	Modification to: • Fully fund the Adobe perpetual license in the Base Year instead of in Option Years 2 and 3 and, as a result, make corresponding reductions to the estimated cost and award fee for Option Years 2 and 3.
Modification 7, 10-4-13	Undefinitized, unilateral change order modification per FAR 52.243-2, Changes Cost Reimbursement – Alternate II, directing CGI Federal to: • Assist CMS in its development and implementation of a solution to replace the functionality of Enterprise Identity Management (EIDM) currently provided by another contractor; • Assist CMS in developing, implementing, and maintaining a solution to replace the EIDM using similar software/equivalent software as approved by CMS by working at CMS' direction; and • Assert its right to an equitable adjustment within thirty (30) days if additional funding is needed for this effort as per FAR 52.243-2, Alternate II.

5. What security standards do you use? Do you use FISMA standards for your private contracts? How would FISMA standards compare to equivalent commercial security standards? Would you describe it as a higher or lower standard?

CGI Federal Response: CGI Federal's design for the FFM system adheres strictly to CMS standards for security and data transmission, which are incorporated into CGI Federal's task order with CMS. Specifically, the FFM complies with all applicable portions of the Federal Information Security Management Act (FISMA), the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH), and regulations implementing those statutes. The FFM also complies with HHS' Policy for Information

Systems Security and Privacy, which establishes comprehensive IT security and privacy requirements for HHS' IT security programs and information systems.

Although no data will be stored on any hardware owned or operated by CGI Federal, because CGI Federal is sensitive to the fact that the FFM will be used to collect personal health information and other sensitive information necessary for individuals to enroll in health care, it has spent considerable time and effort to ensure that the FFM complies fully with these requirements. In addition, CGI Federal has undergone an independent evaluation and test of its systems security program as part of its task order requirements.

CGI Federal operates primarily within the federal government marketplace as a prime contractor or subcontractor on federal agency projects. As a result, CGI Federal is not in a position to offer a comparative analysis of FISMA standards to commercial security standards.

CGI Federal Responses to Attachment 2—Member Requests for the Record

During the hearing, Members asked you to provide additional information for the record, and you indicated that you would provide that information. For your convenience, descriptions of the requested information are provided below.

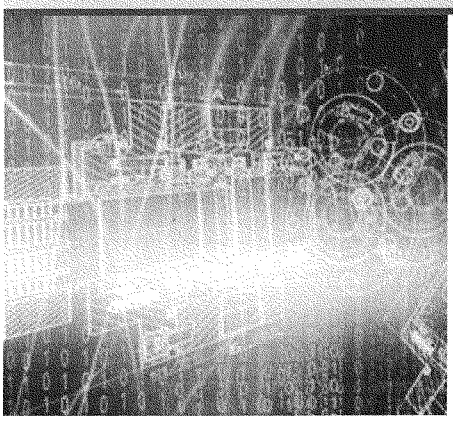
The Honorable Michael C. Burgess

I. In your testimony, you referenced that your company has achieved all its milestones and the last one you referenced was the operational readiness review in September of 2013. Would you please submit that report to the committee?

CGI Federal Response: CGI Federal is pleased to submit the attached Summary Presentation regarding the Operational Readiness Review.

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
OFFICE OF INFORMATION SERVICES

FFM Operations Readiness Review



September 4, 2013

Agenda

Area to review	Reviewed by
Overview of Functionality	
Release Detail	Monica
Interfaces	Justin
User/Partner Interactions	Justin
Architecture Overview (Physical, Software, Data Flow, Operations)	Keith
Performance	Keith
Production Planning	Scott
Testing	Mazen
Call Center / Helpdesk Readiness	Brandi

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
OFFICE OF INFORMATION SERVICES

Architecture Overview

- ***FFM***

FFM Build Out Approach

- Maintain PM/FM as-is (as much as possible) in current production environment
  - Reduce risk during cutover
  - Different release, patch cycles
- EE is a merger of existing LOA and PRIME infrastructure
  - Lite Account is replaced by MyAccount
- Shared resources across PM/FM/EE
  - MarkLogic
  - Alfresco
  - Gluster
- Shared resources across FEPS
  - Gluster
  - F5s

