STATEMENT OF

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ON

AFFORDABLE CARE ACT IMPLEMENTATION

BEFORE THE

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Affordable Care Act Implementation

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Good morning, Chairman Issa, Ranking Member Cummings, and members of the Committee. I appreciate the opportunity to update you on CMS' progress and our continuing work to implement the Affordable Care Act and provide consumers with affordable access to high quality coverage. As we prepare for the second year of Health Insurance Marketplace Open Enrollment, CMS is building on our successes and lessons we have learned, while continuing our focus on providing consumers with more affordable coverage options and a secure, consumer friendly online Marketplace. CMS remains committed to ensuring that the Marketplace continues to adhere to the stringent privacy and security protocols necessary to protect consumers' personally identifiable information.

A new wave of evidence shows that the Affordable Care Act is working to make health care coverage more affordable, accessible and of a higher quality, for families, seniors, businesses, and taxpayers alike. Thanks to the Affordable Care Act, consumers today enjoy better access to affordable health coverage, stronger protections in the case of illness or changes in employment, and a competitive Marketplace that allows them to choose from and enroll in insurance coverage that is right for them. Millions of people have obtained private insurance coverage in the Marketplace, over seven million children, families, and individuals have gained coverage through Medicaid and CHIP, and more than three million young adults gained or retained insurance under the Affordable Care Act by staying on their parents' plan. The Marketplace is enrolling people every day and is available when people need it – currently consumers are getting coverage through the Marketplace when they qualify for a special enrollment period, available to those that lose employer coverage, get married or have a baby, or have other qualifying life events.

As we plan for the second Open Enrollment, including the first opportunity for many consumers to re-enroll in coverage, we are focused on building on the advances made for consumers during

the first year. Our focus is on providing consumers more choices for coverage and affordable options, assisting them with selecting the right plan for them, and educating first-time and newly insured consumers about their benefits, their eligibility requirements, and their financial protections.

At the same time we are keenly aware of the challenges we face as a new program of this scale matures, particularly one that faced significant challenges in its first year. It is thanks to the work of a committed team heeding the lessons of the last year that we will continue to build on the success of the first year of State-based and Federally-facilitated Marketplace (FFM).

Continued Focus on Privacy and Security

Each and every day, U.S. businesses and government IT systems and individual consumers face a myriad of cyber threats. No website is immune from attempted attacks, and CMS acknowledges that risks exist inherently for every IT system. CMS appreciates the work of the Government Accountability Office and HHS Office of Inspector General to help us identify controls and processes that could be improved to further reduce or mitigate risk.

CMS remains committed to privacy and security protocols to protect consumers' personally identifiable information; consumers can use the Marketplace with the confidence that their personal information is secure. To date, there is no evidence that a person or group has maliciously accessed personally-identifiable information (PII) from the site. The privacy and security of consumers' PII are top priorities for CMS. As part of that effort, CMS has taken many steps and implemented several security controls to secure PII related to the FFM and its supporting databases.

CMS developed the Marketplace systems consistent with Federal statutes, guidelines, and industry standards that help ensure the security, privacy, and integrity of the systems and the data that flow through them. Components of the website that are operational have been determined to be compliant with the Federal Information Security Management Act (FISMA), based on standards promulgated by the National Institute of Standards and Technology (NIST).

Marketplace systems are also in compliance with all the relevant privacy and security statutes, including the Privacy Act. Additionally, the Internal Revenue Service accepted the CMS Safeguard Procedures Report as certification that the confidentiality of Federal tax information disclosed to CMS would be adequately protected.

Systems Designed with Security as a Top Priority

Privacy and security has been a high priority throughout the development of HealthCare.gov and related FFM systems. CMS has developed a tool, known as the Federal Data Services Hub (the Hub), that provides an electronic connection between the eligibility systems of the Marketplaces to already existing, secure Federal and state databases to verify the information a consumer provides in their Marketplace application. The Hub was specifically designed to minimize security risk by developing a system that does not retain or store PII. The Hub increases efficiency and security by eliminating the need for each Marketplace, Medicaid agency, and CHIP agency to set up separate data connections to each database.

The Marketplace application on HealthCare.gov never asks for personal health information beyond what is normally asked for in Medicaid eligibility applications. This is due to the provisions in the Affordable Care Act, which prohibit issuers from denying applicants insurance based on pre-existing conditions or charging more based on health status. Consumers in the Marketplace do not need to disclose details of their medical history as they might have had to do to apply for health coverage in the past.

