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Implementing Obamacare: A Review of CMS' Management of the State-Based Exchanges



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II. Executive Summary

In March 2010, President Obama signed the Patient Protection and Affordable Care Act (PPACA) into law. The law created an entirely new framework for individuals to purchase health care insurance, known as a health care insurance exchange. The law anticipated that these exchanges, also known as marketplaces, would allow individuals to easily compare health insurance plans on the internet and select a plan that was affordable and addressed their health needs.

The health insurance exchange was initially proposed as a single federal marketplace to purchase insurance. Former Senator Ben Nelson (D-NE), however, advocated that the states should remain the primary regulators of the market and should have the opportunity to establish their own exchanges, with the federal exchange available as a backup. The final legislation, in Section 1311, gave each state the authority to establish its own State-Based Exchange (SBE) to sell qualified health insurance plans. Section 1311 further authorized the federal government to provide grants to states to facilitate the establishment of SBEs.

The Department of Health and Human Services (HHS) tasked its Centers for Medicare and Medicaid Services (CMS) with administering many provisions of the law, including the creation of the federal exchange and its IT platform, healthcare.gov. CMS also oversaw, on behalf of the federal government, the establishment of SBEs. Many states did not establish their own exchanges and instead rely upon the Federal IT platform, healthcare.gov. Ultimately, 16 states and the District of Columbia established their own exchanges under the authority of Section 1311. CMS provided federal grants totaling nearly \$4.6 billion to SBEs and was supposed to ensure that the exchanges spent the grant money in accordance with the law.

To date, four SBEs—Oregon, Hawaii, New Mexico, and Nevada—have failed, and one other, Kentucky, has announced that it plans to close by the end of 2017. While each state's circumstances are unique, there appear to be common factors in each state's experience of failing to sustain its SBE—lower-than-expected enrollment, higher-than-anticipated costs, and more complicated-than-anticipated technology challenges. The same challenges continue to plague many of the surviving SBEs, and in testimony before the Energy and Commerce Subcommittee on Oversight and Investigation on December 8, 2015, CMS Acting Administrator Andrew Slavitt did not express confidence that the remaining SBEs would succeed in the long run.

The committee began its investigation in the spring of 2015 for the purposes of examining the failures of the SBEs and CMS's oversight of the \$4.6 billion in federal grant funding administered to the SBEs. The committee requested and received documents from the 17 original SBEs, heard testimony from SBE administrators and federal officials, and received briefings from CMS officials regarding its oversight of SBE activities. These efforts have provided the committee with a detailed understanding of the status of SBEs and CMS's authorities and responsibilities for administering and overseeing the program.

The committee's investigation found that CMS has not met its regulatory responsibilities to conduct robust oversight over the SBEs and the \$4.6 billion in grants they received, resulting

in the waste of federal tax dollars. While PPACA explicitly stated that states receiving Section 1311 establishment grants must be self-sustaining by January 1, 2015, CMS uniformly approved No Cost Extensions to allow the use of establishment grant funding after January 1, 2015. The PPACA also explicitly prohibited the use of establishment grant funds for operational costs. The committee's investigation, however, found that CMS allowed states to violate this provision when it approved states' requests to use establishment grant funds for operational costs.

The committee also found CMS' actions deficient in several other areas. First, the PPACA explicitly requires states receiving Section 1311 grants to identify wasteful uses of grant funds, and post them publically, but only one SBE has appeared to fulfill this requirement. Yet, CMS does not appear to have taken any action to enforce this statutory requirement. Second, CMS made exceptions for consumer assistance personnel in SBEs that it expressly prohibited in federally facilitated exchange states due in part to concerns that such a system provides adverse incentives to enroll individuals regardless of whether enrollment was in the best interest of the individual. Third, the committee found that CMS ignored the recommendations of third-party watchdogs—the nonpartisan Government Accountability Office (GAO) and the HHS Office of Inspector General (HHS OIG)—who found issues with the states' use of establishment grants. HHS OIG further identified misspent federal dollars that CMS has refused to recoup. In fact, the committee found that CMS recovers only a small fraction of misspent funds from SBEs. Such actions—and inactions—on the part of CMS mean that SBEs have escaped public accountability for monies spent to establish and operate SBEs.

CMS now appears to be encouraging SBEs to close and join the federal exchange by allowing failed SBEs to keep user fees collected by insurance carriers intended to pay for the use of healthcare.gov and offering a reduced user fee to failed SBEs beginning in 2017. To date, CMS has not imposed any negative consequences on a state for abandoning its SBE and transitioning to healthcare.gov, and has given no indication that it plans to do so in the future.

By 2017, at least five of the original SBEs will have closed, leaving only 12 remaining. These five SBEs alone represent hundreds of millions in wasted taxpayer dollars. Effective oversight and implementation of the SBE program involves several entities, requiring CMS and various state agencies and departments to work together to administer operations. While no single entity can bare total blame for past failure, it is imperative that the responsible federal agency, CMS, be held accountable to ensure the protection of taxpayer dollars. Neglecting to limit the dollars granted to SBEs and inadequate oversight of documented wasteful spending has cost the American taxpayer millions of dollars. Six years into the implementation of the president's signature health care law, it is time that the administration strengthen its measures to account for the significant waste of taxpayer dollars, and improve oversight on the SBE program.

III. Findings

- CMS is not confident that the remaining SBEs will be sustainable in the long term.
- As of September 2016, every SBE still relies upon federal establishment grant funds—20 months after SBEs were to be self-sustaining by law.
- CMS flagged four categories of possible operational expenses in Minnesota’s SBE budget, but permitted the expenditures of federal grant money in each case.
- *Only one* SBE—Kentucky—complied with PPACA’s requirement that all SBEs publish the costs associated with operating its exchange on the internet, including monies lost to waste, fraud, and abuse.
- CMS prohibits pay-per-enrollee schemes in federally facilitated exchange states, but permits the same problematic scheme in SBEs in order to increase enrollment numbers.
- The HHS Inspector General found that Maryland and Nevada violated federal rules and used federal dollars* to pay for unpermitted SBE expenses.
- CMS failed to enforce its own rules on Medicaid allocations, and did not recover the misspent dollars identified by the HHS Inspector General.
- CMS has recovered *only* \$1.6 million in misspent federal funds from three SBEs. Nearly \$1 million was for impermissible construction costs that went undetected by CMS for over a year.
- The Government Accountability Office issued two reports on CMS oversight of the SBEs. All six of the recommendations for how CMS can improve its oversight of the SBEs remain “open,” indicating that CMS has not implemented a single one.
- CMS eased the transition for failed SBEs to join healthcare.gov by allowing them to keep user fees collected by insurance carriers intended to pay for the use of healthcare.gov.
- Starting in 2017, CMS will offer failed SBEs a “reduced” rate of 1.5 percent to use healthcare.gov, at the expense of federal taxpayers.
- According to CMS, SBEs have “a right to change their mind” if a state decides it no longer wants to operate an exchange.

*An earlier version of this report included the word “Medicaid” above and on page 46.

IV. Background

A. PPACA Authorizes States to Establish State-Based Health Care Insurance Exchanges

President Obama signed PPACA into law on March 23, 2010.¹ The law imposed new taxes and regulations regarding health care insurance for individuals and families, including a mandate requiring individuals to purchase insurance or pay a tax. The sweeping law also created an entirely new framework for individuals to purchase health care insurance, known as a health care insurance exchange. The law anticipated that these exchanges, also known as marketplaces, would allow individuals to compare various aspects of health insurance plans on the Internet, including premiums and deductibles, and purchase the best plan for the individual's lifestyle. President Obama envisioned that the consumer could shop for health insurance on an exchange "the same way you'd shop for a plane ticket on Kayak or a TV on Amazon."²

Initial proposals envisioned a single federal marketplace to purchase insurance; however, Senator Nelson advocated instead for states to have the option of establishing their own exchanges, with the federal exchange available as a "[b]ackup if a state was either unable or unwilling to create an exchange."³ Senator Nelson further argued that the states should remain the primary regulators of the market.⁴ As a result, the final framework for the PPACA authorized the establishment of state-based exchanges. When the law was signed, lawmakers assumed that most states would establish their own state-based exchanges.⁵

1. How State-Based Exchanges are Intended to Work

The PPACA intended that state-based health care insurance exchanges would create "more efficient and competitive health insurance markets for individuals and small employers."⁶ SBEs were supposed to help consumers compare health care insurance plans by price, benefits, and the quality of coverage. The PPACA also created new entitlement programs in the form of

¹ Patient Protection and Affordable Care Act, Pub. L. No 111-148, 124 Stat. 119 (2010).

² President Barack Obama, Remarks by the President on the Affordable Care Act and the Government Shutdown (Oct. 1, 2013), *available at* <https://www.whitehouse.gov/the-press-office/2013/10/01/remarks-president-affordable-care-act-and-government-shutdown>.

³ Letter from Hon. Ben Nelson, former U.S. Senator, Nebraska, to Hon. Robert P. Casey, Jr., U.S. Senator, (Jan. 27, 2015), *available at* http://theusconstitution.org/sites/default/files/briefs/Senator_Casey_re_King_v_Burwell-27_JAN_2015.pdf.

⁴ *Id.*

⁵ Robert Pear, *Four Words That Imperil Health Care Law Were All a Mistake, Writers Now Say*, N.Y. TIMES, May 25, 2015 ("[S]enators and staff lawyers came to believe that some states — 'five or 10 at the most' — would choose not to set up exchanges, said Christopher E. Condeluci, who was a staff lawyer for Republicans on the Finance Committee.").

⁶ U.S. Dep't of Health & Human Serv., Centers for Medicare & Medicaid Serv., Center for Consumer Info. & Ins. Oversight, *Cooperative Agreement to Support Establishment of the Affordable Care Act's Health Insurance Exchanges*, Funding Opportunity Number: IE-HBE-12-001 (Dec. 6, 2013).

the Advanced Premium Tax Credit (APTC) and the Cost Sharing Reduction (CSR) Program, which provide health insurance subsidies to qualified individuals.

Pursuant to the PPACA, SBEs may only sell health insurance plans that comply with HHS regulations and offer the required essential health benefits.⁷ The PPACA also requires that SBEs be capable of carrying out certain functions. For example, each SBE must:

- Enable individuals to determine his or her eligibility for enrollment in private health care coverage and other federal programs, such as Medicaid;⁸
- Allow the individual to apply for enroll for coverage for which they are qualified;⁹
- Certify qualified health plans submitted by state agencies and health plan issuers;¹⁰
- Determine an individual's eligibility for subsidies provided under the APTC and the CSR Program;¹¹ and
- Facilitate payment of premiums to issuers and payment of CSRs for qualified individuals.¹²

A SBE must also have the capability to assist individuals as they attempt to enroll, and answer questions about eligibility and different coverage options. SBEs accomplish this through grants for in-person assistance programs, and through hotlines and call centers. SBEs are required to have their own IT systems facilitating enrollment and real-time eligibility queries, that has the capability to cross check an individual's information with information in other federal databases.

Although the PPACA initially anticipated that every state would establish its own exchange, many states' reticence to establish a full-fledged SBE led to the creation of hybrid models wherein the federal and state governments share responsibilities. Currently, there are three types of exchanges in addition to the SBE model.

⁷ 42 U.S.C. § 18031.

⁸ *Id.*

⁹ *Id.*

¹⁰ *Id.*

¹¹ *Id.*

¹² *Id.*

Exchange Model	States
State-Based Exchange	California, Colorado, Connecticut, District of Columbia, Idaho, Kentucky, Maryland, Massachusetts, Minnesota, New York, Rhode Island, Vermont, Washington
Federally-Supported Exchange	Oregon, Nevada, New Mexico, Hawaii
State-Partnership Exchange	Arkansas, Delaware, Illinois, Iowa, Michigan, New Hampshire, West Virginia
Federally-Facilitated Exchange	Alabama, Alaska, Arizona, Florida, Georgia, Indiana, Kansas, Louisiana, Maine, Mississippi, Missouri, Montana, Nebraska, New Jersey, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Wisconsin, Wyoming

In a *federally-supported exchange*, the state performs all exchange functions, like consumer assistance and plan management, but the consumers use healthcare.gov. Four former SBEs – Oregon, Hawaii, Nevada, and New Mexico – use this model. A *state-partnership exchange* requires that states administer in-person consumer assistance functions, but HHS performs all other functions and consumers use healthcare.gov. Seven states use this model. In a *federally-facilitated exchange*, HHS performs all marketplace functions, and consumers in these states apply for coverage through healthcare.gov. Twenty-seven states use the federally-facilitated exchange.

2. Section 1311 Authorizes Federal Grants to States

Under the PPACA, each state had the option to establish a SBE. To facilitate this, the law granted HHS the ability to award federal grants (known as “1311 grants,” or “establishment grants”) to states to assist with establishing SBEs. HHS ultimately awarded establishment grants to 49 states and the District of Columbia.¹³ While nearly every state received money through establishment grants, only 16 states and the District of Columbia ultimately established a SBE.¹⁴

The PPACA provided parameters within which SBEs could spend federal grant money, including establishment grants. First, the law required that SBEs be “self-sustaining” by January 1, 2015, and authorized the states to raise revenue to support the operations of the exchange:

(A) No federal funds for continued operations

In establishing an Exchange under this section, the State shall ensure that such Exchange is self-sustaining beginning on January 1, 2015, including

¹³ Alaska was the only state that did not apply for or receive a grant from CMS to establish a state-based exchange. See U.S. Dep’t of Health & Human Serv., Centers for Medicare & Medicaid Serv., *Health Insurance Exchange Establishment Grants*, available at www.cms.gov/ccio/resources/marketplace-grants/ (last visited Apr. 28, 2016).

¹⁴ U.S. Dep’t of Health & Human Serv., Centers for Medicare & Medicaid Serv., Center for Consumer Info. & Ins. Oversight, *State Health Insurance Marketplaces*, <https://www.cms.gov/ccio/resources/fact-sheets-and-faqs/state-marketplaces.html>, last updated June 15, 2015.

allowing the Exchange to charge assessments or user fees to participating health insurance issuers, or to otherwise generate funding, to support its operations.¹⁵

Second, the law prescribed that grants shall be used for “activities (including planning activities) related to establishing an [exchange].”¹⁶ In other words, establishment grants could not be used to pay the operational expenses of the SBE.¹⁷

The law also expressly prohibited the wasteful use of funds:

(B) Prohibiting wasteful use of funds

In carrying out activities under this subsection, an Exchange shall not utilize any funds intended for the administrative and operational expenses of the Exchange for staff retreats, promotional giveaways, excessive executive compensation, or promotion of Federal or State legislative and regulatory modifications.¹⁸

HHS awarded four different types of 1311 establishment grants to the states:

- **Planning Grant:** Planning Grants provided resources to conduct research and planning activities related to establishing a state-based exchange. States were to focus on nine core areas of planning: Stakeholder Involvement, Governance, Program Integration, Regulatory/Legislative Actions, Technical Infrastructure, Finance, Resources and Capabilities, and Business Operations.¹⁹
- **Early Innovator Grant:** Early Innovator Grants provided funding to assist states that were identified as early leaders in designing and implementing IT infrastructure to operate the exchange. The intent was to adopt or modify the software and data models of the “early innovator” states for other states.²⁰
- **Level 1 Establishment Grant:** These grants provided funding to help states undertake additional marketplace activities, such as responding to legislative or regulatory requirements, developing IT systems, and

¹⁵ 42 U.S.C. 18031(d)(5).

¹⁶ 42 U.S.C. § 18031(a)(3).

¹⁷ *Id.*

¹⁸ 42 U.S.C. § 18031(d).

¹⁹ U.S. Dep’t of Health & Human Serv., Centers for Medicare & Medicaid Serv., Center for Consumer Info. and Ins. Oversight, *State Planning and Establishment Grants for the Affordable Care Act’s Exchanges* (July 29, 2010).

²⁰ U.S. Dep’t of Health & Human Serv., *Cooperative Agreements to Support Innovative Exchange Information Technology Systems* (Oct. 29, 2010).

consulting with stakeholders. Once awarded, the funds were available for one year, and a state could apply for multiple grants.²¹

- **Level 2 Establishment Grant:** These grants provided funding to help the states carry out all marketplace activities, including consumer and stakeholder engagement and support, eligibility and enrollment, plan management, and technology development. The grants were awarded between May 2011 and December 2014. Once awarded, the grant funds remained available for up to 3 years. Grantees submitted progress reports documenting financial expenditures and program progress through an online data collection system on a monthly and semi-annual basis.²²

The law authorized HHS to award establishment grants through December 2014.²³ HHS awarded approximately \$4.6 billion in 1311 grants to the 16 states and the District of Columbia that decided to establish a state-based exchange.^{24 25}

State-Based Exchange	Grant Award
California	1,065,683,056
New York	575,079,804
Washington	302,333,280
Kentucky	289,303,526
Massachusetts	233,803,787
Vermont	199,718,542
District of Columbia	195,141,151
Maryland	190,130,143
Minnesota	189,363,527
Colorado	184,986,696
Connecticut	175,870,421
Rhode Island	152,574,494
Idaho	105,290,745
Oregon	305,206,587
New Mexico	123,281,600
Nevada	101,001,068
Hawaii	205,342,270
Total	\$4,594,110,697

For those states that did not elect to establish an exchange, the PPACA also directed the federal government to establish and operate a health insurance exchange for consumers in those

²¹ U.S. Dep’t of Health & Human Serv., Centers for Medicare & Medicaid Serv., Center for Consumer Info. and Ins. Oversight, *Cooperative Agreement to Support Establishment of the Affordable Care Act’s Health Insurance Exchanges*, Funding Opportunity Number: IE-HBE-12-001 (Dec. 6, 2013).

²² *Id.*

²³ 42 U.S.C. § 18031(d).