FFM Build Out Approach

- Configured Blue/Green EE paths to support patching
  - SOAP (business and data), Tomcat
- Merge and Cutover Phases
  - Prep PRIME for 95% completion.
  - Targeted for 9/15
  - Cutover to complete merge of current Prod and Prod' during 9/20-9/22
- Data Merge
  - MarkLogic
  - Alfresco
  - Oracle

FFE-PM Physical VMs – Production (Existing)

PM/FM Server	Zone	Qty	VCPU/VM	RAM/VM
Apache RP	Presentation	2	2	4
Apache - Tomcat	Application	2	2	8
Jboss SOA-P Business Services	Application	4	2	16
Jboss SOA-P Batch	Application	6	2	16
Gluster	Application	2	4	16
BRMS	Application	2	2	16
EHCACHE	Application	2	2	32
AV Calc	Application	2	2	6
Apache - Tomcat Alfresco	Data	4	2	16
Jboss SOA-P Data Services	Data	2	4	16
Jboss SOA-P Batch	Data	2	4	16
Oracle DB	Data	2	4	16
Gluster	Data	2	4	16
MarkLogic (E-Nodes)	Data	2	4	16
MarkLogic (D-Nodes)	Data	3	8	64

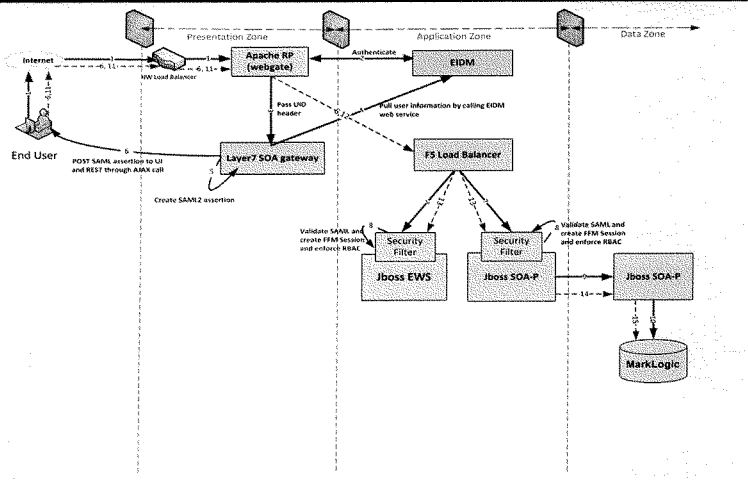
FFE-EE Physical VMs – Production

EE Server	Zone	Qty	VCPU/VM	RAM/VM
Apache RP	Presentation	4	2	4
Layer 7	Presentation	6	4	16
Terracotta	Presentation	2	2	16
Apache - Tomcat	Application	2	2	16
Layer 7	Application	4	4	16
Jboss SOA-P Business Services	Application	16	2	16
Jboss SOA-P Batch	Application	4	2	16
Gluster	Application	6	4	16
BRMS	Application	2	1	8
Terracotta	Application	6	2	16
Load Balancer/F5	Data	2		
Tomcat Alfresco	Data	6	2	16
Jboss SOA-P Data Services	Data	12	4	16
Jboss SOA-P Batch	Data	4	4	16
Oracle DB	Data	2	4	16
Gluster	Data	8	4	16
MarkLogic (D-Nodes)	Data	7	8	64

Multiple Access Methods

- Consumer Access
- CCR web services
- CCR (NGD) web access (current)
- CCR (NGD) web access (contingency)
- CCR (SHOP) web access

Consumer Access



CCR Web Services

1. CCR user login to NGD or PIMS (SHOP)
2. Consumer or SHOP call CCR
3. CCR does a search within the NGD or SHOP
4. NGD or SHOP call the CCR web services over internet
5. Hits port 6443 on HW LB which sends the traffic to the L7 gateway in presentation zone
6. L7 validates the cert (SSL mutual auth) and ws-username token
7. Routes the call internally and sends the response back

CCR (NGD) Web Access (current)

1. CCR user login to NGD
2. CCR clicks on access FFM link
3. NGD federates with EIDM over internet
4. EIDM validates SAML from NGD and establishes EIDM Session
5. CCR user redirected back to NGD
6. NGD access FFM URL with applicationID and applicant ID
7. L7 obtains CCR information from EIDM session and establishes FFM application session
8. L7 redirects the user to FFM CCR landing page

