



September 2016

PATIENT PROTECTION AND AFFORDABLE CARE ACT

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

Accessible Version

GAO Highlights

Highlights of [GAO-16-792](#), a report to congressional requesters

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 act 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 enrollment and verification controls for the marketplaces.

This report, which follows earlier testimony, provides final results of GAO testing and describes (1) undercover attempts to obtain health-plan coverage from the federal Marketplace and selected state marketplaces for 2015, and (2) undercover attempts to obtain Medicaid coverage through the federal Marketplace and the selected state marketplaces. GAO submitted, or attempted to submit, 18 fictitious applications by telephone and online. Ten applications tested controls related to obtaining subsidized coverage available through the federal Marketplace in New Jersey and North Dakota, and through state marketplaces in California and Kentucky. GAO chose these states based partly on range of population and whether the state had expanded Medicaid eligibility under PPACA. The other 8 applications tested controls for determining Medicaid eligibility. The results, while illustrative, cannot be generalized. GAO discussed results with CMS and state officials to obtain their views. The states identified several actions being taken in response to GAO's findings.

View [GAO-16-792](#). For more information, contact Seto Bagdoyan at (202) 512-6722 or bagdoyans@gao.gov.

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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. Verification steps include reviewing and validating an applicant's Social Security number, if one is provided; citizenship, status as a U.S. national, or lawful presence; and household income and family size.

GAO's undercover testing for the 2015 coverage year found that the health-care marketplace eligibility determination and enrollment process for qualified health plans—that is, coverage obtained from private insurers—remains vulnerable to fraud. The federal Health Insurance Marketplace (Marketplace) or selected state marketplaces approved each of 10 fictitious applications GAO made for subsidized health plans. Although 8 of these 10 fictitious applications failed the initial online identity-checking process, all 10 were subsequently approved. Four applications used Social Security numbers that, according to the Social Security Administration, have never been issued, such as numbers starting with "000." Other applicants obtained duplicate enrollment or obtained coverage by claiming that their employer did not provide insurance that met minimum essential coverage.

For eight additional fictitious applications, initially made for Medicaid coverage, GAO was approved for subsidized health-care coverage in seven of the eight cases, through the federal Marketplace and the two selected state marketplaces.

- Three of GAO's applications 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 Social Security Administration records. For two applications, the marketplace or state Medicaid agency 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 was unable to obtain approval for Medicaid but was subsequently able to gain approval of subsidized health-plan coverage. In one case, GAO falsely claimed that it was denied Medicaid and was able to obtain the subsidized health plan when in fact no Medicaid determination had been made 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.

For both sets of testing, GAO submitted fictitious documentation as part of the application and enrollment process. According to officials from the Centers for Medicaid & Medicare Services (CMS), California, Kentucky, and North Dakota, the marketplace or Medicaid office 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.

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Abbreviations

CMS	Centers for Medicare & Medicaid Services
HHS	Department of Health and Human Services
Marketplace	Health Insurance Marketplace
PPACA	Patient Protection and Affordable Care Act

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September 9, 2016

Congressional Requesters

The Patient Protection and Affordable Care Act (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 \$56 billion for fiscal year 2017, rising to \$106 billion for fiscal year 2026, and totaling \$866 billion for fiscal years 2017–2026.¹

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.² 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. In addition, PPACA provided for the expansion of the Medicaid program.³ Under the expansion, states may 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 calendar year 2016 for the Medicaid expenditures of “newly eligible” individuals who gained Medicaid eligibility through the expansion.⁴ According to the Office of the Actuary of the

¹Related spending includes health-insurance marketplace grants to states and other items.

²Enrollees 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.

³PPACA 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.

⁴The “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.

Centers for Medicare & Medicaid Services (CMS), federal expenditures for the Medicaid expansion are estimated at \$430 billion from 2014 through 2023.⁵

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.⁶ Under PPACA, states may elect to operate their own health-care marketplaces, or they may rely on the federal Health Insurance Marketplace (Marketplace), known to the public as HealthCare.gov.⁷

In light of the government's substantial fiscal commitment under the act, we have conducted a body of work examining enrollment and verification controls of the federal Marketplace. Specifically, 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.⁸ 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.⁹ You asked us to

⁵According 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 from 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.

⁶Specifically, PPACA 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.

⁷As of March 2015, 37 states were using HealthCare.gov, according to the Department of Health and Human Services' Office of the Assistant Secretary for Planning and Evaluation, with the federal Marketplace accounting for 76 percent (8.8 million) of consumers' plan selections.

⁸GAO, *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).

⁹GAO, *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).

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. We testified in October 2015 on 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 act’s second open-enrollment period ending February 2015.¹⁰ This report provides the final results of that testing and includes formal comments from the Department of Health and Human Services (HHS) and a marketplace in the selected states in response to our findings. Specifically, this report describes for the 2015 coverage year (1) results of undercover attempts to obtain qualified health-plan coverage from the federal Marketplace and selected state marketplaces, and (2) results of undercover attempts to obtain Medicaid coverage through the federal Marketplace and selected state marketplaces.

For both objectives, 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.¹¹ 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—

¹⁰See GAO, *Patient Protection and Affordable Care Act: Preliminary Results of Undercover Testing of the Federal Marketplace and Selected State Marketplaces for Coverage Year 2015*, [GAO-16-159T](#) (Washington, D.C.: Oct. 23, 2015). In this report, 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.

¹¹For 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.

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.¹² 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.¹³

For our first objective, we used 10 applicant scenarios to test controls for verifications related to qualified health-plan coverage. We 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.¹⁴ For our second objective, we used 8 additional applicant scenarios to test controls for verifications related to Medicaid coverage.¹⁵ In cases where we did not obtain approval for

¹²According 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. Although North Dakota delegated Medicaid eligibility determinations to the federal Marketplace at the time of our testing, it ceased doing so in November 2015 and now makes its own eligibility determinations.

¹³In December 2015, Kentucky notified the Department of Health and Human Services (HHS) it would dismantle its state-operated health-insurance marketplace, known as kynect, and instead rely upon the federal Marketplace, as soon as the transition can be made.

¹⁴To qualify for these income-based subsidies, an individual must be eligible to enroll in marketplace coverage; meet income requirements; and not be eligible for minimum essential coverage, such as employer-sponsored coverage that is affordable and meets the minimum value standard, for Medicaid, or for 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.

¹⁵According to CMS officials, when an individual applies through a marketplace for coverage with financial assistance, he or she completes 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 report. The application is signed under penalty of perjury, the CMS officials noted.