An independent security control assessor tested each piece of the FFM that went live October 1 prior to that date with no open high findings. All high, moderate, and low security risk findings for the portions of the website that launched October 1 were either fixed or had strategies and plans that met industry standards in place to fix the findings. In keeping with industry practice, CMS established strong security controls and standards for each state to meet in order to connect to the Hub. These controls and standards are based on Federal security guidelines. Each state had to sign a Computer Matching Agreement, an Interconnection Security Agreement and an Information Exchange Agreement, all of which bind the state to rules and operating procedures

related to data security and privacy. Additionally, each state was required to complete a security plan, a risk assessment which can either be a self-assessment or a third-party assessment, and a corrective action plan to address risks. Every state that was connected to the Hub adhered to these procedures.

Ongoing Security Focus

CMS has implemented other measures to protect PII, including penetration testing, which happens on an ongoing basis using industry best practices to appropriately safeguard consumers' personal information. As part of the ongoing testing process, and in line with Federal and industry standards, any open risk findings are appropriately addressed with risk mitigation strategies and compensating controls. The security of the system is also monitored by sensors and other tools to deter and prevent unauthorized access. CMS conducts continuous monitoring using a 24/7, multi-layer IT professional security team, added penetration testing, and ongoing testing and mitigation strategies implemented in real time. These layered controls help protect the privacy and security of PII related to the FFM.

CMS continues to test security functionality through quarterly Security Control Assessments (SCAs) which is beyond the industry standard. In addition to daily operational security testing, a comprehensive end-to-end Security Control Assessment that meets industry standards will be conducted by independent assessors next month. This Security Control Assessment will test security for open enrollment and plan year functionality.

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

Recent years have seen historically low growth in overall health spending, and a variety of recent data show that slow growth in health care costs is continuing.[1,2] Preventive benefits, including

[1] Council of Economic Advisers. 2014. "Recent Trends in Health Care Costs, Their Impact on the Economy, and the Role of the Affordable Care Act." *Economic Report of the President*, http://www.whitehouse.gov/sites/default/files/docs/erp_2014_chapter_4.pdf.

[2] Jason Furman. "Good News on Employer Premiums Is More Evidence of a Dramatic Change Economic Change for the Better," http://www.huffingtonpost.com/jason-furman/good-news-on-employer-pre_b_5798244.html.

wellness visits and screenings with no cost sharing for Medicare beneficiaries, as well as new incentives to pay doctors and hospitals for improving outcomes, are aimed at improving the quality of the health care that Americans receive.

Thanks to the Affordable Care Act, we are also taking important steps to improve the quality of care for Medicare beneficiaries, while improving Medicare's long-term solvency. More than 8.2 million seniors have saved more than $11.5 billion on prescription drugs since 2010. Medicare Part B premiums are projected by the Medicare Trustees to be the same in 2015 as they were in 2013 and 2014. Additionally, the Medicare Trustees recently projected that the trust fund that finances Medicare's hospital insurance coverage will remain solvent until 2030, four years beyond what was projected in last year's report.[3] Due in part to reforms in the Affordable Care Act, per beneficiary spending is projected to continue to grow slower than the overall economy for the next several years. We have made major progress in improving patient safety, decreasing hospital readmissions, and establishing new payment models such as accountable care organizations aimed at reducing costs and improving quality. These reforms are designed to slow the rise in health care spending while improving the quality of care for beneficiaries. In addition, the Congressional Budget Office (CBO) recently released updated projections[4] providing further evidence that Medicare is stronger today than it was prior to the Affordable Care Act – including that the rate of growth in spending is expected to be slower than the rate of growth in the number of beneficiaries in 2014.

The Affordable Care Act benefits Americans broadly, not simply those who are newly insured. Over the past three years, Americans have benefitted from insurance reforms that have already gone into effect, such as allowing adult children up to age 26 to stay on their parents' insurance, eliminating lifetime dollar limits on essential health benefits, and prohibiting rescissions of insurance because someone gets sick.

[3] http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/downloads/tr2014.pdf
[4] http://cbo.gov/sites/default/files/cbofiles/attachments/45653-OutlookUpdate_2014_Aug.pdf

Now, in 2014, pre-existing conditions no longer preclude individuals from gaining health insurance, and consumers have better access to comprehensive, affordable coverage. Consumers now have the comfort of knowing that if their employment changes or they lose coverage for any reason, they can purchase affordable coverage through the Marketplace—regardless of their personal health history. New protections also ensure that consumers' premium dollars are spent primarily on medical care, rather than on administrative expenses. Since the Medical Loss Ratio program's inception in 2011, consumers have saved an estimated $9 billion. This year, 6.8 million consumers across all states and markets will receive over $330 million in refunds, with an average rebate of $80 per family.[5]

The market reforms are effective because they have benefits across the health care system. Reductions in the uninsured rate generally mean that doctors and hospitals provide less uncompensated care, the costs of which are often passed along to taxpayers as well as consumers and employers who pay premiums for health coverage. And new pools of people buying insurance means insurers have an opportunity to grow by competing to provide better access to quality, affordable choices, the benefits that consumers are used to in any competitive marketplace. The creation of a successful, viable health insurance market has benefits for all Americans no matter where they get their health insurance.