²⁴ U.S. Dep’t of Health & Human Serv., Centers for Medicare & Medicaid Serv., *Health Insurance Exchange Establishment Grants*, available at www.cms.gov/ccio/resources/marketplace-grants/ (last visited April 28, 2016).

²⁵ HHS awarded an additional \$900,000 to the 34 states that ultimately decided against establishing a SBE.

states that elected not to establish an exchange.²⁶ This federal exchange uses the IT platform known as healthcare.gov.

B. Some State-Based Exchanges Failed

Four of the 17 SBEs – in Oregon, Hawaii, Nevada, and New Mexico – have closed. Another state, Kentucky, has announced its intention to shutter its state exchange and join the federal exchange in 2017, in response to the commitment of a newly elected governor.²⁷ Consumers in states with failed SBEs apply for and enroll in coverage through the federally managed healthcare.gov, although each state still performs some exchange functions, such as plan management and consumer assistance.

Following are brief summaries of the circumstances surrounding the failures of the SBEs in Oregon, Hawaii, Nevada, and New Mexico, and the announcement of the intention to close the SBE in Kentucky. These summaries highlight common trends, such as the complicated nature of the technical requirements and the inability to generate sufficient revenues to sustain the exchange. While there are common reasons contributing to the overall failure of SBEs, the committee discovered additional challenges unique to each SBE's operation.

1. Oregon

Oregon shut down its SBE, Cover Oregon, in April 2014. Oregon was the first state to abandon its enrollment website,²⁸ and is perhaps the most high-profile failure of the SBEs. Cover Oregon received \$305 million²⁹ in federal grants—the third highest award of all 17 SBEs (see chart on page 8)—and yet failed to create a functional website and failed to enroll a single consumer for private health insurance online. Oregon received five federal Section 1311 grants: two Level One Establishment Grants totaling \$17,847,391, one Level Two Establishment Grant totaling \$226,442,074, an Early Innovator Grant totaling \$59,917,212, and a State Planning Grant totaling \$1,000,000.³⁰

Enrolling in Cover Oregon was a cumbersome process. Despite the millions of dollars spent to build a state exchange, the Cover Oregon online enrollment portal did not work for the October 1, 2013 launch.³¹ In order for individuals to enroll in a health insurance plan through the SBE, they had to complete a 20-page paper application and submit it by fax to Cover Oregon

²⁶ 42 U.S.C. § 18041(c).

²⁷ Lena H. Sun, *Kentucky Governor Moves to Shut Down State's ACA Insurance Exchange*, WASH. POST, Jan. 11, 2016.

²⁸ Jason Millman, *Cover Oregon Finally Admits Enrollment Site is Broken Beyond Repair*, WASH. POST, Apr. 25, 2014.

²⁹ U.S. Dep't of Health & Human Serv., Centers for Medicare & Medicaid Serv., *Health Insurance Exchange Establishment Grants*, available at www.cms.gov/ccio/resources/marketplace-grants/ (last visited April 28, 2016).

³⁰ U.S. Dep't of Health & Human Serv., Centers for Medicare & Medicaid Serv., *Oregon Health Insurance Marketplace Grant Awards List*, available at <https://www.cms.gov/ccio/Resources/Marketplace-Grants/or.html> (last visited Aug. 8, 2016).

³¹ Jason Millman, *How Oregon Wound up with Nation's Worst Obamacare Web Site*, WASH. POST, Mar. 20, 2014.

headquarters;³² however, Cover Oregon’s backup plan of processing paper applications was not ready and did not function well either.³³

The backup plan to use paper applications to enroll individuals began working in November. At that point, the SBE used hundreds of state workers and temporary agency hires to help process all of the paper applications.³⁴ The paper application process itself contained glitches—thousands of people faced challenges from the manual enrollment system, and others were left without coverage as of January 1, 2014, due to errors and incomplete applications.³⁵

Not surprisingly, given this cumbersome process, Cover Oregon enrolled only 68,308 individuals in the initial enrollment period and reached only 29% of its first year enrollment goal of 237,000 individuals.³⁶ An independent review commissioned by the Governor of Oregon in January 2014 found that Cover Oregon was plagued with poor management, “unrealistic optimism,” and overly ambitious project scope.³⁷ The report evaluated the role of Maximus, the Quality Assurance contractor, and also found that communication between the three state entities charged with implementing the SBE—Cover Oregon, the Oregon Health Authority, and the Oregon Department of Human Services—was “ineffective” and “contentious.” The Governor’s independent review report stated:

Communication and lack of transparency – It is clear that communication across agencies was ineffective and at times contentious. The lack of a single point of authority slowed the decision making process and contributed to inconsistent communication, and collaboration across agencies was limited at best. In addition, communication with oversight authorities was inconsistent and at time confusing or misinterpreted. This resulted in an unclear or incorrect understanding about the true status of the project approaching the October 1, 2013 deadline.³⁸

In September 2012, a full year before the launch of Cover Oregon’s website, one state representative raised concerns about the mismanagement of Cover Oregon and the challenges contractors faced. The aforementioned independent review highlighted a letter from Representative Dennis Richardson (R) to the governor noting concerns that Cover Oregon’s website would be a “fiasco.” The report stated:

In September 2012, Representative Richardson notified the Governor of concerns raised by Maximus in their August 2012 HIX-IT Project

³² Samantha Masunaga, *Oregon Abolishes its Hopelessly Bungled Health Insurance Exchange*, L.A. TIMES, Mar. 7, 2015.

³³ Nick Budnick, *Cover Oregon: Health exchange failure predicted, but tech watchdogs' warnings fell on deaf ears*, OREGON LIVE, Jan. 18, 2014.

³⁴ Nick Budnick, *Cover Oregon health exchange draws mixed reviews in partial launch*, OREGON LIVE, Feb. 18, 2014.

³⁵ *Id.*

³⁶ Haeyoun Park et al., *Health Exchange Enrollment Ended with a Surge*, N.Y. TIMES, May 1, 2014.

³⁷ First Data, *Cover Oregon Website Implementation Assessment*, April 23, 2014.

³⁸ *Id.*

Monthly Status Report. The letter notes that “the Q.A. is sounding an alarm that this project is in substantial jeopardy of being Oregon’s next multi-million dollar I.T. project fiasco.” However, following that communication, the Governor’s Office was told the problems were addressed, and the project was on track.³⁹

Despite warnings from the state representative, the problems continued. Auditors found that the Cover Oregon leadership became “de-sensitized” to the “ongoing red status,” referring to the overwhelming number of problems leading up to the rollout. The auditors stated:

The QA contractor, Maximus, consistently raised concerns about the project and its ability to be ready for the October 1, 2013 rollout. Although the Maximus reports regularly rated many areas of the project red and labeled them as high risk, they were generally viewed as nothing unusual for a project of its scope and with such an aggressive schedule. Overall, leadership became desensitized to the ongoing red status.⁴⁰

The audit, issued March 2014, concluded with numerous recommendations to improve Cover Oregon. Oregon state leadership decided, however, to scrap the exchange just one month later in April 2014.⁴¹ In March 2015, Governor Kate Brown signed a bill dissolving Cover Oregon. The Cover Oregon office closed on June 30, 2015, and the state is now considered a “federally-supported” exchange.

While the Cover Oregon website is now closed, the fallout surrounding the failure of Cover Oregon has continued. After Cover Oregon’s website made headlines for its disastrous opening in October 2013, the State of Oregon sued its main contractor, Oracle, for breach of contract, starting a bitter legal dispute that has, to date, resulted in six different lawsuits.⁴² In addition, former Governor John Kitzhaber resigned his position and he and his staff were put under criminal investigation by the Department of Justice and the Oregon Attorney General due to evidence that they had redirected Cover Oregon funds to Kitzhaber’s campaign.⁴³

Notably, on March 28, 2016, Oracle filed a lawsuit against HHS Secretary Sylvia Burwell in hopes of compelling HHS to utilize its mandatory authority to investigate the allegations of misconduct, mismanagement, and fraud made against Cover Oregon and Oracle. Oracle asserts in the lawsuit that HHS has not investigated the allegations behind the misconduct that has led the failure of the SBEs in Oregon or any of the other failed SBEs.⁴⁴

³⁹ *Id.*

⁴⁰ *Id.*

⁴¹ Maria Ganga, *Oregon scraps state health insurance exchange*, LA TIMES, Apr. 25, 2014.

⁴² Jeff Manning, *Oregon vs. Oracle: Legal war gets personal as company goes on the attack*, OREGON LIVE, Apr. 8, 2016.

⁴³ Jack Inglewood, *It’s Time For Congress To Rein In Obamacare Fraud*, WESTERN JOURNALISM, July 26, 2016.

⁴⁴ Elizabeth Hayes, *Oracle files another Cover Oregon lawsuit to force feds to investigate*, PORTLAND BUS. J., Mar. 6, 2016.

2. Hawaii

CMS awarded Hawaii over \$205 million in federal Section 1311 grants. Hawaii received four grants: two Level One Establishment Grants totaling \$76,255,636, one Level Two Establishment Grant totaling \$128,086,634, and a State Planning Grant totaling \$1,000,000.⁴⁵

Hawaii enrolled 8,592 individuals in its first year, and at its peak enrollment reached less than 40,000 individuals.⁴⁶ Although Hawaii's enrollment was not far from its enrollment projection of 9,000, the number of individuals enrolled was not enough to sustain the operational costs of the exchange particularly since Hawaii has the second lowest uninsured rate in the country.⁴⁷

A report released by HHS on May 1, 2014, included data on the number of individuals enrolled in the exchanges during the first open enrollment period.⁴⁸ Based on that report and data on the amount that Hawaii Health Connector spent on establishing the exchanges, the average cost per enrollee in Hawaii in the first open enrollment period was \$23,899, the highest in the country.⁴⁹

⁴⁵ U.S. Dep't of Health & Human Serv., Centers for Medicare & Medicaid Serv., *Hawaii Health Insurance Marketplace Grant Awards List*, available at <https://www.cms.gov/ccio/Resources/Marketplace-Grants/hi.html> (last visited Aug. 8, 2016).

⁴⁶ Haeyoun Park et al., *Health Exchange Enrollment Ended With a Surge*, N.Y. TIMES (May 1, 2014).

⁴⁷ U.S. DEP'T OF COMMERCE, U.S. CENSUS BUREAU, P60-250, HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2013 (2014), available at <http://www.census.gov/content/dam/Census/library/publications/2014/demo/p60-250.pdf>.

⁴⁸ U.S. Dep't of Health & Human Serv., Office of the Assistant Sec'y for Planning & Evaluation, ASPE Issue Brief, *Health Insurance Marketplace: Summary Enrollment Report for the Initial Annual Open Enrollment Period* (May 1, 2014), available at https://aspe.hhs.gov/sites/default/files/pdf/76876/ib_2014Apr_enrollment.pdf.

⁴⁹ Memorandum by Jay Angoff, Mehri & Skalet, PLLC to Interested Parties, Cost-Per-Enrollee in Each State's Exchange (May 7, 2014), available at http://media.wix.com/ugd/520423_2d62f1a4b0a74496a01391f87cc1b158.pdf.

	Number of Enrollees	HHS Grants to States	HHS Spending on Federal Exchange	Total HHS Spending on Exchange	Cost to Taxpayers per Enrollee
State-run Exchanges					
California	1,405,102	\$ 1,065,212,950	\$ -	\$ 1,065,212,950	\$ 758
Colorado	125,402	\$ 178,931,023	\$ -	\$ 178,931,023	\$ 1,427
Connecticut	79,192	\$ 164,466,460	\$ -	\$ 164,466,460	\$ 2,077
District of Columbia	10,714	\$ 133,573,927	\$ -	\$ 133,573,927	\$ 12,467
Hawaii	8,592	\$ 205,342,270	\$ -	\$ 205,342,270	\$ 23,899
Kentucky	82,747	\$ 253,167,439	\$ -	\$ 253,167,439	\$ 3,060
Maryland	67,757	\$ 171,063,110	\$ -	\$ 171,063,110	\$ 2,525
Massachusetts	31,695	\$ 180,067,775	\$ -	\$ 180,067,775	\$ 5,681
Minnesota	48,495	\$ 155,020,465	\$ -	\$ 155,020,465	\$ 3,197
Nevada	45,390	\$ 90,773,768	\$ -	\$ 90,773,768	\$ 2,000
New York	370,451	\$ 429,065,407	\$ -	\$ 429,065,407	\$ 1,158
Oregon	68,308	\$ 303,011,587	\$ -	\$ 303,011,587	\$ 4,436
Rhode Island	28,485	\$ 105,305,029	\$ -	\$ 105,305,029	\$ 3,697
Vermont	38,048	\$ 168,124,081	\$ -	\$ 168,124,081	\$ 4,419
Washington	163,207	\$ 266,026,060	\$ -	\$ 266,026,060	\$ 1,630
TOTAL	2,573,585	\$ 3,869,151,351	\$ -	\$ 3,869,151,351	\$ 1,503

In January 2015, the Hawaii state auditor released an audit report that found Hawaii’s SBE had wasted millions of federal taxpayer dollars due to a poorly implemented contract with its IT contractor, Mansha Consulting. The audit also found that Hawaii’s SBE lacked vision and leadership. The audit noted that Hawaii’s Connector never had a “finalized strategic plan” that envisioned “what Hawaii’s exchange could be or should be.”⁵⁰ The audit stated:

The Hawaii Health Connector Board of Directors and management could not agree on what Hawaii’s health insurance exchange could be or should be. The Connector board never made that fundamental decision but continued its work without a finalized strategic plan. As a result, the Connector is unsustainable due to high operating costs and Hawaii’s unique market of uninsured – only 8 percent of the population, about 100,000 residents. The interim executive director concluded that even with substantial reductions to the estimated \$15 million annual operating budget, the Connector would not be sustainable. It would have to dramatically increase fees on participating exchange plans or the State would need to assess a fee across the market to preserve services.

In addition the Connector did not have IT staff to manage the project’s development or monitor contracts, relying on vendors to self-report their progress. In addition, the board’s ability to monitor its massive IT system’s development progress was impaired by an uncooperative

⁵⁰ AUDITOR OF THE STATE OF HAWAII, REPORT NO. 15-01, A REPORT TO THE GOVERNOR AND THE LEGISLATURE OF THE STATE OF HAWAII, AUDIT OF THE HAWAII HEALTH CONNECTOR (Jan. 2015), available at <http://files.hawaii.gov/auditor/Reports/2015/15-01.pdf>.

executive director who withheld information. Through the website development process, the board was largely unaware of the Connector's myriad problems.⁵¹

In general, the SBEs attempt to generate revenue to support administrative costs through user fees charged to each insurer that sells a plan through the SBE. Hawaii's low enrollment numbers left the SBE with insufficient revenue to cover administrative and operational costs. The only other potential source of funding - state taxpayer funds allocated by the state government - also fell short. In May 2015, Hawaii's state legislature rejected legislation that would have granted an additional \$28 million to assist the SBE.

With inadequate funding, the Hawaii Health Connector failed to demonstrate that it could be financially stable, as required by law for all of the SBEs.⁵² Because the Hawaii Health Connector did not have enough funding to sustain its operational and administrative costs, and had not integrated its enrollment website with the Medicaid system, CMS determined that Hawaii was out of compliance with the requirement that SBEs be financially-sustainable in the PPACA.⁵³ On June 5, 2015, Hawaii Governor David Ige announced that Hawaii Health Connector would shut down, and join the federal IT platform, healthcare.gov.⁵⁴ The Hawaii Health Connector ceased operations on December 4, 2015.⁵⁵

3. Nevada

Nevada received over \$90 million in federal grants to establish its SBE, the Silver State Health Insurance Exchange. This included five Level One Establishment Grants totaling \$39,757,756, one Level Two Establishment Grant totaling \$50,016,012, and a State Planning Grant totaling \$1,000,000.⁵⁶ Much like the other SBEs, the Silver State Health Insurance Exchange had a glitch-plagued launch and in the first month following its open enrollment on October 1, 2013, only 513 Nevadans enrolled.⁵⁷ In the first year of enrollment, Nevada only reached 39 percent of its target enrollment, enrolling 45,390 out of 115,000 individuals.⁵⁸

The first enrollment period was plagued by website problems. Individuals who signed up for insurance through the SBE in 2014 were unable to get insurance cards in January 2015 despite having paid through the Nevada Health Link insurance exchange website.⁵⁹ Even worse,

⁵¹ *Id.*

⁵² 42 U.S.C. § 18031.

⁵³ *Insurance exchange sets deadlines in preparation of ending services*, INSURANCENEWSNET, May 9, 2015.

⁵⁴ Press Release, *State to Assist with Transition of Private Non-Profit Hawaii Health Connector Operations*, June 5, 2015, available at <http://governor.hawaii.gov/newsroom/news-release-state-to-assist-with-transition-of-private-non-profit-hawaii-health-connector-operations/>.

⁵⁵ Cathy Bussewitz, *Hawaii's troubled health exchange closing its doors*, WEST HAWAII TODAY, Dec. 4, 2015.

⁵⁶ U.S. Dep't of Health & Human Serv., Centers for Medicare & Medicaid Serv., *Nevada Health Insurance Marketplace Grant Awards List*, available at <https://www.cms.gov/ccio/Resources/Marketplace-Grants/nv.html> (last visited Aug. 8, 2016).

⁵⁷ Jason Hidalgo, *Nevada Health Exchange Glitch Delays Insurance Cards*, RENO GAZETTE-J., Jan. 23, 2014.

⁵⁸ Haeyoun Park et al., *Health Exchange Enrollment Ended with a Surge*, N.Y. TIMES, May 1, 2014.

