

**THE ONLINE FEDERAL HEALTH INSURANCE
MARKETPLACE: ENROLLMENT CHALLENGES
AND THE PATH FORWARD**

HEARING
OF THE
**COMMITTEE ON HEALTH, EDUCATION,
LABOR, AND PENSIONS**
UNITED STATES SENATE
ONE HUNDRED THIRTEENTH CONGRESS

FIRST SESSION

ON

EXAMINING THE ONLINE FEDERAL HEALTH INSURANCE MARKET-
PLACE, FOCUSING ON ENROLLMENT CHALLENGES AND THE PATH
FORWARD

NOVEMBER 5, 2013

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TUESDAY, NOVEMBER 5, 2013

U.S. SENATE,
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
Washington, DC.

The committee met, pursuant to notice, at 10 a.m. in room SD-106, Dirksen Senate Office Building, Hon. Tom Harkin, chairman of the committee, presiding.

Present: Senators Harkin, Alexander, Mikulski, Murray, Hagan, Franken, Bennet, Whitehouse, Baldwin, Murphy, Warren, Enzi, Burr, Isakson, Roberts, Murkowski, Kirk, and Scott.

OPENING STATEMENT OF SENATOR HARKIN

The CHAIRMAN. The Senate Committee on Health, Education, Labor, and Pensions will please come to order.

About 5 years ago, Richard Streeter, a 47-year-old truck driver from Eugene, OR, was frustrated and worried. As *New York Times* columnist Nicholas Kristof described in his column this weekend, Mr. Streeter couldn't find affordable insurance in the individual market. Back in the bad old days, no insurance company would cover him. So he did what people locked out of the market do. He just went without care.

After months of ignoring pain, Mr. Streeter finally went in for a colonoscopy, but he couldn't afford one. The only way he could get it was from a doctor who agreed to take half payment now and half payment later whenever he could afford it.

After driving 100 miles to get the results, he found out he had advanced colon cancer. His doctor said this,

"It was heartbreaking to see the pain on his face, and it got me very angry with the people who insist that Obamacare is a train wreck, when the real train wreck is what people are experiencing every day because they can't afford care."

Mr. Streeter is the second patient the doctor had seen this year who put off getting a test because of a lack of health insurance and now has advanced colon cancer. He has a long tough road ahead of him, but at least now he won't have to worry about how he'll pay for his treatment. He signed up for health insurance starting January 1, which now can't turn him down because of his preexisting condition.

We passed the Affordable Care Act so that this would never happen to another family. Right now, millions of Americans are shop-

ping on new health insurance marketplaces for coverage that starts next year. Seven hundred thousand people have filed applications. And why is there this surge in interest? Because for the first time in history, their health, whether or not they have a chronic illness or an allergy or had a back operation 10 years ago, will not prevent them from getting insurance.

These reforms will finally deliver on a long overdue promise to all Americans. If you work hard and play by the rules and pay your fair share, you'll never have to stay awake at night worried that you can't afford to see a doctor or pay your medical bills. It's a promise I wish we could have kept sooner for Mr. Streeter.

Today we'll hear a status report on the implementation of these reforms. As everyone knows, the rollout of the Federal health insurance marketplace has been bumpy, to put it mildly. Consumers have run into roadblocks. The site has been functional 1 day and unresponsive the next. Americans who have been waiting for years for this moment deserve better.

The President, Secretary Sebelius, and our witness today have taken full responsibility for the technical flaws in the Web site and have said that no resource will be spared to fix the problem quickly. And I look forward to hearing an update today on those efforts.

I share my Republican colleagues' concern about the Web site's technical flaws and the bumpy rollout, and I look forward to a discussion about how we can move forward. But I want to be very clear that I hope we're here for a constructive discussion, not a game of gotcha. I am as upset as anyone with the difficulties that individuals who want to apply for coverage on the Federal marketplace have experienced, and I want to learn today how those problems will be fixed.

But herein may be a difference. I want it fixed so the Affordable Care Act will succeed, not be torn down. There are many who have spent the last 3 years doing nothing but trying to tear this law down. Quite frankly, I feel they've kind of surrendered their right to express indignation that it's not working flawlessly.

We voted 32 times, many of my colleagues on the Republican side—32 times to repeal or defund the law. As an appropriator and as chair of the Appropriations Subcommittee that funds the implementation of this law, my Republican colleagues year after year have denied implementation funds at every turn, tried to stop navigators from spreading the word. They even sent letters to the National Football League warning them against reaching out to fans.

Republican Governors and legislatures, who in most cases are on a platform of strong States' rights and less Federal Government, handed over the responsibility of running the marketplace to the Federal Government. Before we get into the details, I think everyone should take a deep breath. This is, after all, a Web site. This is a machine that will be fixed.

Americans have until the end of March of next year to sign up. As the President has said, the promise of the Affordable Care Act is far more than just a Web site. The promise of the Affordable Care Act is a benefit to 105 million Americans who have been protected against lifetime limits since 2010.

It's a benefit to more than 3 million young people who can stay on their parents' policies until they're age 26. It's a benefit to 7 mil-

lion seniors who have already saved \$8 billion in discounts on prescription drugs. It's a benefit to the 71 million people on private insurance that have used, at no cost and no co-pay, preventative services, which Mr. Streeter could have used had this law been in effect.

It's a benefit to the 129 million non-elderly Americans with pre-existing conditions who, beginning January 1, can no longer be denied or discriminated against by health insurance companies. That's the big picture, and we shouldn't forget it. Health reform is the promise of the health and financial security that insurance coverage brings.

I can tell you that in Iowa, Iowa's marketplace premiums are among the 10 lowest nationwide. A family of four making \$50,000 will be able to get bronze level coverage for \$103 a month. A 27-year-old making \$25,000 will be able to get a plan for less than \$100 a month. That's real choice, real affordability.

So let's get the Web site fixed as fast as possible so that every American can shop easily and enroll smoothly. But let's not forget the big picture, that because of Obamacare, if you want to call it that, or the Affordable Care Act, millions of Americans will not be in the same situation as Mr. Streeter found himself. That's what it's about.

Slowly but surely, Americans who have waited years to get covered are enrolling in health insurance for the first time. We owe them our very best efforts to move the ball forward. So I will be listening closely when questions are asked today of our witness. Is this in order to help and fix this system so we can move forward to make this Affordable Care Act work, or is it another means to try to tear it down and discourage participation?

I want to thank our witness, Ms. Tavenner, for her leadership of the Centers for Medicare and Medicaid Services and for her long dedication to making sure our healthcare system in America works for all. I know we'll have some tough questions. That's fine, because I do want to know why this problem came up. But I want to keep the big picture in mind as to what we're really doing here, and that is to make the system work.

Finally, I have one administrative matter. I request that the record remain open for 10 days from today for statements to be submitted for the record.

Now I'll turn to our Ranking Member, Senator Alexander.

OPENING STATEMENT OF SENATOR ALEXANDER

Senator ALEXANDER. Thanks, Mr. Chairman.

Welcome, Ms. Tavenner. When I was in President Bush's cabinet, I used to testify before this committee from that seat, and I used to think that Senators deliberately put the chair down low so they could be up high. So we welcome you.

My late friend, Alex Haley, used to say, "Lamar, if instead of making a speech, you'd just tell a story, somebody might listen to you." So here's a story.

Sixteen thousand Tennesseans have insurance through CoverTN, a low-cost narrow-coverage State program. Obamacare is canceling their policies. CoverTN is an example of what President Obama

calls bad apples, an insurance plan that Washington decides isn't good enough for you.

I recently heard from one of those Tennesseans whose policy will be canceled on January 1. Her name is Emily. She's 39. She has lupus. She told me, "I cannot keep my current plan because it doesn't meet the standards of coverage. This alone is a travesty."

She said,

"CoverTN has been a lifeline. With the discontinuation of CoverTN, I'm being forced to purchase a plan through the exchange. My insurance premiums alone will increase a staggering 410 percent. My out-of-pocket expense will increase by more than \$6,000 a year. That includes subsidies. Please help me understand how this is affordable."

Our healthcare system makes up nearly 20 percent of our economy, touching the lives of every American. And today, Obamacare is pushing that 20 percent of our economy in the wrong direction.

The President has said repeatedly—and I looked up the White House Web site this morning—"If you like your plan, you can keep it, and you don't have to change a thing due to the healthcare law." Let me repeat, you don't have to change a thing due to the healthcare law. That's the White House Web site today.

It's more than a Web site, as the President said. It's a law transforming our healthcare delivery system in the wrong direction, we believe, by increasing premiums, canceling insurance plans, destroying relationships with doctors, raising taxes, forcing people into Medicaid, spending a half trillion Medicare dollars on new programs instead of making Medicare solvent, and encouraging employers to reduce their employees to a 30-hour work week, and then having the IRS threaten to fine Americans for failing to sign up for insurance on a Web site that doesn't work.

As the President promised, if you like your healthcare plan, you can keep it. But, in fact, the law cancels millions of individual policies, and for millions of others, employers are dropping insurance programs as they discover the added cost of Obamacare.

For these Americans, the new promise is if you want healthcare, go find it on a Web site that the Administration says won't be working properly until the end of November. That's an unwelcome Christmas present—only 2 weeks to shop for and buy a new insurance policy by December 15, so that you're covered next year when Obamacare outlaws your policy.

Ms. Tavenner, the President put Secretary Sebelius in charge of implementing this law. I've called on her to resign because it's hurt so many Americans.

Before the Internet, RCA could tell you every day how many records Elvis was selling. Ford could tell you how many cars it was selling. McDonald's could tell you how many hamburgers it had sold. Congressman Issa has posted on his Web site notes from meetings in the Obama administration's war rooms, where you're apparently telling each other how many people are enrolling in Obamacare. But why won't you tell Congress and the American people?

One Senator has described this law as an approaching train wreck. Well, my grandfather was a railroad engineer in Kansas. His job was to drive the locomotive onto a roundtable, they called

it, turn it around and head it off in the right direction. That's what our country needs to do. We need to turn this train around, turn the law around, and head it in the right direction.

Obamacare is the wrong direction because it expands the healthcare delivery system that we already knew costs too much. The right direction is more choices and more competition that lower costs so Americans can afford to buy insurance.

Now, don't expect Republicans to show up on the Senate floor with our version of a 3,000-page bill to try to move the healthcare delivery system in the direction we want it to go. We don't believe in that approach. We believe instead in moving step by step in the right direction, make Medicare solvent, reform Medicare Advantage to compete with Medicare, make Medicaid flexible, encourage employee wellness plans, small business plans, expand health savings accounts, buy insurance across State lines, change 30-hour work weeks to 40-hours.

That 39-year-old Tennessee woman I told you about, Emily, who is losing her insurance because Obamacare has decided it isn't good enough for her, finished her story with these words,

"This is one of the biggest betrayals our government has ever committed on its citizens. I beg you to continue to fight for those like me," she says, "who would only ask to be allowed to continue to have what we already enjoy, a fair health insurance plan at a fair price. Please find a way to return to affordable healthcare," writes Emily.

My message to Emily is that we will do our best to turn this train around and head our healthcare delivery system in the right direction so that you can buy and keep healthcare that you can afford.

The CHAIRMAN. On behalf of the committee, I'd like to welcome our witness today, Marilyn Tavenner, the Administrator of the Centers for Medicare and Medicaid Services. She was confirmed by the Senate on May 15 of this year. Prior to her confirmation, Ms. Tavenner was Principal Deputy Administrator for CMS. She also served for 4 years as Governor Tim Kaine's Secretary of Health and Human Resources in Virginia.

Before entering government service, Ms. Tavenner spent 25 years working for the Hospital Corporation of America, and she began her career as a nurse at the Johnston-Willis Hospital in Richmond. Ms. Tavenner holds a Bachelor of Science degree in nursing and a Master's degree in health administration, both from the Virginia Commonwealth University.

I know you're very, very busy these days. But I thank you for coming up here to share your experience and answer questions here today, Ms. Tavenner. And, now, what I'd like to do, since this is such an intricate subject—we usually give the witness 5 minutes. With the indulgence of the committee, I'd like to give you up to, but no more, than 10 minutes to make your opening statement, and then we'll have our questions.

So welcome, and your statement will be made a part of the record in its entirety. Please proceed.

STATEMENT OF MARILYN TAVENNER, ADMINISTRATOR, CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS), U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Ms. TAVENNER. Thank you, Chairman Harkin, Ranking Member Alexander, and members of the committee.

On October 1, we launched one of the key provisions of the Affordable Care Act, the new marketplace where people without health insurance, including those who could not afford health insurance and those who were not part of a group plan, could actually go get affordable healthcare coverage. We know that some consumers are still having difficulty enrolling via the marketplace Web site, and we are focused on identifying and solving those problems quickly.

But it is important to remember that the Affordable Care Act is more than just a Web site. It has created a new market which allows people access to quality affordable health insurance options. It does this by pooling consumers into statewide group plans that spread risk between sick people and healthy people, between young and old, and then bargains on their behalf for the best deal on health insurance.

By creating competition where there wasn't competition before, insurers are now eager for business and have created new healthcare plans with more choices. The premiums for coverage on the marketplace are lower than expected, and millions of Americans will also qualify for tax credits to make this coverage even more affordable. People will have comprehensive coverage that cannot be taken away, even if they get sick.

We know that consumers are eager to purchase this coverage, and I want to assure you that Healthcare.gov can and will be fixed quickly, and we are working literally around the clock to make that happen. We have made significant progress in improving the performance and functionality of the Web site, and we expect the user experience to continue to improve with each passing week.

Over the past month, millions of Americans have visited Healthcare.gov to look at their new healthcare coverage options under the Affordable Care Act. In that time, nearly 700,000 applications for coverage have been submitted from across the Nation, more than half in the Federal marketplace alone. This tremendous interest confirms that the American people are looking for quality, affordable healthcare coverage.

We know that the initial consumer experience on Healthcare.gov has been very frustrating for many Americans. Some have had trouble creating accounts and logging into the site, while others have received confusing error messages or had to wait for slow page loads or forms that failed to respond in a timely fashion. In the first few days that we went live, few consumers could create an account. We have now resolved that issue.

Users can successfully create an account and continue through the full application and enrollment process. We are now able to process nearly 17,000 registrants per hour or five per second with almost no errors. We've updated the site several times since October 1, fixing bugs and improving the Healthcare.gov experience.

We've added more capacity, and we've doubled the number of servers in order to meet demand. We reconfigured various system components to improve site responsiveness. This has increased performance across the site, but, in particular, the viewing and filtering of health plans during the online shopping experience. This now responds in just seconds, whereas it was taking minutes before.

We've also resolved issues so that eligibility notices now display properly to consumers at the completion of the application process. Consumers can now view and compare plans without registering for an account. This functionality was not working well in the days leading up to October 1, so we opted to prioritize work on the application process instead.

One of our highest priorities was ensuring that consumer information was transmitted correctly to issuers. Over the past week, our team has worked with issuers to resolve outstanding issues, and now all necessary consumer information will be sent to issuers after they've enrolled in the plan of their choice. We will continue to work closely with issuers to identify and solve problems quickly.

We've also seen success in improving response time across the Web site. For the first few weeks, we estimate that users were waiting, on average, 8 seconds for pages across the site to load. We've now lowered this time to less than 1 second, and we will continue to take aggressive steps to bring response downtime even further.

We are pleased with these quick improvements and the parts of the system that are already working well. For example, the data hub, the routing tool that provides an efficient and secure way to verify information submitted by consumers, is sending determination to the marketplace in less than 1.2 seconds. The Social Security Administration has reported 4.2 million transactions with the hub, and the IRS has responded to more than 1.3 million requests.

When consumers fill out the online application, they can trust that the information they are providing is protected by stringent security standards and that the technology underlying the application process has been tested and is secure. CMS has decades of experience at protecting personal information in Medicare, and we are extending that commitment to the highest security standards for the marketplace.

Any system that is this large is inherently risky. We have continued to monitor the security of the system as envisioned in the risk mitigation and compensating control plan and have had no serious issues. Security testing never ends. It will never end, and it will not for this system or for any other large system.

While we continue to improve Healthcare.gov, it is important to remember that the Web site is, in fact, working, and more people are applying and enrolling each week. In addition to the Web site, there are other ways for consumers to approach Healthcare.gov. One is they can choose to apply by phone and a 24/7 toll-free number. A customer service representative will work with each consumer to make sure that they can complete the application and enrollment process.

Second, people can find in-person help in their communities and work with people trained or certified to help them understand their

healthcare options. Third, consumers can fill out a paper application and mail it in, and they'll find out whether they're eligible for private insurance, Medicaid or CHIP, and then they can go online to compare, choose, and enroll in a plan, or they can contact the call center and do it by phone if they prefer.

Today, more than three out of every four Americans get insurance from an employer, from Medicare, from Medicaid, or from the VA system. Americans who purchase insurance on their own, however, generally buy coverage on the individual market. Before the Affordable Care Act, coverage in the individual market often was unaffordable, had high co-pays or deductibles, or lacked basic benefits like maternity care, mental health services, and prescription drug coverage.

These plans also had high turnover rates, greater than 50 percent per year frequently, and often were not renewed at the end of a plan year. The healthcare law is creating new protections for people in the individual market as well as strengthening employer-based coverage. In the health insurance marketplace, consumers will no longer be charged more because of their gender or a pre-existing condition.

Recommended preventive services will be covered at no additional out-of-pocket cost. There will be caps on out-of-pocket cost, and plans will have to offer a basic package of 10 essential benefits.

Plans that were in place before the Affordable Care Act passed and have not been changed in ways that substantially cut benefits or increase cost sharing are grandfathered in and are exempt from offering most of the new consumer protections. They must notify their enrollees that they are grandfathered plans, however, and for these enrollees, nothing has to change in 2014.

Some of the 5 percent of Americans who currently get insurance on the individual market have recently received notices from their insurance companies suggesting that their plans will no longer exist. These Americans do have a choice. They can choose a different plan being offered by their insurer, or they can shop for coverage in the marketplace or outside the marketplace.

As insurers have made clear, they are not dropping consumers. They are improving their coverage options, often offering better value plans with additional benefits.

Indeed, the majority of people in the individual market today will qualify for discounted or free healthcare coverage when signing up for coverage through the marketplace. One study found that, not counting the 1 million who qualify for Medicaid, 48 percent of people who buy insurance through the individual market will have a tax credit that averages over \$5,500.

The Affordable Care Act is almost 4 years old now, and during its time, we have seen many improvements in our healthcare system, Medicare, Medicaid, Medicare Advantage. The opening of the marketplace on October 1 is the latest step in the implementation of the law, and we acknowledge that we have a lot more to do, and we're ready to do it.

Thank you, Mr. Chairman.

[The prepared statement of Ms. Tavenner follows:]

PREPARED STATEMENT OF MARILYN TAVENNER

Good morning, Chairman Harkin, Ranking Member Alexander, and members of the committee. On October 1, we launched one of the key provisions of the Affordable Care Act—the new Health Insurance Marketplace, where people without health insurance, including those who cannot afford health insurance, and those who are not part of a group plan, can go to get affordable coverage. Consumers can access the Marketplace in several ways—through a call center, by filling out a paper application, with the help of in-person assistance, or by going online and filling out an application on HealthCare.gov.

Over the past month, millions of Americans have visited HealthCare.gov to look at their new health coverage options under the Affordable Care Act. In that time, nearly 700,000 applications have been submitted to the Federal and State marketplaces from across the Nation. This tremendous interest—with over 20 million unique visits to date to HealthCare.gov—confirms that the American people are looking for quality, affordable health coverage. Unfortunately, the experience on HealthCare.gov has been frustrating for many Americans. I want to assure you that HealthCare.gov can and will be fixed, and we are working around the clock to deliver the shopping experience that you deserve. We are seeing improvements each week, and by the end of November, the experience on the site will be smooth for the vast majority of users.

IMPROVEMENTS ALREADY MADE TO HEALTHCARE.GOV

To ensure that we make swift progress, and that the consumer experience continues to improve, our team called in additional help to solve some of the more complex technical issues we are encountering. We brought on board management expert and former CEO and Chairman of two publicly traded companies, Jeff Zients, to work in close cooperation with our HHS team to provide management advice and counsel to the project. We have also enlisted the help of QSSI to serve as a general contractor for the project. They are familiar with the complexity of the system, and the work they provided for HealthCare.gov—the Federal data hub—is working well and performing as it should. They will work with CMS leadership and contractors to prioritize the needed fixes and make sure they get done.

A number of fixes have already been completed. Two weeks ago, the tech team put into place enhanced monitoring tools for HealthCare.gov, enabling us to get a high level picture of the Marketplace application and enrollment system. Thanks to this work, we are now better able to see how quickly pages are responding, and to measure how changes improve user experience on the site.

We reconfigured various system components to improve site responsiveness. This has increased performance across the site, but in particular the viewing and filtering of health plans during the online shopping process now responds in just seconds. It was taking minutes. We have also resolved issues with how the eligibility notices are presented to consumers. They now display properly at the completion of the application process.

Another place where we have seen a lot of consumer frustration is in their ability to successfully create an account. This issue is something that we identified on October 1, and we have made significant progress since then to deliver a much smoother process for consumers. Users can now successfully create an account and continue through the full application and enrollment process. We are now able to process nearly 17,000 registrants per hour, or 5 per second, with almost no errors.

Other fixes include software configuration changes and optimization that have increased the efficiency of system interactions. We also added capacity by doubling the number of servers and have replaced the virtual data base with a high-capacity physical one. This allowed us to be more efficient and effective in our processing time and significantly reduced the account registration failures. While significant work remains, these changes are already making the shopping process easier for consumers.

EXPANDING ACCESS TO AFFORDABLE COVERAGE THROUGH THE HEALTH INSURANCE MARKETPLACE

We are committed to improving the consumer experience with HealthCare.gov, which serves as an important entry point to the new Marketplace. The new Marketplace is a place that enables people without health insurance, including those who cannot afford health insurance, and those who are not part of a group plan, to finally start getting affordable coverage.

Just a few weeks into a 6-month open enrollment period, while some consumers have had to wait too long to access the Marketplace via HealthCare.gov, the Mar-

ketplace is working for others and consumers are also utilizing the call center, paper applications and in-person assistance to apply for coverage.

The idea of the Marketplace is simple. By enrolling in private health insurance through the Marketplace, consumers effectively become part of a form of statewide group coverage that spreads risk between sick people and healthy people, between young and old, and then bargains on their behalf for the best deal on health insurance. Because of enhanced competition, insurers are now eager for new business, and have created new health care plans with more choices.

The premiums being charged by insurers provide clear evidence that the Marketplace is encouraging plans to compete for consumers, resulting in more affordable rates. The weighted average premium for the second-lowest-cost silver plan, looking across 47 States and DC, is 16 percent below the premium level implied by earlier Congressional Budget Office (CBO) estimates.¹ Outside analysts have reached similar conclusions. A recent Kaiser Family Foundation report found that, “while premiums will vary significantly across the country, they are generally lower than expected,” and that 15 of the 18 States examined would have premiums below the CBO-projected national average of \$320 per month for a 40-year-old in a silver plan.²

This is good news for consumers. In fact, some insurers lowered their proposed rates when they were finalized. In Washington, DC, some issuers have reduced their rates by as much as 10 percent.³ In Oregon, two plans requested to lower their rates by 15 percent or more.⁴ New York State has said, on average, the approved 2014 rates for even the highest coverage levels of plans individual consumers can purchase through its Marketplace (gold and platinum) represent a 53 percent reduction compared to last year’s direct-pay individual market rates.⁵ Furthermore, States are using their rate review powers to review and adjust rates accordingly. In Oregon, the State has reduced rates for some plans by as much as 35 percent,⁶ and in Maryland, the State has reduced some rates for coverage offered through the Marketplace by almost 30 percent,⁷ offering consumers an even better deal on their coverage for the 2014 plan year.

