



Testimony

Before the Subcommittee on Health,  
Committee on Energy and Commerce,  
House of Representatives

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**PATIENT PROTECTION  
AND AFFORDABLE  
CARE ACT**

**Preliminary Results of  
Undercover Testing of the  
Federal Marketplace and  
Selected State  
Marketplaces for  
Coverage Year 2015**

Statement of Seto Bagdoyan, Director, Forensic Audits  
and Investigative Service

# GAO Highlights

Highlights of [GAO-16-159T](#), a testimony before the Subcommittee on Health, Committee on Energy and Commerce, House of Representatives

## Why GAO Did This Study

PPACA provides for the establishment of health-insurance marketplaces where consumers can, among other things, select private health-insurance plans or apply for Medicaid. The Congressional Budget Office estimates the cost of subsidies and related spending under PPACA at \$60 billion for fiscal year 2016. PPACA requires verification of applicant information to determine enrollment or subsidy eligibility. In addition, PPACA provided for the expansion of the Medicaid program. GAO was asked to examine application and enrollment controls for the marketplaces and Medicaid.

This testimony provides preliminary results of undercover testing of the federal and selected state marketplaces during the 2015 open-enrollment period, for both private health-care plans and Medicaid. GAO submitted, or attempted to submit, 18 fictitious applications by telephone and online, 10 of which tested controls related to obtaining subsidized health-plan coverage available through the federal Marketplace in New Jersey and North Dakota, and through state marketplaces in California and Kentucky. GAO chose these four states based partly on a range of population sizes and whether the state had expanded Medicaid eligibility under terms of the act. The other 8 applications, among the 18 GAO made, tested marketplace and state controls under the marketplace system for determining Medicaid eligibility in these four states. The undercover results, while illustrative, cannot be generalized to the full population of enrollees. GAO discussed the results of its testing with CMS and state officials to obtain their perspectives.

View [GAO-16-159T](#). For more information, contact Seto Bagdoyan at (202) 512-6722 or [BagdoyanS@gao.gov](mailto:BagdoyanS@gao.gov).

October 23, 2015

## PATIENT PROTECTION AND AFFORDABLE CARE ACT

### Preliminary Results of Undercover Testing of the Federal Marketplace and Selected State Marketplaces for Coverage Year 2015

## What GAO Found

Under the Patient Protection and Affordable Care Act (PPACA), health-insurance marketplaces are required to verify application information to determine eligibility for enrollment and, if applicable, determine eligibility for income-based subsidies or Medicaid. These verification steps include reviewing and validating information about an applicant's Social Security number, if one is provided; citizenship, status as a national or lawful presence; and household income and family size.

For 10 fictitious applicants, GAO tested application and enrollment controls for obtaining subsidized health plans available through the federal Health Insurance Marketplace (Marketplace) (for New Jersey and North Dakota) and two selected state marketplaces (California and Kentucky). Although 8 of these 10 fictitious applications failed the initial identity-checking process, all 10 were subsequently approved by the federal Marketplace or the selected state marketplaces. Four applications used Social Security numbers that, according to the Social Security Administration (SSA), have never been issued, such as numbers starting with "000." Other applicants had duplicate enrollment or claimed their employer did not provide insurance that meets minimum essential coverage.

For 8 additional fictitious applicants, GAO tested enrollment into Medicaid through the same federal Marketplace and the two selected state marketplaces, and was able to obtain either Medicaid or alternative subsidized coverage for 7 of the 8 applicants. Specifically:

- Three were approved for Medicaid, which was the health-care program for which GAO originally sought approval. In each case, GAO provided identity information that would not have matched SSA records. For two applications, the marketplace directed the fictitious applicants to submit supporting documents, which GAO did (such as a fake immigration card), and the applications were approved. For the third, the marketplace did not seek supporting documentation, and the application was approved by phone.
- For four, GAO did not obtain approval for Medicaid; however, GAO was subsequently able to gain approval of subsidized health plans based on the inability to obtain Medicaid coverage. In 1 case, GAO falsely claimed that it was denied Medicaid in order to obtain the subsidized health plan when in fact no Medicaid determination had been made by the state at that time.
- For one, GAO was unable to enroll into Medicaid, in California, because GAO declined to provide a Social Security number. According to California officials, the state marketplace requires a Social Security number or taxpayer-identification number to process applications.

According to officials from the Centers for Medicaid & Medicare Services (CMS), California, Kentucky, and North Dakota, the marketplaces and Medicaid offices only inspect for supporting documentation that has obviously been altered. Thus, if the documentation submitted does not show such signs, it would not be questioned for authenticity. GAO's work is continuing, and GAO plans to issue a final report at a later date.

