S. HRG. 114–557

HEALTHCARE.GOV: A REVIEW OF OPERATIONS AND ENROLLMENT

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED FOURTEENTH CONGRESS

SECOND SESSION

MARCH 17, 2016

Printed for the use of the Committee on Finance

U.S. GOVERNMENT PUBLISHING OFFICE

24–057—PDF WASHINGTON : 2017

For sale by the Superintendent of Documents, U.S. Government Publishing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
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HEALTHCARE.GOV: A REVIEW OF OPERATIONS AND ENROLLMENT

THURSDAY, MARCH 17, 2016

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:03 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Orrin G. Hatch (chairman of the committee) presiding.

Present: Senators Burr, Isakson, Coats, Heller, Scott, Wyden, Stabenow, Brown, and Bennet.

Also present: Republican Staff: Chris Campbell, Staff Director; Christopher Armstrong, Deputy Chief Oversight Counsel; Kimberly Brandt, Chief Health-care Investigative Counsel; and Jill Wright, Detailee. Democratic Staff: Joshua Sheinkman, Staff Director; David Berick, Chief Investigator; Elizabeth Jurinka, Chief Health Advisor; and Juan Machado, Professional Staff Member.

OPENING STATEMENT OF HON. ORRIN G. HATCH, A U.S. SENATOR FROM UTAH, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The committee will come to order. It has been a little bit disruptive here this morning. We have a lot on our plate. It is a pleasure to welcome everybody here this morning.

Today, we will be talking with representatives from the Office of Inspector General for the Department of Health and Human Services and from the Government Accountability Office about their ongoing oversight work with respect to *HealthCare.gov* and enrollment in the Federal health insurance marketplace. I want to thank both entities for their hard work on these issues and acknowledge the contributions both have made to help this committee perform more accurate and timely oversight.

Now, it is no secret that I have never been a fan of the so-called Affordable Care Act, and, as we approach the sixth anniversary of this law and look closely into how it is working and being implemented, the evidence overwhelmingly shows that I and the many others who opposed the law from the beginning have been right all along.

The facts speak for themselves. Since Obamacare was signed into law, HHS/OIG and GAO have cumulatively released at least six dozen reports detailing various operation and implementation issues, demonstrating the numerous areas where the law is falling short. These reports are specific and focused on key operational failures, like enrollment controls or system issues, some of which we will hear more about today.

Let us keep in mind that GAO and HHS/OIG are not partisan entities. They are independent watchdogs tasked with the responsibility of objectively and dispassionately assessing what is and what is not working in various Federal programs, including those created or amended by the Affordable Care Act. And there is no better record showing how this happened than the reports we received from these offices.

Today, we are going to specifically discuss operations issues related to *HealthCare.gov* and enrollment problems at the Federal insurance marketplace, otherwise known as the Federal exchange.

Let us start with the *HealthCare.gov* launch. As a result of numerous problems and shortcuts taken with the initial development and deployment of *HealthCare.gov* and its supporting systems, consumers encountered widespread performance issues when trying to create accounts and enroll in health plans.

After numerous inquiries and reports, we now know what ultimately caused these performance issues. For example, there was inadequate capacity planning. The Centers for Medicare and Medicaid Services, CMS, cut corners and did not plan for adequate capacity to maintain *HealthCare.gov* and its supporting systems.

There were also problems with the software that were entirely avoidable. CMS and its contractors identified errors in the software coding for the website, but did not adequately correct them prior to the launch, and we saw a lack of functionality as CMS did not adequately prepare the necessary systems and functions of the website and its supporting systems prior to the initial launch.

CMS also failed to apply recognized best practices for system development, which contributed to the problem. Admittedly, since the initial launch, CMS has taken steps to address these problems, including increasing capacity, requiring additional software quality reviews, and awarding a new contract to complete development and improve the functionality of key systems. However, many of the problems have still not been entirely resolved and continue to cause frustration, especially for consumers trying to obtain health insurance.

I wish we could boil down all of Obamacare's problems to the functions of a single website. Indeed, if this was just an IT problem, all of our jobs would be a lot easier. However, the problems with Obamacare, and the Federal insurance marketplace in particular, go much deeper, and many of them remain unaddressed.

We know, for example, that the enrollment controls for the Federal marketplace have been inadequate. During undercover testing by GAO, the Federal marketplace approved insurance coverage with taxpayer-funded subsidies for 11 out of 12 fictitious phone or online applicants. In 2014, the GAO applicants—which, once again, were fake, made-up people—obtained a total of about $30,000 in annual advanced premium tax credits, plus eligibility for lower insurance costs at the time of the service. These fictitious enrollees maintained subsidized coverage throughout the year even though GAO sent either clearly fabricated documents or no documents at all to resolve the application inconsistencies.

While the subsidies, including those granted to GAO's fictitious applicants, are paid to health-care insurers, they nevertheless represent a benefit to consumers and a cost to the government.

Now, GAO did find that CMS relies on a contractor charged with document processing to basically uncover and report possible instances of fraud. Yet, GAO also found that the agency does not require that the contractor have any fraud detection capability.

According to GAO, CMS has not performed a single comprehensive fraud risk assessment—the recommended best practice—of the Obamacare enrollment and eligibility process. Until such assessment is completed, CMS is unlikely to know whether existing control activities are suitably designed and implemented to reduce inherent fraud risk to an acceptable level. In other words, CMS is not even sure if CMS's fraud prevention systems are designed correctly or if they are effective.

Lastly, while it is not the focus of the reports that will be covered by the testimony today, another matter we have been tracking closely and where the GAO is issuing a report today is CMS's oversight of the health care CO-OPs. We had a hearing on this topic in late January, where we examined a number of financial and oversight-related explanations for the abject failure of the CO-OP programs.

Today's GAO report describes CMS's efforts to deal with financial or operations issues at the CO-OPs, including the use of an escalation plan for CO-OPs with serious problems that may require corrective actions or enhanced oversight.

As of November 2015, 18 CO-OPs had enough problems that they had to submit to a CMS escalation plan, including nine that have discontinued operation. And just last week, we heard that yet another CO-OP, this time the one in Maine, is on the verge of financial insolvency, despite the fact that it had been on a CMS-mandated escalation plan.

In other words, CMS's efforts to address all the problems faced by CO-OPs appear to have failed, just like virtually every other element of this program. The failure of CMS to adequately implement the CO-OP program is well-documented here on the Finance Committee and elsewhere. As with so many other parts of Obamacare, the high-minded rhetoric surrounding this program has fallen short of reality.

With nearly half of the CO-OPs now closed, the failed experiment has wasted taxpayer dollars and forced patients and families to scramble for new insurance. With so many CO-OPs now in financial jeopardy, I believe that CMS should work with and not against States to safeguard taxpayer dollars.

So as always, we have a lot to discuss, and I look forward to hearing more from the officials we have testifying here today.

So with that, I will turn to Senator Wyden for his opening remarks.

[The prepared statement of Chairman Hatch appears in the appendix.]

OPENING STATEMENT OF HON. RON WYDEN, A U.S. SENATOR FROM OREGON

Senator WYDEN. Thank you, Mr. Chairman.

Mr. Chairman and colleagues, it is old news that the initial rollout of *HealthCare.gov* 3 years ago was botched. It is new news that the Inspector General of the Health and Human Services Depart-

ment recently said, and I want to quote here—this is a quote, colleagues, from the Inspector General: "CMS recovered the *HealthCare.gov* website for high consumer use within 2 months and adopted more effective organizational practices." That is what the Inspector General said, that the Department recovered the website for high consumer use within 2 months. That quote comes from one of two reports looking back at 2013 and 2014 that the Finance Committee will be presented with today.

I think we ought to start by recognizing that the story here is well-documented. After the launch went badly, some of the best minds in technology and a new contractor were brought in. They scrambled to overhaul the system, and the exchange was soon up and running, and the Centers for Medicare and Medicaid Services are now following up on each of the Inspector General's recommendations, which the Inspector General notes in its report.

In the most recent enrollment period, nearly 10 million Americans used *HealthCare.gov* to sign up for a plan or reenroll automatically. In my home State, which had its own problems, close to 150,000 people have used the website to sign up for a plan as of January 31st. That is up by more than 30 percent compared to last year.

The committee will also hear an update from the Government Accountability Office on what has been called the secret shopper investigation. The Government Accountability Office first brought this study before the committee in July of last year. I am going to repeat what I said back then.

On this side of the aisle, we do not take a back seat to anybody in fighting fraud and protecting taxpayer dollars—$1 ripped off is $1 too many. But let us recognize that what was true last summer remains true today.

This GAO investigation has not uncovered one single shred of real-world fraud in the insurance marketplace. It was built on fictitious characters with specially created identities, not real consumers and not real fraudsters. It is true that the Government Accountability Office found that there are sometimes differences between the information on somebody's insurance application and their tax forms and citizenship records. But when it comes to these inconsistencies in people's data, this investigation cannot differentiate between fraud and a typo.

Meanwhile, Health and Human Services does not look the other way when it finds the red flags. In 2014, the year of GAO's investigation, the Centers for Medicare and Medicaid Services closed more than 100,000 insurance policies because documents did not match or were not provided. Tax credits were adjusted for nearly 100,000 households. In 2015, Health and Human Services closed more policies and adjusted more tax credits.

If you come at this from the left, you might say that is too harsh. If you come at it from the right, you might take a different view. But there is no basis whatsoever for the argument that Health and Human Services ignores problems in people's records or leaves the door open to fraud. It seems to me, rather than rehashing old news, we ought to be looking at the facts and talking in a bipartisan way about how to move forward together.

Because of the Affordable Care Act, the number of Americans without health insurance is at or near its lowest point in half a century. For the 160 million people who get their insurance from their employer, colleagues, premiums climbed 4 percent last year. Let me repeat that. For 160 million people who get their insurance from their employer, premiums climbed only 4 percent. Working-age Americans in Oregon and nationwide with preexisting conditions—80 million people or more—can no longer be denied insurance.

So, instead of battling out what happened 3 years ago, we ought to be pulling on the same end of the rope and solving some problems. For example, Democrats and Republicans ought to be working together to look at ways in which we can provide even more competition and bring costs down for consumers, and a lot of you in this room have worked with me on that issue for some time.

Second, there are going to be spectacular new cures in the future, and there are real questions as to whether our health-care system is going to be able to afford them. Here, Senator Grassley has worked very closely with me to put together a bipartisan case study, which looked at one blockbuster drug involving hepatitis C. Solving the cost of these blockbuster drugs is going to take a lot of hard work. It, again, can only be done on a bipartisan basis.

Finally, I want to express my appreciation to colleagues on both sides of the aisle, because I think we are on the cusp of being able to make real progress on a huge opportunity for older people in our country, and that is protecting the Medicare guarantee, this very sacred guarantee we have for seniors, while updating the program to look at the great new challenge, which is chronic illness.

I want to thank Senator Bennet, who was out in front on this issue for some time. He is not here, but Senator Isakson and Senator Warner were champions as well. I want to express my appreciation to the chairman for the progress that we are making.

I have to make some comments with respect to something we did not know about until about an hour ago, and that is this matter of the CO-OPs.

What we have said is that we want to work in a bipartisan way to improve a variety of sections of the Affordable Care Act. Now, this new material on the CO-OPs, which neither I nor anyone on this side knew anything about, was available something like an hour ago. I intend to look at it with an eye to what can be done on a bipartisan basis going forward.

But my work, and I think the work of colleagues here, always ought to come back to this idea of making health-care policy more accessible and more affordable. And for now—and I certainly have not seen this report—I am not going to be participating in any celebration of people suffering, because the CO-OPs were tied up in a congressionally induced economic straightjacket.

Thank you, Mr. Chairman.

[The prepared statement of Senator Wyden appears in the appendix.]

The CHAIRMAN. Thank you, Senator.

I am going to introduce today's witnesses. Our first witness is Ms. Erin Bliss, the Assistant Inspector General for Evaluation and Inspections in the Office of Inspector General, or OIG, at HHS.

Ms. Bliss has served in many roles at OIG since her career began. I think your career began in 2000, if I have it correctly. She started as an analyst for the Office of Evaluation and Inspections and later went on to serve as a senior advisor, where she provided management advice and expert analysis to the Inspector General and other senior executives on programmatic priorities and internal policies and operations.

Afterwards, she worked from 2009 to 2014 as Director of External Affairs at OIG and was responsible for overseeing and implementing OIG's communication strategies and relationship management with the administration, Congress, media, the health-care industry and providers, and the public.

Ms. Bliss received her bachelor's degree in government from the University of Notre Dame before receiving her master's degree in public policy from the University of Chicago.

Our second witness is Mr. Seto Bagdoyan, the Director for Audit Services in GAO's Forensics, Audits, and Investigative Service Mission Team. During his GAO career, Mr. Bagdoyan has served in a variety of positions, including as Legislative Advisor in the Office of Congressional Relations and as Assistant Director for Homeland Security in Justice.

Mr. Bagdoyan has also served on congressional details with the Senate Finance Committee and the House Committee on Homeland Security. We are glad to see you back here again.

Mr. Bagdoyan has also held a number of senior positions in consultancies in the private sector, including most recently focusing on political risk in homeland security.

Mr. Bagdoyan received his bachelor's degree in international relations and economics from Claremont McKenna College and an MBA in strategy from Pepperdine University.

I want to thank you both for coming. We will hear the witness testimonies in the order that they were introduced.

Ms. Bliss, please proceed with your 5-minute statement.

STATEMENT OF ERIN BLISS, ASSISTANT INSPECTOR GENERAL FOR EVALUATION AND INSPECTIONS, OFFICE OF INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Ms. BLISS. Thank you. Good morning, Chairman Hatch and other distinguished members of the committee. Thank you for the opportunity to testify today about the Office of Inspector General's case study which examines the management of *HealthCare.gov*.

This is the website consumers use to apply for health insurance through the Federal marketplace. As is well known, on October 1, 2013, the *HealthCare.gov* website failed almost immediately upon launch. Yet, within 2 months, CMS had substantially improved the site's performance.

How did such a high priority project start so poorly, and how did CMS turn the website around? Our case study provides insights into these questions and lessons learned to help *HealthCare.gov* and other Federal projects work better.

We believe that our assessment of the intersection of technology, policy, and management can benefit a broad range of Federal projects and programs. Our report chronicles the breakdown and turn-

around of *HealthCare.gov* over a 5-year period. This morning I will summarize the highlights.

From the outset, the *HealthCare.gov* project faced a high risk of failure. It was technically complex, with a fixed deadline and many uncertainties. Still, HHS and CMS made many missteps in its implementation. Most critical was the absence of clear leadership and overall project responsibility, which had ripple effects.

Policy decisions were delayed, affecting the technical decisions. Policy and technical staff were in silos and not well-coordinated, and contract management was disjointed. Changes to the project were not well-documented and progress not adequately monitored.

This culminated in CMS not fully communicating or acting upon many warnings of problems before the launch. CMS failed to fully grasp the poor status of the build. One reason was that no one had a full view into all of the problems and how they fit together.

Red flags raised to leadership did not always flow to staff working on the build, and staff did not always alert leadership to problems on the front lines. CMS was unduly optimistic.

Last-minute attempts to correct problems were rushed and insufficient. In the 2 months before the launch, CMS added twice the staff to the project and cut many planned website functions. And just 72 hours ahead, CMS asked its contractor to double its computing capacity.

Even with these efforts, the *HealthCare.gov* website experienced major problems within hours of its launch. The website received five times the number of expected users, but the problems went beyond capacity. The website entry tool worked poorly, and software coding defects caused malfunctions. CMS and its contractors did not have coordinated tools to diagnose these problems. However, CMS pivoted quickly to make corrections to the website. They brought in additional staff and expertise from across government and the private sector.

One key was creating a badgeless culture, where Federal employees and contractors worked together as a team. CMS designated clear leadership, integrated policy and technical staff, and developed redundant systems to avoid future website problems.

CMS also took a more realistic approach to building website functions. It practiced what officials called ruthless prioritization, which focused on effectively developing the most critical functions, like reenrollment, and delaying other features. They measured progress and monitored problems to respond more quickly and effectively. These factors contributed to an improved website and important organizational changes.

Looking ahead, CMS continues to face challenges in improving *HealthCare.gov* and managing the Federal marketplace. This includes addressing more than 30 recommendations from OIG's other Federal marketplace reports. We will continue to monitor CMS's actions in response to our recommendations and its overall management of this and other programs.