In addition to the more affordable rates resulting from competition among insurers, insurance affordability programs, including premium tax credits and cost-sharing reductions, will help many eligible individuals and families, significantly reducing the monthly premiums and cost-sharing paid by consumers. Premium tax credits may be paid in advance and applied to the purchase of a qualified health plan through the Marketplace, enabling consumers to reduce the upfront cost of purchasing insurance. In addition, cost-sharing reductions will lower out-of-pocket payments for deductibles, coinsurance, and copayments for eligible individuals and families. A recent RAND report⁸ indicated that, for the average Marketplace participant nationwide, the premium tax credits will reduce out-of-pocket premium costs by 35 percent from their unsubsidized levels.⁹

CBO has projected that about 8 in 10 Americans who obtain coverage through the Marketplace will qualify for assistance to make their insurance more affordable, an estimated 20 million Americans by 2017.¹⁰ A family’s eligibility for these affordability programs depends largely on its family size, household income, and access to other types of health coverage.

The fact is that the Affordable Care Act delivered on the product: quality, affordable health insurance. The tremendous interest shown in HealthCare.gov shows that people want to buy this product. We know the initial consumer experience at HealthCare.gov has not been adequate. We will address these initial and any addi-

¹ http://aspe.hhs.gov/health/reports/2013/MarketplacePremiums/ib_marketplace_premiums.cfm#_ftnref18.

² <http://kaiserfamilyfoundation.files.wordpress.com/2013/09/early-look-at-premiums-and-participation-in-marketplaces.pdf>.

³ <http://hbx.dc.gov/release/dc-health-link-applauds-aetna-decision-cut-rates>.

⁴ http://www.oregonlive.com/health/index.ssf/2013/05/two_oregon_insurers_reconsider.html.

⁵ <http://www.Governor.ny.gov/press/07172013-health-benefit-exchange>.

⁶ http://www.oregonlive.com/health/index.ssf/2013/06/oregon_slashes_2014_health_ins.html.

⁷ <http://www.kaiserhealthnews.org/stories/2013/july/26/maryland-marketplace-premiums-exchange.aspx>.

⁸ http://www.rand.org/content/dam/rand/pubs/research_reports/RR100/RR189/RAND_RR189.pdf.

⁹ This is a simple calculation based on Figure 6 of the RAND study, available at the link above.

¹⁰ http://www.cbo.gov/sites/default/files/cbofiles/attachments/44190_EffectsAffordableCareActHealthInsuranceCoverage_2.pdf.

tional problems, and build a Web site that fully delivers on this promise of the Affordable Care Act.

OTHER BENEFITS OF THE AFFORDABLE CARE ACT

While we are working around the clock to address problems with HealthCare.gov, it is important to remember that the Affordable Care Act is much more than the opportunity to purchase insurance through HealthCare.gov. Most Americans already have health coverage through an employer-based plan, or health benefit program, such as Medicare, Medicaid, or the Children's Health Insurance Program (CHIP). For these Americans, the Affordable Care Act provides new benefits and protections, many of which have been in place for some time. For example, because of the Affordable Care Act, millions of young adults have been able to stay on their parents' plans until they are 26. Because of the Affordable Care Act, seniors on Medicare receive greater coverage of their prescription medicine, saving them billions. Because of the Affordable Care Act, for millions of Americans, recommended preventive care like mammograms is free through employer-sponsored health coverage. And in States where Governors and legislatures have allowed it, the Affordable Care Act provides the opportunity for many Americans to get covered under Medicaid for the first time. In Oregon, for example, a Medicaid eligibility expansion will help cut the number of uninsured people by 10 percent, as a result of enrollment efforts over the last few weeks, resulting in 56,000 more Americans who will now have access to affordable health care.

The Affordable Care Act is also holding insurers accountable for the rates they charge consumers. For example, insurance companies are now required to justify a rate increase of 10 percent or more, shedding light on unnecessary costs. Since this rule was implemented,¹¹ the proportion of rate filings requesting insurance premium increases of 10 percent or more has plummeted from 75 percent in 2010¹² to an estimated 14 percent in the first quarter of 2013,¹³ saving Americans an estimated \$1.2 billion on their health insurance premiums.¹⁴ These figures strongly suggest that the rate review program has materially influenced premiums that ultimately get charged to individuals and small businesses.

The rate review program works in conjunction with the so-called 80/20 rule (or Medical Loss Ratio rule),¹⁵ which generally requires insurance companies in the individual and small group markets to spend at least 80 percent of premiums on health care and quality improvement Activities and no more than 20 percent on administrative costs (such as executive salaries and marketing) and profits. In the large group market (generally coverage sold to employers with more than 50 employees), insurers must spend at least 85 percent of premiums on medical care and quality improvement Activities. If insurers fail to meet their medical loss ratio requirement, they must provide rebates to their customers.

New rules will help make health insurance even more affordable for more Americans beginning next year.¹⁶ Marketplace health insurance plans will be prohibited from charging higher premiums to applicants because of their current or past health problems or gender, and will be limited in how much more they can charge Americans based on their age.

CONCLUSION

The Affordable Care Act has already provided new benefits and protections to Americans with health coverage, and we are committed to improving the experience for consumers using HealthCare.gov so that all other Americans can easily access the quality, affordable health coverage they need. By enlisting additional technical help, aggressively monitoring for errors, testing to prevent new issues from cropping up, and regularly deploying fixes to the site, we have already made significant improvements to the performance and functionality of HealthCare.gov. These continuing improvements will ensure that HealthCare.gov will be fully functional for the vast majority of consumers by the end of November. I appreciate the commit-

¹¹ Health Insurance Rate Review—Final Rule on Rate Increase Disclosure and Review: <http://www.gpo.gov/fdsys/pkg/FR-2011-05-23/pdf/2011-12631.pdf>.

¹² <http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/rate-review0912012a.html>.

¹³ <http://aspe.hhs.gov/health/reports/2013/rateIncreaseInduMkt/rb.cfm>.

¹⁴ http://aspe.hhs.gov/health/reports/2013/acaannualreport/ratereview_rpt.cfm.

¹⁵ Medical Loss Ratio Final Rule: <https://www.Federalregister.gov/articles/2012/05/16/2012-11753/medical-loss-ratio-requirements-under-the-patient-protection-and-affordable-care-act>.

¹⁶ Health Insurance Market Rules: <http://www.gpo.gov/fdsys/pkg/FR-2013-02-27/pdf/2013-04335.pdf>.

tee's ongoing interest in our efforts to deliver on the promise of the Affordable Care Act, and I look forward to your questions.

The CHAIRMAN. Thank you, Ms. Tavenner.

Now we'll start a series of 5-minute questions. I know everyone has questions. I'm going to hold myself and everyone else to 5 minutes. It might be you only get one question. But that way, we can go around once, we'll go around twice, and we'll go around three times, as long as it takes, so that people can get their questions asked. But I hope that we'll just keep within 5 minutes so everyone gets to ask a question. So we'll start now.

Ms. Tavenner, as we evaluate the problems with the Web site, it's important to get the facts straight. Some have said that fixing the Web site could take 6 months to a year. Others state that there are 5 million lines of code to rewrite. Some have urged you to pull down the entire system and start from scratch. So I hope you can bring some facts to this much overheated debate.

I understand this can get very technical very quickly. But I want to give you an opportunity to explain the problems with the site and the path forward just in plain English. What's the plan for fixing the Web site? Who is leading the effort? What is your role in this work? And what's your expected time table for the process to run smoothly?

Ms. TAVENNER. Let me start with the plan. As you all may be aware, we engaged QSSI to serve as the general contractor. They were engaged last week, they will be leading the effort, working with me directly. They will be responsible for coordinating contracts.

I would describe the problems with the Web site in two categories. The first problem had to do with performance and speed. We added capacity, and we made system performance improvements. That has to do more with what I would call the hardware side of the equation. That work was done immediately.

Although we had projected demand for the Web site, we obviously underestimated that demand, so we had to go back and catch up and add additional capacity and improve performance. That's some of what I was referring to in my opening comments about the slowness of the system as you were going through pages.

The second issue has to do with software improvements. The first big one was the ability to establish an email account. That was a problem that we solved in the first week. We've had success there. There is not the problem of establishing an email account or going on to the identity proof. That problem has been resolved.

Now we're into what I would call the internal piece of the architecture. I'll remind you that this Web site is covering 34 States and 50 Medicaid programs and also services the State-based exchanges. So it's pretty complicated. We knew all along we would have bugs in the system. I think we obviously had more bugs than we realized, particularly around the application.

We actually are doing a series of software upgrades pretty much several times a week. We will continue that. You will see improvement week by week, but this is weeks, not months, and we are not rewriting the architecture.

The CHAIRMAN. Could you address yourself to the issue of security? There have been several reports that you and others had con-

cerns about the site's security protections leading up to October 1. Could you discuss your concerns, how they were addressed, and what efforts are we making to ensure that consumers' information is secure?

Ms. TAVENNER. Let me try to take the security question in a couple of different buckets, because I think there's been a lot of confusion around security. First of all, in the hearings over the summer, a lot of the questions that I answered and others answered had to do with security, the hub.

The contractor is QSSI. The hub serves not only the Federal marketplace but all of the States as well and has been a smooth operating system. That security, including end-to-end testing, was completed by September, and there was sign-off on the hub.

When it comes to the FFM, or the actual exchange, there was security testing by component, and then we did a short-term authorization to operate, because we knew we were going to be making software enhancements. We had announced prior to October 1 that we were not going to bring shop up right away. We were not bringing the Spanish Web site up right away.

We did a temporary or short-term authorization to operate, because we knew we would have to do continuous security testing while those programs were being installed and while software was being upgraded, which is routine. I think there's confusion about what was tested and what was not tested. So I need to separate those.

The CHAIRMAN. I only have 27 seconds. When someone comes on, will they be assured that their social security number, for example, will be kept secure, that no one can hack in and take their social security number?

Ms. TAVENNER. Yes. And remember that the hub does not store any information. The hub is a router. So when you go in and fill in an application, it pings, if you will, social security. It pings the IRS to validate your income, to validate your citizenship, to validate your social security number. But that's not stored.

What is stored is in your individual application, which is secure, and that was part of the secure or the identity proofing on the front end that was a little complicated, because we had taken additional steps to make sure that an individual application was secure. Now, in addition to all this, we also have continuous monitoring of all systems, which is something we do for Medicare as well.

The CHAIRMAN. Thank you very much, Ms. Tavenner.
Senator Alexander.

Senator ALEXANDER. Thanks, Mr. Chairman.

Ms. Tavenner, let me go back to the President's words. I'm sure you'll be able to fix the Web site, and I'm not as concerned about the IRS fines that will come next year. What I'm more concerned about are the canceled policies and the inability of people to have time after you presumably fix the Web site by the end of November to replace their policies by January 1 so that they'll actually have health insurance.

And I'm concerned about the kind of health insurance they get because of the large number of cancellation letters that are coming into our office from Tennessee. So let me suggest that a way to fix this problem of canceled policies in the individual market is to go

to a Web site that does work pretty well. It still says if you like your plan, you can keep it, and you don't have to change a thing due to the healthcare law. That's the White House Web site. Those are the President's words in 2009.

So why don't we put those words into law? Why don't we solve the problem of Emily, the lady I read about from Tennessee, who is losing her CoverTN insurance and finding that to replace it, it'll cost 410 percent more? Senator Ron Johnson has introduced a bill that he calls If You Like Your Healthcare Plan, You Can Keep It. It would basically put the President's words into law and assure those millions of Americans like Emily that they'll be able to keep a plan like CoverTN, and she won't be out of insurance on April 1.

We're talking about millions of Americans. So my question to you is would the Administration support Senator Johnson's bill, which would put the President's words into law by saying to Americans that if you had a plan before the law was passed on March 23, 2010, or even a plan all the way up to the end of this year, that you can keep it? Wouldn't that solve a lot of problems and reassure many Americans that they can have affordable healthcare?

Ms. TAVENNER. Senator Alexander, when we wrote the regulation back in 2010, that's exactly what we did. We grandfathered in existing plans, both in the employer market and in the individual market. There was a lot of back and forth about that regulation. What was the phase-in time? So that's why we delayed it until—we said, basically, plans could be grandfathered over this period of time, and also we allowed the grandfathering to continue as long as it did not reduce benefits significantly. There were some things put in place.

So I do think we put in steps, the ability to keep plans. Now, in these cancellation letters, these cancellation letters are also followed by a statement in each of them that says—

Senator ALEXANDER. Ms. Tavenner, I want to give you a chance to answer. But will you support Senator Johnson's bill?

Ms. TAVENNER. I would not—I have not even looked at Senator Johnson's bill. I'm happy to look at any—

Senator ALEXANDER. I'll get a copy to you. And if I may say, we know about the regulations that were written in 2010. They effectively made it impossible to grandfather a lot of the plans that people had. And according to your own regulations, it was estimated that 40 percent to 67 percent of those individual policies wouldn't be able to be grandfathered because of all the conditions you put in the regulations.

So, in effect, didn't you know in 2010 that there would be a big turnover in these individual policies, and that it was wrong to go across the country saying that if you like your plan, you can keep it without having to change a thing?

Ms. TAVENNER. I don't think the regulation assumed that it was because of the grandfathering that these plans would change. These plans routinely change. The churn in these plans is greater than 50 percent per year, often not renewed. People move about this market. This is part of what the Affordable Care Act was designed to do, to try to stabilize this market and give individuals some protection.

Senator ALEXANDER. But your regulations said if you increase cost sharing, co-pays, change the employer contribution, change the fixed amount, change the benefits—all of those would mean that those plans didn't continue. And, basically, Washington is saying to people like the 16,000 who lose their CoverTN plan, "We know better than you do what is a good plan for you. We want you to buy a better plan even though you like the plan you have."

So why not put the President's words into law and simply say,

"If you like the plan you have, we're not going to decide for you. You can decide it, you as an individual. If you like the plan you have, you can keep it without having to change a thing."

That's what's on the White House Web site today.

Ms. TAVENNER. Senator Alexander, for those 16,000 individuals that you listed, they were also given the option of renewing with a new plan. And, yes, maybe some of those plans were more expensive. But I would encourage those individuals to go on the Web site and take a look at what's available in the individual market in Tennessee. I think you will see that the pricing in the individual market actually came in about 18 percent lower. Also, some of these individuals may qualify for a subsidy. So I would just encourage them to look at their current issuer, but also to go on the Web site, take a look at plans that are available in Tennessee, and also check to see if they qualify for a subsidy.

Senator ALEXANDER. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Alexander.

Senator Mikulski.

STATEMENT OF SENATOR MIKULSKI

Senator MIKULSKI. Good morning, Administrator Tavenner. Actually, I'm glad to see you, and I hope you're doing well. We're very proud of the fact that CMS is headquartered in Maryland, and there are thousands of people who work there every day in every way trying to make sure Medicare, Medicaid, and Obamacare is delivered effectively and efficiently, even though you've been revenue starved and kind of battered around in the failure to confirm permanent administrators.

But we'll put that aside for this conversation, because the launching of the Affordable Care Act has been more than bumpy. I believe that there's been a crisis of confidence created in the dysfunctional nature of the Web site, the canceling of policies, and sticker shock from some people. In my own State of Maryland, it was also bumpy. We read in the Baltimore Sun this morning that 73,000 Marylanders' policies will be canceled. So there has been fear, doubt, and a crisis of confidence.

So let me get to where I am, because it's not to finger point. It's to pinpoint. What I worry about is that there's such a crisis of confidence that people won't enroll. And the very people we need to enroll, particularly our young people, to make this whole system work, won't happen.

As you know, the people who are the most desperate—Senator Alexander's compelling story of Emily is the kind of person—seri-

ous health problems. But I'm looking for that 24-year-old working at Harbor East at a .com startup to be able to apply.

Can you tell me what you're doing in terms of the crisis of confidence? And, also, how are we going to get young people back to looking at how they're going to apply, to make it attractive, to give them confidence in the system, and also then to make the whole system more affordable?

Ms. TAVENNER. Let me start with the affordability. I will talk about it both from the State-based exchange—

Senator MIKULSKI. I have 2 minutes and 46 seconds. So do you have a plan to get the young people back?

Ms. TAVENNER. Yes, we do, and we will roll out that plan. Our goal is to stabilize the Web site this month, and then we do have a targeted plan that includes not only young people, but the large populations of the uninsured in markets. So, yes, there is a plan.

Senator MIKULSKI. Well, what kind of plan is it?

Ms. TAVENNER. It's a combination of media, both television and radio, and some print. It's identified by top markets, and I'm happy to share that plan with you all.

Senator MIKULSKI. And do you think you're going to restore the confidence in this plan?

Ms. TAVENNER. Yes.

Senator MIKULSKI. How?

Ms. TAVENNER. I think, first of all, by the improvements in the Web site, which we're already seeing, and I would encourage folks if they've not been on the Web site in the last few days to please go on the Web site. It has improved. We're seeing more folks being able to complete applications. We're getting more positive feedback from individuals, and there is a tremendous amount of interest in this plan.

Like I said, there's over 700,000 completed applications. Obviously, we've seen over 13 million visitors to the Web site. So the information is out there. We just need to ensure people that the site is working.

Senator MIKULSKI. Well, I'd like to move to going to the Web site, which also goes to many of my loyal constituents. We talk a lot about, of course, the robust Baltimore-Washington corridor, but not everybody has access to a computer, and not everybody knows how to use a computer, including young people. We worry in Maryland about the digital divide—Governor O'Malley, Ben Cardin, Barb Mikulski.

But you say you can go to the phone. Are you publicizing this number? No. 2, if you want a paper application, or you want to be able to talk to someone in person, as you said, where do you go, and where do you get this information? And are there designated sites? In other words, will we do this in post offices? Will we do this in libraries? What are we going to do where people actually can be able to do this if they're not going to go to a computer, or a computer is not available, or their friend?

Ms. TAVENNER. That is a great question. We do advertise the 1-800 number, and we advertise that you can call there to also get information if you don't want to use the computer.

We also advertise who in the community—we have currently over 70,000 agent brokers who have been trained to assist people.

We have navigators in every State, and they are covering the entire State. So we advertise that. We also have many hospitals and other associations, including libraries, who have been certified and are offering to help.

Senator MIKULSKI. Well, I'm going to be blunt, because I really want this to be a success. And my job is to pinpoint solutions, not finger point, looking at a retro way. I think it's very confusing. I know my time is up.

But I think it's very confusing about where you go. We hear about the navigators and the this and that. But I can tell you people really don't know. They really, really don't know.

The CHAIRMAN. Senator Isakson.

STATEMENT OF SENATOR ISAKSON

Senator ISAKSON. Thank you, Mr. Chairman.

Administrator Tavenner, thank you very much for coming today. You said, I think, that 10 days ago, QSSI, Quality Software Services, Inc., we put in charge of coordinating the Web site and the hub. Is that right?

Were you aware that in June of this year, the inspector general issued the following report on QSSI? It said,

“Quality Software Services, Inc., did not sufficiently implement CMS required information system security controls over USB ports and devices, thus risking exposure of personal identification information for over 6 million Medicare beneficiaries.”

Were you aware of that?

Ms. TAVENNER. No, sir.

Senator ISAKSON. I'd like to put in the record the IG's report from June, because it did expose—because of their lack of discipline in following Federal information, they exposed over 6 million Medicare beneficiaries' information. [The information referred to may be found at <https://oig.hhs.gov/oas/reports/region4/4120545.pdf>.]

The reason I bring that up is—and I don't believe everything I see on television. In fact, I try and check everything out. But this morning, there was what seemed to be a pretty credible claim that a lawyer in South Carolina who had gone on the Web site and gotten access and set up an account was called by a man from North Carolina telling him when he went on and put in his password, he got that man's information.

This information security is extremely important. Mike Rogers in the House has made some pretty strong statements about the importance of keeping it secure. So I would ask that you follow the IG's report and make sure QSSI is in compliance, and if they aren't, that they get in compliance.

Ms. TAVENNER. I will followup on that report. And there's two things. Mitre is actually the contractor that does the security of the marketplace, and we are working closely with them. On this incident in South Carolina, we actually were made aware of that yesterday, and we implemented a software fix yesterday to fix that. That would be treated as a personal identification issue, and we will do a complete followup on that to make sure.

Senator ISAKSON. You said in your testimony that this was going to be ongoing, because we all know cyber security is an ongoing challenge. But I think it's critically important to tell whoever you said the person in charge of security was to get with QSSI and make sure they met compliance.

Ms. TAVENNER. I will make sure, and I'll give you feedback.

Senator ISAKSON. Second, as one who was an independent contractor for 33 years and had about 1,000 independent contractors working for me, most of the people who are uninsured or have had lack of access to good insurance were independent contractors, because their employer could not, by law, provide it to them.

But the unintended consequence—yesterday, I was with a group of them in Atlanta, speaking to them, not about healthcare, and I had three of them come up to me. One of them was a Mrs. Russell, who had had her own insurance that she had bought as an independent contractor. She had just received a cancellation notice, had tried to go to the Web site, couldn't, had called the toll free number and had gotten help from a human being who said they could send the information, but they could not guarantee when it would come.

My point in this is when we passed the Affordable Care Act, it precluded insurance agents from being navigators and put in a medical loss ratio so high that you could not pay a commission to a salesperson. So the only access to human beings that could be incentivized to tell somebody what's in the plan was either to call the Web site, go on the Web site, or find a navigator.

I really think CMS should consider rethinking the prohibitions, both on medical loss ratio and the unintended consequence of not allowing health insurance agents to be navigators, because that's limiting access of the American people to the information that you want them to have. That's just an editorial comment.

My last statement—if you'd put up the chart on the iceberg. When everybody thinks of Georgia, they think of Atlanta. But there's a lot more to Georgia than Atlanta. A lot of our State is very rural, very agricultural. In southwest Georgia today, premiums are doubling and more than doubling in many cases, and health insurance cost is going through the roof.

When you said that the Web site was only the tip of the iceberg, you were right, because you have tremendous problems and tremendous challenges. But the biggest one of all are the premium increases to the people who can least afford them. And in rural southwestern Georgia, that is by far the case.

On behalf of those Georgians in my State, we're seeing a doubling of their premiums. We need to address that, and we need to make sure that the unintended consequence of requiring so much coverage is not running people out of coverage rather than providing the coverage they need. Do you know what's contributing to the cost of rural healthcare going up so much in terms of premiums?

Ms. TAVENNER. I would not be the expert there, but, obviously, the more competition we have, it tends to lower prices. And I find rural areas—I'm not familiar with Georgia, but I'm certainly familiar with Virginia, and that was part of the problem. There was not enough competition. The rates tended to be high. The rates were high prior to the implementation of the Affordable Care Act.