CCR (NGD) Web Access (contingency)

1. CCR user login to NGD
2. CCR clicks on access FFM link
3. NGD federates with FFM over CMS Net
4. FFM validates SAML, obtains all CCR information and establishes FFM application session
5. L7 redirects the user to FFM CCR landing page

FFM Infrastructure Readiness

- IMPL1A Region
  - Support End to End and Issuers testing.
  - Available 9/11 for internal validation and 9/15 for E2E testing
- IMPL1B Region
  - Supporting internal performance testing
- PROD Region
  - Target for 9/15 to support ACA performance testing

Infrastructure Discussion Items

- SLA Confirmation/Downtime Windows
  - Standard CMS Window is Sunday (morning) midnight to 5:00am
  - Should additional windows be defined during break-in period? Expectations set that patches will occur.
- Disaster Recovery
- Desire for more test environment
  - Need a sustainable deployment schedule

FFE PM Performance Testing Approach

- Performance/Capacity Planning
  - MarkLogic capacity planning
  - Layer7
  - Alfresco
  - Gluster
- Functional Performance Testing, focused on these key areas:
  - Individual Application
  - Plan Compare/Rating Engine
  - Enrollment

Questions?

FRED UPTON, MICHIGAN
CHAIRMAN

HENRY A. WAXMAN, CALIFORNIA
RANKING MEMBER

ONE HUNDRED THIRTEENTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON ENERGY AND COMMERCE

2125 RAYBURN HOUSE OFFICE BUILDING
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Majority (202) 225-2927
Minority (202) 225-3641

September 26, 2013

Mr. John Lau
Program Director
Serco
1818 Library Street, Suite 1000
Reston, VA 20190

Dear Mr. Lau:

Thank you for appearing before the Subcommittee on Health on Tuesday, September 10, 2013, to testify at the hearing entitled "PPACA Pulse Check: Part 2."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your response to that question in plain text.

Also attached are Member requests made during the hearing. The format of your responses to these requests should follow the same format as your responses to the additional questions for the record.

To facilitate the printing of the hearing record, please respond to these questions and requests by the close of business on Thursday, October 10, 2013. Your responses should be mailed to Sydne Harwick, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to **Sydne.Harwick@mail.house.gov**.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Frank Pallone, Jr., Ranking Member, Subcommittee on Health

Attachments

Bringing service to life

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United States

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www.serco-na.com

October 9, 2013

The Honorable Joseph R. Pitts
Chairman, Subcommittee on Health, Committee on Energy and Commerce
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, D.C. 20515

Re: Additional Questions for the Record and Member Requests from the Hearing, "PPACA Pulse Check: Part 2," on September 10, 2013

Dear Mr. Chairman:

I received your letter of September 26, 2013, containing additional questions for the record as well as Member requests from the hearing in which I testified, "PPACA Pulse Check: Part 2." Those questions and requests, along with my answers, are provided in the prescribed format below.

The Honorable Gus Bilirakis: **Did CMS, in any of your conversations, state why they waited until July to issue the contract? Did they not know there would be paper processing required when the Exchanges go online? Do you usually get contracts affecting 6.2 million people, three months before they are to occur?**

Response:

CMS did not give me a reason as to why the contract was awarded on July 1. I have no personal knowledge regarding CMS's rationale in this regard. In my experience, contracts like this one vary in requirements and it is difficult to characterize what is "usual." Transition times vary considerably, depending upon the requirements.

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The Honorable Gus Bilirakis: **Has HHS, CMS, or another government agency come back to you and asked you to modify the initial contract? If so, what was changed? Did CMS state why they needed to make this change or why this was not included in the original bid?**

Response:

Serco received from CMS a request for a modification to re-baseline our contract based on a change in circumstances: (1) CMS indicated that the Congressional Budget Office ("CBO") had updated and revised its projections of the likely number of applications that would be received on paper, and (2) better information had become available on the estimated processing times for an application. The original bid had this type of information, which we used as the basis for our original proposal. The new CBO estimates in May 2013 revised those numbers, creating a need to adjust the contract requirements accordingly.