Reductions in the Uninsured Rate

Several recent reports make clear that the Affordable Care Act is reducing the uninsured rate. A study published in the *New England Journal of Medicine* found that, as compared with the baseline trend, the non-elderly uninsured rate declined by 5.2 percentage points by the second quarter of 2014, a 26 percent relative decline from the 2012–2013 period, corresponding to 10.3 million adults gaining coverage.[6] Other independent surveys all point to the same overarching trend—the success of the Affordable Care Act in lowering the number of uninsured Americans.

[5] http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Final-MLR-Report_07-22-2014.pdf

[6] New England Journal of Medicine, Health Reform and Changes in Health Insurance Coverage in 2014.

Consumers are finding affordable coverage options, a greater choice of plans, and coverage that meets their care needs. The vast majority of consumers who gained private insurance coverage through the Marketplace are paying $100 or less per month. In fact, nearly half of individuals selecting plans with tax credits in the FFM – specifically, 46 percent – were able to get covered for $50 per month or less. For many it was the first time they had a real choice in health plans - during Open Enrollment for the 2014 plan year, consumers could choose from an average of over 40 Marketplace plans.[7] The Commonwealth Fund survey found that nearly two in three of newly-covered consumers who went to the doctor or filled a prescription said they would not have been able to afford or access those services were it not for their new coverage, and more than three in four newly-insured consumers expressed satisfaction with their coverage.

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

As we embark on the second Open Enrollment period, CMS is concentrating now on several critical priorities to build on the progress from the first year of operations. We are focused on increasing the value to consumers by continuing to improve the information, plan options, and affordability of the shopping experience. We are working to ensure that consumers satisfied with their current Marketplace coverage can reenroll, while continuing our efforts to reach those who are eligible, but not yet enrolled in coverage. We are also addressing the execution and technology lessons we learned during the first open enrollment period with a disciplined, highly accountable and visible management structure.

Bringing More Value to Consumers in the Marketplace

Like any marketplace, the Marketplace leverages technology to bring more value, better information and a better shopping experience to consumers. Driven by competition and the significant demand for health coverage, our goal is to expand health plan options with more affordable premiums for consumers.

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

The Affordable Care Act has increased competition in the market and offered more plan options to consumers. In the coming year we expect insurers to bring more options in more geographic markets, including in markets where consumers have historically had limited options for coverage. While we are still reviewing the proposed plans to ensure they meet the requirements for participation in the Marketplace, we have seen an increase in the number of insurers seeking to participate in the Marketplace in the 2015 plan year. With more choices in year two, consumers should have an even greater opportunity to find a quality health plan that best meets their needs.

As we work to bring greater choice to consumers, CMS is also bringing more value to consumers in the coming year is by improving the transparency for provider networks. CMS will hold insurers to a "reasonable access" standard for network adequacy and will identify provider networks that fail to provide access without unreasonable delay, especially in areas that have historically raised network adequacy concerns, such as hospital systems, mental health providers, oncology providers, and primary care. Many health insurers are strengthening their networks, increasing inclusion of Essential Community Providers, and improving access to prescription drugs. We are also working to prevent cost sharing discrimination so that consumers have access to the appropriate services.

CMS is also continuing to monitor consumers' access to provider directories to help consumers more easily find network providers. Insurers are now expected to provide links that connect consumers directly to provider directories specific to a given plan option without needing to log in, enter a policy number, or navigate through various websites. CMS expects that insurers will maintain these directories and that they will be kept up to date and will include location, contact information, specialty, medical group, institutional affiliations, and whether the provider is accepting new patients—information consumers need to make informed health plan decisions.

While many are already utilizing their new coverage, we know that many consumers have received coverage for the first time in years – some for the first time ever, so they may need a little extra help in understanding their rights and their new coverage. Our From Coverage to Care

initiative helps people with new health care coverage understand their benefits and connect to primary care and the preventive services that are right for them, so they can live a long and healthy life. The goal of the initiative is to help the newly insured navigate the healthcare system, improve their health and insurance literacy, promote patient engagement, and know what services are available in their local community.

For those who are currently enrolled in Marketplace coverage, CMS is working to make the process of renewing coverage as simple as possible. We will encourage everyone to come back to the Marketplace to update their eligibility information and shop for the best coverage option that meets their needs. And for those consumers who are satisfied with their current plan and don't want to change, we will follow the model used by most employers and in the Medicare Advantage and Part D programs, and allow people to automatically re-enroll.