We have seen new entrants into the market in most all States. So we're hoping that as these new entrants happen, it will continue to press the pricing downward, because competition does help.

Senator ISAKSON. Thank you for your testimony. My time is up. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Isakson.
Senator Murray.

STATEMENT OF SENATOR MURRAY

Senator MURRAY. Thank you, Mr. Chairman.

Thank you, Administrator Tavenner, for being here and for all the work you're putting into this. When we passed the Affordable Care Act, we really designed it to have States lead the way and drive market reforms by building their own marketplaces. States like Kentucky and my home State of Washington planned and designed and created their own marketplaces. And, of course, many States declined the opportunity to build their own marketplace and relied on the Federal Government to do the work for them.

Washington State's Health Plan Finder has been really a national leader on the launch of their new marketplaces and in its first month enrolled nearly 55,000 people from my State for new health insurance coverage, including 10,000 kids. So I'm very proud of the work that's been done in my State to provide access to quality affordable coverage.

I wanted to ask you to tell us a little bit about what you are seeing in the States, like mine, that developed their own marketplaces.

Ms. TAVENNER. Well, you certainly listed some of the top. I'll just list a few. All the States are working hard. We have 17 partners at the State level, including Washington, DC, and I would say that what we're seeing in Washington and Kentucky is probably some of the strongest performances, which is great. They have good systems. They've had lots of application interest.

The other area that I would say we're pleased with—because of the size of the States, they're so important—is New York and California, where we're seeing good progress. But each of the States are moving along. And part of what we will be submitting in mid-November, as I've talked about in previous hearings, is some information about applications and enrollments that will look at the State and what's inside the State as well as the Federal marketplace. So we'll have more data for you.

Senator MURRAY. Good. And we're going to be using some of those States to use their best practices to help?

Ms. TAVENNER. We are, indeed, and we have a meeting with them this Thursday. We meet with them regularly. We have a good relationship.

Senator MURRAY. And I also wanted to ask you about the next round of outreach to Americans and what it will look like. Everybody is focused a lot on the Web site, and we all know it's improving, and those issues will be solved.

But, obviously, a lot of Americans were frustrated by their initial applications, and we've got to get them to return to the site—the crisis of confidence that Senator Mikulski talked about. But in addition to those people, I want to know about the Administration's

plan to reach out to those Americans whose individually purchased plans are being canceled by their insurance companies.

There was a story in our paper in Seattle about a 56-year-old woman who received one of those cancellation notices and who, like a lot of other people, was told to blame the Affordable Care Act in that letter. But, of course, she wasn't told that if she accessed the ACA marketplace, it could save her and her family thousands of dollars and provide her with upgraded, more comprehensive healthcare coverage.

So when I read her story, I thought that's an important reminder that it's going to be an uphill battle against some political and industry interests to get those individuals good information that have received those letters. And I wanted to know what you are doing to get information out to those people whose policies have been canceled that we've been hearing about.

Ms. TAVENNER. This is actually a conversation we're having today about how do we use—we have a Consumer Assistance Program within CMS, within the CCIIO component. Is there a way we can actively engage to reach out to people who have been canceled. Although they're canceled, they are offered another policy.

But I think what's important for them to understand is that it's not just that policy. It's also the ability to go on the exchange. As you mentioned, in Washington State, they don't even have to apply. They can go take a look at what the rates are. You can now do that on the Federal exchange as well. So we are working on a plan, and I'll be happy to get back to you on that. But I won't get back to you like this week.

Senator MURRAY. I think that's really important, because a lot of them are just seeing "Your policy has been canceled by Obamacare" and not being told "Here is what your options are," and we've got to really work on that.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Murray.

Senator Enzi.

STATEMENT OF SENATOR ENZI

Senator ENZI. Thank you, Mr. Chairman. I'm from a low population State. We're pretty much rural, and we do recognize that the problems with the Web site are probably just the tip of the iceberg, much as this chart demonstrates back here.

Saturday, 2,600 people in Wyoming had their policies canceled. Fortunately, 3 years ago, I noticed that the rules were changing and that people would not be able to keep what they had been promised. We have a method for petitioning on that. It's called the Congressional Review Act. And I petitioned, got enough signatures, and we had a little debate about repealing the rule that would have kept them from keeping the policy that they like.

That was voted down on straight party lines. I think some people will probably be paying for that in the next election. But on the accountants, I'll go into some of the more technical questions with this Web site. It's my understanding that CGI's contract is a cost-plus contract, where the company will continue to be paid for its work while they try to straighten out problems that maybe they even caused.

How much more will it cost to fix the Web site, and where will these funds come from? Also, if it's their fault for delivering a product that didn't meet specifications, do you intend to recover payments for them, and what recourse is available?

Ms. TAVENNER. You are correct. The CGI contract is a cost-plus contract. First of all, there is not additional funding being provided to CGI. They will work and make these repairs within the existing contract. I meet regularly with not only CGI Federal but also CGI Global to have these conversations, including one at 8:30 this morning. So the work is expected to be completed.

There are recovery processes, even in a cost-plus contract, and I'll have to get you that information. I would not want to rely on my brain for that one. But I will work with our contracting person.

Senator ENZI. I'd like to be able to get a copy of the contract as well. And then there must be a contract with QSSI as well?

Ms. TAVENNER. Yes.

Senator ENZI. Is that a cost-plus one as well?

Ms. TAVENNER. I'll have to get you the details on the QSSI. But I thought we had—we can certainly get you the information you requested.

Senator ENZI. Where is CGI headquartered?

Ms. TAVENNER. CGI headquarters is actually in Virginia.

Senator ENZI. And QSSI?

Ms. TAVENNER. That's a good question—Minnesota. I'm guessing on that one, because it's part of Optim. They also have offices in Virginia. We're working currently with both the national and local. They're in Virginia, and they're also in Maryland.

Senator ENZI. I also serve on the Finance Committee, and in the Finance Committee, CMS testified on doing the testing on this Web site. We were assured that it had all been done. It's my understanding that there was testing still going on the day before the Web site opened, and that there had not been the security testing that either was called for or wasn't called for to see that the Web site would be secure and intact.

How much security testing was done as part of the beta testing?

Ms. TAVENNER. This is what I was trying to explain earlier. There are two components to the Federal exchange. One is the hub, and the hub was completely tested. Security testing signed off.

In the case of the FFM, or the actual exchange itself, each component was tested, both by us, independently verified security tested. It was not signed off in a complete package, because we were still upgrading modules. That's ongoing. We signed the short-term authorization to operate, which would be customary if you were continuing to do work on the project.

Senator ENZI. You also mentioned that this information that goes in there is just pinged and it's not stored. How do you identify the person later with whatever contract that there is if there isn't any of that information kept?

Ms. TAVENNER. What I'm saying is not stored is the social security number, and this sort of thing is not stored in the data hub. Obviously, when you complete an application, it has social security number information in it, and individuals can store that online. That's part of the ID proofing that an individual can do to store their application.

We also have some storage in what I'll call the enrollment and eligibility process in case there's an appeal on this sort of thing. But what I was trying to say is there's no data stored in the hub. We obviously have information on some records.

Senator ENZI. I don't think people care where it's stored. They're just concerned about their privacy and whether the storage is secure or not. So I'll have some more questions to followup on that. But my time is almost up.

Thank you.

The CHAIRMAN. Thank you, Senator Enzi.
Senator Bennet.

STATEMENT OF SENATOR BENNET

Senator BENNET. Thank you, Mr. Chairman.

Thank you, Ms. Tavenner, for being here today. As I've watched this—and I've had some experience in the private sector and in local government and State level and here—I hope, as we go forward, that we don't lose sight of the fact that government does not do a great job with procurement, with IT, or with customer service. And I think we're seeing that here in spades.

My hope is that we use this as an occasion not just to point fingers, but to figure out how to improve things for the American people going forward. In the short term, I think the customer service element of this is enormously important so we don't face the kind of crisis of confidence that Senator Mikulski talked about.

That ought to be job No. 1, to figure out whether people—put the politics aside—whether people sitting at their kitchen table can decide and evaluate for themselves whether this is a better deal or not for them. And in Colorado, as you know, we've set up our own exchange.

One of the things that I've been told is that people have to go through numerous pages to have a determination made about their Medicaid eligibility before they can actually get access to the private marketplace. And there's been some suggestion that that's been required by the Federal Government. I don't know whether that's true or not. But I wonder whether you can enlighten me on that or shed some light on it, and whether we can figure out how to work together to make that less of a burden to people.

It seems to me that a customer service friendly Web site would have a button that said "If you think you might be eligible for Medicaid, click here," and it would take them through that. But for somebody who knows they're not eligible they could skip the cumbersome process and get to the private exchange.

And as you talk about that, Ms. Tavenner, if you could, broadly address the question of this sort of customer service part of this, the changes that you have made to try to give people the opportunity on the Federal exchange to make their own decision.

Ms. TAVENNER. Let me start by saying it is a common application, whether you're going on to shop without a subsidy, or to see if you qualify for a subsidy, or for Medicaid. And I think that's what you're referring to. It's a common application. But whether you are Medicaid eligible or whether you are applying for a subsidy, it's a single application. So Medicaid doesn't add any additional steps to that process.

Senator BENNET. My understanding is that on the—and, again, this is the Colorado exchange, not the Federal. My understanding is that you need to be denied by Medicaid before you can have access to shop in the private marketplace.

Ms. TAVENNER. I would need to check with Colorado, because they did devise—but I'll get back to you on that.

Senator BENNET. OK. Let's do that.

Ms. TAVENNER. So let's go back to the customer service.

Senator BENNET. Can we do that today?

Ms. TAVENNER. Yes, we can get you that information today.

The customer service issue is very important to us. And as we stabilize the site, we're going to go back and deal with those individuals that we think may have had a bad experience on the front end, such as the establishment of an email account. We have individuals' information, so we're going to reach out to them and invite them to come back.

Some of them may have already gone ahead and created a separate account, or maybe they were just on there out of curiosity. But at least we'll make an effort to go back and touch individuals and say, "If you had trouble in the first week, please come back and try to establish your account again because we've solved that problem." That's the first step.

The second step is how we handle it in the media and in the market. We do have what I was talking about before, a campaign to reach out to consumers. But we will not start that campaign until we stabilize the site over the next few weeks, and then we will spend December, January, February, and March reaching out to individuals.

If you're in a State-based exchange, the State is responsible for doing their own marketing campaign. If you're in the Federal exchange, we have that opportunity. We've identified key markets based on the number of young uninsured and the number of uninsured in general in the population. We do have a targeted campaign for the next 4 months.

Senator BENNET. What are the implications for your timelines with respect to eligibility, signup, and all the rest if you don't get this Web site fully functional by the end of the month or the end of—yes, this month?

Ms. TAVENNER. The end of November. Based on our analysis, we will have it fully functioning by the end of November. There will always be people who don't want to use the Web site, who want to do paper, or who want to call in. That's fine. We'll support that.

But I think we always assumed, based on Massachusetts' experience, that the initial signup would be very slow. And, in fact, no payments have to be made until December 15 for coverage on January 1. So while we don't like the problems we had in October and fixing it in November, we do not think it will impact the timeline, because we have a 6-month enrollment. We will still have 4 months left, and individuals can apply up until the end of March.

Senator BENNET. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Bennet.

And now Senator Roberts.

STATEMENT OF SENATOR ROBERTS

Senator ROBERTS. Thank you, Mr. Chairman. I'm going to focus, if I can, on the concern raised by Senator Isakson and Senator Alexander and by the chairman on security and privacy.

We have a law, the Federal Information Security Management Act, FISMA. Everything has to have an acronym. This is FISMA. And it requires each agency to appoint a chief security officer to sign off on the security of government web systems to ensure Americans' private, financial, and identifying information is protected, and that's a big issue.

Secretary Sebelius revealed last week that the exchange is operating on a temporary authority to operate. There's a 2012 memo from Jeffrey Zients. That's the gentleman that has been picked by the President to fix the Affordable Healthcare Act, and they call him Mr. Fix-it. While head of OMB, he stated clearly that OMB does not recognize interim authority to operate per security authorizations.

My first question is why was the exchange allowed to go operational without the apparent clearance required by the Office of Management and Budget? I'm going to go on and you just think about that for a minute. I don't like to do this, but time is limited.

Again, as part of the FISMA security assessment, an independent testing organization must perform, must perform, a risk analysis of the security of the system. So my second question, or you can answer the first—did an independent testing organization ever test the whole integrated system end to end? I'm sorry to ask you two questions.

Ms. TAVENNER. That's all right. The first question—OMB does approve of short-term authorization, so we were following the rules as outlined by OMB, and I double checked that. The second one is, yes, we are FISMA and NIST compliant, and we did use an independent security firm. That would be Mitre, who actually did the work and did the testing.

The only piece that was not completed, which is the piece I've talked about before, is we could not test in a live environment until October 1, which is the reason we went with the short-term authority, because the testing will continue this month and next month as we do the software upgrades, and it'll be tested in a live environment.

Senator ROBERTS. Well, without revealing publicly, which, obviously, you can't do due to what you've just said, will you submit confidentially to the committee the results of the independent testing?

Ms. TAVENNER. I will submit everything I can within the security guidelines, yes, sir.

Senator ROBERTS. All right.

A September 27 memo addressed to you states that due to system readiness issues, the required security assessment was only partly completed. The memo notes that untested parts of the system pose a high security risk, and the contractor was not able to test all parts of the system in one complete version of the system.

I have here a CBS News analysis, which I would like to include in the record at this point.

[The information referred to follows:]

[CBS News, November 4, 2013]

HEALTHCARE.GOV DUCKED FINAL SECURITY REQUIREMENTS BEFORE LAUNCH

(By Sharyl Attkisson)

WASHINGTON.—The health care Web site went down again Monday for an hour and a half, and no one is sure why. It's being taken offline on purpose every night from 1 a.m. to 5 a.m. for repairs. Millions are still having trouble buying insurance on it, and it turns out that even when the Web site works, it may not be secure enough to protect privacy.

As HealthCare.gov was being developed, crucial tests to ensure the security and privacy of customer information fell behind schedule.

CBS News analysis found that the deadline for final security plans slipped three times from May 6 to July 16. Security assessments to be finished June 7 slid to August 16 and then August 23. The final, required top-to-bottom security tests never got done.

The House Oversight Committee released an Obama administration memo that shows 4 days before the launch, the government took an unusual step. It granted itself a waiver to launch the Web site with "a level of uncertainty . . . deemed as a high (security) risk."

WH docs: Paper applications for Obamacare were problematic, too.

Obamacare: Memo reveals health care adviser warned W.H. was losing control 3 years ago.

Complete Coverage: Obamacare Kicks Off.

Agency head Marilyn Tavenner accepted the risk and "mitigation" measures like frequent testing and a dedicated security team. But three other officials signed a statement saying that "does not reduce the risk" of launching October 1.

Georgetown Law professor Lawrence Gostin is a big supporter of the Affordable Care Act. He helped Congress write the law to meet constitutional standards. But he's critical of the launch without proper security.

Watch: Obamacare enrollment got off to very slow start, below.

"Nothing can undermine public confidence more than the fear of a security and privacy breach," Gostin said. "You could have somebody hack into the system, get your Social Security number, get your financial information."

HealthCare.gov exchanges data through a massive hub that includes the IRS and Social Security Administration, to verify income and identity, and Veterans Affairs, for military personnel who receive special benefits.

Last week at a congressional hearing, Health and Human Services Secretary Kathleen Sebelius told Democrat G.K. Butterfield that Americans have no reason to worry.

Asked if she had confidence in measures the Administration was taking to protect the security of Americans' personal information, Sebelius responded, "I do, sir."

While officials try to fix all the problems with the Web site, internal notes released Monday from a government meeting last week reflect a new concern: that the media may begin to follow customer experiences. In some cases, CMS fears, there are "fewer health insurance options than would be desired" and "relatively high-cost plans."

Senator ROBERTS. This found that the deadline for a final security plan slipped three times from May 6 to July 16. Security assessments to be finished June 7 slid to August 16 and August 23. The final required top to bottom security test never got done.

Agency head Marilyn Tavenner, according to this analysis, accepted the risk and mitigation measures like frequent testing and a dedicated security team. But three other officials signed a statement saying that it does not reduce the risk of launching as of October 1.

That September 27 memo recommends a mitigation plan to address these risks and recommends a 6-month authority to operate. That recommendation was signed by you. Are you the official at CMS responsible for making the security authorization decisions?

Ms. TAVENNER. I think in the case, because of the visibility of the exchange, the chief information officer wanted to make me aware of it, and I agreed to sign it with no recommendation to proceed.

Senator ROBERTS. Does anybody else review or approve that decision before it's final?

Ms. TAVENNER. No, sir.

Senator ROBERTS. Like Secretary Sebelius or—

Ms. TAVENNER. No, sir. That was my decision.

Senator ROBERTS. I appreciate that. Thank you very much.

The CHAIRMAN. I'll take the remaining 30 seconds of the Senator's time to just say, again, as I talk to my fellow Senators on both sides of the aisle, this is a paramount concern. Consumers have to be absolutely certain that when they go on and fill out that application and give all that information that that is secure, that no one can hack into that and steal their social security numbers or identity—another thing. I just think this is an issue that really has to be focused on thoroughly so that there's absolute assurance that that is secure.

Senator ROBERTS. Mr. Chairman, could I get my 30 seconds back?

The CHAIRMAN. Well, you gave it up already.

Senator ROBERTS. Well, no, you took it. I just sort of gave it up. [Laughter.]

I'd just like to reflect on what you said, sir. There is a lady named Margaret from Manhattan, KS, who I promised that I would bring this issue up. She tried to get on the exchange, and then she tried the call number about three to six, seven, eight times.

She finally got somebody, and then she said, "Well, if I selected that plan, would it be secure?" And the answer was, "Well, you know, I'm pretty sure." That's a direct quote. And she said, "Well, if you're pretty sure, I want to be sure," and hung up and called our office. So that's just an example of the concern that you've raised.

The CHAIRMAN. I appreciate that. I do share that concern.

Senator Baldwin.

STATEMENT OF SENATOR BALDWIN

Senator BALDWIN. Thank you, Mr. Chairman. I want to thank you and the Ranking Member for convening us today.

Administrator Tavenner, thank you for being here.

Mr. Chairman, I appreciated your opening remarks and setting a context for where we are with real and significant challenges, but also a story of the earlier implementation of the Affordable Care Act that has proven to help many. I think about the parents of children with preexisting health conditions who can now secure insurance for their children and the peace of mind that provides.

I think about the 6.6 million young adults who are covered on their parents' health insurance, and I take personal pride in that, because I worked on that amendment as a House member when we were marking this bill up in Energy and Commerce. I think about the \$6 billion in prescription drug savings that seniors have had the advantage of since the passage of this bill.

And then I think about the rough implementation of this next phase of the Affordable Care Act, and even with the significant technical issues around the Web site, Healthcare.gov, I've heard from families in Wisconsin who are already recognizing some of the new insurance options that are available. And as you said in context in your opening remarks, that's what this is about, a new marketplace, especially for those who are shut out.

I heard from Carl and Bonnie, who own a farm in Hayward, WI, which is in the north woods of our State. They shared about their struggle to find health insurance prior to the passage of the Affordable Care Act. They were both dropped from their plan after health tests showed that Carl was at risk of developing prostate cancer.

They had to buy a new plan—they were lucky they could find one—that had a \$10,000 deductible and an \$800 premium. But it had a rider that said it would not cover prostate cancer if Carl ever got sick. But due to the Affordable Care Act, they are now comparing and shopping for new coverage in the marketplace. And they contacted me to share that they are thankful and really excited to be able to find healthcare plans that are not only affordable but actually cover cancer.

Given the quality health insurance options available on the marketplace, we need all of the doors to that marketplace to be wide open. The ongoing technical problems are unacceptable, and they must be fixed as soon as possible, and I'm glad to hear your update on the progress. They should have been fixed yesterday.

The need for a well functioning Healthcare.gov is particularly acute in a State like the one that I represent, because our Governor chose not to build a Wisconsin-made State-based health insurance marketplace for individuals and small businesses. He also failed to seize the opportunity that the Affordable Care Act presented to strengthen what we call BadgerCare in Wisconsin when he decided not to expand Medicaid under the Affordable Care Act.

Instead, Governor Walker decided to kick off as many as we think will be around 90,000 to 92,000 people from their current Medicaid coverage. And I think about all our discussion about if you like your healthcare plan, you can keep it. Well, there's tens of thousands of Wisconsinites who like their BadgerCare, and the reason that they can't keep it is because of our Governor's decision.

I wanted to ask you, Administrator Tavenner, to start off, can you confirm that Wisconsin is one of the only States in the Nation that's poised to kick off a large number of individuals from their current Medicaid coverage in 2014?

Ms. TAVENNER. Senator Baldwin, right now—and we are in discussions with Wisconsin—they and Maine are the two States that are looking at this idea. Other States have talked about it, but these are the two that have actually put proposals forward. And you're right. It is 92,000 people. And we are working with Wisconsin, our Medicaid agency, to try to make sure that those individuals are at least aware of the marketplace for those that would qualify for the marketplace.

Senator BALDWIN. I want to ask you a little bit more about that, because this is a significant number of people in my State. And in order to avoid a lapse in coverage, individuals losing BadgerCare must enroll by December 15 in the Federal exchange—

The CHAIRMAN. I'm sorry. The Senator's time has expired.

Senator BALDWIN. Oh.

The CHAIRMAN. I'm trying to hold everyone to 5 minutes.

Senator BALDWIN. Very good.

The CHAIRMAN. Everyone's been very good about this.

Senator Scott.

Senator SCOTT. I wanted her to continue to talk to get more time for my side.

The CHAIRMAN. What?

Senator SCOTT. I wanted her to continue so I'd have more time.

The CHAIRMAN. No, we're trying to keep it to 5 minutes. We'll get a second round. Everybody will get a second round.

Senator SCOTT. Republican jokes aren't funny. I'm sorry. I apologize.

[Laughter.]

STATEMENT OF SENATOR SCOTT

Senator SCOTT. Thank you, Mr. Chairman. It's my southern drawl. Anyway, let's get back to the topic here.

Ms. Tavenner, thank you very much for being here. We are now more than 30 days into one of the greatest Web site disasters in history. After nearly \$400 million, Healthcare.gov is synonymous now with failure. The public's trust has been broken, and the reports I'm hearing reinforces why.

One, in particular—and we've already heard discussion on this case of the South Carolina man—is so painful that I want to dedicate my time and my questions to try to resolve his issues. The case starts with Justin Hadley from North Carolina attempting on October 1 to get Obamacare through the Healthcare.gov. By Halloween, just 4 or 5 days ago, he was still unable to sign up for Obamacare.

However, Mr. Hadley from North Carolina immediately saw two download links. The linked document was an eligibility notice to Mr. Dougall from South Carolina, including Mr. Dougall's name, his address, and his eligibility for subsidies. Mr. Dougall is now requesting that the personal information for all of his family be removed from Healthcare.gov because he could not remove it himself because there is no delete option for consumers.