Thank you again for inviting OIG to speak with the committee today, and I will be happy to answer your questions.

[The prepared statement of Ms. Bliss appears in the appendix.]

The CHAIRMAN. Thank you so much.

Mr. Bagdoyan, we will turn to you.

STATEMENT OF SETO J. BAGDOYAN, DIRECTOR OF AUDITS, FORENSIC AUDITS AND INVESTIGATIVE SERVICE, GOVERNMENT ACCOUNTABILITY OFFICE, WASHINGTON, DC

Mr. BAGDOYAN. Good morning, Chairman Hatch, Ranking Member Wyden, and members of the committee. I am pleased to be here today to discuss results from our February 2016 report on enrollment and verification controls for ACA health-care coverage obtained through the Federal marketplace during the 2014 open enrollment period.

Our results are based on extensive forensic analyses of relevant data from CMS and other agencies, such as SSA, IRS, and DHS—involving originally the entire 2014 applicant and enrollee universe—and are independent of the undercover work we performed for that period.

A central feature of ACA's enrollment controls is the Federal data services hub, which is the primary vehicle for CMS to initially check information provided by applicants against various Federal data sources. In addition, the ACA established a process to resolve inconsistencies, *i.e.,* instances where applicant information does not match that from marketplace sources.

In terms of context for our work, coverage offered through the Federal marketplace is a significant expenditure for the Federal Government. Current levels of coverage involve millions of enrollees, of whom about 85 percent receive subsidies. CBO has estimated Fed subsidy costs at about $880 billion for fiscal years 2016 through 2025.

I would note that while subsidies are paid to insurers and not directly to enrollees, they nevertheless represent a financial benefit to them. As I have stressed before, a program of this scope and scale remains inherently at risk for errors, including improper payment and fraud. Accordingly, it is essential that effective enrollment controls are in place to help narrow the window of opportunity for such risk and safeguard the government's investment.

Against this backdrop, I will now discuss our two principal analytical results.

First, we found that CMS does not track or analyze aggregate outcomes of data hub inquiries or the extent to which a queried agency delivers information responsive to a request or whether an agency reports that that information was not available.

In this regard, for example, we found that SSA could not match 4.3 million queries related to names, dates of birth, or Social Security numbers, and 8.2 million queries related to citizenship claims. IRS could not match queries involving about 31 million people related to income and family size, and, within this, 1.3 million people had ID theft issues. Finally, DHS could not match 510,000 queries related to citizenship and immigration status.

Accordingly, CMS foregoes opportunities for gaining valuable insights about significant program integrity issues, including vulnerabilities to potential fraud, as well as information useful for enhancing overall program management.

Second, we found that CMS did not have an effective process for resolving inconsistencies for applicants using the Federal marketplace. For example, we found that about 431,000 applications, with about $1.7 billion in associated subsidies, still had about 679,000

inconsistencies unresolved as of April 2015. That is 4 months after the close of the 2014 coverage year.

Within these, CMS did not resolve Social Security number inconsistencies for about 35,000 applications, with about $154 million in associated subsidies, or incarceration inconsistencies for about 22,000 applications, with about $68 million in associated subsidies.

By leaving inconsistencies unresolved, CMS risks granting eligibility to and making subsidy payments on behalf of individuals who are ineligible to enroll in qualified health plans. One important example emphasizes this point. According to IRS, accurate data are vital for income tax compliance and the reconciliation of advanced premium tax credits through filing tax returns, which is a key backend control under ACA.

In closing, our work to date collectively shows that CMS has assumed a generally passive approach to managing fraud risks in ACA, weakening the program's integrity. Accordingly, we continue to underscore that CMS needs to make ACA program integrity a priority and implement effective controls to help reduce improper payment and fraud risks and preclude them from being embedded early in the program's life cycle.

In this regard, we made eight recommendations to CMS in our February report, which are intended to help mitigate the vulnerabilities and risks we identified. While the agency agreed with the recommendations, it is incumbent on CMS to implement them in a timely fashion and achieve and sustain measurable results.

Mr. Chairman, this concludes my statement. I look forward to the committee's questions, and I appreciate the indulgence for an extra 30 seconds.

[The prepared statement of Mr. Bagdoyan appears in the appendix.]

The CHAIRMAN. I am happy to give you that extra time.

Ms. Bliss, previous reports at the Office of Inspector General criticized *HealthCare.gov* and the marketplace, describing important problems with internal controls, such as inadequate procedures for checking the eligibility of enrollees.

How does the case study differ from previous reports of the Office of Inspector General on the same topic?

Ms. BLISS. Thank you for your question, Mr. Chairman. The case study is one of a dozen reports that OIG has issued on the Federal marketplaces. Most of those were more-targeted audits or evaluations examining aspects of eligibility controls, payment accuracy, contracting, and security of information.

The case study took a different approach and cast a wide lens at CMS's management of the project in its entirety, from multiple perspectives and over a long period of time, in order to glean lessons learned about what went wrong and what went right in an effort to help improve both this *HealthCare.gov* project and other Federal projects moving forward.

The CHAIRMAN. Thank you.

Mr. Bagdoyan, your report pointed out the key role played by the, quote, "data services hub," which is the electronic clearinghouse for checking applicant information against Federal databases.

Now, you said that CMS needs to make better use of this important enrollment control process. Would you explain that a little bit?

Mr. BAGDOYAN. I would be happy to do that, Mr. Chairman.

Basically, the data hub is a key cog, if you will, in the overall control environment for ACA. It is up-front. It processes a lot of queries for information. A lot of those queries—all of those queries, in fact, are not captured for future analysis.

We believe that such capture and analysis would provide CMS with a lot of insight into potential indicators of improper payments, as well as fraud. So a comprehensive control system would theoretically enable that sort of analysis for the long term, and we do actually have a recommendation to that effect to CMS.

The CHAIRMAN. Thank you. We have been long told by CMS, "Do not worry. Even if there are issues with awarding subsidies, everything eventually gets fixed when people file their income taxes."

The GAO found practices that undermine tax compliance. Am I right about that?

Mr. BAGDOYAN. Yes. We identified a number of inconsistencies. Out of the 431,000, I believe we had about 35,000 that involved tax or SSN inconsistencies. And according to IRS, when we discussed this at length, they told us that this was not only important for tax compliance purposes, but also for the tax reconciliation process to reconcile the advanced premium tax credits at the end.

This is the third main back-end control, if you will, in the overall setup. So without that information that is accurate and reliable, IRS pointed out that their job is made much more difficult, not only to do the tax return processing, but also to reconcile the subsidies.

So it is a long-term problem if it is not addressed.

The CHAIRMAN. All right. Ms. Bliss, what are the most important lessons learned from *HealthCare.gov* for the administration, and do you think that the lessons learned from your case study apply to other large programs and projects, whether being planned by the Department of Health and Human Services or other government agencies?

Ms. BLISS. Thank you. We certainly do. The intersection between policy, technology, and management is not only essential for *HealthCare.gov*, but we believe these lessons will apply to other Federal projects and Federal programs.

We gleaned 10 lessons learned, and I will highlight what I believe to be the three most significant.

First is establishing clear leadership. We found that the lack of clear leadership in overall responsibility and clear lines of delegation had ripple effects, caused a number of cascading problems across the project, and made problem resolution more difficult.

We also found that a disconnect between those working on the policy and making decisions and those working on the technical aspects of the project created problems on both sides. And delays in policy decision-making compressed an already tight time frame for achieving the technical build successfully.

So, better integration across lines of business, policy, and technical, as well as across government and contractors through this badgeless culture, are some of the keys we saw to correction and success.

And then, finally, taking a posture of continuous learning is essential, which means being flexible and adaptable, especially with a startup-type project like *HealthCare.gov* was. We found that CMS got stuck on an unwinnable path, and it was too late before they realized it and tried to make changes.

So keeping that continuous learning posture, being innovative and flexible, and constantly monitoring for problems to adjust plans where needed are all important.

Thank you.

The CHAIRMAN. Thank you.

Senator Stabenow, we will turn to you.

Senator STABENOW. Thank you very much, Mr. Chairman. And welcome and thank you to both of you.

Ms. Bliss, I am wondering—to start, just a "yes" or "no" question. Based on your case study, do you think that the *HealthCare.gov* website should be taken down and a completely new website be built?

Ms. BLISS. No.

Senator STABENOW. Thank you. Like many of my colleagues, we were very frustrated about what happened in the past, and clearly you have laid out the problems with the launch, and I think everyone agrees that there were serious problems with the launch of *HealthCare.gov* and it created a lot of difficulties, and certainly for people in Michigan, to get coverage in 2013.

But that was 3 years ago, and we are now in year 3 of the Affordable Care Act marketplace operations. So when we look at the report, the report is really looking backwards, and we can agree there were problems.

The question is moving forward and how do we ignore the fact that over 20 million people have received health-care coverage because of the Affordable Care Act, literally saving people's lives? That is not just a rhetorical statement. I have talked to people who were able to get surgery or were able to get care for their children that they have never been able to receive before and save lives, and I think that is a good part of things when we talk about the numbers, the real-life experiences of people.

The un-insurance rate is the lowest it has ever been, and Medicaid expansion has resulted in literally millions of our most vulnerable families receiving the care that they deserve.

So, given the fact that the ACA is the law of the land and it is our responsibility to make it better, I first want to say that I hope that all of us will work on how to make it better, and that is why we appreciate your recommendations as we look forward, not just in the case of this particular website and process, but others as well.

But the question is, how do we make it better? So we want to make sure that we have quality access to health care for every American, whether it is Medicare, Medicaid, the Children's Health Program, and so on and so on.

So with that in mind, Mr. Bagdoyan, let me ask about any other recommendations from a GAO standpoint that you have not already spoken of today on how we can make these better, because, frankly, I want the over 20 million people who have health insurance today who did not have it before to have the peace of mind

going to bed at night of knowing they are going to be able to take their children to a doctor if they get sick. I want to keep that. And I am hopeful we can even get as close to zero as possible in terms of the number of people in our country who do not have access to health care.

So I am interested in your recommendations on how we go forward to work together to make this system work better.

Mr. BAGDOYAN. Sure. Thank you for your question, Senator Stabenow.

As you mentioned, we operate under the premise that this is the law on the books, and my charge is to help make it work as intended. With that in mind, our report makes eight specific recommendations. We try not to be too prescriptive to allow CMS some latitude to explore various options.

However, the key recommendation, I believe, the big-picture recommendation, is for CMS to conduct a comprehensive risk assessment of the entire program, sort of top to bottom, and identify the control vulnerabilities and the risks for improper payments and fraud.

In that regard, GAO issued, in July of 2015, its framework for managing fraud risk in Federal programs. So that is a comprehensive leading practice compilation from the private and public sectors that would provide the agency with quite a solid roadmap to perform that risk assessment.

So everything should flow from that assessment in terms of the types of actions, policy changes, control improvements, and so forth.

Senator STABENOW. And are you working with CMS? What is their reaction on this? Are they objecting to that?

Mr. BAGDOYAN. No. I think I should give CMS credit that they accepted all eight recommendations, including this one. But as they say, the proof is in the pudding. They need to execute, do so successfully, and then achieve results and sustain them over the long term. This is not a one-and-done proposition by any means.

Senator STABENOW. Sure. So just to be clear, you have made the recommendations. They have accepted all eight recommendations, and they are in the process of doing them.

Mr. BAGDOYAN. That is correct. We had informal discussions, as well as the formal letter responding to our recommendations.

Senator STABENOW. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Coats?

Senator COATS. Thank you, Mr. Chairman. And I want to thank our two witnesses.

Lord knows where we would be if we did not have GAO and Inspectors General. The alarming malfeasance and incompetence of the rollout of this plan is just stunning. And here we are, we cannot just simply brush it off and say, well, this was a bad start, but everything is going great now.

On the cost to the taxpayer, probably we will never know. But thank goodness that we have your organizations providing us information and spurring on a seemingly bureaucratic nightmare that exists within the Federal Government in terms of handling these kinds of programs.

Anybody in the private sector who had done this would have been bankrupt; investors would have lost all their money. It is just stunning to continue to observe what it takes to get these agencies to—I think they are well-intended, they are just overwhelmed in terms of the complexity of getting this done.

I go the floor of the Senate every week and talk about a waste of the week, and, Mr. Bagdoyan, I have referenced your name, not as part of the problem, but as part of the solution. And the information that you have provided here for me continues to stun people when they hear about some of the incompetency.

I was particularly interested, because I think it speaks to a bigger problem, in your, what was called the secret shopper investigation, where you deliberately made applications as a test—you made applications for compliance with the Affordable Care Act and receiving subsidies. And 11 of the 12—I think my numbers are right—everything you submitted was fraudulent, but 11 of the 12 were accepted. And even after it was revealed that they were accepted, follow-up phone calls, pretending to be that person who was given notice that they were not eligible, were accepted.

That percentage is pretty high, and if you multiply that out, it just really makes you wonder if this whole thing was not gamed or at least so intent on providing numbers to make it look successful that we really were not getting the information, the verification, that we needed.

Then there was the question with CMS at one point releasing a statement, "Well, we are not in the verification business." I think basically what you just said was that they are now taking a different stand on that.

But I wonder if you could respond to where are we now in terms of verification capacity so that we do not have this fraudulent and wasteful situation moving on. I am happy to have either one of you or both of you address that. But it just seems easy: an evaluation of Social Security numbers to determine their validity would make it fairly easy to make a determination as to whether they qualify or whether they do not qualify.

But where is CMS in terms of putting that process in place, and what is the success to date of that process?

Mr. BAGDOYAN. Sure. If I may, Ms. Bliss, take first crack on that.

First, I appreciate the plug on the floor, Senator.

Senator COATS. Sure. [Laughter.]

Keep sending us stuff; I will keep going to the floor.

Mr. BAGDOYAN. So in terms of where CMS is with the controls, what we call the control environment, which is a series of controls designed to verify information, identify potential indicators of fraud, and so forth, as our undercover work indicated, both for 2014 and 2015, where we were equally successful, there is a semblance of controls in place.

Senator COATS. A semblance?

Mr. BAGDOYAN. A semblance of controls in place, some basic things in place, like identity-proofing the document reconciliation process to clear inconsistencies, for example. But in each case, we were able to work around those reasonably easily and obtain coverage both for 2014 and 2015. So the vulnerabilities are still in place.

Now, with the recommendations we made in this report, actually, in late February, we made eight recommendations. As I explained to Senator Stabenow, the big one is to perform a comprehensive risk assessment.

Now, that is going to take time. It is going to take time for CMS to absorb the results and then craft, hopefully, appropriate solutions for the future. So this is a long-term proposition. It is not going to be an easy fix.

Senator COATS. Well, I think this speaks to the point that we got a bad start and everything is going great right now. Everything is not going great right now. As you said, this is going to take a long-term effort to try to put these verification procedures in place and to be able to say that we are successfully avoiding fraud and waste and an inefficiency and taxpayer cost level that is just absolutely astounding.

So, with due respect to my colleagues, to tout this as something that has happened in the past but is corrected now and we are sailing into the bright future, I think we have a lot of work to do.

Thanks, Mr. Chairman.

The CHAIRMAN. Senator Wyden?

Senator WYDEN. Thank you, Mr. Chairman.

I want to again say that the initial rollout was botched, and I appreciated the Inspector General making it clear that a couple months in, there was serious progress.

So you all reported that after the first open enrollment, the agency demonstrated a strong sense of urgency to take action, accepted new work processes, and they, quote, "improved the *HealthCare.gov* website substantially within 2 months."

I think it would be helpful, Ms. Bliss, if you could tell us two things. What were the operational and strategic changes that were made after that first open enrollment, and do you feel they are better-equipped to deal with the challenge now?

Ms. BLISS. Thank you, Ranking Member Wyden, for that question. As we discussed in the case study, some of the key strategic and operational changes that were made as part of the correction were to, one, establish more clear leadership and designate roles and responsibilities, and they did it in a way that really brought together staff and contractors across all of the important business lines that were affected and needed to be involved in the correction. That includes the policy people, the technical, the communications, and the contractors all coming together.

With the influx of experts from across government and the private sector, there was the potential that it could have become more chaotic, but, in fact, we saw that the reverse was true. It was well-organized. Folks were working together in a badgeless culture as a team. There was better communication, there was better measurement and monitoring of problems, and there was progress in order to apply solutions more quickly and effectively.