Medicaid, we instead attempted, as appropriate, to obtain coverage for subsidized qualified health plans.

For both objectives, after concluding our undercover testing for 2015, we briefed officials from CMS; officials from the state marketplaces; and Medicaid officials from California, Kentucky, and North Dakota on our results. We offered to brief Medicaid officials from New Jersey but they declined our offer. 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 fictitious applicants. We also reviewed statutes, regulations, and other policy and related information. For a full discussion of our scope and methodology, see appendix I.

We conducted this performance audit from November 2014 to September 2016 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 conducted our related investigative work in accordance with investigative standards prescribed by the Council of the Inspectors General on Integrity and Efficiency.

Background

Under PPACA, health-care 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 not paid directly to enrollees, but instead are paid to health-insurance issuers—and, as applicable, obtain an eligibility determination or assessment of eligibility for other health-coverage programs. These other programs include Medicaid and the Children’s Health Insurance Program.¹⁶ CMS, a unit of HHS, is responsible for overseeing the establishment of these online marketplaces, and the agency maintains the federal Marketplace.

¹⁶Individuals 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 report, our testing was only for Medicaid eligibility.

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 be lawfully present in the United States; reside in the marketplace service area; and not be incarcerated (unless incarcerated while awaiting disposition of charges). 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.

When applying for coverage, individuals report family size and the amount of projected income. Based, in part, on that information, the Marketplace will calculate the maximum allowable amount of advance premium tax credit. An applicant can then decide if he or she wants all, some, or none of the estimated credit paid in advance, in the form of payment to the applicant’s insurer that reduces the applicant’s monthly premium payment.¹⁷

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;¹⁸ verifying citizenship, status as a U.S. 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

¹⁷If enrollees do not choose to receive the income-tax credit in advance, they may claim it later when filing tax returns. If an applicant chooses to have all or some of his or her credit paid in advance, the applicant is required to “reconcile” on his or her federal tax return the amount of advance payments the government sent to the applicant’s insurer on the applicant’s behalf with the tax credit for which the applicant qualifies based on actual reported income and family size.

¹⁸A 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.

Internal Revenue Service, as well as data on Social Security benefits from the Social Security Administration.¹⁹

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

In February 2016, we issued a report addressing CMS enrollment controls and the agency's management of enrollment fraud risk for the federal Marketplace.²⁰ Based on our 2014 undercover testing for qualified health plans and related work, this report included eight recommendations to HHS to strengthen oversight of the federal Marketplace. HHS concurred with our recommendations; however, it is too early to determine whether HHS will fully address the issues we identified. Our recommendations addressed issues also relevant to our 2015 testing described in this report, including studying changes to improve eligibility determinations and the data services hub process; tracking the value of subsidies terminated or adjusted for failure to resolve application inconsistencies; implementing procedures for resolving Social Security number inconsistencies; and conducting a comprehensive fraud risk assessment of the potential for fraud in the process for applying for qualified health plans through the federal Marketplace.

¹⁹For 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).

²⁰GAO, *Patient Protection and Affordable Care Act: CMS Should Act to Strengthen Enrollment Controls and Manage Fraud Risk*, [GAO-16-29](#) (Washington, D.C.: Feb. 23, 2016).

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 for qualified health plans remains vulnerable to fraud.²¹ As shown in figure 1, the federal Marketplace or selected state marketplaces approved each of our 10 fictitious applications for subsidized qualified health plans.²² We subsequently paid premiums to put these policies into force.

²¹As noted earlier, we conducted similar undercover testing for the first open-enrollment period. See [GAO-15-702T](#).

²²For 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 2015 Subsidized Qualified Health-Plan Coverage

Marketplace	State	Application type	Scenario for testing	Obtained subsidized qualified health-plan coverage?
▶ Federal				
	New Jersey	 Phone	Impossible Social Security number	✓
		 Online	Employer-sponsored coverage not meeting “minimum essential” standards	✓
	North Dakota	 Phone	Impossible Social Security number	✓
		 Online	Employer-sponsored coverage not meeting “minimum essential” standards	✓
▶ State				
	California	 Phone	Impossible Social Security number	✓
		 Online	Employer-sponsored coverage not meeting “minimum essential” standards	✓
		 Phone ^a	Duplicate enrollment	✓
	Kentucky	 Phone	Impossible Social Security number	✓
		 Online	Employer-sponsored coverage not meeting “minimum essential” standards	✓
		 Phone	Duplicate enrollment ^b	✓

Source: GAO. | GAO-16-792

^aWe initially applied by phone for coverage. At the time of application, the call representative stated that the federal data services 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.

^bIn addition to obtaining coverage under a subsidized qualified health plan, we were also subsequently approved for Medicaid.

As figure 1 shows, for these 10 applications, we were approved for subsidized coverage—the premium tax credit, paid in advance, and cost-

sharing reduction subsidies—for all cases.²³ 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.²⁴ 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.²⁵ 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.²⁶ 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

²³To 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.

²⁴According 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.”

²⁵See [GAO-15-702T](#).

²⁶Known 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 the other person’s knowledge. Although intended to counter such identity theft involving others, identity proofing thus also serves as an enrollment control for those applying online.

our applications were subsequently approved. The other two applicants were accepted by phone.²⁷

For each of the 10 fictitious 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.²⁸

For all 10 of these fictitious 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. Nevertheless, 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 did not contact

²⁷We 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.

²⁸CMS 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.

our fictitious employer to confirm the applicant's account that the company offers only substandard coverage.

In August 2015, we briefed CMS, California, and Kentucky 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.²⁹ Further, California officials told us in June 2016 that the marketplace is upgrading its system in an effort to prevent use of impossible Social Security numbers. In the case of applicant identity verification in particular, Covered California officials told us they believed it was likely our applicants had their identities confirmed because they ultimately submitted paper applications, signed under penalty of perjury. That attestation satisfied identity verification requirements, the officials said.

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. In June 2016, California officials further told us the marketplace is updating its application process to provide tools to consumers to help them determine whether their employer-sponsored insurance meets minimum essential coverage standards. They also told us the marketplace is updating policies and procedures for sending notices to employers and developing longer-term plans for an automated system to send notices to employers. Kentucky officials told us after our 2015 testing 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

²⁹As noted earlier, Kentucky has since notified HHS it would dismantle its state-operated health-insurance marketplace, known as kynect, and instead rely upon the federal Marketplace, as soon as the transition can be made.

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.