Of course, now, Mr. Dougall nor Mr. Hadley will use the Web site to purchase insurance. Making matters worse, when my office was contacted for assistance, we called the Healthcare.gov's 800 number as well, and we asked a very specific question, "Can you remove Mr. Dougall's personal information?" The response was silence, not a yes, not a no, not a maybe, not let me check with my supervisor. They just simply refused to have an audible word in response to our question.

It's hard to believe that your account managers really do not know if they can delete accounts internally, especially after such an egregious breach of trust. By the way, Mr. Dougall has called on several occasions, but no one will call him back. Not a single person has taken the time, after having his information exposed, to even call Mr. Dougall back.

I tell you this story because it illustrates what happened as a result of incompetence with this Web site and this program. The Ad-

ministration and HHS knew that Americans' personal information was at risk before the Web site went up. I think Senator Roberts just spoke about the inspector general's report from August that warned that Obamacare's exchanges may end up illegally exposing Americans' private records to hackers and criminals.

The report noted that CMS is working with a very tight deadline to ensure that security measures for the hub are assessed, tested, and implemented. Further, Senator Roberts alluded to the internal memo from September 27 obtained by the Washington Post. And to quote that memo, it says, "Inherent security risks exposed a level of uncertainty that can be deemed as a high risk to personal financial information being exposed."

The memo—of course, as you have taken responsibility, and we do appreciate that—was written specifically to you from your consortium administrator for health plan operations and the deputy CIO. You signed the authority for Healthcare.gov to operate for the next 6 months with a mitigation plan to be implemented. In other words, you authorized Healthcare.gov to go forward, realizing that the potential of exposing personal information was, and I quote from the memo, "a high risk."

Here are my questions. Do you believe that 6 months is an acceptable amount of time for this Web site to operate in a manner that puts Americans' financial information at high risk for a security breach? Has this happened before? Can you guarantee that social security numbers—and it seems like you've addressed this—are secure? Will you shut down the Web site, as my friends from the left have already suggested, until security issues are fixed?

I would also like to finish by asking that we get Mr. Dougall an answer as it relates to deleting his information from the system, and that we get that answer today, if possible. I have a copy of the letter that he is requesting, and I would like to ask Catherine to bring the information over to your stack, as well.

And I certainly realize at the beginning of this testimony, the answer was given that the software fix has happened on this information. But the software fix was simply to disable the links. So when Mr. Hadley goes back on the Web site, he still sees the links. He simply cannot click the links. So the guarantee or the clarification or the resolution that simply tells Mr. Dougall that he has complete confidence that his information has been deleted from the system has not yet been achieved.

Ms. TAVENNER. First of all, Senator Scott, we have reached out to Mr. Dougall several times, and we will find him, and we will followup on his question.

Senator SCOTT. I'm happy to give you his phone numbers.

Ms. TAVENNER. I think we have them. Thank you, though.

Senator SCOTT. He doesn't think so, actually, because no one has called him.

Ms. TAVENNER. Well, we have a disagreement there.

Senator SCOTT. Yes, ma'am.

Ms. TAVENNER. Your second question about the hub is the hub was—and I keep trying to separate the two, because they are two different systems. The hub was completely tested all the way through, and there was a signoff by the chief information officer. So we should put the hub aside.

What we're actually talking about is the FFM or the exchange piece, and that's the part that I described. And in the 6-month period, let me tell you what's going on at that site. There's a dedicated security team that works under the chief information officer. We do weekly testing of all border devices, including Internet facing web servers. We run daily, weekly, 24/7 continuous scans.

We will have a full SSA test and a stable environment with all the security controls once the software upgrade is done, and that's standard operating procedure. And that will be within 60 to 90 days of us going live on October 1.

Senator SCOTT. My only response—and my time is up. Thank you very much for your answers. I would only suggest that whether it's the hub or the other entity, the thing that the consumer sees is not what's going wrong. It's that their confidence is going down, and we're only trying to make sure that we alert you all to the fact that if any aspect of it doesn't work, then the confidence is gone.

The CHAIRMAN. Thank you, Senator Scott.

Senator SCOTT. Thank you, Senator.

The CHAIRMAN. Senator Scott, I wonder if you would also make that information, what you gave her, available to the minority and majority staff directors of the committee.

Senator SCOTT. Yes, sir.

The CHAIRMAN. I'd appreciate that. Thank you.

Senator Murphy.

STATEMENT OF SENATOR MURPHY

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

Welcome, Ms. Tavenner. I will concede that when you reorder one-sixth of the American economy, there are going to be some people who are unhappy with that experience. And I also concede that when you stand up a brand new mechanism to give 30 million people access to healthcare that they didn't have, there are also going to be some people that are unhappy with their experience.

I think at some level this should be an exercise in setting the right expectations, that when you undergo this kind of effort to reorder a healthcare system that everyone on this committee agrees is broken, there are going to be some people who win, and there are going to be some people who lose. And, frankly, under any reform plan that has been debated in this place over the last 20 years, that was true.

What we are suggesting is that there are going to be far more people over the course of the rollout of this legislation who have a better experience than what is happening currently in the system than have a worse experience. And while it's always risky to legislate by anecdote—we're telling stories here today, and so let me just add one to the mix, and that's Betty Berger from Meriden, CT.

Betty and her family had insurance. Her husband switched jobs, and during the several week period in between his first job and his second job, their son was diagnosed with cancer. And guess what? His new employer wouldn't pick up coverage for the son.

Betty's story became one that can be repeated 2 million times every single year across this country. They went bankrupt, they lost their house, they lost their savings, simply because their son had the misfortune to be diagnosed during a 2-week period in

which they didn't have insurance. Their problem wasn't that they got dropped from coverage. Their problem was that they couldn't find any coverage, and their story can be told millions of times over.

While this is a disruption to a large section of the economy, my confidence that, in the end, there are going to be far, far more winners than losers is rooted in part in Connecticut's experience. We have an exchange that is up and working, and in the first month of the exchange, we have hit nearly 10 percent of our overall enrollment goal, even given the fact that the Massachusetts connector, which was actually run by the same guy who's running Connecticut's exchange, in the first month only saw .3 percent of their total enrollees sign up.

I have confidence that this product will fly off the shelves once people can get into the Web site, because I've seen what is happening in Connecticut. And I also am optimistic that once this site is up, it is going to be up in time for the largest number of people to enroll, because as you said in response to Senator Bennet's questions, the reality is that the vast majority of people are going to be looking for coverage as the enrollment date draws near.

I guess that's the frame of my question to you. From the experience of people who have been able to access these exchanges, either at the national level or the State level, what do we know about the quality of the product? And what do we know about the timing of when people actually sign up for plans like this?

We have the Massachusetts experience. We have the experience of Medicare Part D. To the extent that your timeline plays out and we have a fully functioning Web site within the next 30 to 60 days, is that in time for what we expect to be the majority of people coming in and wanting to access the product?

Ms. TAVENNER. Let me start with the product. I think that we are extremely pleased with the product, and I think it's important not to lose sight of that. As I said before, we had about 25 percent new entrants into the market, new issuers, offering new plans. We had over 200 issuers and over—I think it was close to 3,000 products, but I'll get you that specific information.

There's a lot of interest. The insurance market wants us to succeed. They see it as a new line of business. So we've been pleased with the States and the competition. There are some rural exceptions, as we've talked about before, and we want to stimulate that as time goes on.

The second piece—we have always believed that the first enrollment surge would come mid-December, and the second enrollment surge would come late February or early March, that there would be people who would want to sign up by January 1, but that there would always be another group who would wait until the last minute to sign up. They're presumably the younger, the healthier folks, who would wait until it became an issue for them.

That's what we believe. The product is very strong. We would like to see more competition. That will occur year to year. This is our first year on the market. But we have been pleased, and, in fact, the pricing came in about 18 percent below what CBO estimates were. We would like more introduction in some markets for sure, but it was a good year-one start for us.

Senator MURPHY. Thank you, Mr. Chairman.
 The CHAIRMAN. Thank you, Senator.
 Senator Burr.

STATEMENT OF SENATOR BURR

Senator BURR. Administrator Tavenner, welcome. Last week during your time in the House, you noted that while many insurance companies have decided to cancel or stop offering insurance plans on the individual market, the ACA did not force insurers to make such decisions. You stated, “The insurer has decided to change the plan. It didn’t have to,” and that plans were grandfathered in 2010. If they didn’t make significant changes in cost sharing, they could keep the plans they had.

Do you believe that was an accurate statement you made?

Ms. TAVENNER. Yes, I believe that was an accurate statement. When we did the regulation back in 2010, this is what plans could change.

Senator BURR. Let me read your statement again. “The ACA did not force insurers to make such decisions. The insurer has decided to change the plan. It didn’t have to.”

Ms. TAVENNER. And I will stick by my statement.

Senator BURR. Let me—

Ms. TAVENNER. Can I finish my sentence?

Senator BURR. Well, let me just say you said today, “Insurers that do not cut benefits or increase cost sharing”—

Ms. TAVENNER. I will try to list that out. They were allowed under regulation to make modest changes to benefits, modest increases in fixed dollar co-payments and deductibles if healthcare costs increase. In other words, if healthcare costs went up, they could move up. They could modify their provider networks. They could update drug formularies. They could change the plan structure to add features like health reimbursement accounts. So, yes, there was some room if they wanted to stay.

Senator BURR. So for an insurance product that didn’t meet the minimum coverage benefit that was established under the ACA, they can’t offer that insurance product, can they?

Ms. TAVENNER. They could be grandfathered in under this, yes.

Senator BURR. But with the decisions that are made, if they don’t meet the minimum benefit that was established under the ACA, that is an individual that will have a plan canceled. Is that not correct?

Ms. TAVENNER. No. What I’m saying is they could continue these plans. These plans could be grandfathered in. If they made these kinds of changes, if they started to reduce benefits, then they fell under the requirements of the ACA. So they could stay in these policies.

Senator BURR. Did you personally share with the Secretary that there were problems with the exchange?

Ms. TAVENNER. I personally shared with the Secretary in September that there were modules that we were going to delay—shop, Medicaid account transfer, Spanish version.

Senator BURR. We’ve had a lot of conversations on security. Let me ask you very specifically—and this is on the exchange. It’s not

on the hub. Was there ever any end-to-end testing on the exchange?

Ms. TAVENNER. There was end-to-end testing on the hub.

Senator BARR. I'm talking about the exchange.

Ms. TAVENNER. There was individual modular testing and demonstration testing inside the exchange, meaning we had sample cases, sample situations, that we tested all the way through. We obviously could not test live until we went live, therefore, the temporary authorization.

Senator BARR. But one of the requirements is end-to-end testing. But, again, you signed on September 27 the authority to operate the Web site. And the memo noted this,

“From a security perspective, the aspects of the system that were not tested due to the ongoing development exposed a level of uncertainty that can be deemed as a high risk for federally facilitated marketplace systems.”

Did you bring that security concern to the Secretary's attention and to OMB's attention?

Ms. TAVENNER. I did not.

Senator BARR. Secretary Sebelius said last week that the implementation took place on October 1 because that was the law. I've read the act several times. My interpretation is that Secretary Sebelius had the authority not to execute that on October 1. And, clearly, my interpretation is if you had not signed the authority to operate the Web site, it would not have stood up on October 1. Are my two statements accurate?

Ms. TAVENNER. I don't know that your statements are accurate. The law says that January 1 is when individuals have to have coverage. We put a reg in place that said October 1 would be the day we would start so that people would have time to sign up. We declared the 6-month enrollment window.

Senator BARR. Do you think that the Secretary had the authority to waive the October 1 reg?

Ms. TAVENNER. I do not know the answer to that question.

Senator BARR. Is it true that individuals who were enrolled in the health plan after March 23, 2010, are not eligible for grandfathered plans?

Ms. TAVENNER. Ask me that question again.

Senator BARR. Is it true that individuals who enrolled in healthcare plans after March 23, 2010, are not eligible for grandfathered plans?

Ms. TAVENNER. That is true.

Senator BARR. Do you think, personally, that Americans should—

The CHAIRMAN. Senator.

Senator BARR. Last question. Do you think Americans should have the ability to keep their plan?

Ms. TAVENNER. I think individuals—as we talked about, in the grandfathered plan, we allowed that to happen, and in large employer plans. Large employer plans were grandfathered as well. So I think we tried to look after those individuals through that grandfathering.

Senator BARR. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Senator Franken.

STATEMENT OF SENATOR FRANKEN

Senator FRANKEN. Thank you, Mr. Chairman, for convening this hearing.

Ms. Tavenner, like my colleagues, I'm frustrated and disappointed that a month into the open enrollment, there are still problems with the Federal marketplace. I appreciate your being here today. I think it's important that we understand what you're doing to fix the problems that have hindered comparison shopping and enrollment over the past month.

My No. 1 priority is to see to it that Minnesotans have access to our State-run marketplace and that access is protected. Things seem to be going better with MNSure—that's Minnesota's health insurance marketplace—than with Healthcare.gov, and it's been going better in a lot of States. MNSure is reporting that thousands of individuals and families are completing applications for comprehensive affordable health coverage.

Although MNSure was developed and operated by Minnesota, it does rely on the Federal hub for its eligibility determinations, and this is a problem we had very early on, getting people to be verified. And, also, when the hub is taken offline, MNSure must also go offline. What are you doing to make sure that Minnesotans can continue to enroll in health plans through MNSure, our State-run marketplace, while Healthcare.gov is undergoing maintenance?

Ms. TAVENNER. In the case of the hub, there's been very little downtime of the hub itself. We do have a window from 1 a.m. to 5 a.m. that we had agreed to prior to ever going live with the system, and there are certain components, such as social security, which is not active during that time. That's the routine maintenance for social security.

But the hub has actually worked flawlessly. So it has not been the issue. And, certainly, the Minnesota State-based exchange is doing well, and they have access to the hub. When we are going to schedule downtime of the hub for maintenance or other reasons, we let States know ahead of time so that they can plan accordingly and put up appropriate signage on their sites.

Senator FRANKEN. But the hub didn't work flawlessly the first week.

Ms. TAVENNER. I think the hub was not the problem. I think we had a problem with email accounts being established at the Federal level, and that was fixed. And I think Minnesota had some problems, too, as it related to account development. But I think those are all behind us. They were not hub issues.

Senator FRANKEN. MNSure is almost entirely separate from Healthcare.gov.

Ms. TAVENNER. Right. It just uses the hub.

Senator FRANKEN. And I believe it's been working a lot better. However, one of the critical elements of success for the State-run marketplaces will be clear communications with CMS about problems like those that MNSure saw in the first few days with the Federal Web site.

Do you have open lines of communication with the States that are operating their own marketplaces about the challenges that they're facing interacting with Healthcare.gov?

Ms. TAVENNER. We certainly do. We have regular, almost daily communications with States, and we have teams assigned to work with States. And then we, every week or two, do either a video conference or calls with States. We've also had them in for meetings. So, yes, we have very open lines of communication with States.

Senator FRANKEN. There's been a number of questions about security of private information. I'm chairman of the Judiciary Committee on Privacy, Technology, and the Law, and I've spent a lot of time working on protecting consumer privacy, and this is very concerning to me.

Can you tell me what you're doing now to make sure that consumers' health information is securely protected?

Ms. TAVENNER. As I talked about earlier, we are meeting all the FISMA standards. We do continuous security testing, and I've kind of walked through those. We have a dedicated security team. We also do independent security analyses. So it is continuous. We treat the marketplace the same way we would treat Medicare or any other system.

These systems are inherently high risk, and I think that's important. Every quarter, I'm doing reports to the GAO and others about the high-risk nature of these systems. So we treat it as a high-risk system. We monitor it continuously, and we have a team dedicated to report on it and make us aware of things right away.

Senator FRANKEN. My time has expired.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Senator Kirk.

STATEMENT OF SENATOR KIRK

Senator KIRK. I have two questions. I think what we see here is a tale of two beltway bandits, QSSI and CGI, to mainly build what you have. Who is the CEO of CGI?

Ms. TAVENNER. CGI Federal?

Senator KIRK. CGI Federal.

Ms. TAVENNER. Yes.

Senator KIRK. Is it the appropriately named Michael Roach?

Ms. TAVENNER. George Schindler, and Michael Roach is the CEO of CGI Global, and I'm in close communication with both.

Senator KIRK. My guess, from what information we have, is that you have provided upwards of \$400 million to Michael Roach to do this work?

Ms. TAVENNER. I think current spending to date—the \$400 million includes CGI, it includes QSSI, and it includes other vendors.

Senator KIRK. Could you provide the committee with a copy of the contract?

Ms. TAVENNER. I certainly can.

Senator KIRK. Why do it in such a sneaky way? Why refuse to provide the contract to Congress? I'm from Chicago where we always kind of follow the money, and if I can't find out where it went—

Ms. TAVENNER. I'm happy to go back and check. I thought a lot of information had been provided to Congress, but I'm happy to check.

Senator KIRK. So you will be able to provide the contract with CGI to us?

Ms. TAVENNER. I will get you everything I can, yes. I thought that had already been shared.

Senator KIRK. Good. Don't you have money missing that has not been paid to CGI? My understanding is there's about \$100 million to go. After a disaster of this nature, is there a way to have some accountability here with the remaining funds and not give it to Michael Roach?

Ms. TAVENNER. I will get back to you with that information.

Senator KIRK. Maybe he can skip a holiday in the Bahamas. Thank you. I will go—because it appears you're going to inflict CGI on the people of Illinois, where credible media reports tell us about upwards of 30,000 citizens of Illinois may lose their health insurance because of this program. I think the AP just ran a story about 3.5 million Americans will lose their healthcare because of this program.

Ms. TAVENNER. I'm not sure that that's accurate. I think you're referring to canceled policies, but they were canceled old policies. They were offered new policies. They can also shop on the exchange.

Senator KIRK. I'm referring to the AP story.

Ms. TAVENNER. I don't know which AP story, but there are not 3 million people losing coverage.

Senator KIRK. Are you accountable for the taxpayers' funds?

Ms. TAVENNER. I certainly think I am.

Senator KIRK. Yes, you are, hundreds of millions of dollars, I would say. For Michael Roach, I would think that you have provided substantial wealth to him. I would just point out I think we ought to know the full details of the contract that you've signed with him.

Ms. TAVENNER. Unless I'm wrong, I think you have statements of work. You have a lot of information already, but I'll get you anything else that you think you want.

Senator KIRK. The other CEO of QSSI is Bikram Bakshi that you have been paying money to? So how much—I was just thinking of a phone call that might have happened when you were getting ready for this hearing. "Hey, Bikram, it's Marilyn. Whiskey, tango, foxtrot on my Web site," as we would say in the Navy. WTF, yes. So it would be like that. Just after hundreds of millions of dollars, you should have something. I would just wonder what Mr. Roach is driving right now, probably something really nice after the amount of money you've given to him.

All right, Mr. Chairman. I yield back.

The CHAIRMAN. Senator Hagan.

STATEMENT OF SENATOR HAGAN

Senator HAGAN. Thank you, Mr. Chairman.

Thank you, Ms. Tavenner, for being here. Let me just ask about the December contingency planning. At the end of this month, either one of two things is going to be true, either the Web site is

going to be working smoothly for the vast majority of its users, or it won't. And in both cases, the Administration is going to have to take quick action to ensure that individuals across the country are being treated fairly. And I'm sure people are planning for this at the end of the month since it failed.

If the site works, then individuals will just have 2 weeks to really shop and enroll in a plan that will take effect on January 1. Is the Administration planning an education and outreach strategy to match this tech surge that's currently underway?

And if the site is not working, then what steps is the Administration going to take, including delaying the penalty for not buying the insurance? And then what are they going to do to help individuals to be sure there's not going to be a gap in their insurance coverage?

Ms. TAVENNER. Yes, there is a press or a public campaign that will match—the end of November and going into December, January, February, and March. There are no plans to delay the individual mandate.

Senator HAGAN. So what if the site is not working?

Ms. TAVENNER. The site will be working. The site is working now. What we're doing now is making performance improvements. But the site will be working.

Senator HAGAN. And are enough people able to get on the site?

Ms. TAVENNER. Yes.

Senator HAGAN. Do you have numbers?

Ms. TAVENNER. I already said earlier that we had over 700,000 who have completed applications, and we will have numbers mid-November for October in more detail. So I think that's what you're asking.

Senator HAGAN. I have called for extending the open enrollment period and then waiving penalties for not buying insurance for 2 months to make up for the lost time that it's taking to get the site up and working. I think that's going to continue to be an issue.

One of the things that I was concerned about in reading the material was the contract to build the site. Was it really awarded to companies that had bid on an IT contract that was back in 2007? Was it not open to other companies?

Ms. TAVENNER. It was actually what's called an IDIR contract. Back in 2007, there was a list of IT vendors that do this kind of work.

Senator HAGAN. But a lot has changed since 2007 to 2011 or 2012.

Ms. TAVENNER. I think this is more around the process. These are certainly current IT vendors. But, yes, the process was IDIR.

Senator HAGAN. So you're saying if you weren't on that contract in 2007, would you not be eligible to bid?

Ms. TAVENNER. Yes, that's correct. You would not be eligible. But the IDIR process was completed in 2007. It's been used for IT projects inside CMS. It's a series of contractors who have been prescreened, prequalified. They still go through a competitive bid process, but it's limited to the individuals who qualified in 2007.

Senator HAGAN. For the tech surge that's just started recently, would those companies have been on that list of 2007 qualified contractors?

Ms. TAVENNER. I would have to look at the individuals inside the tech surge. Certainly, some of the contractors that you would have seen on that list are common in the IT space. So it would not be unusual.

Senator HAGAN. On September 30, the night before the site was set to launch, what were your expectations for the launch day?

Ms. TAVENNER. That's a great question. My first expectation is that we would go live shortly after midnight, because we were doing a soft launch at midnight, and we had pretty much promoted that the site would go live at 8 a.m. the morning of October 1. So we went live shortly after midnight.

We had tremendous interest, even during the night. And my expectation was that the site would work. It would have its customary glitches of a new site. It's a complicated Web site. So I think we knew all along it would have bugs that would have to be handled.

We also knew all along that we had pulled certain functionality out in order to spend more time concentrating on the application process. Those are the ones we've talked about publicly—shop, Spanish, Medicaid account transfers. So what I expected was a site that worked with some issues.

What we saw is more volume than we had anticipated, and we anticipated pretty high volume. And then we ran into the issue with the establishment of the email accounts right away. We had to problem solve for that. Those were two things we did not expect.

Senator HAGAN. It seems like the information that I have been reading was that there was warning before the site was to open, and that there was a lot of concern that testing had not been done. And I think in hindsight now, a lot of people are saying,

“Why didn't the Administration and the CMS give more forewarning about the site not living up to the expectations that were being called for?”

And many people understood that it would be up and running and they would be able to access it quite easily.

Ms. TAVENNER. I would say that the testing, again, around the hub was complete. I think the testing that had not been finished was the testing in the live environment with real individuals, which we couldn't do until after October 1. But in our analysis and in our modular testing throughout the FFM, we had done independent verification. It had passed security checks.

So we were comfortable and we did not have any high-risk recommendations in any of those components. We just could not do the live end-to-end testing until October 1 when we actually signed up. We did case testing prior to that.

The CHAIRMAN. Thank you very much, Senator. I wasn't watching my clock. I went over and I apologize.