The Honorable Gus Bilirakis: **What security standards do you use? Do you use FISMA standards for your private contracts? How would FISMA standards compare to equivalent commercial security standards? Would you describe it as a higher or lower standard?**

Response:

The majority of Serco's Federal Government contracts require FISMA or DIACAP standards. Even our non-Federal, non-DoD contracts (such as for the Virginia Dept. of Transportation) require a standard based on the same NIST Risk Management Framework (RMF) and Security Controls of FISMA. Serco's internal standard for its corporate systems is also FISMA/NIST-based. I would not describe the FISMA standard as higher or lower than commercial security standards, such as ISO 17799 or COBIT, but rather would describe it as consistent with commercial risk-management practice and controls.

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The Honorable John D. Dingell: **How many people has Serco hired to work on this CMS contract? Please elaborate.**

Response:

For the CMS-ES contract, Serco is contracted to provide eligibility support services. Contract tasks include the intake, routing, processing, reviewing, and troubleshooting of applications submitted for enrollment into a Qualified Health Plan and for insurance affordability programs beginning October 1, 2013.

To meet the needs of this contract, Serco will hire new employees in three major groups: 1) baseline staff utilized year-round; 2) contingent or on-call employees available for unanticipated increases in volume during non-peak periods; and 3) seasonal workers for peak volume periods associated with health plan enrollment opportunity windows. These employees will handle project management, mail, file/case management, document scanning, analysis, and quality control. A full listing of Serco CMS-ES jobs is available at http://www.serco-na.com/cms-es/cms-es-jobs.

On August 21, 2013, Serco received a request from CMS for a proposal to modify the contract due to changes in the government's estimates on workload. In addition, CMS requested that Serco include translation and interpreter services, as well as pricing for performing employee background checks for all project staff members. Serco provided a complete modification proposal on September 5, 2013, and received a formal contract modification on September 25, 2013.

These jobs are currently available in three locations. As a result of the modification, Serco will perform the work in four facilities, located in Arkansas, Kentucky, Missouri, and Oklahoma. The locations were selected for a variety of reasons, including the high-caliber employee base and competitive labor costs with higher unemployment rates. Serco's goal is to create a positive impact on local economies. In these locations, Serco is running or will be running radio and newspaper advertisements to increase awareness of the jobs and to drive candidates to the Serco website to apply and for job fair information. The Company's staff are reviewing, selecting, screening, and scheduling interviews with candidates for available positions. The job fairs have been well-received and follow HR best practices, such as:

- Establishing relationships with local stakeholders (unemployment offices, Chambers of Commerce, higher learning institutions, veteran's groups, etc.) to raise awareness and assist with promoting the job opportunities

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- Using advertising to promote the job opportunities, through the channels that reach the majority of candidates, such as job websites, newspapers, radio, and word of mouth
- Pre-screening applications to achieve a high on-site interview-to-hire ratio
- Placing an operations and senior HR employee at the sign-in desk at job fair events to review incoming resumes and confirm position assignments prior to each interview
- Beginning the background checks process at the job fairs
- Ensuring that sub-contractors provide Serco with daily hiring results by labor category for tracking
- Completing Mass Onboarding/Data Entry spreadsheets on a daily basis to report updated hiring numbers
- Providing on-site computers for job fair walk-ins to apply online

The roll-out of Serco's hiring and sites is a phased approach. Details regarding each location are noted below as of October 4, 2013:

	KENTUCKY	ARKANSAS	MISSOURI	OKLAHOMA	TOTALS
Hiring Goal	909	1,615	783	477	**3,784**
Applicants to Date	1,359	2,407	5,444	249	**9,459**
Interviews Scheduled	739	704	1,170	1	**2,614**
Offers Accepted	615	574	775	-	**1,964**
Total Employees on Board	**615**	**574**	**16**	**-**	**1,205**

Thank you for this opportunity to provide additional information to the Subcommittee.

Sincerely,

John Lau
Program Director
Serco Inc.