After our 2015 testing, CMS, California, and Kentucky officials also told us there was no process to identify individuals with multiple enrollments through different marketplaces. California officials noted in June 2016 that the federal government has not made data available that would allow California to identify duplicate 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 coverages.

Kentucky officials told us that in response to our 2015 findings, call-center staff were retrained on identity-proofing processes, and that they are improving training for other staff as well. They also said they plan to make 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.

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. This is important so that such inconsistencies can be addressed later, after eligibility is granted at time of application. CMS officials noted to us in June 2016 that PPACA and federal regulations provide for instances when an individual who is otherwise eligible can receive coverage while an inconsistency is being resolved. 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.

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

For our additional eight fictitious applications for Medicaid coverage in 2015, we were approved for subsidized health-care coverage in seven of the eight applications. As shown in figure 2, 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. The monthly amount of the advance premium tax credit for these four applicants totaled approximately \$1,100 per month, or about \$13,000 annually.³⁰ For one of the eight applications, we could not obtain Medicaid coverage because we declined to provide a Social Security number.

³⁰As a result, 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.

Figure 2: Summary of Outcomes for Eight Fictitious Applications for 2015 Medicaid Coverage

Marketplace	State	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	✓	
	▶ State	California	 Phone	Did not provide Social Security number	X Application denied
			 Online	Invalid Social Security identity	✓
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	✓	

Source: GAO. | GAO-16-792

As with our applications for qualified health plans described earlier, we also failed to clear the initial identity-checking step for six of eight Medicaid applications.³¹ 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.³² After we discussed the results of our undercover testing with California officials in 2015, 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.

Details of Medicaid Applications through the Federal Marketplace

For the four fictitious Medicaid applications submitted to the federal Marketplace for 2015, 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 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 in 2015, attempting to

³¹We 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.

³²Because this was outside the scope of our review of the marketplaces, we did not follow this avenue.

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.³³ 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.

In July and August 2015, we offered to meet with New Jersey Medicaid officials to discuss the results of our testing, but they declined our offer. CMS officials told us at the time 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 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.

³³Earlier 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.

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.³⁴ 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 in 2015, 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 applicant-reported information does not match Social Security Administration records.

³⁴As 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 office.

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 2015 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.

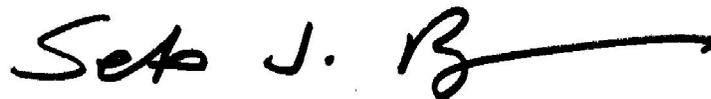
By contrast, during the Medicaid application process for one applicant, California did not direct that we submit any documentation. In this case, our fictitious applicant was approved over the phone even though the fictitious identity did not match Social Security records. We shared this result with California officials, who said they could not comment on the specifics of our case without knowing details of our undercover application.

Agency Comments

We provided a draft of this report to HHS, the California Department of Health Care Services, Covered California, the Kentucky Department for Medicaid Services, the Kentucky Health Benefit Exchange, and the North Dakota Department of Human Services. HHS and Covered California provided written comments, reproduced in appendixes II and III. HHS said it is committed to verifying eligibility of consumers who apply for health coverage through the federal Marketplace. The agency is continuing to make improvements to strengthen program integrity and Marketplace controls, HHS said. The Marketplace will continue to end coverage or adjust advance premium tax credit or cost-sharing reduction subsidies for failure to provide satisfactory documentation, HHS said. Covered California said it is committed to improving its processes with lessons learned from results of our undercover testing. Covered California said it takes vulnerabilities to fraud seriously and stressed the importance of effective fraud risk management, including an emphasis on consumer protection. HHS and Covered California also provided us with technical comments, which we have incorporated, as appropriate.

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the Secretary of Health and Human Services, the Acting Administrator of CMS, and other interested parties. In addition, the report will be available at no charge on the GAO website at <http://www.gao.gov>.

If you or your staff have any questions about this report, please contact me 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 report. GAO staff who made key contributions to this report are listed in appendix IV.



Seto J. Bagdoyan
Director of Audits
Forensic Audits and Investigative Service

List of Requesters

The Honorable Orrin Hatch
Chairman
Committee on Finance
United States Senate

The Honorable Fred Upton
Chairman
Committee on Energy and Commerce
House of Representatives

The Honorable Kevin Brady
Chairman
Committee on Ways and Means
House of Representatives

The Honorable Joseph Pitts
Chairman
Subcommittee on Health
Committee on Energy and Commerce
House of Representatives

The Honorable Peter Roskam
Chairman
Subcommittee on Oversight
Committee on Ways and Means
House of Representatives

The Honorable Charles Boustany, Jr.
Chairman
Subcommittee on Tax Policy
Committee on Ways and Means
House of Representatives

Appendix I: Objectives, Scope, and Methodology

The objectives of this report, which concludes work we initially presented in a testimony in October 2015, are to describe for the 2015 coverage year (1) results of undercover attempts to obtain qualified health-plan coverage from the federal Health Insurance Marketplace (Marketplace) and selected state marketplaces under the Patient Protection and Affordable Care Act (PPACA), for the act's second open-enrollment period, for 2015 coverage; and (2) results of undercover attempts to obtain Medicaid coverage through the federal Marketplace and selected state marketplaces.¹

For both objectives, 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.² The undercover results, while illustrative, cannot be generalized to the full population of enrollees. For all 18 fictitious 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

¹For our previous testimony, see GAO, *Patient Protection and Affordable Care Act: Preliminary Results of Undercover Testing of the Federal Marketplace and Selected State Marketplaces for Coverage Year 2015*, [GAO-16-159T](#) (Washington, D.C.: Oct. 23, 2015). In this report, 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. To be eligible to enroll in a qualified health plan offered through a marketplace, an individual must be a U.S. citizen or national, or otherwise lawfully present in the United States; reside in the marketplace service area; and not be incarcerated (unless incarcerated while awaiting disposition of charges). Marketplaces, in turn, are required by law to verify application information to determine eligibility for enrollment and, if applicable, determine eligibility for the income-based subsidies.

²For all our applicant scenarios, we sought to act as an ordinary consumer would 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.

eligibility determinations to the federal Marketplace at the time of our testing. In addition, we chose two state marketplaces, California and Kentucky, for our undercover testing. We chose these two states based on factors including Medicaid expansion; population size (selection of California allowed inclusion of a significant portion of all state-based marketplace activity); differences in population (California is about nine times as populous as Kentucky); and progress made in reducing the percentage of uninsured residents. Our testing included only applications through a marketplace and did not include, for example, applications for Medicaid made directly to a state Medicaid agency.

