

Affordable Care Act Markets Will Remain Viable After a One-Time Correction in 2017

Policy improvements can accelerate the transition to equilibrium

Testimony of Topher Spiro
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U.S. House of Representatives Committee on Oversight & Government Reform
September 14, 2016

Thank you for the opportunity to testify today about the status of Affordable Care Act (ACA) markets. Contrary to hyperbolic media coverage, the Affordable Care Act is not in crisis. As a result of underpricing by insurers in early years, and the phase-out of mechanisms to stabilize risk, the markets are undergoing a one-time correction in 2017. Even so, additional policy measures would be prudent to accelerate the transition to equilibrium.

Comparison with pre-ACA markets

When evaluating the status of ACA markets, context is important. Before the ACA, the individual market was volatile and people in rural areas did not have much choice.

The difference is that this market did not work at all for those who needed it. Insurers charged women, older people, and sick people much higher premiums; they restricted or denied coverage entirely for people with pre-existing conditions; they charged consumers much more in deductibles and other out-of-pocket costs; and they did not cover essential benefits such as prescription drugs, mental health care, and maternity care. People with pre-existing conditions were quarantined into severely underfunded high-risk pools.

Even as the ACA put in place consumer protections to address these issues, and enhanced the value of coverage, the average benchmark premium in 2014 was 10 percent *lower* than the average individual market premium in 2013.¹ In other words, people are getting more coverage for less money.

Millions more people have better financial protection. Although more work needs to be done to increase enrollment, more than 18 million people are enrolled in ACA markets as of March 2016.² This estimate is comprised of 11.1 million enrolled in ACA-compliant plans through exchanges and about 7 million people enrolled directly in ACA-compliant plans.³ Along with the ACA's expansion of Medicaid coverage, this enrollment has driven the rate of the uninsured to a historic low – giving peace of mind to an additional 21.3 million Americans.⁴

One-time correction in 2017

Contrary to popular perception, the ACA “risk pool” – the balance of healthy and sick enrollees – is stable and improving. From 2014 to 2015, the cost per enrollee in exchanges actually fell by 0.1 percent.⁵ The reason is that total enrollment increased by 66 percent in 2015, resulting in a broader risk pool. Although data is not yet available for 2016 and results vary by state, this data is a good sign.

This begs the question: why are insurers increasing premiums substantially or withdrawing from markets?

When the new markets launched in 2014, there were new insurers, new market rules, and a new consumer population. Insurers did not have experience or claims data to accurately price their products. In addition, the markets were hyper-competitive as insurers jockeyed to establish a foothold.

As a result of these factors, insurers significantly underpriced premiums in 2014. The average benchmark premium came in 15 percent lower than the Congressional Budget Office (CBO) had projected.⁶ According to a study by the Commonwealth Fund, insurers' actual costs turned out to be 6 percent higher than they had projected.⁷ The reinsurance program, which reimburses insurers for the costs of high-cost enrollees, helped to cushion this shortfall.⁸

However, the risk corridor program – which was designed specifically to address pricing uncertainty in a new market – did not.⁹ This is because Congress constrained the program and prevented it from operating as intended. Moreover, Congress did so *after* insurers had already priced their products (for both 2015 and 2016) under the assumption that they did not need to be overly conservative.¹⁰ The resulting risk corridor shortfall is responsible for about two-thirds of the financial losses incurred by insurers in 2014.¹¹

The average benchmark premium increased by only 2 percent in 2015 and 7.2 percent in 2016.¹² These increases were not sufficient to close the gap from 2014. Compounding the problem, the reinsurance program began to phase out in 2015 and 2016. As a result of these factors, the gap between actual premiums and expected premiums widened to 20 percent.¹³

Nonetheless, there are signs that insurer financial performance is improving. Whereas not-for-profit Blue Cross plans had an operating loss of 1.1 percent in 2015, they now have an operating profit of 1.5 percent as of the second quarter of 2016 – driven by improvement in their ACA exchange business.¹⁴

Which brings us to 2017. It is not surprising, given the context discussed above, that the markets are due for a correction.¹⁵ For 2017, the average benchmark premium is expected to increase by about 10 percent.¹⁶ Although this correction is significant, the ACA's subsidy structure will hold harmless many consumers and act as a stabilizing force.¹⁷ Even after the correction, premiums will be still be much lower than the CBO had projected and 11 percent lower than average individual market premiums would have been in the absence of the Affordable Care Act.¹⁸

The financial losses of insurers must also be viewed in context. Losses are normal and to be expected whenever a business enters a new market. As Aetna CEO Mark Bertolini explained recently, Aetna's losses are well below what it would have normally cost the company to expand its business.¹⁹ (In Pennsylvania, where Aetna is withdrawing, it is even profiting.²⁰)

Policy options to accelerate equilibrium

Even though ACA markets are not in crisis, with no risk of a death spiral, policymakers should take additional actions to accelerate the transition to equilibrium.