Senator WYDEN. So, in effect, after the first few months, which everybody has acknowledged were not ideal, your characterization was that essentially it was well-organized.

Ms. BLISS. It was much better organized——

Senator WYDEN. I was using your word——

Ms. BLISS [continuing]. And they continue to make progress.

Senator WYDEN. All right. Good. Mr. Bagdoyan, first, I am probably the biggest user of GAO products here in the Congress. I so admire the professionalism of the agency, and I think you heard me say I do not take a back seat to anybody when it comes to cracking down on actual real-world fraud.

My question to you is, is it not correct that when you testified before the committee last year, you stated that the secret shopper investigation failed to uncover a single real-world example of fraud?

Mr. BAGDOYAN. Yes, that is what I said, Senator Wyden, and I would also couch that very carefully for you and the committee.

The intent of that investigation was not to uncover fraud but to flag control vulnerabilities, as well as identify indicators of potential fraud, which I think we did quite successfully.

So I just want to make clear my charge is not to find fraud. Fraud is determined through a separate criminal proceeding in courts to definitively determine that. So my job, again, is to look for vulnerabilities in controls, as well as identify indicators of potential fraud or improper payments.

Senator WYDEN. So let us go then from last year when there was not one single real-world example of fraud to where we are now. Is it correct to say that the entire investigation failed to identify any actual fraud?

Mr. BAGDOYAN. Well, again, I would refer you to my answer. That was not our intent. So if I am not looking for fraud, I am not going to find it. What I am looking for is vulnerabilities in controls and indicators of potential fraud, such as the inconsistencies with the Social Security numbers, as well as, in the case of the IRS, 1.3 million people having potential ID theft issues, which is a significant red flag.

Senator WYDEN. I think that, as is always the case, you all are right to talk about various issues that ought to be part of the debate. That is not what is going on here. What people are saying is, this is fraud, fraud, fraud, fraud, and I appreciate your taking us through this in, I think, a better-balanced view.

Ms. Bliss, at HHS, you all do audits, OIG does audits. Have you uncovered, in connection with this, any confirmed cases of fraud?

Ms. BLISS. No, we have not had any cases that have resulted in criminal convictions or civil settlements to date. We do have a few investigations that are ongoing, and I cannot predict what those outcomes will be.

Senator WYDEN. Look, I do not know how many times I have said in this committee that when there are big, important issues—and certainly the Affordable Care Act is right at the top—we need to work in a bipartisan fashion, and there is not a program anywhere in government where you cannot find opportunities to work together and be bipartisan.

I ticked off a number of them. The chairman and I are working together on what I think is the future of the Medicare program, chronic care; Senator Grassley and I are finishing what I think is a blockbuster study looking at hepatitis C. And it raises the question of, when we have cures, will people be able to afford them?

What I think is important is that, to do bipartisan work, we have to move away from, first, the past, because everybody has acknowl-

edged that the first few months were botched. I do not know how many times you can say it. But you all said—and I read your comments—after the first few months, you said they had made substantial improvements. I think I can come back to it and perhaps read it one more time.

"The Centers for Medicare and Medicaid Services recovered the health care government website for high consumer use within 2 months." Now, that is the new news. That is just a few weeks old. That is new news, and I want people to hear that, and I want people to hear that there were no actual real-world cases of fraud uncovered.

Now, one final question, if I might, for you, Ms. Bliss. Do you disagree with the statement that I made with respect to the accomplishments of the Affordable Care Act? That is not your formal role as Inspector General, but does anything strike you as being inaccurate there with respect to the uninsured rate or anything of that nature?

Ms. BLISS. As an independent oversight agency, we do not take positions on whether particular programs should exist, but we look to make sure they are operating correctly.

Senator WYDEN. That is not the question. The question was about the facts, and what I think, again, is, this is a hard fact that is not in dispute, that the uninsured rate is now at or near the lowest level recorded across 5 decades of data, with about 20 million previously uninsured Americans gaining coverage since the Act's provisions went into effect.

So I will keep the record open so that if you or your agency has any information suggesting that is wrong, I would surely like to know about it.

Ms. BLISS. Thank you. I do not have any information suggesting that that is wrong.

Senator WYDEN. Wonderful. Mr. Chairman, thank you.

The CHAIRMAN. Senator Scott?

Senator SCOTT. Ms. Bliss, do you have any information suggesting that those numbers are right?

Ms. BLISS. I cannot validate those numbers. I do not have any reason to believe they are not.

Senator SCOTT. But you have no indication either way, actually.

Ms. BLISS. I have no basis, no.

Senator SCOTT. If I tell you that the number is 30 million, you have no reason to believe that it is not 30 million.

Ms. BLISS. I do not have a basis for validating that number. Our case study—I am sorry.

Senator SCOTT. Thank you. Mr. Bagdoyan, our ranking member asked you several questions about fraud, and I certainly understand and appreciate why so many Americans look at this process and become disenchanted.

Your objective was never to figure out how much fraud was in the system. Your objective, it appeared to me, was to show us how fraud could happen.

Mr. BAGDOYAN. Yes, essentially, Senator, you are correct. The big picture we are looking at is for any vulnerabilities in the controls that are in place and also for any indicators of potential fraud that pop up. For example, our ability to circumvent the controls we en-

countered during our undercover work—we did that for 2014, and we repeated that experience in 2015, in which case we were successful 17 out of 18 attempts.

Now, I would have to caution that, of course, further to the point that Senator Coats made earlier, that is not a projectable number. So we have to be very careful that that does not represent the actual universe; that is just a data set that we use to continue our work in this area.

Senator SCOTT. Thank you very much. No one is going to mistake me for a fan of Obamacare or the ACA, without any question. For a number of reasons, I am not a fan of the website nor the actual policy itself, the legislation.

I think of the Independent Payment Advisory Board, what some have referred to as a death panel, and the ability to ration care into the future. This is one of the classic examples of why so few Americans have the same appreciation of the ACA that others have talked about.

I think the fact that we are talking about taxing Americans, whether it is their income or their profits, an additional 3.8-percent tax, raising somewhere over $120 billion, is another reason why so few Americans have the same positive theme that we have heard from some of our friends on the other side.

Think about the whole notion of how the health-care law is going to regulate the posting of calories at pizza parlors, grocery stores, all over the place, and, by default, increase the price of these groceries, these pizzas and other non-food items, reducing the number of employees' hours, talking about the impact on middle-income America, so many Americans losing perhaps up to 25 percent of their income because of the ACA.

We can see why so many Americans have found frustration with where we are with the ACA, that it is not old news to them.

It is not old news, actually, when you think about the fact that so many Americans are facing higher premiums. We have heard so many different numbers this morning. We know that at least some States have seen an increase of more than 25 percent in their health-care costs. Two States have seen those numbers go over 35 percent. Those are real dollars for struggling Americans who cannot afford the cost of health insurance.

Not only are the premiums higher, the deductibles are higher, the out-of-pocket expenses are higher. The only thing that is actually lower are the doctors to choose from and the hospitals to go to.

We have seen a catastrophic occurrence under this health-care law. And even at one of the most recent Democratic town halls, a young lady, supportive of President Obama, who supports the health-care law, said that her premiums had doubled, tripled. Her concerns were strong, clear.

Here is one real case example that, Ms. Bliss, I hope is no longer happening. A young man named Tom Dougall from Elgin, SC, who created an account on *HealthCare.gov*, was called shortly thereafter by a man named Mr. Justin Hadley from North Carolina who had done the exact same thing: gone online to *HealthCare.gov* and created an account. But what he found populating his account was information from Mr. Dougall.

He called HHS and could not get any assistance. Finally, they called our office, and, during one of the hearings, we were able to get that situation solved, or at least the beginning of that situation solved.

Can you guarantee me that that situation is no longer occurring anywhere within *HealthCare.gov*?

Ms. BLISS. I cannot guarantee that. We have overseen and conducted reviews of the controls to ensure that the website and other parts of the program for identity verification, no eligibility verification, are working properly. But we have raised concerns about some flaws or weaknesses in those controls, similar to GAO, and I cannot make that guarantee. But we are certainly working hard to identify where there is a vulnerability of that happening and make recommendations on how to improve it.

Senator SCOTT. My last statement, since I am out of time so quickly here today, is, it appears that as we have celebrated the success of improving the system in the first couple months—I will note it was a new $1-trillion program—one of the recommendations is for clear leadership. Earth-shattering. Thank you.

The CHAIRMAN. Senator Isakson?

Senator ISAKSON. Thank you, Mr. Chairman.

I apologize for missing your testimony, and I apologize for being late. But I do have one question based on a letter that I have sent previously to CMS, and I want to ask this question.

Mr. Bagdoyan, do you agree that increasing the utilization of existing, tested data sources is one easy way that CMS could reach the mutual goal of expanding program integrity and management and better assess fraud risk?

Mr. BAGDOYAN. Yes. That is, in fact, one of our recommendations to CMS: to consider doing that on an active basis, both to capture the data and then analyze the data for whatever indicators that they may throw off and act upon those. Yes.

Senator ISAKSON. Then do you have any idea when CMS is going to move forward to actually take advantage of that and do it?

Mr. BAGDOYAN. Well, as I stated before in response to several Senators' questions, CMS has accepted those recommendations. They are on record in writing as having done so. And as I said in my opening statement, it is now incumbent on the agency to take action on a timely basis. But as I said, it will take time to work through this. It is not an easy fix. It is not a short-term fix. It is not a one-and-done fix.

Senator ISAKSON. Well, I apologize for being late, because obviously you covered it in your opening statement. But there is readily available data and companies that are already under contract to CMS that are available to provide information that could greatly enhance the integrity of the program and uproot fraud a lot easier, and I appreciate your testimony to that effect.

Mr. BAGDOYAN. Yes. The data are available, definitely.

Senator ISAKSON. Thank you. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you. I want to thank our witnesses for appearing here today. The work that each of you does is very important, as far as we are concerned, you and your organizations. It is vitally important to this committee, and we are thankful for the

quality product that both the HHS/OIG and GAO produce to assist us in our policymaking and oversight efforts.

I also want to thank my colleagues for their participation in this important hearing. I think the hearing has been insightful. It has been enlightening. Unfortunately, I think this hearing further revealed that we are only now getting to the water level of the Obamacare iceberg, it seems to me.

As premiums continue to skyrocket and insurance options become more and more limited, an increasing number of Americans are being hung out to dry. Over the past year, we had a reasonable amount of consensus on several of the unworkable and failed provisions of Obamacare, but for some reason, many still have their heads stuck in the sand hoping that things will finally start working out at some point.

Now, I implore my Democratic colleagues to work with me and my Republican friends to repeal and replace the so-called Affordable Care Act before it is altogether too late. Insurance premiums and health-care costs continue to rise, and little is being done to stem the tide.

It is high time to put partisan politicking and bickering aside and find workable bipartisan solutions. There is more we can do. There is more we, it seems to me, have to do. Honestly, I earnestly believe that we can do it. The American people deserve better than what they have right now and, more importantly, than what they are about to have in the next few years.

So I encourage each of my colleagues to meet with me and find workable solutions, and I encourage both of you to keep doing the jobs that you are doing. They are very important to this committee and I think to our country at-large.

I would ask that any written questions for the record be submitted by Thursday, March 31st of this year.

With that, this hearing will be adjourned. Thank you for being here.

[Whereupon, at 11:10 a.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF SETO J. BAGDOYAN, DIRECTOR OF AUDITS, FORENSIC AUDITS AND INVESTIGATIVE SERVICE, GOVERNMENT ACCOUNTABILITY OFFICE

Chairman Hatch, Ranking Member Wyden, and members of the committee:

I am pleased to be here today to discuss enrollment and verification controls for health-care coverage that individuals obtain through the Federal health-insurance exchange under the Patient Protection and Affordable Care Act (PPACA). The act expands the availability of subsidized health-care coverage, and it provides for the establishment of health-insurance exchanges, or marketplaces, to help consumers in comparing and selecting among insurance plans offered by participating private issuers of health-care coverage. Under PPACA, States may elect to operate their own health-care marketplaces, or may rely on the federally facilitated marketplace, or Health Insurance Marketplace (Marketplace).[1] The Centers for Medicare and Medicaid Services (CMS), a unit of the Department of Health and Human Services (HHS), maintains the Federal Marketplace.

To be eligible to enroll in a qualified health plan offered through a marketplace, an individual must be a U.S. citizen or national, or otherwise lawfully present in the United States; reside in the marketplace service area; and not be incarcerated (unless incarcerated while awaiting disposition of charges). Marketplaces, in turn, are required by law to verify application information to determine eligibility for enrollment and, if applicable, determine eligibility for income-based subsidies the act provides.

PPACA provides subsidies to those eligible to purchase private health-insurance plans who meet certain income and other requirements. According to the Congressional Budget Office, the estimated cost of subsidies and related spending under the act is $880 billion for fiscal years 2016–2025. While subsidies under the act are not paid directly to enrollees, participants nevertheless benefit through reduced monthly premiums or lower costs due at time of service, such as copayments.[2] Because subsidy costs hinge on eligibility for coverage, enrollment controls that help ensure only qualified applicants are approved for coverage with subsidies are a key factor in determining Federal expenditures under the act.

A central feature of the enrollment controls is the Federal "data services hub" (data hub), which, among other things, provides a vehicle to check applicant-provided information against a variety of data sources.[3] Verification steps include vali-

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[1] Specifically, the act required, by January 1, 2014, the establishment of health-insurance marketplaces in all States. In States not electing to operate their own marketplaces, the Federal Government was required to operate a marketplace.

[2] Enrollees can pay lower monthly premiums by virtue of a tax credit the act provides.

[3] In particular, PPACA requires that consumer-submitted information be verified, and that determinations of eligibility be made, through either an electronic verification system or another method approved by HHS. To implement this verification process, CMS developed the data hub, which acts as a portal for exchanging information between the Federal Marketplace, State-based marketplaces, and Medicaid agencies, among other entities, and CMS's external partners, including other Federal agencies. The Marketplace uses the data hub in an attempt to verify that applicant information necessary to support an eligibility determination is consistent with external data sources.

dating an applicant's Social Security number, if one is provided;[4] verifying citizenship, status as a national, or lawful presence by comparison with Social Security Administration (SSA) or Department of Homeland Security (DHS) records; and verifying household income and family size by comparison against tax-return data from the Internal Revenue Service (IRS), as well as data on Social Security benefits from SSA.

If the eligibility information applicants provide to the Federal Marketplace cannot be verified through the external sources, such as SSA, IRS, and DHS, an "inconsistency" will result. In particular, an inconsistency can arise when the data hub query process yields no information; or when information is available through the data hub, but it does not match information the applicant has provided.[5]

My testimony today is based on a report we issued on February 23, 2016, that examined eligibility and enrollment controls, and fraud risk, of the Federal Marketplace.[6] It addresses:

1. The extent to which applicant information is verified through the data hub—the primary means for verifying eligibility; and
2. The extent to which the Federal Marketplace resolved inconsistencies that resulted from the data hub verification process.[7]

In our report, to examine outcomes of the data hub applicant verification process, we obtained summary data from key Federal agencies involved in the process—SSA, IRS, and DHS—on the nature and extent of their responses to electronic inquiries made through the data hub, for the 2014 and 2015 coverage years.[8] We also interviewed agency officials and reviewed statutes, regulations, and other policy and related information. In addition, we obtained applicant data on inconsistencies, subsidies awarded, and submission of required verification documentation, from CMS data systems for coverage year 2014. To determine the reliability of data we used, we interviewed CMS officials and others responsible for their respective data, reviewed relevant documentation, and performed electronic testing to determine the validity of specific data elements we used to perform our work. Based on this reliability examination, we concluded that the data we used were sufficiently reliable for our purposes.

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[4] A marketplace must require an applicant who has a Social Security number to provide the number. 42 U.S.C. § 18081(b)(2) and 45 CFR § 155.310(a)(3)(i). However, having a Social Security number is not a condition of eligibility.

[5] When an inconsistency is generated, the Marketplace is to proceed with determining other elements of eligibility using the attestations of the applicant, and ensure that subsidies are provided on behalf of the applicant, if he or she is qualified to receive them, while the inconsistency is being resolved. As part of this resolution process, the applicant is generally required to submit documentation to substantiate eligibility for the program. In the case of the Federal Marketplace, CMS uses a document-processing contractor, which reviews documentation applicants submit, by mail or online upload, to resolve inconsistencies. Inconsistencies are discussed more fully later in this testimony.

