

114TH CONGRESS
1ST SESSION

S. 1368

To establish the Office of the Special Inspector General for Monitoring the Affordable Care Act, and for other purposes.

IN THE SENATE OF THE UNITED STATES

MAY 19, 2015

Mr. ROBERTS (for himself and Mr. PORTMAN) introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

A BILL

To establish the Office of the Special Inspector General for Monitoring the Affordable Care Act, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Special Inspector Gen-
5 eral for Monitoring the ACA Act of 2015” or the “SIGMA
6 Act of 2015”.

7 **SEC. 2. FINDINGS.**

8 The Congress finds the following:

1 (1) The writing, passage, and implementation
2 of the Affordable Care Act has utterly lacked trans-
3 parency.

4 (2) Presidential candidate Barack Obama re-
5 peatedly promised that if elected President, he would
6 hold open, public negotiations on health care reform
7 among public and private stakeholders, including at
8 a Democratic Presidential debate on January 31,
9 2008, when he said, “That’s what I will do in bring-
10 ing all parties together, not negotiating behind
11 closed doors, but bringing all parties together, and
12 broadcasting those negotiations on C-SPAN so that
13 the American people can see what the choices are,
14 because part of what we have to do is enlist the
15 American people in this process.”.

16 (3) Then-Senator Obama repeated this promise
17 multiple times, including at an Ohio town hall on
18 March 1, 2008, when he said, “But here’s the thing:
19 we’re gonna do all these negotiations on C-SPAN.
20 So the American people will be able to watch these
21 negotiations.”.

22 (4) Then-Senator Obama also repeated this
23 promise at a Virginia town hall on August 21, 2008,
24 when he said, “I’m going to have all the negotiations
25 around a big table. We’ll have doctors and nurses

1 and hospital administrators. Insurance companies,
2 drug companies—they’ll get a seat at the table . . .
3 But what we will do is, we’ll have the negotiations
4 televised on C-SPAN, so that people can see who is
5 making arguments on behalf of their constituents,
6 and who are making arguments on behalf of the
7 drug companies or the insurance companies. And so,
8 that approach, I think is what is going to allow peo-
9 ple to stay involved in this process.”.

10 (5) In a September 26, 2011, interview, Brian
11 Lamb, the CEO of C-SPAN confirmed the negotia-
12 tions of the health reform law had not been broad-
13 cast publicly, noting, “The President said that they
14 were all going to be on C-SPAN. He never asked
15 us.”.

16 (6) President Obama, in leading the national
17 health reform debate, broke his promise, admitting
18 in a January 25, 2010, interview with ABC News
19 that locking the public out of key health reform dis-
20 cussions was a “mistake” and explaining, “We had
21 to make so many decisions quickly in a very difficult
22 set of circumstances that after awhile, we started
23 worrying more about getting the policy right than
24 getting the process right. But I had campaigned on
25 process—part of what I had campaigned on was

1 changing how Washington works, opening up, trans-
2 parency and I think it is—I think the health care
3 debate as it unfolded legitimately raised concerns
4 not just among my opponents, but also amongst
5 supporters that we just don’t know what’s going on.
6 And it’s an ugly process and it looks like there are
7 a bunch of backroom deals.”.

8 (7) On March 9, 2010, then-Speaker of the
9 House Nancy Pelosi said of what would become the
10 Affordable Care Act, “We have to pass the bill so
11 that you can find out what is in it.”.

12 (8) Dr. Jonathan Gruber, a professor of eco-
13 nomics at the Massachusetts Institute of Tech-
14 nology, was awarded a contract by the Department
15 of Health and Human Services to provide “technical
16 assistance in evaluating options for national
17 healthcare reform” due to his “proprietary statis-
18 tically sophisticated micro-simulation model” which
19 could assess the impact of changes in Federal health
20 care policies.

21 (9) Dr. Gruber described himself as a health re-
22 form architect who contributed to the crafting of the
23 Affordable Care Act in a 2012 opinion editorial, not-
24 ing, “Several of the architects of Massachusetts re-
25 form, including myself, worked closely with the Ad-

1 ministration and Congress to translate the lessons
2 from Massachusetts onto the national stage.”.

3 (10) Dr. Gruber’s MIT biography has described
4 him as “a key architect” of the Massachusetts
5 health reform effort and a 2009 and 2010 “technical
6 consultant” who “worked with both the Administra-
7 tion and Congress to help craft the Patient Protec-
8 tion and Affordable Care Act.”.

9 (11) An October 11, 2011, report by NBC
10 News described White House visitor logs that show
11 Dr. Gruber had at least five meetings at the White
12 House in 2009 in the lead up to the passage of the
13 Affordable Care Act, including a meeting in the Oval
14 Office with President Obama to evaluate options for
15 national health reform.

16 (12) In a video posted April 12, 2012, by the
17 Obama Presidential campaign to YouTube, Dr.
18 Gruber states that he went “down to Washington to
19 help President Obama develop his national version of
20 that law.”.

21 (13) A March 28, 2012, article in the New
22 York Times reports that “After Mr. Gruber helped
23 the administration put together the basic principles
24 of the proposal, the White House lent him to Capitol

1 Hill to help congressional staff members draft the
2 specifics of the legislation.”.

3 (14) In a January 18, 2012, lecture on the
4 structure of the Affordable Care Act, Dr. Gruber re-
5 fers to the law’s small business tax credits as a por-
6 tion of the bill that he “actually wrote.”.

7 (15) Dr. Gruber’s initial contract with the De-
8 partment of Health and Human Services (HHS)
9 was for \$297,000, and later a Federal grant of
10 \$95,000 brought his total Federal compensation for
11 work on the Affordable Care Act to at least
12 \$392,000.

13 (16) In 2009, the White House annual report
14 to Congress on Presidential staff salaries lists that
15 twenty-two White House staffers made the highest
16 Presidential staff salary rate of \$172,200, including
17 the White House Chief of Staff, senior advisers,
18 White House Counsel, and National Security Ad-
19 viser.

20 (17) In 2010, the White House annual report
21 to Congress on Presidential staff salaries lists that
22 twenty-three White House staffers made the highest
23 Presidential staff salary rate of \$172,200, again in-
24 cluding the President’s top management, policy,
25 communications, and security advisers.

1 (18) In 2009 and 2010, each of President
2 Obama's most senior White House staff received less
3 compensation than Dr. Gruber.