When evaluating policies to further stabilize the risk pool, the administration should err on the side of caution in the short term – acting as urgently and proactively as possible. For their part, to build trust and provide focus, insurers should refrain from opportunistically seeking policy changes that are not absolutely necessary. With this preface, the following menu of policy options should be considered:

The administration should verify eligibility for Special Enrollment Periods (SEPs).

There is some evidence that some individuals are enrolling in exchange plans through SEPs when they are not eligible. For instance, some individuals who applied through SEPs outside of the exchange, but who did not submit any proof of eligibility, subsequently enrolled through the exchange.²¹ Although there is no evidence yet that this sort of gaming is widespread, even a small number of high-cost individuals can affect the risk pool. Actuaries believe that verification of SEP eligibility could lower premiums by 2-5 percent.²²

In designing and implementing a verification process for SEP eligibility, the administration should adopt the following guidelines:²³

- Verification should only be required when the necessary documentation is easy to provide, such as a utility bill. In the case of the SEP for loss of prior coverage, when individuals leave a plan, insurers should be required to provide a notice that documents the loss of coverage and advertises the opportunity to enroll in exchange coverage through an SEP. If insurers are unwilling to provide this notice, verification for this SEP should not be required.
- Ultimately, verification should only be required when it can be carried out electronically (including through “real time” data checks where possible). Until this system is ready, insurers could be allowed to verify documents and submit a recommendation on eligibility to the exchange, which would retain responsibility for the eligibility determination and appeals.
- If insurers do not make a recommendation to the exchange within 15 days, the applicant is enrolled in coverage.
- Once an applicant’s eligibility is verified, coverage is effective when it otherwise would have been – retroactively if necessary.

With verification, insurers should have confidence that any gaming has been eliminated. For their part, they should then re-instate broker fees for enrollment through SEPs. The administration should enforce parity between broker fees paid for open enrollment and broker fees paid for special enrollment.

The administration should quickly enforce a prohibition against third-party payments from financially interested providers who are steering high-cost patients from Medicare and Medicaid to the exchanges.

For instance, dialysis providers are paying for their patients to receive coverage through exchange plans instead of Medicare. This is significant because dialysis can cost commercial insurance hundreds of thousands of dollars per patient per year.

The administration should continue to refine risk adjustment so that transfers accurately reflect actual costs.

Although costs per enrollee may be stable market-wide, insurers that suffered large financial losses may have attracted a greater share of sick enrollees. The administration has proposed several improvements to the risk adjustment methodology, such as including the cost of prescription drugs.²⁴

In 2014, CMS reported that its risk score model under-predicts actual costs for adults with the lowest costs (by 17 percent for silver plans and by 29 percent for bronze plans) and over-predicts actual costs for adults with the highest costs.²⁵ CMS should adjust its risk score model accordingly to remove this bias or explore retrospective reconciliation using actual claims data.

Because risk adjustment payments are based on the average premium, which includes administrative costs, the formula inflates the amount of transfers, penalizing more efficient plans with lower-than-average administrative costs. CMS should remove administrative costs from the formula.

Finally, CMS must speed up the timing of the process to release more information before insurers price their plans for the following year.

States should establish their own reinsurance programs, with help from federal savings.

In June, Alaska passed legislation establishing a new reinsurance fund.²⁶ This was necessary because Premera, the only insurer remaining in the state, paid out 24 percent of its claims for just 37 high-cost enrollees.²⁷ After enactment of the reinsurance fund, Premera lowered its proposed premium increase for 2017 from 40 percent to 9.8 percent.²⁸

Under Section 1332 Innovation Waivers, the administration should offer states the federal savings that would result from lower premium tax credits to help pay for reinsurance. The administration should quickly issue a template or guidelines to advertise this opportunity and assist states in carrying it out.

The administration and states should expand rating areas to cover larger geographical areas.