[6] GAO, *Patient Protection and Affordable Care Act: CMS Should Act to Strengthen Enrollment Controls and Manage Fraud Risk,* GAO–16–29 (Washington, DC: February 23, 2016). In addition, we have presented two other related testimonies prior to issuance of the report. *See* GAO, *Patient Protection and Affordable Care Act: Preliminary Results of Undercover Testing of Enrollment Controls for Health Care Coverage and Consumer Subsidies Provided Under the Act,* GAO–14–705T (Washington, DC: July 23, 2014); and GAO, *Patient Protection and Affordable Care Act: Observations on 18 Undercover Tests of Enrollment Controls for Health-Care Coverage and Consumer Subsidies Provided under the Act,* GAO–15–702T (Washington, DC: July 16, 2015).

[7] In addition to findings presented in this testimony—and as described in detail in our July 2015 testimony, with additional information provided in our February 2016 report—our work also identified vulnerability to fraud, when we obtained, through covert vulnerability testing, Federal Marketplace approval of subsidized coverage for 11 of 12 fictitious applicants for 2014, with coverage continuing into 2015. We concluded CMS has assumed a passive approach to identifying and preventing fraud, and that adopting a more strategic, risk-based approach could help identify fraud vulnerabilities before they could be exploited in the enrollment process. We recommended that HHS direct CMS to conduct a fraud risk assessment, consistent with best practices provided in GAO's framework for managing fraud risks in Federal programs, of the potential for fraud in the process of applying for qualified health plans through the Federal Marketplace. HHS concurred with our recommendation and said it plans to conduct such an assessment. *See* the framework at GAO, *A Framework for Managing Fraud Risks in Federal Programs,* GAO–15–593SP (Washington, DC: July 2015).

[8] In this testimony, we use "outcomes" to mean results obtained from inquiries made through the data hub, and not any ultimate determination made whether an applicant inconsistency exists.

Additional details on our scope and methodology can be found in our report. We conducted our performance audit from January 2014 to February 2016 in accordance with generally accepted government auditing standards.

CMS'S APPROACH TO APPLICANT VERIFICATION INFORMATION NEEDS IMPROVEMENT

HHS officials described the data hub process to us as being part of an innovative, multilayered approach to verifying applicant information efficiently and without undue burden on individuals and families. Through secure electronic connections, the data hub provides real-time responses to eligibility queries, HHS told us.

In our February 2016 report, however, we found that although the data hub plays a key role in the eligibility and enrollment process, CMS officials said the agency does not track the extent to which the Federal agencies deliver responsive information to a request, or, alternatively, whether they report that information was not available. Additionally, CMS officials said they do not analyze data provided in response to data hub inquiries. This is because, they said, by design, the data hub does not store individual transactional data that could be collectively analyzed over time. For policy reasons, the officials said, the agency did not want the data hub to become a data repository itself, and in particular, a repository of sensitive personal data.[9] The CMS officials also said the agency is barred legally from maintaining IRS taxpayer information in the data hub.

Asked about analysis of data hub responses, CMS officials told us when we conducted work for our February 2016 report that the key performance measures for the data hub are the extent to which the system is available for queries, and the extent to which transmissions of queries and responses are successfully accomplished; that is, that an inquiry is made and a corresponding reply received, without regard to content.[10]

Further, the Federal agencies responding to data hub queries generally told us they do not analyze outcomes of data hub inquiries. Instead, SSA, IRS, and DHS officials said they focus on responding to inquiries received. Our review also found that SSA, IRS, and DHS had limited information on the nature and extent of the inquiries made by the data hub. According to the three agencies, available statistics reflect data hub inquiries in general, and cannot be broken out by program, such as a qualified health plan or Medicaid. In addition, according to agency officials, an unknown number of data hub applicant inquiries were duplicates, which we could not eliminate from our examination.[11] Instead, agency officials told us, they generally process inquiries sequentially as they are received from the data hub. Thus, we found that while the agencies can provide some information on data hub queries, they cannot provide comprehensive information specifically on number of inquiries and individuals represented by those queries.

We further found, based on our examination of available statistics from SSA, IRS, and DHS, that while the agencies could successfully provide applicant verification information in a large percentage of cases, they did not have data in their records to verify information for millions of data hub inquiries over the course of PPACA's first two enrollment cycles, for 2014 and 2015 coverage.[12]

We concluded that by not assessing the extent to which data hub—provided data matches applicant-provided information, CMS foregoes analysis of the extent to which responding agencies successfully deliver applicant verification information in

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[9] In particular, according to CMS officials, the data hub does not read and store the content of requests received. It only validates message structure and determines routing information to send the request to the correct destination. The data hub next returns the response it receives to the requester. The data hub stores data such as transaction identifier for each request. By CMS requirements, the data hub cannot store privacy data, the officials said.

[10] According to CMS officials, the data hub only captures a code for type of reply that is generated when agencies respond to the inquiries, and those codes are not associated with any other applicant-identifying information or information that may have been provided in response to the query. There are no additional data kept on what information might have been transmitted in the source agency's response, such as income or family size. Likewise, the data hub does not track whether information provided through the data hub matches information originally provided by the applicant, the officials said.

[11] The agencies could not comprehensively identify the number of duplicates.

[12] For example, SSA accomplished a match on name, Social Security number, and date of birth in about 95 percent of cases for PPACA's first enrollment cycle, for 2014 coverage. However, for about 4.4 million inquiries—or about 5 percent of the total—the applicant information did not match SSA records. In addition, after completion of the name, Social Security number, and date of birth match, when SSA attempted to verify additional information, the agency could not confirm citizenship in about 8.2 million inquiries where individuals claimed they were citizens.

response to data hub requests. In doing so, CMS foregoes information that could suggest potential program issues or potential vulnerabilities to fraud, as well as information that might be useful for enhancing program management.[13] We recommended that HHS direct CMS to conduct a comprehensive feasibility study on actions CMS can take to monitor and analyze, both quantitatively and qualitatively, the extent to which data hub queries provide requested or relevant applicant verification information, for the purpose of improving the data-matching process and reducing the number of applicant inconsistencies; and for those actions identified as feasible, create a written plan and schedule for implementing them. HHS said it concurred with our recommendation and is reviewing options for such a study.

THE FEDERAL MARKETPLACE DID NOT RESOLVE ABOUT ONE-THIRD OF APPLICANT INCONSISTENCIES FOR COVERAGE YEAR 2014, INVOLVING $1.7 BILLION IN ASSOCIATED SUBSIDIES

For qualifying applicants, the act provides two forms of subsidies for consumers enrolling in individual health plans, both of which are paid directly to insurers on consumers' behalf. One is a Federal income tax credit, which enrollees may elect to receive in advance of filing tax returns, and which reduces a consumer's monthly premium payment. This is known as the advance premium tax credit (APTC).[14] The other, known as cost-sharing reduction (CSR), is a discount that lowers the amount consumers pay for out-of-pocket charges such as deductibles, coinsurance, and copayments.

In our report, for applicants who obtained subsidies but had application inconsistencies, we identified about 1.1 million applications with a total of about 2 million inconsistencies.[15] These applications had combined APTC and CSR subsidies of about $4.4 billion associated with them for coverage year 2014. We found, based on our analysis of CMS data, that the agency resolved about 58 percent of the total inconsistencies, meaning the inconsistencies were settled by consumer action, such as document submission, or removed due to events such as life change, application deletion, or consumer cancellation. Meanwhile, our analysis found that about 34 percent of inconsistencies, with about $1.7 billion in associated subsidies, remained open, as of April 2015—that is, inconsistencies still open several months following the close of the 2014 coverage year.[16]

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[13] By analyzing the outcomes of data hub inquiries, and in particular, clarifying the nature and extent of inconsistencies arising from this process, CMS could, for example, assess whether other sources of data, such as the National Directory of New Hires, could be useful for more current applicant information on income. Similarly, CMS could analyze the information to examine whether other sources of citizenship information, such as the Department of State's passport data, could be used to aid in verifying applicant citizenship. There may also be correlations observed between various types of applicants and types of information available from trusted data sources.

[14] When applicants apply for coverage, they report family size and the amount of projected income. Based, in part, on that information, the Marketplace will calculate the maximum allowable amount of APTC. An applicant can then decide if he or she wants all, some, or none of the estimated credit paid in advance, in the form of payment to the applicant's insurer that reduces the applicant's monthly premium payment. If an applicant chooses to have all or some of his or her credit paid in advance, the applicant is required to "reconcile" on his or her Federal tax return the amount of advance payments the government sent to the applicant's insurer on the applicant's behalf with the tax credit for which the applicant qualifies based on actual reported income and family size.

[15] In particular, we obtained data from CMS on applicant inconsistencies generated for the Federal Marketplace and the value of APTC and CSR subsidies associated with them, for the 2014 coverage year. Specifically, to observe the number of inconsistencies created and subsequently resolved, we examined applications that were awarded subsidies and that were created and submitted during the 2014 open-enrollment period plus a special enrollment period extension that followed. The open-enrollment period ran from October 1, 2013, to March 31, 2014, and the extension was through April 19, 2014.

We excluded from our analysis applications modified after submission, because CMS officials told us that inconsistencies can be generated or resolved based on consumer actions, such as updating of application information. We selected the unmodified applications that had received subsidies as presenting the simplest case for examining inconsistency generation and subsequent resolution.

Our selection criteria meant excluding 17 percent of the total number of applications with subsidies and inconsistencies because they had been modified. A single application may reflect more than one person, each of whom might have different inconsistencies in different stages of resolution. The CMS data provided the APTC and CSR amounts at the application level. Consequently, the results of our analysis are not mutually exclusive by type of inconsistency, and applications and their associated subsidy amounts may be represented in multiple categories.

[16] The remainder were terminations or adjustments based on failure to submit documentation to resolve inconsistencies. By comparison with the inconsistency results in our analysis, HHS

We also found, based on our analysis of the 2014 data, that CMS did not terminate or adjust subsides for any applications with incarceration or Social Security number inconsistencies, plus other inconsistencies.[17] Further, CMS officials told us that they currently do not plan to take any actions on individuals with unresolved Social Security number or incarceration inconsistencies.

Social Security number inconsistencies. Under CMS regulations, the Marketplace must validate all Social Security numbers provided by submitting them to SSA along with other identifying information. If the Marketplace is unable to validate the Social Security number, it must follow the standard process for resolving all types of inconsistencies.[18] In our analysis, we identified about 35,000 applications that had an unresolved Social Security number inconsistency, which were associated with about $154 million in combined subsidies.

We reported that CMS officials told us they did not take action to terminate coverage or adjust subsidies during 2014 based on Social Security number inconsistencies. They said this was because such inconsistencies are generally related to other inconsistencies, such as citizenship or immigration status, and that document submissions for citizenship or immigration status may also resolve Social Security number inconsistencies. Overall, CMS officials told us they do not consider missing or invalid Social Security number information to be a stand-alone inconsistency that must be resolved, and do not take adverse action in such cases.

However, CMS regulations state that "to the extent that the [Marketplace] is unable to validate an individual's Social Security number through the Social Security Administration," the Marketplace must follow its standard inconsistency procedures.[19] Further, when promulgating this regulation, CMS explained that transmitting Social Security numbers to SSA for validation "is separate from the [PPACA] provision regarding citizenship verification, and only serves to ensure that SSNs [Social Security numbers] provided to the [Marketplace] can be used for subsequent transactions, including for verification of family size and household income with IRS."[20]

In addition to unresolved Social Security number inconsistencies generally, our analysis also found in particular more than 2,000 applications with Social Security number inconsistencies that had no corresponding citizenship or immigration inconsistencies. We also identified nearly 5,500 applications with Social Security number inconsistencies that had no corresponding income inconsistency. These applications had total subsidies of about $10 million and $31 million associated with them, respectively. They indicate that Social Security number inconsistencies can stand alone, unrelated to other inconsistencies.

Social Security number inconsistencies also affect tax compliance. Missing or invalid Social Security numbers can affect IRS verification that taxpayers have properly filed APTC information on their tax returns, as well as impair IRS outreach to taxpayers who have received the APTC subsidy.[21]

We recommended that HHS direct CMS to identify and implement procedures to resolve Social Security number inconsistencies where the Marketplace is unable to verify Social Security numbers or applicants do not provide them. HHS concurred with our recommendation, but did not provide details on how it would seek to implement it.

Incarceration inconsistencies. In our inconsistency analysis that we reported on in February 2016, we identified about 22,000 applications having an unresolved incarceration inconsistency, which were associated with about $68 million in combined subsidies. CMS officials, however, told us they did not terminate eligibility for incarceration inconsistencies, because the agency determined in fall 2014 that SSA's Prisoner Update Processing System (PUPS) was unreliable for use by the Market-

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reported that more than 8.84 million people selected or were automatically reenrolled in 2015 plans through the Federal Marketplace as of the end of the second open enrollment period on February 15, 2015.

[17] These other inconsistencies relate to American Indian status, and presence of qualifying employer-sponsored coverage or other minimum essential coverage.

[18] 45 CFR § 155.315(b).

[19] 45 CFR § 155.315(b).

[20] 77 Fed. Reg. 18310, 18355 (March 27, 2012).

[21] *See* GAO–16–29 for a full discussion.

place.[22] As a result, CMS officials told us the agency elected to rely on applicant attestations on incarceration status.[23]

PPACA provides that incarcerated individuals are not eligible to enroll in a qualified health plan through a marketplace, with the exception of those incarcerated pending disposition of charges. CMS currently uses PUPS to generate incarceration inconsistencies when there are indications an applicant may be incarcerated. As part of the inconsistency resolution process, the Marketplace notifies applicants to send documentation to resolve the inconsistency. To do so, consumers can submit documentation such as release papers, CMS officials told us.

Under CMS's approach to incarceration inconsistencies, agency officials told us, the Marketplace continues to make an initial verification attempt using the PUPS data. If a consumer maintains he or she is not incarcerated, CMS will rely on that representation and not take adverse action, regardless of what PUPS indicates, officials told us. According to HHS officials, based on the data reliability issue, the Marketplace no longer requires applicants to submit documentation on incarceration status.

In its 2013 computer-matching agreement with CMS, SSA acknowledged that PUPS is not as accurate as other SSA data and contains information that SSA may not have independently verified. Thus, the agreement states that CMS will independently verify information it receives from PUPS and will provide individuals an opportunity to contest an incarceration inconsistency before any adverse action in an eligibility determination. Overall, according to SSA officials, PUPS information can be used to identify individuals who require additional follow-up to determine eligibility.

We reported that our review of documentation CMS provided for its decision to take no adverse action on incarceration inconsistencies showed it did not contain key information supporting the agency's decision to not use PUPS data. Specifically, the documentation did not provide specific details on why, or to what extent, people were misidentified as incarcerated; why CMS also judged inmate release information to be unreliable; any criteria or assessment employed to conclude that the PUPS data were not sufficiently current or accurate; or the potential cost associated with not verifying incarceration status.

We concluded that without clearly identifying such elements as analysis, scope, and costs of significant decisions, CMS is at greater risk of providing benefits to ineligible applicants, and also may undermine confidence in the applicant verification process and compromise overall program integrity. We further concluded that by not using PUPS data as a lead for further investigation, and by relying on applicant attestation in the alternative, CMS may be granting eligibility to, and making subsidy payments on behalf of, individuals who are ineligible to enroll in qualified health plans.

We recommended that HHS direct CMS to reevaluate use of PUPS incarceration data and make a determination to either (1) use the PUPS data, among other things, as an indicator of further research required in individual cases, and to develop an effective process to clear incarceration inconsistencies or terminate coverage; or (2) if no suitable process can be identified to verify incarceration status, accept applicant attestation on status in all cases, unless the attestation is not reasonably compatible with other information that may indicate incarceration, and forego the inconsistency process. HHS concurred with our recommendation, but did not provide details on how it would seek to implement it.

We also recommended that HHS direct CMS to fully document prior to implementation, and have readily available for inspection thereafter, any significant decision on qualified health plan enrollment and eligibility matters, with such documentation to include details such as policy objectives, supporting analysis, scope, and ex-

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[22] The PUPS system contains information on incarcerated individuals in all 50 State corrections departments, the Federal Bureau of Prisons, and local and other facilities. According to SSA, it is the only national database with records of Federal, State, and local incarcerations. SSA uses PUPS to identify individuals who may no longer be eligible for SSA benefits due to incarceration. In addition to SSA, other Federal programs, such as Medicare, use PUPS data.