4 (19) In a November 5, 2012, speech at the Uni-
5 versity of Rhode Island, Dr. Gruber described the
6 mechanism of the Affordable Care Act, stating, "It's
7 a very clever, you know, basic exploitation of the
8 lack of economic understanding of the American
9 voter."

10 (20) At an October 17, 2013, panel at the Uni-
11 versity of Pennsylvania, Dr. Gruber described the
12 Affordable Care Act, stating, "This bill was written
13 in a tortured way to make sure CBO did not score
14 the mandate as taxes. If CBO scored the mandate
15 as taxes, the bill dies. Okay, so it's written to do
16 that."

17 (21) In the same speech, Dr. Gruber stated
18 that, "if you had a law which said that healthy peo-
19 ple are going to pay in you made explicit healthy
20 people pay in and sick people get money, it would
21 not have passed."

22 (22) Dr. Gruber went on to claim, "Lack of
23 transparency is a huge political advantage. And basi-
24 cally, call it the stupidity of the American voter or

1 whatever, but basically that was really, really critical
2 for the thing to pass.”.

3 (23) Since the passage of the Affordable Care
4 Act, President Obama called for a new, more trans-
5 parent approach to the health reform law moving
6 forward, saying in a January 25, 2010, ABC News
7 interview, “The process didn’t run the way I ideally
8 would like it to and that we have to move forward
9 in a way that recaptures that sense of opening
10 things up more.”.

11 (24) The Obama Administration’s implementa-
12 tion of the Affordable Care Act has been marked by
13 Executive overreach.

14 (25) On at least 28 occasions, President Obama
15 and his administration have unilaterally delayed, ex-
16 tended, or changed provisions of the Affordable Care
17 Act, including in contravention of the law and the
18 Constitution of the United States.

19 (26) Section 1513 of the Patient Protection and
20 Affordable Care Act (26 U.S.C. 4980h note) re-
21 quires applicable large employers with more than 50
22 full-time employees to provide qualifying health in-
23 surance to their employees or pay a fine, and the ef-
24 fective date under such section specified the amend-

1 ments made by such section applied to months be-
2 ginning after December 31, 2013.

3 (27) Contrary to the plain meaning of the stat-
4 utory requirement, and acting without authority pro-
5 vided by law, the Internal Revenue Service published
6 in the Federal Register Notice 2013–45 to change
7 the effective date of the employer mandate require-
8 ment, stating, “Section 1513(d) of the Affordable
9 Care Act provides that section 4980H applies to
10 months after December 31, 2013; however Notice
11 2013–45, issued on July 9, 2013, provides as transi-
12 tion relief that no assessable payments under section
13 4980H will apply for 2014.”.

14 (28) On July 12, 2013, the Director for the
15 Center for Consumer Information and Insurance
16 Oversight at the Centers for Medicare & Medicaid
17 Services denied the request for exemption from cer-
18 tain Affordable Care Act requirements made by rep-
19 resentatives of the United States territories, writing
20 to the Secretary of Commerce for the Common-
21 wealth of the Northern Mariana Islands, “However
22 meritorious your request might be, [the Department
23 of Health and Human Services] is not authorized to
24 choose which provisions [of the Affordable Care Act]
25 . . . might apply to the territories.”.

1 (29) A year later, on July 16, 2014, the Admin-
2 istrator of the Centers for Medicare & Medicaid
3 Services notified representatives of the United States
4 territories that they would in fact receive an exemp-
5 tion from requirements under the Affordable Care
6 Act, despite the previous explanation from CMS that
7 CMS does not have the legal authority to provide
8 such an exemption. As the CMS Administrator now
9 rationalized, “Currently, the Department uses the
10 existing Public Health Service Act (PHS Act) defini-
11 tion of ‘State’ for new PHS Act requirements and
12 funding opportunities included in title I of the Af-
13 fordable Care Act. Under this definition, the new
14 market reforms in the PHS Act apply to the terri-
15 tories. We have been informed by representatives of
16 the territories that this interpretation is under-
17 mining the stability of the territories’ health insur-
18 ance markets. After a careful review of this situation
19 and the relevant statutory language, HHS has deter-
20 mined that the new provisions of the PHS Act en-
21 acted in title I are appropriately governed by the
22 definition of ‘State’ set forth in that title, and there-
23 fore that these new provisions do not apply to the
24 territories.”.

1 (30) The Obama Administration has claimed
2 that the Affordable Care Act will save money and
3 improve the economy, with WhiteHouse.gov stating,
4 “‘In keeping with the President’s pledge that reform
5 must fix our health care system without adding to
6 the deficit, the Affordable Care Act reduces the def-
7 icit, saving over \$200 billion over 10 years and more
8 than \$1 trillion in the second decade. The law re-
9 duces health care costs . . . [and] is improving our
10 economic competitiveness[.]’”.

11 (31) \$70.2 billion of the White House’s esti-
12 mated savings was to come from the Community
13 Living Assistance Services and Supports (CLASS)
14 Act provisions of the Affordable Care Act, a pro-
15 gram that was deemed actuarially unsound and
16 never implemented by the Obama Administration.

17 (32) An April 2010 report from the Office of
18 the Actuary for the Centers for Medicare & Medicaid
19 Services describes that additional savings under the
20 Affordable Care Act were to be paid for with Medi-
21 care Fee-for-Service and Medicare Advantage cuts
22 and reductions in payments to hospitals, skilled
23 nursing facilities, and home health centers. These
24 cuts have been delayed and may never materialize.
25 Even if implemented, the projected savings may

1 never accrue as the CMS Actuary’s report concludes
2 that such cuts will cause about 15 percent of hos-
3 pitals and post-acute care facilities like nursing
4 homes to go out of business.

5 (33) \$52 billion in deficit reduction savings was
6 projected to come from employer penalties paid to
7 the Government for failure to comply with the em-
8 ployer mandate requirement to provide employees
9 health insurance, a requirement that the Obama Ad-
10 ministration has repeatedly delayed and modified,
11 causing penalties and associated savings to not ac-
12 crue.

13 (34) Initial estimates of savings under the Af-
14 fordable Care Act projected at least \$15.5 billion in
15 savings over the next decade attributable to Medi-
16 care cuts through the Independent Payment Advi-
17 sory Board, which has not yet been appointed and
18 through which no cuts or savings have been realized.