The decline in insurer participation and consumer choice is concentrated in rural areas.²⁹ In states that have a mixture of urban and rural areas, this policy option would provide greater choice in rural areas. Eleven states and the District of Columbia already either have a single rating area or limit variation in premium rates across areas.³⁰ The administration should set a minimum size of rating areas based on population.

States should prohibit insurers from selling plans exclusively outside of the exchange – or go further and require all plans to be sold through the exchange.³¹

Off-exchange plans have higher administrative costs than on-exchange plans.³² Although there is a single risk pool for each insurer, insurers that sell plans only outside of the exchange in effect steal enrollees who might help broaden and balance the risk pools of other insurers.

States that have not done so should expand their Medicaid programs.

In states that expanded Medicaid, ACA market premiums are about 7 percent lower than in states that did not.³³ This is because in states that did not expand Medicaid, people with income between 100-138 percent of poverty (a population with poorer health) are included in the exchange risk pool. It is no coincidence that the “states left with the most limited exchange participation as a result of 2017 market exits are likely to be in the south.”³⁴

The government should treat federal health care programs holistically and use active purchasing to get the best deal from insurers for all consumers in all programs.

ACA marketplaces are one small part of the nation’s health insurance system. In a true partnership between the government and insurers, insurers would benefit financially across programs *and* the public’s interest would be served across programs. Insurers that profit from participation in Medicaid and Medicare Advantage (which were not always profitable) should be willing to participate in the exchanges.³⁵

For instance, Nevada requires Medicaid managed care plans to offer at least one silver and gold plan in the exchange – perhaps why UnitedHealthcare is participating in Nevada’s exchange while exiting nearly every other state.³⁶

Medicaid managed care plans are the most successful exchange plans and also ensure continuous coverage when enrollees switch eligibility.

Congress should create a “Guaranteed Choice Plan.”

In perhaps less partisan times, Congress created a “fallback option” in the Medicare Part D prescription drug program.³⁷ In ACA markets, consumers should never be subject to the whims of insurer withdrawals or threats of withdrawals.

The lack of plan choices in rural areas is a problem that long pre-dated the ACA. The reason is that insurers’ fixed costs must be spread over a small potential market population. Recognizing this reality means that private insurers, unless they are heavily subsidized, cannot be relied upon to increase plan choice in rural areas.

Congress should tackle the high cost of specialty drugs.

This is one of the biggest factors cited by large insurers for leaving ACA markets.³⁸ Yet to date the insurance industry has done little to push for meaningful reforms. The Center for American Progress is working with insurers and drug manufacturers in an effort to find common ground.

Congress should increase cost-sharing subsidies to lower deductibles and increase premium tax credits for young and middle-income people.

For instance, student loan payments should be deducted from income for purposes of determining tax credits and the cliff at the 400 percent eligibility threshold should be smoothed.

Insurers, too, can take actions to improve the markets.³⁹

For instance, insurers that are succeeding are very effective at controlling nonmedical administrative costs.⁴⁰

Conclusion

Most of all, the administration, Congress, states, insurers, and other stakeholders should act in a constructive spirit to make the law work and fix any problems that arise – rather than root for its failure or cut and run. As Bernard Tyson, CEO of Kaiser Permanente, said: “I view it through the lens of my mission. It obligates to us to figure it out, not to get out.”⁴¹

Endnotes

¹ Loren Adler and Paul B. Ginsburg, *Obamacare Premiums are Lower Than You Think*, Health Affairs, July 21, 2016, available at:

<http://healthaffairs.org/blog/2016/07/21/obamacare-premiums-are-lower-than-you-think/>.

² ACASignups.net, September 6, 2016, available at:

<http://acasignups.net/16/09/08/steve-davis-robert-laszewski-confirm-what-ive-been-saying-all-along-appx-40-aca-indy-market>.

³ Because there is a single risk pool, and off-exchange plans must follow the same ACA rules as on-exchange plans, there is no reason to exclude enrollment in off-exchange plans from estimates of enrollment in ACA coverage.

⁴ Robin A. Cohen et al., *Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, January-March 2016*, National Center for Health Statistics, September 2016, available at:

<http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201609.pdf>.

⁵ U.S. Department of Health and Human Services, *Changes in ACA Individual Market Costs from 2014-2015: Near-Zero Growth Suggests an Improving Risk Pool*, August 11, 2016, available at: https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-resources/Downloads/Final-Risk-Pool-Analysis-8_11_16.pdf.

⁶ Adler and Ginsburg, fn1.