For our first objective, we used 10 applicant scenarios to test controls for verifications related to qualified health-plan coverage. Specifically, we created application scenarios with fictitious applicants claiming to have impossible Social Security numbers; 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. 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.³

For our second objective, we used 8 additional applicant scenarios to test controls for verifications related to Medicaid coverage. 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. In situations where we were asked to provide immigration document numbers, we provided impossible immigration document numbers. 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

³To qualify for these income-based subsidies, an individual must be eligible to enroll in marketplace coverage; meet income requirements; and not be eligible for minimum essential coverage, such as employer-sponsored coverage that is affordable and meets the minimum value standard, for Medicaid, or for 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.

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.

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 created our applicant scenarios without knowledge of specific control procedures, if any, that CMS or other federal agencies may use in accepting or processing applications. We thus did not create the scenarios with intent to focus on a particular control or procedure.

Overall, our review covered the act's second open-enrollment period, for 2015 coverage, as well as follow-on work after close of the open-enrollment period. We shared details of our work with CMS and the selected state marketplaces. We had additional discussions with federal and state marketplace officials in June 2016.

For both objectives, we also reviewed statutes, regulations, and other policy and related information.

We conducted this performance audit from November 2014 to September 2016 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 conducted our related investigative work in accordance with investigative standards prescribed by the Council of the Inspectors General on Integrity and Efficiency.

Appendix II: Comments from the Department of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

AUG 26 2016

Seto Bagdoyan
Director, Forensic Audits and Investigative Service
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Mr. Bagdoyan:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "*Patient Protection and Affordable Care Act: Final Results of Undercover Testing of the Federal Marketplace and Selected State Marketplaces for Coverage Year 2015*" (GAO-16-792).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

A handwritten signature in cursive script that reads "Jim R. Esquea".

Jim R. Esquea
Assistant Secretary for Legislation

Attachment

**GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
(HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT
ENTITLED: PATIENT PROTECTION AND AFFORDABLE CARE ACT: FINAL RESULTS OF
UNDERCOVER TESTING OF THE FEDERAL MARKETPLACE AND SELECTED STATE
MARKETPLACES FOR COVERAGE YEAR 2015 (GAO-16-792)**

The Department of Health and Human Services (HHS) appreciates the opportunity to review and comment on the Government Accountability Office's (GAO) draft report. HHS is committed to verifying the eligibility of consumers who apply for enrollment in qualified health plans (QHPs) through a Federally-facilitated Marketplace (Marketplace) or for insurance affordability programs, including Medicaid and the Children's Health Insurance Program (CHIP). HHS takes seriously its responsibilities to protect taxpayer funds, while making coverage available to eligible individuals. As the GAO mentioned in their report, the results cannot be generalized to the overall population of applicants or enrollees.

Marketplace Program Integrity

In order to better protect consumers and taxpayer dollars, HHS is implementing a number of initiatives to enhance operations with a focus on program integrity. HHS has expertise in preventing and detecting fraud, waste, and abuse from its other programs and is applying program integrity best practices to the Marketplace. HHS has experienced program integrity staff that works to prevent and address instances of potential fraud. As recommended by the GAO,¹ HHS is conducting a Marketplace Fraud Risk Assessment, leveraging the GAO's fraud risk framework.² The GAO's framework identifies leading practices for managing fraud risks and was developed to help managers combat fraud and preserve integrity in government agencies and programs. HHS is using this framework to identify and prioritize key areas for potential risk in the Marketplace.

If someone provides false or fraudulent information to the Marketplace, HHS, or its law enforcement partners, use their penalty authority, including fines of up to \$250,000 for individuals who knowingly and willfully provide false or fraudulent information to the Marketplace. Issuers may also rescind coverage that has been obtained fraudulently. HHS has trained more than 200 investigators who work for federal law enforcement and special investigations units in private health insurance companies to identify and help stop possible fraudulent activities. HHS meets regularly with law enforcement to identify emerging fraud trends and discuss new fraud detection analytics. HHS has partnered with insurance companies to share information and best practices related to fraud through the Healthcare Fraud Prevention Partnership. In addition, HHS can terminate or immediately suspend its relationships with individuals and organizations that it has approved or registered to help consumers apply and enroll if these individuals or organizations fail to comply with applicable statutes or regulations. HHS continually assesses policies and processes, and makes improvements to protect the Marketplace and its consumers as needed.

The Marketplace Eligibility Verification Process

¹ "Patient Protection and Affordable Care Act: CMS Should Act to Strengthen Enrollment Controls and Manage Fraud Risk" (GAO-16-29, released February 2016)

² "A Framework for Managing Fraud Risks in Federal Programs" (GAO-15-593SP, released July 2015)

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: PATIENT PROTECTION AND AFFORDABLE CARE ACT: FINAL RESULTS OF UNDERCOVER TESTING OF THE FEDERAL MARKETPLACE AND SELECTED STATE MARKETPLACES FOR COVERAGE YEAR 2015 (GAO-16-792)

HHS uses technology that allows the federal government to provide individuals with real-time, electronic eligibility verification via the Federal Data Services Hub (Hub). The Hub provides a secure electronic connection between the Marketplace and already-existing federal, state, and private databases. These databases are used to verify the eligibility information in each application by matching it against trusted records, including records maintained by the Social Security Administration (SSA), the Internal Revenue Service (IRS), the Department of Homeland Security (DHS), Equifax, the Department of Veterans Affairs, Medicare, Medicaid, CHIP, and TRICARE. Additionally, the Peace Corps and the Office of Personnel Management (OPM) use a secure electronic file transfer process to conduct monthly transmissions of Peace Corps and OPM data to help verify application information about employer-sponsored coverage. The Hub supported tens of millions of data verifications during the first three open enrollment periods. State Medicaid and CHIP agencies also access the verification services available through the Hub to verify eligibility of applicants that apply through the state.

Sometimes an applicant's eligibility cannot be verified in real time by the trusted data source. These situations often involve people who have gained or lost a job, divorced, or changed their name. The verification process relies on the data contained within the trusted data sources, which may be out of date when a consumer submits an application. For example, IRS data is the primary source of income information as required by the Patient Protection and Affordable Care Act (ACA), and it may be up to two years old depending on the most recent tax return filed by the applicant. The statute accounts for these situations. If an applicant provides information that cannot be verified by the trusted data sources, then the statute requires the Marketplace to make a reasonable effort to identify and address the cause of the data inconsistency. For individuals who are assessed as potentially Medicaid or CHIP eligible and whose eligibility cannot be verified through the Hub, the applications are transferred to the state to resolve the data inconsistency, in accordance with Medicaid and CHIP Regulations.