⁵⁹ Jason Hidalgo, *Nevada Health Exchange Glitch Delays Insurance Cards*, RENO GAZETTE-J., Jan. 23, 2014.

at that time the SBE—blaming technical glitches—could not determine exactly how many Nevadans were affected by this insurance card problem. After finally receiving their insurance cards, consumers noticed errors in the amount of their monthly insurance payment.⁶⁰ One consumer recounted that he was charged \$749 instead of the \$150 per month that he was supposed to pay because federal subsidies should have covered the difference.⁶¹

On May 20, 2014, Nevada’s SBE closed as a result of the board’s unanimous vote “to end its relationship” with its IT contractor, Xerox, citing Xerox’s performance as the reason the state opted to switch to the federal exchange IT system, healthcare.gov, while exploring other options going forward.⁶² One option that the state explored included adopting a software program that had successfully established a website for Connecticut’s SBE; adapting to Connecticut’s IT systems, however, was estimated to cost anywhere from \$40 to \$70 million.⁶³

Nevada could have followed Maryland’s example and adopted Connecticut’s IT system after Maryland’s SBE website faced significant operational difficulties.⁶⁴ A decision to adopt a successful system, like Connecticut’s, would come at a much lower cost because Connecticut’s IT system had already been built using federal dollars. As a result, the only cost would have been to transition to the new IT system, rather than build a new system entirely. Ultimately, the Nevada State Exchange Board opted to use the federal system, healthcare.gov.

4. New Mexico

New Mexico received four grant awards totaling \$123.3 million to build its SBE: three Level One Establishment Grants totaling \$122,281,600 and a State Planning Grant totaling \$1,000,000.⁶⁵ In the first year of enrollment, New Mexico only reached 39 percent of its target enrollment, enrolling 32,062 out of 83,000 individuals.⁶⁶ Because of delays in developing its website, New Mexico used the federal exchange IT platform, healthcare.gov, during the first enrollment period beginning October 1, 2013.⁶⁷ Based on an HHS May 1, 2014 report⁶⁸ and data on how much was spent to establish New Mexico’s state-based exchange, New Mexico had the seventh highest cost per enrollee, averaging \$6,181 per enrollee. This is an unusually high number, given that New Mexico never had a functional website for its exchange.

⁶⁰ *Id.*

⁶¹ *Id.*

⁶² Kyle Cheney, *Nevada Latest to Scrap Exchange*, POLITICO, May 20, 2014.

⁶³ Arielle Levin Becker, *Updated: Nevada considered CT exchange software, but didn’t commit*, CT MIRROR, May 22, 2014.

⁶⁴ Andrea K. Walker, Meredith Cohn, & Erin Cox, *MD Votes to Adopt Health Exchange Software Used in Connecticut*, BALTIMORE SUN, April 2, 2014.

⁶⁵ U.S. Dep’t of Health & Human Serv., Centers for Medicare & Medicaid Serv., *Nevada Health Insurance Marketplace Grant Awards List*, available at <https://www.cms.gov/ccio/Resources/Marketplace-Grants/nm.html> (last visited Aug. 8, 2016).

⁶⁶ Haeyoun Park et al., *Health Exchange Enrollment Ended with a Surge*, N.Y. TIMES, May 1, 2014.

⁶⁷ U.S. GOV’T ACCOUNTABILITY OFFICE, GAO-15-527, STATE HEALTH INSURANCE MARKETPLACES: CMS SHOULD IMPROVE OVERSIGHT OF STATE INFORMATION TECHNOLOGY PROJECTS (2015).

⁶⁸ U.S. Dep’t of Health & Human Serv., Office of the Assistant Sec’y for Planning & Evaluation, ASPE Issue Brief, *Health Insurance Marketplace: Summary Enrollment Report for the Initial Annual Open Enrollment Period* (May 1, 2014), available at https://aspe.hhs.gov/sites/default/files/pdf/76876/ib_2014Apr_enrollment.pdf.

New Mexico’s health exchange structure is unique because while the state runs the small business health options (SHOP) platform for small businesses to provide health coverage to employees, individuals use the federal IT platform to enroll in the individual exchange. Despite multiple Level One Establishment Grants and No Cost extensions,⁶⁹ CMS informed New Mexico that the technology design that New Mexico had been implementing, and that CMS approved, would “no longer be supported by CMS.”⁷⁰ CMS denied New Mexico’s request for an additional \$97 million necessary for New Mexico to make the design change to one that CMS would support going forward. Although 75 percent of the website was complete, New Mexico decided to continue using the federal IT platform rather than finish its website with state funds, reasoning that it would be the most fiscally responsible option.⁷¹ Members of New Mexico’s SBE board were not in favor of continuing work on the website and acknowledged that completing the website would have been more expensive.⁷²

5. Kentucky

Kentucky received five grant awards totaling \$253,698,351 to build its SBE: three Level One Establishment Grants totaling \$69,990,613, one Level Two Establishment Grant totaling \$182,707,738, and one State Planning Grant totaling \$1,000,000. In the first year of enrollment, Kentucky only reached 38 percent of its target enrollment, enrolling 82,747 out of 220,000 individuals.⁷³ Despite spending \$288 million in federal grants and creating an operational SBE, on December 30, 2015, Governor Matthew Bevin notified HHS Secretary Sylvia Burwell that Kentucky would “wind down and cease operation of the Commonwealth’s State Based Exchange, ‘Kynect,’ and transition to the Federal Exchange as soon as is practicable.”⁷⁴

⁶⁹ No Cost Extensions are grant mechanism to make funds available to the grantee beyond the end date for the grant. This will be discussed further in Section V(A).

⁷⁰ Letter from Amy Dowd, Chief Executive Officer, NMHIX, to Hon. Fred Upton, Chairman, H. Comm. on Energy & Commerce (Dec. 8, 2015).

⁷¹ Louise Norris, *New Mexico Health Insurance Marketplace: Another Carrier Shakeup for 2017*, HEALTHINSURANCE.ORG, July 12, 2016, available at https://www.healthinsurance.org/new_mexico-state-health-insurance-exchange/.

⁷² Rosalie Rayburn, *Plans for State-Run Health Exchange Dropped*, ALBUQUERQUE J., Apr. 8, 2015.

⁷³ Haeyoun Park et al., *Health Exchange Enrollment Ended with a Surge*, N.Y. TIMES, May 1, 2014.

⁷⁴ Letter from Hon. Matthew G. Bevin, Governor, State of Kentucky, to Hon. Sylvia Burwell, Sec’y, U.S. Dep’t of Health & Human Serv. (Dec. 30, 2015).

December 30, 2015

VIA FEDERAL EXPRESS

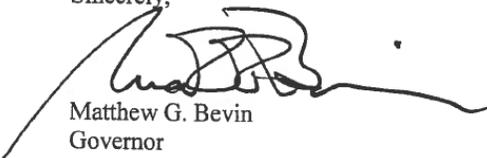
Hon. Sylvia Mathews Burwell
Secretary of the U.S. Department of
Health & Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Burwell:

Pursuant to 45 C.F.R. §155.106(b), notice is hereby given that it is the intention of the Commonwealth of Kentucky to wind down and cease operation of the Commonwealth's State Based Exchange, "kynect", and transition to the Federal Exchange as soon as is practicable. We look forward to coordinating a transition plan with you in order to fulfill this objective.

Should you have any questions, please feel free to contact Vickie Yates Brown Glisson, the Commonwealth's Health and Family Services Cabinet Secretary, at (502) 564-7042.

Sincerely,



Matthew G. Bevin
Governor

In addition to the taxpayer dollars that Kynect spent to build and then subsequently abandon the state exchange, it is expected to cost Kentucky state taxpayers \$23 million to transition to the federal platform.⁷⁵ Kentucky's decision to close its SBE is unique because it was fully functional, unlike the other SBEs whose financial or technical challenges forced their hand.

As the federal funds granted to the state were running out, Kentucky state leaders had concerns that Kynect would not remain financially self-sustaining as required by the law.⁷⁶ Leaders believed that Kynect's financial model was not viable over the long term, costing taxpayers \$39.9 million in 2014, \$50.5 million in 2015, and \$35.5 million in 2016.⁷⁷ Conversely, using healthcare.gov would cost an estimated \$11 million.⁷⁸ Kentucky was able to make the decision to transition from Kynect to healthcare.gov because CMS failed to impose requirements on a state once it accepted the grant money. For example, CMS could have required states to operate a state-based exchange for a certain amount of time in exchange for millions of dollars in grant money to create the exchange. But CMS failed to do so.

⁷⁵ Amber Phillips, *Kentucky, once an Obamacare exchange success story, now moves to shut it down*, WASH. POST, Jan. 14, 2016.

⁷⁶ John Cheves, *Kynect was not Sustainable, Kentucky Officials Say*, HERALD LEADER, Feb. 16, 2016.

⁷⁷ Josh Archambault, *3 Reasons Gov. Matt Bevin Is Wise to Close Kentucky's ObamaCare Exchange*, FORBES, June 7, 2016.

⁷⁸ *Id.*

Billions of federal dollars have gone out the door to 16 states and the District of Columbia, yet the SBEs continue to rely on federal dollars and struggle to become financially sustainable. Thus far, the four closed SBEs have suffered no repercussions for wasting a combined \$239 million federal dollars on IT funding for websites that no longer have any value to the taxpayer.⁷⁹

The ability for a state to abandon a fully functioning SBE after spending millions of federal taxpayer dollars is troubling. By failing to impose requirements on the grant funding and failing to impose negative consequences for wasting hundreds of millions of taxpayer dollars by closing a state exchange, CMS risked its entire federal investment in state exchanges. The federal dollars invested in state exchanges are entirely subject to the whims of state governments, since CMS has no authority to require a state to continue operating exchanges if the state decides against it.

The brief summaries of the circumstances under which the states of Oregon, Hawaii, Nevada, New Mexico, and Kentucky have struggled to establish and sustain SBEs despite the availability of billions of federal dollars, shows a variety of challenges and obstacles, some common and some unique. In Oregon, the SBE was mismanaged from the start, with one independent auditor blaming an “overly ambitious project scope” and “unrealistic optimism.” Hawaii was plagued by financial instability from the outset, since the SBE could not find adequate sources of funding for the operational costs of the exchange, when user fees and state taxpayer funds came up short. Nevada faced challenges with its IT contractor, and New Mexico faced last-minute design changes, confusing communications from CMS and a delayed timeline. Lastly, Kentucky’s concerns about the inability to reach financial sustainability long term lead to the governor’s decision to wind down a largely functional SBE.

C. Many Remaining State Exchanges Continue to Struggle

While each state with a failed SBE is unique, there are common trends as to why each of the SBEs failed. In a number of cases, states did not anticipate the magnitude of the technical and technology requirements necessary to build an effective enrollment system. And in a number of cases, states failed to accurately predict the costs of operating and maintaining an effective system. On the revenue side, states failed to enroll sufficient customers, and when user fees were inadequate, states declined to provide general revenues to make up the difference. These common challenges continue to plague and threaten the sustainability of many of the remaining SBEs.

⁷⁹ U.S. GOV’T ACCOUNTABILITY OFFICE, GAO-15-527, STATE HEALTH INSURANCE MARKETPLACES: CMS SHOULD IMPROVE OVERSIGHT OF STATE INFORMATION TECHNOLOGY PROJECTS (2015). In September 2015, GAO calculated the amount each SBE had spent in federal funds on IT for its website. Hawaii spent \$89,467,000, New Mexico spent \$34,096,000, Oregon spent 78,490,000, and Nevada spent \$37,485,000.

1. Operational Costs Cause Financial Challenges

In September 2015, leaders of six SBEs testified before the Energy and Commerce Committee's Subcommittee on Oversight and Investigations. This testimony shed light on the challenges of running an exchange, including lower than expected enrollment numbers and growing maintenance costs.⁸⁰ The HHS OIG and GAO have also reported on numerous vulnerabilities plaguing the SBEs, including failed IT projects, unclear guidance from CMS on grant spending, and misused Medicaid reimbursements.⁸¹ Through these efforts, the committee has become aware that a number of states face continuing challenges estimating costs for their SBEs. Examples include:

- **Colorado:** Connect for Health, Colorado's SBE, budgeted \$14.88 million for customer service center costs for fiscal year 2015, yet spent \$17.71 million.⁸² Subsequently, Colorado requested to move \$2.8 million from their reserves to the Customer Service Center Budget in order to cover service center costs.⁸³
- **Massachusetts:** Officials for the Massachusetts SBE projected spending \$174 million to create a health insurance exchange website, but in reality spent \$281 million to enroll just 321,000 people. These expenses included costs for developing and trying to repair the website, purchasing new software, and creating a new exchange IT system in 2015.⁸⁴
- **Vermont:** Vermont Health Connect, Vermont's SBE, underestimated maintenance and operational costs by \$8.3 million for the first six months of the year.⁸⁵ A state audit conducted on the SBE in 2015, detailed numerous unresolved problems with Vermont Health Connect, and concluded it would be "prudent" to develop a plan for "an alternative model for running an exchange."⁸⁶

⁸⁰ On September 29, 2015, the Subcommittee on Oversight and Investigations of the Committee of Energy and Commerce held a hearing entitled, *An Overdue Checkup: Examining the ACA's State Insurance Marketplaces*.

⁸¹ See U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-15-527, *CMS SHOULD IMPROVE OVERSIGHT OF STATE INFORMATION TECHNOLOGY PROJECTS* (2015); U.S. Dep't of Health & Human Serv., Office of Inspector Gen., A-01-14-02509, *Early Alert: Without Clearer Guidance, Marketplaces Might Use Federal Funding Assistance for Operational Costs When Prohibited by Law* (Apr. 27, 2015).

⁸² Connect for Health Colorado, *Customer Service Center Budget Update: Prepared for Finance Committee*, (Feb. 2015), available at <http://connectforhealthco.com/wp-content/uploads/2013/04/February-Service-Center-Budget-Update-Feb-2015.pdf>.

⁸³ *Id.*

⁸⁴ Shira Schoenberg, *Temporary Medicaid Coverage after Massachusetts Health Exchange Website Failed Cost \$650 million, State says*, MASSLIVE (June 16, 2015).

⁸⁵ Morgan True, *Vermont Health Connect Will Cost \$9.7 Million More Than Anticipated in This Fiscal Year*, VT DIGGER (Jan. 22, 2014).

⁸⁶ Abby Goodnough, *In Vermont, Frustrations Mount Over Affordable Care Act*, N.Y. TIMES (June 4, 2015).

- **Minnesota:** As of November 3, 2015, nearly half of MNSure’s 2015 budget and a third of its 2016 budget—including operating expenses—relied on funds that MNSure never received authority to spend, yet MNSure continued to portray the SBE as a self-sustaining endeavor.⁸⁷ State lawmakers reported that after MNSure spent over \$3 million for its failed billing system, and cost the state an additional \$850,000 was to upgrade old financial systems to accommodate the exchange.⁸⁸ State lawmakers further detected that 11 percent of MNSure’s 2017 budget relies on spending that MNSure has yet to receive spending authority.⁸⁹

Rising or unexpected operational and maintenance costs could incentivize states to abandon their SBEs and move to the FFE where the state will not be responsible for operating and maintaining its own IT system.

2. SBEs Fail to Meet Enrollment Projections

As federal funding for establishment costs dwindled, and as the restriction against using establishment grant money for operational expenses came into effect, SBEs had to identify viable solutions to manage unpredictable operational expenses. A majority of SBEs attempted to meet these expenses by imposing “user” or “assessment” fees. These fees apply to both issuers participating in the FFE, and issuers in SBEs that have chosen to charge a user fee to QHPs selling plans to help fund their exchange.⁹⁰ The purpose of this fee is to cover the administrative costs of running an exchange.

While the FFE charges each QHP a user fee equal to 3.5 percent of the premium charged to each individual who selects a plan through healthcare.gov, the rate for SBEs varies by state. In order for assessment fees to function properly, SBEs are dependent upon strong enrollment, as these fees are based on how many people enroll into a plan. The stronger the pool of insured individuals, the more funding that goes back to a SBEs’ budget. While this plan sounds viable in theory, enrollment data indicates that SBEs are significantly underperforming initial expectations, accordingly reducing the amount collected in user fees. To cover the gap, state governments have appropriated funding and even misused Medicaid funds to supplement the shortfall.

Three years into the SBE program, only *half* of what CMS projected for enrollment has actually come to fruition. When the PPACA was enacted in 2010, CMS projected *24.8 million* people would enroll, while the Congressional Budget Office (CBO) projected 21 million

⁸⁷ Letter from the Hon. Gregory M. Davids, State Representative, District 28B, Minnesota House of Representatives, to Daniel Kane, Office of Acquisitions and Grants Management, Centers for Medicare & Medicaid Serv., (Nov. 3, 2015).

⁸⁸ *Id.*

⁸⁹ *Id.*

⁹⁰ 45 CFR § 155.160(b)(1) (“States may generate funding such as through user fees on participating issuers, for Exchange operations[.]”).

enrollees.⁹¹ During the 2016 open enrollment, however, *only 12.7 million* individuals signed up for a QHP through the marketplace. Further, actual enrollment for 2016 will be lower, as the 12.7 million figure only reflects people who signed up for a plan, not those who actually paid their premiums.

For example, in 2015, 10.2 million people enrolled into a QHP during open enrollment, yet just 9.3 million remained enrolled after paying premiums.⁹² These low enrollment numbers demonstrate the aggregate enrollment. Using a different metric to capture the low enrollment problem, such as the mode, also indicates that the low enrollment is a systemic problem on a micro-level for states. The following chart provides an approximate look at 2016 enrollment figures for the twelve remaining SBEs, comparing each SBE's total enrollment versus its estimated enrollment, and identifies the percentage of eligible individuals that actually enrolled into the exchange.⁹³

⁹¹ Brian Blase. *Obamacare Enrollment Year 3 Summary—Increase in Mandate Penalty Has Not Improved Risk Pools*, FORBES, Mar. 16, 2016.