⁷ Mark Hall and Michael J. McCue, *How Has the Affordable Care Act Affected Health Insurers' Financial Performance?* The Commonwealth Fund, July 20, 2016, available at: <http://www.commonwealthfund.org/publications/issue-briefs/2016/jul/the-affordable-care-act-and-health-insurers-financial-performance>.

⁸ In 2014, insurers' actual costs were only 2 percent higher than projected costs after factoring in reinsurance payments. Hall and McCue, fn6.

⁹ For the same reason, Congress created a permanent risk corridor program for the Medicare Part D prescription drug program. Yet Congress has not exhibited the same concern with respect to that program.

¹⁰ "Because the risk corridor program offered insurers financial protection against underpricing their marketplace products, the program may have resulted in insurers pricing their individual market products less conservatively than they otherwise would have in light of the substantial amount of uncertainty when setting rates." Milliman, *2014 commercial health insurance: Overview of financial results*, March 2016, available at: <http://us.milliman.com/uploadedFiles/insight/2016/2014-commercial-health-insurance.pdf>.

¹¹ "The risk corridor shortfall resulted in individual market composite underwriting results decreasing from negative 2.1% to negative 6.1%." Milliman, fn10.

¹² Adler and Ginsburg, fn1.

¹³ Adler and Ginsburg, fn1.

¹⁴ Goldman Sachs, *Blue Cross show further improvement in 2Q*, September 1, 2016, available at:

<https://360.gs.com/research/portal/?st=1&action=action.binary&d=22341892&fn=/document.pdf&a=ae79c897e77147d290a10bf98d1351b2>.

¹⁵ Adler and Ginsburg, fn1: "...it is likely that premiums through 2016 have been *too low* to be sustainable in many cases given the financial difficulties many insurers are having, whether the result of underestimating the cost of serving new populations, loss leader strategies to build a customer base, or other reasons." Hall and McCue, fn7: "...improved financial performance will require increased premiums, especially as the ACA's reinsurance component phases out, starting in 2017. This reinsurance has played a crucial role in helping insurers transition."

¹⁶ Cynthia Cox et al., *Analysis of 2017 Premium Changes and Insurer Participation in the Affordable Care Act's Health Insurance Marketplaces*, July 2016, available at: <http://files.kff.org/attachment/Issue-Brief-Analysis-of-2017-Premium-Changes-and-Insurer-Participation-in-the-ACA-Marketplaces>; Avalere, *Early Analysis Finds 2017 Proposed Exchange Premiums for Low Cost Silver Plans Increasing 8 Percent on Average*, July 13, 2016, available at: <http://avalere.com/expertise/life-sciences/insights/update-early-analysis-finds-2017-proposed-exchange-premiums-for-low-cost-si>.

¹⁷ McKinsey therefore concludes that “there is little risk of a market-wide ‘death spiral’ given stabilizing subsidies.” McKinsey Center for U.S. Health System Reform, *Exchanges three years in: Market variations and factors affecting performance*, May 13, 2016, available at: http://healthcare.mckinsey.com/sites/default/files/Intel%20Brief%20-%20Individual%20Market%20Performance%20and%20Outlook%20%28public%29_vF.pdf.

¹⁸ Adler and Ginsburg, fn1.

¹⁹ *Aetna (AET) Mark T. Bertolini on Q1 2016 Results – Earnings Call Transcript*, April 29, 2016: “If we were to go out and buy those members, it would cost us somewhere around \$1.2 billion to acquire them. If we were to build out 15 markets, it would cost us somewhere between \$600 million to \$750 million to enter those markets and build out the capabilities necessary to grow that membership. So in the broad scheme of things, we are well, well below any of those numbers from the standpoint of losses we’ve incurred in the first two-and-a-half years of this program.”

²⁰ Richard Mayhew, *Balloon Juice*, August 17, 2016, available at: <https://www.balloon-juice.com/2016/08/17/aetna-cynicism-and-pennsylvania/>.

²¹ Blue Shield of California, *Emerging CoHC Deep Dive*; John Bertko, *Emerging Potential Trends for Covered California Special Enrollment Period Enrollees*, Covered California Board Meeting, February 18, 2016, available at: <http://board.coveredca.com/meetings/2016/2-18/PPT-Covered%20California%20SEP%20Policy.pdf>.

²² Bertko, fn21.

²³ Washington State, Idaho, and Minnesota have implemented a pre-verification process similar in concept to these guidelines.