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Chairman Pitts, Ranking Member Green, and Members of the Subcommittee:

I am pleased to be here today to discuss enrollment for health-care coverage obtained through the health-insurance exchanges, or marketplaces, established under the Patient Protection and Affordable Care Act (PPACA) and, in particular, to discuss the preliminary results of our undercover testing of eligibility and enrollment controls for the federal Health Insurance Marketplace (Marketplace) and selected state marketplaces for the 2015 coverage year. PPACA provides subsidies to those eligible to purchase private health-insurance plans who meet certain income and other requirements. With those subsidies and other costs, the act represents a significant, long-term fiscal commitment for the federal government. According to the Congressional Budget Office, the estimated cost of subsidies and related spending under the act is \$60 billion for fiscal year 2016, rising to \$105 billion for fiscal year 2025, and totaling \$880 billion for fiscal years 2016–2025.<sup>1</sup>

While subsidies under the act are not paid directly to enrollees, participants nevertheless benefit financially through reduced monthly premiums or lower costs due at time of service, such as copayments.<sup>2</sup> Because subsidy costs are contingent on who obtains coverage, enrollment controls that help ensure only qualified applicants are approved for subsidized coverage are a key factor in determining federal expenditures under the act.<sup>3</sup> In addition, PPACA provided for the expansion of the Medicaid program.<sup>4</sup> Under the expansion, states may

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<sup>1</sup>Related spending includes marketplace grants to states and other items.

<sup>2</sup>Enrollees can pay lower monthly premiums by virtue of a tax credit the act provides. They may elect to receive the tax credit in advance, to lower premium cost, or to receive it at time of income-tax filing, which reduces tax liability.

<sup>3</sup>According to Department of Health and Human Services' (HHS) Centers for Medicare & Medicaid Services (CMS) data, about 11.7 million people selected or were automatically reenrolled into a 2015 health insurance plan under the act. A large share of those enrollees—87 percent, in states using the HealthCare.gov system—qualified for the advance premium tax-credit subsidy provided by the act, which is described later in this statement.

<sup>4</sup>PPACA provides states with additional federal funding to expand their Medicaid programs to cover adults under 65 with income up to 133 percent of the federal poverty level. Because of the way the limit is calculated, using what is known as an "income disregard," the level is effectively 138 percent of the federal poverty level.

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choose to provide Medicaid coverage to nonelderly adults who meet income limits and other criteria. Under PPACA, the federal government is to fully reimburse states through fiscal year 2016 for the Medicaid expenditures of “newly eligible” individuals who gained Medicaid eligibility through the expansion.<sup>5</sup> According to the Office of the Actuary of the Centers for Medicare & Medicaid Services (CMS), federal expenditures for the Medicaid expansion are estimated at \$430 billion from 2014 through 2023.<sup>6</sup>

PPACA provides for the establishment of health-insurance marketplaces to assist consumers in comparing and selecting among insurance plans offered by participating private issuers of health-care coverage.<sup>7</sup> Under PPACA, states may elect to operate their own health-care marketplaces, or they may rely on the federal Marketplace, known to the public as HealthCare.gov.<sup>8</sup> These marketplaces were intended to provide a single point of access for individuals to enroll in private health plans, apply for income-based subsidies to offset the cost of these plans—which, as noted, are paid directly to health-insurance issuers—and, as applicable, obtain an eligibility determination or assessment of eligibility for other health-coverage programs, such as Medicaid or the Children’s Health Insurance Program.<sup>9</sup> CMS, a unit of the Department of Health and Human

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<sup>5</sup>The “newly eligible” reimbursement rate drops to 95 percent in calendar year 2017, 94 percent in calendar year 2018, 93 percent in calendar year 2019, and 90 percent afterward.

<sup>6</sup>According to the CMS Office of the Actuary, an average of 4.3 million newly eligible adults are projected to have been enrolled in Medicaid in 2014, with newly eligible adult enrollment projected to reach 12.0 million people by 2023—representing 7 percent and 15 percent, respectively, of total projected program enrollment. Expenditures for newly eligible adults are estimated to have been \$23.7 billion in 2014 and are projected to total \$460 billion over 2014 through 2023, according to the actuary. About \$430 billion, or 93 percent, of these costs are expected to be paid by the federal government.

<sup>7</sup>Specifically, the act required, by January 1, 2014, the establishment of health-insurance marketplaces in all states. In states not electing to operate their own marketplaces, the federal government was required to operate a marketplace.

<sup>8</sup>As of March 2015, 37 states were using HealthCare.gov, according to HHS’ Office of the Assistant Secretary for Planning and Evaluation, with the federal Marketplace accounting for 76 percent (8.8 million) of consumers’ plan selections.

<sup>9</sup>Individuals may also continue to apply for Medicaid coverage or the Children’s Health Insurance Program through direct application to their respective state agencies. According to CMS officials, eligibility requirements are generally the same for both programs. In this statement, our testing was only for Medicaid eligibility.

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Services (HHS), is responsible for overseeing the establishment of these online marketplaces, and the agency maintains the federal Marketplace.