⁹² U.S. Dep't of Health & Human Serv., Centers for Medicare & Medicaid Serv., *Effectuated Enrollment Snapshot* (Mar. 31, 2015), *available at* <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-06-02.html>.

⁹³ Kaiser Family Foundation analysis based on March 31, 2016 Effectuated Enrollment Snapshot, *available at* <http://kff.org/health-reform/state-indicator/marketplace-enrollment-as-a-share-of-the-potential-marketplace-population-2015/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

State Based Exchange	Total Enrollment	Estimated Number of Potential Marketplace Enrollee	Percentage of Potential Marketplace Population Enrolled in 2016
California	1,415,428.00	2,986,000.00	47%
Colorado	108,311.00	486,000.00	22%
Connecticut	102,917.00	292,000.00	35%
D.C.	17,666.00	31,000.00	58%
Idaho	94,270.00	187,000.00	51%
Maryland	135,208.00	394,000.00	34%
Massachusetts	207,121.00	353,000.00	59%
Minnesota	74,060.00	330,000.00	22%
New York	224,014.00	1,036,000.00	22%
Rhode Island	35,583.00	86,000.00	41%
Vermont	27,883.00	60,000.00	46%
Washington	158,245.00	580,000.00	27%

Of the remaining SBEs, only 25 percent managed to enroll at least half of its projected estimates in 2016. Low enrollment into SBEs raises concerns regarding the use of user fees as an effective tactic to establish and maintain financial solvency. Despite imposing user fees, the financial sustainability for several SBEs remains questionable due to lower than expected enrollment:

- Washington:** For fiscal year 2015, the Washington Health Benefit Exchange forecasted \$26.1 million in revenues (20.6 percent of total revenues) from premium taxes and fees for fiscal year 2015, based on 213,000 enrollees. Only 160,000, however, had enrolled as of February 15, 2015 (75 percent of projected enrollment).⁹⁴

⁹⁴ U.S. Dep't of Health & Human Serv., Office of Inspector Gen., A-01-14-02509, *Early Alert: Without Clearer Guidance, Marketplaces Might Use Federal Funding Assistance for Operational Costs When Prohibited by Law* at 6 (Apr. 27, 2015).

- **California:** In 2015, Covered California, the California SBE, was one of the worst performing states, with only 1% net enrollment growth despite its large population.⁹⁵ Covered California imposed a monthly assessment fee of \$13.95 on each policy sold on its exchange, yet still experienced an \$80 million budget deficit for 2015-2016.⁹⁶
- **Colorado:** Connect for Health Colorado, the Colorado SBE, initially projected exchange operations at \$26 million. After failing to meet enrollment numbers and experiencing costly call center expenses, at the actual costs were more than double the projection at \$54 million.⁹⁷ As a result of the failed projections, Connect for Health Colorado raised fees on 2016 plans from 1.4 percent of premiums to 3.5 percent—the same rate the federal exchange charges—in addition to increasing a broad market assessment fee charged monthly to each policy sold on the exchange from \$1.25 to \$1.80.⁹⁸

When user fees are not enough to pay for SBE operational and maintenance costs, states must find alternate funding. Several SBEs have turned to state appropriations in order to help bridge the gap. For example, in 2014, Rhode Island’s SBE, Health Source RI, requested \$6.2 million in non-federal dollars from the state budget to sustain its SBE through 2015.⁹⁹ The Hawaii Health Connector, Hawaii’s SBE, requested a total of \$10 million from the State’s general appropriation fund in 2015.¹⁰⁰ The Hawaii Legislature approved only 20 percent of the original request, which contributed to the closure of Hawaii’s SBE.¹⁰¹

The financial sustainability of the remaining SBEs is uncertain as unpredictable operational costs exceed revenues, enrollment into SBEs remains low, and solutions such as user fees have proven to be ineffective. Several SBEs, including Colorado, Massachusetts, Hawaii, Vermont, and Minnesota have all underestimated budgets by millions of dollars after experiencing unpredictable operational costs. Of the remaining twelve SBEs, only 25 percent managed to enroll at least half of projected estimates, reducing the amount of collected user fees that could have alleviate increasing operational expenses. Additionally, audits on the remaining SBEs have identified improperly used Medicaid funds as an attempt to manage mounting

⁹⁵ Chad Terhune, *Amid Slower Growth, California’s Obamacare Exchange Cuts Proposed Spending*, L.A. TIMES, May 13, 2015.

⁹⁶ Orange County Register Editorial, *Red ink could kill Covered California*, OC REGISTER, Apr. 22, 2015.

⁹⁷ Katie Kerwin McCrimmon, *Exchange Board Votes to Scoop Up Millions from Two Higher Fees*, HEALTH NEWS COLORADO, May 15, 2015.

⁹⁸ CONNECT FOR HEALTH COLORADO, 2015-2016 STRATEGIC PLAN & BUDGET (June 1, 2015), available at <http://connectforhealthco.com/wp-content/uploads/2013/04/2016-Plan-and-Budget-FINAL.pdf>.

⁹⁹ Sean Misekll et al., *State-Based Marketplaces Look for Financing Stability in Shifting Landscape*, COMMONWEALTH FUND, May 14, 2015, <http://www.commonwealthfund.org/publications/blog/2015/may/state-marketplaces-and-financing-stability>.

¹⁰⁰ Lorin Eleni Gill, *Legislature Approves \$2M for Hawaii Health Connector*, PACIFIC BUSINESS NEWS, May 5, 2012, <http://www.bizjournals.com/pacific/news/2015/05/05/legislature-approves-2m-for-hawaii-health.html>.

¹⁰¹ *Id.*

operational costs. As four of the original seventeen SBEs have transitioned to using the federal platform, and another announced its intention to close in 2017, it is likely that the remaining SBEs will eventually opt out of running their own SBE as well.

FINDING: CMS is not confident that the remaining SBEs will be sustainable in the long term.

The SBE's failure rate is concerning, given the billion-dollar federal taxpayer investment. Further, the remaining SBEs face the significant challenge of paying for expensive IT systems and administrative costs with state funds and user fees alone. At the Subcommittee on Oversight and Investigations hearing on struggling state exchanges on December 8, 2015, members asked Acting Administrator Slavitt about the likelihood that other SBEs would fail and join the federal IT platform:

Mr. Flores. So do you expect more State exchanges to fail and make the transition to the Federal exchange?

Mr. Slavitt. So all the States have access to a source of their own funding either through an assessment that they have on the health insurers in their State or –

Mr. Flores. So are you saying no State exchanges are going to fail?

Mr. Slavitt. I'm saying all States currently have sources of funding now. Because it's a dynamic world, we do an evaluation at least twice a year –

Mr. Flores. Okay. Based on those evaluations, how many State exchanges do you expect to be unsustainable and to fail and move to the Federal system?

Mr. Slavitt. Well, I can't predict who's going to come into the Federal exchange in large part because there's a lot of factors, including –

Mr. Flores. Okay.

Mr. Slavitt. -- their own decision about whether or not they want to --

Mr. Flores. So let me continue. Given this trend, do you think the self-sustainability is and always has been a serious situation facing these exchanges, the State exchanges?

Mr. Slavitt. **So, as I said, as of today, all of the States are sustainable. Whether they will be in the future, I'm not willing to predict.**¹⁰²

At the hearing, not even Acting Administrator of CMS was willing to bet on the long-term survival of the rest of the SBEs.

D. The Committee's Investigation

The committee began its investigation in the spring of 2015, after multiple SBEs failed and joined the federal IT platform, healthcare.gov. In April 2015, the HHS OIG released an “Early Alert” notifying CMS that, based on the precarious financial position of many SBEs, the OIG was concerned that the remaining SBEs were at risk of misusing federal grant dollars in order to stay solvent.¹⁰³ At the same time, media reports suggested that many of the remaining SBEs were in precarious financial positions and would not be able to survive without federal funding.¹⁰⁴

The committee's investigation sought to verify that SBEs spent taxpayer dollars appropriately and in accordance with federal law. The alert by the HHS OIG that SBEs were at risk of misusing federal tax dollars, coupled with apprehension that CMS did not adequately oversee the SBEs, gave the committee reason for concern. Should more SBEs shut down and join the federal exchange, hundreds of millions more in taxpayer dollars could be wasted on CMS's watch. Unfortunately, this investigation found these concerns to be valid.

Leading up to its first hearing in September 2015, committee staff participated in multiple meetings, phone calls, briefings, and discussions with CMS, the state exchanges, and contractors. The Subcommittee on Oversight and Investigations convened a hearing on September 29, 2015, entitled “An Overdue Checkup: Examining the ACA's State Insurance Marketplaces.” This hearing examined issues surrounding SBEs from the perspective of the state exchanges, and featured testimony from the leaders of six state exchanges—California, Connecticut, Hawaii, Massachusetts, Minnesota, and Oregon.¹⁰⁵ Witnesses testified about the challenges of running an exchange, including growing maintenance costs and lower than expected enrollment numbers, as well as interactions with CMS on federal funding for the SBEs.

¹⁰² *An Overdue Checkup Part II: Examining the ACA's State Insurance Marketplaces: Hearing before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations*, 114th Cong. 64-65 (Dec. 8, 2015) (emphasis added).

¹⁰³ U.S. Dept. of Health & Human Serv., Office of the Inspector Gen., A-01-14-02509, *Early Alert: Without Clearer Guidance, Marketplaces Might Use Federal Funding Assistance for Operational Costs When Prohibited by Law* (Apr. 27, 2015).

¹⁰⁴ See e.g. Lena H. Sun and Niraj Chokshi, *Almost half of ObamaCare Exchanges Face Financial Struggles in the future*, WASH. POST, May 1, 2015; Michael Gomes, *Half of State Exchanges Struggling Financially: Future of State-run Exchanges Seems Uncertain*, HEALTHCAREEXCHANGE, May 13, 2015; and Sally Pipes, *State-Run ObamaCare Exchanges are Careening Toward Disaster*, FORBES, May 18, 2015.

¹⁰⁵ *An Overdue Checkup: Examining the ACA's State Insurance Marketplace: Hearing before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations*, 114th Cong. (Sept. 29, 2015).

On October 14, 2015, the committee wrote letters to all seventeen SBEs. The committee requested that each SBE provide eight categories of documents and information:

1. All “work plans” the state exchange has provided to CMS from June 2010 to the present.
2. All reports, updates, audits, memoranda, presentations, analyses, and other documents provided to the HHS, CMS, and Centers for Consumer Information and Insurance Oversight (CCIIO) relating or referring to the status of the state exchange, including, but not limited to, any federal grants or funds for the building, operation, or maintenance of the state exchange.
3. A list of all meetings between employees or representatives of HHS, CMS, and CCIIO and employees or representatives of the state exchange. This includes, but is not limited to, state administration officials and private companies or organizations responsible for performing work on the state exchange.
4. An explanation for the unused federal establishment grant funds that have been provided to the state exchange....As part of this explanation, please also provide answers to the following questions:
 - a. Does the state exchange plan to use the remainder of the funds? If yes, how does the state plan to use the remaining funds?
 - b. Did CMS grant permission for the use of these funds? If yes, who, when and how?
5. Did the state exchange receive any federal funds between October 1, 2014 and December 31, 2014? If yes, how will the funds be spent?
6. Has the state exchange applied for a “No Cost Extension” from CMS for the use of federal establishment grant funds? If yes, please include all documents related to the No Cost Extension, including, but not limited to, communications between the state exchange and CMS.
7. Has the state exchange used any federal dollars from cost allocation, including, but not limited to Medicaid reimbursement dollars, to fund any aspect of the state exchange, including but not limited to operational expenses? If yes, please explain. As part of this explanation, address whether the expenditure of federal cost

allocation or reimbursement dollars for state exchange activities approved by CMS or any other federal government agency? [sic]

8. Did the state exchange conduct any independent audit reports of its IT systems or financial records, including but not limited to projections for financial sustainability of its exchange? If yes, provide all independent, third party audits. Did CMS request the state exchange to conduct and/or provide any independent audits? If yes, explain CMS' requirements.¹⁰⁶

Hawaii, Nevada, New Mexico, and Oregon—whose SBEs had already shuttered by this time—were asked to provide additional information:

1. An explanation of the process of transitioning from the state-supported IT platform to healthcare.gov. As part of this explanation, please provide answers to the following questions:
 - a. Who and how did the state exchange or the state notify the federal government about the state's decision to transition to healthcare.gov?
 - b. What was [the] federal government's response?
 - c. Did CMS, or any other federal government agency, conduct any audit, analysis, examination, review, inspection, assessment, and/or investigation of the state exchange before or as it transitioned to healthcare.gov? If so, provide all documents relating or referring to this audit, examination, review, inspection, assessment and/or investigation.
2. A list of the employees, representatives, departments, and offices within HHS, CMS, and CCIIO to or with which the state exchange reported, worked, and/or consulted during the transition to healthcare.gov.
3. Has CMS, or any other federal government agency, tried to recoup any federal establishment grant funds after the state exchange's decision to transition to healthcare.gov? If yes, how much? How was the amount of recoupment determined?

¹⁰⁶ See, e.g. Letter from Hon. Fred Upton, Chairman, H. Comm. on Energy & Commerce, to Peter Lee, Executive Director, Covered California, (Oct. 14, 2015).

4. The total amount it cost to transition to healthcare.gov. Separately note both the cost to the state and the federal government.¹⁰⁷

The committee received substantive responses and documents pursuant to its request from all 17 SBEs.

The committee convened a second hearing on December 8, 2015, with CMS Acting Administrator Slavitt as the sole witness.¹⁰⁸ Acting Administrator Slavitt testified about CMS' oversight efforts to ensure the 17 SBEs were not spending federal dollars improperly. Acting Administrator Slavitt also addressed questions about the long-term sustainability of SBEs still in operation.

The documents produced by 17 state-based exchanges, hearing testimony, briefings with CMS Chief of Staff Mandy Cohen, and Deputy Administrator of CCHIO Christen Linke Young, and reports issued by the HHS OIG¹⁰⁹ and GAO,¹¹⁰ have allowed the committee to assess the financial health of the state-based exchanges, as well as CMS' oversight relationship with SBEs.

¹⁰⁷ See, e.g. Letter from Hon. Fred Upton, Chairman, H. Comm. on Energy & Commerce, to Jeffrey Kissel, Executive Director, Hawaii Health Connector, (Oct. 14, 2015).

¹⁰⁸ *An Overdue Checkup Part II: Examining the ACA's State Insurance Marketplaces: Hearing before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations*, 114th Cong. (Dec. 8, 2015).

¹⁰⁹ U.S. Department of Health & Human Serv., Office of Inspector Gen., A-01-14-02509, *Early Alert: Without Clearer Guidance, Marketplaces Might Use Federal Funding Assistance for Operational Costs When Prohibited by Law* (Apr 27, 2015).

¹¹⁰ U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-15-527, STATE HEALTH INSURANCE MARKETPLACES: CMS SHOULD IMPROVE OVERSIGHT OF STATE INFORMATION TECHNOLOGY PROJECTS (2015); U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-16-265, HEALTHCARE.GOV: ACTIONS NEEDED TO ENHANCE INFORMATION SECURITY AND PRIVACY CONTROLS (2016).

V. CMS Fails to Conduct Adequate Oversight of the SBEs

HHS tasked CMS with awarding 1311 grants to states to SBEs and ensuring that SBEs spent the grant money in accordance with the law. In addition to the statutory requirements in the PPACA, CMS issued regulatory guidance to SBEs on a range of matters related to the establishment of SBEs, including in-person assistance, insurance plan management, controls to determine eligibility for health care insurance subsidies, and the appropriate use of federal grant funds.¹¹¹ CMS' role is to implement the law, which gives states the opportunity to establish state exchanges and ensure that federal funds are spent appropriately.

CMS is responsible for administering the establishment of SBEs, including the issuance and use of Section 1311 grants. First and foremost, CMS is responsible for ensuring compliance with the statutory language providing that grants shall be used for “activities (including planning activities) related to establishing an [exchange].”¹¹² The law also requires that SBEs publish the costs associated with operating its exchange on the internet to “educate consumers on such costs.” These costs include administrative costs, licensing, regulatory fees, and monies lost to “waste, fraud, and abuse.”¹¹³

In his written testimony submitted to the Subcommittee on Oversight and Investigations for its December 8, 2015 hearing, CMS Acting Administrator Slavitt acknowledged that CMS is responsible for the oversight of how SBEs spend 1311 grants. Acting Administrator Slavitt testified that CMS restricted IT funds until SBEs demonstrated that the request for funding is reasonable and that the technical approach is appropriate. In his testimony, Acting Administrator Slavitt explained that, “[i]f a state’s request is determined to be unreasonable, unsound, or duplicative of previously-funded activities, CMS denies the SBE’s request for the release of grant funds.”¹¹⁴ Yet, the committee has seen no evidence that CMS has denied these requests.

As part of its authority to oversee the use of federal funds to establish and operation SBEs, CMS has rule making authority. On October 30, 2013, CMS issued a new rule that established standards for CMS’ oversight of state-based exchanges. These standards require SBEs to maintain records, report data and findings to HHS, and publish certain findings. The rule requires a SBE to:

- Keep an accurate accounting of exchange receipts and expenditures in accordance with generally accepted accounting principles;

¹¹¹ Patient Protection & Affordable Care Act; Exchange Functions: Standards for Navigators and Non-Navigator Assistance Personnel; Consumer Assistance Tools and Programs of an Exchange and Certified Application Counselors, 78 Fed. Reg. 42823 (July 17, 2013) (codified at 45 C.F.R. 155).

¹¹² 42 U.S.C. § 18031.