19 (35) On September 9, 2009, President Obama
20 pledged to a joint session of Congress, “I will not
21 sign a [health care reform] plan that adds one dime
22 to our deficits—either now or in the future.”.

23 (36) The Congressional Budget Office esti-
24 mated in February 2014 that health insurance sub-
25 sidies under the Affordable Care Act would cost the

1 Federal Government \$47 billion in fiscal year 2015
2 and \$1.197 trillion over fiscal years 2015–2024.

3 (37) The Committees on Finance and Health,
4 Education, Labor, and Pensions of the Senate esti-
5 mated in September 2014 that the Affordable Care
6 Act will add at least \$340 billion to Federal budget
7 deficits.

8 (38) Dr. Gruber stated, “The [Affordable Care
9 Act] isn’t designed to save money.”.

10 (39) On at least 37 occasions, President Obama
11 or a top official in the executive branch repeated the
12 promise that “If you like the [health insurance] plan
13 you have, you can keep it. If you like the doctor you
14 have, you can keep your doctor.”.

15 (40) The Associated Press calculated at least
16 4.7 million Americans had their health insurance
17 cancelled for 2014 and later, when the President
18 issued a last-minute fix to try to prevent these can-
19 cellations as required by the Affordable Care Act,
20 the changes came too late for approximately 2.4 mil-
21 lion Americans to keep the plans they had and liked.

22 (41) The nonpartisan, fact-checking publication
23 Politifact rated “If you like your health care plan,
24 you can keep it.” as the Lie of the Year for 2013.

1 (42) Then-Presidential candidate Barack
2 Obama repeatedly promised that, if elected Presi-
3 dent, his national health care reforms would, “cut
4 the cost of a typical family’s premium by up to
5 \$2,500 a year.”.

6 (43) A November 2013 analysis by the Manhat-
7 tan Institute calculates that the Affordable Care Act
8 would increase individual marketplace health insur-
9 ance premiums by 41 percent nationwide between
10 2013 and 2014.

11 (44) A December 2013 study by Health Pocket,
12 Inc., found that the average individual deductible for
13 a Bronze plan was \$5,081 a year, a 42-percent in-
14 crease from the average plan purchased by an indi-
15 vidual in 2013.

16 (45) A February 2013 study by Health Pocket
17 Inc., found that exchange plans under the Affordable
18 Care Act averaged a 34-percent increase in drug-
19 cost sharing compared to copayment and coinsur-
20 ance rates in the pre-Affordable Care Act market.
21 For the sickest patients needing specialty drugs, the
22 study found copayments increased by 226 percent
23 under a Bronze plan via the Affordable Care Act.

24 (46) A December 2013 study by McKinsey and
25 Company found that insurers offered almost three

1 times as many narrow or ultranarrow network plans
2 in 2014 compared to 2013. Fully 70 percent of Af-
3 fordable Care Act plans analyzed had narrow or
4 ultranarrow network coverage, meaning coverage for
5 fewer doctors and hospitals than plans sold on the
6 individual market before the law took effect.

7 (47) Details consumers require to make in-
8 formed decisions about their health care plan cov-
9 erage under the Affordable Care Act have been with-
10 held or lacked transparency.

11 (48) On September 26, 2013, President Obama
12 said, “It will say clearly what each plan covers, what
13 each plan costs. The price will be right there. It will
14 be fully transparent . . . And so if you’ve ever tried
15 to buy insurance on your own, I promise you this is
16 a lot easier. It’s like booking a hotel or a plane tick-
17 et.”.

18 (49) HealthCare.gov was established as the
19 website to implement the Federal exchange portion
20 of the Act at a cost of as much as \$840 million, in-
21 cluding more than \$150 million in cost overruns, ac-
22 cording to the Government Accountability Office in
23 March 2014.

24 (50) On October 1, 2013, HealthCare.gov
25 launched without adequate security testing, leaving

1 the approximately 250,000 unique users it drew not
2 only vulnerable to identity theft by hackers, but un-
3 able to even use the site, as the website was demon-
4 strably unable to handle even 1,100 simultaneous
5 users.

6 (51) For the subsequent months after its
7 launch, HealthCare.gov continued to be plagued by
8 crippling malfunctions, and the dismal performance
9 of the website led only to problems and frustration
10 for millions of Americans.

11 (52) A June 2013 study by the Department of
12 Health and Human Services' Office of Inspector
13 General revealed that software designed by a prin-
14 cipal HealthCare.gov vendor was highly insecure and
15 put the information of more than 6 million Medicare
16 beneficiaries at "greater risk from malware, inappro-
17 priate access or theft".

18 (53) An April 2014 study by Avalere Health de-
19 termined that 38 percent of health insurance plans
20 offered on the exchanges under the Affordable Care
21 Act had no information about drug coverage avail-
22 able. Avalere also found that nearly 1 in 4 plans of-
23 fered insufficient information on which doctors and
24 hospitals are covered.

1 (54) In September 2014, the Administrator of
2 the Centers for Medicare and Medicaid Services re-
3 ported to Congress that 7.3 million Americans had
4 enrolled in plans through exchanges under the Af-
5 fordable Care Act, meeting enrollment targets esti-
6 mated by the Congressional Budget Office and held
7 as a goal by the Obama Administration.

8 (55) Four months later, HHS Secretary
9 Burwell stated that this enrollment data was a “mis-
10 take” that included some 400,000 dental insurance
11 enrollments, the inclusion of which allowed the ad-
12 ministration to claim for months that the Affordable
13 Care Act was performing as anticipated which was
14 not in fact a true or accurate representation of the
15 data they had, but would not release to the public.

16 (56) Since implementation of the ACA began,
17 the HHS Secretary has granted over \$1 billion in
18 Federal taxpayer dollars to States to help build
19 websites for their own State-based exchanges, yet
20 development and usability issues on short timelines
21 repeatedly caused these same States to seek dif-
22 ferent options for the 2015 open enrollment period,
23 including opting to revert to enrolling via the Fed-
24 eral HealthCare.gov website.

1 (57) The Affordable Care Act provides opportu-
2 nities for fraud within subsidy and tax credit
3 issuance.

4 (58) A September 2013 report by the Treasury
5 Inspector General for Tax Administration concluded
6 that, “the IRS’s existing fraud detection system may
7 not be capable of identifying ACA refund fraud or
8 schemes prior to the issuance of tax return re-
9 funds.”.