To be eligible to enroll in a “qualified health plan” offered through a marketplace—that is, one providing essential health benefits and meeting other requirements under PPACA—an individual must be a U.S. citizen or national, or otherwise lawfully present in the United States; reside in the marketplace service area; and not be incarcerated (unless incarcerated while awaiting disposition of charges).<sup>10</sup> To be eligible for Medicaid, individuals must meet federal requirements regarding residency, U.S. citizenship or immigration status, and income limits, as well as any additional state-specific criteria that may apply.

Marketplaces are required by PPACA to verify application information to determine eligibility for enrollment and, if applicable, determine eligibility for the income-based subsidies or Medicaid. These verification steps include validating an applicant’s Social Security number, if one is provided;<sup>11</sup> verifying citizenship, status as a national, or lawful presence by comparison with Social Security Administration or Department of Homeland Security records; and verifying household income and family size by comparison with tax-return data from the Internal Revenue Service, as well as data on Social Security benefits from the Social Security Administration.<sup>12</sup>

In light of the government’s substantial fiscal commitment under the act, congressional requesters originally asked us to examine enrollment and

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<sup>10</sup>In this statement, we use “qualified health plan” to refer to coverage obtained from private insurers, as distinguished from enrollment in a public health program such as Medicaid.

<sup>11</sup>A marketplace must require an applicant who has a Social Security number to provide the number. 42 U.S.C. § 18081(b)(2) and 45 C.F.R. § 155.310(a)(3)(i). However, having a Social Security number is not a condition of eligibility.

<sup>12</sup>For further background, see Department of Health and Human Services, Office of Inspector General, *Not All of the Federally Facilitated Marketplace’s Internal Controls Were Effective in Ensuring That Individuals Were Properly Determined Eligible for Qualified Health Plans and Insurance Affordability Programs*, A-09-14-01011 (Washington, D.C.: Aug. 6, 2015); GAO, *Patient Protection and Affordable Care Act: IRS Needs to Strengthen Oversight of Tax Provisions for Individuals*, [GAO-15-540](#) (Washington, D.C.: July 29, 2015); and GAO, *Healthcare.gov: CMS Has Taken Steps to Address Problems, but Needs to Further Implement Systems Development Best Practices*, [GAO-15-238](#) (Washington, D.C.: Mar. 4, 2015).

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verification controls of the federal Marketplace.<sup>13</sup> In July 2014, we presented testimony on the results of our initial work, which focused on application for, and approval of, coverage for fictitious applicants for the 2014 coverage year—the first under the act—through the federal Marketplace.<sup>14</sup> In July 2015, we testified on the final results of that work, including the maintenance of the fictitious applicant identities and extension of coverage through 2014 and into 2015, payment of federally subsidized premiums on policies we obtained, and the Marketplace’s verification process for applicant documentation.<sup>15</sup> We plan to issue a final report on the results of our undercover eligibility and enrollment controls testing for the 2014 coverage year shortly.

Following the original request, you and other congressional requesters asked us to continue to examine enrollment and verification controls of the federal Marketplace and state marketplaces as well, for the 2015 coverage year—the second under the act. My statement today is based on the preliminary results and analysis from this ongoing work.<sup>16</sup> Specifically, today’s statement describes the preliminary results of our undercover testing of the federal Marketplace and selected state marketplaces, for application, enrollment, and eligibility-verification controls, for both qualified health-care plans and Medicaid, during the

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<sup>13</sup>Our original requesters were: in the U.S. Senate, the then–Ranking Member of the Committee on Homeland Security and Government Affairs and the then–Ranking Member of the Committee on Finance; and in the House of Representatives, the then–Chairman of the Committee on Ways and Means and the then–Chairman of the Subcommittee on Oversight, Committee on Ways and Means.

<sup>14</sup>GAO, *Patient Protection and Affordable Care Act: Preliminary Results of Undercover Testing of Enrollment Controls for Health Care Coverage and Consumer Subsidies Provided Under the Act*, [GAO-14-705T](#) (Washington, D.C.: July 23, 2014).

<sup>15</sup>GAO, *Patient Protection and Affordable Care Act: Observations on 18 Undercover Tests of Enrollment Controls for Health-Care Coverage and Consumer Subsidies Provided under the Act*, [GAO-15-702T](#) (Washington, D.C.: July 16, 2015).

<sup>16</sup>Our original requesters are: in the U.S. Senate, the Chairman of the Committee on Finance; and in the House of Representatives, the Chairman of the Committee on Energy and Commerce, the Chairman of the Subcommittee on Health, Committee on Energy and Commerce; the former Chairman of the Committee on Ways and Means and the former Chairman of the Subcommittee on Oversight, Committee on Ways and Means.

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act's second open-enrollment period ending February 2015.<sup>17</sup> We plan to issue a final report at a later date.