[23] In the absence of an approved data source, the Marketplace may accept applicant attestation on incarceration status without further verification, unless the attestation is not reasonably compatible with other information in its records. 45 CFR § 155.315(e).

pected costs and effects. HHS concurred with our recommendation, and said it was committed to documenting significant decisions.[24]

Chairman Hatch, Ranking Member Wyden, and members of the committee, this completes my prepared statement. I would be pleased to respond to any questions that you may have at this time.

QUESTIONS SUBMITTED FOR THE RECORD TO SETO J. BAGDOYAN

QUESTIONS SUBMITTED BY HON. CHUCK GRASSLEY

I would like the record to show that I was unable to attend this hearing in person. As Chairman of the Senate Judiciary Committee, I was overseeing the debate about the Supreme Court vacancy. The two hearings were at the same time.

It was pretty disturbing to hear the report of your undercover testing of the Federal Marketplace last year.

Eleven of 12—that's over 90%—of fictitious GAO phone or online applicants were able to obtain a total of $30,000 in Obamacare subsidies and were able to maintain coverage throughout 2014. People signed up and received subsidies and coverage in some cases without any documentation.

And as shocking as that is, today's report is even worse. You reveal vulnerabilities at the data hub of *HealthCare.gov* that could cost taxpayers billions of dollars.

Question. Your report found that CMS does not track the responses to inquiries made of Federal agencies at the data hub. If CMS does not track or analyze this information, how can eligibility for Obamacare and subsidies be verified, as required by law?

Answer. In accordance with our audit objectives, our work focused on macro-analysis of data hub query outcomes, and did not address the process of making eligibility determinations for individual applications.

Thus, in our February 2016 report, we found that although the data hub plays a key role in the eligibility and enrollment process, Centers for Medicare and Medicaid Services (CMS) officials said the agency does not track the extent to which the Federal agencies deliver responsive information to a request, or, alternatively, whether they report that information was not available. Additionally, CMS officials said they do not analyze data provided in response to data hub inquiries.[1]

By analyzing the outcomes of data hub inquiries and, in particular, clarifying the nature and extent of inconsistencies arising from this process, CMS could, for example, assess whether other sources of data could be useful to provide more current information on applicant income.[2] There may also be correlations observed between various types of applicants and types of information available from data sources.

We concluded that by not assessing the extent to which data provided through the data hub matches applicant-provided information, CMS foregoes analysis of the extent to which responding agencies successfully deliver applicant verification information in response to data hub requests. Without such an analysis, CMS foregoes information that could suggest potential program issues or potential vulnerabilities to fraud, as well as information that might be useful for enhancing program management.

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[24] In all, our February 2016 report contained eight recommendations to HHS, and the agency concurred with all of them. *See* GAO–16–29 for the complete list of recommendations, as well as HHS agency comments and our evaluation of them.

[1] *See* GAO, *Patient Protection and Affordable Care Act: CMS Should Act to Strengthen Enrollment Controls and Manage Fraud Risk,* GAO–16–29 (Washington, DC: February 23, 2016). A central feature of enrollment controls under the Patient Protection and Affordable Care Act (PPACA) is the Federal "data services hub" (data hub), which, among other things, provides a vehicle to check applicant-provided information against a variety of data sources. In particular, the act requires that consumer-submitted information be verified, and that determinations of eligibility be made, through either an electronic verification system or another method approved by the Department of Health and Human Services (HHS). To implement this verification process, CMS developed the data hub, which acts as a portal for exchanging information between the Federal Health Insurance Marketplace, State-based marketplaces, and Medicaid agencies, among other entities, and CMS's external partners, including other federal agencies.

[2] An "inconsistency" arises when an applicant's information does not match information from marketplace data sources.

Question. Monitoring activities are an important part of fraud prevention. What does CMS need to do in order to implement effective monitoring activities?

Answer. In our February 2016 report, we recommended that CMS should conduct a comprehensive feasibility study on actions it can take to monitor and analyze, both quantitatively and qualitatively, the extent to which data hub queries provide requested or relevant applicant verification information, for the purpose of improving the data-matching process and reducing the number of applicant inconsistencies; and for those actions identified as feasible, create a written plan and schedule for implementing them. The Department of Health and Human Services (HHS), CMS's parent agency, concurred with our recommendation.

Question. Rather than track the amounts of the subsidies, CMS compiles the number of individuals or households affected when a subsidy is terminated for incomplete information. These changes to these subsidies have a cost to taxpayers. Federal internal control standards state that managers need financial information to make operating decisions, among other activities. How can CMS improve in this area in order to be a better steward of the taxpayers' dollars?

Answer. In our February 2016 report, we recommended that CMS track the value of advance premium tax credit and cost-sharing reduction subsidies that are terminated or adjusted for failure to resolve application inconsistencies, and use this information to inform assessments of program risk and performance.[3] HHS concurred with our recommendation.

Question. In your testimony, you explained that GAO had used a "secret shopper" technique to explore possible vulnerabilities to fraud within *HealthCare.gov.*

Is this technique a well-accepted tool for government and private auditors to use?

Answer. We have not examined the prevalence of covert testing in other settings, but GAO has conducted undercover work, including the use of fictitious applicants, to test controls in other Federal programs, in addition to health-care coverage provided under the Patient Protection and Affordable Care Act. GAO has received requests for undercover work from chairs or ranking members of a number of congressional committees and subcommittees.

Question. How do you interpret your findings of this particular "secret shopper" activity?

Answer. Through covert vulnerability testing, we obtained Federal Health Insurance Marketplace (Marketplace) approval of subsidized coverage for 11 of 12 fictitious applicants for 2014, with coverage continuing into 2015. These results, while not generalizable, nevertheless illustrate that the Marketplace enrollment process is vulnerable to fraud. Further, for a second round of testing—for 2015 coverage, and which also included two State marketplaces in addition to the Federal Marketplace—we obtained subsidized marketplace coverage for fictitious applicants in 10 of 10 instances.[4]

Question. In your professional opinion, are the findings of this "secret shopper" activity concerning?

Answer. As noted above, our results illustrate that the Marketplace enrollment process is vulnerable to fraud. A program of this scope and scale is inherently at risk for errors, including improper payments and fraud. Accordingly, it is essential that effective enrollment controls are in place to help narrow the window of opportunity for such risk and safeguard the government's investment. Based on our test-

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[3] For qualifying applicants, PPACA provides two possible forms of subsidies for consumers enrolling in individual health plans, both of which are paid directly to insurers on consumers' behalf. One is a Federal income tax credit, which enrollees may elect to receive in advance, and which reduces a consumer's monthly premium payment. This subsidy is known as the advance premium tax credit. The other, known as cost-sharing reduction, is a discount that lowers the amount consumers pay for out-of-pocket charges for deductibles, coinsurance, and copayments.

[4] *See* GAO, *Patient Protection and Affordable Care Act: Preliminary Results of Undercover Testing of the Federal Marketplace and Selected State Marketplaces for Coverage Year 2015,* GAO–16–159T (Washington, DC: October 23, 2015). In addition to our 10 applications for subsidized private health plans, we also made eight additional fictitious applications for Medicaid coverage, in order to test the ability to apply for that program through the marketplaces. In these tests, we were approved for subsidized health-care coverage for seven of the eight applications. For three of the eight applications, we were approved for Medicaid, as originally sought. For four of the eight applications, we did not obtain Medicaid approval, but instead were subsequently approved for subsidized qualified health-plan coverage. Thus, for the second round of testing overall, we obtained coverage for 17 of 18 applicants.

ing and related work, we concluded that CMS has assumed a passive approach to identifying and preventing eligibility and enrollment fraud. In February 2016, we recommended that CMS conduct a fraud risk assessment, consistent with best practices provided in GAO's framework for managing fraud risks in Federal programs, of the potential for fraud in the process of applying for qualified health plans through the Federal Marketplace.[5] HHS concurred with our recommendation.

QUESTIONS SUBMITTED BY HON. ROB PORTMAN

Question. I am extremely concerned that a large number of enrollees in Ohio and across the country may be receiving coverage when they are not legally eligible to do so, because they have already been offered coverage through their employers. Many are unaware that they will owe enormous tax bills at the end of the year, all because HHS lacks the ability to verify whether an applicant has actually been offered coverage and is providing subsidies when they should not.

That is why I introduced S. 1996, the Commonsense Reporting Act. This would allow employers to prospectively report to the IRS before the open enrollment period opens whether they are offering coverage to their employees. The government would definitively have this information well before enrollment begins—today, they only receive this information after employees may already be enrolled in coverage and receiving subsidies, meaning the IRS will have to claw back the money.

Do you believe it would help make subsidy approval more accurate if IRS and HHS had this type of information prior to open enrollment beginning?

Why has HHS been unable to help tax payers avoid these repayment penalties?

Do you believe it would lower the instances of employees who are offered coverage from being hit with surprise tax bills because they were not eligible for the subsidies they received?

Answer. We did not report on the availability of employer-sponsored insurance at time of enrollment, and thus we cannot offer any observations.

Question. Your report also identifies that CMS is not tracking the extent to which agencies respond to individual's inaccuracies. Can you explain how this information could potentially be used by CMS, if they were to track it?

Answer. Please see the answer to Senator Grassley's first question. As discussed there, by not tracking outcomes of data hub queries, CMS foregoes information that could suggest potential program issues or potential vulnerabilities to fraud, as well as information that might be useful for enhancing program management.

Question. Wouldn't a better system provide timely updated information about the availability of employer-sponsored insurance at the time of enrollment?

Answer. We did not report on the availability of employer-sponsored insurance at time of enrollment, and thus we cannot offer any observations.

QUESTIONS SUBMITTED BY HON. DEAN HELLER

Question. As of March 2016, there were 88,145 Nevadans on the Exchange, but only 76,821 of these enrollees have selected a plan.

How can CMS count consumers as "enrollees" if they have not "enrolled" in a plan?

What barriers exist that would have prevented nearly 12,000 Nevadans from selecting a plan?

Answer. According to the HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE), Nevada activity for the 2016 open enrollment period (November 1, 2015 to February 1, 2016), as of March 2016, was as follows:

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[5] *See* GAO, *A Framework for Managing Fraud Risks in Federal Programs,* GAO–15–593SP (Washington, DC: July 2015).

STAGE OF APPLICATION	NUMBER
A. Total completed applications	93,255
B. Total individuals applying for coverage in completed applications	134,454
C. Total individuals eligible to enroll in a marketplace plan	107,525
D. Number of individuals eligible to enroll in a marketplace plan with financial assistance	89,716
E. Number of individuals who selected a marketplace plan	88,145
F. Number of individuals with 2016 marketplace plan selections with advance premium tax credit	76,821

Notes: For items A–E, for complete details, including explanatory notes on the figures shown, see Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, ''Addendum to the Health Insurance Marketplaces 2016 Open Enrollment Period: Final Enrollment Report,'' ASPE Issue Brief (March 11, 2016). For item F, for complete details and explanatory note, see Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, ''Health Insurance Marketplaces 2016 Open Enrollment Period: Final Enrollment Report,'' ASPE Issue Brief (March 11, 2016).

QUESTION SUBMITTED BY HON. MICHAEL F. BENNET

Question. The investigation concludes that no cases of real world fraud were found. Did GAO take measures to identify cases of actual fraud in the scope of the overall investigation?

Answer. As we said in our March 17, 2016 testimony, the purpose of our work was to seek to identify eligibility and enrollment control vulnerabilities, and not to attempt to identify actual cases of fraud. As noted above, our covert vulnerability testing demonstrated that the Marketplace enrollment process is vulnerable to fraud, as 11 of 12 applicants in our tests obtained coverage through fraudulent means.

QUESTIONS SUBMITTED BY HON. SHERROD BROWN

Question. CMS is responsible for working in collaboration with public and private entities—including other Federal agencies, State Medicaid agencies, private contractors, health insurance issuers, and not-for-profit organizations—to manage the Affordable Care Act (ACA) marketplace.

As part of its responsibilities, CMS must ensure accurate eligibility determinations, process enrollments, facilitate Medicaid enrollment for those who qualify, and communicate timely and accurate information to issuers and consumers.

CMS also provides support functions for the State marketplaces and administers Federal financial assistance and premium stabilization programs related to the marketplaces.

The GAO report discusses some inconsistencies that have come up as CMS has balanced these priorities during a period of time where Republicans were doing everything they could to sabotage the law's implementation. But the GAO report fails to acknowledge two things:

- These inconsistencies are not indicative of any widespread fraud by real-world enrollees, and
- The significant work CMS has undertaken to resolve inconsistencies by either eliminating coverage or adjusting an individual's advance premium tax credit.

Isn't it true that, in order to correct these inconsistencies, during the first nine months of 2015, CMS ended the enrollments of approximately 471,000 individuals because they failed to properly verify their identities?

Isn't it also true that CMS has adjusted the tax credits of approximately 1,153,000 households whose incomes could not be properly verified?

Answer. We cannot comment on these figures, as CMS provided us with statistics covering a different period, which we included in our February 2016 report. Specifically, according to CMS officials, from April through June of 2015, enrollment in coverage through the Federal Marketplace was terminated for about 306,000 consumers with citizenship or immigration status data-matching issues who failed to produce sufficient documentation. In addition, according to the officials, about 735,000 households with income inconsistencies had their advance premium tax credit or cost-sharing reduction subsidies adjusted for coverage year 2015.

In February 2016, we also reported on results of a GAO analysis of application inconsistencies and subsequent resolutions for the 2014 coverage year. We found

that for a group of about 1.1 million applications with a total of about 2 million inconsistencies, about 34 percent of the inconsistencies, with about $1.7 billion in associated subsidies, remained open as of April 2015—that is, still open several months following the close of the 2014 coverage year.

Otherwise, as noted above, the objectives of our work were to test enrollment controls and identify vulnerabilities, if any, and not to determine the extent of fraud perpetrated by actual enrollees.

Question. Has the GAO elsewhere acknowledged the work CMS did to correct these inconsistencies?

Answer. Yes, our February 2016 report (p. 34) reflects CMS's actions on terminations and adjustments. Also in that report (beginning at pp. 17 and 45), as noted above, we presented results of an analysis of application inconsistencies, including by type of inconsistency (such as income or citizenship/immigration status) and resolution. Terminations of policies and adjustments of subsidies were among resolutions we reported.

PREPARED STATEMENT OF ERIN BLISS, ASSISTANT INSPECTOR GENERAL FOR EVALUATION AND INSPECTIONS, OFFICE OF INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTHCARE.GOV: CASE STUDY OF CMS MANAGEMENT OF THE FEDERAL MARKETPLACE

Good morning, Chairman Hatch, Ranking Member Wyden, and other distinguished Members of the Committee. I am Erin Bliss, Assistant Inspector General for Evaluation and Inspections in the Office of Inspector General (OIG), U.S. Department of Health and Human Services (HHS or the Department). Thank you for the opportunity to testify about OIG's case study reviewing the management of the Federal Marketplace website *HealthCare.gov* by the Centers for Medicare and Medicaid Services (CMS).

OIG's mission is to protect the integrity of HHS programs and the health and welfare of the people they serve. We advance our mission through a nationwide network of audits, evaluations, investigations, enforcement actions, and compliance efforts. OIG has identified oversight and operation of the Health Insurance Marketplaces as a Top Management Challenge for HHS.

The case study is an important component of our marketplace oversight strategy. It primarily examines implementation of *HealthCare.gov*, the consumer-facing website for the Federal Marketplace, by CMS from passage of the Patient Protection and Affordable Care Act (ACA) in 2010 through the second open enrollment period in 2015. As required by the ACA, *HealthCare.gov* is the Federal website that facilitates purchase of private health insurance for consumers who reside in States that did not establish health insurance marketplaces. At its highly publicized launch on October 1, 2013, and for some time after, *HealthCare.gov* users experienced substantial website outages and technical malfunctions. After corrective action by CMS and contractors following the launch, CMS ended the first open enrollment period with 5.4 million individuals having selected a plan through the Federal Marketplace.

OIG'S STRATEGY FOR OVERSIGHT OF THE MARKETPLACES

OIG has completed and planned a significant body of audits and evaluations regarding the Federal Marketplace and other ACA provisions of high interest and concern to the Department, Congress, and other stakeholders. OIG's marketplace oversight strategy focuses on four areas that we have determined to be most critical: payment, eligibility, management and administration, and security.