Senator Murkowski.

STATEMENT OF SENATOR MURKOWSKI

Senator MURKOWSKI. Thank you, Mr. Chairman.

Ms. Tavenner, thank you for joining us in the committee today. I want to talk about Alaska. I had a meeting just about 10 days or so ago with the navigators that are trying to help facilitate the

exchanges in Alaska as well as Enroll Alaska, which is an insurance broker that has been set up specifically for this. These are all folks that want this to work.

What I heard from them was: Stop. It's not working. As of the 29th of October, Enroll Alaska confirmed that there were exactly three Alaskans that had successfully enrolled. There is nobody else that has confirmed that they have successfully enrolled in the exchange from Alaska. Now, this is the 5th. We may have had somebody come in yesterday. But as best I can tell, it's three.

In a letter that I received from Enroll Alaska, they confirm this, and they have specifically asked that the Administration pull the Web site down, rebuild it, and redeploy it. Again, these are the folks that really want this exchange process to work.

One thing that was very disconcerting in that meeting was to learn that perhaps the three that have been enrolled have been given incorrect information, because it has been discovered that the FFM was calculating the subsidy for Alaskans incorrectly. Therefore, Enroll Alaska has suspended all enrollments until the issue is resolved. This was last week. I understand that they still have not had confirmed that this subsidy calculator has been resolved.

Are you aware of this? Has it been resolved? Are we working on it? The concern is that not only can people not get on to enroll, but if they do, their subsidy calculations are incorrect.

Ms. TAVENNER. We are aware, meaning the staff is aware of this issue, and they are working on a fix to the system to correct the Alaska issue, and it's specific to Alaska.

Senator MURKOWSKI. In the meantime, what should Alaskans do? Should they stay off, as Enroll Alaska and the other navigators have suggested?

Ms. TAVENNER. I will get that information for you.

Senator MURKOWSKI. Watching the news yesterday, I saw that the exchanges will be offline between 1 a.m. and 5 a.m. Eastern Standard Time until further notification. Is that correct information?

Ms. TAVENNER. The 1 a.m. to 5 a.m. window is the window that we use to do software upgrades. So that is why.

Senator MURKOWSKI. That's fair enough. But unlike what some may believe here, the sun does not rise and set in Washington, DC, or on Eastern Standard Time. So when a family finishes up dinner, does the dishes, puts the kids to bed in Alaska, 9 p.m. is 1 a.m. So the time period that Alaskans would be able to actually sit and move through any aspect of this exchange, you're shut down.

Can you give me some indicator as to when this might be available for all Americans to take a look at?

Ms. TAVENNER. Yes. The software fixes will just be done during this month. As we said, we were trying to complete the upgrades this month.

Senator MURKOWSKI. So we are in the situation where we have a concern with the subsidy calculator in the State. We have maybe three people who may be enrolled correctly. We're not sure yet. We can't get onto the exchanges when most people would have an opportunity to do so when they have some downtime.

I'm having Alaskans coming to me and saying, "OK. What happens on January the 5th? I have an incident where I need my in-

insurance. My insurance has been canceled.” Just about 60 percent of the folks who receive their insurance through Premera, which is our largest health insurance by a long margin, have received their cancellation notices. So you’ve got that going on. You can’t get onto the exchanges.

We’re all saying that this exchange is going to get worked out. But what they’re coming to me and saying is,

“What happens if something happens to me and my family that first week in January if I have been able to apply for coverage timely, but for some reason, there’s a glitch in the confirmation, getting my premium check?”

If there’s a health crisis in January, is it the individual who’s on the hook? Is it HHS, because there’s been a glitch here? They want to know if they fall through the cracks, are they going to be taken care of? And I don’t have an answer for them.

Ms. TAVENNER. First of all, as just a reminder, this is 4 hours of the day, a short period of time when the system will be down.

Senator MURKOWSKI. I understand that. I understand that. But it’s very significant for—

Ms. TAVENNER. I understand. The call center is available 24/7, and that’s true in Alaska as well. So individuals can go on the call center and get help. They can also, if they want to, submit paper applications which would be processed and returned to them. So they shouldn’t wait is my point.

Senator MURKOWSKI. And come January 1, what happens then? Who’s on the hook?

Ms. TAVENNER. They would have time before January 1.

Senator MURKOWSKI. Thank you.

The CHAIRMAN. Thank you, Senator.

Senator Warren.

STATEMENT OF SENATOR WARREN

Senator WARREN. Thank you, Mr. Chairman. Thank you for holding this hearing.

Thank you, Administrator Tavenner, for being here to provide us with an update. I want to talk about Massachusetts. Everyone is frustrated by the first few weeks of Healthcare.gov, and everyone is looking for answers, including me. But last week, President Obama came to Boston where he said that health reform in Massachusetts, like the Affordable Care Act, is not a Web site. It’s a value statement.

The President is right. Leaders in Massachusetts, like generations of national leaders, sought to reform healthcare, not because it was easy, but because we all knew that the old system was broken for years. Cost exploded. Insurance companies discriminated against people with preexisting conditions. Too many consumers and patients, including those with insurance, were threatened with financial ruin if they got sick.

Now, there have been a lot of comparisons between the ACA roll-out and our experience in Massachusetts. And what I can tell you all from the experience is that getting everyone into a new healthcare system wasn’t easy and it wasn’t quick. In the first

month that people could sign up for subsidized coverage during our health reform launch in 2007, we got 123 people enrolled.

But because we were committed to making the law work and making sure that people had affordable healthcare, we kept working on it. We fixed the problems. We hit the pavement. We did whatever it took to get people signed up. Our enrollment period for subsidized insurance lasted almost a full year, and yet it was only in the last month that 20 percent of the total pool got themselves enrolled.

People signing up for unsubsidized insurance had a shorter period of time, and yet over a quarter of them waited until the last month to get enrolled. So I understand that the beginning of an enrollment period is important. It allows people to shop and to carefully evaluate their options. But what we learned in Massachusetts is that when it comes to enrolling in healthcare, many of us wait until the end to get it done.

So, Administrator Tavenner, what did the Administration anticipate would be the pattern of enrollment through the exchanges? What would it look like over time? What were you thinking about prior to the launch of Healthcare.gov? And do you think that the early problems you've had are going to affect the long-term pattern in enrollment?

Ms. TAVENNER. We always assumed that we would be able to enroll folks throughout the 6-months, but that the greatest surge would come in December, because we thought there were people who would want to get covered January 1, and then the second surge would probably come in late-February, early-March, by those individuals who probably weren't as motivated to get insurance but understood they needed it and it was required by law.

So we had enrollment figures, but they were lower for October, and I think they will be low. It pretty much follows the Massachusetts experience, and that was part of the reason for such a long enrollment period in the first year.

Senator WARREN. So you still are confident that you've got time, if you can get these problems fixed, to get people enrolled?

Ms. TAVENNER. Yes. It's important for us to get the problems fixed in November. But, yes, I think we have time.

Senator WARREN. Well, good. I know we agree that the problems with the Web site are unacceptable and that they need to be fixed. But our experience in Massachusetts suggests that it might be prudent for us to take a deep breath about this.

I'm sympathetic to your position. The launch of our own Health Connector Web site for insurance wasn't smooth, but we kept working on it. And when we had data mapping and volume problems during our launch in 2007, we kept working on it. When we needed our own tech surge to fix it, we kept working on it. We kept working on it because we stayed focused on what mattered, our conviction that no one deserved to be bankrupted or shut out of the healthcare system when they got sick.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much, Senator Warren.
Senator Whitehouse.

STATEMENT OF SENATOR WHITEHOUSE

Senator WHITEHOUSE. Thank you, Chairman.

Like Senator Warren, I'd like to talk about my home State's experience. Governor Chafee, who was a Republican member of this body, decided early on that he was going to do this and get it right. We may be a small State, but we're a pretty smart State. And he put Christy Ferguson—who some of the people who have been around here a while might remember as John Chafee's staffer on this committee years ago—in charge of the project. I want to say that in Rhode Island, it's been a success.

The first time that I went to visit, I walked through the front door. It was late afternoon. It was probably 5:30 or 6 o'clock. I think it was on a weekend. We're open all the time to make sure people can come in. And there was a family, mom, dad, three little kids, and they were at the reception desk.

They had come in earlier in the day, and they'd been walked through the whole process. They were so thrilled with what they had heard that they had gone out—and this was their return trip—with two big boxes of Dunkin' Donuts coffee and a stack of doughnut boxes, because they wanted to give coffee and doughnuts to everybody who was working in the call center, because they were so happy.

I walked around the call center and talked to people who were taking the calls and dealing with people over the computer, and one woman was just beaming. I said to her, "You look like something wonderful just happened. You've got quite a smile." She had just talked to somebody who was paying—I want to say \$800 a month—into COBRA and had just found a better plan for \$500 a month, and \$300 a month is actually a pretty big deal in that family's life. So she had had a really wonderful exchange with that person who had called in.

We have people who, when they come in live, they're taken into private rooms to discuss their options. And when they find out what the deal is, we have a lot of people who are getting hugs. There's a story in the *New York Times* today about a woman who burst into tears of joy when she found she'd get coverage. In fact, I'd like to ask unanimous consent to have that *New York Times* study put into the record.

[The information referred to follows:]

[THE NEW YORK TIMES, NOVEMBER 5, 2013]

FOR UNINSURED, CLEARING A WAY TO ENROLLMENT: NEW YORK TIMES

(By Abby Goodnough)

LA GRANGE, KY.—Kelli Cauley's fingers raced over her keyboard as she asked the anxious woman at her side a series of questions. What was her income? How many people lived in her household? Did she smoke? ("That's the only health question it asks," Ms. Cauley said of the application they were completing.)

The woman, a thin 61-year-old who refused to give her name, citing privacy concerns, had come to the public library here to sign up for health insurance through Kentucky's new online exchange. She had a painful lump on the back of her hand and other health problems that worried her deeply, she said, but had been unable to afford insurance as a home health care worker who earns \$9 an hour.

Within a minute, the system checked her information and flashed its conclusion on Ms. Cauley's laptop: eligible for Medicaid. The woman began to weep with relief. Without insurance, she said as she left, "it's cheaper to die."

Known as “navigators” or “assisters,” people like Ms. Cauley are going to work across the country, searching for the uninsured and walking them through the enrollment process. Under the Affordable Care Act, these trained, paid counselors typically work for community groups or government agencies, with a mandate to provide impartial guidance. Given the problems plaguing the Federal online insurance exchange used by 36 States, the workers have become even more important in helping people understand their insurance options.

But in Kentucky and some of the 13 other States that have their own exchanges, which in general are running more smoothly than the Federal site, watching navigators on the job also provides the clearest view yet of how enrollment could work once the technical problems of HealthCare.gov are resolved.

President Obama and proponents of the health care law have held up Kentucky in recent weeks as a model for the national enrollment effort. The State is far ahead of most of the Nation in signing up people: As of Nov. 1, more than 27,854 Kentuckians had enrolled in Medicaid under the law’s expansion of that program, and 4,631 had signed up for private plans through the State-run exchange, known as Kynect. The State says it is enrolling 1,000 people a day.

In contrast to the federally run exchange with all its problems, Kynect has had relatively few—for several reasons, Kentucky officials said. The primary contractor, Deloitte, worked closely with the State agency that runs health programs, ensuring guidance and oversight. Unlike the Federal Government, the State tested its online exchange early and often, so problems were addressed before the Web site went live. And people can check whether they qualify for Medicaid or subsidies without creating an account, a requirement that caused huge bottlenecks on the Federal exchange.

While most States lack enough navigators to reach all who need help, Kentucky is spending \$11 million in Federal money to promote its exchange, and it shows: Ads for Kynect blanket television and radio, city buses and highway billboards in Louisville.

“Compared to other States, we’re sitting pretty,” said Jacquelynn Engle, who is overseeing the sign-up effort at Family Health Centers, a network of seven clinics in Louisville that treats thousands of the city’s uninsured. The clinics enrolled 421 people in October and helped an additional 260 start the application process. Officials in Louisville, a city of 600,000, have set a goal of enrolling about 29,000 people in Medicaid and 27,000 more in private plans by mid-2014.

So far, a total of 5,200 have signed up in Jefferson County, which includes Louisville, far more than in any other county in the State.

Still, the first month’s tally barely starts Kentucky on the path toward enrolling the 640,000 uninsured residents in the State who are eligible for health coverage, a goal that Governor Steven L. Beshear, a Democrat, has said is urgent because the State has high rates for smoking and obesity, among other health problems. And if Medicaid sign-ups continue to far outpace enrollments in private exchange plans, with only the sickest people buying private coverage, the cost of premiums could rise.

Though people can sign up on their own, navigators can help those confused by the sea of insurance options. The navigators listen to people voice their hopes and fears about the law, and their hard stories about being uninsured. Often hugs are exchanged. Sometimes tears flow.

After Samantha Davis helped Deborah and Joseph Willis enroll in Medicaid one morning at a Family Health Centers clinic, Mrs. Willis, 49, told her how she felt some doctors and nurses had treated her unkindly because she lacked insurance. “Maybe they’ll look at me a lot different now,” she said.

As the couple prepared to leave the clinic, Mr. Willis, who is 55 and has severe foot and back pain from injuries but has not seen a doctor in years, turned to Ms. Davis and extended his hand.

“God bless you,” he said.

HIGH DEMAND FOR HELP

Ms. Cauley has put 1,000 miles on her car in the last month, driving across Louisville and the surrounding counties. She has met with the uninsured at doctors’ offices, workplaces and their own kitchen tables, her laptop at the ready.

Ms. Cauley, who is 42, is a “kynector,” Kentucky’s name for an assister. She was hired in September by the Kentuckiana Regional Planning Development Agency, a council of local governments, which won a \$937,000 contract with the State to help with enrollment in 16 counties.

The job is high pressure: The contract calls for eight kynectors to enroll 699 people per month in Medicaid or private plans through the exchange. They are required

to hold educational events around the region, and the agency's phones have been ringing nonstop with requests for enrollment help at health fairs, cultural festivals and other events that the uninsured might attend.

At a sign-up sponsored by AARP last month, a well-dressed woman approached Ms. Cauley with a problem: She had learned that she would be eligible for Medicaid under the new law, but she was unwilling to enroll because of what she saw as a stigma attached to the program. As a substitute teacher, she wanted to know whether she could afford full-priced private exchange plans.

"I don't want to be a freeloader," said the woman, who asked to be identified only by her middle name, Kay, because she said she was embarrassed about qualifying for Medicaid. "I believe in paying our way in life."

Ms. Cauley told her that she understood: "I can remember meal after meal of beans and corn bread because that's all we could afford," she said. "My father would not get food stamps."

She found that Kay's cheapest option through the exchange would be a plan with a \$356 monthly premium and a \$6,300 deductible. "Holy cow," Kay said, shaking her head at the cost. Ms. Cauley thought for a moment and offered an alternative: Kay could sign up for Medicaid, but only use it in catastrophic events. For checkups and other routine care, Kay could pay her own way, perhaps negotiating a discount with her doctors.

"You're giving me an alternative I can live with," Kay said.

Ms. Cauley gave her a card and told her to call when she was ready to sign up. "At least it's there in case you need it," she told her. "Isn't that what insurance is for?"

Ms. Cauley, who is a former home economics teacher, has left her house near Louisville as early as 4:30 a.m. to answer phones on a call-in show about the law. With little time for lunch, she has lost 12 pounds. She once forgot to put on makeup before leaving home and then forgot to turn off her car lights at her first pre-dawn appointment.

Some fellow Republicans called her a traitor when she took the job, she said, but she has been happy to dispel myths about the health care law. Laughing, she called herself "a Republican with a socialist agenda, or a social agenda anyway."

She expects the job to get harder as she comes under pressure to help people who might be more reluctant to sign up than the early enrollees. But she has some strategies: visiting small day care centers, for example, where workers are likely to be uninsured. For now, just meeting the initial flood of requests is a strain.

"You do have to be on your A-game constantly," she said.

A NEW CHALLENGE FOR AGENTS

Near the end of the 2 hours he spent helping Judy Shields choose a health plan through Kynect, Donald Mucci let out an emphatic sigh. Mr. Mucci, an insurance agent for more than three decades, has yet to get comfortable with the new system and does not much like it.

Some of his colleagues refuse to sell plans through the exchanges, which they see as a threat, and have instead focused on selling other insurance, like property and casualty.

Other agents—especially the young and aggressive ones—have jumped in, eager to capture new customers and prove their expertise is needed to help Americans grapple with the law's complexities.

Mr. Mucci resents that the health care law prompted insurance companies to cut commissions paid to agents. And he thinks the exchange Web site makes it hard for people to understand the pros and cons of various plans, such as which hospitals and doctors they cover. Yet Mr. Mucci, an affable man in monogrammed shirt cuffs, said he wants the system to work.

"I have a social conscience, no question about it," said Mr. Mucci, 53, whose firm, the Garrett-Stotz Company, has been in Louisville for 82 years.

So far, he has enrolled just a few longtime customers in exchange plans. They include Mrs. Shields, 49, a widow who had been rejected by insurance companies because she has diabetes. She is paying \$745 a month for coverage through a program for people with pre-existing conditions, but the program will end in January.

Mrs. Shields, who has an annual income of about \$17,000, qualified for a monthly premium subsidy of \$232 a month. With Mr. Mucci's help, she chose a silver-tier plan offered by Anthem that has a \$2,450 deductible and a \$4,500 out-of-pocket maximum. She will pay a monthly premium of \$151 after the subsidy.

Mr. Mucci said he would get a commission of \$18 from the transaction. Before the health care law, he said, he would typically receive a lot more.

"Is it a win?" he said. "For Judy, it sure is."

The question for Mr. Mucci is how to make it financially worthwhile to sell the exchange plans, which about 1,500 agents in Kentucky have been certified to do.

The law requires insurers to spend at least 80 percent of money from premiums on medical care instead of on administrative costs, which include commissions to agents and brokers. Consequently, some insurers cut commissions, infuriating many agents and brokers.

Some companies reduced commissions further just before the exchange opened, Mr. Mucci said, and enrollments are proving more time-consuming than he expected.

Mr. Mucci did have an idea for how to “help people and still get paid for it.”

On Saturday, he held a series of seminars about the new private plans offered through the exchange, explaining who qualifies for subsidies and how to apply. He secured an auditorium at a local college, invited 1,100 customers and bought 3 hours of time on a local radio station to spread the word.

But only about 40 people showed up.

“I don’t know if it’s ignorance, apathy or procrastination,” he said on Monday, sounding downcast. “That thing should have been standing room only.”

The State, he said, should be doing a better job of letting people know they could turn to brokers for advice. Navigators and assisters can explain various plans but not recommend one over another. “All the marketing is, ‘It’s easy, just a couple of clicks and you’re in,’”—Mr. Mucci said. “They’d be serving themselves better and the consumers better if they said, ‘You ought to call an agent.’”

Mrs. Shields said she was stunned by how much financial assistance she qualified for. She sponsors six children at an orphanage in Guatemala, she said, but could afford to pay only \$30 a month for each of them, mostly because of her expensive health insurance.

“Now I get to give more,” she said.

OVERWHELMED BY OPTIONS

David Elson leaned in front of a computer at a Family Health Centers clinic one recent morning, squinting at the screen. Uninsured for years, with medical bills accumulating in a cardboard box in his kitchen, he had just applied for coverage through Kynect.

Samantha Davis, the clinic employee who helped Mr. Elson apply, explained that based on his income of about \$22,000 last year, he was not eligible for Medicaid but had qualified for a Federal subsidy of \$252 a month toward premium costs for a private plan. “It’s a pretty big one,” she said, reassuringly.

Through the exchange, Mr. Elson, 60, who has advanced diabetes and kidney disease, was offered a choice of 24 health plans, with premiums ranging from \$92 to \$501 a month after the subsidy. But if he felt elation or relief, he was too preoccupied to show it.

Bleeding at the back of his eyes, caused by a complication of diabetes, had blurred his vision. He had run out of insulin the previous week and had not refilled his prescriptions, which cost almost \$500 a month, because a recent tax bill had depleted his bank account. He had an appointment with an eye specialist that afternoon, and the possibility of more debt was hanging heavily over him.

Overwhelmed by his insurance choices, he told Ms. Davis that he would study the options at home, consult with his doctors and get back to her.

A few days later, in the kitchen of his small home here, he contemplated the dusty box of bills at his feet and wondered whether January would truly be a turning point in his fortunes. A hospitalization in May had sharply increased his debt.

“I’m hoping once I have insurance that I can sit down and figure out a budget and see if I have to go bankrupt,” he said.

Above all, he said, he hoped that being insured would allow him to work long enough to someday turn his alarm installation business over to his grandson.

“It’s not a fact that I want to sponge off of somebody,” he said. “I want to be able to pay my bills and be able to go through life without feeling I owe somebody.”

Senator WHITEHOUSE. So there’s more than one story about this. And, like I said, Rhode Island isn’t a very big State, and we made this work, and it’s worked actually pretty well. We had a glitch recently where the hub was down and a couple of hundred people couldn’t get through. You solved it and we’re working through that.

But when I see these much bigger States who didn’t even try, and now everybody’s sitting back and complaining that the Federal Government didn’t do it for them well enough, there’s a part of me

that says, "Well, you know, next time, stand up and give it a try yourself. You don't have to be just a recipient."

We're up to nearly 4,000 people enrolled but not paid. We're up to about 10,000 accounts of people who are working through the process, but they've got their account established. We've got all these wonderful stories.

There's another path, and we're all very sorry that you guys had to botch up the healthcare Web site rollout. But it shouldn't mask that underneath it, there's a plan that is making a lot of families really, really happy. And if you go to the front lines and go to your State exchange and see what people are seeing, you'll see a lot of those stories. They're happening really across the board.

So there's more to this. And if you didn't want to take the trouble to bother to set one up yourself, it's a little nervy to be complaining that the Federal Government didn't do it for you well enough, when you perfectly well could have by yourself as a State if you'd simply saddled up and done it.

You know, there are these letters that people have been talking about, that people have gotten. When we got this started, you remember, we were dealing with a health insurance industry that was so cold hearted that when it took a client who had been paying premiums for years and suddenly came in with a big claim, their first reaction wasn't "How do we help this family?" It was,

"Let's look back in the records and see if we can find a way to dis-enroll them and get rid of this liability. Oh, they had acne. Is that a preexisting condition they didn't disclose to us? Can we throw them off?"

I mean, that's the attitude. So there's some pretty nasty stuff, I think, that is happening through some of these letters. I want to use the example of Rhode Island Blue Cross Blue Shield. I'd like to put their letter in the record.

[The information referred to was not available at time of print.]

Senator WHITEHOUSE. It is a wonderful, terrific letter. It's very clear. It lays out what your choices are. It says if you like what you've got, you can keep it, and here's how. And it says if you don't like it, if you want to use the exchange, here's how. It's three steps to stay in Blue Cross Blue Shield of Rhode Island. It's two steps to get onto the exchange.

There's another way to do this. And I think Rhode Island has done it right, and as a result, we're seeing pretty low drama. So good luck getting through this mess. It has been frustrating for all of us. But I think it's pretty safe to see that across the river, there are broad and sunlit uplands, to quote Winston Churchill, broad and sunlit uplands for us to go to.