²⁴ U.S. Department of Health and Human Services, *HHS Notice of Benefit and Payment Parameters for 2018*, available at: <https://www.gpo.gov/fdsys/pkg/FR-2016-09-06/pdf/2016-20896.pdf>.

²⁵ John Kautter et al., *The HHS-HCC Risk Adjustment Model for Individual and Small Group Markets under the Affordable Care Act*, Medicare & Medicaid Research Review, Exhibit 7, available at: https://www.cms.gov/mmrr/Downloads/MMRR2014_004_03_a03.pdf.

²⁶ Alaska State Legislature, House Bill No. 374, available at: <http://www.akleg.gov/basis/Bill/Text/29?Hsid=HB0374D>.

²⁷ Timothy Jost, *Alaska Reinsurance Plan Could Be Model For ACA Reform, Plus Other ACA Developments*, *Health Affairs*, June 16, 2016, available at: <http://healthaffairs.org/blog/2016/06/16/alaska-reinsurance-plan-could-be-model-for-aca-reform-plus-other-aca-developments/>.

²⁸ Kevin Counihan, *Building on Premium Stabilization for the Future*, *The CMS Blog*, August 11, 2016, available at: <https://blog.cms.gov/2016/08/11/building-on-premium-stabilization-for-the-future/>.

²⁹ Cynthia Cox, *Preliminary Data on Insurer Exits and Entrants in 2017 Affordable Care Act Marketplaces*, Henry J. Kaiser Family Foundation, August 28, 2016, available at:

<http://kff.org/health-reform/issue-brief/preliminary-data-on-insurer-exits-and-entrants-in-2017-affordable-care-act-marketplaces/>.

³⁰ Justin Giovannelli et al., *Implementing the Affordable Care Act: State Approaches to Premium Rate Reforms in the Individual Health Insurance Market*, December 2014, available at: http://www.commonwealthfund.org/~media/files/publications/issue-brief/2014/dec/1795_giovannelli_implementing_aca_state_premium_rate_reforms_rb_v2.pdf.

³¹ To date, only Vermont and the District of Columbia have adopted this policy. Henry J. Aaron, *How to rescue Obamacare as insurers drop out*, Washington Post, August 19, 2016, available at: https://www.washingtonpost.com/opinions/how-to-rescue-obamacare-as-insurers-drop-out/2016/08/19/edb038b2-6641-11e6-be4e-23fc4d4d12b4_story.html?utm_term=.3004fe5795a0.

³² Michael J. McCue and Mark A. Hall, *Comparing Individual Health Coverage On and Off the Affordable Care Act's Insurance Exchanges*, Commonwealth Fund, August 2015, available at: <http://www.commonwealthfund.org/publications/issue-briefs/2015/aug/comparing-coverage-on-off-aca-exchanges>.

³³ Aditi P. Sen and Thomas DeLeire, *The Effect of Medicaid Expansion on Marketplace Premiums*, Office of the Assistant Secretary for Planning and Evaluation, August 25, 2016, available at: <https://aspe.hhs.gov/pdf-report/effect-medicaid-expansion-marketplace-premiums>.

³⁴ Cynthia Cox, fn29.

³⁵ With regard to Medicare Advantage contracts with insurers, Section 1857(e) of the Social Security Act provides that: "The contract shall contain such other terms and conditions not inconsistent with this part...as the Secretary may find necessary and appropriate."

³⁶ Louise Norris, Nevada health insurance exchange/marketplace: All current carriers remaining in Nevada exchange in 2017, healthinsurance.org, August 20, 2016, available at: <https://www.healthinsurance.org/nevada-state-health-insurance-exchange/>.

³⁷ Social Security Act Section 1860D-11(g), available at: https://www.ssa.gov/OP_Home/ssact/title18/1860D-11.htm#act-1860d.11-g.

³⁸ Tim Mullaney, *How Gilead "Broke" Obamacare*, Marketwatch, August 21, 2016, available at: <http://www.marketwatch.com/story/how-gilead-broke-obamacare-2016-08-31>.

³⁹ McKinsey, fn17: "There are also specific actions carriers can take to improve near-term performance on the public exchanges and position their businesses for longer-term sustainability."

⁴⁰ Tim Mullaney, *Insurers Can Make Obamacare Work, But They Need Help From Congress*, FiveThirtyEight, August 31, 2016, available at: <http://fivethirtyeight.com/features/insurers-can-make-obamacare-work-but-they-need-help-from-congress/>.