My testimony focuses on the OIG report "*HealthCare.gov*: Case Study of CMS Management of the Federal Marketplace" (OEI–06–14–00350) released on February 23, 2016. The case study report evaluates CMS's implementation and management of *HealthCare.gov*. Consistent with the OIG's statutory purpose to promote economy, efficiency, and effectiveness in the administration of Departmental programs, the rollout of *HealthCare.gov* presented a unique opportunity to assess CMS's management and operations. The implementation of *HealthCare.gov* provides lessons that will be increasingly important as the success of Government programs becomes more dependent on the effective intersection of policy, technology, and management. The case study enabled OIG to draw conclusions about factors that contributed to the website's breakdown and subsequent improvement, and lessons learned to promote effective Government operations moving forward.

In summary, our case study report provides three takeaways about the development and implementation of *HealthCare.gov*, presented in chronological order over a 5-year period from passage of the ACA through the Marketplace's second open enrollment period:

Development and Launch: The poor launch of the website was caused by many avoidable organizational missteps, in addition to problems with website technology;

Correction Through Second Open Enrollment Period: After the breakdown, CMS improved processes and worked with contractors and others to fix the website, and this approach led to broader organizational changes focused on leadership, decisionmaking, and communication; and

Call for Continued Progress: Challenges remain in managing the Federal Marketplace and improving operations and services provided by *HealthCare.gov,* including issues identified in related OIG reports. CMS must continue applying lessons learned from *HealthCare.gov* to complete this work and address new challenges as they arise.

BACKGROUND ON THE FEDERAL MARKETPLACE AND *HEALTHCARE.GOV*

The ACA was signed into law on March 23, 2010, and amended on March 30, 2010.[1] The ACA required the establishment of a health insurance exchange (marketplace) in each State that would be operational on or before January 1, 2014.[2] For States that elected not to establish their own marketplaces, the Federal Government was required to operate a marketplace on behalf of the State.[3]

The marketplaces provide those seeking health insurance a single point of access to view qualified health plan (health plan)[4] options, determine eligibility for coverage, and purchase insurance coverage. Individuals also use the marketplaces to determine eligibility for insurance affordability programs (*e.g.,* Medicaid, premium tax credits, and cost-sharing reductions) that lower insurance premiums and costs of care.[5] At the beginning of the third open enrollment period, November 1, 2015, the Federal Government operated a marketplace (the Federal Marketplace) for 38 States, including 7 State-partnership marketplaces for which HHS and the State share responsibilities for core functions and 4 federally supported State marketplaces in which States perform most marketplace functions.[6] Thirteen States (including the District of Columbia) operated their own State marketplaces.[7]

CMS has had responsibility for managing the marketplace programs since January 2011.[8] To implement the ACA provisions related to the marketplaces, CMS has worked in collaboration with public and private entities, including other Federal agencies as required by the ACA,[9] State Medicaid agencies, private contractors, health insurance issuers (issuers), and not-for-profit organizations. As it continues to operate the Federal Marketplace, CMS must ensure accurate eligibility determinations, process enrollments, facilitate Medicaid enrollment for those who qualify, and communicate timely and accurate information to issuers and consumers. CMS also provides support functions for the State marketplaces and administers Federal financial assistance and premium stabilization programs related to the marketplaces.

HealthCare.gov is the public website for the Federal Marketplace through which individuals can browse health insurance plans, enroll in plans, and apply for Federal financial assistance to help cover their premiums and other costs. This is the consumer-facing, or "front end," portion of the marketplace. The "back end" systems

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[1] Pub. L. No. 111–148 (March 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111–152 (March 30, 2010), collectively referred to as the Affordable Care Act (ACA).

[2] *Ibid.* § 1311(a), (b).

[3] *Ibid.* § 1321(c).

[4] Private health insurance plans certified as meeting certain standards and covering a core set of benefits including doctor visits, preventive care, hospitalization, and prescriptions.

[5] ACA §§ 1401, 1402.

[6] The Henry J. Kaiser Family Foundation, *State Decisions on Health Insurance Marketplaces and the Medicaid Expansion,* December 17, 2015. Accessed at *http://kff.org/health-reform/state-indicator/state-decisions-for-creating-health-insurance-exchanges-and-expanding-medicaid/* on January 6, 2016. CMS, *Hawaii: For 2016 insurance coverage, use HealthCare.gov to apply and enroll.* Accessed at *https://www.healthcare.gov/hawaii-2016/* on January 6, 2016.

[7] *Ibid.*

[8] 76 Fed. Reg. 4703 (Jan. 26, 2011).

[9] ACA §§ 1411, 1412.

of the Federal Marketplace perform functions such linking consumers' information from *HealthCare.gov* to multiple supporting systems that facilitate the enrollment process and payment to issuers.

Key components of *HealthCare.gov* and the Federal Marketplace include an identity management system to enable consumers to create accounts and verify their identities; the Data Services Hub, which routes information requests from the marketplaces to other Federal agencies and back, such as the Internal Revenue Service (IRS); and the Federally-facilitated Marketplace (FFM) that comprises the core of the overall system. The FFM includes three main subcomponents to facilitate various aspects of acquiring health insurance: eligibility and enrollment determinations, plan management, and financial management.

OIG'S CASE STUDY APPROACH

The objective of the case study was to gain insight into CMS implementation and management of the Federal Marketplace, focusing primarily on *HealthCare.gov*. The case study identifies organizational factors that contributed to the website's poor launch and subsequent improvement, and lessons for employing core management principles in navigating program implementation and change. These organizational factors and the lessons learned identify principles that can contribute not only to improving the Marketplace, but also contribute to improving the economy, efficiency, and effectiveness of the Department's other programs and operations.

Our review examined the 5-year period from March 2010 to February 2015, providing a chronology of events and identifying factors that contributed to the website's breakdown at launch, its recovery following corrective action, and implementation of *HealthCare.gov* through the second open enrollment period. In conducting this review, we interviewed current and former HHS and CMS officials, staff, and contractors involved with the development and management of the website. We also reviewed thousands of HHS and CMS documents, including management reports, internal correspondence, and website development contracts.

OIG FINDINGS FROM PREPARATION AND DEVELOPMENT OF *HEALTHCARE.GOV* (MARCH 2010–SEPTEMBER 2013)

The development of *HealthCare.gov* faced a high risk of failure, given the technical complexity required; the fixed deadline; and a high degree of uncertainty about mission, scope, and funding. Still, we found that HHS and CMS made many missteps throughout development and implementation. Most critical was the absence of clear leadership, which caused delays in decisionmaking, lack of clarity in project tasks, and the inability of CMS to recognize the magnitude of problems as the project deteriorated.

The HealthCare.gov project encountered problems at the beginning of development that set the stage for the poor launch. Implementing the Federal Marketplace required substantial policy development and decisionmaking to inform technical planning and implementation of the website. This included not only writing regulations to govern the marketplaces, but also establishing partnerships with other entities involved in implementation, such as other departments, States, and issuers. This policy work was made more difficult and protracted by a lack of certainty regarding the mission, scope, and funding for the Federal Marketplace and website and by varying internal and external expectations for the marketplaces. Delays caused by the lack of certainty used valuable time and made an already compressed time frame more difficult.

Additionally, the project's poor transition to CMS after 10 months in the HHS Office of the Secretary resulted in problems that lasted long after the move. Initial work in the HHS Office of the Secretary made significant strides in establishing the policy framework, but did not focus attention on planning for the project's longer-term technical and operational needs. CMS had to reconfigure roles and timelines, determine how it would leverage its resources, and begin work behind schedule. Further, while CMS's infrastructure and experience provided greater resources for the project, it led to the Federal Marketplace operating within a large bureaucratic structure that separated contract, policy, and technical staff, further diffusing the project team and making implementation more complex. Our review found that CMS leadership failed to foster effective collaboration and communication, particularly between CMS policy and technical staff and with contractors.

Lack of clear project leadership led to project diffusion and poor coordination. From the beginning and well into the project, CMS did not assign clear project lead-

ership, which was particularly problematic for the policy and technological work needed to set up *HealthCare.gov*. For example, CMS continued to make changes to the project's business requirements that then changed technical aspects of the website build, in large part because mid-level staff and managers did not have clear direction or the authority to make decisions. Effective leadership would have enabled a comprehensive view across the project to better identify problems and determine priorities. Instead, lack of a single lead entity inhibited progress assessments and changing course as needed.

IT contracting for the FFM encountered significant problems. CMS mismanagement of the key *HealthCare.gov* contract continued throughout the website build. CMS did not employ an acquisition strategy to develop contracts and solicit contractors, a tool used to precisely assess project needs and make a systematic assessment of the contractors' ability to meet those needs. Further, due to CMS's contracting process and uncertainty about funding and specifications, CMS received a limited number of bids for the contract. CMS hired CGI Federal to build the core of the overall FFM system, as well as the online application for consumers. CMS oversight of the contract was disjointed and spread across different divisions with little coordination. CMS made frequent changes to contract specifications, and did not effectively communicate these changes or adequately assess how they would affect staffing and schedules.

Despite many warnings of substantial problems, CMS moved forward without serious discussion of delaying the launch. Throughout the course of building *HealthCare.gov*, staff at HHS and CMS, as well as outside entities, identified problems with the program and warned that these problems warranted action. In all, CMS received 18 "documented warnings" of concerns regarding *HealthCare.gov* between July 2011 and July 2013. These documented warnings contained substantial detail about the project's shortcomings and were formally submitted to CMS senior leadership or project managers at CMS. However, these reports were not shared broadly due to diffuse leadership and poor communication. As a result, no one person in CMS had a comprehensive view of the poor progress and, given the problems were complex, information became unwieldy and difficult to prioritize. Without a single comprehensive view, CMS leadership and staff took little action to respond to warnings, remained overly optimistic about the launch, and developed few contingency plans. As the project degraded further and problems became more well-known, CMS officials and staff became desensitized to bad news about progress.

In early 2013, CMS attempted to take corrective action, but these efforts were largely unsuccessful because they were not fully and diligently executed. For example, after criticism that there was no clear leadership, CMS assigned its newly appointed Chief Operating Officer in early 2013 to head the Federal Marketplace program, but the assignment was not formally announced, the position was not supported by clear responsibilities, and the designee had an already large responsibility as CMS Chief Operating Officer. As another example, a CMS advisor recommended that the project hire a technical systems integrator to coordinate operations, and CMS and contractors discussed this need at several points in the project. However, in correspondence and congressional testimony, it was clear CMS technical leadership perceived that CMS itself was already serving as the systems integrator.[10] CGI Federal managers reported that the lack of a true systems integrator created extra work that was outside the scope of their contract.

Due to the poor contract management and ensuing delays, the final months of development and implementation for *HealthCare.gov* were chaotic. CMS continued to make changes to business requirements and technical specifications well into 2013, delaying development to a point where it was not feasible to complete and test the website as initially planned. Critical tasks went uncompleted, including testing website functionality and security and ensuring adequate capacity for users. CMS continued with the same plans for a full launch. Changing the project's path would have required a leader or team to conduct a comprehensive assessment of status, and to either possess the authority to alter tasks and processes or to fully communicate that assessment to leaders with authority. Instead, CMS and contractors continued with the initial strategy and goals, falling further behind schedule, with largely the same diffuse leadership structure, staffing, and project plan.

By the time CMS took more drastic action to change the project's path in August and September of 2013, it was too late to adequately affect change, given the sub-

[10] U.S. House of Representatives, House Energy and Commerce Committee, *PPACA Implementation Failures: Answers from HHS,* October 30, 2013.

stantial need for progress and improved execution. CMS cut functions that were at one time considered critical to a successful launch, such as the Spanish language and SHOP websites, to divert resources to the main build. This occurred in the last few weeks before launch, when developers and testers reported they were months behind schedule. The rush to launch affected all aspects of the build, including moving forward with only an interim authorization to operate and requesting double computing capacity late in September. CMS sought to deliver a version of *HealthCare.gov* that had only the minimum necessary functions to operate, but did so without a comprehensive and thoughtful strategy.

OIG FINDINGS FROM LAUNCH, CORRECTION AND TURNAROUND OF *HEALTHCARE.GOV* (OCTOBER 2013—FEBRUARY 2015)

HealthCare.gov launched at midnight on October 1, 2013, and experienced substantial problems within hours. The website received five times the number of expected users, but the problems involved more than capacity. The website entry tool was overwhelmed, and software code defects caused malfunctions. Fixing the website required substantial corrections to the software code and to further increase capacity. Compounding problems further, some responsible staff were furloughed when the Government shut down on October 1, 2013.

CMS began corrective action, reorganizing the work to focus on key priorities and to improve execution. CMS and contractors quickly brought in new staff and expertise following the launch, developing an all-hands environment wherein fixing problems with *HealthCare.gov* was the key agency mission. Most of the additional staffing came to the project within 3 weeks, including technological and project management experts from CMS, contractors, and the private sector. By late October, CMS and contractors began to move command center operations, establishing what would become the formal *HealthCare.gov* command center—the Exchange Operations Center (XOC). The structure at the XOC was based on active coordination between technical and policy staff, a key component missing during the website preparation and development. It also employed comprehensive website monitoring tools to identify problems and assess performance. The widespread attention to the launch and the number of parties involved could have created bureaucratic paralysis, but those working on the repairs directed their attention to immediate action and improved the *HealthCare.gov* website substantially in 2 months.

Before the launch, artificial distinctions and divisions among staff contributed to poor collaboration, lack of communication, disjointed management, and slow progress. Following the launch, first with the technological team and then more broadly, CMS promoted a culture that was "badgeless" and "titleless," working as a single team regardless of employer and job title.

According to CMS, this change in culture fostered a greater sense of mission and teamwork that further improved daily operations.

CMS initiated organizational change, such as a deeper integration between policy and technological tasks. The Federal Marketplace and *HealthCare.gov* needed expertise and coordination across CMS divisions and many contractors. CMS integrated the various functions within the project, which improved daily work. This integration allowed CMS to identify and address problems more quickly, make informed decisions, and provide clearer direction to those involved in the website development and operations. CMS also assigned clear project and technical leadership, hiring a technical systems integrator, and restructuring its divisions to allow for greater visibility and oversight of technical staff and contractors by senior leadership.

This greater sense of "operational awareness" also prompted CMS to plan for and mitigate potential problems by considering contingencies, building redundant systems, and increasing capacity. CMS's lack of contingency plans before the launch meant that CMS had few options when the functionality and computing capacity of *HealthCare.gov* encountered problems. Essential to success was identifying possible problems and developing systems and strategies specific to each concern.

By the end of the first open enrollment period, CMS had a stable website that functioned well at high capacity, but some planned components had yet to be completed. CMS immediately began preparation for the second open enrollment period to begin seven months later. CMS practiced what officials called "ruthless prioritization" of tasks to focus on the most urgent needs and functionality. This strategy served to align goals with available resources, guide daily work and accountability, and temper unrealistic expectations about results. According to CMS, officials developed a list of technological needs, then debated and cut about half of the

items requested. Cuts included key elements of the Federal Marketplace system, such as completion of the automated financial management system.

This process for strategic and organized prioritization marked a significant improvement over the rushed reprioritization efforts that occurred prior to launch. Project documentation indicated that in 2013, CMS and contractors were frantic to establish basic website functionality. They pushed forward faulty and untested functionality and hoped to fix it after the launch. Project documentation indicated that in 2014, CMS maintained a more disciplined project schedule, meeting deadlines with a goal to implement only technology that had what project documentation referred to as optimal functionality, or "perfect execution." When this standard could not be met in time, CMS identified problems more quickly to allow time to employ contingency plans. CMS stated that this higher standard led to improved practices overall, such as targeting earlier deadlines for delivery and imposing stricter testing standards. For example, the new *HealthCare.gov* consumer application, App 2.0, was tested through a "soft launch" prior to open enrollment. This approach meant that CMS did not always deliver according to schedule, but was able to test the application's functionality prior to use in the second open enrollment.

CMS documentation indicated the technical aspects of the website and supporting systems performed well during the second open enrollment period, with no system outages and few consumer reports of problems applying for coverage or selecting plans. CMS further solidified project leadership, worked to better align project goals with resources, and renewed its focus on contract management, particularly emphasizing the agency-contractor relationship. As of February 1, 2016, CMS reported that over 9.6 million consumers had selected a health insurance plan through the Federal Marketplace or had their coverage automatically renewed.[11]

CALL FOR CONTINUED PROGRESS

CMS continues to face challenges in implementing the Federal Marketplace, and in improving operations and services provided through *HealthCare.gov*. As CMS moves forward, challenges include improving the website and systems as planned, such as completing the automated financial management system and improving consumer tools to select plans. CMS must also continue to address areas OIG has identified in past reports as problematic or needing improvement, including contract oversight, the accuracy of payments and eligibility determinations, and information security controls.