Consistent with the law and regulations, when such an inconsistency is identified, the Marketplace contacts the applicant to confirm the information, and if this does not resolve the issue, provides the applicant the opportunity to present satisfactory documentary evidence to resolve the inconsistency within 90 or 95 days (as applicable, depending on the inconsistency type). Contracted staff review the supporting documentation submitted by applicants to check that it is valid and sufficient to verify the application information before resolving the inconsistency. Contracted reviewers are given examples of valid documents and are trained to escalate possibly invalid or fraudulent documents. Under our operating procedures, if HHS suspects that someone made a fraudulent representation, HHS will investigate the issue, take appropriate administrative action, and/or report the issue to our law enforcement partners in the HHS Office of Inspector General and Department of Justice.

During this inconsistency resolution period, the ACA provides the applicant with eligibility for coverage through the Marketplace or for an insurance affordability program based on the

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information they attested to in their application. When submitting the application information required by the ACA, individuals attest, under penalty of perjury, that the information they submit is accurate. Knowingly and willfully providing false or fraudulent information is a violation of federal law and subject to a fine of up to \$250,000.

If an applicant does not provide satisfactory documentation within the required time, the Marketplace will determine the applicant's eligibility based on the information contained within the trusted data sources, as required by the law. In 2015, the Marketplace ended coverage for about 500,000 consumers who failed to produce sufficient documentation on their citizenship or immigration status as requested and required, and about 1.2 million households had their advanced premium tax credit (APTC) and/or cost sharing reduction (CSR) adjusted.³ For 2016 coverage, as of March 31, 2016, the Marketplace ended coverage for approximately 17,000 consumers who failed to produce sufficient documentation on their citizenship or immigration status as requested and required, and 73,000 households had their APTC and/or CSR adjusted.⁴ The Marketplace continues to review documentation submitted by consumers and will continue to end coverage and/or adjust APTC and/or CSR amounts as appropriate.

Medicaid Eligibility

Individuals who apply for coverage at the Marketplace can receive an eligibility decision for APTC, CSR, Medicaid on the basis of modified adjusted gross income (MAGI), or CHIP. States have elected to either have the Marketplace make initial assessments of Medicaid/CHIP eligibility (assessment states) or they have delegated the authority to make MAGI Medicaid and CHIP eligibility determinations to the Marketplace (determination states). When the Marketplace makes a determination or an assessment of Medicaid/CHIP eligibility (or potential eligibility on a non-MAGI basis), the application and verification information and other data used by the Marketplace to make the eligibility decision are transferred to the state through an account transfer process. States served by the Marketplace have built functionality to receive and send account transfers. HHS monitors and reviews these transfers through weekly reporting and provides technical assistance to states on the account transfer process and appropriate handling of accounts received by the state.

The Marketplace also transfers the accounts of individuals who are potentially eligible for Medicaid/CHIP but have a data inconsistency between the application and the trusted sources. The state Medicaid/CHIP agency are responsible for resolving all inconsistencies in accordance with federal verification regulations which may include providing coverage to otherwise eligible individuals while the inconsistency is resolved. Medicaid and CHIP regulations require Medicaid

³ December 31, 2015 Effectuated Enrollment Snapshot.

<https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-03-11.html>

⁴ March 31, 2016 Effectuated Enrollment Snapshot.

<https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-06-30.html>

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and CHIP agencies to file a MAGI Verification Plan with HHS. HHS reviews these plans to ensure they are in compliance with federal verification regulations. The verification procedures reflected in the plans are applicable to the processing of applications submitted directly to the state and when a state must resolve an inconsistency transferred from the Marketplace.

Additionally, many of the program integrity improvements to the Marketplace will also improve the quality of Medicaid/CHIP determinations and assessments made by the Marketplace. Like the Marketplace, Medicaid and CHIP regulations require that an application for Medicaid/CHIP be signed under penalty of perjury.

Tax Filing Requirement

To further protect the integrity of the Marketplace and in accordance with the eligibility process created by the ACA, at the end of the tax year, every tax filer on whose behalf APTC were paid must file a federal income tax return to reconcile the APTC received. The IRS, through the tax filing process, reconciles the difference between the APTC paid to the QHP issuer on the tax filer's behalf and the actual amount of the premium tax credit that the tax filer was entitled to claim. If Marketplace consumers do not file their tax return, they are not eligible to continue to receive APTC. The IRS provides information to Marketplaces on consumers who received APTC in the prior coverage year but have not taken the necessary steps to file a tax return and reconcile.

Due to the normal time lag of data updating in IRS systems and consumers' ability to receive tax filing extensions from the IRS, HHS accepted tax filers' attestations to having filed a tax return beginning with the 2016 open enrollment period. Consumers who were enrolled in Marketplace coverage with APTC in 2015 but did not return to the Marketplace to submit or update their application and select a plan during open enrollment for 2016 coverage, were auto-reenrolled without APTC if IRS data indicated to the Marketplace they had not filed a 2014 tax return and these consumers did not attest that the tax filer had met the requirement to file a tax return and reconcile APTC paid for 2014. After open enrollment, HHS conducted a check of IRS data to confirm whether consumers who were enrolled in Marketplace coverage with APTC and had attested to filing a tax return for 2014 had, in fact, filed a tax return for 2014. These applications are currently being rechecked against IRS data and those that have still not filed a tax return according to IRS data will have their APTC and any income-based CSRs ended for the remainder of coverage year 2016.

Partnership with States

HHS works with all states to address the specific needs of their consumers while also meeting the requirements and responsibilities set by the ACA. The ACA allows individual states to decide which type of Marketplace is best for their state and their residents. To assist states in implementing the ACA's requirements, HHS has awarded grant funding pursuant to section

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1311 of the ACA, provides technical assistance, and conducts monitoring of the State-based Marketplaces (SBMs). As part of ongoing monitoring, SBMs are required to submit semi-annual grant progress reports, monthly budget reports, as well as a State-based Marketplace Annual Reporting Tool (SMART) through which SBMs fulfill key regulatory reporting requirements. As with other federal grant recipients, states that received section 1311 grants are subject to a post-award, ongoing monitoring process to provide technical support and examine whether they are meeting the grant's terms and conditions.