Thank you, Chairman.

The CHAIRMAN. Thank you, Senator Whitehouse.

I know, Ms. Tavenner, that you have to be out of here also. I wanted to make it so that people could have 5 minutes and have a chance to ask another round. I'll just say, first of all, I thank Senator Whitehouse for mentioning the Rhode Island matter. That will be put in the record.

Also, Senator Isakson asked earlier for an IG report to be made a part of the record, and I wanted to say that that also will be made a part of the record. I didn't mention that at the time.

Again, I like what Senator Warren said about what President Obama's statement is on this. This new Affordable Care Act, or Obamacare, if you want to call it that, is not just a Web site. It's not about a Web site or some technical fix. It is a value system.

Do we like the old value system where people couldn't get coverage, or if when someone got sick, they would drop your policy—cancellations? I hear so much talk from my friends on the Republican side about all these cancellations. I didn't hear much in the past when insurance companies would just automatically cancel you if you got sick or wouldn't renew your policy if you had cancer or something like that. I didn't hear much about that.

What we're saying is that's over with. That old value system was no good for this country, because too many people, like Mr. Streetter, whom I mentioned in the beginning—or I could mention Kathleen Ferguson from Des Moines. Eight years ago, her son died at age 33, and she said,

“My son died needlessly because he had a preexisting condition and could not get insurance and could not get the medication he needed.”

I want us to take better care of each other. I am grateful that people with preexisting conditions can now get coverage. That's the old value system. Mary Lapis from Swisher, IA, wrote and told me about her brother, who had been trying to find insurance to cover his wife for years. He tried to buy coverage with a \$50,000 deductible, but no one would sell her a policy.

When he logged onto the Federal exchange, he enrolled himself and his wife, saving \$700 a month on what he was paying before. Mary Lapis writes that the ACA gives folks with chronic conditions a chance to avoid bankruptcy. A new value system.

I guess there's going to be disruptions and things like that when you're moving from that old system to a new system. And, certainly, we have to make sure that we fix these problems in the Web site and other things. I will refer again to what I said earlier about security—paramount. I think that's maybe one thing that we all agree on here, is that security is paramount in this system. But in terms of the system itself, it's going to work, and it's going to be better for this country.

I might say in terms of these cancellations that I love the Rhode Island letter. It's very clear. Blue Cross Blue Shield of Rhode Island sent a letter out and said, “Don't worry. Nothing is set in stone yet. You still have choices,” and they give another page that says “You can either stay with us or you can go on the exchange.” But they said, “Don't worry. You've got plenty of time.” That's the cancellation notices.

In the past, you know what a cancellation notice was? “You're no longer eligible for insurance. Good luck.” That was the old cancellation notice. Now you have choices and options. So, again, I say to people to take a deep breath and wait and get more people to understand what's going on.

Now, I must say that there was a story the other day in the paper about somebody who said, “Well, gee, now I have to take this policy that covers maternity care, but my wife and I aren't having any more children.” I don't know if they were older or something

like that. “Why should I have to have a policy that covers maternity care?”

I got to thinking about that. I thought,

“Well, you know what? Maybe because my wife and I don’t have any more children and they’re grown up, maybe I shouldn’t have to pay property taxes to pay for my local schools. My kids aren’t there anymore. Why should I worry about it? Maybe only the people that have kids that go to the public schools ought to pay for it.”

No, we’re better than that in this country. We’re talking about being a part of our society. It’s to our benefit, my wife and I, to pay our property taxes to support our local schools, because that’s our next generation. We want them well taught. We want well-paid teachers. It’s the same way with healthcare. It is a value system. I am indebted to Senator Warren for mentioning that.

And the value is that no one is going to be left behind. No one is going to go without insurance. No one is going to have to wait until they get advanced colon cancer or prostate cancer or breast cancer before they can go to the emergency room and get help before it’s too late. That’s the new value system, and we’re not turning back. Fix the problems. Move ahead. But let’s aggressively get people enrolled in this system and have a new value system with healthcare in America.

I’ve used up my time.

Senator Alexander.

Senator ALEXANDER. Thanks, Mr. Chairman.

Thank you, Ms. Tavenner, for being here today. The chairman is describing the fundamental difference of opinion that we’ve had for about 4 years here, because the value system that he likes, I believe, is a value system that transforms our healthcare delivery system in the wrong direction by expanding a system that we already knew costs too much.

And the result is increasing premiums for millions, canceling insurance plans for millions, destroying relationships with doctors for millions, raising taxes by a trillion, forcing people into Medicaid, spending a half trillion Medicare dollars on new programs instead of investing in Medicare to make it more solvent, and encouraging employers to have their employees work 30 hours instead of 40. That’s not the value system that I support.

We have a different approach, which would say let’s encourage competition, let’s encourage choices, and let’s try to make healthcare cheaper so people can actually afford it. But that’s our fundamental difference.

May I ask you, Ms. Tavenner, don’t you know now with the improvements in the Web site how many people are trying to sign up every day for Obamacare, how many are succeeding, and what their level of insurance that they’re buying is, what zip code they live in? Don’t you actually know that now?

Ms. TAVENNER. That’s the information, Senator Alexander, that we are putting together, and we will have available next week.

Senator ALEXANDER. Next week?

Ms. TAVENNER. Mid-November, and that’s what I had said all along.

Senator ALEXANDER. You're going to release it once? I mean, why don't you release it daily?

Ms. TAVENNER. We had said all along, long before the program went live, that we would do monthly data, very similar to how we do Medicaid, how we do Medicare.

Senator ALEXANDER. But this is a little different. This is people who are making decisions, people who are going to lose their insurance starting January 1, people who have to sign up by December 15.

Ms. TAVENNER. And I would say that's all the more reason to do it monthly, because the fact is that this is early on, and people can decide to go in and out, and they don't have to make payments until December.

Senator ALEXANDER. But the people who need to know about it are Members of Congress who have appropriated \$400 million. Let's say I'm a Governor in one of the States that hasn't decided whether to expand Medicaid. I'd like to know whether 90 percent of the people who have signed up are going on Medicaid, or whether it's 80 percent or whether it's 70 percent.

If we can know how many hamburgers and cars and records are being sold every day, why can't we know how many people are enrolling in Obamacare. If it's such a success, wouldn't that promote the success of the program and build confidence in it?

Ms. TAVENNER. We'll have that information next week.

Senator ALEXANDER. But that's once. I mean, why don't we know it every day? You know it now, right?

Ms. TAVENNER. We are in the process of putting together that information.

Senator ALEXANDER. But we're the U.S. Congress, elected to represent the people, and we're entitled to know answers to these questions so we can make our judgments about what to do. So are Governors and so are the consumers across America.

Ms. TAVENNER. I understand.

Senator ALEXANDER. As far as the example I used of Emily from Tennessee from CoverTN, isn't it true that the CoverTN program was simply canceled by Obamacare? I mean, it's a case of Washington saying, "That insurance isn't good enough for you, so you can't buy it anymore."

Ms. TAVENNER. First of all, I don't think it was canceled by Obamacare. I think the insurance company made a decision to cancel a policy and offer something else.

Senator ALEXANDER. Well, now, there's a letter from the State of Tennessee that says,

"CoverTN won't be available starting January 1. This affects all CoverTN members. The new Federal healthcare law will bring many changes, including new health insurance coverage options for Tennessee."

Obamacare said if you didn't meet the standard for maximum limits, you couldn't offer that insurance anymore. That's the law. So in this case, for these 16,000 Tennesseans, Obamacare said, "That insurance isn't good enough for you." So Emily can't buy it anymore, and she has to pay \$6,000 more. Isn't that true?

Ms. TAVENNER. I think we've been down this issue before. They could have been grandfathered in. They could have kept their—

Senator ALEXANDER. No, ma'am. No. The law says that if the State program doesn't meet the maximum limits, it's outlawed. Does the law not say that?

Ms. TAVENNER. For new plans. I'd have to look at—

Senator ALEXANDER. No, for the old plans.

Ms. TAVENNER. There was an opportunity for old plans to be grandfathered in. We keep going around on this.

Senator ALEXANDER. Ms. Tavenner, there are provisions in the law passed in 2010 that say if a plan doesn't meet the maximum limits, the plan can't be offered. Tennessee and—

Ms. TAVENNER. So you're talking about lifetime limits.

Senator ALEXANDER. That's correct.

Ms. TAVENNER. I'll be glad to get you that information.

Senator ALEXANDER. Well, no. So the fact is Obamacare outlawed that plan, and millions of Americans are having their plans canceled. Why don't we put the President's words into law and say, "If you like your plan, you can keep it," and end the debate?

My time is up.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Senator Baldwin.

Senator BALDWIN. Thank you, Mr. Chairman, and I thank you for staying around for a second round of questions.

When I had my first opportunity, we were talking a little bit about the situation in the State of Wisconsin. We're hearing a lot of people reference this idea of if you like your insurance plan, you can keep it. In the State of Wisconsin, a lot of people like BadgerCare. But because of the decision of our Governor, having nothing to do with what Congress did years ago, 92,000 people who may really like their healthcare plan are being kicked off.

Because of this, I really think it is a shared responsibility to figure out how to most effectively help these 92,000 transition from BadgerCare to participate and enroll in the Federal exchange. So I want to sort of ask the companion questions. If it's a shared responsibility, what specific steps can the Administration take to ensure that these individuals are enrolled as soon as possible? But, also, what options are available to the State of Wisconsin to eliminate the risk of losing this BadgerCare Medicaid coverage January 1?

Ms. TAVENNER. Let me take that in reverse order. Obviously, Wisconsin, like every other State, had the ability to have the expanded Medicaid at no cost. About 25 States have elected to do Medicaid expansion, including many Republican States. But, obviously, Wisconsin was not one of those.

As part of the process, we'll work with the State of Wisconsin with the Medicaid office to identify those individuals and make sure they are aware of what is available on the exchange. Obviously, there's a cost to that, and so you get into the issues of subsidy and this sort of thing. But we will try to work with the State closely to help those people at least identify what's available to them. It's unfortunate.

Senator BALDWIN. Earlier, you were asked questions about, you know, how you can target young people, young healthy people. How do you target these 92,000 people? And what is the State's role?

What is the Administration's role when the State decided not to expand Medicaid?

Ms. TAVENNER. Obviously, the State knows who these individuals are. So they'll be able to send them information. What we're doing under the waiver is asking Wisconsin to give us a plan on how they're going to do that. So it's a shared responsibility. We obviously aren't sitting inside Wisconsin, but we will try to help.

Senator BALDWIN. I just have to say as commentary before the exchange marketplace opened, a letter went out from the State. And you were mentioning that the State is aware of who these people are. Well, it basically said, "Someone in your household may be on BadgerCare and may be losing it." That type of information, in my mind, is not adequate to assure that people don't have a lapse or a gap in their health coverage.

I guess the other question in my remaining time relates to the experiences of those States in the country in the early phases of this marketplace. What is their experience versus States in the Federal exchange, like Wisconsin, in enrolling people? What comparisons can you make at this point? And can the 36 States that rely on Healthcare.gov and the Federal exchange expect similar results when the technical issues with the Web site are fully worked out?

Ms. TAVENNER. Yes, I think we would obviously expect similar results to what the States are seeing. I think we've released some information around applications submitted. Some States have talked about that publicly. But that will be part of what we release next week. But, yes, we would think the Federal—if you look at Texas, Florida, there are some very large States with large numbers of uninsured. So that will be part of our targeted campaign, too, in December and beyond.

Senator BALDWIN. And with regard to the State-based exchanges, State-based marketplaces, can you talk about any of the successes that they've had or challenges in the early phases of enrollment?

Ms. TAVENNER. I think many of you have read about Kentucky. Kentucky has certainly been a successful State, both on the Medicaid side and on the exchange side. Their Governor has been, obviously, 100 percent behind this. He has led the effort. And so they have released some numbers publicly, and I can get those to you. Washington State was another, New York, California. The States all vary in process, but this will be part of what will be reported out next week.

The CHAIRMAN. Thank you, Senator.

Senator Burr.

Senator BURR. Thank you, Mr. Chairman. Mr. Chairman, since you ended with a story, let me talk about Mr. Hood, who lives close to me in North Carolina. He now pays \$324 a month for a plan with a \$10,000 deductible. Under the new law, the comparable plan suggests for next year, he'll pay \$895.27 per month, with an \$11,000 family deductible. Their annual healthcare payment would almost double from \$14,000 to \$24,000. And he is unlikely to be eligible for a subsidy.

Let me just suggest that the reason Congress has covered this so thoroughly is that this could be a hell of a lot easier. And I might remind the chairman that Dr. Coburn and I came up with

an alternate bill. We were denied the ability to amend on the floor of the U.S. Senate and to offer an alternative.

That alternative took care of preexisting conditions. It kept children on their parents' insurance longer. It actually accomplished many of the things that Republicans and Democrats highlight about the Affordable Care Act, but it didn't get into a large top-down, government-designed program that picks winners and losers.

When you can have stories that are as passionate as yours, and I can have stories as passionate as mine, clearly, the system we have designed picks the winners and losers. It's not individual Americans who get to choose what they want, who get to choose how much exposure or how much benefit—in other words, their healthcare coverage matches their age, their health condition, and their pocketbook, and that's not what this does.

Let me ask you, Ms. Tavenner, what is the target enrollment number for the end of November for the exchange?

Ms. TAVENNER. For the end of November?

Senator BURR. Yes, ma'am.

Ms. TAVENNER. I think that we were looking at between October and November—I think that number was, I want to say, around 800,000.

Senator BURR. On April 1, 2014, insurers are required to begin submitting bids for the 2015 plans. And extension was granted on enrollment to March 31. So for many Americans who are not going to sign up until next year, considering that insurers will have no experience or very little to go on to base their quotes for 2015, what accommodations will you make to ensure that insurers make informed decisions?

Ms. TAVENNER. I think the open enrollment period was actually—we worked in cooperation with insurers, so they think they will have the information necessary.

Senator BURR. So they still, between April 1, 2014 and April 27, 2014, will have to submit their costs for their plans for the 2015 plan year.

Ms. TAVENNER. They will submit that over the second quarter of 2014, yes.

Senator BURR. Without much experience of what the plan mix is that they're—

Ms. TAVENNER. I think they will have the experience that they've had for the first 4 or 5 months, yes.

Senator BURR. Well, again, there are many people that aren't required to sign up until March 31. That's the month right before April, in other words, a day before they start submitting.

Ms. TAVENNER. I understand.

Senator BURR. You said earlier in your testimony that all the fixes done by CGI would be required without additional fees, and that's in a cost-plus contract. Can you assure the committee that there will be nothing on the plus side that the Federal Government pays to CGI for their repairs on a Web site contract?

Ms. TAVENNER. The cost-plus contract is already paid or planned for payment through March 2014. So I'm assuring you that that's the contract that they will operate under, yes.

Senator BURR. I'm asking a very specific question, though.

Ms. TAVENNER. I understand.

Senator BURR. There's a fixed base part of the contract, and there's a plus base part of the contract. And I'm sure that the plus base deals with additional work done over the stated scope of the contract. Clearly, fixing this exchange was not part of the stated scope of the contract, I don't think. We haven't seen——

Ms. TAVENNER. But it's required of their work in their existing contract. They have to fix these problems.

Senator BURR. Well, let me say this. I do know that many of us are going to be looking at the payment that's made on the plus side to see if, in fact, we are paying CGI for their individuals to fix a Web site that they were contracted to produce for the Federal Government.

Ms. TAVENNER. I understand.

Senator BURR. Again, I thank you for the work that you've done on this. I know this is not fun to come up and answer the questions. I would say that the moral of this story is the more we share up front, which we haven't on the Affordable Care Act, the more informed all members are.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much, Senator Burr.

Again, Ms. Tavenner, thank you very much for being here and for being forthright in your answers. I thought this was a good session. I think that you and your staff understand some concerns that both sides have on this. I think there were legitimately good questions pertaining to that aspect of it.

Of course, as my friend from Tennessee points out, we still have some philosophical differences on this issue. That's fine. But there are some points, I think, on which both sides agree that we need to ensure get fixed going forward, and I think we expounded on those quite forthrightly. But thank you very much.

And, as I said, the record will stay open for 10 days for other statements and questions.

Thank you, Ms. Tavenner.

The committee will stand adjourned.

[Additional material follows.]

ADDITIONAL MATERIALS

PREPARED STATEMENT OF SENATOR CASEY

Chairman Harkin, thank you for convening this important oversight hearing into the implementation of the *Affordable Care Act*. I appreciate your leadership in overseeing the implementation of this law, following the passing of Senator Kennedy, who was the chair of the committee when we drafted the bill that was the basis of the *Affordable Care Act*. I would also like to thank Administrator Tavenner for coming to the HELP Committee today. I look forward to hearing your testimony.

I am disturbed that the rollout of the health insurance marketplaces on Healthcare.gov has been so rocky. I do not believe the problems are indicative of flaws in the law, but I do think that they are indicative of flaws in implementation.

Too many people have experienced problems with Healthcare.gov since October 1. They have had problems creating accounts, logging in, determining eligibility for premium assistance tax credits, and selecting plans. Insurers are having problems getting the information they need from Healthcare.gov, so that they can appropriately bill new enrollees for the coverage they have selected.

Pennsylvania is one of the 36 States with a federally facilitated marketplace, that is, one being run by CMS. These States are entirely dependent on the federally created infrastructure; individuals in those States must use Healthcare.gov from start to finish if they wish to be able to see and compare all the available plans in their area.

One constituent from Philadelphia wrote to me regarding her troubles with the Web site:

“Some time ago I created an account on Healthcare.gov with all of our personal information. The data was scrambled badly the next time I logged in. I called and was told to delete the bad data and correct it. Bad advice. A consumer cannot do that. For the last 3 days the site indicates that I don’t have an account.”

These problems are unacceptable. I am grateful that the Administration has taken steps to address these issues, and I understand that the account creation process has been significantly improved, but I believe we need a clearer accounting of what happened: where the breakdowns occurred, what problems were predictable and could have been avoided or mitigated earlier, whether there were unusual factors that led to unpredictable results.

That being said, there is evidence that when the system works as intended, consumers are pleased. I have heard from another constituent from Palmyra, PA, who said,

“Since I moved here 4-plus years ago my rates have gone up 9.9 percent per year, I do not qualify for a subsidy with the ACA, but even so—because of the ACA going into effect I will be saving approximately \$135 per month on my new private insurance starting in January.”

These examples demonstrate that the intent of the law, to provide consumers with an easy way to compare and select from affordable health insurance options, is achievable. Now we need to

figure out how everyone who needs to purchase health insurance has the same experience, and I am looking to Administrator Tavenner to provide insight on when the fixes to Healthcare.gov will enable the Web site to live up to its promise.

I have never claimed that the *Affordable Care Act* is perfect, and I am open to reasonable improvements to the law. However, it is the law, and it has been upheld by the Supreme Court. Millions of Americans are eagerly awaiting its benefits: health insurance that doesn't cost more because you're a woman, or that excludes treatment for a preexisting condition, or charges outrageous rates without any guarantee of renewability at the end of the year. October 1 was an eagerly awaited date, but January 1, 2014 is even more eagerly awaited by so many people who have struggled for many years to access the health insurance they need to get the health care they need for themselves and their families.

Administrator Tavenner, thank you again for appearing before the committee today. I hope that your testimony will be helpful, and that we will be able to work together to ensure that the *Affordable Care Act* is a success.

RESPONSE FROM MARILYN TAVENNER TO QUESTIONS OF SENATOR HARKIN,
SENATOR CASEY, SENATOR HAGAN, SENATOR ALEXANDER AND SENATOR ROBERTS

SENATOR HARKIN

The Affordable Care Act establishes many important consumer protections and respects the significant authority of State licensing boards to regulate health care providers. I also appreciate your efforts to personally champion consumer rights and competition in the delivery of health care services. However, I am concerned by the Administration's guidance on enforcement of a key consumer protection in the law—new Section 2706 of the Public Health Service Act. Specifically, a frequently asked questions document recently posted on your Web site implies that the law allows insurers to exclude from network participation whole categories of providers operating under a State license or certification. In addition, the FAQ advises insurers that section 2706 allows discrimination in reimbursement rates based on broad "market considerations" rather than the more limited exception cited in the law for performance and quality measures. A plain reading of section 2706 prohibits exactly these types of discrimination.

Question 1. Can you explain the Administration's position on the two specific issues described above and the legal basis for that position?

Answer 1. The statutory language of Section 2706(a) of the Public Health Service Act applies to non-grandfathered group health plans and health insurance issuers offering group or individual health insurance coverage for plan years (in the individual market, policy years) beginning on or after January 1, 2014.

Until any further guidance is issued, group health plans and health insurance issuers offering group or individual coverage are expected to implement the requirements of section 2706(a) using a good-faith, reasonable interpretation of the law.

The Departments will work together with employers, plans, issuers, States, providers, and other stakeholders to help them come into compliance with the provider nondiscrimination provision and will work with families and individuals to help them understand the law and benefit from it as intended.

SENATOR CASEY

Question 1. Please detail the steps CMS intends to undertake to assist people who may have begun the enrollment process at Healthcare.gov, but not completed it (due to problems with the Web site or other reasons). Will there be outreach targeted to these individuals to find out why they did not complete the enrollment process, and provide extra assistance if they need it?

Question 2. Similarly, one of the complaints I have heard is that individuals who had difficulty creating accounts ended up creating, intentionally or otherwise, multiple accounts on the site. Has CMS taken steps to improve the system specifically to address this problem? For example, many consumer Web sites require you to use

your email address as your username, or to include that in the registration process. If an individual already has an account, they are then prompted to enter their password or given the option to reset the password. While Healthcare.gov appears to have this feature, it clearly was not working as intended.

Answers 1 and 2. Unfortunately, the experience on HealthCare.gov has been frustrating for many Americans. The initial consumer experience of HealthCare.gov has not lived up to the expectations of the American people and is not acceptable. We are committed to fixing these problems as soon as possible. As part of our efforts to improve HealthCare.gov, we've established a new management structure, led by a general contractor, QSSI. This nerve center for technical operations is diagnosing problems and making quick decisions with developers and vendors to analyze, troubleshoot, prioritize and resolve issues in real time.

This team has put in place enhanced monitoring and instrumentation tools for HealthCare.gov—providing us with data that enables us to get a high level picture of what's going on in the Marketplace application and enrollment process. We are now better able to see how quickly pages are responding, and measure how changes improve a user's experience on the site. We're also getting information on which parts of the application are causing the most errors—enabling us to prioritize what we fix next. We expect the vast majority of users will be able to successfully enroll through HealthCare.gov by the end of November.

Question 3. Please provide an overview of the core teams that have been established with QSSI to address the “punch list” of work that needs to be done, and how each team is prioritizing its work.

Answer 3. In October we announced QSSI as general contractor, which has brought in its top talent—a deep team with expertise across a full range of technology and program management. There is a rigorous management structure that is focused on prioritizing the punch list and real-time decisionmaking, 24/7.