CMS concurred with OIG's call for continued progress, stating that it will continue to employ the lessons identified in the case study and that, since OIG's review, it has implemented several initiatives to further improve its management. The 10 lessons articulated in the report comprise core management principles that could apply to other organizations. They include assigning clear project leadership, encouraging staff to identify and communicate problems, and better integrating policy and technological work. OIG will continue to monitor CMS's actions to address specific recommendations from our work, as well as its overall management of this program.

In addition to the lessons learned from the case study, OIG has also completed 12 audits and evaluations of the Federal Marketplace, which combined make over 30 recommendations to CMS. We continue to monitor CMS's progress toward implementing these recommendations. OIG has also published numerous other reports related to State marketplaces and other significant programs created by the ACA. All of our ACA-related work is available at: *http://oig.hhs.gov/reports-and-publications/aca/*.

OIG has ongoing and planned work in several areas related to marketplaces, including examining the accuracy of financial assistance payments for individual enrollees for the Federal Marketplace, analysis of CMS's oversight of the State marketplaces, and a review of the funding that established the Federal Marketplace. We are also currently developing work related to the premium stabilization programs. In addition, OIG has established relationships with its law enforcement partners to investigate fraud and closely monitor activities and concerns related to the marketplaces.

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[11] CMS, *Health Insurance Marketplace Open Enrollment Snapshot—Week 13,* February 4, 2016. Accessed at *https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-02-04.html* on February 8, 2016.

CONCLUSION

The Department, and the health care system generally, are in the process of implementing major changes to health care delivery. Most of those changes will depend on the successful implementation of information technology, but success will require more than just ensuring that the right code is written or that the right technology is purchased. As our case study demonstrates, whether these changes will result in more effective, efficient, and economic health care and human service programs will depend on the interaction of technology, management, and policy.

OIG believes the lessons learned identified in the case study may be beneficial to the Department beyond the operation and management of the Federal Marketplace. Assessing Departmental management will continue to be a vital component of OIG's oversight of Department programs going forward. Many programs or projects that OIG oversees will not require the same level of coordination or resources required of the Federal Marketplace; however, the principles identified in the Case Study can help foster the effectiveness and efficiency of Departmental and program management.

The growing intersection of programs and technology requires OIG to grow its own capabilities to provide effective oversight. OIG is building necessary expertise in data analytics, information technology, and forensic accounting. Increasing our proficiencies and resources in these disciplines will allow OIG to provide meaningful analysis to inform decision-makers and program managers.

Thank you again for inviting OIG to speak with the committee today to share the results of the case study reviewing CMS management of *HealthCare.gov*. I would be happy to submit the case study report for the record, and I would be happy to answer any questions the committee may have.

QUESTIONS SUBMITTED FOR THE RECORD TO ERIN BLISS

QUESTION SUBMITTED BY HON. CHUCK GRASSLEY

I would like the record to show that I was unable to attend this hearing in person. As Chairman of the Senate Judiciary Committee, I was overseeing the debate about the Supreme Court vacancy. The two hearings were at the same time.

Question. Ms. Bliss, in your recent case study report, you summarized many of the mistakes at HHS and CMS that resulted in the disastrous launch of *HealthCare.gov*.

Some of the problems identified by OIG included a lack of leadership, a failure to act on warnings and address problems, and corrections that were too little too late.

In the final countdown to the launch of *HealthCare.gov,* it seems CMS was more concerned about launching anything rather than following the advice of their own advisors and waiting and then releasing a product that would be useful to Americans.

CMS continues to have problems with implementing and operating the Federal Marketplace.

Ms. Bliss, what are the 10 lessons CMS should have learned?

Answer. The Centers for Medicare and Medicaid Services (CMS) continue to face challenges in implementing the Federal Marketplace and in improving services provided through *HealthCare.gov.* The HHS OIG called on CMS to continue progress in applying lessons learned from *HealthCare.gov* to avoid future problems and to maintain improvement across the agency. These 10 lessons comprise core management principles that address both specific project challenges and organizational structure, and could apply to other organizations.

1. Assign clear project leadership for cohesion across tasks and a comprehensive view of progress.
2. Align project and organizational strategies with the resources and expertise available.
3. Identify and address factors of organizational culture that may affect project success.
4. Seek to simplify processes, particularly for projects with a high risk of failure.

5. Integrate policy and technological work to promote operational awareness.
6. Promote acceptance of bad news and encourage staff to identify and communicate problems.
7. Design clear strategies for disciplined execution and continually measure progress.
8. Ensure effectiveness of information technology (IT) contracts by promoting innovation, integration, and rigorous oversight.
9. Develop contingency plans that are quickly actionable, such as redundant and scalable systems.
10. Promote continuous learning to allow for flexibility and changing course quickly when needed.

CMS concurred with OIG's call for continued progress and stated that it will continue to employ the lessons. Since OIG's review, CMS has implemented several initiatives to further improve its management.

QUESTIONS SUBMITTED BY HON. MICHAEL B. ENZI

Question. In the hearing, some of the operational and strategic changes which were made after the first enrollment period were briefly discussed. Those changes were described as "clearer leadership amongst staff and contractors," and "key organizational changes."

Please list and describe the specific changes made to make the leadership amongst HHS staff and contractors more clear.

Answer. Assigning and supporting clear project leadership was perhaps the most critical change CMS made to improve *HealthCare.gov* project management. Prior to the launch, *HealthCare.gov* lacked clear project leadership to give direction and unity of purpose, responsiveness in execution, and a comprehensive view of progress. CMS and its contractors took a number of steps to improve leadership, including the following:

1. Tasked top agency management to assume daily leadership of the *HealthCare.gov* project, first the CMS Administrator and subsequently the Principal Deputy Administrator. This served to provide project visibility across agency functions and clear authority to implement changes. Following the website recovery and before the start of the second open enrollment period, CMS hired a Marketplace CEO to serve in that leadership role. CMS senior leaders also alternated as the website's Executive on Call, serving 24-hour shifts to make decisions more rapidly.
2. Improved the coordination and transparency of work shared among CMS staff and multiple contractors by hiring a systems integrator to organize technological tasks and report progress and problems to leadership. CMS continues to employ a contractor to serve as systems integrator, having established this position within weeks of the launch in late October 2013.
3. Promoted coordination of CMS divisions working on various aspects of the Federal and State-based marketplaces by forming the Strategic Planning and Management Council, composed of five workgroups: appeals; eligibility and enrollment; plan oversight; security and privacy; and workforce planning.
4. Shifted from following known processes to continually assessing outcomes and progress. For example, CMS identified a number of problems in the lead-up to the second open enrollment through "deep dives," assigning staff to scrutinize the performance of a specific area or function (such as eligibility) and bring to CMS leadership their assessments of weaknesses.
5. Focused on blending the policy and technical components of CMS with a greater sense of what CMS leaders called "the physics of operations" or "operational awareness." Policymakers acquired a better understanding of the effort required to effectuate policy decisions, both in terms of time and resources, so that those considerations could better inform decision making and avoid a longstanding agency bifurcation between operations and policy.
6. Instructed staff coordinating technological work and supervising contracts about rules and provisions related to contracted work; also instructed contractors to work more collaboratively with each other and the CMS divisions. This

served to avoid staff concerns about violating Government contracting rules, promoting closer collaboration and a sense that CMS and contractors were a single team working toward the same goals.

Question. Please list and describe the key organizational changes mentioned by Ms. Erin Bliss.

Answer. CMS also made other key organizational changes as it improved the *HealthCare.gov* website. This required significant and focused effort to measure website performance, correct problems with website capacity and functions, and establish a new project structure. To implement these practices, CMS and its contractors took the following steps:

1. Began correction of website problems immediately following launch, changing the project management strategy. CMS and contractors brought in new staff and expertise following the launch, developing an all-hands environment wherein fixing problems with *HealthCare.gov* was the key agency mission. These changes allowed CMS to make quick progress in identifying the source of problems and developing a strategy going forward.
2. Adopted a "badgeless" culture that encouraged full collaboration by CMS staff and contractors regardless of employer status and job title, fostering innovation, problem solving, and communication among teams. The enhanced team of CMS staff, contractors, and technological experts correcting problems with *HealthCare.gov* included people at all levels of CMS and contracted entities with varied experience on the project. First with the technological team and then more broadly, CMS promoted a culture wherein all team members could speak out about problems and develop creative solutions.
3. Integrated all functions into the organizational structure to align with project needs, enhancing CMS and contractor accountability and collaboration. The Federal Marketplace needed expertise and personnel across CMS, including policy, technical, and communications staff, as well as many contractors. Key to the correction, CMS integrated the various functions both operationally and technically, improving daily work and promoting the larger project mission. This integration allowed CMS to identify and address problems more quickly, make informed decisions, and provide clearer direction to those involved in the website development and operations.
4. Planned for problems, establishing redundant (backup) systems in the event of further breakdowns and restructuring the key development contract to ensure better performance. CMS began to plan for and mitigate potential problems by considering contingencies, building redundant systems, and increasing capacity. Given limited resources, CMS leadership had to analyze past problems with *HealthCare.gov* and carefully consider how and to what extent it would develop new systems and strategies, such as enhancing training for call center staff. Key to success was identifying all possible problems and developing systems and strategies specific to the concern.
5. Adopted a policy of "ruthless prioritization" to reduce planned website functionality, focusing resources on the highest priorities. Because the time frame and resources available to prepare for the second open enrollment period were fixed, CMS focused on reducing scope to meet deadlines. The day after first open enrollment closed, CMS leadership met to prioritize tasks to focus on the most urgent needs and functionality. These decisions and resulting changes were then locked down and measured for progress and results. Ruthless prioritization served to align goals with the resources available, guide daily work and accountability, and temper unrealistic expectations about results.
6. Prioritized quality over on-time delivery, employing extensive testing to identify and fix problems and delaying new website functionality if unready. CMS adopted a project management approach of going live with website functionality only when it could ensure what one CMS official called "perfect execution." This policy of requiring optimal functioning before delivery led to improved practices overall, such as targeting earlier deadlines for delivery and imposing stricter testing standards.
7. Simplified systems and processes to enable closer monitoring of progress, increased transparency and accountability, and clearer prioritization. CMS simplified both technical aspects of the build and the organizational structure of the agency itself by closely monitoring progress and results with daily reports and close communication with contractors. Reduced complexity in tasks and or-

ganizational structure made it easier for CMS to identify those responsible for carrying out tasks and to track progress toward goals.

8. Adopted continuous learning for policy and technological tasks, balancing project plans with system and team capacity and changing course as needed to improve operations. In preparation for the second open enrollment period, much about the *HealthCare.gov* project was still unfolding. For example, CMS did not know how much website capacity consumers would require, and it was still developing and testing new and improved functionality in the final weeks before open enrollment. Given that the design and proportion of the project was evolving, it was critical to CMS's success that the organization continuously learn as the project progressed. As the *HealthCare.gov* project matured, CMS's knowledge and experience became more concrete and its planning more effective, but the project continued to require adaptation.

Question. In the hearing, Ms. Bliss was asked whether or not the office of Inspector General had uncovered, in connection with open enrollment, any confirmed cases of fraud. Ms. Bliss responded that there are no fraudulent cases which have resulted in criminal convictions or civil settlements. However, she did mention that there are some ongoing investigations.

How many "ongoing investigations" remain since the first open enrollment period?

Answer. At this time, OIG has two ongoing investigations specifically looking at enrollment fraud in the Federally Facilitated or State-Based Marketplaces. The conduct under investigation may involve more than one open enrollment period.

Question. There have been concerns about the "back end" of the *HealthCare.gov* website, specifically as it concerns subsidy payments to insurance companies.

Please describe the process in which insurers receive payments of subsidies for premiums and out-of-pocket expenses.

Answer. To date, OIG has performed two audits that specifically examine the "back end" of the *HealthCare.gov* website.[1] These reports examine the interim manual payment process that CMS utilized during the first 2 years of Marketplace operations. In both reports, OIG found deficiencies that limited the effectiveness of the interim manual payment process. Please see these reports for detailed explanations of the interim process.

In response to these reports, CMS explained that it expected all issuers on the Federal Marketplace would be using an automated policy-based system in 2016. In December 2015, CMS issued guidance related to issuer implementation of the automated policy-based system.[2] According to this policy, issuers are expected to transition to this system in early 2016. CMS has provided training regarding the new system, which OIG attended to gain a better understanding as CMS continues to work with issuers to implement automated policy-based payments.

We also plan to conduct work on CMS's automated policy-based payments system at the Federal Marketplace potentially by looking at the accuracy of the determination of financial assistance payments and the use of enrollment and payment data. The CMS Center for Consumer Information and Insurance Oversight (CCIIO) would be the best source of information about specific details of this process.

Question. What steps have been taken to ensure that those individuals who have signed up for a plan on the *HealthCare.gov* website end up in the right plan?

Answer. To date, OIG has not conducted work specifically assessing internal controls at *HealthCare.gov* that would ensure individuals are enrolled in the Qualified Health Plan they select.

Based on our related work on the interim manual payment process, controls for confirming enrollment may be included in the initial and confirmation "834" trans-

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[1] HHS OIG, *CMS's Internal Controls Did Not Effectively Ensure the Accuracy of Aggregate Financial Assistance Payments Made to Qualified Health Plan Issuers Under the Affordable Care Act* (A–02–14–02006) (June 2015); and HHS OIG, *CMS Could Not Effectively Ensure That Advance Premium Tax Credit Payments Made Under the Affordable Care Act Were Only for Enrollees Who Paid Their Premiums* (A–02–14–02025) (December 2015). Available at *http://www.oig.hhs.gov/reports-and-publications/aca/*.

[2] HHS CMS, "Policy-Based Payments Bulletin—INFORMATION" (December 2015). Available at *https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Policy-based-Payment-Guidance.pdf*.

actions.[3] OIG's audits did not assess the 834 transactions with respect to this specific issue, and the automated policy-based payment system may utilize different processes. Due to those considerations, CMS–CCIIO would be the best source of information about specific internal controls the Federal Marketplace has in place to ensure individuals are enrolled in the plans they select.

Question. Please describe the process of adding new information, like the birth of a child or marriage to an existing plan.

OIG has not assessed the process for adding information to an existing plan. The *HealthCare.gov* website provides instructions for consumers to report information about life changes through their Marketplace accounts online or by phone. CMS–CCIIO would be the best source of further information about this process.

QUESTIONS SUBMITTED BY HON. MICHAEL F. BENNET

Question. As HHS and CMS concur with and move toward implementing OIG recommendations, how can you continue to be a resource to the agency based on your findings?

Answer. OIG believes that our case study's assessment of the intersection of technology, policy, and management, and the lessons that we identified can benefit a broad range of Federal projects and programs. These lessons comprise core management principles that address both specific project challenges and organizational structure and can be applied broadly.

We will continue to monitor CMS's actions in response to our recommendations and its overall management of the Federal Marketplace and other programs. OIG has ongoing and planned work in several areas related to Marketplaces, including examining the accuracy of financial assistance payments for individual enrollees for the Federal Marketplace, analysis of CMS's oversight of the State Marketplaces, and a review of the funding that established the Federal Marketplace. We are also developing work related to the premium stabilization programs. In addition, OIG has established relationships with its law enforcement partners to investigate fraud related to the Federal Marketplace and make appropriate referrals to partner agencies. OIG will also draw upon these lessons to examine HHS's and CMS's implementation and management of other programs.

Question. The OIG Case Study report published in February 2016 highlights changes that CMS underwent including realignment of project goals and resources as well as enhancing coordination between CMS staff and contractors. What are the main operational changes that CMS should focus on as they work toward optimizing the Federal Marketplace?

Answer. In addition to the lessons learned from the case study, OIG has also completed 12 audits and evaluations of the Federal Marketplace, which combined make over 30 recommendations to CMS.[4] We continue to monitor CMS's progress toward implementing these recommendations. OIG has also published numerous other reports related to State Marketplaces and other significant programs created by the ACA.[5]

With regard to the Federal Marketplace, in particular, successful implementation of the automated policy-based payment system is one of the main operational challenges facing CMS in 2016. Additionally, CMS must continue to refine the eligibility determination systems for the Federal Marketplace to improve the accuracy and timeliness of those determinations, and continue to focus on resolving inconsistencies in eligibility determinations.