10 (59) A July 2014 undercover study by the Gov-
11 ernment Accountability Office determined that ficti-
12 tious applicants were able to obtain health insurance
13 coverage and taxpayer-funded subsidies on the Fed-
14 eral exchanges using falsified documents in 11 out
15 of 12 cases.

16 (60) The Affordable Care Act has had a nega-
17 tive impact on the American economy.

18 (61) A February 2014 calculation by the Con-
19 gressional Budget Office found the Affordable Care
20 Act will significantly harm the American economy,
21 reducing the number of hours worked by millions of
22 full-time employees worth of hours. The CBO study
23 noted, “The reduction in CBO’s projections of hours
24 worked represents a decline in the number of full-

1 time-equivalent workers of about 2 million in 2017,
2 rising to about 2.5 million in 2024.”.

3 (62) History has shown the Special Inspector
4 General model to be successful at saving taxpayer
5 dollars and rooting out waste, fraud, and abuse in
6 large Federal Government programs.

7 (63) Congress and the President have enacted
8 legislation creating Special Inspectors General on
9 three occasions, including to oversee Federal spend-
10 ing and policy implementation for Afghanistan re-
11 construction (SIGAR), Iraq reconstruction (SIGIR),
12 and the Troubled Asset Relief Program (SIGTARP).

13 (64) SIGAR, SIGIR, and SIGTARP have suc-
14 cessfully conducted audits and investigations saving
15 the Federal Government billions in waste, fraud, and
16 abuse, and have helped to identify and prosecute
17 theft and corruption.

18 (65) As of an October 2014 report, SIGAR has
19 produced 57 referrals for suspension and debarment
20 of Federal contractors and employees and produced
21 over \$500 million in direct taxpayer savings.

22 (66) According to its final report, SIGIR cost
23 \$245 million to operate, but resulted in \$645 million
24 in direct savings to the Federal Government, in ad-
25 dition to producing \$192 million in seizures and

1 court-ordered penalties, as well as 90 criminal con-
2 victions.

3 (67) As of an October 2014 report, SIGTARP
4 has produced 146 convictions and \$7.38 billion in
5 fines, penalties, and restitution to the Government
6 and victims.

7 (68) On August 5, 2014, the Associated Press
8 reported that 47 Federal inspectors general sent an
9 unprecedented joint letter to Congress to decry,
10 “Obama administration efforts to delay or stall their
11 investigations,” citing three examples where Federal
12 agencies have hindered substantive inspector general
13 oversight work by refusing to provide information or
14 documents they are entitled to under the law.

15 (69) The letter from more than half of the Fed-
16 eral Government’s independent inspectors general
17 correctly states, “Section 6(a)(1) of the IG Act re-
18 flects the clear intent of Congress that an Inspector
19 General is entitled to timely and unimpeded access
20 to all records available to an agency that relate to
21 that Inspector General’s oversight activities. The
22 constricted interpretations of Section 6(a)(1) by
23 these and other agencies conflict with the actual lan-
24 guage and Congressional intent. The IG Act is clear:
25 no law restricting access to records applies to In-

1 spectors General unless that law expressly so states,
2 and that unrestricted access extends to all records
3 available to the agency, regardless of location or
4 form.”.

5 (70) Congress has a responsibility to exercise
6 prudent stewardship of public dollars, to ensure that
7 laws are well and faithfully executed by the executive
8 branch, to provide for efficacious services for the
9 American people, and to ensure that those who
10 cheat, steal from, or defraud the Federal Govern-
11 ment are held to account.

12 **SEC. 3. SPECIAL INSPECTOR GENERAL FOR MONITORING**
13 **THE AFFORDABLE CARE ACT.**

14 (a) OFFICE OF SPECIAL INSPECTOR GENERAL.—
15 There is hereby established the Office of the Special In-
16 specter General for Monitoring the Affordable Care Act
17 (in this section, referred to as the “Office”) to carry out
18 the duties described under subsection (e).

19 (b) APPOINTMENT OF INSPECTOR GENERAL; RE-
20 MOVAL.—

21 (1) APPOINTMENT.—The head of the Office is
22 the Special Inspector General for Monitoring the Af-
23 fordable Care Act (in this section referred to as the
24 “Special Inspector General”), who shall be appointed

1 by the President, by and with the advice and consent
2 of the Senate.

3 (2) QUALIFICATIONS.—The appointment of the
4 Special Inspector General shall be made solely on
5 the basis of integrity and demonstrated ability in ac-
6 counting, auditing, financial analysis, law, manage-
7 ment analysis, health care expertise and financing,
8 public administration, or investigations.

9 (3) DEADLINE FOR APPOINTMENT.—The ap-
10 pointment of an individual as the Special Inspector
11 General shall be made not later than 30 days after
12 the date of the enactment of this Act.

13 (4) COMPENSATION.—The annual rate of basic
14 pay of the Special Inspector General shall be the an-
15 nual rate of basic pay provided for positions at level
16 IV of the Executive Schedule under section 5315 of
17 title 5, United States Code.

18 (5) PROHIBITION ON POLITICAL ACTIVITIES.—
19 For purposes of section 7324 of title 5, United
20 States Code, the Special Inspector General shall not
21 be considered an employee who determines policies
22 to be pursued by the United States in the nation-
23 wide administration of Federal law.

24 (6) REMOVAL.—The Special Inspector General
25 shall be removable from office in accordance with

1 the provisions of section 3(b) of the Inspector Gen-
2 eral Act of 1978 (5 U.S.C. App.).

3 (c) ASSISTANT INSPECTORS GENERAL.—The Special
4 Inspector General shall, in accordance with applicable laws
5 and regulations governing the civil service—

6 (1) appoint an Assistant Inspector General for
7 Auditing who shall have the responsibility for super-
8 vising the performance of auditing activities relating
9 to the duties described under subsection (e); and

10 (2) appoint an Assistant Inspector General for
11 Investigations who shall have the responsibility for
12 supervising the performance of investigative activi-
13 ties relating to such duties.

14 (d) SUPERVISION.—

15 (1) IN GENERAL.—Except as provided under
16 paragraph (2), the Special Inspector General shall
17 report directly to, and be under the general super-
18 vision of, the Secretary of Health and Human Serv-
19 ices.