⁴¹ The Dallas Morning News, Let's root for those trying to make Obamacare work, August 22, 2016, available at: <http://www.dallasnews.com/opinion/editorials/20160822-lets-root-for-those-trying-to-make-obamacare-work.ece>.

Congress of the United States
House of Representatives

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

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September 1, 2016

Topher Spiro
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1333 H Street, NW, 10th Floor
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Dear Mr. Spiro:

The Committee on Oversight and Government Reform hereby requests your testimony at a hearing on Wednesday, September 14, 2016, at 9:00 a.m. in room 2154 of the Rayburn House Office Building.

The hearing is examining the rising health insurance premiums under the Patient Protection and Affordable Care Act (PPACA). You should be prepared to provide a five-minute opening statement and answer questions posed by Members.

Instructions for witnesses appearing before the Committee are contained in the enclosed Witness Instruction Sheet. In particular, please note the procedures for submitting written testimony at least two business days prior to the hearing. Please contact the Committee by **September 8, 2016**, to confirm your attendance. If you have any questions, please contact Natalie Turner or Sarah Vance of the Committee staff at (202) 225-5074.

Sincerely,



Jason Chaffetz
Chairman



Elijah E. Cummings
Ranking Member

Enclosure

Committee on Oversight and Government Reform
Witness Disclosure Requirement – "Truth in Testimony"
Required by House Rule XI, Clause 2(g)(5)

Name:

1. Please list any federal grants or contracts (including subgrants or subcontracts) you have received since October 1, 2012. Include the source and amount of each grant or contract.

None

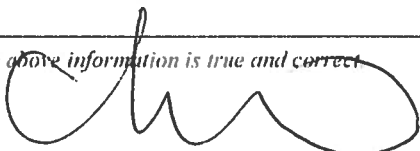
2. Please list any entity you are testifying on behalf of and briefly describe your relationship with these entities.

Center for American Progress
Vice President for Health Policy

3. Please list any federal grants or contracts (including subgrants or subcontracts) received since October 1, 2012, by the entity(ies) you listed above. Include the source and amount of each grant or contract.

None

I certify that the above information is true and correct.
Signature:



Date:

9/2/16

Witness Instruction Sheet
Non-governmental Witness
Full Committee Hearing

The following are pertinent rules and procedures applicable to a witness testifying before the Committee on Oversight and Government Reform.

1. The witness should prepare written testimony, provide a short biographical summary, and complete the "Truth in Testimony" disclosure form. **These three documents need to be provided to the Committee no later than 10:00 a.m. two business days prior to the hearing.**
 - a. **Electronic submission:** The witness should submit an electronic version of the written testimony, biographical information, and completed disclosure form to Willie Marx at William.Marx@mail.house.gov
 - i. The Committee prints the final record after the hearing. Considering printing costs, please submit your testimony single-spaced and no font size larger than 12 point.
 - b. **Delivery of hard copies:** The witness should print 70 copies of the written testimony and staple a copy of the biographical summary and a copy of the completed disclosure form behind each copy of the written testimony. These 70 packets should be delivered to Willie Marx at 2157 Rayburn House Office Building. Please do not send the packets by U.S. Mail, UPS, Federal Express, or other shippers. Such packages are processed through an offsite security facility and will arrive 7-10 days late.
2. At the hearing, the witness will be asked to summarize his or her written testimony in five minutes or less in order to maximize the time available for discussion and questions. However, the written testimony may extend to any reasonable length.
3. At the conclusion of the hearing, the witness' written testimony, biographical summary, and completed disclosure form will be posted on the Committee's website. The documents will also be entered into the hearing record. Therefore it is recommended that personally identifiable information, such as addresses and phone numbers, not be included.
4. The Committee does not provide financial reimbursement for witness travel or accommodations. However, a witness with extenuating circumstances may submit a written request for such reimbursements to Robin Butler, Financial Administrator, 2157 Rayburn House Office Building, at least one week prior to the hearing. Reimbursements will not be made without prior approval.
5. A witness with a disability should contact Committee staff to arrange any necessary accommodations.
6. The Committee on Oversight and Government Reform is the principal oversight committee in the U.S. House of Representatives. The jurisdiction of the Committee is set forth in the House Rules X, clauses 1(m), 2, 3, and 4.
7. Committee Rules governing this hearing are online at <http://oversight.house.gov/>.

For inquiries regarding these rules and procedures, please contact the Committee on Oversight and Government Reform at (202) 225-5074.