FRED UPTON, MICHIGAN
CHAIRMAN

HENRY A. WAXMAN, CALIFORNIA
RANKING MEMBER

ONE HUNDRED THIRTEENTH CONGRESS

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COMMITTEE ON ENERGY AND COMMERCE

2125 RAYBURN HOUSE OFFICE BUILDING
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Majority (202) 225–2927
Minority (202) 225–3641

September 26, 2013

Ms. Lynn Spellecy
Corporate Counsel
Equifax Workforce Solutions
11432 Lackland Road
St. Louis, MO 63146

Dear Ms. Spellecy:

Thank you for appearing before the Subcommittee on Health on Tuesday, September 10, 2013, to testify at the hearing entitled "PPACA Pulse Check: Part 2."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions by the close of business on Thursday, October 10, 2013. Your responses should be mailed to Sydne Harwick, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to **Sydne.Harwick@mail.house.gov**.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Frank Pallone, Jr., Ranking Member, Subcommittee on Health

Attachment

Equifax Workforce Solutions
Additional Questions for the Record
Re: the Subcommittee on Health
Committee on Energy & Commerce
U.S. House of Representatives
PPACA Pulse Check: Part 2

The Honorable Gus Bilirakis

1. **You have data on about one third of the working population. How do you handle verification for people that you do not have data on? Are we to trust what they say?**

   Equifax Workforce Solutions Work Number data is one of several sources of information used by CMS to determine applicant eligibility. Under the Equifax Workforce Solutions contract with CMS, the data hub will send us the applicant's name, date of birth and social security number, which CMS has already verified through other sources. Equifax Workforce Solutions will return the required data elements to CMS if the applicant's information matches a record in The Work Number database. Equifax Workforce Solutions will return a "no match" code to CMS if there is not a matching record in The Work Number database.

2. **In your testimony, you talk about the confidence in the data in your results. Will you talk more about how you determine confidence in the results? What makes you confident the data on a person is valid? What would give you pause?**

   Equifax Workforce Solutions' core business is verifying employment and payroll information. Employers who participate in The Work Number database provide their regular payroll information directly to us in an electronic feed, which becomes the foundation for our verification services. Equifax Workforce Solutions works with employers to assist in the secure transfer of the data including an initial and then an ongoing process to verify the data quality. As our testimony stated, employees can access their Employment Data Report that includes a record of all verifications completed for that employee and the information that was shared. We have processes in place to investigate any disputes and to work with our employer clients to correct any data errors.

3. **Has HHS, CMS, or another government agency come back to you and asked you to modify the initial contract? If so, what was changed? Did CMS state why they needed to make this change or why this was not included in the original bid?**

   CMS has modified the contract to reflect updated CMS Information Security requirements, a new Contracting Officer and her contact information, and a modification that includes a Technical Direction Clause that was not previously provided for in the

contract. These modifications requested by CMS do not change the intent or the ongoing work being performed by Equifax Workforce Solutions. These changes were originated by CMS to reflect the most current regulations and points-of-contact because these items have changed since the award.

4. **What security standards do you use? Do you use FISMA standards for your private contracts? How would FISMA standards compare to the equivalent commercial security standards? Would you describe it as a higher or lower standard?**

As stated in our testimony, Equifax Workforce Solutions is certified to ISO 27001, a global security standard, and also has a FISMA certification. Both FISMA and ISO 27001 require organizations to establish a formal security program, perform risk analysis, and implement administrative, technical and physical security controls that address those risks. FISMA is a federal law, applicable to executive branch agencies and their contractors, and supported by a standard for selecting and applying security controls. The standard is found in NIST SP 800-53. ISO 27001 is a global commercial standard that is also supported by requirements for selecting and applying security controls. We do not use FISMA in private contracts, but our approach to security through ISO 27001 is comparable to the standard that federal agencies maintain under FISMA.

FRED UPTON, MICHIGAN
CHAIRMAN

HENRY A. WAXMAN, CALIFORNIA
RANKING MEMBER

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COMMITTEE ON ENERGY AND COMMERCE

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September 26, 2013

Mr. Michael Finkel
Executive Vice President for Program Delivery
QSSI
131 Elden Street, Suite 200
Herndon, VA 20170

Dear Mr. Finkel:

Thank you for appearing before the Subcommittee on Health on Tuesday, September 10, 2013, to testify at the hearing entitled "PPACA Pulse Check: Part 2."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your response to that question in plain text.

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Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Frank Pallone, Jr., Ranking Member, Subcommittee on Health

Attachments

U.S. House Committee on Energy & Commerce Subcommittee on Health
Hearing on "PPACA Pulse Check: Part 2"
Supplemental Written Testimony of Michael Finkel
Quality Software Services, Inc.
October 10, 2013

Supplemental Responses to Member Questions

The Honorable Joseph R. Pitts' Questions

Q: Will you please elaborate on the security systems that will protect data in the hub you are creating?