20 (2) INDEPENDENCE TO CONDUCT INVESTIGA-
21 TIONS AND AUDITS.—No employee or officer of any
22 of the following entities shall prevent or prohibit the
23 Special Inspector General from initiating, carrying
24 out, or completing any audit or investigation related
25 to the duties described under subsection (e) or from

1 issuing any subpoena during the course of any such
2 audit or investigation:

3 (A) The Executive Office of the President
4 and the Office of Personnel Management.

5 (B) The Department of Health and
6 Human Services.

7 (C) The Department of the Treasury.

8 (D) The Social Security Administration,
9 the Department of Homeland Security, the De-
10 partment of Veterans Affairs, the Department
11 of Defense, the Department of Labor, and the
12 Peace Corps.

13 (E) Any other Federal agency involved in
14 implementing or administering the Affordable
15 Care Act.

16 (e) DUTIES.—

17 (1) OVERSIGHT OF THE IMPLEMENTATION AND
18 ADMINISTRATION OF THE AFFORDABLE CARE ACT.—

19 It shall be the duty of the Special Inspector General
20 to conduct, supervise, and coordinate audits and in-
21 vestigations of the implementation and administra-
22 tion of programs and activities established under,
23 and payment system changes made by, the Afford-
24 able Care Act, including by collecting and summa-
25 rizing the following:

1 (A) A description of the individual man-
2 date requirement for applicable individuals to
3 maintain minimum essential coverage or pay a
4 penalty under section 5000A of the Internal
5 Revenue Code of 1986, including a description
6 of the number of individuals maintaining such
7 coverage and the number of individuals paying
8 such penalties.

9 (B) A description of any increases or de-
10 creases in—

11 (i) premiums for qualified health
12 plans (as defined in section 1301 of the
13 Patient Protection and Affordable Care
14 Act (42 U.S.C. 18021));

15 (ii) deductibles under qualified health
16 plans; and

17 (iii) cost-sharing under qualified
18 health plans, including by copayments and
19 coinsurance,

20 affecting individuals enrolling in coverage under
21 such plans through an exchange established
22 under title I of the Patient Protection and Af-
23 fordable Care Act (including a State-run ex-
24 change, a federally administered exchange, and
25 a Small Business Health Options Program).

1 (C) A description of any increases or de-
2 creases in the maximum out-of-pocket costs af-
3 fecting individuals enrolling in qualified health
4 plans through such a State-run exchange, a fed-
5 erally administered exchange, and a Small
6 Business Health Options Program.

7 (D) A description of any increases or de-
8 creases in the size of physician and other health
9 care provider networks affecting individuals en-
10 rolling in qualified health plans through such a
11 State-run exchange, a federally administered
12 exchange, and a Small Business Health Options
13 Program.

14 (E) A description of any type of health in-
15 surance coverage lost because of the treatment
16 under title I of the Patient Protection and Af-
17 fordable Care Act of grandfathered health plans
18 (as defined in section 1251(e) of such Act (42
19 U.S.C. 18011(e))).

20 (F) A description of any credits under sec-
21 tion 36B of the Internal Revenue Code of 1986
22 (and the amount (if any) of the advance pay-
23 ment of the credit under section 1412 of the
24 Patient Protection and Affordable Care Act (42
25 U.S.C. 18082)) and any cost-sharing reduction

1 under section 1402 of the Patient Protection
2 and Affordable Care Act (42 U.S.C. 18071)
3 (and the amount (if any) of the advance pay-
4 ment of the reduction under section 1412 of
5 such Act (42 U.S.C. 18082)) provided to indi-
6 viduals enrolling under qualified health plans
7 through an exchange established under title I of
8 the Patient Protection and Affordable Care Act.

9 (G) A description of any projections, esti-
10 mates, analysis, goals, or targets made by any
11 employee of the Federal Government or any
12 contractor of the Federal Government in car-
13 rying out duties associated with the Patient
14 Protection and Affordable Care Act with re-
15 spect to the enrollment of individuals in a quali-
16 fied health plan through an exchange estab-
17 lished under title I of the Patient Protection
18 and Affordable Care Act.

19 (H) A description of the employer mandate
20 requirement that applicable large employers
21 provide eligible employees with minimum essen-
22 tial coverage or pay a fine under section 4980H
23 of the Internal Revenue Code of 1986, includ-
24 ing a description of the type and number of em-

1 employers providing such coverage and the type
2 and number of employers paying such fines.

3 (I) A description of any projections, esti-
4 mates, analyses, goals, or targets made by any
5 employee of the Federal Government or any
6 contractor of the Federal Government in car-
7 rying out duties associated with the Patient
8 Protection and Affordable Care Act with re-
9 spect to employers providing minimum essential
10 coverage to applicable employees.

11 (J) A description of any reports, meetings,
12 discussions, or materials of any employee of the
13 Federal Government or any contractor of the
14 Federal Government in carrying out duties as-
15 sociated with the Patient Protection and Af-
16 fordable Care Act relating to any employers
17 converting full-time employees to part-time em-
18 ployees or hiring new part-time employees in-
19 stead of full-time employees for the purposes of
20 avoiding the fines provided for under the em-
21 ployer mandate requirement described in sub-
22 paragraph (H).

23 (K) A description of any reports, meetings,
24 discussions, or materials of any employee of the
25 Federal Government or any contractor of the

1 Federal Government in carrying out duties as-
2 sociated with the Patient Protection and Af-
3 fordable Care Act relating to any employers hir-
4 ing no more than 50 employees for the purposes
5 of avoiding the requirement to provide min-
6 imum essential coverage or pay a fine under the
7 employer mandate requirement described in
8 subparagraph (H).

9 (L) A description of any reports, meetings,
10 discussions, or materials of any employee of the
11 Federal Government or any contractor of the
12 Federal Government in carrying out duties as-
13 sociated with the Patient Protection and Af-
14 fordable Care Act relating to any employers
15 dropping the health insurance coverage offered
16 to their employees, or employees' spouses or de-
17 pendents, for the purposes of avoiding the re-
18 quirement to provide minimum essential cov-
19 erage or pay a fine under the employer mandate
20 requirement described in subparagraph (H).