To perform our undercover testing of the federal and selected state eligibility and enrollment processes for the 2015 coverage year, we created 18 fictitious identities for the purpose of making applications for health-care coverage by telephone and online.<sup>18</sup> The undercover results, while illustrative, cannot be generalized to the full population of enrollees. For all 18 applications, we used publicly available information to construct our scenarios. We also used publicly available hardware, software, and materials to produce counterfeit or fictitious documents, which we submitted, as appropriate for our testing, when instructed to do so. We then observed the outcomes of the document submissions, such as any approvals received or requests to provide additional supporting documentation.

Because the federal government, at the time of our review, operated a marketplace on behalf of the state in about two-thirds of the states, we focused part of our work on two states using the federal Marketplace—New Jersey and North Dakota. We chose these two states because they had expanded Medicaid eligibility and also delegated their Medicaid eligibility determinations to the federal Marketplace at the time of our testing.<sup>19</sup> In addition, we chose two state marketplaces, California and Kentucky, for our undercover testing. We chose these two states, in part, based on the states having expanded Medicaid eligibility and differences in population.

For 10 applicant scenarios, we tested controls for verifications related to qualified health-plan coverage. Specifically, we created application

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<sup>17</sup>Our testing included only applications through a marketplace and did not include, for example, applications for Medicaid made directly to a state Medicaid agency.

<sup>18</sup>For all our applicant scenarios, we sought to act as ordinary consumers might in attempting to make a successful application. For example, if, during online applications, we were directed to make phone calls to complete the process, we acted as instructed.

<sup>19</sup>According to CMS officials, for states that have delegated the determinations, the federal Marketplace will make an eligibility determination if there are no application "inconsistencies"—instances in which information an applicant has provided does not match information contained in data sources used for eligibility verification at the time of application, or such information is not available. If there are inconsistencies, state Medicaid agencies make the determination.

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scenarios with fictitious applicants claiming to have impossible Social Security numbers;<sup>20</sup> claiming to be working for an employer that offers health insurance, but not coverage that meets “minimum essential” standards; or already having existing qualified health-plan coverage.<sup>21</sup> We made 4 of these 10 applications online and the other 6 applications by phone. In these tests, we also stated income at a level eligible to obtain both types of income-based subsidies available under PPACA—a premium tax credit, to be paid in advance, and cost-sharing reduction.<sup>22</sup>

For 8 additional applicant scenarios, we tested controls for verifications related to Medicaid coverage.<sup>23</sup> Specifically, our fictitious applicants provided invalid Social Security identities, where their information did not match Social Security Administration records, or claimed they were noncitizens lawfully present in the United States and declined to provide Social Security numbers.<sup>24</sup> In situations where we were asked to provide immigration document numbers, we provided impossible immigration

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<sup>20</sup>According to the Social Security Administration Program Operations Manual System, the Social Security Administration has never issued a Social Security number with the first three digits as “000,” “666,” or in the 900 series; the second group of two digits as “00”; or the third group of four digits as “0000.”

<sup>21</sup>In the case of the employer-provided coverage, we created a fictitious company with fictitious employer contact information. For the existing-coverage testing, we used an identity that had previously obtained coverage during our testing of enrollment for coverage-year 2014; see [GAO-15-702T](#).

<sup>22</sup>To qualify for these income-based subsidies, an individual must be eligible to enroll in marketplace coverage; meet income requirements; and not be eligible for coverage under a qualifying plan or program, such as affordable employer-sponsored coverage, Medicaid, or the Children’s Health Insurance Program. Cost-sharing reduction is a discount that lowers the amount consumers pay for out-of-pocket charges for deductibles, coinsurance, and copayments. Because the benefit realized through the cost-sharing reduction subsidy can vary according to medical services used, the value to consumers of such subsidies can likewise vary.

<sup>23</sup>According to CMS officials, when an individual applies through a marketplace for coverage with financial assistance, they complete a single application that is an application for all insurance affordability programs; that is, individuals do not apply specifically for individual programs such as Medicaid. For our Medicaid testing, we applied using an income level we selected as eligible for Medicaid coverage. On that basis, we refer to our “Medicaid applications” throughout this statement. The application is signed under penalty of perjury, the officials noted.

<sup>24</sup>Note that we distinguish between impossible Social Security numbers—numbers never issued—and invalid Social Security identities—in which applicant-submitted information does not match Social Security Administration records.



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document numbers.<sup>25</sup> We made half of these applications online and half by phone. In these tests, we also stated income at a level eligible to qualify for coverage under the Medicaid expansion, where the federal government is responsible for reimbursing the states for 100 percent of the Medicaid costs in 2015. In cases where we did not obtain approval for Medicaid, we instead attempted, as appropriate, to obtain coverage for subsidized qualified health plans in the same manner as described earlier.