¹¹³ *Id.*

¹¹⁴ *An Overdue Checkup Part II: Examining the ACA’s State Insurance Marketplaces: Hearing before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations, 114th Cong. (Dec. 8, 2015) (prepared statement of Acting Administrator Andy Slavitt).*

- Monitor and report to HHS on exchange related activities;
- Provide a financial statement by April 1 of each year, eligibility and enrollment reports, and performance monitoring data;
- Conduct an annual external financial and programmatic audit and make such information available to HHS for review;
- Inform HHS of any material weakness or significant deficiency identified in the annual external audit and must develop and inform HHS of a corrective action plan for such material weakness or significant deficiency; and
- Make a summary of the audit results public.¹¹⁵

According to CMS, these oversight measures are in place to ensure that SBEs “[meet] the standards of the Affordable Care Act in a transparent manner.”¹¹⁶ CMS is charged with evaluating the information the SBEs submit and holding SBEs in compliance with requirements under the law.

The committee has found that CMS has not met its regulatory responsibilities to conduct robust oversight over the SBEs and to protect federal taxpayers from wasteful and fraudulent spending. Specifically, CMS has failed to enforce the statutory requirement that establishment grants cannot be used for operational expenses. CMS has failed to require states to comply with a basic statutory requirement to report wasteful spending and has failed to protect consumers equally for the stated purpose of maximizing enrollment. Finally, CMS has allowed the failed SBEs to use healthcare.gov for free to ease its transition to the federal exchange.

A. CMS Issued Permissive Guidance to SBEs

Under the PPACA, SBEs must be “self-sustaining” by January 2015, and may not use federal 1311 grants after January 1, 2015.¹¹⁷ Despite this prohibition, CMS has awarded SBEs flexibility in the form of “No Cost Extensions,” a commonly used grant practice that in this case allows SBEs to use federal establishment grants for certain expenditures through 2016.¹¹⁸ To

¹¹⁵ Patient Protection and Affordable Care Act; Program Integrity: Exchange, Premium Stabilization Programs, and Market Standards; Amendments to the HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 65046 (Oct. 30, 2013) (Final Rule).

¹¹⁶ U.S. Dep’t of Health & Human Serv., Centers for Medicare & Medicaid Serv., *Program Integrity Rule*, available at <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/pi-final-10-24-2013.html> (last visited August 8, 2016).

¹¹⁷ 42 U.S.C. 18031.

¹¹⁸ U.S. Department of Health & Human Serv., *No Cost Extension Requests*, available at http://www.acf.hhs.gov/sites/default/files/fysb/no_cost_extension_0.pdf (last visited Aug. 8, 2016).

date – 20 months after the time the law requires SBEs to be self-sustaining - every surviving SBE is still using establishment grants pursuant to a CMS “No Cost Extension” waiver.

FINDING: As of September 2016, every SBE still relies upon federal establishment grant funds—20 months after SBEs were to be self-sustaining by law.

Under CMS rules, the 1311 grants subject to the No Cost Extension must be spent to complete “design, development and implementation” of activities already approved by CMS in the SBE’s previous work plan.¹¹⁹ These 1311 grants, however, may only be used for “establishment” expenses, or activities required to set up the SBE.¹²⁰ This is distinct from spending for “operational” costs, or activities required for the day-to-day operations of the SBE, which is prohibited.

On March 14, 2014, CMS issued a one-page guidance to SBEs about how to use federal establishment grants through No Cost Extensions after January 2015.¹²¹ In this guidance, CMS clarified that, without a No Cost Extension approved by CMS, 1311 grant funds would not be usable after December 31, 2014. The guidance stated, “CMS will review each [No Cost Extension] request for allowability, allocability, and reasonableness or costs” based on Section 1311 of PPACA.¹²²

¹¹⁹ U.S. Dep’t of Health & Human Serv., Centers for Medicare & Medicaid Serv., *FAQs on the Use of 1311 Funds and No Cost Extensions*, available at <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/no-cost-extension-faqs-3-14-14.pdf> (last visited Aug. 8, 2016).

¹²⁰ *Id.*

¹²¹ *Id.*

¹²² *Id.*

FAQs on the Use of 1311 Funds and No Cost Extensions

Question: May grantees whose State-based Marketplace (SBM) or State Partnership Marketplace (SPM) provide coverage in 2014 seek an extension of their grant project period beyond the first year of operations, and if so, for what types of activities?

Answer: Yes, consistent with existing HHS grant rules and policies, grantees may request No Cost Extensions (NCEs) to extend the project period beyond the first year of operations (December 31, 2014) where the grantee reasonably requires additional time to complete the design, development, and implementation of activities that were part of the grantees' approved work plan under a specific grant. CMS will review each NCE request for allowability, allocability, and reasonableness of costs based on section 1311 of the Affordable Care Act and HHS grant rules and policies.

Question: Are there activities that may not be supported with funds made available to a grantee pursuant to an NCE?

Answer: Yes, where funds are made available during a project period that was extended pursuant to an NCE, the funds may not be used to cover maintenance and operating costs, including but not limited to rent, software maintenance, telecommunications, utilities, and base operational personnel/contractors. CMS will thoroughly review all NCE requests to ensure that project periods are extended only for approved and permissible establishment activities.

CMS defined prohibited “operational” expenses as “maintenance and operating costs, including but not limited to rent, software maintenance, telecommunications, utilities, and base operational personnel/contractors.”¹²³

One year later, in April 2015, the HHS OIG identified deficiencies in CMS’s guidance and expressed concerns that SBEs may have used 1311 grants for impermissible expenses. The HHS OIG issued an Early Alert advising CMS Acting Administrator Slavitt that SBEs “may have used, and might continue to use, establishment grant funding for operating expenses after January 1, 2015, contrary to law.”¹²⁴ For example, the HHS OIG identified budget documents from Washington State’s SBE, Washington Health Based Exchange (WHBE), which indicated WHBE considered using \$10 million in establishment grants to support operations from July 1, to December 31, 2015. Specifically, WHBE allocated \$2 million for operating costs such as printing and postage, and another \$2 million for bank fees—expenses approved by CMS.¹²⁵ The HHS OIG alert stated:

Current guidance that implements the statutory prohibitions describes only broad categories of costs that SBMs cannot cover using this funding assistance. For example, the current guidance states that the ACA, section

¹²³ *Id.*

¹²⁴ U.S. Department of Health & Human Serv., Office of Inspector Gen., A-01-14-02509, *Early Alert: Without Clearer Guidance, Marketplaces Might Use Federal Funding Assistance for Operational Costs When Prohibited by Law* (Apr. 27, 2015).

¹²⁵ *Id.*

1311, funds made available for an extended period through an NCE cannot be used to cover maintenance and operating costs, such as rent, software maintenance, telecommunications, utilities, and base operational personnel and contractors, but does not provide specifics on other key costs, such as call centers and in-person assisters. Without specific guidance that clearly defines the difference between a design, development, and implementation expense (potentially allowable) and an operating expense (statutorily prohibited), there is a risk that SBMs might inappropriately use establishment grant funds for operational costs. ... In addition more specific guidance should make clear that the ACA, section 1311, applies to funds made available through [No Cost Extensions] and newly awarded grants. Specific examples of potentially allowable and statutorily prohibited costs would be useful. Additional guidance would help the [State based exchanges] by providing better clarity and certainty of the allowability of costs and would help ensure proper oversight of this funding limitation in the ACA.¹²⁶

The HHS OIG concluded that without more detailed guidance from CMS, SBEs might continue to use establishment grant funds for operating expenses, contrary to law.

The HHS OIG acknowledged that the precarious and uncertain financial positions of many SBEs may lead those SBEs to use 1311 establishment grant funds to cover operational costs. The HHS OIG also signaled that CMS's vague guidance to SBEs may contribute to the misuse of grants dollars, and characterized this issue as a "significant matter" that required CMS's "immediate attention."¹²⁷ The HHS OIG noted that certain terms in section 1311—such as "operating expense" and "design, development, and implementation expenses"—lacked "meaningful distinction."¹²⁸

In its initial guidance, CMS defined the prohibited operational costs, but did not define the permitted "establishment" costs. CMS' lack of clarification places the burden on SBEs to interpret what costs are allowable. The HHS OIG accordingly encouraged CMS to develop and issue clear guidance to SBEs on the acceptable use of establishment grant funds. Specifically, the HHS OIG encouraged CMS to clarify what "constitutes (1) operational costs and (2) design, development, and implementation costs to minimize the marketplaces' improper use of establishing grant funding."¹²⁹ The HHS OIG further encouraged CMS to review the SBE's No Cost Extension applications to ensure that CMS' guidance addresses real-world examples such as call centers, in-person assisters, bank fees, and printing and postage expenses. The HHS OIG also encouraged CMS to actually monitor the SBEs' use of establishment grant funds.¹³⁰

¹²⁶ *Id.*

¹²⁷ *Id.*

¹²⁸ *Id.*

¹²⁹ *Id.*

¹³⁰ *Id.*

CMS responded to the HHS OIG's early alert by issuing an additional two pages of guidance to SBEs on June 8, 2015. In this supplementary guidance, CMS listed examples of permissible establishment expenses, including designing, developing, and testing information technology functions, setting up federally compliant financial and program audit policies and procedures, outreach and education to boost enrollment, call center activities, and long-term capital planning. States also can use these funds to cover costs indirectly supporting establishment work such as salaries.¹³¹ The CMS guidance stated:

Allowable uses of 1311 funds after January 1, 2015 are for establishment activities that were specifically described in the grantee's approved work plan, including:

- Stabilizing Marketplace IT Systems through the design, development, and testing of IT functionality;
- Instituting financial and programmatic audit policies and procedures to comply with the State-based Marketplace Annual Reporting Tool (SMART), including establishment of data systems that support compliance;
- Outreach and education, including in-person assistance, to support increasing total enrollment to designated targets in a grantee's approved work plan that reflect a documented level of participation that was not achieved by January 1, 2015, and is necessary for the viability of the Marketplace;
- Call center activities to support establishment-related outreach or to provide manual support while IT functionality is developed; and
- Long-term capital planning to support the successful establishment of the Marketplace.

Disappointingly, this guidance did not provide many real-world examples to help clarify what constitutes and distinguishes establishment and operational costs, and did not give much more detail than the first guidance document. The guidance provided only a short discussion of unallowable expenses:¹³²

Examples of unallowable costs related to ongoing operations include but are not limited to: rent, hardware/software maintenance and operations, telecommunications, utilities, and call center operations that do not constitute establishment activities or indirect costs flowing from allowable establishment activities.

Further, CMS does not appear to have taken additional steps to review No Cost Extension applications and bolster its oversight of the SBEs' use of establishment grant funds, even though they were encouraged to do so by the HHS OIG. The lack of specific and detailed guidance—a total of three pages covering the expenditure of millions of dollars of grant funds for the complex

¹³¹ U.S. Dep't of Health & Human Serv., Centers for Medicare & Medicaid Serv., *FAQs on the Clarification of the Use of 1311 Funds for Establishment Activities* (June 8, 2015), available at <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FINAL-1311-FAQ-06-08-15.pdf>.

¹³² *Id.*

purpose of establishing health insurance exchange networks—suggests that CMS’s priority was not to ensure compliance with the law, but rather to facilitate spending of the grant dollars.

Even after the additional guidance, CMS’ rules remain murky. In response to the HHS OIG’s alert, CMS reexamined its initial award to the WHBE and confirmed its original analysis. CMS considered WHBE’s original request of \$11.5 million, including \$3.3 million in bank fees, and noted that CMS required a \$1.5 million reduction in the bank fees. However, CMS maintained that bank fees and postage costs qualified as establishment expenses and were permitted.¹³³ CMS did not provide an adequate explanation for its decision that postage and bank fees are “establishment” expenses and not operational costs. These fees are incurred as an exchange operates, not as expenses necessary to establish an exchange, especially three years into the life of the exchange. It is very difficult to understand CMS’s rationale for this decision, and troubling to contemplate the implications for the decisions it may have made on other state requests to use federal establishment grants for operational expenses.

Despite warnings from the HHS OIG, CMS has continued its anemic and permissive oversight policies leading to misuse of federal funds by SBEs. The Committee is also dissatisfied with the technical guidance and believes it to be confusing and permissive to exchanges, at the expense of the federal taxpayer. The committee questions CMS’ oversight on the use of establishment grants for operational costs moving forward.

B. CMS Approved Questionable SBE Spending

In the course of this investigation, the committee sent letters to all 17 SBEs established under the PPACA requesting documents and information about how these SBEs spent federal funds and how CMS tracked SBE spending.¹³⁴ Documents produced to the committee by the Minnesota SBE show instances of questionable spending that CMS permitted.

FINDING: CMS flagged four categories of possible operational expenses in Minnesota’s SBE budget, but permitted the expenditures of federal grant money in each case.

At the end of 2014, CMS awarded Minnesota’s SBE, MNSure, a No-Cost Extension so that MNSure could continue to use federal grant dollars on approved “establishment” activities through 2015. No-Cost Extensions are commonly used grant practice to allow grantees to use federal funds beyond the grant award period. MNSure applied for and received a No-Cost Extension to use federal grants in 2016 as well. CMS’s guidance for what constitutes an “establishment” grant has been permissive, vague and placed the burden on states to determine whether an expense was an operational or establishment cost.

¹³³ Email from Staff, Centers for Medicare & Medicaid Servs., to Staff, H. Comm. on Energy & Commerce (June 16, 2016) (on file with Committee staff).

¹³⁴ See, e.g. Letter from Hon. Fred Upton, Chairman, H. Comm. on Energy & Commerce, to Allison O’Toole, Interim Chief Executive Officer, MNSure (Oct. 14, 2015).

In its application for a No-Cost Extension, MNSure explained how it planned to spend its remaining federal grant dollars. CMS required MNSure to show not only that the funds were for establishment activities, but also that CMS had already approved that same expenditure earlier in the grant process.¹³⁵ MNSure’s application also noted how the SBE would spend Medicaid funds in accordance with the cost allocation process described in Section V(E). Like establishment grants, SBEs may not spend Medicaid funds on operational costs.

After reviewing MNSure’s application, the committee identified costs that appear to be operational. For example, in its initial 2014 No Cost Extension application, MNSure requested an additional 134 full-time employees with experience in information technology, and 49 full-time consultants to assist with the establishment of the exchange.¹³⁶

Staffing	Amount	Description
<p>Staff at MN.IT @DHS (interagency agreement)</p> <p>HBEIE120176 HBEIE120177 HBEIE130163 HBEIE140181</p>	19,660,000	<p>134 FTE – See Exhibit D for detailed list</p> <p>The budget amount is based on MN.IT’s average salary/fringe rate of \$59 per hour multiplied by the anticipated hours tracked to the project. Actual charges will be based on the actual position hours/costs tracked to the project.</p>
<p>Staff augmentation (consultant contracts)</p> <p>HBEIE120177</p>	17,835,000	<p>49 FTE – See Exhibit D for detailed list</p> <p>The budget amount is based on MN.IT’s average paid contract rate of \$150 per hour multiplied by the anticipated hours tracked to the project. Actual charges will be based on the actual consultant hour/costs tracked to the project.</p>

For these additional 183 staff, MNSure allotted \$1.6 million in federal grant awards for office supplies, furniture, and to lease office space. MNSure also budgeted for travel expenses and training for staff using the federal dollars that were awarded to them under establishment grants:¹³⁷

¹³⁵ U.S. Dep’t of Health & Human Serv., Centers for Medicare & Medicaid Serv., *FAQs on the Use of 1311 Funds and No Cost Extensions*, available at <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/no-cost-extension-faqs-3-14-14.pdf>.

¹³⁶ *MNSure Grant Adjustment Application* (Nov. 14, 2014) (on file with Committee staff).

¹³⁷ *Id.*

General administration	Amount	Description
Travel expenses HBEIE130163	100,000	Travel to health exchange and technical conferences (estimate based on 134 additional MN.IT @DHS staff)
Office supplies HBEIE130163	200,000	Office supplies including copiers, pens, paper, , toner, chairs, etc. (estimate based on 134 additional MN.IT@DHS staff and additional 49 consultants)
Equipment and furniture HBEIE130163	1,200,000	Staff computers, office equipment, and repairs. (estimate based on 134 additional MN.IT @DHS staff and additional 49 consultants)
Occupancy costs HBEIE130163	200,000	Short-term lease expenses (estimate based on 134 additional MN.IT @DHS staff and additional 49 consultants)
Training HBEIE120177	250,000	Staff training on technical tools and methods (estimate based on 134 additional MN.IT @DHS staff)

CMS questioned some of the expenses detailed in MNSure’s application. Notably, CMS staff questioned whether the extra 183 employees were necessary because MNSure had been operating for over year at the time of the request.¹³⁸

5. Why does MN need 134 additional FTEs and 49 Consultants during this phase of development? (p. 9 of 18). Is this sustainable?

Response

The additional staff funding requested is intended to complete the IT build, incorporating the priorities of the MNSure Board, and reflects a belief that MNSure will be in full project mode for another year. These roles are described in the project narrative of the grant request. MNSure plans to transition away from its former DDI model that relied heavily on vendor staffing secured through deliverables-based contracts and towards a staffing plan that is based on state staffing with some consultant augmentation. This transition is more financially sustainable and better positions MNSure to be able to support the system in operations. Attachment D identifies the additional staffing need and their roles, and also provides a preliminary assessment of operational staffing needs beyond 12-31-2015. The estimates for the vendor contracts assumed a period of overlap while the vendor staff transitioned their work and knowledge to the new state positions, with services required through at least March 2015.

CMS also noted that the supplies and equipment costs appeared to be operational.¹³⁹

¹³⁸ CCHIO/CMS Follow Up Questions for MNSure (Dec. 1, 2014) (on file with Committee staff).

¹³⁹ *Id.*

Exhibit E - CCIIO/CMS Follow-up Questions (12-1-2014 e-mail)

1. Office Supplies @ \$200,000, Equipment & Furniture @ \$1,200,000, Occupancy Costs @ \$200,000, and Training @ 250,000 for the additional staffing is questionable if that staff is already in place. These costs appear to be operational. Please explain how they are classified as DDI.