21 (M) A description of the transitional rein-
22 surance program established under section
23 1341 of the Patient Protection and Affordable
24 Care Act (42 U.S.C. 18061), including a de-
25 scription of reinsurance contributions collected

1 or required to be collected under such program,
2 a description of any reinsurance payments
3 made or required to be made to health insur-
4 ance issuers under such program, a description
5 of the health insurance coverage and related
6 costs for high-cost individuals for plans related
7 to such program, an explanation of the impact
8 of such reinsurance program on adverse selec-
9 tion in the marketplace, and an explanation of
10 any premium-stabilizing effects of such pro-
11 gram.

12 (N) A description of the temporary risk
13 corridors for qualified health plans established
14 under section 1342 of the Patient Protection
15 and Affordable Care Act (42 U.S.C. 18062), in-
16 cluding a description of participating plans and
17 the allowable costs and target amounts of such
18 plans, a description of risk corridor ratios of
19 such plans, and a description of payment ad-
20 justments made under such program.

21 (O) A description of the permanent risk
22 adjustment program established under section
23 1343 of the Patient Protection and Affordable
24 Care Act (42 U.S.C. 18063), including a de-
25 scription of any plans participating in such pro-

1 gram, a description of any risk adjustment pay-
2 ments made or required to be made under such
3 program, a description of the health insurance
4 coverage and related costs for high-cost individ-
5 uals for plans related to such program, an ex-
6 planation of the impact of such program on ad-
7 verse selection in the marketplace, and an ex-
8 planation of any premium-stabilizing effects of
9 such program.

10 (P) A list of all contracts awarded under
11 the Affordable Care Act and an analysis of
12 whether Federal contracting procedures were
13 followed when awarding any contract associated
14 with such Act.

15 (Q) A description of the development of
16 the health insurance marketplace for the Inter-
17 net portal established under section 1103 of the
18 Patient Protection and Affordable Care Act (42
19 U.S.C. 18003), including a description of the
20 design, features, and security systems of such
21 web portal and a description of all costs associ-
22 ated with such development.

23 (R) A description of any threats, risks,
24 problems, or functionality issues identified by
25 any employee of the Federal Government or any

1 contractor of the Federal Government in car-
2 rying out duties associated with the Patient
3 Protection and Affordable Care Act prior to the
4 launch of such web portal on October 1, 2013.

5 (S) A description of any decisionmaking or
6 activities by any employee of the Federal Gov-
7 ernment or any contractor of the Federal Gov-
8 ernment in carrying out duties associated with
9 the Patient Protection and Affordable Care Act
10 in response to such threats, risks, problems, or
11 functionality issues.

12 (T) A description of the systems (on the
13 Federal and State levels) in place or in develop-
14 ment to allow health insurance issuers and
15 plans and government entities to verify infor-
16 mation is accurate for purposes of enrollments
17 in qualified health plans through exchanges es-
18 tablished under title I of the Patient Protection
19 and Affordable Care Act, including that data
20 verification and validation can occur with re-
21 spect to information provided or stored by indi-
22 viduals, the Department of Health and Human
23 Services, the qualified health plans, States, and
24 other applicable Federal agencies, including for
25 purposes of credits under section 36B of the In-

1 ternal Revenue Code of 1986 (and the amount
2 (if any) of the advance payment of the credit
3 under section 1412 of the Patient Protection
4 and Affordable Care Act (42 U.S.C. 18082))
5 and any cost-sharing reduction under section
6 1402 of the Patient Protection and Affordable
7 Care Act (42 U.S.C. 18071) (and the amount
8 (if any) of the advance payment of the reduc-
9 tion under section 1412 of such Act (42 U.S.C.
10 18082)).

11 (U) A description of the development of
12 the Federal Data Services Hub, including its
13 design, features, and security systems, and a
14 description of the type of data accessed through
15 such data hub, and a description of the actual
16 storage location of such data accessed through
17 such data hub.

18 (V) A list of the duties and responsibilities
19 assigned to the Internal Revenue Service as a
20 result of the enactment of the Affordable Care
21 Act, a description of any plans of the Internal
22 Revenue Service for how to carry out such du-
23 ties, and an explanation of the resources and
24 personnel required to carry out such duties, in-
25 cluding a description of any new resources or

1 personnel required to carry out such duties not
2 already available to the Internal Revenue Serv-
3 ice.

4 (W) A description of any plans of the In-
5 ternal Revenue Service to verify the eligibility of
6 individuals enrolling in qualified health plans
7 for any credits under section 36B of the Inter-
8 nal Revenue Code of 1986 (and the amount (if
9 any) of the advance payment of the credit
10 under section 1412 of the Patient Protection
11 and Affordable Care Act (42 U.S.C. 18082))
12 and any cost-sharing reduction under section
13 1402 of the Patient Protection and Affordable
14 Care Act (42 U.S.C. 18071) (and the amount
15 (if any) of the advance payment of the reduc-
16 tion under section 1412 of such Act (42 U.S.C.
17 18082)), including a description of any such
18 verification completed and a description of any
19 such individuals determined to be ineligible.

20 (X) A description of any plans by the In-
21 ternal Revenue Service to calculate the amount
22 of overpayment of any such credit or reduction
23 for which an individual enrolled in a qualified
24 health plan was determined to be ineligible, in-

1 including a description of any such calculations
2 completed.

3 (Y) A description of any plans by the In-
4 ternal Revenue Service to notify individuals de-
5 termined to be ineligible for such credits or re-
6 ductions, including a description of such notifi-
7 cations completed.

8 (Z) A description of any plans by the In-
9 ternal Revenue Service to recapture such over-
10 payments of such credits and reductions for in-
11 dividuals determined to be ineligible, including
12 a description of such recapturing completed.

13 (AA) A description of the impact of the Af-
14 fordable Care Act on the right of conscience, in-
15 cluding on—

16 (i) religious employers and institutions
17 that were not exempted from the mandate
18 issued by the Department of Health and
19 Human Services requiring individual and
20 group health plans to cover sterilization
21 and Food and Drug Administration ap-
22 proved contraceptives;

23 (ii) individuals; and

24 (iii) medical professionals.

1 (BB) A description of abortion coverage
2 offered under qualified health plans purchased
3 through State-run exchanges, federally adminis-
4 tered exchanges, and Small Business Health
5 Options Programs, including costs associated
6 with such coverage.

7 (CC) A description of any actions by De-
8 partments or Agencies of the Federal Govern-
9 ment to modify or delay the programs or activi-
10 ties authorized by the Affordable Care Act, in-
11 cluding an explanation from the head of such
12 Department or Agency of the specific authority
13 used to implement such a modification or delay.