After concluding our undercover testing, we briefed officials from CMS; officials from the state marketplaces; and Medicaid officials from California, Kentucky, and North Dakota on our results. We asked to brief Medicaid officials from New Jersey but they declined our request. To protect our undercover identities, we did not provide the marketplaces with specific applicant identity information. CMS and selected state officials generally told us that without such information, they could not fully research handling of our applicants. We also reviewed laws, regulations, and other policy and related information.

We are conducting the work upon which this statement is based in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. We are conducting our related investigative work in accordance with investigative standards prescribed by the Council of the Inspectors General on Integrity and Efficiency.

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<sup>25</sup>Specifically, we provided numbers that did not match the format for the document(s) at issue.

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## Preliminary Results of Undercover Attempts to Obtain Qualified Health-Plan Coverage from the Federal Marketplace and Selected State Marketplaces











Our undercover testing for the 2015 coverage year found that the health-care marketplace eligibility determination and enrollment process remains vulnerable to fraud.<sup>26</sup> As shown in figure 1, the federal Marketplace or selected state marketplaces approved each of our 10 fictitious applications for subsidized qualified health plans.<sup>27</sup> We subsequently paid premiums to put these policies into force.

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<sup>26</sup>As noted earlier, we conducted similar undercover testing for the first open-enrollment period. See [GAO-15-702T](#).

<sup>27</sup>For our testing involving applications for qualified health-plan coverage, our fictitious applicants initially applied online or by telephone.

**Figure 1: Summary of Outcomes for 10 Fictitious Applications for Subsidized Qualified Health-Plan Coverage**

Marketplace	State	Initial application type	Scenario for testing	Obtained subsidized qualified health-plan coverage?
<b>► Federal</b>				
	New Jersey	 Phone	Impossible Social Security number	✓ Yes
		 Online	Employer-sponsored coverage not meeting “minimum essential” standards	✓ Yes
	North Dakota	 Phone	Impossible Social Security number	✓ Yes
		 Online	Employer-sponsored coverage not meeting “minimum essential” standards	✓ Yes
<b>► State</b>				
	California	 Phone	Impossible Social Security number	✓ Yes
		 Online	Employer-sponsored coverage not meeting “minimum essential” standards	✓ Yes
		 Phone <sup>a</sup>	Duplicate enrollment	✓ Yes
	Kentucky	 Phone	Impossible Social Security number	✓ Yes
		 Online	Employer-sponsored coverage not meeting “minimum essential” standards	✓ Yes
		 Phone	Duplicate enrollment <sup>b</sup>	✓ Yes

Source: GAO. | GAO-16-159T

<sup>a</sup>We initially applied by phone for coverage. At the time of application, the call representative stated that the data hub was not working and that we could send in the application by mail, fax it, or visit in person. We chose to mail the application with supporting documentation (for example, driver’s license) to the state marketplace. We subsequently obtained coverage.

<sup>b</sup>In addition to obtaining coverage under a subsidized qualified health plan, we were also subsequently approved for Medicaid.

As the figure shows, for these 10 applications, we were approved for subsidized coverage—the premium tax credit, paid in advance, and cost-

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sharing reduction subsidies—for all cases.<sup>28</sup> The monthly amount of the advance premium tax credit for these 10 applicants totaled approximately \$2,300 per month, or about \$28,000 annually, equal to about 70 percent of total premiums. For 4 of these applications, we used Social Security numbers that could not have been issued by the Social Security Administration.<sup>29</sup> For 4 other applications, we said our fictitious applicants worked at a company—which we also created—that offered health insurance, but the coverage did not provide required minimum essential coverage under PPACA. For the final 2 applications, we used an identity from our prior undercover testing of the federal Marketplace to apply for coverage concurrently at two state marketplaces.<sup>30</sup> Thus, this fictitious applicant received subsidized qualified health-plan coverage from the federal Marketplace and the two selected state marketplaces at the same time.

For 8 applications among this group of 10, we failed to clear an identity-checking step during the “front end” of the application process, and thus could not complete the process.<sup>31</sup> In these cases, we were directed to contact a contractor that handles identity checking. The contractor was unable to resolve the identity issues and directed us to call the appropriate marketplace. We proceeded to phone the marketplaces and

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<sup>28</sup>To receive advance payment of the premium tax credit (described earlier), applicants agree they will file a tax return for the coverage year, and must indicate they understand that the premium tax credits paid in advance are subject to reconciliation on their federal tax return, based on actual income earned. Cost-sharing reduction is a discount that lowers the amount consumers pay for out-of-pocket charges for deductibles, coinsurance, and copayments.

<sup>29</sup>As noted earlier, the Social Security Administration does not issue Social Security numbers with certain strings of digits.

<sup>30</sup>See [GAO-15-702T](#).

<sup>31</sup>Known as “identity proofing,” the process uses personal and financial history on file with a credit-reporting agency. The marketplace generates questions that only the applicant is believed likely to know. According to CMS, the purpose of identity proofing is to prevent someone from creating an account and applying for health coverage based on someone else’s identity and without their knowledge. Although intended to counter such identity theft involving others, identity proofing thus also serves as an enrollment control for those applying online.