With QSSI, we have established dedicated teams to fix and monitor both software and infrastructure issues. There are four core teams:

- Application and software—this team addresses glitches so the site is faster and smoother for users;
- Infrastructure and hardware—this team is focused on adding capacity and redundancy to minimize disruptions;
- Security—this team is continuously working to ensure rigorous protections of the system and its data; and
- Monitoring and troubleshooting—this team is focused on analyzing system performance and spotting problems early.

With these teams in place, we have the right management structure and accountability to make the necessary progress.

Question 4. Can you describe the security measures in place to protect consumer data submitted by individuals applying for health insurance through Healthcare.gov, and how those protections compare to similar protections for other Federal programs like Medicare Part D?

Answer 4. The privacy and security of consumers' personal information are a top priority for the Department. When consumers fill out their online Marketplace applications, they can trust that the information they are providing is protected by a comprehensive set of security standards and practices. Security testing happens on an ongoing basis using industry best practices to appropriately safeguard consumers' personal information. The components of the Federally Facilitated Marketplace (FFM) that are operational have been determined to be compliant with the Federal Information Security Management Act (FISMA), based on standards by the National Institutes of Standards and Technology (NIST) and on those promulgated through the Office of Management and Budget (OMB). Additionally, all of CMS's Marketplace systems of records are subject to the Privacy Act of 1974 and the Computer Security Act of 1987.

Security testing is conducted on an ongoing basis using industry best practices to appropriately safeguard consumers' personal information. The security of the system is also monitored by sensors and other tools to deter and prevent any unauthorized access. CMS conducts continuous monitoring by a 24/7, multi-layer information technology (IT) professional security team, added penetration testing and a change management process with ongoing testing and mitigation strategies implemented in real time. As part of the ongoing testing process, CMS implemented risk-management strategies such as implementation of additional or stronger controls where appropriate.

Question 5. I have heard that many individuals are turning to paper applications due to frustrations with the Web site, but I also understand that these paper applications will be processed using the same computer systems causing problems at Healthcare.gov. Does CMS, or the appropriate contractor, have the ability to ensure that these applications are processed in a timely fashion?

Answer 5. We are processing them as quickly as possible. The individuals who apply on paper will receive an eligibility notice with their determination in the mail and will receive instructions on how to make their plan selections.

SENATOR HAGAN

When the extent of the technical problems facing Healthcare.gov became fully apparent last month, President Obama announced his goal of ensuring that the “vast majority of users” could use the site properly by the end of November. Since that announcement, fixes have been identified and made on a daily basis, yet much work remains to be completed in order to meet the President’s goal.

Question 1. If the online Federal health insurance marketplace is not functioning well for the vast majority of users on December 1, what contingency plans—including direct enrollment through insurers, access to the online marketplace for online brokers, or delaying the individual mandate—does the Administration plan on implementing to ensure that nobody has a gap in their health insurance coverage because the Web site wasn’t working?

Answer 1. We are committed to ensuring that consumers have a range of affordable health insurance options.

The law says that if the Secretary finds that an individual has “suffered a hardship with respect to the capability to obtain coverage,” then he or she may be exempt from the requirement to have insurance. We are holding this hearing today because online applicants are unable to shop and buy a plan online. Yet, the online applicants aren’t the only ones finding that Healthcare.gov is a barrier to selecting a plan. According to notes from your own staff, even people trying to enroll by phone or paper “are all stuck in the same queue” as the online applicants.

Question 2. As a result, do you think it’s a hardship to obtain coverage if the Web site isn’t working since online, paper, and phone applicants “are all stuck in the same queue.” and, if so, do you believe the Secretary has the authority to exempt individuals from the penalty for not buying insurance?

Answer 2. Beginning January 1, 2014, the individual shared responsibility provision requires each individual to maintain health coverage (known as minimum essential coverage), qualify for an exemption from the requirement to maintain minimum essential coverage, or make a shared responsibility payment when filing a Federal income tax return. To help make coverage affordable for millions of individuals and families, the Affordable Care Act provides, among other things, a premium tax credit to eligible individuals and families to help pay for the cost of health insurance coverage purchased through Health Insurance Marketplaces.

The shared responsibility payment generally applies to people who have access to affordable coverage during a taxable year but who have more than a short gap in coverage. The Affordable Care Act gives HHS the authority to establish hardship exemptions from the payments for individuals who “have suffered a hardship with respect to the capability to obtain coverage under a qualified health plan.” Under this authority, HHS has enumerated several situations that constitute such a hardship.

HHS recognizes that the duration of the initial open enrollment period implies that individuals have until the end of the initial open enrollment period to enroll in coverage through the new Marketplaces while avoiding liability for the shared responsibility payment. Yet, unless a hardship exemption is established, individuals who purchase insurance through the Marketplaces toward the end of the initial open enrollment period could be required to make a shared responsibility payment when filing their Federal income tax returns in 2015. HHS has determined that it would be unfair to require individuals in this situation to make a payment. Accordingly, HHS is exercising its authority to establish an additional hardship exemption in order to provide relief for individuals in this situation.

Specifically, if an individual enrolls in a plan through the Marketplace prior to the close of the initial open enrollment period, when filing a Federal income tax return in 2015 the individual will be able to claim a hardship exemption from the shared responsibility payment for the months prior to the effective date of the individual’s coverage, without the need to request an exemption from the Marketplace. Additional detail will be provided in 2014 on how to claim this exemption.

The State of North Carolina has submitted a State Plan Amendment to provide an additional 50 hours of personal care services to Medicaid recipients who need additional supervision, care, and safeguards related help fight the effects of memory dysfunction. I understand that these additional hours are critical to assuring that many of our State's frailest seniors are able to access the level of care that they need in the setting of their choice. I also understand that the State Plan Amendment (SPA) includes a significant reduction in the reimbursement rate from \$15.52 per hour to \$13.12 per hour, which will make it difficult for many providers to continue to offer personal care services to those who need it most. For these reasons, I am concerned that the rate reduction may threaten the ability of seniors to access the additional hours of care authorized by the SPA.

As you know, the Social Security Act requires that States,

“assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.”

Question 3. Has the Department provided any updated historical cost data showing that a sufficient number of providers will be able to provide these PCS services at a rate of \$13.12?

Question 4. Has the Department provided any justification for reducing the reimbursement rate by 20 percent from a rate that previously was set by the Department with provider cost data that is less than a year old?

Answers 3 and 4. In reviewing the State Plan Amendment (SPA), CMS has asked North Carolina to provide data that would justify the reduction and substantiate that the rates contemplated under the SPA would be sufficient to ensure that this service would remain available to Medicaid beneficiaries in the State.

Question 5. Has CMS ever approved a decrease in a PCS reimbursement rate as severe as what is proposed by the Department? If not, what is the biggest decrease CMS has approved?

Answer 5. Given the volume of SPAs CMS considers each year, CMS is unable to undertake a comprehensive review of all similar SPAs considered and approved and thus is not able to provide a documented answer to this question.

Question 6. What is the anticipated timeline for CMS action on the State plan amendment?

Answer 6. CMS is reviewing the SPA in abidance with the review process as described in 42 CFR 430.16 and is unable to provide a timeline for completion of that review.

SENATOR ALEXANDER

Question 1a. Who created the timeline for deliverables and testing ahead of the October 1 launch date?

Who made the decision to allot only 2 weeks for end-to-end testing? When was that decision made?

Answer 1a. The FFM eligibility and enrollment system consists of numerous modules. Each module of this system was tested for functionality. Each interface with our business partners and other Federal agencies was also tested. Numerous test cases were used to exercise the end-to-end functionality of the system, and through those tests, CMS was able to identify problems and address them. We know now that we underestimated the volume of users who would attempt to log onto the system at the same time, and therefore our testing did not include performance testing at the volume we experienced at launch.

We are encouraged that the Hub is working as intended, and that the framework for a better-functioning FFM eligibility and enrollment system is in place. By enlisting additional technical help, aggressively monitoring for errors, testing to prevent new issues from cropping up, and regularly deploying fixes to the site, we have already made significant improvements to the performance and functionality of the system.

Question 1b. Were any contractors consulted and asked for their opinions prior to the creation of the timeline for deliverables? Which contractors provided input on the timeline?

Answer 1b. CMS worked closely with our FFM contractors throughout the development of the systems. At a staff level, there was almost-constant communication about deadlines and timelines. At a higher level, senior CMS officials met multiple times with the presidents and vice presidents of the main FFM contractors to dis-

cuss deliverable timelines and deadlines. CGI was the main contractor working on the FFM, while QSSI was the main contractor working on the Data Services Hub.

Question 2. *The Wall Street Journal* reported on October 28th that employees of CMS who were charged with setting deadlines for contractors skipped at least some of the sessions at which they were supposed to meet with policymakers to hammer out specifications for the Web site.

Are you aware that CMS employees skipped key meetings?

Why was this allowed to occur?

How did these absences affect contractor deadlines and/or contribute to the Web site's problems?

Answer 2. As Administrator, I cannot speak to staff attendance at each individual meeting held in CMS. Overall, CMS staff has worked closely across the Agency and with contractors throughout the Affordable Care Act implementation process to ensure contractors had the information required to perform their work.

Question 3a. Reports indicate that CMS, CCHIO, and White House officials were often giving conflicting orders to contractors, and that orders were not prioritized by importance.

Who is now in charge of making sure the November 30 deadline is successfully achieved?

Answer 3a. The general contractor, QSSI, is making sure there is coordinated approach to the punch list for November 30th, and that the Tech Surge experts are being used as efficiently and productively as possible. Along with QSSI, CMS has established dedicated teams to fix and monitor both software and infrastructure issues.

There are four core teams:

1. Application and software—this team addresses glitches so the site is faster and smoother for users;
2. Infrastructure and hardware—this team is focused on adding capacity and redundancy to minimize disruptions;
3. Security—this team is continuously working to ensure rigorous protections of the system and its data; and
4. Monitoring and troubleshooting—this team is focused on analyzing system performance and spotting problems early.

Question 3b. Is Jeffrey Zients responsible if the November 30 deadline is not met? If not, who is responsible?

If Mr. Zients is now in charge, what is your role? What is Secretary Sebelius' role?

Answer 3b. As the head of CMS, I am ultimately responsible for the management and operations of Healthcare.gov. QSSI is now CMS's general contractor for the system. Jeff Zients is serving as an Advisor to me and to Secretary Sebelius and is working in close cooperation with our CMS team to provide management advice and counsel to the project. Working alongside our team, and using his rich expertise and management acumen, Mr. Zients will provide short-term advice, assessments, and recommendations to our CMS team to improve the functionalities of Healthcare.gov.

Question 4. *The Washington Post* on October 21, 2013, reported that CMS knew a few days before October 1, 2013, that the exchange crashed with just a few hundred simultaneous users.

Who was told of these results?

If the Web site could not function with even a fraction of the expected traffic, why was the decision made to continue with the rollout?

Answers 4. CMS leadership issued an authorization to operate the FFM application on September 27, 2013. An independent security control assessor tested each piece of the FFM that went live on October 1 prior to that date with no open high-risk findings. We know now that we underestimated the volume of users who would attempt to log onto the system at the same time, and therefore our testing did not include performance testing at the volume we experienced at launch.

Question 5. Multiple news outlets have reported that insurers are receiving corrupted information about enrollments in what is called 834 reports—for example, spouses are submitted as children; three children become three spouses; insurers get an individual's application then cancellation then another application again in the same day—creating a huge amount of confusion.

Did anyone at CMS know about the problems transmitting the 834 reports to insurers before the launch?

Were there functionality tests done prior to the launch to see what kind of information insurers were receiving on the back end?

For the people who have already signed up for insurance through the exchange, what, if any, steps are you taking to make sure that insurers have the correct information for these people?

Answer 5. We've made specific fixes, correcting information provided to insurers that allow applications to be processed and consumers to complete their payments. One of our highest priorities is ensuring that consumer information is transmitted correctly to issuers. We also installed more upgrades, focusing on direct enrollment and improving the consumer experience.

Question 6a. Both you and Secretary Sebelius testified that the Web site will be working normally and without problems by November 30.

When the Web site is working normally, how many people will be able to log on to the Web site at one time?

Answer 6a. The site will be able to support 50,000 concurrent users, or more than 800,000 consumer visits per day.

Question 6b. How long will it take consumers to see options specific to their situations and the actual prices they will pay for the different plans?

Answer 6b. The HealthCare.gov tech team is working around the clock to address performance issues including the site's response time. Average response time on the site as of November 1, 2013, was less than 1,000 milliseconds, an 80 percent improvement from the 8 seconds it took for pages to load in the site's first few weeks.

Question 6c. How long will it take consumers to choose a plan and get approved?

Answer 6c. The time it takes for a consumer to choose a plan and get approved will vary widely based on each consumer's unique circumstances. Some consumers may be able to make a selection from among their QHP options right away; others might need some time to consider their options before proceeding to the next step in the process.

Question 6d. How long will it take insurance companies to know who has signed up for their plans?

Answer 6d. We are working closely with issuers to transmit to them the information they need to timely process consumers' applications for QHPs.

Question 7. How much money, in total, has already been spent on the Federal exchange—not just the Web site and its supporting technology? Please provide a breakdown of these costs.

How much money has been obligated since October 1, 2013?

How much money do you anticipate obligating through March 31, 2014?

Answer 7. From enactment of the Affordable Care Act through September 30, 2013, HHS has obligated \$490 million for Marketplace IT, and of that amount has spent \$230 million. This includes the Healthcare.gov Web site, and all of the systems and services that support enrollment through the Marketplaces, such as the data services hub and the Federally Facilitated Marketplace IT systems. During that same time period, HHS has obligated approximately \$175 million in other IT costs necessary to support the Marketplace IT systems, such as cloud computing and enterprise identity management. We are not able to provide a specific estimate of further spending at this time.

Question 8. How much more will it cost to fix all the problems with the Web site, and from where will these funds come?

How much more will be paid to QSSI as a result of its recent engagement to be the end-to-end integrating contractor?

Answer 8. QSSI is receiving \$10 million as a supplemental agreement to an existing cost-plus fee contract, which is subject to change based on a final agreement with QSSI.

Question 9a–c. On October 18, 2013, HHS notified the Senate that \$450 million would be transferred from the Department's Nonrecurring Expenses Fund to the exchanges.

(a) What, specifically, will that \$450 million be used for? Please provide an itemized list.

(b) Will any of the \$450 million be spent on repairing the problems with the exchange? How much, and for what services?

(c) Will any of the \$450 million be spent on marketing efforts to encourage enrollment?

Answer 9a–c. The estimated \$450 million will support both one-time Marketplace work and needed capital improvements to Medicare and Medicaid systems. This amount will support development for Healthcare.gov and related systems, including

functionalities that will first come online for 2015 (reinsurance, risk adjustment, risk corridors), and new development to improve consumers' abilities to find and select quality plans that best meet their needs. Additionally, this funding will support updating aging IT infrastructure that houses Medicare data, making consumer information more secure.

There is no final estimate for future costs related to the work that is being done to address capacity and other functionality issues with Healthcare.gov. Software fixes have been made under existing contracts, but CMS may need to add funding to these contracts to cover continued development of systems through the end of the performance period. Of note, CMS also awarded a contract for approximately \$10 million to QSSI to act as a general contractor over the HealthCare.gov system, but that amount was from the prior year's NEF notification.

By statute, the NEF may only be used for IT acquisitions and other capital acquisitions. Marketing efforts generally would not be an authorized purpose for the NEF, and accordingly we have not planned to use any of the estimated \$450 million for this type of outreach.

Question 10. If any of the contractors who built or contributed to Healthcare.gov are at fault for delivering a product that did not meet specifications, do you intend to recover any payments to these contractors?

What recourse is available under any of these contracts if the contractor is found to be negligent?

Answer 10. The terms of the task orders for FFM contractors provide recourse for CMS to hold contractors accountable.

CMS will continue to monitor contractors' performance on their task orders. The past performance assessment will be reported in the governmentwide Past Performance Information Retrieval System and will be available for other agencies to use in making sources selection decisions for future contract awards.

Question 11. CNN reported that private user information on the Web site is vulnerable to hackers, using nothing more than a user's email address. Private researchers discovered another security flaw in the Spanish-language site that would have allowed a hacker to obtain account information as a user typed.

Have these security problems been repaired?

What other user information security problems have been reported to CMS?

Why was Healthcare.gov allowed to go live with these serious security vulnerabilities?

What steps are being taken to ensure all security holes have been identified and resolved?

Answer 11. CMS protects the FFM through intensive and stringent security testing. CMS conducts continuous anti-virus and malware scans, as well as monitors data flow and protects against threats by denying access to known bad IPs and actors. Additionally, we conduct two separate types of penetration testing on a weekly basis. The most recent penetration testing showed no significant findings. Also on a weekly basis, CMS reviews the operation system, infrastructure, and the application software to be sure that these systems are compliant and do not have vulnerabilities. Vulnerabilities are often mitigated immediately onsite, and re-tested to ensure the strength of our systems' security. Vulnerabilities that cannot be mitigated immediately are tracked using the system's plan of action and milestones which provides a process for assigning responsibility, allocating resources, and identifying specific milestones and completion dates. For the FFM, we conduct SCAs on a quarterly basis, which is beyond FISMA requirements.

Question 12a. You have repeatedly stated that people can use the call center or in-person assisters to enroll in coverage if they are unable to enroll through the Web site.

For those people using the call center or an in-person assister, does that application still have to be submitted and verified through the Web site?

Answer 12a. Applications submitted by individuals on their own, or on an individual's behalf by a call center representative or in-person assister, are all routed through the FFM's eligibility and enrollment IT systems.

Question 12b. From the date a paper application is mailed, how long does it take until that applicant is actually enrolled in an insurance plan? What are the steps of this process, from beginning to end?

Answer 12b. When an application is mailed, it is processed by Serco, a private-sector contractor tasked by CMS with handling the paper application process for the FFM. Serco converts the information on an applicant's paper application into an electronic application, which is then routed through the HealthCare.gov eligibility

and enrollment IT system. The system generates the applicant's determination of eligibility to purchase a qualified health plan through the Marketplace, subsidy eligibility if the applicant has applied for insurance affordability programs, and plan options, which are then mailed to the applicant to consider. Once the applicant has considered his or her options and selected a plan, the applicant pays their premium with the issuer. Because consumers vary on the amount of time they need to consider their plan options, there is no set length of time for the application process to be completed.

Question 12c. For the call center, how long does it take from the initial phone call to actual enrollment in an insurance plan?

Answer 12c. Because consumers vary on the amount of time they need to consider their plan options, there is no set length of time for the application process to be completed.

Question 12d. What is the average wait time to speak with someone at the call center?

Answer 12d. Wait times for consumers accessing the call center are in the minutes.

Question 12e. How many people have called in to the call center since October 1, 2013?

Answer 12e. As of October 23, 2013, the FFM call center had received 121,887 calls.

Question 12f. How many people have enrolled in insurance coverage by using the call center?

Answer 12f. CMS is working to prepare the first monthly enrollment report for the Marketplace, which we expect to release in mid-November.

Question 13a. NPR reported that the Administration needs at least 2 million healthy people who do not use a lot of health care services to enroll in coverage to subsidize coverage for the sick. Republicans have been warning about an "insurance death spiral" for years; we are concerned that if not enough people, especially young and healthy people, sign up for plans in the individual market, rates will increase in 2015. This is a problem for the people who buy the plans, for the insurers in the market, and for the taxpayers who pay for subsidies.

What is the minimum number of enrollments needed to keep rates in the individual market at or below current levels for 2015?

Answer 13a. As the Marketplace open enrollment period continues until March 31, 2014, and issuers will not submit rates for the 2015 plan year until after that time, it is premature to speculate on 2015 rates.

Question 13b. How many young, healthy persons are projected to enroll in health insurance through the Federal exchange?

Answer 13b. One of the things we've learned since the start of Open Enrollment on October 1 is that the demand for affordable health coverage is very, very high. And, in fact, a new Commonwealth Fund survey confirms just how eager Americans are to purchase coverage through the new Health Insurance Marketplace. The survey found that Americans across our country are aware of the Marketplace and plan to shop for affordable coverage. Some of those who are the most eager to purchase affordable coverage happen to be young, healthy adults. In fact, according to this study, one in five visitors to the Marketplace during the first month was between ages 19 and 29. A majority (nearly 60 percent) say they are committed to shopping some more for a plan in the Marketplace and checking out their eligibility for financial help.

Question 13c. What will happen to insurance premiums if a lower-than-expected number of these young, healthy people do not enroll in insurance through the exchanges?

Answer 13c. Rates are developed by issuers, who in turn make projections about the health status of the Marketplace enrollees. It is premature to speculate about 2015 rates.

Question 13d. Has CMS conducted any analysis with respect to questions a, b, or c above, either in-house or by a contractor? If so, will you share a copy of those analyses with this committee?

Answer 13d. CMS has not conducted this type of analysis. We note that because enrollees are in a single risk pool whether they purchase coverage in or out of the

Marketplace, looking only at the enrollment mix in the Marketplace may not result in an accurate analysis.

Question 14. What specific efforts are you undertaking to encourage young people to sign up for health insurance? What evidence do you have to suggest that these efforts will be successful?

Answer 14. The outreach campaign is using a range of communications tactics, with an emphasis on paid media and digital outreach, to make the uninsured aware of the Marketplace and the health insurance options available to them. This includes targeted outreach to young adults in sports programming and other popular shows on television. We understand that to reach a younger demographic we need to engage in new outreach, which is why we also have created a robust set of social media tools both on Facebook and Twitter.

Question 15. What is your back-up plan if your marketing efforts do not work, and not enough young people enroll in coverage through the exchange?

Answer 15. We are confident of our outreach plans, as well as the plans of our State partners. The Affordable Care Act creates many new low-cost options for younger Americans to buy quality, affordable health insurance.

Question 16a. We have learned that CMS is working on guidance for States regarding the applicability of asset tests and scope of long-term care services for individuals who apply for Medicaid based on their modified adjusted gross income (MAGI). Can you please clarify the following for the committee.

Must a Medicaid applicant still meet aged, blind and disabled criteria in order to receive Medicaid long-term services and supports (LTSS), regardless of their income?

Answer 16a. MAGI-based individuals to whom long-term services and supports (LTSS) are available must meet the eligibility requirements for the category in which they are enrolled. MAGI-based categories generally do not require that individuals meet aged, blind and disabled non-financial criteria, and asset tests may not be imposed against individuals being evaluated for eligibility in MAGI-based categories.

Question 16b. Under the statute and CMS' implementing regulations, in a State that takes up the new Medicaid eligibility expansion option, is the State permitted to apply an asset test to individuals who qualify for Medicaid based on their income and request LTSS? Or is the State Medicaid agency required to offer Medicaid beneficiaries a choice between the standard Medicaid package—including LTSS—and the alternative benefit plan (ABP) which may not necessarily include LTSS? If the latter, does this create any inconsistencies in policy for individuals who qualify for Medicaid LTSS based on criteria other than income?

Answer 16b. Medicaid applicants who are being evaluated for eligibility in the new adult category in States that have adopted the Medicaid expansion may not have an asset test imposed against them. Individuals who qualify for the new adult category must be offered an alternative benefit plan (ABP) that includes essential health benefits (EHB). In some States, the ABP will include LTSS. A State's choice to offer LTSS within its EHB-related ABP does not modify the prohibition against an asset test for new adult category enrollees or other MAGI-based individuals to whom such a plan is offered.