A: Under the Federal Information Security and Management Act, CMS is required to follow the National Institute of Standards and Technology's security standards and guidelines for federal IT systems. As a system integrator, QSSI was responsible for assuring that the design and development of the Data Services Hub complied with these NIST standards. QSSI has met its obligations from a system design and development standpoint.

As I mentioned in my testimony, the Data Services Hub code is being developed, will launch, and will operate from within the CMS secure cloud hosted at the Terremark Data Center. Once in production, CMS will enforce additional security controls to protect the system, including controlling access and changes to the system. The Data Services Hub will be monitored continually by CMS and its information security contractors.

While QSSI does not have full visibility into all of the layers of security CMS has in place, CMS has announced that the Data Service Hub and the associated component systems that comprise the health insurance market place (other than the State-Based Marketplaces) have several layers of protection in place to mitigate information security risk. For example, these systems will employ a continuous monitoring model that will utilize sensors and active event monitoring to quickly identify and take action against irregular behavior and unauthorized system changes that could indicate a potential incident. If a security incident occurs, CMS has noted that its Incident Response capability would be activated, which allows for the tracking, investigation, and reporting of incidents. This allows CMS and the Department of Health and Human Services (HHS) to quickly identify security incidents and ensure that the relevant law enforcement authorities, such as the HHS Office of Inspector General Cyber Crimes Unit, are notified for purposes of possible criminal investigation.

Q: Has QSSI completed stress testing of their system? Will you describe what stress testing entails and when you expect such stress testing to be complete?

A: QSSI has completed its stress testing of the Data Service Hub. Based on that testing, QSSI believes that the Data Services Hub will be able to transmit the necessary number of queries.

The Honorable Gus Bilirakis' Questions

Q: In your statement, you mention that a security risk assessment by a contractor did not identify any issues that would prevent the data services hub from launching. Did the security assessment find any security concerns? Will you provide this committee with a copy of that report?

A: The Security Risk Assessment did not find any issues that would preclude authorization to operate. As is common, the Security Risk Assessment identified a number of areas for enhancement. For example, the Security Risk Assessment proposed documentation enhancements and password setting protocol enhancement. QSSI has either addressed the recommendations or, in the case of a few non-critical items, identified enhancements that are pending approval or completion. The Mitre Corporation provided the final version of the Security Risk Assessment to CMS, and QSSI does not have a copy currently.

Q: According to the Inspector General's report, it says that CMS's Chief Information Officer is expected to make his Security Authorization on September 30, one day before the Exchanges go online. Is it responsible to make this decision so late in the process? The original timeline was for it to be made on September 4.

A: As noted in our testimony, an independent third-party tester, the Mitre Corporation conducted an independent Security Risk Assessment of the Data Services Hub which was completed on August 30, 2013. The Mitre Corporation provided its Security Risk Assessment to the CMS Chief Information Officer to allow him to assess whether or not to authorize operation of the Data Services Hub by CMS.

Based on the Mitre Corporation Security Risk Assessment, the CMS Chief Information Officer provided the security authorization on September 6, 2013, well in advance of October 1.

Q: According to the Inspector General's report, the final report for the Security Control Assessment (SCA) is not due until September 20. That gives CMS 10 days to review the report and make any changes to your system. Is that really adequate time for CMS to do this? How much time would you have in the commercial sector?

A: As noted above, the Security Risk Assessment was completed on August 30, 2013, and the security authorization was signed on September 6, 2013, well in advance of October 1. In

our experience, the timing of assessments depends on numerous variables. The timing of the assessment and the authorization is not notable based on QSSI's past experience in prior projects.

Q: Has HHS, CMS, or another government agency come back to you and asked you to modify the initial contract? Is so, what was changed? Did CMS state why they needed to make this change or why this was not included in the original bid?

A: As is common, CMS has issued contract modifications since the original Data Services Hub contract was awarded. Among other things, the modifications provided for the development of an Electronic Data Interchange which will be used to translate files from the federal and state marketplaces into a format that is more readily processed by issuers. As with the Data Services Hub, the Electronic Data Interchange is housed at the Terremark Data Center and operated by CMS. Other aspects of the modifications included the provision of additional hardware and software, as well as infrastructure support for CMS to operate its operations center.