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our applications were subsequently approved. The other two applicants were accepted by phone.<sup>32</sup>

For each of the 10 undercover applications where we obtained qualified health-plan coverage, the respective marketplace directed that our applicants submit supplementary documentation. The marketplaces are required to seek postapproval documentation in the case of certain application “inconsistencies”—instances in which information an applicant has provided does not match information contained in data sources that the marketplace uses for eligibility verification at the time of application, or such information is not available. If there is an application inconsistency, the marketplace is to determine eligibility using the applicant’s attestations and ensure that subsidies are provided on behalf of the applicant, if qualified to receive them, while the inconsistency is being resolved using “back-end” controls. Under these controls, applicants will be asked to provide additional information or documentation for the marketplaces to review in order to resolve the inconsistency.

As part of our testing, and to respond to the marketplace directives, we provided counterfeit follow-up documentation, such as fictitious Social Security cards with impossible Social Security numbers, for all 10 undercover applications.<sup>33</sup>

For all 10 of these undercover applications, we maintained subsidized coverage beyond the period during which applicants may file supporting documentation to resolve inconsistencies. In one case, the Kentucky marketplace questioned the validity of the Social Security number our applicant provided, which was an impossible Social Security number. In fact, the marketplace told us the Social Security Administration reported that the number was not valid. Despite this, however, the Kentucky marketplace notified our fictitious applicant that the applicant was found eligible for coverage. For the four fictitious applicants who claimed their employer did not provide minimum essential coverage, the marketplace

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<sup>32</sup>We were not required to go through the contractor identity proofing for the two phone applications through the federal Marketplace. All phone and online applications to the state marketplaces, and the online applications to the federal Marketplace, did require the contractor identity proofing.

<sup>33</sup>CMS officials said provision of a Social Security number is not a condition of eligibility, but we note the number is nevertheless important for identity verification and tax reconciliation.

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did not contact our fictitious employer to confirm the applicant's account that the company offers only substandard coverage.

In August 2015, we briefed CMS and California and Kentucky state officials on the results of our undercover testing, to obtain their views. According to these officials, the marketplaces only inspect for documents that have obviously been altered. Thus, if the documentation submitted does not appear to have any obvious alterations, it would not be questioned for authenticity. In addition, according to Kentucky officials, in the case of the impossible Social Security number, the identity-proofing process functioned correctly, but a marketplace worker bypassed identity-proofing steps that would have required a manual verification of the fictitious Social Security card we submitted. The officials told us they plan to provide training on how to conduct manual verifications to prevent this in the future.

As for our employer-sponsored coverage testing, CMS and California officials told us that during the 2015 enrollment period, the marketplaces accepted applicants' attestation on lack of minimum essential coverage. As a result, the marketplaces were not required to communicate with the applicant's employer to confirm whether the attestation is valid. Kentucky officials told us that applicant-provided information is entered into its system to determine whether the applicant's claimed plan meets minimum essential coverage standards. If an applicant receives a qualified health-plan subsidy because the applicant's employer-sponsored plan does not meet the guidelines, the Kentucky marketplace sends a notice to the employer asking it to verify the applicant information. The officials told us the employer letter details, among other things, the applicant-provided information and minimum essential coverage standards. However, our fictitious company did not receive such notification.

CMS, California, and Kentucky officials also told us there is no current process to identify individuals with multiple enrollments through different marketplaces. CMS officials told us it was unlikely an individual would seek to obtain subsidized qualified health-plan coverage in multiple states. We conducted this portion of our testing, however, to evaluate whether such a situation, such as a stolen identity, would be possible. CMS officials told us the agency would need to look at the risk associated with multiple coverage.

Kentucky officials told us that in response to our findings, call center staff have been retrained on identity-proofing processes, and that they are

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improving training for other staff as well. They also said they plan changes before the next open-enrollment period so that call center representatives cannot bypass identity-proofing steps, as occurred with our applications. Further, they said they plan to improve the process for handling of applications where employer-sponsored coverage is at issue. Also in response to our findings, California officials said they are developing process improvements and system modifications to address the issues we raised, and would share details later.

Finally, in the case of the federal Marketplace in particular, for which, as noted, we conducted undercover testing previously, we asked CMS officials for their views on our second-year results compared to the first year. They told us the eligibility and enrollment system is generally performing as designed. According to the officials, a key feature of the system, when applicant information cannot immediately be verified, is whether proper inconsistencies are generated, in order that they can be addressed later, after eligibility is granted at time of application. Earlier, CMS officials told us the overall approach is that CMS must balance consumers' ability to effectively and efficiently select Marketplace coverage with program-integrity concerns.