Response

These are general administrative costs associated with the additional DDI staff and contractors listed in Attachment D. The basis for these estimates is detailed below including corrections to some of the original amounts requested.

Travel / training expenses were based on an assumption that 75% of the 134 additional staff would travel once for training purposes, at a total travel / training cost of \$2500 per trip. The total for these two categories should have been \$250,000, composed of \$100,000 travel and \$150,000 training. The amount requested for training inadvertently included the travel.

Office supplies / equipment & furniture expenses were based on an average cost of \$6500 for each for the 134 additional staff and 49 additional consultants. This includes temporary office landscaping (e.g. dividers/cubicles and work surfaces), chairs, computer/monitor, phones, shared MFD device (and related supplies), as well as office supply basics. The total requested for the two categories should have been \$1,200,000, composed of \$200,000 supplies and \$1,000,000 equipment. The amount requested for equipment inadvertently included the supplies.

Short-term occupancy expenses are based on past cost experience with short-term leases. On average, short-term leases have cost \$1500 per person on an annualized basis. The amount requested of \$200,000 was based on the 134 additional staff, but inadvertently excluded the 49 consultants. The adjusted request amount is \$270,000.

CMS permits SBEs to spend federal grants on “portions of indirect costs, such as salaries” *only if they support establishment activities*.¹⁴⁰ CMS does not name any other indirect costs, besides salaries, that are permissible. In this case, CMS first questioned whether MNSure could hire 183 new employees so late in the establishment of the exchange and define that expenditure an establishment cost. At the time of the request, MNSure had been operational for over one year and had been working with IT contractors to create an IT system since 2012.¹⁴¹

CMS then questioned whether the expenditure of \$6,500 in supplies for each new employee was an appropriate use of federal taxpayer dollars since these also seemed to be operational expenses. In its guidance, CMS expressly approved salary costs as “establishment” expenses if the employee was working on activities to establish the exchange. CMS did not expressly approve supplies such as pens, paper, copiers, toner, and chairs to be establishment expenses. In this case, if the hiring of the additional employees is suspect, these expenses are even more questionable.

¹⁴⁰ U.S. Dep’t of Health & Human Serv., Centers for Medicare & Medicaid Serv., *FAQs on the Clarification of the Use of 1311 Funds for Establishment Activities* (June 8, 2015), available at <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FINAL-1311-FAQ-06-08-15.pdf>.

¹⁴¹ U.S. Dep’t of Health & Human Serv., Centers for Medicare & Medicaid Serv., Center for Consumer Info. & Ins. Oversight, *Minnesota Health Insurance Marketplace Grants Awards List*, available at <https://www.cms.gov/cciio/Resources/Marketplace-Grants/mn.html> (last accessed Aug. 8, 2016).

Despite these concerns, however, CMS ultimately approved the expenditure of the majority of these federal funds. The document below reflects the amount CMS approved. While MNSure reduced the requested funds by a nominal amount, CMS permitted MNSure to spend federal funds for these activities.¹⁴²

General administration	Amount	Description
Travel expenses HBEIE130163	92,700	Travel to health exchange and technical conferences (estimate based on 134 additional MN.IT @DHS staff)
Office supplies HBEIE130163	185,400	Office supplies including pens, paper, copier, toner, chairs, etc. (estimate based on 134 additional MN.IT @DHS staff and additional 49 consultants)
Equipment and furniture HBEIE130163 - Restricted	927,000	Staff computers, office equipment, and repairs. (estimate based on 134 additional MN.IT @DHS staff and additional 49 consultants)
Occupancy costs HBEIE130163	185,400	Short-term lease expenses. (estimate based on 134 additional MN.IT @DHS staff and additional 49 consultants)
Training HBEIE120177	139,050	Staff training on technical tools and methods. (estimate based on 134 additional MN.IT @DHS staff and additional 49 consultants)

CMS flagged two additional requests from MNSure that appeared to be operational costs.¹⁴³

¹⁴² MNSure Supplemental Adjustment Request (on file with Committee staff).

¹⁴³ CCHIO/CMS Follow Up Questions for MNSure (Dec. 1, 2014) (on file with Committee staff).

9. MN.IT Central Services @ \$3,500,000 appears to be operational in nature.

Response

There are several services provided by MN.IT Central that directly correlate to the DDI effort. Those include the costs associated with the management of development database instances, virtual server hosting, application hosting services, SAN services as well as infrastructure for recovery services directly related to the DDI efforts. The original cost estimated included these DDI services, plus on-going operational services. Our revised estimate of DDI-related MN.IT Central Service charges is \$1,500,000. Additional detail can be provided if necessary.

10. Environment @ \$10,000,000 appears to be operational funding given the number of environments already funded for the MNSure development to date. What additional environments are required beyond what already exist?

Response

The last IV&V report for QR5 highlighted this issue with a finding described as "Inadequate Test Environment to Perform Batch Testing." Additional environments for DDI are needed as MN takes on a greater development role from contractors and plans to accelerate development in the coming year. The additional environments will allow multiple development tracks, to accommodate use of time travel software, and perform load testing. Additional detail can be provided if necessary.

CMS ultimately approved the majority of these funds, despite concerns from that these funds were operational in nature. The document below shows that CMS awarded \$1,390,500 for MN.IT Central Services out of the original \$3,500,000 request, and \$9,270,000 for new software acquisition of the original request for \$10,000,000.¹⁴⁴ Minnesota had revised its request from \$3,500,000 to \$1,500,000, and was awarded only \$1,390,500 because of a government-wide sequestration.

¹⁴⁴ *MNSure Supplemental Adjustment Request* (on file with Committee staff).

Other IT contracts	Amount	Description
MN.IT Central services HBEIE120176 - Restricted	1,390,500	In order to support the continued development effort there is a necessity to provide services that include networking, desktop support, telecom, virtual desktops, and development environments. MN.IT Central charges are based on Federal DCA approved central-services cost allocation, rate-setting methodology.

Hardware/software	Amount	Description
Environments HBEIE130163 - Restricted	9,270,000	In order to adequately performance and load test the code being developed and delivered there is a need to build out additional environments as well as acquire software and services to provide the necessary framework. The state has currently been contracting for several of these. The overall needs include infrastructure and licensing of the overall solution to incorporate training, load and performance regions. In coordination with these new environments and the complexity of eligibility there is a necessity to emulate both future and past testing. Time travel is a critical component that needs funding to support the existing efforts to allow for success going forward. There is also an increased need in licensing for the regions that are already in production.

In total, CMS flagged four distinct categories of expenses in MNSure’s application for a No Cost Extension that appeared to be operational, and approved them all nonetheless. This example seems to further illustrate that CMS did not prioritize enforcing regulations established in the law detailing that federal establishment grants should not be used for SBE operational purposes. Rather CMS’s interest was in helping states rationalize the spending of awarded federal taxpayer dollars.

C. CMS Failed to Enforce SBE Transparency Requirement Mandated by the PPACA

FINDING: *Only one SBE—Kentucky—complied with PPACA’s requirement that all SBEs publish the costs associated with operating its exchange on the internet, including monies lost to waste, fraud, and abuse.*

PPACA created parameters for how SBEs could spend 1311 grants. Section 1311 prescribed that grants shall be used for “activities (including planning activities) related to establishing an [exchange].”¹⁴⁵ The law requires that SBEs publish the costs associated with operating its exchange on the internet to “educate consumers on such costs.” These costs include administrative costs, licensing, regulatory fees, and monies lost to “waste, fraud and abuse.”¹⁴⁶

Only one SBE, however, has complied with this legal requirement to post monies lost to waste, fraud and abuse. Kentucky’s SBE posted a public accounting of the costs associated with operating its exchange, and noted that “\$0” dollars have been lost due to waste, fraud, and abuse.¹⁴⁷ Kentucky relied upon audits by the state department of health—not CMS—to determine amount of funds lost to waste, fraud, and abuse. While Kentucky was the only SBE to comply with the requirement, the numbers listed on Kentucky’s SBE website are out of date; the website lists only cumulative expenditures by the SBE from September 30, 2010 through December 31, 2014.¹⁴⁸

It does not appear that CMS has taken any action to enforce this statutory requirement that state exchanges publish the monies lost to waste, fraud and abuse. As a result, these SBEs have escaped public accountability—required by law—for monies spent to establish and operate a SBE. When the Committee alerted the HHS OIG that SBEs had not complied with this requirement, the HHS OIG commenced an inquiry with CMS to “understand [CMS’] monitoring and enforcement of this reporting provision.”¹⁴⁹ CMS’ failure to enforce this important legal requirement suggests CMS has a lax attitude toward the enforcement of the PPACA, particularly as it relates to the public accountability for costs incurred by SBEs and monies lost to waste, fraud, and abuse.

¹⁴⁵ 42 U.S.C. § 18031.

¹⁴⁶ *Id.*

¹⁴⁷ Kentucky Health Benefit Exchange, *Financial Information*, available at <http://healthbenefitexchange.ky.gov/Pages/Financial-Information.aspx> (last visited Aug. 8, 2016).

¹⁴⁸ *Id.*

¹⁴⁹ Email from Staff, U.S. Dep’t of Health & Human Serv., Office of Inspector Gen., to Staff, H. Comm. on Energy & Commerce (July 13, 2016) (on file with Committee staff).

D. CMS Failed to Protect Consumers Equally by Imposing Lenient Consumer Protections for SBEs

FINDING: CMS prohibits pay-per-enrollee schemes in federally facilitated exchange states, but permits the same problematic scheme in SBEs in order to increase enrollment numbers.

CMS’s permissive attitude toward SBEs is also evident in the exceptions that CMS made for consumer assistance personnel in SBEs. The PPACA required that each SBE establish a “Navigator” program. This program awards grants to community organizations responsible for assisting consumers in applying and enrolling for health care insurance coverage under the law.¹⁵⁰ Since the law mandated that individuals enroll in coverage, Navigators were to help individuals who did not have previous experience with health care insurance and had questions about eligibility and different types of coverage available. HHS created a twin program, the “In-Person Assistor” program as a substitute for Navigators in the 34 states that did not establish SBEs.

HHS did not require the recipients of Navigator and In-Person Assistor Grants to have experience in health insurance or past training regarding the protection of personally identifiable information. As a result, concerns existed that Navigators would accidentally give consumers inaccurate information about available health plans, or poor advice about the best plan for that individual’s family. Since some Navigators received a flat-fee for each completed application, there were additional concerns that the compensation structure provided adverse incentives to enroll individuals regardless of whether that was in the individuals’ best interest.

Further, the sum Navigators received for each submitted application can be significant. In Minnesota, for example, Navigators receive \$70 per submitted application. CMS not only permits these expenditures, but also permits state-based exchanges to pay for them with enrollment grants funded by taxpayer dollars. The below proposal appeared in MNSure’s Work Plan for Grant 81 submitted to CMS:¹⁵¹

- QHP Enrollment Grants - \$1,125,000.

Activity: QHP enrollment grants allow in person assisters to be paid \$70 per person when they enroll a consumer into private coverage through MNSure. An extension is requested to support these Establishment-oriented consumer assistance activities. These activities are an important part of MNSure achieving future enrollment targets necessary for MNSure’s financial sustainability plan.

Timing: Funds will be used throughout all 12 months of calendar year 2016. We anticipate most activity related to QHP enrollment will occur during the Open Enrollment period for 2017 coverage.

Responsibility: MNSure Assister program.

¹⁵⁰ 42 U.S.C. § 18031.

¹⁵¹ *MNSure Grant 81 Work Plan* (on file with Committee staff).

In response to these concerns, HHS issued rules to regulate both the SBE Navigator program and the federally facilitated In-Person Assister programs. After acknowledging a clear conflict of interest when Navigators and In-Person Assistors are paid per enrollee, CMS prohibited a pay-per-enrollee compensation scheme in federal-facilitated states, but approved it for state-based exchanges.¹⁵² For federally facilitated exchanges, CMS noted an “interest and a concern in ensuring that [In-Person Assistors] are not incentivized to hurry through an assistance session with a consumer, and possibly to avoid assisting those consumers who may have complex situations that require them to have extra time for completing an application.”¹⁵³ CMS also noted that a pay-per-enrollee structure can “create an incentive for Navigators...to focus primarily on facilitating enrollment in or selection of a QHP, as applicable, which is only one of the several duties required of Navigators[.]”¹⁵⁴

Yet, CMS reasoned that SBEs should be allowed to utilize this prohibited compensation practice because some Navigators in SBEs were already doing it this way. CMS cited the “successful enrollment efforts” state-based exchanges reported using a pay-per-enrollee model and stated “it is not our intent to disrupt compensation practices that are currently used or authorized by State Exchanges.”¹⁵⁵ While some commenters suggested a transition period for state-based exchanges using this compensation scheme if CMS were to prohibit it, instead CMS fully supported this payment structure state-based exchanges going forward.

It is unfair that consumers in states with SBEs do not have the same protections as those in the FFE. Moreover, CMS acknowledged the risks to consumers and the potential for misuse of federal funds inherent in this payment structure, and ruled that higher enrollment numbers and a permissive culture toward state exchanges outweighed those concerns.

E. CMS Failed to Recover Misspent Dollars Identified by the Inspector General

Audits conducted by the HHS OIG determined that several SBEs improperly used federal dollars* to pay for operational expenses of their SBEs. Even though the HHS OIG identified these misspent federal dollars and recommended that CMS recoup the dollars, CMS still refused.

FINDING: The HHS Inspector General found that Maryland and Nevada violated federal rules and used federal dollars* to pay for unpermitted SBE expenses.

Under the PPACA, SBEs may use federal Medicaid reimbursement money to fund some aspects of the SBEs. For example, SBEs can help states coordinate eligibility for enrollment in other state-based public health care programs, such as Medicaid and the Children’s Health

¹⁵² Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond, 79 Fed. Reg. 30240 (May 27, 2014) (Final Rule).

¹⁵³ *Id.*

¹⁵⁴ *Id.*

¹⁵⁵ *Id.*

Insurance Program.¹⁵⁶ When SBEs perform such permitted functions, the methodology for allocation of funds should have “some reasoning based on expected transactions, expected program population, etc., and cannot be arbitrary” (e.g., costs cannot be split simply half and half because there are two programs sharing in the investment).¹⁵⁷ In addition, SBEs should identify and allocate indirect costs based on a methodology that reflects the proportionate benefits received by the programs (e.g., total direct costs for administrative costs, square footage for building and operations costs, number of accounts for telecommunications costs).¹⁵⁸ Moreover, state Medicaid agencies must submit Advance Planning Documents (APDs) to obtain enhanced federal funding for Medicaid IT system projects related to Medicaid eligibility and enrollment, including eligibility and enrollment through a marketplace system.¹⁵⁹

Two states, however, have been found to have used federal Medicaid dollars to pay for unpermitted SBE expenses. A recent report from HHS OIG found the state of Maryland misallocated \$28.4 million in costs to establishment grants instead of the Medicaid program.¹⁶⁰ Nevada similarly misallocated nearly \$900,000 from the Medicaid program.¹⁶¹ In addition, the Massachusetts SBE improperly enrolled over 300,000 people who did not qualify for Medicaid into temporary Medicaid coverage, when website glitches prohibited enrollment into the private marketplace.¹⁶²

In the state of Maryland, the HHS OIG found that the Maryland SBE misallocated \$15.9 million to establishment grants using outdated estimated enrollment data instead of updated, actual enrollment and another \$12.5 million using a cost allocation methodology that included a material defect, totaling over \$28.4 million of misallocated costs.¹⁶³ The HHS OIG identified the following causes of the misallocated claimed costs:

- There was no written policy that explained how to perform the allocations or the necessity to use updated enrollment data;
- There was insufficient staff oversight to identify and correct enrollment projection errors, obtain better, updated enrollment data, and ensure the application of these data to the allocation costs;

¹⁵⁶ See, e.g. U.S. Dep’t of Health & Human Serv., Centers for Medicare & Medicaid Serv., Center for Consumer Info. and Ins. Oversight, *Initial Guidance to States on Exchanges*, available at https://www.cms.gov/CCIIO/Resources/Files/guidance_to_states_on_exchanges.html (last accessed Sept. 7, 2016) (“Section 1311(d)(4)(F) requires Exchanges to evaluate and determine eligibility for applicants in Medicaid, the Children’s Health Insurance Program (CHIP), and other health programs.”).

¹⁵⁷ U.S. Dep’t of Health & Human Serv., Centers for Medicare & Medicaid Serv., *Supplemental Guidance on Cost Allocation for Exchange and Medicaid Information Technology (IT) Systems Questions and Answers* (Oct. 5, 2012).

¹⁵⁸ *Id.*

¹⁵⁹ 42 CFR § 1311.

¹⁶⁰ U.S. DEP’T OF HEALTH & HUMAN SERV., OFFICE OF INSPECTOR GEN., A-01-14-02503, MARYLAND MISALLOCATED MILLIONS TO ESTABLISHMENT GRANTS FOR A HEALTH INSURANCE MARKETPLACE (Mar. 2015).

¹⁶¹ U.S. DEP’T OF HEALTH & HUMAN SERV., OFFICE OF INSPECTOR GEN., A-09-14-01007, NEVADA MISALLOCATED COSTS FOR ESTABLISHING A HEALTH INSURANCE MARKETPLACE TO ITS ESTABLISHMENT GRANTS (Feb. 2016).

¹⁶² Chris Cassidy, *Internal Documents Suggest \$1B ACA Costs in Massachusetts*, BOSTON HERALD (Oct. 11, 2014).

¹⁶³ U.S. DEP’T OF HEALTH & HUMAN SERV., OFFICE OF INSPECTOR GEN., A-01-14-02503, MARYLAND MISALLOCATED MILLIONS TO ESTABLISHMENT GRANTS FOR A HEALTH INSURANCE MARKETPLACE (Mar. 2015).