Q: What security standards do you use? Do you use FISMA standards for your private contracts? How would FISMA standards compare to the equivalent security standards? Would you describe it as a higher or lower standard?

A: As noted in our testimony, as a CMS system, the Data Services Hub is covered by the Federal Information Security and Management Act and the security requirements set forth therein. Federal Information Security and Management Act was signed into law in 2002 and has been subsequently amended. Systems that are developed for private parties do not typically need to conform to the security requirements set forth in the Federal Information Security and Management Act. Commercial standards are often developed based on the Federal Information Security and Management Act standards.

<u>The Honorable John Dingell's Requests</u>

Q: Some have argued that the data hub will be a new government database with personal medical information. Is this an accurate characterization of the program? If not, what is the correct representation of the circumstances?

A: No, it is not an accurate characterization. The Data Services Hub is a tool that will transfer data. The Hub's function will be to move data, acting as a router of data between a given marketplace and various data sources.

The Data Services Hub will route data that will be used by the health insurance marketplaces to verify applicant information data to determine eligibility for qualified health plans and insurance programs, as well as for Medicaid and CHIP. A consumer interested in purchasing health insurance online will go to a health insurance marketplace's web portal to fill out

enrollment forms and select a plan. Certain information the consumer provides to the marketplace, such as citizenship, will have to be verified. The marketplace will direct a query to external information sources, such as government databases, through the Data Services Hub. The Data Services Hub will not store the verification data or the content of the queries made by the marketplaces.

Once the requested verification information is sent back to the marketplace, eligible consumers are then able to enroll in one of the available plans. The Data Services Hub will not determine consumer eligibility, nor will it determine which health plans are available in the marketplaces. The enrollment data, such as name, address, and premium amount, will then be transferred through the Data Services Hub from the originating marketplace to the health plan the consumer chooses.

While the Data Services Hub will pass eligibility data from verification sources to the federal and state marketplaces, and enrollment data from marketplaces to plan issuers, it will not handle any personal medical records.

CMS owns and will operate the Hub, which is housed in the CMS secure cloud hosted at the Terremark Data Center.

Q: Would you please provide a summary of the functions of the data hub?

A: The principal functions of the Data Services Hub are the following services provided to the Federally-Facilitated Marketplace and the State-Based Marketplaces (collectively "marketplaces"):

- Eligibility Verification Support:
    - The Data Services Hub will transmit verification requests from health insurance marketplaces to trusted databases, such as databases operated by the Social Security Administration, the Internal Revenue Service, the Department of Homeland Security, the Department of Veterans Affairs, Medicare, TRICARE, and Equifax. The Data Service Hub will then transmit the responses from the relevant database back to the originating marketplace.
    - For State-Based Marketplaces, the Data Services Hub will transmit an identity verification request to Experian. The Data Services Hub will then transmit the response from Experian to the originating marketplace.
    - The data transmitted will pertain to the applicant's identity and enrollment information, but will not include personal medical information.
    - The marketplaces, not the Data Services Hub, will serve as the "front door" for consumers to fill out an online health insurance application and to review qualified plans.
    - The Data Services Hub does not make eligibility determinations, which is a function of the marketplaces.

- The Data Services Hub does not store the content of the verification requests or the responses from the trusted sources.

- Enrollment Support:
  - The Data Services Hub will transmit enrollment data from the Federally-Facilitated Marketplace to issuers. The Data Services Hub will then transmit an acknowledgement from the issuer to the Federally-Facilitated Marketplace.
  - The Data Services Hub does not make enrollment selections, which are made by the applicant.
  - The Data Services Hub does not store the content of the qualified plans or the enrollment data.

- Plan Management Support:
  - The Data Services Hub will transmit information about qualified health insurance plans from issuers to the Federally-Facilitated Marketplace. The Data Services Hub does not make plan qualification determinations.
  - The Federally-Facilitated Marketplace is the tool that CMS will use to certify and manage qualified plans.

- Financial Management Support:
  - The Data Services Hub will transmit a list of issuers from the Federally-Facilitated Marketplace to the CMS accounting system for purposes of premium amounts.
  - The Data Services Hub does not determine reinsurance payments, risk adjustments and corridors, or premium amounts. The Federally-Facilitated Marketplace is the tool that CMS will use to calculate reinsurance payments, risk adjustments and corridors, and premium amounts.