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## Preliminary Results of Undercover Attempts to Obtain Medicaid Coverage through the Federal Marketplace and Selected State Marketplaces

In addition to our applications for subsidized private health plans, we also made eight additional fictitious applications for Medicaid coverage in order to test the ability to apply for that program through the marketplaces. As shown in figure 2, in these tests, we were approved for subsidized health-care coverage for seven of the eight applications. For three of the eight applications, we were approved for Medicaid, as originally sought. For four of the eight applications, we did not obtain Medicaid approval, but instead were subsequently approved for subsidized qualified health-plan coverage.<sup>34</sup> The monthly amount of the advance premium tax credit for these four applicants totaled approximately \$1,100 per month, or about \$13,000 annually.<sup>35</sup> For one of









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<sup>34</sup>Thus, while we did not obtain Medicaid coverage as initially sought, we nevertheless obtained federally subsidized coverage instead.

<sup>35</sup>Thus, our total advance premium tax credit subsidies received—for the qualified health-plan applications described earlier and the initial Medicaid applications described here that ultimately produced qualified health-plan coverage—totaled approximately \$3,400 per month, or about \$41,000 annually.

the eight applications, we could not obtain Medicaid coverage because we declined to provide a Social Security number.

**Figure 2: Summary of Outcomes for Eight Fictitious Applications for Medicaid Coverage**

Marketplace	State	Initial application type	Scenario for testing	Obtained Medicaid coverage?	
▶ Federal	New Jersey	 Phone	Did not provide Social Security number	Obtained subsidized qualified health-plan coverage in lieu of Medicaid	
		 Online	Invalid Social Security identity	Obtained subsidized qualified health-plan coverage in lieu of Medicaid	
	North Dakota	 Phone	Did not have Social Security number; provided impossible immigration document number	Obtained subsidized qualified health-plan coverage in lieu of Medicaid	
		 Online	Invalid Social Security identity	✓ Yes	
	▶ State	California	 Phone	Did not provide Social Security number	<b>X Application denied</b>
			 Online	Invalid Social Security identity	✓ Yes
Kentucky		 Phone	Did not have Social Security number; provided impossible immigration document number	Obtained subsidized qualified health-plan coverage in lieu of Medicaid	
		 Online	Invalid Social Security identity	✓ Yes	

Source: GAO. | GAO-16-159T



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As with our applications for qualified health plans described earlier, we also failed to clear an identity-checking step for six of eight Medicaid applications.<sup>36</sup> In these cases, we were likewise directed to contact a contractor that handles identity checking. The contractor was unable to resolve the identity issues and directed us to call the appropriate marketplace. We proceeded to phone the marketplaces. However, as shown in figure 2, the California marketplace did not continue to process one of our Medicaid applications. In this case, our fictitious phone applicant declined to provide what was a valid Social Security number, citing privacy concerns. A marketplace representative told us that, to apply, the applicant must provide a Social Security number. The representative suggested that as an alternative, we could apply for Medicaid in person with the local county office or a certified enrollment counselor.<sup>37</sup>

After we discussed the results of our undercover testing with California officials, they told us their system requires applicants to provide either a Social Security number or an individual taxpayer-identification number to process an application. As a result, because our fictitious applicant declined to provide a Social Security number, our application could not be processed.

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## Details of Medicaid Applications through the Federal Marketplace

For the four Medicaid applications submitted to the federal Marketplace, we were told that we may be eligible for Medicaid but that the respective Medicaid state offices might require more information. For three of the four applications, federal Marketplace representatives told us we would be contacted by the Medicaid state offices within 30 days. However, the Medicaid offices did not notify us within 30 days for any of the applications. As a result, we subsequently contacted the state Medicaid

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<sup>36</sup>We were not required to go through identity proofing for the two phone applications that went through the federal Marketplace. All phone and online applications from the state marketplaces and the online applications from the federal Marketplace required identity proofing.

<sup>37</sup>Because this was outside the scope of our review of the marketplaces, we did not follow this avenue.

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offices and the federal Marketplace to follow up on the status of our applications.

For the two New Jersey Medicaid applications, we periodically called the state Medicaid offices over approximately 4 months, attempting to determine the status of our applications. In these calls, New Jersey representatives generally told us they had not yet received Medicaid information from the federal Marketplace and, on several occasions, said they expected to receive it shortly. After our calls to New Jersey Medicaid offices, we phoned the federal Marketplace to determine the status of our Medicaid applications.

- In one case, the federal Marketplace representative told us New Jersey determined that our applicant did not qualify for Medicaid.<sup>38</sup> As a result, the phone representative stated that we were then eligible for qualified health-plan coverage. We subsequently applied for coverage and were approved for an advance premium tax credit plus the cost-sharing reduction subsidy.
- In the other case, the federal Marketplace representative told us the Marketplace system did not indicate whether New Jersey received the application or processed it. The representative advised we phone the New Jersey Medicaid agency. Later on that same day, we phoned the federal Marketplace again and falsely claimed that the New Jersey Medicaid office denied our Medicaid application. Based on this claim, the representative said we were eligible for qualified health-plan coverage. We subsequently applied for coverage and were approved for an advance premium tax credit plus the cost-sharing reduction subsidy. The federal Marketplace did not ask us to submit documentation substantiating our Medicaid denial from New Jersey.