14 (DD) A description of the Independent
15 Payment Advisory Board under section 1899A
16 of the Social Security Act (42 U.S.C. 1395kkk)
17 and any actions taken to alter or reduce the use
18 of medical products, treatments or procedures,
19 including an explanation from the Independent
20 Payment Advisory Board of the reasons for tak-
21 ing such actions, whether such actions could be
22 expected to result in worsened medical out-
23 comes for individuals affected by such alter-
24 ations or reductions, and an explanation of the
25 medical information used to determine whether

1 such alterations or reductions could be expected
2 to result in such worsened outcomes.

3 (EF) A description of individuals enrolled
4 in the Medicaid program under title XIX of the
5 Social Security Act through an exchange estab-
6 lished under title I of the Patient Protection
7 and Affordable Care Act, including a descrip-
8 tion of the cost of health care services utilized
9 by such individuals and a description of the cost
10 to States and the cost to the Federal Govern-
11 ment to provide health care services to such in-
12 dividuals.

13 (FG) Any additional topic related to the
14 implementation and administration of the Af-
15 fordable Care Act, the inclusion of which helps
16 to provide the public a full and objective ac-
17 counting of such law.

18 (2) DATA TO BE INCLUDED.—In carrying out
19 the duties described under paragraph (1), the Spe-
20 cial Inspector General shall, to the greatest extent
21 possible, collect and summarize data described under
22 such paragraph according to each type of insurance
23 marketplace and according to the age and gender of
24 individuals enrolling in coverage under qualified
25 health plans through an exchange established under

1 title I of the Patient Protection and Affordable Care
2 Act.

3 (3) OTHER DUTIES RELATED TO OVERSIGHT.—

4 The Special Inspector General shall establish, main-
5 tain, and oversee such systems, procedures, and con-
6 trols as the Special Inspector General considers ap-
7 propriate to discharge the duties described under
8 paragraph (1).

9 (4) DUTIES AND RESPONSIBILITIES UNDER
10 THE INSPECTOR GENERAL ACT OF 1978.—In addition
11 to the duties described under paragraphs (1) and
12 (2), the Special Inspector General shall also have the
13 duties and responsibilities of inspectors general
14 under the Inspector General Act of 1978 (5 U.S.C.
15 App.).

16 (f) COORDINATION OF EFFORTS.—In carrying out
17 the duties, responsibilities, and authorities of the Special
18 Inspector General under this section, the Special Inspector
19 General shall coordinate with, and receive the cooperation
20 of each of the following:

21 (1) The Inspector General of the Department of
22 Health and Human Services.

23 (2) The Inspector General of the Department of
24 the Treasury.

1 (3) The Inspectors General of the Social Secu-
2 rity Administration, the Department of Homeland
3 Security, the Department of Veterans Affairs, the
4 Department of Defense, the Department of Labor,
5 and the Peace Corps.

6 (4) The inspector general of any other Federal
7 entity, as determined by the Special Inspector Gen-
8 eral.

9 (g) POWERS AND AUTHORITIES.—

10 (1) AUTHORITY TO ACCESS MATERIALS, RE-
11 QUEST INFORMATION, COMPEL RESPONSE, AND
12 OTHER AUTHORITIES UNDER THE INSPECTOR GEN-
13 ERAL ACT OF 1978.—In carrying out the duties de-
14 scribed under subsection (e), the Special Inspector
15 General shall have all of the authorities provided
16 under section 6 of the Inspector General Act of
17 1978 (5 U.S.C. App.).

18 (2) EXEMPTION FROM REQUIREMENT FOR INI-
19 TIAL DETERMINATION BY ATTORNEY GENERAL.—
20 For purposes of section 6(e) of the Inspector Gen-
21 eral Act of 1978 (5 U.S.C. App.), the Special In-
22 spector General shall be considered exempt from the
23 requirement of an initial determination of eligibility
24 by the Attorney General under paragraph (2) of
25 such section.

1 (3) AUDIT STANDARDS.—The Special Inspector
2 General shall carry out the duties specified under
3 subsection (e)(1) in accordance with section 4(b)(1)
4 of the Inspector General Act of 1978 (5 U.S.C.
5 App.).

6 (h) PERSONNEL, FACILITIES, AND OTHER RE-
7 SOURCES.—

8 (1) PERSONNEL.—The Special Inspector Gen-
9 eral may select, appoint, and employ such officers
10 and employees as may be necessary for carrying out
11 the duties of the Special Inspector General, subject
12 to the provisions of title 5, United States Code, gov-
13 erning appointments in the competitive service, and
14 the provisions of chapter 51 and subchapter III of
15 chapter 53 of such title, relating to classification and
16 General Schedule pay rates.

17 (2) EMPLOYMENT OF EXPERTS AND CONSULT-
18 ANTS.—The Special Inspector General may obtain
19 services as authorized by section 3109 of title 5,
20 United States Code, at daily rates not to exceed the
21 equivalent rate prescribed for grade GS–15 of the
22 General Schedule by section 5332 of such title.

23 (3) CONTRACTING AUTHORITY.—To the extent
24 and in such amounts as may be provided in advance
25 by appropriations Acts, the Special Inspector Gen-

1 eral may enter into contracts and other arrange-
2 ments for audits, studies, analyses, and other serv-
3 ices with public agencies and with private persons,
4 and make such payments as may be necessary to
5 carry out the duties of the Special Inspector Gen-
6 eral.

7 (4) RESOURCES.—The Secretary of Health and
8 Human Services shall provide the Special Inspector
9 General with appropriate and adequate office space
10 at appropriate locations of the Department of
11 Health and Human Services together with such
12 equipment, office supplies, and communications fa-
13 cilities and services as may be necessary for the op-
14 eration of such offices, and shall provide necessary
15 maintenance services for such offices and the equip-
16 ment and facilities located therein.

17 (5) ASSISTANCE FROM FEDERAL AGENCIES.—

18 (A) IN GENERAL.—Upon request of the
19 Special Inspector General for information or as-
20 sistance from any Department, Agency, or
21 other entity of the Federal Government (includ-
22 ing any entity listed under subsection (d)(2)),
23 the head of such entity shall, insofar as is prac-
24 ticable and not in contravention of any existing
25 law, furnish such information or assistance to

the Special Inspector General, or an authorized designee.