Improving our Programs

HHS looks forward to continuing to benefit from suggestions from our partners in the GAO and HHS OIG on ways to improve our operations so eligible consumers can gain coverage through the Marketplaces and insurance affordability programs in a way that prevents consumer harm and protects taxpayer money. When provided specific findings and recommendations from our partners in the GAO and the HHS OIG, HHS uses that information to improve its programs. For example, the HHS OIG report⁵ about the Marketplace eligibility process helped HHS make further enhancements to our program integrity efforts, in part due to the specific data provided by the HHS OIG during its audit. For this specific GAO investigation, HHS has met with the GAO frequently to better understand the investigation and its findings. While the GAO has not provided details on the fictitious persons they used nor made recommendations to address the findings in this report, HHS continues to make ongoing improvements to strengthen program integrity efforts and Marketplace controls.

⁵ "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-09-14-01001, released August 2015)

Appendix III: Comments from Covered California



August 30, 2016

Christopher H. Schmitt
Senior Analyst
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Mr. Schmitt,

Thank you for providing Covered California the opportunity to review and comment on the U.S. Government Accountability Office's (GAO) draft report entitled, *Patient Protection and Affordable Care Act: Final Results of Undercover Testing of the Federal Marketplace and Selected State Marketplaces for Coverage Year 2015* (GAO-16-792). This performance audit (undercover testing) was conducted in response to a congressional request to continue to examine enrollment and verification controls of the federal marketplace and state marketplaces for the 2015 coverage year. The GAO's examination included testing whether the federal marketplace and state marketplaces are validating an applicant's Social Security number, if one is provided; 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 Social Security Administration, with 18 fictitious identities created by the GAO.

For California, three fictitious identities were used to test verification controls for subsidized qualified health-plan coverage. Specifically, the GAO used impossible Social Security numbers, obtained duplicate coverage concurrently with California and Kentucky, and claimed that a fictitious employer did not provide insurance that met minimum essential coverage. Covered California would like to note that the findings were based on an attribute sample of three enrollments for the 1.4 million who enrolled through Covered California. This letter is in response to the opportunity to review and comment on the draft report.

As part of our efforts to improve the process for handling applications where employer sponsored-coverage is at issue, Covered California began mailing employer notices in August 2016. These notices detail applicant-provided information, minimum essential coverage standards, and inform the employer they could be liable for the shared responsibility payment. The notice also informs employers of their right to appeal with

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August 30, 2016
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the U.S. Health and Human Services agency. As the report notes, California is updating its application process to provide tools to consumers to help them determine whether their employer-sponsored insurance meets minimum essential coverage standards.

In response to duplicate enrollment, there is no current process to identify individuals with duplicate coverage concurrently through different marketplaces. Covered California would like to note that the federal government has not made data available that would allow state marketplaces to identify duplicate enrollment.

Without specific information pertaining to GAO's fictitious applications, Covered California could not comment on specific outcomes. However, our marketplace processes, such as identity-proofing, worked as designed. We are committed to process improvements, with lessons learned from the results of undercover testing, and have put in place many processes to minimize the potential for fraud. For example, in May 2016, Covered California implemented a system check to guard against use of impossible Social Security numbers.

Covered California's information technology system (California Healthcare Eligibility Enrollment and Retention System) and operational processes are designed to make sure all eligible consumers receive coverage through Covered California's exchange. Covered California verifies eligibility factors against federal and state electronic data sources to help ensure only qualified applicants are approved for subsidized coverage. However, Covered California's operational processes are large and complex, which requires effective fraud risk management.

Covered California takes potential vulnerabilities to fraud seriously and strives to take opportunities to consider, enact, and improve measures to detect, deter, and prevent fraud before it occurs. Central to fraud risk management efforts is a focus on consumer protection. Covered California, through its Office of Consumer Protection, has implemented numerous safeguards in the design of its programs and activities to protect consumers and build confidence in the marketplace. Fraud control strategies include promoting program integrity by identifying, investigating, and resolving reported or suspected cases of incidences of fraud, waste and abuse; coordinating efforts within Covered California's divisions by raising awareness of fraud risks and taking the lead in coordinating the dissemination of information; and partnering with other State agencies to refer complaints under their jurisdictions for investigations, coordination with law enforcement, and prosecutors, as appropriate.

Covered California acknowledges there is room to build upon successes as it matures. We thank the engagement team in assisting Covered California in efforts to effect continuous improvement.

Sincerely,



Peter V. Lee
Executive Director

Appendix IV: GAO Contact and Staff Acknowledgments

GAO Contact

Seto J. Bagdoyan, (202) 512-6722 or bagdoyans@gao.gov

Staff Acknowledgments

In addition to the contact named above, Matthew Valenta, Philip Reiff, and Gary Bianchi, Assistant Directors; Maurice Belding, Jr.; Mariana Calderón; Ranya Elias; Colin Fallon; Suellen Foth; Maria McMullen; James Murphy; George Ogilvie; Ramon Rodriguez; Christopher H. Schmitt; Julie Spetz; and Elizabeth Wood made key contributions to this report.

Appendix V: Accessible Data

Agency Comment Letter

Text of Appendix II:
Comments from the
Department of Health and
Human Services

Page 1

DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation

Washington, DC 20201

AUG 26 2016

Seto Bagdoyan

Director, Forensic Audits and Investigative Service

U.S. Government Accountability Office

441 G Street NW Washington, DC 20548

Dear Mr. Bagdoyan:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "Patient Protection and Affordable Care Act: Final Results of Undercover Testing of the Federal Marketplace and Selected State Marketplaces for Coverage Year 2015" (GAO-16-792).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

Jim R. Esquea

Assistant Secretary for Legislation

Attachment

Page 2

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: PATIENT PROTECTION AND AFFORDABLE CARE ACT: FINAL RESULTS OF UNDERCOVER TESTING OF THE FEDERAL MARKETPLACE AND SELECTED STATE MARKETPLACES FOR COVERAGE YEAR 2015 (GAO-16-792)

The Department of Health and Human Services (HHS) appreciates the opportunity to review and comment on the Government Accountability Office's (GAO) draft report. HHS is committed to verifying the eligibility of consumers who apply for enrollment in qualified health plans (QHPs) through a Federally-facilitated Marketplace (Marketplace) or for insurance affordability programs, including Medicaid and the Children's Health Insurance Program (CHIP). HHS takes seriously its responsibilities to protect taxpayer funds, while making coverage available to eligible individuals. As the GAO mentioned in their report, the results cannot be generalized to the overall population of applicants or enrollees.