We asked to meet with New Jersey Medicaid officials to discuss the results of our testing, but they declined our request. CMS officials told us that New Jersey had system issues that may have accounted for problems in our Medicaid application information being sent to the state. CMS officials told us that this system issue is now resolved. In addition, CMS officials told us they do not require proof of a Medicaid denial when processing qualified health-plan applications; nor does the federal

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<sup>38</sup>Earlier that day, in a phone call with the New Jersey Medicaid agency, a representative said—contrary to the federal Marketplace statement—that the agency had not received application information from the federal Marketplace.

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Marketplace verify the Medicaid denial with the state. CMS officials said that instead, they accept the applicant's attestation that the applicant was denied Medicaid coverage.

For our North Dakota Medicaid application in which we did not provide a Social Security number but did provide an impossible immigration document number, we called the North Dakota Medicaid agency to determine the status of our application. An agency representative told us the federal Marketplace denied our Medicaid application and therefore did not forward the Medicaid application file to North Dakota for a Medicaid eligibility determination.<sup>39</sup> We did not receive notification of denial from the federal Marketplace. Subsequently, we called the federal Marketplace and applied for subsidized qualified health-plan coverage. The federal Marketplace approved the application, granting an advance premium tax credit plus the cost-sharing reduction subsidy. Because we did not disclose the specific identities of our fictitious applicants, CMS officials could not explain why the federal Marketplace originally said our application may be eligible for Medicaid but subsequently notified North Dakota that it was denied.

For the North Dakota Medicaid application for which we did not provide a valid Social Security identity, we received a letter from the state Medicaid agency about a month after we applied through the federal Marketplace. The letter requested that we provide documentation to prove citizenship, such as a birth certificate. In addition, it requested a Social Security card and income documentation. We submitted the requested documentation, such as a fictitious birth certificate and Social Security card. The North Dakota Medicaid agency subsequently approved our Medicaid application and enrolled us in a Medicaid plan.

After our undercover testing, we briefed North Dakota Medicaid officials and obtained their views. They told us the agency likely approved the Medicaid application because our fake Social Security card would have cleared the Social Security number inconsistency. The officials told us they accept documentation that appears authentic. They also said the agency is planning to implement a new system to help identify when

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<sup>39</sup>As noted earlier, the federal Marketplace representative stated that our application may be eligible for Medicaid but more information may be needed by the Medicaid state offices.

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applicant-reported information does not match Social Security Administration records.

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## Details of Medicaid Applications through State Marketplaces

As with our applications for coverage under qualified health plans, described earlier, the state marketplace for Kentucky directed two of our Medicaid applicants to submit supplementary documentation. As part of our testing and in response to such requests, we provided counterfeit follow-up documentation, such as a fake immigration card with an impossible numbering scheme for these applicants. The results of the documentation submission are as follows:

- For the application where the fictitious identity did not match Social Security records, the Kentucky agency approved our application for Medicaid coverage. In our discussions with Kentucky officials, they told us they accept documentation submitted—for example copies of Social Security cards—unless there are obvious alterations.
- For the Medicaid application without a Social Security number and with an impossible immigration number, the Kentucky state agency denied our Medicaid application. A Kentucky representative told us the reason for the denial was that our fictitious applicant had not been a resident for 5 years, according to our fictitious immigration card. The representative told us we were eligible for qualified health-plan coverage. We applied for such coverage and were approved for an advance premium tax credit and the cost-sharing reduction subsidy. In later discussions with Kentucky officials, they told us the representative made use of an override capability, likely based on what the officials described as a history of inaccurate applicant immigration status information for a refugee population. Kentucky officials also said their staff accept documentation submitted unless there are obvious alterations, and thus are not trained to identify impossible immigration numbers. Finally, Kentucky officials said they would like to have a contact at the Department of Homeland Security with whom they can work to resolve immigration-related inconsistencies, similar to a contact that they have at the Social Security Administration to resolve Social Security-related inconsistencies.

By contrast, during the Medicaid application process for one applicant, California did not direct that we submit any documentation. In this case, our fictitious applicant was approved over the phone even though the fictitious identity did not match Social Security records. We shared this result with California officials, who said they could not comment on the

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specifics of our case without knowing details of our undercover application.

As noted earlier, the findings discussed in this statement are preliminary, and we plan to issue a final report later, upon completion of our work.

Chairman Pitts, Ranking Member Green, and Members of the subcommittee, this concludes my statement. I look forward to the subcommittee's questions.

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## GAO Contact and Staff Acknowledgments

For questions about this statement, please contact Seto Bagdoyan at (202) 512-6722 or BagdoyanS@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement.

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