- Maryland initially assigned the responsibility for computing cost allocations to a staff accountant who did not have the requisite skills for the assigned duty. A Chief Financial Officer for the Maryland was not hired until January 2014; and
- Maryland did not amend its Corrective Action Plan for the establishment of its SBR to allocate costs corresponding to program benefits received.¹⁶⁴

The state of Maryland did not agree with HHS OIG’s findings, or its recommendations to return the funds. CMS also did not agree with the OIG’s recommendations, and did not take actions to recoup those funds. The HHS OIG responded:

After considering CMS’s comments on our draft report, we maintain that all of our findings and recommendations are valid. Even though CMS directed States to update their cost allocation methodology annually, CMS also directed States to reassess their cost allocation “if there is a substantive change in program participation.” CMS has not issued specific guidance that directs the State-based marketplaces to update their cost allocation methodology using enrollment data that are “final” at a certain point in time or that have stabilized. Absent any specific guidance from CMS, the State agency should have used updated and better enrollment data on March 31, 2014, to update the cost allocation methodology.¹⁶⁵

Additionally, the state of Nevada, which functioned as a SBE until the end of 2014, was also found to have misallocated operational costs affecting the Medicaid program. Prior to transitioning its enrollment to the Federal Platform, Nevada’s SBE, The Silver State Health Insurance Exchange, received establishment grant funds to assist with the business functions of the Nevada exchange.¹⁶⁶ In 2014, the HHS OIG determined that The Silver State Health Insurance Exchange misallocated \$893,464 in costs to the establishment grants rather than to Medicaid.¹⁶⁷ The HHS OIG found that, similar to Maryland, the exchange did not have a written policy that explained how to perform the allocations or explained the necessity to use updated, better data when available, and had insufficient staff oversight.¹⁶⁸

FINDING: CMS failed to enforce its own rules on Medicaid allocations, and did not recover the misspent dollars identified by the HHS Inspector General.

¹⁶⁴ *Id.* at 5.

¹⁶⁵ *Id.* at iii.

¹⁶⁶ U.S. DEP’T OF HEALTH & HUMAN SERV., OFFICE OF INSPECTOR GEN., A-09-14-01007, NEVADA MISALLOCATED COSTS FOR ESTABLISHING A HEALTH INSURANCE MARKETPLACE TO ITS ESTABLISHMENT GRANTS (Feb. 2016).

¹⁶⁷ *Id.* at 8.

¹⁶⁸ *Id.*

Neither CMS nor Nevada agreed with the HHS OIG's recommendations that Nevada return the funds to CMS. Again, CMS maintained that, despite their guidance that states reassess their cost allocation "if there is a substantive change in program participation," Nevada was not required to update the cost allocation formula when there was significant change in enrollment in the exchange. CMS decision not to recover these misspent federal funds is alarming.

The committee found similar problems in Massachusetts. As a result of the Massachusetts SBE Health Connector's failed website, the state spent over \$658 million of federal and state money enrolling people into temporary Medicaid coverage.¹⁶⁹ The Health Connector website, which was infested with glitches, blocked the web portal from enrolling certain individuals into private health care insurance plans. The state instead enrolled more than 300,000 individuals in a temporary Medicaid program. Many of these individuals made too much money to qualify for Medicaid enrollment under normal circumstances.¹⁷⁰ This maneuver was made possible through an amendment in the States' Medicaid waiver, which effectively eliminated any initial eligibility determination into the Medicaid program.¹⁷¹ Specifically, in 2014, Massachusetts amended its Section 1115 Demonstration Project, which is essentially a waiver from CMS allowing the state to experiment with innovative strategies for delivering and financing health care for its Medicaid eligible residents.¹⁷² In a response letter to the committee, CMS confirmed they approved the Commonwealth Section 1115 demonstrations, which authorized the SBE to temporarily enroll individuals with income up to 300 percent of federal poverty level (FPL) into Medicaid.¹⁷³

When asked by the committee if the Massachusetts Health Connector used Medicaid reimbursement dollars to fund any aspect of the state exchange, Executive Director Louis Gutierrez of the Massachusetts Health Connector responded, "No, Medicaid reimbursement dollars have not been used to fund any aspect of the Massachusetts state exchange, including operational expenses."¹⁷⁴ Yet enrolling individuals who do not qualify for Medicaid in a temporary Medicaid coverage erroneously expends federal taxpayer dollars as soon as those individuals seek medical care with Medicaid coverage. To the committee's knowledge, CMS has not attempted to quantify the federal dollars spent or recoup those funds from the State.

F. CMS Recovers Only a Small Fraction of Misspent Federal Funds from SBEs

¹⁶⁹ Chris Cassidy, *Internal Documents Suggest \$1 B ACA Costs in Massachusetts*, BOSTON HERALD, Oct. 11, 2014.

¹⁷⁰ *Id.*

¹⁷¹ Josh Archambault, *Obamacare's Bay State Bailout*, THE APOTHECARY, FORBES (Oct. 23, 2014), <http://www.forbes.com/sites/theapothecary/2014/10/23/obamacares-bay-state-bailout/#707196f22537>.

¹⁷² SEIFERT, W. ROBERT ET AL., CENTER FOR HEALTH LAW AND ECON., UNIV. OF MASS. MEDICAL SCHOOL, THE MASSHEALTH WAIVER EXTENSION FOR STATE FISCAL YEARS 2015-2019: FOUNDATION FOR COVERAGE, ENGINE FOR INNOVATION (2015), available at

http://bluecrossfoundation.org/sites/default/files/download/publication/MassHealth_Waiver_report_FINAL.pdf.

¹⁷³ Letter from Marilyn Tavenner, Administrator, Centers for Medicare & Medicaid Serv., to Hon. Fred Upton, Chairman, H. Comm. on Energy & Commerce (Jan. 30, 2015).

¹⁷⁴ Letter from Louis Gutierrez, Director, Mass. Health Connector, to Hon. Tim Murphy, Chairman, Oversight and Investigations Subcomm., H. Comm. on Energy & Commerce (Oct. 30, 2015).

In total, CMS awarded \$4.6 billion in establishment grants to the 17 SBEs. Five of those SBEs ultimately closed down and joined the federal IT platform, healthcare.gov, and retained some portion of SBE duties. Of all 17 SBEs, including those that failed due to mismanagement and low enrollment, CMS has recovered just \$1.6 million in federal taxpayer funds.

In only one instance has an IT contractor returned money to a state or the federal government after failing to perform as required by the terms of their contract. Maryland—whose SBE has not failed—encountered significant challenges from the start in establishing its SBE. The Maryland Health Benefit Exchange entered into a \$193 million contract with Noridian Healthcare Solutions, the prime contractor hired to build the state exchange website. Before the exchange launched, however, Maryland officials disregarded warning signs that the system had design and functionality problems. As a result, Maryland’s health exchange crashed moments after launching and faced glitches for months.

The Maryland Health Benefit Exchange fired Noridian and hired another firm to rebuild the site. In a legal settlement, Noridian agreed to pay \$45 million—only 61 percent of the total paid to the company—to the state and federal governments to avoid a lawsuit over its performance.¹⁷⁵ Maryland’s Attorney General stated that the settlement is a “fair deal” for taxpayers, even though Noridian will not pay back the full amount that it received. The state of Maryland will keep \$12.5 million of the \$45 million settlement, and \$32.5 million will be returned to the federal government.¹⁷⁶ CMS had awarded Maryland four federal grants to build its SBE, totaling \$190,130,143.

1. CMS Misled the Committee on Funds Recouped from SBEs

In December 2015, the Subcommittee on Oversight and Investigations held a hearing on SBEs, focusing primarily on CMS’ oversight of the SBE’s use of federal funds. CMS Acting Administrator Slavitt was the sole witness at this hearing, and gave misleading testimony to the Committee about the amount and nature of federal funds recovered by CMS from the 17 SBEs. The committee’s findings are detailed in a report released on May 10, 2016, entitled “Misleading Congress: CMS Acting Administrator Offers False Testimony to Congress on State Exchanges.”¹⁷⁷

In his opening testimony, Acting Administrator Slavitt testified, “over \$200 million of the original grant awards have already been returned to the federal government, and we’re in the process of collecting and returning more.”¹⁷⁸ After the hearing, it was widely reported by the

¹⁷⁵ Josh Hicks, *Noridian to Pay \$45 Million to State, U.S. Government for Flawed State Exchange*, WASH. POST, July 21, 2015.

¹⁷⁶ Letter from Andrew Slavitt, Acting Administrator, Centers for Medicare & Medicaid Serv., to Hon. Fred Upton, Chairman, H. Comm. on Energy & Commerce (May 27, 2016).

¹⁷⁷ STAFF REPORT, H. COMM. ON ENERGY & COMMERCE, 114TH CONG., MISLEADING CONGRESS: CMS ACTING ADMINISTRATOR OFFERS FALSE TESTIMONY TO CONGRESS ON STATE EXCHANGES (May 9, 2016).

¹⁷⁸ *An Overdue Checkup Part II: Examining the ACA’s State Insurance Marketplaces: Hearing before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations*, 114th Cong. (Dec. 8, 2015).

media that CMS “recouped” over \$200 million from failed state exchanges.¹⁷⁹ Information and documents CMS provided to the committee, however, failed to corroborate Acting Administrator Slavitt’s testimony.

According to the document CMS produced to the committee on March 18, 2016, CMS had only recovered \$21.5 million in unspent federal grant dollars from the 17 SBEs out of the approximately \$4.6 billion originally awarded by the agency.¹⁸⁰ Further, that \$21.5 million was not recouped because of misspending by the SBE, but was rather de-obligated, because the time for the grant had expired or the funds were no longer needed. None of the funds recovered from the seventeen SBEs reflect grant dollars recouped by CMS due to improper spending.

The CMS chart, available in the Appendix, also shows that the 34 states that did not establish SBEs returned nearly \$300 million in unspent grant dollars to the federal government. This sum, however, was returned only because these states never established a SBE, and therefore had no use for the funds. This \$300 million was not part of the \$4.6 billion disbursed for the purposes of establishing the seventeen SBEs, but was part of a larger pool of money that went to 49 states and the District of Columbia.

Acting Administrator Slavitt’s testimony misled the committee in two ways: he misstated the amount of grant money returned to the Treasury, and he wrongfully implied that the funds were returned because of improper spending and CMS’ oversight efforts. Acting Administrator Slavitt’s misleading testimony, and the three-month delay to receive information about his testimony, raises questions about CMS’s ability to conduct appropriate and effective oversight and safeguard taxpayer dollars.

¹⁷⁹ See e.g. Stephanie Armour, *U.S. Recoups Funds from States That Faltered on Health Exchanges*, WALL STREET J., Dec. 8, 2015; Sara Hansard, *More Than \$200M Recouped From State ACA Exchanges, Official Says*, BLOOMBERG, Dec. 9, 2015; Peter Sullivan, *Lawmakers Press Obamacare Chief on State Money Troubles*, THE HILL, December 8, 2015; and Paige Winfield Cunningham, *Official Under Fire for Oversight of Obamacare Funds*, WASH. EXAMINER, Dec. 8, 2015.

¹⁸⁰ This chart can be found in the Appendix of this report.

2. CMS Has Recovered Only \$1.6 Million in Misspent Federal Funds

FINDING: CMS has recovered *only* \$1.6 million in misspent federal funds from three SBEs. Nearly \$1 million was for impermissible construction costs that went undetected by CMS for over a year.

Acting Administrator Slavitt responded to the committee's report in a letter dated May 27, 2016.¹⁸¹ In this letter, CMS revealed new information about the amount of misspent funds CMS had recouped from SBEs. At the December 8, 2015, hearing, Acting Administrator Slavitt testified that CMS identified three SBEs that misspent federal funds that CMS subsequently worked with states to recover.

CMS identified \$515,475 in unallowable spending by MNSure, Minnesota's SBE. MNSure spent federal grants on construction costs, which MNSure originally described as a lease expense for office space. CMS discovered this spending while reviewing documents during a site visit in October 2015, though the unallowable spending occurred years earlier from July 2013 to February 2015.

Oregon's SBE, Cover Oregon, misspent \$448,000 in federal funds. Like MNSure, Cover Oregon used federal grant funds for construction costs, which was again discovered by CMS during a site visit in May 2015. CMS found that the unallowable construction costs occurred nearly two years prior in September 2013.

CMS found that Arkansas' state-partnership exchange misspent \$652,351 in federal funds. Arkansas expressed interest in establishing a SBE very late in the process, and CMS awarded nearly \$100 million to Arkansas in December 2014, the last month 1311 grants were available under the law. During a review of spending and budget submissions in August 2015, CMS discovered Arkansas spent 1311 grants on unallowable non-establishment activities that occurred between January and June 2015, including spending on 2015 plan management functions, consumer assistance activities, and maintenance and operations.

All of these cases indicate egregious examples misspending by the states. Oregon and Minnesota managed to fund a half million-dollar construction projects with federal funds, and CMS staff did not find out until they visited these sites in person. Arkansas spent federal funds intended for establishing a state-based exchange after affirmatively deciding not to establish one. While the Committee is pleased that CMS has identified these unallowable costs, and endeavored to recoup them, they are just a small fraction of the total funds expended.

¹⁸¹ Letter from Andrew Slavitt, Acting Administrator, Centers for Medicare & Medicaid Serv., to Hon. Fred Upton, Chairman, H. Comm. on Energy & Commerce (May 27, 2016).

VI. CMS Failed to Implement Recommendations from Non-Partisan Government Auditor

FINDING: The Government Accountability Office issued two reports on CMS oversight of the SBEs. All six of the recommendations for how CMS can improve its oversight of the SBEs remain “open,” indicating that CMS has not implemented a single one.

In addition to CMS’ refusal to recoup misspent dollars identified by the HHS OIG, as discussed in Section V(E), CMS has also dismissed the recommendations the nonpartisan watchdog GAO. The GAO released two reports within the last year, that highly critical of CMS’ oversight of state exchanges. Both reports focused on CMS’ oversight of the IT platforms created by each SBE to enroll individuals in health care coverage.

Costs associated with establishing SBE websites took up the vast majority of SBE budgets.¹⁸² Each of the seventeen SBEs entered into contracts with IT vendors to create the technology for seventeen distinct websites, each containing the same functionality to not only comparison shop insurance plans, but also verify whether each individual applicant was eligible for subsidized coverage or other government health care programs. Thus, in large part, these SBEs reinvented the wheel 17 different times, all on the federal taxpayer’s dime.

A. GAO Issues Three Recommendations to Improve CMS Oversight

In September 2015, GAO released a report entitled “CMS Should Improve Oversight of State Information Technology Projects.”¹⁸³ GAO examined how SBEs used federal funds for IT projects to support the exchanges, the role CMS and states played in overseeing the IT projects, and the IT challenges faced by SBEs. As of March 2015, the 17 original SBEs reported spending nearly 89 percent of 1311 grant funds on information technology contracts.¹⁸⁴ In addition to these grants, the seventeen original SBEs also spent a combined \$813 in Medicaid funds to integrate Medicaid eligibility and enrollment capabilities into the SBE IT system.¹⁸⁵ GAO reported three major findings demonstrating that CMS did not conduct effective oversight of the SBE IT systems.

¹⁸² U.S. GOV’T ACCOUNTABILITY OFFICE, GAO-15-527, STATE HEALTH INSURANCE MARKETPLACES: CMS SHOULD IMPROVE OVERSIGHT OF STATE INFORMATION TECHNOLOGY PROJECTS (2015).

¹⁸³ *Id.*

¹⁸⁴ The specific amount spent on marketplace-related projects was uncertain as only a selection number of states reported to GAO that they tracked or estimated this information.

¹⁸⁵ U.S. GOV’T ACCOUNTABILITY OFFICE, GAO-15-527, STATE HEALTH INSURANCE MARKETPLACES: CMS SHOULD IMPROVE OVERSIGHT OF STATE INFORMATION TECHNOLOGY PROJECTS AT 31 (2015).

First, GAO found that CMS “did not always clearly document, define, or communicate its oversight roles and responsibilities to states.”¹⁸⁶ States reported to GAO that CMS’ failure to document oversight roles and responsibilities resulted in “poor communication” which “adversely affected states’ deadlines, increased uncertainty, and required additional work.”¹⁸⁷ Eleven out of 17 SBEs provided both mixed and negative comments about the “completeness and timeliness of CMS guidance that included roles and responsibilities.”¹⁸⁸ For example:

- States reported moving forward to develop solutions “without knowing if the agency would approve or disapprove” because of delays hearing back from CMS.
- States reported “delay in message delivery from CMS, insufficient communication with the stakeholders, and misunderstandings or misinterpretations of the messages communicated.”
- States lacked “complete and timely policy and business guidance from CMS, which impacted their IT development deadlines.”¹⁸⁹

In response, CMS officials acknowledged that CMS did not have a “comprehensive communications plan” explaining all of the relevant oversight roles and responsibilities.¹⁹⁰ CMS officials argued, however, that such a documented oversight structure was not necessary because the roles and responsibilities of CMS personnel were “general public knowledge for which no detailed documentation was necessary.”¹⁹¹

Second, GAO found that CMS also did not involve “all relevant senior executives in decisions to approve federal funding for states’ IT marketplace projects.”¹⁹² The report noted that by involving senior executives, CMS could have increased “accountability for decision making” for the federal funding grants to SBEs.¹⁹³ For example, CMS’s Objective Review Committee, comprised of subject matter experts from inside and outside the federal government, scored state applications for 1311 federal grants to establish SBEs. The CMS State officer’s recommendation was based on the scores from subject matter experts, and the Deputy Director of the State Exchange Group within CMS’ Center for Consumer Information and Insurance Oversight made the final decision on 1311 grant awards. GAO found it was “unclear who these subject matter experts were or whether there were executives at the appropriate level involved with these decisions.”¹⁹⁴ Regarding approval of Medicaid funds for marketplace IT projects, CMS could not provide any evidence that the approval process included senior executives from CMS.