While we know millions have signed up for new coverage, we know more work remains to reach out to those who are not yet covered, to educate them about the benefits of health insurance and assist them in signing up for plans that fit their needs. We recognize these challenges cannot be managed from Washington alone. One of the lessons we learned over the past year was that one of the most effective ways to get people enrolled is through in-person help in their own communities. In a survey of Marketplace assister programs, including Navigators, in-person assisters, certified application counselors, and others, Kaiser Family Foundation found that assistor programs helped an estimated 10.6 million people during the first open enrollment period.[8] We've put a priority on recruiting more organizations to sign up to be Certified Application Counselors and recruiting more local leaders to be in-person assistors. We will also continue working with agents and brokers as they utilize their experience and existing relationships with consumers and small businesses to assist them in enrolling in coverage.

Adding Critical Functionality to Operate the Marketplace

Significant technological improvements are underway to support the operation of the Marketplace in a more automated fashion and to allow consumers to renew their coverage as

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

seamlessly as possible this year. Building this functionality means ruthlessly prioritizing efforts to execute on critical capabilities, while setting the course for further improvement and development of new functionality in coming years.

Critical focal areas include completing functionality that was targeted for the first year of development, but has not yet been completed, such as launching an online exchange for small businesses and their employees. In addition, we are building the functionality required for renewing members and adding to the infrastructure to better support open enrollment. As we make these improvements, we are focused on managing our resources efficiently and are conscious of the limited time available for technology development this year.

We have created clear accountability for the leadership of this project. Earlier this year, Secretary Burwell announced a series of organizational changes designed to strengthen the implementation of the Affordable Care Act, including the recent addition of Kevin Counihan as Marketplace Chief Executive Officer, with responsibility and accountability for leading the FFM, and managing relationships with the state Marketplaces. Most recently, he served as Connecticut's Health Insurance Exchange CEO. Our new leadership structure will improve the discipline and focus of the project, enhance communications, and identify risks throughout the project. Like any project of this size, there will always be ongoing challenges, but we are building an operation better suited to identify and resolve them.

Conclusion

The Affordable Care Act is delivering on the promise of access to high quality, affordable health care coverage, while controlling the growth of health care costs. While the Marketplace is still at an early stage, we are hard at work building on the successes and lessons learned from the first open enrollment, and look forward to meeting the needs of consumers and insurers as we continue to learn and improve for future years. The transition to a reformed health insurance market will take sustained effort, persistence, and focus from all stakeholders, but CMS is committed to continuing to deliver on the promise of the Affordable Care Act and improving

health care access, cost, and quality for all Americans. I thank you for the opportunity to update you on our efforts, and look forward to answering any questions you may have.

Marilyn Tavenner is currently the Administrator for the Centers for Medicare & Medicaid Services. Previously, Ms. Tavenner was Principal Deputy Administrator for the Centers for Medicare & Medicaid Services (CMS). As the Principal Deputy Administrator, Ms. Tavenner served as the agency's second-ranking official overseeing policy development and implementation as well as management and operations.

Prior to assuming her CMS leadership role, Ms. Tavenner served for four years as the Commonwealth of Virginia's Secretary of Health and Human Resources in the administration of former Governor Tim Kaine. In this top cabinet position, she was charged with overseeing 18,000 employees and a $9 billion annual budget to administer Medicaid, mental health, social services, public health, aging, disabilities agencies, and children's services.

Before entering government service, Ms. Tavenner spent 25 years working for the Hospital Corporation of American (HCA). She began working as a nurse at the Johnson-Willis Hospital in Richmond, Va., in 1981 and steadily rose through the company. By 1993, she began working as the hospital's Chief Executive Officer and, by 2001, had assumed responsibility for 20 hospitals as President of the company's Central Atlantic Division. She finished her service to HCA in 2005 as Group President of Outpatient Services, where she spearheaded the development of a national strategy for freestanding outpatient services, including physician recruitment and real estate development.

Ms. Tavenner holds a bachelor's of science degree in nursing and a master's degree in health administration, both from the Virginia Commonwealth University.

She has worked with many community and professional organizations, serving as a board member of the American Hospital Association, as president of the Virginia Hospital Association, as chairperson of the Chesterfield Business Council, and as a life-long member of the Rotary Club. Her contributions also include providing leadership in such public service organizations as the March of Dimes, the United Way and the Juvenile Diabetes Research Foundation. In addition to numerous business awards, Ms. Tavenner has been recognized for her volunteer activities, including the 2007 recipient of the March of Dimes Citizen of the Year Award.