Additionally, new adult category enrollees who meet one of the exceptions listed in the version of 42 CFR 440.315 that is effective January 1, 2014 ("Benchmark and Benchmark-Equivalent Coverage—Exempt Individuals"), must be offered the choice between the ABP that includes EHB or an ABP that includes all State plan services. Where a new adult category enrollee meets an exception in the regulation (*e.g.*, the individual meets the criteria for the "medically frail") and chooses the ABP that includes all State plan services, his or her need for LTSS does not modify the prohibition against an asset test for enrollees of the category.

Medicaid applicants who are not eligible for MAGI-based categories and seek coverage for LTSS (or any other Medicaid-covered services) are subject to the eligibility requirements that apply to the other categories for which they may qualify.

Question 17a. There have been some reports about the account transfer process that involves the Federally Facilitated Marketplace (FFM) sending Medicaid applications to the State Medicaid agency.

Can you please provide an overview of the timeline for the necessary guidance and detailed business rules that CMS provided States so that they could build their systems to link into the account transfer process. Is there further guidance that States still need to go live with account transfers?

Answer 17a. CMS has worked closely with States to provide information on the business processes necessary to both send and receive account transfers to and from the FFM. CMS is currently working with States to determine their readiness to receive and send such files and will begin to transmit the accounts to the States at their readiness.

Question 17b. What is your understanding of the scope and type of review that State Medicaid agencies will need to undertake to verify Medicaid eligibility for individuals who submitted an application and were either assessed or determined eligible for Medicaid by the FFM?

Answer 17b. In the case of a State that has chosen to have the FFM determine eligibility for Medicaid and CHIP, the State will need to complete the enrollment process specific to their State but will not take any additional eligibility action as they have agreed to enroll individuals based on the determination made by the FFM. In States that have chosen to have the FFM make an assessment of Medicaid and CHIP eligibility, those States will finalize the eligibility determination process prior to enrolling an individual in the correct program.

Question 17c. Have States indicated how much time they will need to process the backlog of eligibility determinations and enrollments submitted through the FFM by January 1, 2014? How will CMS ensure that States have sufficient time to process the Medicaid applications that are sent from the FFM through the account transfer process?

Answer 17c. As we work with States to determine readiness for the transfer of accounts, we have sent States "flat files" which contain information that will help them prioritize and prepare for the full transfer of accounts. A State's ability to work through the accounts transferred from the FFM will depend on a number of factors including, but not limited to, whether the State is an assessment or determination State, when the State is prepared to accept the account transfer and the number of individuals that must be processed through the system.

Question 17d. Has CMS developed a program integrity plan that will identify the source of and resolve inconsistencies or gaps that may arise during the initial period of these hand-offs and determinations? How will this information be reported?

Answer 17d. The FFM is making accurate eligibility determinations. However, as with any system, it is important to review those determinations and make any adjustments needed to ensure the reliability of the determination system. CMS is reviewing the determinations made by the FFM and has a system in place to flag and review determinations that may contain an error. In addition, to the extent that a State discovers an error in a determination, CMS has set up a system by which the State can communicate that finding to the FFM in order to both resolve the individual error and provide a data point for continual improvement of eligibility determinations.

Question 18. In States with an FFM model, can you describe the communications processes and tools that are in place to ensure the FFM is communicating accurate information to consumers about their State Medicaid program and its policies?

Answer 18. Consumers who request financial assistance for coverage through the Marketplace will be determined or assessed potentially eligible for Medicaid and CHIP coverage in their State. The FFM processes Medicaid and CHIP eligibility using the 2014 MAGI-based eligibility rules provided by the State agency and validated by CMS.

Question 19. Does CMS have processes in place to allow States to communicate with officials at CMS responsible for the FFM and vice versa? And if so, please describe how these are working and whether you are planning to modify and improve these critical lines of communication.

Answer 19. CMS has State officers, who communicate frequently with States regarding Marketplace-related issues. In addition, CMS coordinates internally to make sure Marketplace issues are coordinated across CMS components. States can also communicate with CMS through learning collaborative calls and technical assistance activities.

SENATOR ROBERTS

Question 1. The Federal Information Security Management Act (FISMA) requires each agency to appoint a chief security officer to sign off on the security of government web systems, to ensure Americans private financial and identifying information is protected. Secretary Sebelius revealed last week that the exchange is operating on a temporary authority to operate. What does that mean?

Who decides whether a temporary authority to operate meets FISMA standards? A 2012 memo from Jeffrey Zients, while head of OMB, states clearly that OMB does not recognize interim authority to operate for security authorizations. Why was the exchange allowed to go live without the apparent clearance required by OMB?

Can you provide this committee with the documentation to show OMB cleared the launch with temporary authority?

Answer 1. CMS protects the FFM through intensive and stringent security testing. CMS conducts continuous anti-virus and malware scans, as well as monitors data flow and protects against threats by denying access to known bad IPs and actors. Additionally, we conduct two separate types of penetration testing on a weekly basis. The most recent penetration testing showed no significant findings. Also on a weekly basis, CMS reviews the operation system, infrastructure, and the application software to be sure that these systems are compliant and do not have vulnerabilities. Vulnerabilities are often mitigated immediately onsite, and re-tested to ensure the strength of our systems' security. Vulnerabilities that cannot be mitigated immediately are tracked using the system's plan of action and milestones which provides a process for assigning responsibility, allocating resources, and identifying specific milestones and completion dates. For the FFM, we conduct SCAs on a quarterly basis, which is beyond FISMA requirements.

Question 2a-b. As part of the FISMA security assessment, an independent testing organization must perform a risk analysis of the security of the system. Who performed those tests and for what parts of the exchange?

(a) Did an independent testing organization ever test the whole integrated system end-to-end?

(b) Did the independent testing of the exchange identify any security risks to the system?

Answer 2a-b. An independent security control assessor tested each piece of the FFM that went live on October 1 prior to that date with no open high findings. Protecting the privacy and security of consumers' personal information is a top priority for us. The components of the FFM that are operational have been determined to be compliant with FISMA, based on standards by NIST and on those promulgated through OMB.

Security testing is conducted on an ongoing basis using industry best practices to appropriately safeguard consumers' personal information. The security of the system is also monitored by sensors and other tools to deter and prevent any unauthorized access. CMS conducts continuous monitoring by a 24/7, multi-layer information technology (IT) professional security team, added penetration testing and a change management process with ongoing testing and mitigation strategies implemented in real time. As part of the ongoing testing process, CMS implemented risk management strategies such as implementation of additional or stronger controls where appropriate.

Question 2c. Without revealing publicly at this hearing, will you submit confidentially to the committee the results of the independent testing?

Answer 2c. We will work with the committee to address your concerns within the security guidelines.

Question 3a. A September 27 memo addressed to you states that, "due to system readiness issues, [the required security assessment] was only partly completed." The memo notes that untested parts of the system pose a high security risk, and the contractor was not able to test all parts of the system in one complete version of the system.

The memo recommends a mitigation plan to address these risks, and recommends a 6-month authority to operate. That recommendation was signed by you. Are you the official at CMS responsible for making the Security Authorization Decision?

Does anyone else review or approve that decision before it is final?

Answer 3a. I am the appropriate senior executive to serve as the authorizing official, as I am the CMS Administrator and am in the best position to assess the acceptable risk level for operating the system given the administrator's budget and mission authorities. This approach is consistent with NIST guidelines.

Question 3b. What training do you have to qualify you to make decisions about the security of information systems?

Answer 3b. The authorizing official is a senior official or executive with the authority to formally assume responsibility for operating an information system at an acceptable level of risk to organizational operations and assets, individuals, other organizations, and the Nation. Authorizing officials typically have budgetary over-

sight for an information system or are responsible for the mission and/or business operations supported by the system.

Question 4a. Healthcare.gov's privacy policy states that "no personally identifiable information is collected by these tools." And yet, in apparent violation of its own privacy policy, it was reported last week that Healthcare.gov sends user information to third party advertisers. This is the same activity Facebook and My Space were fined by the FTC for. Was CMS aware that user information is sent to third party advertisers? Is this consistent with the privacy policy?

Is this an issue the contractors are working to resolve?

Answer 4a. This incident was remedied before an unauthorized person saw any PII. In this case, the username and password resets are included in an encrypted URL sent to Google Analytics. However, this information was not visible to any outside user and Google Analytics was unable to see the information. CMS stopped sending the information to Google Analytics shortly after being notified of the issue.

Question 4b. Was the Web site tested before going live to ensure this was not possible?

Answer 4b. CMS determined that the data sent to the site is encrypted and there was no indication that personal data would be sent to this service.

Question 5. As a followup if "no personally identifiable information is collected by these tools" as was stated several times publicly, how and using what information, will CMS and HHS followup with those individuals, which has also been a public commitment, who have been unable to sign up in the first few months? As in what contact information or "personally identifiable information" has been retained to allow CMS and HHS to get in touch with the individuals who had problems?

Answer 5. The Hub is not a database; it does not retain or store information. The FFM and State-based Marketplace eligibility, redetermination, and appeals systems do store certain eligibility and enrollment records in order to fulfill specific functions, including helping a consumer with an application or eligibility problem.

Question 6. Privacy advocates have expressed concerns about an issue called "clickjacking" on Healthcare.gov, where users may click what appears to be a legitimate link but instead a malicious script runs. According to web security experts, Healthcare.gov does not deploy any defenses against this activity at the time it was launched. Has the Web site improved to prevent this sort of malicious hijacking of the Web site?

Why was the site allowed to go live without this sort of basic privacy protection?

Answer 6. Clickjacking is a well-known attack vector that CMS tests for and guards against. In order to defend against clickjacking, CMS designs Web sites to reduce the number of links that would take an individual off of the original source, or refer it to another site. Additionally, CMS uses extensible markup language options which protect against this, and runs tests against the site to independently verify the integrity of the system.

Question 7a. We have seen the memo signed by you from September 27 giving the "go-ahead" to launch the exchanges despite known problems. I am told that while initial testing had happened, it was limited to a few large plans operating within the Federal exchange. That this testing showed significant problems however CMS decided to move forward with further testing 2 weeks before the scheduled launch. We also know that this further testing shows that the site crashed with just a few hundred users logging in. My question to you then, is with all these known problems, why would you sign a memo authorizing authority to operate?

Who did you notify that things were going to move forward despite known problems?

Answer 7a. CMS leadership issued an authorization to operate the FFM application on September 27, 2013. An independent security control assessor tested each piece of the FFM that went live on October 1 prior to that date with no open high-risk findings.

Protecting the privacy and security of consumers' personal information is a top priority for us. When consumers fill out their online Marketplace applications, they can trust that the information they are providing is protected by a comprehensive set of security standards and practices. The components of the FFM that are operational have been determined to be compliant with FISMA, based on standards by NIST and on those promulgated through OMB.

Question 7b. Were you instructed by anyone to move forward with the launch even if unresolved issues could not be mitigated?

Answer 7b. We know now that we underestimated the volume of users who would attempt to log onto the system at the same time, and therefore our testing did not include performance testing at the volume we experienced at launch. We are committed to fixing these problems so that the experience using the federally facilitated eligibility and enrollment system improves for the vast majority of consumers by the end of November 2013.

Question 7c. Why was there not a greater effort to notify those in charge of the program, HHS, and the White House of identified problems?

Answer 7c. The FFM eligibility and enrollment system consists of numerous modules. Each module of this system was tested for functionality. Each interface with our business partners and other Federal agencies was also tested. Numerous test cases were used to exercise the end-to-end functionality of the system, and through those tests, CMS was able to identify problems and address them. We know now that we underestimated the volume of users who would attempt to log onto the system at the same time, and therefore our testing did not include performance testing at the volume we experienced at launch.

We are encouraged that the Hub is working as intended, and that the framework for a better functioning FFM eligibility and enrollment system is in place. By enlisting additional technical help, aggressively monitoring for errors, testing to prevent new issues from cropping up, and regularly deploying fixes to the site, we have already made significant improvements to the performance and functionality of the system.

Question 8. My understanding is that the SHOP Exchanges were delayed until November 1, however last week I believe they were delayed again until sometime in November. Do you have a specific date for them to go live?

How much testing have you allowed for in the timeline to go live?

Was any testing done prior to November 1?

Answer 8. We are exploring all options to ensure that small businesses have access to coverage in the federally facilitated SHOP Marketplace. Federally facilitated SHOP online functionality will be appropriately tested before being launched.

Question 9. Very early this year, and even last year, members of this committee and their staff began asking for timelines related to the implementation of the exchanges. To my knowledge the timeline, plans, outlines were never provided. From a transparency perspective, from an oversight perspective, most especially knowing what we know now, why has that information not been provided?

Additionally CMS was asked whether time had been built in for testing of the exchanges. Specific questions were asked about whether there would be enough time allowed for plans to test information exchange capabilities. Assurances were given that time was built in for these activities, but we now know they were not. What happened?

Answer 9. CMS has been responsive to congressional requests for timelines related to the implementation of the Marketplaces, as well as other details regarding Affordable Care Act implementation. HHS and CMS officials have testified before congressional committees eight times this year, including a hearing held by this committee in April, and have participated in numerous staff-level briefings. CMS published online the Marketplace timeline with an accompanying narrative description.¹

As you can see from this timeline, our goal was to complete during the month of September the IT development and integration testing. We know now that we underestimated the volume of users who would attempt to log onto the system at the same time, and therefore our testing did not include performance testing at the volume we experienced at launch.

Question 10. People were promised that they could sign up on October 1, they were told it would be as easy as shopping on Orbitz, we've repeatedly been told that their data is secure, despite all evidence to the contrary. Why can you not be honest with the American people on exactly how bad this is?

Answer 10. We know that consumers are having difficulty enrolling via the Marketplace Web site. To the millions of Americans who have attempted to use HealthCare.gov to shop and enroll in health coverage: I want to apologize that the Web site has not worked as well as it should. Consumers have four ways to access the Marketplace—online using HealthCare.gov, by phone, using our dedicated call center where customer services representatives are available 24 hours a day, 7 days

¹ Available at <http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/marketplace-timeline.pdf>.

a week, to work with them to complete the application process, mailing in a paper application, or seeking in-person help in their communities from a Navigator or other assistance personnel trained and certified to help them understand their health insurance options.

The privacy and security of consumers' personal information are a top priority for the Department. When consumers fill out their online Marketplace applications, they can trust that the information they are providing is protected by a comprehensive set of security standards and practices. Security testing happens on an ongoing basis using industry best practices to appropriately safeguard consumers' personal information. The components of the Federally Facilitated Marketplace (FFM) that are operational have been determined to be compliant with the Federal Information Security Management Act (FISMA), based on standards by the National Institutes of Standards and Technology (NIST) and on those promulgated through the Office of Management and Budget (OMB). Additionally, all of CMS's Marketplace systems of records are subject to the Privacy Act of 1974 and the Computer Security Act of 1987.

Question 11. Kansans were promised if they like their health plan they can keep it. I'd like to read a message I received from Paige in Augusta, KS:

"I am one of the many who received a notice from my health care company that I was no longer insured as of the first of the year. A company I had insurance with for the last 30 years. I am hoping to find something by the first of the year. At this point it looks doubtful. I need a suggestion from you as to what I need to do. Healthcare operated by the Federal Government won't work. We all know it. I do need the insurance in case of a catastrophic loss, plus the government has TOLD me I have to have insurance, which I planned on having anyway. Where do we go from here?"

What shall I tell Paige who obviously wants to keep her health plan, but can't?

Question 12. Stephen from Topeka can't keep his coverage either because of the new Federal requirements. However, President Obama promised that the typical family would save up to \$2,500 on their insurance. Stephen is particularly concerned because "The plan that is being offered as a comparable coverage has an increase of premiums by 191 percent." He thinks he may be eligible for a subsidy but can't get on the Web site. Subsidy or not, how can plan rates that increase by almost double be a return on the commitment for saving him or his family money?

Question 13. I also want to share Nancy's story from Kensington. Nancy called because she needed to talk to someone about the Affordable Care Act. Nancy and her husband are farmers who purchase coverage for themselves as employer coverage. They shared that they worked a really long time to find a great plan that works for them. However, Nancy just found out that the coverage that they've had for the last few years is no longer being offered because it doesn't meet the minimum requirements for the ACA. She's additionally frustrated and finally felt the need to call my office because she *supported* the President, she *supported* the Secretary, in fact has even spoken to her on occasion, and she *supported* Obamacare. She did this because her and her husband had such a hard time finding affordable coverage that worked for them. And she *believed* the President when he told her she could keep her plan. But she finally felt the need to call me because the President and Secretary Sebelius keep saying on TV that the plans that are dropping or pulling coverage are substandard, and she wanted me to know that this is just NOT TRUE! The plan was a good one. Her plan was NOT substandard. She liked her plan. She searched a long time for her plan. And she wanted to keep her plan. But now she can't. She feels like she was sold a bill of goods and that this Administration just lied to her and she really hopes that I can do something to bring light to these lies. Ms. Tavenner, what do I tell Nancy?

Answer 11–13. We are committed to ensuring that consumers have a range of affordable health insurance options. The premiums being charged by insurers provide clear evidence that the Marketplace is encouraging plans to compete for consumers, resulting in more affordable rates. The weighted average premium for the second-lowest-cost silver plan, looking across 47 States and DC, is 16 percent below the premium level implied by earlier CBO estimates.² Outside analysts have reached similar conclusions. A recent Kaiser Family Foundation report found that, "while premiums will vary significantly across the country, they are generally lower than expected," and that 15 of the 18 States examined would have premiums below the pro-

² http://aspe.hhs.gov/health/reports/2013/MarketplacePremiums/ib__marketplace_premiums.cfm#_ftnref18.

jected national average of \$320 per month for a 40-year-old in a silver plan (calculations are based on CBO's premium projections).³

In addition to the more affordable rates resulting from competition among insurers, insurance affordability programs, including premium tax credits and cost-sharing reductions, will help many eligible individuals and families, significantly reducing the monthly premiums and cost-sharing paid by consumers. Premium tax credits may be paid in advance and applied to the purchase of a QHP through the Marketplace, enabling consumers to reduce the upfront cost of purchasing insurance. In addition, cost-sharing reductions will lower out-of-pocket payments for deductibles, coinsurance, and copayments for eligible individuals and families. CBO has projected that about 8 in 10 Americans who obtain coverage through the Marketplace will qualify for assistance to make their insurance more affordable, an estimated 20 million Americans by 2017. A family's eligibility for these affordability programs depends largely on its family-size, household income, and access to other types of health coverage.

Question 14. I have received several reports of citizens trying to find out which plans on the exchange include abortion and finding it nearly impossible to get this basic information. Secretary Sebelius indicated in testimony before the House the week before this hearing that she, didn't know this information, but would "check and make sure that it is clearly identifiable." Can you tell us how a consumer can get information about whether a plan includes abortion before purchasing a plan?

Question 15. In an article the Friday before this hearing, NPR reported "that whether or not abortion is a plan benefit remains largely a mystery." The average person seeking coverage on a marketplace should not have to spend hours trying to obtain basic information about whether or not they will have to pay a surcharge for a procedure that dismembers and chemically poisons innocent unborn children. In addition to providing this committee with the same information you promised the House prior to this week—a list of plans that include abortion coverage and plans that do not—what steps are you taking to make sure consumers can easily access information about abortion coverage and the abortion surcharge?

Question 16. As you know, Section 1303 of the ACA sets up a system in which those who enroll in plans that include abortion will pay an abortion surcharge. Since many Americans will not want to pay such a surcharge, it is important that consumers are able to ascertain which plans will charge the abortion surcharge so they can make an informed choice. I have received reports that consumers are not able to obtain this information on the Web site. And a NPR article from Friday has reported the same in their article entitled: "Which plans cover abortion? No Answers on Healthcare.gov." What steps are you taking to make sure consumers can access information about abortion coverage?

Question 17. During an online "chat," a Healthcare.gov representative told one consumer that "You may have to wait until you pick a plan to see if they cover abortions." Do you think consumers should be able to find out whether a plan covers abortion before they purchase the plan? If so, what are you doing to make sure this information is readily available for every plan on the exchanges?

Question 18. Rep. Chris Smith (R-NJ) has introduced a bill called the "Abortion Insurance Full Disclosure Act" (H.R. 3279). The bill would require the exchange to prominently display whether each plan includes abortion coverage. It also says if a plan includes abortion (and thus charges an abortion surcharge), the surcharge should be displayed anywhere the price is displayed. Would you support this legislation?

Question 19. Section 1303(b)(3)(A) of the ACA says,

"A qualified health plan that provides for coverage of the services described in paragraph (1)(B)(i) shall provide notice to enrollees, only as part of the summary of benefits and coverage explanation, at the time of enrollment, of such coverage."

I have seen copies of the summary of benefits documents posted on the DC exchange. None of these documents say anything about abortion coverage and at least some of these plans are reported in the press to be plans that will include abortion coverage. I understand the same problem can be found on other exchanges including the Federal Facilitated Marketplace. Can you explain why information about abor-

³ <http://kaiserfamilyfoundation.files.wordpress.com/2013/09/early-look-at-premiums-and-participation-in-marketplaces.pdf>.

tion coverage does not appear in the Summary of Benefits document posted on the exchanges?

Answer 14–19. CMS is committed to ensuring that HealthCare.gov provides the key information consumers need to make an informed selection from among the Qualified Health Plans (QHPs) available to them. The Affordable Care Act requires that each plan in the Marketplace include a Summary of Benefits and Coverage and a link to the plan brochure, where consumers can learn more about which services are covered. The Affordable Care Act requires plans in the Marketplace to cover the 10 essential health benefits. It is up to the issuer to determine which additional services they cover, and consumers may always contact issuers with any questions.

Question 20. The Affordable Care Act establishes caps on out-of-pocket spending for individuals enrolled in qualified health plans offered through the health insurance marketplaces. However, these caps only apply to in-network services. If an individual requires treatment from an out-of-network provider, there is no cap on the subsequent cost sharing obligation. This is a significant concern for patients, especially those with rare diseases who may require treatment from a number of different medical specialists. There is a crucial need for regulatory oversight to ensure that plans are providing patients with comprehensive provider networks that include the types of specialists required to manage and treat complex diseases. Additionally, when individuals are searching for a health plan on the marketplace, they should have the ability to easily search a plan's provider network to confirm whether their physicians are included in the network.

Given the significant difference in potential financial liability for in-network versus out-of-network services, the need for provider network transparency is of paramount importance. Can you please explain the actions you are taking to ensure that enrollees have the necessary search tools to easily review a plan's network offerings and identify the providers included in that network?

Answer 20. HealthCare.gov includes a function that allows consumers to preview plans without creating an account. Consumers can simply click and see the qualified health plan's summary of benefits and coverage, the online issuer provider network, and a list of covered prescription drugs. CMS will continue to post additional consumer materials on appeals and other consumer rights created by the Affordable Care Act in the future.

We encourage consumers to be informed shoppers, and to shop for the coverage that best fits their needs. In addition to shopping online through HealthCare.gov, consumers can reach out to Marketplace-approved assisters, including agents, brokers and Navigators, to assist with network questions.

[Whereupon, at 12:31 p.m., the hearing was adjourned.]

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