¹⁸⁶ *Id.* at Highlights.

¹⁸⁷ *Id.*

¹⁸⁸ *Id.* at 49

¹⁸⁹ *Id.*

¹⁹⁰ *Id.* at 47.

¹⁹¹ *Id.* at 47-48.

¹⁹² *Id.* at Highlights.

¹⁹³ *Id.*

¹⁹⁴ *Id.* at 51.

Third, GAO found that CMS did not enforce the requirement that SBEs fully test their IT systems. While CMS established a process that required testing of SBEs to determine whether they were ready to operate, the IT systems “were not always fully tested.”¹⁹⁵ As GAO noted, failing to test the IT systems increased the risk that SBEs would not operate as intended. Regardless, CMS conditionally approved all of the SBEs—without confirming under their own process that states’ systems had been fully tested—and they went live on October 1, 2013. As a result, many SBEs had significant problems with their IT systems, resulting in long wait times, websites breaking down and freezing, and forcing the last minute use of paper applications to enroll.

GAO provided three recommendations for concrete actions CMS could take to improve its oversight of the state exchanges. As of August 2016, all three of GAO’s recommendations remain “open,” indicating that CMS has not implemented the recommendations and has not taken the necessary actions to respond to the negative findings in the report.

B. GAO Issues Three Recommendations to CMS to Improve SBE Information Security

In March 2016, GAO released another report that, in part, examined the security of three SBEs, as well as CMS’ oversight of SBEs generally. The report, entitled “Healthcare.gov: Actions Needed to Enhance Information Security and Privacy Controls,” found that CMS had still not fully implemented required security and privacy oversight of SBE. For example, GAO found that CMS had not defined “what follow-up corrective actions should be performed if deficiencies are identified.”¹⁹⁶ The GAO also found that three SBEs had “significant” security weaknesses, and noted its concern that CMS only required security testing for the SBEs to take place once every three years.¹⁹⁷

Again, GAO provided three recommendations for concrete actions CMS could take to improve its oversight of the state exchanges, specifically regarding the SBE’s privacy and security controls. As of August 2016, all three of GAO’s recommendations remain “open,” indicating that CMS has not implemented the recommendations and has not taken the necessary actions to respond to the negative findings in the report.

¹⁹⁵ *Id.* at Highlights.

¹⁹⁶ U.S. GOV’T ACCOUNTABILITY OFFICE, GAO-16-265, HEALTHCARE.GOV: ACTIONS NEEDED TO ENHANCE INFORMATION SECURITY AND PRIVACY CONTROLS at 28 (2016).

¹⁹⁷ *Id.* at 27.

VIII. CMS Appears to Encourage SBEs to Close and Join the Federal Exchange

The PPACA clearly states that HHS cannot provide establishment grants under section 1311 to the states after January 1, 2015.¹⁹⁸ Through No-Cost Extensions, CMS has extended the life of the federal funds awarded to the SBEs and allowed SBEs to use federal grants for establishment expenses through 2016. When federal funds eventually run out, states will feel urgent financial pressure to support the full cost of the SBEs, and it is likely that more states will abandon their SBEs and transition to healthcare.gov. To date, CMS has not imposed any negative consequences on a state for abandoning its SBE and transitioning to healthcare.gov, and has given no indication that it plans to impose any consequences in the future. In fact, CMS has eased the transition for failed SBEs.

A. CMS Offers Failed State Exchanges Free Use of Healthcare.gov

The FFE and most SBEs collect “user fees” from Qualified Health Plans (QHPs) that sell plans on an exchange. For individual who signs up for a health care insurance plan through the exchange, the insurance carrier will pay a percentage of that individual’s premium to the exchange. These user fees—set at 3.5 percent for the FFE—pay for the administrative costs of operating the exchange.

FINDING: CMS eased the transition for failed SBEs to join healthcare.gov by allowing them to keep user fees collected by insurance carriers intended to pay for the use of healthcare.gov.

When each of the four SBEs failed and joined healthcare.gov, CMS allowed these failed SBEs to set and collect user fees, even though the plans were sold through healthcare.gov and not the SBE’s website. This policy allows these states use healthcare.gov for free, and keep the user fees charged to QHPs in their state for the state’s own use. According to a CMS chart produced to the Committee, the user fees collected by failed SBEs are not insignificant.¹⁹⁹ For example, the chart below shows that the state of Oregon reported collected \$10.5 million in user fees alone in 2015:

¹⁹⁸ U.S. Dep’t of Health & Human Serv., Centers for Medicare & Medicaid Serv., *FAQs on the Use of 1311 Funds and No Cost Extensions*, available at <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/no-cost-extension-faqs-3-14-14.pdf> (last visited Aug. 8, 2016).

¹⁹⁹ *Marketplace Issuer Assessment and Fee Revenue* (Mar. 15, 2016) (document produced to the Committee by CMS in March 2016).

Marketplace Issuer Assessment and Fee Revenue

As of 3/15/16

State	2014	2015	2016	2017**	Data Source
Hawaii (Fiscal Year (FY) basis)	\$120,836*	\$145,011*	\$1,250,000 (plan/calendar year)***	\$1,250,000 (plan/calendar year)***	Hawaii Health Connector 2014 Annual Report; Combined Operating and Transition Budget FY 2015, reported 11/6/15; Budget submitted to CMS on 3/4/2016.
Nevada (FY basis)	\$660,581*	\$5,162,970*	\$6,841,447	\$8,178,391	Budget submitted to CMS on 2/3/2016.
New Mexico (Calendar Year (CY) basis)	Fee collection did not start until 2015	\$5,727,689*	\$16,703,355	\$12,159,924	Budget submitted to CMS on 2/12/2016.
Oregon (CY basis)	\$6,567,283*	\$10,543,917*	\$13,531,147	\$8,816,450	Budget submitted to CMS on 2/12/2016.

* The state reported the revenue amount as actual.

** ** FY 2017 amounts were provided prior to finalization of the 2017 Notice of Benefit and Payment Parameters, which finalized the user fee that CMS will charge to SBM-FP issuers.

*** Obtained from budget submitted to CMS on 3/4/2016 (which was based on state budget projection).

CMS' policy to allow failed SBEs to use healthcare.gov for free is particularly troubling because the 3.5 percent user fee charged to QHPs on the FFE has not been sufficient to cover healthcare.gov's administrative expenses. For example, in its fiscal year 2016 budget, HHS requested \$629 million in appropriated funds to cover the user fee shortfall.²⁰⁰

FINDING: Starting in 2017, CMS will offer failed SBEs a "reduced" rate of 1.5 percent to use healthcare.gov, at the expense of federal taxpayers.

In February 2016, CMS issued a rule imposing only a 1.5 percent user fee on SBEs that closed and joined healthcare.gov.²⁰¹ While this does require failed SBEs to pay for their use of healthcare.gov starting in 2017, this rate is 2 percentage points lower than the 3.5 percent fee the other 34 states using healthcare.gov must pay. CMS explained the reasons behind the discounted rate: "We will charge issuers operating in a State-based Marketplace on the Federal platform

²⁰⁰ U.S. Dep't of Health and Human Serv., Centers for Medicare & Medicaid Serv., *Justification of Estimates for Appropriations Committees, Fiscal Year 2016* at 3 (2016).

²⁰¹ U.S. Dep't of Health & Human Serv., Centers for Medicare & Medicaid Serv., *Press Release: Final HHS Notice of Benefit and Payment Parameters for 2017* (Feb. 29, 2016), available at <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-fact-Sheets-items/2016-02-29.html>.

(SBM-FP) a reduced user fee rate of 1.5% of premium for the 2017 benefit year, to ease the transition for SBM-FP States, and will allow additional flexibility in the assessment of these charges for those States.”²⁰² After years of permitting failed SBEs to use healthcare.gov for free, it is unnecessary to provide additional flexibility and transition time to these SBEs. CMS also decided to leave the FFE user fee rate at 3.5 percent, despite its shortfall in past years.²⁰³ This leaves the federal taxpayer responsible for more costs related to upkeep of healthcare.gov, four years into its operation.

CMS’ decision to allow failed SBEs to pocket user fees instead of paying for the use of healthcare.gov is troubling. There also do not appear to be any rule or regulations governing how the states’ may use the user fees they collect from QHPs. The lack of consequence for abandoning federally funded state exchanges may incentivize other state exchanges to follow suit—a disturbing and fiscally irresponsible trend. It is unacceptable that the federal taxpayer must continue to pick up the tab for these SBEs’ failures.

B. CMS Welcomes SBEs That Wish to Transition to Healthcare.gov

FINDING: According to CMS, SBEs have “a right to change their mind” if a state decides it no longer wants to operate an exchange.

At a December 8, 2015 hearing before the Oversight and Investigations Subcommittee, Chairman Tim Murphy asked if it was appropriate for state exchanges to transition to healthcare.gov and whether there should be consequences for essentially wasting hundreds of millions of taxpayer dollars. Acting Administrator Slavitt testified:

Mr. Murphy. Is it appropriate for State exchanges to transition Healthcare.gov after spending hundreds of millions of taxpayers’ dollars on their own sites? And shouldn’t there be other consequences for that? I mean they have failed but they spent all this money and then later said, gee, sorry it didn’t work out. Does that seem appropriate?

Mr. Slavitt. Well, I think it is important for us to recognize **States have the right under the law to decide whether they want to be a State-based exchange, a Federal exchange, or to be a State-based exchange and use our platform. They have a right to change their mind for a variety of reasons, including technical or otherwise. So we think that’s important.**²⁰⁴

²⁰² Final HHS Notice of Benefit and Payment Parameters for 2017, 81 Fed. Reg. 12203 (Mar. 8, 2016) (final rule).

²⁰³ *Id.*

²⁰⁴ *An Overdue Checkup Part II: Examining the ACA’s State Insurance Marketplaces: Hearing before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations*, 114th Cong. 29 (Dec. 8, 2015).

Chairman Murphy continued to press Acting Administrator Slavitt as to why there are no real consequences for making the decision to transition to the federal exchange, regardless of the reason:

Mr. Murphy. But my concern is with regard to the States trying to get into the insurance business and it didn't work out for many States, but there is no real consequence if they were able to take the money, say, toss their hands up and say, well, it turns out it didn't work out. We will just go to the Federal exchange. And this is where my concern is, and many of us have a concern that under those circumstances, if there were no consequences, then that is hardly a lesson.

So this is where I want to know, do you have any plan or intention to gather back, to recoup the Federal funds that have been provided to States to set up their exchanges only to then shift into Healthcare.gov?

Mr. Slavitt. So there's the five states that I think have had most significant IT challenges. Two of them maintained their role as State exchanges. Three of them are now using the Federal exchange platform but are still State-based exchanges. And each of those cases is slightly different. In one of those cases we have recovered money. In another case, the State is – two of the other cases, I should say, the State is in the process of trying to recover money, of which we will [sic] go after our Federal share. And in one of the other States we are in the process of also closing down and collecting some money.

So it really varies by State, but I would think it's important to point out that even though States that had challenges, they were by every measure able to enroll people, they had contingency plans, and [were] eventually able to set up a system that worked, which extends, as I said earlier, beyond technology –

Mr. Murphy. I understand that, but it was after a lot of failure and a lot of wasted money[.]²⁰⁵

Despite Chairman Murphy's continued questioning, Acting Administrator Slavitt could not provide a firm answer explaining why CMS has not imposed any negative consequences on failed SBEs.

²⁰⁵ *Id.* at 30-31.

While Acting Administrator Slavitt is correct that states have the right to decide whether to establish a SBE, the law does not require that CMS award 1311 establishment grants with no strings attached. In fact, other grants awarded by CMS require the grantee to adhere to a number of requirements. To date, CMS has failed to take any enforcement action against the SBEs for failing to comply with the terms and conditions of the various grants. Federal regulations permit HHS to impose additional conditions prior to, or at any time of the award, for the purposes of proactively protecting grant funds.²⁰⁶ These matters include suspending grant funding until corrective actions have occurred. The committee is not aware of any instances where CMS has imposed such additional conditions or penalties.

Despite Acting Administrator Slavitt's commitment at the December 8, 2015, hearing to recover misspent dollars, CMS has recovered just a sliver of the billions of dollars awarded to states. To date, CMS has only recovered approximately \$1.6 million in misspent dollars from three states – Arkansas, Minnesota, and Oregon.²⁰⁷ Given the mismanagement evident within some of these exchanges, and the sizeable dollar amount of these grant awards, this is surprising.

CMS's failure to impose conditions on the grants awarded to SBEs, and the very small amount of funds recouped by CMS overall, demonstrate that CMS shirked its duty to hold the failed SBEs accountable for wasting taxpayer dollars. Further, CMS has imposed no real consequences when SBEs shut down, thereby encouraging other SBEs to join the federal exchange IT platform if and when operational costs become too burdensome for the state. States have and will continue to weigh their options, including shutting down their exchanges and migrating to the federal system. Since the remaining SBEs are still struggling to become fully operational and financially sustainable, it is not too late for CMS to start conducting rigorous oversight.

²⁰⁶ See 42 CFR 52.9 (“The Secretary may with respect to any grant award or class of awards impose additional conditions prior to or at the time of any award when in the Secretary’s judgment such conditions are necessary to assure or protect advancement of the approved project the interests of the public health, or the conservation of grant funds.”).

²⁰⁷ Letter from Andrew Slavitt, Acting Administrator, Centers for Medicare & Medicaid Serv., to Hon. Fred Upton, Chairman, H. Comm. on Energy & Commerce (May 27, 2016).

IX. Conclusion

Over the past six years, CMS has awarded nearly \$5 billion to set up SBEs under the PPACA. But this experiment failed. At least five of the original SBEs will have closed by 2017, leaving only twelve remaining. The administration and state governments have been found blameless for poorly managed SBEs and the waste of hard-earned federal taxpayer dollars. This failed experiment illustrates that big government, with unlimited budgets and no accountability, does not serve the American people's interests or wallets. After six long years, the federal taxpayer should no longer be on the hook.

No SBE is currently financially self-sustaining, despite the requirement that each one should have been by January 1, 2015. Rather than protect the federal investment by utilizing their oversight authorities and ensuring that the states become self-sustaining through lawful means, CMS has instead found ways to continue funneling federal dollars to the states through permissive grant policies and No Cost Extensions. Further, when CMS has learned of wasteful and inappropriate SBE spending, instead of immediately recouping the entirety of those costs, CMS has looked the other way. When CMS should be holding SBEs accountable for their failures, instead CMS has encouraged SBEs to join the FFE when federal funds run out, smoothing the transition with free use of healthcare.gov until 2017, when they will be offered a discounted rate.

In addition to the findings of this investigation, HHS OIG and the GAO have released scathing reports about high-level mismanagement of the SBEs. Since the implementation of the PPACA, HHS OIG alone has released at least seventeen reports related to the mismanagement and poor implementation of the law, further exacerbated by poor CMS oversight. Whether inadequate IT testing, a lack of singular leadership, poor management, misallocating funds, or waste, fraud, and abuse of the federal dollars, CMS' implementation of SBEs has been a costly mess.

The blatant lack of oversight and accountability of the state exchanges is unacceptable. In its oversight of the SBEs, CMS has failed to prioritize taxpayer interests and safeguard federal taxpayer dollars. It is time to hold federal and state officials accountable for the SBE mismanagement and poor planning, and it is time for the federal government to impose some consequences for flagrant spending. It is time for states that elected to establish SBEs to be accountable and pay for them.

X. Recommendations

1. **Require SBEs to pay the same user fee as other states.** States that took tens of millions – in some cases, hundreds of millions – of federal taxpayer funds to establish state-based exchanges should not receive a discounted user fee for the use of healthcare.gov if the state-based exchange fails.
2. **Recoup establishment grant funds from SBEs that shut down.** SBEs that ultimately failed to continue operations must return funds to the U.S. Treasury as a means to recoup a portion of its investment. Per 42 CFR 52.9, HHS has the authority, to impose additional conditions prior to, or at the any time of the award, for proactively protecting grant funds. Moreover, the Federal Claims Collection Act²⁰⁸, and, the Federal Claims Collection Standards²⁰⁹ requires an agency to collect debts, and to charge interest on all delinquent debts owed to CMS by recipients. CMS should liquidate remaining assets from failed SBEs as a means to recoup federal funds.
3. **Enforce the requirement that all SBEs publish the costs of the exchange publicly on the Internet.** Citizens of each state should be informed about how much money has been spent by each state-based exchange. Enforce this for all 17 SBEs and 7 state partnership exchanges. Require that information be updated every month.
4. **Require that SBEs publish and cite the source of the number of monies lost to waste, fraud, and abuse.** Enforce this for all 17 SBEs and 7 state partnership exchanges. Require that information be updated every year.
5. **Increase oversight of the current and past expenditure of federal grants for SBEs.** Request that the Department of Health and Human Services Office of the Inspector General conduct annual audits of those SBEs using federal funds, and retrospective audits for past years.

²⁰⁸ Federal Claims Collection Act, P.L. 89-508, 80 Stat. 308 (July 19, 1966); Federal Debt Collection Act of 1982, P.L. 97-365, 96 Stat. 1749 (Oct. 25, 1982); and Debt Collection Improvement Act, P. L.104-134, 110 Stat. 1321 (Apr. 26, 1996).

²⁰⁹ 31 C.F.R. Parts 900-904.

XI. Appendix

The following pages in the Appendix are copies of documents produced by CMS to the Committee on Energy and Commerce on March 18, 2016.

CMS staff created the chart. CMS did not provide any primary source documents or other materials supporting the figures in the chart.