In general, as CMS improves the consumer-facing enrollment process for *HealthCare.gov,* CMS must continue to assess and improve the Federal Marketplace sys-

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[3] For more information about the 834 transaction process, *see* OIG's report *CMS's Internal Controls Did Not Effectively Ensure the Accuracy of Aggregate Financial Assistance Payments Made to Qualified Health Plan Issuers Under the Affordable Care Act* (A–02–14–02006) (June 2015), pp. 6–7.

[4] For a list of significant unimplemented recommendations related to OIG's work on both the Federal and State-based marketplaces, *see* HHS OIG, *Compendium of Unimplemented Recommendations* (April 2016), pp. 34–40. Available at *http://oig.hhs.gov/reports-and-publications/compendium/index.asp.*

[5] All of OIG's ACA-related work is available at *http://oig.hhs.gov/reports-and-publications/aca/.*

tems that operate behind the scenes, particularly the eligibility, administrative, and financial management functions. CMS must ensure that all pathways for enrollment operate with integrity and that consumers' personal information is secure. Vigilant monitoring and testing and rapid mitigation of identified vulnerabilities are essential. Attention must be paid to sound operation of financial assistance and the risk corridor, reinsurance, and risk-adjustment programs. CMS must ensure that consumers and issuers receive accurate Marketplace information, including information relevant for tax purposes, such as Form 1095A tax forms. Furthermore, Marketplaces must continue to protect personally identifiable information and strengthen security controls.

QUESTIONS SUBMITTED BY HON. SHERROD BROWN

Question. We know that *HealthCare.gov* had a rocky start. But—as was acknowledged in the HHS OIG report—after just 2 months (during which a wholly preventable government shutdown occurred, furloughing relevant members of staff), the Centers for Medicare and Medicaid Services (CMS) managed to "substantially" improve the website.

By the end of the first open enrollment period, CMS had a website that functioned at high capacity. The agency ended the first open enrollment period with 5.4 million individuals having selected a plan through the Federal Marketplace.

Ms. Bliss, what corrective actions were taken by CMS and contractors following the website's launch to address the lack of communication and leadership challenges that existed during the first enrollment period?

Answer. Assigning and supporting clear project leadership was perhaps the most critical change CMS made to improve *HealthCare.gov* project management. Prior to the launch, *HealthCare.gov* lacked clear project leadership to give direction and unity of purpose, responsiveness in execution, and a comprehensive view of progress. To improve project leadership, top CMS leadership assumed daily management of the *HealthCare.gov* project, first the CMS Administrator and later the Principal Deputy Administrator. This served to provide a view across agency functions and clear authority to implement changes. Following the website recovery and before the start of the second open enrollment period, CMS hired a Marketplace CEO to serve in that role and coordinate project activities across the agency. CMS senior leaders also alternated as the website's Executive on Call, serving 24-hour shifts to make decisions more rapidly.

CMS also worked to improve the coordination and transparency of work shared among CMS staff and multiple contractors. These efforts included hiring a systems integrator to organize technological tasks and report progress and problems to leadership and merging the work of policy and technical staff more closely to allow for a better sense of the work needed to complete project goals and integrate CMS staff and contractors into a single team. CMS also promoted coordination of CMS divisions working on various aspects of the Federal and State-based marketplaces by forming the Strategic Planning and Management Council, comprising subject area workgroups such as health plan oversight and workforce planning. This improved coordination across divisions allowed CMS to shift from separated, engrained processes to continually assessing outcomes and progress.

CMS made other key organizational changes as it improved the *HealthCare.gov* website. Following the poor launch, CMS and contractors pivoted quickly to corrective action, reorganizing the work to focus on key priorities and improve execution. These efforts benefited from CMS adopting a "badgeless" culture that encouraged full collaboration by CMS staff and contractors regardless of employer status and job title, fostering innovation, problem solving, and communication among teams. The agency also planned for problems, establishing redundant (backup) systems in the event of further breakdowns and restructuring its key development contract to ensure better performance.

Question. What has CMS done to address these challenges and continue to improve operations through the second and third open enrollments? How do you anticipate CMS will build upon these improvements for the upcoming open enrollment period?

Answer. In preparation for the second open enrollment period, CMS restructured project tasks to set more realistic goals and meet core objectives. For example, CMS managers met immediately following the first open enrollment to "ruthlessly

prioritize" remaining tasks and focus resources on the highest priorities. This served to align goals with the resources available, guide daily work and accountability, and temper unrealistic expectations about results. CMS also prioritized quality over on-time delivery, employing extensive testing to identify and fix problems and delaying new website functionality if unready for perfect execution. This contrasted with the launch of *HealthCare.gov* wherein CMS delivered what it knew was faulty functionality, planning to improve the website later.

To manage these efforts, CMS simplified systems and processes to enable closer monitoring of progress, increased transparency and accountability, and clearer prioritization. Reduced complexity in tasks and organizational structure made it easier for CMS to identify those responsible for carrying out tasks and to track progress toward goals. At the same time, the broader CMS organization adopted a strategy of continuous learning for policy and technological tasks, balancing project plans with system and team capacity and changing course as necessary to improve operations. Given that the design and proportion of the *HealthCare.gov* project was evolving, it was critical to CMS's success that the organization continuously learned as the project progressed. CMS continued these strategies, experiencing few technical problems and no system outages during the second open enrollment period.

Still, the agency faces ongoing challenges in implementing the Federal Marketplace and in improving operations and services provided through *HealthCare.gov*. OIG called on CMS to continue progress in applying lessons learned from *HealthCare.gov* to avoid future problems and to maintain improvement across the agency. As CMS moves forward, challenges include improving the website and systems as planned, such as completing the automated financial management system and improving consumer tools to select plans. Also, given CMS's large organization and complex mission, prior management problems could resurface and new problems could emerge. CMS placed intense organizational focus on the Federal Marketplace during the recovery of the website. This level of focus will, by necessity, change in the face of new challenges and priorities within CMS, and inevitably officials and staff with key expertise and deep knowledge of the Federal Marketplace will leave CMS or the project. Such changes in priorities and resources reinforce the need for CMS to fully embed core management principles in its daily work.

In its comments in response to the Case Study, CMS concurred with OIG's call for continued progress in applying the lessons that CMS learned from the *HealthCare.gov* recovery in its management of the Federal Marketplace and CMS's broader organization. CMS stated that since the OIG review it has implemented several initiatives to improve its management, striving to incorporate principles aligned with this report's lessons learned in its culture, operations, and daily work. These principles include a focus on leadership and accountability, continuous reevaluation of priorities and how the project could be more efficient, program measurement, and a flexible and evolving IT strategy aligned with policy requirements. CMS also indicated a commitment to overcoming challenges and deliver results in a transparent manner. OIG will continue to monitor CMS operation and management of the Federal and State-based Marketplaces and *HealthCare.gov,* focusing on oversight of critical aspects such as the integrity of enrollment processes and payment accuracy.

PREPARED STATEMENT OF HON. ORRIN G. HATCH,
A U.S. SENATOR FROM UTAH

WASHINGTON—Senate Finance Committee Chairman Orrin Hatch (R-Utah) today delivered the following opening statement at a hearing examining deficiencies with *HealthCare.gov* and the current state of the Patient Protection and Affordable Care Act (PPACA) and how it is impacting patients and taxpayers:

Good morning. It is a pleasure to welcome everyone to today's hearing.

Today, we'll be talking with representatives from the Office of Inspector General for the Department of Health and Human Services (HHS–OIG) and from the Government Accountability Office (GAO) about their ongoing oversight work with respect to *HealthCare.gov* and enrollment in the Federal health insurance marketplace. I want to thank both entities for their hard work on these issues and acknowledge the contributions both have made to help this committee perform more accurate and timely oversight.

Now, it is no secret that I have never been a fan of the so called Affordable Care Act. And, as we approach the sixth anniversary of this law and look closely into how it's working and being implemented, the evidence overwhelmingly shows that I—

and the many others who opposed the law from the beginning—have been right all along.

The facts speak for themselves.

Since Obamacare was signed into law, HHS–OIG and GAO have cumulatively released at least six dozen reports detailing various operation and implementation issues demonstrating the numerous areas where the law is falling short. These reports are specific and focused on key operational failures like enrollment controls or system issues, some of which we'll hear more about today.

Let's keep in mind that GAO and HHS–OIG are not partisan entities. They are independent watchdogs, tasked with the responsibility of objectively and dispassionately assessing what is and what is not working in various Federal programs, including those created or amended by the Affordable Care Act. And, there is no better record showing how and why Obamacare is not working than the reports we've received from these offices.

Today, we are going to specifically discuss operations issues related to *HealthCare.gov* and enrollment problems at the Federal insurance marketplace, otherwise known as the Federal exchange.

Let's start with the *HealthCare.gov* launch.

As a result of numerous problems and shortcuts taken with the initial development and deployment of *HealthCare.gov* and its supporting systems, consumers encountered widespread performance issues when trying to create accounts and enroll in health plans. After numerous inquiries and reports, we now know what ultimately caused these performance issues.

For example, there was inadequate capacity planning. The Centers for Medicare and Medicaid Services (CMS) cut corners and did not plan for adequate capacity to maintain *HealthCare.gov* and its supporting systems.

There were also problems with the software that were entirely avoidable. CMS and its contractors identified errors in the software coding for the website, but did not adequately correct them prior to launch.

We saw a lack of functionality as CMS did not adequately prepare the necessary systems and functions of the website and its supporting systems prior to the initial launch.

CMS also failed to apply recognized best practices for system development, which contributed to the problems.

Admittedly, since the initial launch, CMS has taken steps to address these problems, including increasing capacity, requiring additional software quality reviews, and awarding a new contract to complete development and improve the functionality of key systems.

However, many of the problems have still not been entirely resolved and continue to cause frustration for consumers trying to obtain health insurance.

I wish we could boil down all of Obamacare's problems to the functions of a single website. Indeed, if this was just an IT problem, all of our jobs would be a lot easier. However, the problems with Obamacare—and the Federal insurance marketplace in particular—go much deeper and many of them remain unaddressed.

We know, for example, that the enrollment controls for the Federal marketplace have been inadequate.

During undercover testing by GAO, the Federal marketplace approved insurance coverage with taxpayer-funded subsidies for eleven out of twelve fictitious phone or online applicants. In 2014, the GAO applicants—which, once again, were fake, made-up people—obtained a total of about $30,000 in annual advance premium tax credits, plus eligibility for lower insurance costs at the time of service. These fictitious enrollees maintained subsidized coverage throughout the year, even though GAO sent either clearly fabricated documents or no documents at all to resolve application inconsistencies.

While the subsidies, including those granted to GAO's fictitious applicants, are paid to health-care insurers, they nevertheless represent a benefit to consumers and a cost to the government. Now, GAO did find that CMS relies on a contractor charged with document processing to uncover and report possible instances of fraud. Yet, GAO also found that the agency does not require that the contractor has any fraud detection capabilities.

And, according to GAO, CMS has not performed a single comprehensive fraud risk assessment—a recommended best practice—of the Obamacare enrollment and eligibility process. Until such an assessment is completed, CMS is unlikely to know whether existing control activities are suitably designed and implemented to reduce inherent fraud risk to an acceptable level.

In other words, CMS isn't even sure if CMS's fraud prevention systems are designed correctly or if they're effective.

Lastly, while it is not the focus of the reports that will be covered by the testimony today, another matter we've been tracking closely, and where the GAO is issuing a report today, is CMS's oversight of the health care CO–OPs. We had a hearing on this topic in late January where we examined a number of financial and oversight related explanations for the abject failure of the CO–OP program.

Today's GAO report describes CMS's efforts to deal with financial or operations issues at the CO–OPs, including the use of an escalation plan for CO–OPs with serious problems that may require corrective actions or enhanced oversight.

As of November 2015, 18 CO–OPs had enough problems that they had to submit to a CMS escalation plan, including nine that have discontinued operations. And, just this week, we heard that yet another CO–OP, this time the one in Maine, is on the verge of financial insolvency, despite the fact that it had been on a CMS-mandated escalation plan.

In other words, CMS's efforts to address all the problems faced by CO–OPs appear to have failed, just like virtually every other element of this program.

The failure of CMS to adequately implement the CO–OP program is well-documented here on the Finance Committee and elsewhere. As with so many other parts of Obamacare, the high-minded rhetoric surrounding this program has fallen short of reality.

With nearly half of the CO–OPs now closed, the failed experiment has wasted taxpayer dollars and forced patients and families to scramble for new insurance. With so many CO–OPs now in financial jeopardy, I believe that CMS should work with, not against States, to safeguard taxpayer dollars.

So, as always, we have a lot to discuss. And I look forward to hearing more from the officials we have testifying here today.

PREPARED STATEMENT OF HON. RON WYDEN,
A U.S. SENATOR FROM OREGON

It is old news that the rollout of *HealthCare.gov* 3 years ago was botched. It is new news that the Inspector General of HHS recently said, quote, "CMS recovered the *HealthCare.gov* website for high consumer use within 2 months, and adopted more effective organizational practices. . . ."

That quote comes from one of two reports looking back at 2013 and 2014 that the Finance Committee will be presented with today. Let's recognize that the story here is well-documented. After the launch went badly, some of the best minds in tech and a new contractor were brought in, they scrambled to overhaul the system, and the exchange was soon up and running. And CMS is following up on every one of the Inspector General's recommendations, which the IG notes in its report.

In the most recent enrollment period, nearly 10 million Americans used *HealthCare.gov* to sign up for a plan or re-enroll automatically.

And in my home State, which has had its own problems, close to 150,000 people have used the website to sign up for a plan as of January 31st. That's up by more than 30 percent compared to last year.

The committee will also hear an update today from the Government Accountability Office on what's called a "secret shopper" investigation. GAO first brought this study before the committee in July last year. And I'll repeat now what I said back then: On this side of the aisle, we don't take a back seat to anybody in fighting fraud and protecting taxpayer dollars. One dollar ripped off is one dollar too many. But let's recognize that what was true last summer remains true today. This GAO investigation has not uncovered one single shred of real-world fraud in the insurance marketplaces. It was built on fictitious characters with specially-created identities, not real consumers or real fraudsters.

It's true the GAO found that there are sometimes differences between the information on somebody's insurance application and their tax forms and citizenship records. But when it comes to these inconsistencies in people's data, this investigation can't differentiate between fraud and a typo.

And meanwhile, HHS does not look the other way when it finds these red flags. In 2014, the year of GAO's investigation, CMS closed more than 100,000 insurance policies because documents didn't match or weren't provided. Tax credits were adjusted for nearly 100,000 households. In 2015, HHS closed more policies and adjusted more tax credits. If you come at this from the left, you might say that's too harsh. If you come at it from the right, you might take a different view. But there is no basis whatsoever for the argument that HHS ignores problems in people's records or leaves the door open to fraud.

So in closing, rather than rehashing old news, I'd prefer to look at the facts. Because of the ACA, the number of Americans without health insurance is at or near its lowest point in half a century. For the 160 million people who get their insurance from their employer, premiums climbed only 4 percent last year. Working-age Americans in Oregon and nationwide with preexisting conditions—80 million people or more—can no longer be denied insurance.

Now, instead of battling it out over what happened 3 years ago, let's start pulling on the same end of the rope and solve some real problems. For example, Democrats and Republicans ought to be working together to stoke more competition in the insurance marketplace and bring costs down for consumers.

Next, there are going to be spectacular, new cures available in the future, and there are real questions as to whether our health care system will be able to afford them. Senator Grassley and I put together a bipartisan case study that looked into one such drug, which treats Hepatitis C. Solving this issue of blockbuster drug costs is going to take a lot of hard work on a bipartisan basis.

Congress also has a duty to take Medicare's historic guarantee and reinforce it for a new generation of Americans. In my view, it starts with revolutionizing the way Medicare handles caring for seniors with chronic conditions like diabetes, cancer and Alzheimer's. Members on both sides of this committee, thanks to steadfast work by Senators Warner and Isakson, and Chairman Hatch's leadership, have built a bipartisan game plan for chronic care. And it's my hope that the committee is able to continue its progress on that front.

Those are the kind of health care challenges I believe this committee should be focused on tackling. With that, I want to thank our witnesses for being here today.