(B) REPORTING OF REFUSED ASSISTANCE.—

(i) REPORTING TO HEALTH AND HUMAN SERVICES AND CONGRESS.—In accordance with clause (ii), as the case may be, whenever information or assistance requested by the Special Inspector General is, in the judgment of the Special Inspector General, unreasonably refused or not provided, the Special Inspector General shall report the circumstances to the Secretary of Health and Human Services and to the appropriate congressional committees without delay.

(ii) REPORTING TO THE PUBLIC ON REFUSAL OR NONCOOPERATION IN TRANSPARENCY.—Whenever any information described in clause (i) is requested by the Special Inspector General and unreasonably refused or not provided, the report to the Secretary of Health and Human Services and the appropriate congressional committees shall be titled “Notice of Re-

1 fusal or Noncooperation in Transparency”
 2 and shall be published on a publicly avail-
 3 able website in an accessible format with-
 4 out delay.

5 (6) USE OF PERSONNEL, FACILITIES, AND
 6 OTHER RESOURCES OF THE OFFICE.—Upon the re-
 7 quest of the Special Inspector General, an Inspector
 8 General—

9 (A) may detail, on a reimbursable basis, to
 10 the Office any of the personnel of such Inspec-
 11 tor General’s office for the purpose of carrying
 12 out this section; and

13 (B) may provide, on a reimbursable basis,
 14 any of the facilities or other resources of the
 15 Office for the purpose of carrying out this sec-
 16 tion.

17 (i) REPORTS.—

18 (1) INITIAL REPORT.—Not later than 90 days
 19 after the date of the enactment of this Act, the Spe-
 20 cial Inspector General shall submit to the appro-
 21 priate congressional committees and the Secretary of
 22 Health and Human Services a report summarizing,
 23 for the period beginning on the date of the enact-
 24 ment of the Health Care and Education Reconcili-
 25 ation Act of 2010 and ending on the completion of

1 a fiscal year quarter after the date of enactment of
2 this Act, the activities during such period of the
3 Special Inspector General required under subsection
4 (e).

5 (2) QUARTERLY REPORTS.—Beginning with the
6 first full fiscal year quarter after the date of the en-
7 actment of this Act, not later than 30 days after the
8 end of each fiscal year quarter, during which the Af-
9 fordable Care Act is in effect, the Special Inspector
10 General shall submit to the appropriate congress-
11 sional committees and the Secretary of Health and
12 Human Services a report summarizing, for the pe-
13 riod of that quarter and, to the extent possible, the
14 period from the end of such quarter to the time of
15 the submission of the report, the activities during
16 such period of the Special Inspector General re-
17 quired under subsection (e).

18 (3) COMMENTS ON REPORT.—Not later than 30
19 days after receipt of a report under this subsection,
20 the Secretary of Health and Human Services shall
21 submit to the appropriate congressional committees
22 any comments on the matters covered by the report.

23 (4) PUBLIC AVAILABILITY; RECORDKEEPING.—

24 (A) IN GENERAL.—The Special Inspector
25 General shall publish on a publicly available

1 website each report described under this sub-
2 section and any comments on the matters cov-
3 ered by the report submitted pursuant to para-
4 graph (3).

5 (B) REQUIREMENT TO INDEX.—Except as
6 provided in subparagraph (C), the Special In-
7 spector General shall, to the greatest extent
8 possible, index and publish on the publicly
9 available website information for each source
10 used in each report described under this sub-
11 section, including whenever applicable the docu-
12 ment name, author, and owner.

13 (C) EXCEPTION TO INDEX REQUIRE-
14 MENT.—The Special Inspector General may ex-
15 cept with a written note of exclusion certain in-
16 formation required to be published pursuant to
17 subparagraph (B) that the Special Inspector
18 General determines is—

- 19 (i) necessary to protect an individual
20 that provided the information; or
21 (ii) classified.

22 (D) RECORDKEEPING REQUIREMENT.—All
23 source material and information used to create
24 a report described under this subsection, includ-
25 ing information excepted under subparagraph

1 (C), shall be identified, indexed (in a classified
 2 annex, if necessary), and maintained (including
 3 any written note of exclusion) by the Special In-
 4 spector General.

5 (5) PROTECTED INFORMATION.—To the extent
 6 possible, information submitted in any report re-
 7 quired under this subsection shall be in a form that
 8 is not prohibited from disclosure under section 552a
 9 of title 5, United States Code (commonly known as
 10 the Privacy Act of 1974).

11 (6) AGGREGATED INFORMATION.—The Special
 12 Inspector General shall, to the maximum extent pos-
 13 sible, aggregate any personally identifiable informa-
 14 tion submitted in a report required under this sub-
 15 section.

16 (j) AMENDMENT TO THE INSPECTOR GENERAL
 17 ACT.—Section 8D of the Inspector General Act (5 U.S.C.
 18 App.) is amended in subsections (e) and (f) by inserting
 19 after “for Tax Administration”, each place it appears, the
 20 following: “and the Special Inspector General for Moni-
 21 toring the Affordable Care Act”.

22 (k) TERMINATION.—The Office of the Special Inspec-
 23 tor General shall terminate the earlier of—

24 (1) January 1, 2025; or

1 (2) the date on which the final report required
 2 by subsection (h) is submitted for the last year the
 3 Affordable Care Act is in effect.

4 (l) DEFINITIONS.—In this section:

5 (1) AFFORDABLE CARE ACT.—The term “Af-
 6 fordable Care Act” means the Patient Protection
 7 and Affordable Care Act and title I and subtitle B
 8 of title II of the Health Care and Education Rec-
 9 onciliation Act of 2010.

10 (2) APPROPRIATE CONGRESSIONAL COMMIT-
 11 TEES.—The term “appropriate congressional com-
 12 mittees” means—

13 (A) the Committees on Appropriations; the
 14 Budget; Education and the Workforce; Energy
 15 and Commerce; Homeland Security; the Judici-
 16 ary; Oversight and Government Reform; Small
 17 Business; and Ways and Means of the House of
 18 Representatives; and

19 (B) the Committees on Appropriations; the
 20 Budget; Commerce, Science, and Transpor-
 21 tation; Finance; Health, Education, Labor, and
 22 Pensions; Homeland Security and Govern-
 23 mental Affairs; the Judiciary; and Small Busi-
 24 ness and Entrepreneurship of the Senate.

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