Marketplace Program Integrity

In order to better protect consumers and taxpayer dollars, HHS is implementing a number of initiatives to enhance operations with a focus on program integrity. HHS has expertise in preventing and detecting fraud, waste, and abuse from its other programs and is applying program integrity best practices to the Marketplace. HHS has experienced program integrity staff that works to prevent and address instances of potential fraud. As recommended by the GAO,¹ HHS is conducting a Marketplace Fraud Risk Assessment, leveraging the GAO's fraud risk framework.² The GAO's framework identifies leading practices for managing fraud risks and was developed to help managers combat fraud and preserve integrity in government agencies and programs. HHS is

¹ "Patient Protection and Affordable Care Act: CMS Should Act to Strengthen Enrollment Controls and Manage Fraud Risk" (GAO-16-29, released February 2016)

² "A Framework for Managing Fraud Risks in Federal Programs" (GAO-15-593SP, released July 2015)

using this framework to identify and prioritize key areas for potential risk in the Marketplace.

If someone provides false or fraudulent information to the Marketplace, HHS, or its law enforcement partners, use their penalty authority, including fines of up to \$250,000 for individuals who knowingly and willfully provide false or fraudulent information to the Marketplace. Issuers may also rescind coverage that has been obtained fraudulently. HHS has trained more than 200 investigators who work for federal law enforcement and special investigations units in private health insurance companies to identify and help stop possible fraudulent activities. HHS meets regularly with law enforcement to identify emerging fraud trends and discuss new fraud detection analytics. HHS has partnered with insurance companies to share information and best practices related to fraud through the Healthcare Fraud Prevention Partnership. In addition, HHS can terminate or immediately suspend its relationships with individuals and organizations that it has approved or registered to help consumers apply and enroll if these individuals or organizations fail to comply with applicable statutes or regulations. HHS continually assesses policies and processes, and makes improvements to protect the Marketplace and its consumers as needed.

The Marketplace Eligibility Verification Process

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HHS uses technology that allows the federal government to provide individuals with real-time, electronic eligibility verification via the Federal Data Services Hub (Hub). The Hub provides a secure electronic connection between the Marketplace and already-existing federal, state, and private databases. These databases are used to verify the eligibility information in each application by matching it against trusted records, including records maintained by the Social Security Administration (SSA), the Internal Revenue Service (IRS), the Department of Homeland Security (DHS), Equifax, the Department of Veterans Affairs, Medicare, Medicaid, CHIP, and TRICARE. Additionally, the Peace Corps and the Office of Personnel Management (OPM) use a secure electronic file transfer process to conduct monthly transmissions of Peace Corps and OPM data to help verify application information about employer-sponsored coverage. The Hub supported tens of millions of data verifications during the first three open enrollment periods. State Medicaid and CHIP agencies also access the verification services available through the Hub to verify eligibility of applicants that apply through the state.

Sometimes an applicant's eligibility cannot be verified in real time by the trusted data source. These situations often involve people who have gained or lost a job, divorced, or changed their name. The verification process relies on the data contained within the trusted data sources, which may be out of date when a consumer submits an application. For example, IRS data is the primary source of income information as required by the Patient Protection and Affordable Care Act (ACA), and it may be up to two years old depending on the most recent tax return filed by the applicant. The statute accounts for these situations. If an applicant provides information that cannot be verified by the trusted data sources, then the statute requires the Marketplace to make a reasonable effort to identify and address the cause of the data inconsistency. For individuals who are assessed as potentially Medicaid or CHIP eligible and whose eligibility cannot be verified through the Hub, the applications are transferred to the state to resolve the data inconsistency, in accordance with Medicaid and CHIP Regulations.

Consistent with the law and regulations, when such an inconsistency is identified, the Marketplace contacts the applicant to confirm the information, and if this does not resolve the issue, provides the applicant the opportunity to present satisfactory documentary evidence to resolve the inconsistency within 90 or 95 days (as applicable, depending on the inconsistency type). Contracted staff review the supporting documentation submitted by applicants to check that it is valid and sufficient to verify the application information before resolving the inconsistency. Contracted reviewers are given examples of valid documents and are trained to escalate possibly invalid or fraudulent documents. Under our operating procedures, if HHS suspects that someone made a fraudulent representation, HHS will investigate the issue, take appropriate administrative action, and/or report the issue to our law enforcement partners in the HHS Office of Inspector General and Department of Justice.

During this inconsistency resolution period, the ACA provides the applicant with eligibility for coverage through the Marketplace or for an insurance affordability program based on the

information they attested to in their application. When submitting the application information required by the ACA, individuals attest, under penalty of perjury, that the information they submit is accurate. Knowingly and willfully providing false or fraudulent information is a violation of federal law and subject to a fine of up to \$250,000.

If an applicant does not provide satisfactory documentation within the required time, the Marketplace will determine the applicant's eligibility based on the information contained within the trusted data sources, as required by the law. In 2015, the Marketplace ended coverage for about 500,000 consumers who failed to produce sufficient documentation on their citizenship or immigration status as requested and required, and about 1.2 million households had their advanced premium tax credit (APTC) and/or cost sharing reduction (CSR) adjusted.³ For 2016 coverage, as of March 31, 2016, the Marketplace ended coverage for approximately 17,000 consumers who failed to produce sufficient documentation on their citizenship or immigration status as requested and required, and 73,000 households had their APTC and/or CSR adjusted.⁴ The Marketplace continues to review documentation submitted by consumers and will continue to end coverage and/or adjust APTC and/or CSR amounts as appropriate.

Medicaid Eligibility

Individuals who apply for coverage at the Marketplace can receive an eligibility decision for APTC, CSR, Medicaid on the basis of modified adjusted gross income (MAGI), or CHIP. States have elected to either have the Marketplace make initial assessments of Medicaid/CHIP eligibility (assessment states) or they have delegated the authority to make MAGI Medicaid and CHIP eligibility determinations to the Marketplace (determination states). When the Marketplace makes a determination or an assessment of Medicaid/CHIP eligibility (or potential eligibility on a non-MAGI basis), the application and verification information and other data used by the Marketplace to make the eligibility decision are transferred to the state through an account transfer process. States served by the Marketplace have built functionality to receive and send account transfers. HHS monitors and reviews these transfers through weekly reporting and provides technical assistance to states on the account transfer process and appropriate handling of accounts received by the state.

³ December 31, 2015 Effectuated Enrollment Snapshot.
<https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-03-11.html>

⁴ March 31, 2016 Effectuated Enrollment Snapshot.
<https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-06-30.html>

The Marketplace also transfers the accounts of individuals who are potentially eligible for Medicaid /CHIP but have a data inconsistency between the application and the trusted sources. The state Medicaid/CHIP agency are responsible for resolving all inconsistencies in accordance with federal verification regulations which may include providing coverage to otherwise eligible individuals while the inconsistency is resolved. Medicaid and CHIP regulations require Medicaid

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and CHIP agencies to file a MAGI Verification Plan with HHS. HHS reviews these plans to ensure they are in compliance with federal verification regulations. The verification procedures reflected in the plans are applicable to the processing of applications submitted directly to the state and when a state must resolve an inconsistency transferred from the Marketplace.

Additionally, many of the program integrity improvements to the Marketplace will also improve the quality of Medicaid/CHIP determinations and assessments made by the Marketplace. Like the Marketplace, Medicaid and CHIP regulations require that an application for Medicaid/CHIP be signed under penalty of perjury.

Tax Filing Requirement

To further protect the integrity of the Marketplace and in accordance with the eligibility process created by the ACA, at the end of the tax year, every tax filer on whose behalf APTC were paid must file a federal income tax return to reconcile the APTC received. The IRS, through the tax filing process, reconciles the difference between the APTC paid to the QHP issuer on the tax filer's behalf and the actual amount of the premium tax credit that the tax filer was entitled to claim. If Marketplace consumers do not file their tax return, they are not eligible to continue to receive APTC. The IRS provides information to Marketplaces on consumers who received APTC in the prior coverage year but have not taken the necessary steps to file a tax return and reconcile.

Due to the normal time lag of data updating in IRS systems and consumers' ability to receive tax filing extensions from the IRS, HHS accepted tax filers' attestations to having filed a tax return beginning with the 2016 open enrollment period. Consumers who were enrolled in Marketplace coverage with APTC in 2015 but did not return to the Marketplace to submit or update their application and select a plan during open enrollment for 2016 coverage, were auto-reenrolled without APTC if

IRS data indicated to the Marketplace they had not filed a 2014 tax return and these consumers did not attest that the tax filer had met the requirement to file a tax return and reconcile APTC paid for 2014. After open enrollment, HHS conducted a check of IRS data to confirm whether consumers who were enrolled in Marketplace coverage with APTC and had attested to filing a tax return for 2014 had, in fact, filed a tax return for 2014. These applications are currently being rechecked against IRS data and those that have still not filed a tax return according to IRS data will have their APTC and any income-based CSRs ended for the remainder of coverage year 2016.

Partnership with States

HHS works with all states to address the specific needs of their consumers while also meeting the requirements and responsibilities set by the ACA. The ACA allows individual states to decide which type of Marketplace is best for their state and their residents. To assist states in implementing the ACA's requirements, HHS has awarded grant funding pursuant to section

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1311 of the ACA, provides technical assistance, and conducts monitoring of the State-based Marketplaces (SBMs). As part of ongoing monitoring, SBMs are required to submit semi-annual grant progress reports, monthly budget reports, as well as a State-based Marketplace Annual Reporting Tool (SMART) through which SBMs fulfill key regulatory reporting requirements. As with other federal grant recipients, states that received section 1311 grants are subject to a post-award, ongoing monitoring process to provide technical support and examine whether they are meeting the grant's terms and conditions.

Improving our Programs

HHS looks forward to continuing to benefit from suggestions from our partners in the GAO and HHS OIG on ways to improve our operations so eligible consumers can gain coverage through the Marketplaces and insurance affordability programs in a way that prevents consumer harm and protects taxpayer money. When provided specific findings and recommendations from our partners in the GAO and the HHS OIG, HHS uses that information to improve its programs. For example, the HHS OIG

report⁵ about the Marketplace eligibility process helped HHS make further enhancements to our program integrity efforts, in part due to the specific data provided by the HHS OIG during its audit. For this specific GAO investigation, HHS has met with the GAO frequently to better understand the investigation and its findings. While the GAO has not provided details on the fictitious persons they used nor made recommendations to address the findings in this report, HHS continues to make ongoing improvements to strengthen program integrity efforts and Marketplace controls.

Text of Appendix III:
Comments from Covered
California

Page 1

COVERED CALIFORNIA

August 30, 2016

Christopher H. Schmitt

Senior Analyst

U.S. Government Accountability Office

441 G Street NW

Washington, DC 20548

Dear Mr. Schmitt,

Thank you for providing Covered California the opportunity to review and comment on the U.S. Government Accountability Office's (GAO) draft report entitled, Patient Protection and Affordable Care Act: Final Results of Undercover Testing of the Federal Marketplace and Selected State

⁵ "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-09-14-01001, released August 2015)

Marketplaces for Coverage Year 2015 (GAO-16-792). This performance audit (undercover testing) was conducted in response to a congressional request to continue to examine enrollment and verification controls of the federal marketplace and state marketplaces for the 2015 coverage year. The GAO's examination included testing whether the federal marketplace and state marketplaces are validating an applicant's Social Security number, if one is provided ; 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 Social Security Administration, with 18 fictitious identities created by the GAO.

For California, three fictitious identities were used to test verification controls for subsidized qualified health-plan coverage. Specifically, the GAO used impossible Social Security numbers, obtained duplicate coverage concurrently with California and Kentucky, and claimed that a fictitious employer did not provide insurance that met minimum essential coverage. Covered California would like to note that the findings were based on an attribute sample of three enrollments for the 1.4 million who enrolled through Covered California. This letter is in response to the opportunity to review and comment on the draft report.

As part of our efforts to improve the process for handling applications where employer sponsored-coverage is at issue, Covered California began mailing employer notices in August 2016. These notices detail applicant-provided information, minimum essential coverage standards, and inform the employer they could be liable for the shared responsibility payment. The notice also informs employers of their right to appeal with

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the U.S. Health and Human Services agency. As the report notes, California is updating its application process to provide tools to consumers to help them determine whether their employer-sponsored insurance meets minimum essential coverage standards.

In response to duplicate enrollment, there is no current process to identify individuals with duplicate coverage concurrently through different marketplaces. Covered California would like to note that the federal government has not made data available that would allow state marketplaces to identify duplicate enrollment.

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Covered California acknowledges there is room to build upon successes as it matures. We thank the engagement team in assisting Covered California in efforts to effect continuous improvement.

Sincerely,

Peter V. Lee Executive Director

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