



September 2016

PATIENT PROTECTION AND AFFORDABLE CARE ACT

Results of Undercover Enrollment Testing for the Federal Marketplace and a Selected State Marketplace for the 2016 Coverage Year

GAO Highlights

Highlights of [GAO-16-784](#), 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. States may operate their own health-care marketplace or rely on the federal Health Insurance Marketplace (Marketplace). The Congressional Budget Office estimates subsidies and related spending under PPACA at \$56 billion for fiscal year 2017.

GAO was asked to review marketplace enrollment and verification controls for the act's third open-enrollment period ending in January 2016. This report provides results of GAO undercover testing of potential vulnerabilities to fraud in the application, enrollment, and eligibility-verification of the federal Marketplace and one selected state marketplace.

GAO submitted 15 fictitious applications for subsidized coverage through the federal Marketplace in Virginia and West Virginia and through the state marketplace in California. GAO's applications tested verifications related to (1) applicants' making required income-tax filings, and (2) applicants' identity or citizenship/immigration status. The results, while illustrative, cannot be generalized to the full population of enrollees. GAO discussed results with CMS, IRS, and state officials. Written comments from HHS and California are included in the report.

GAO currently has eight recommendations to CMS to strengthen its oversight of the federal Marketplace (see [GAO-16-29](#)). CMS concurred with the recommendations and implementation is pending.

View [GAO-16-784](#). For more information, contact Seto J. Bagdoyan at (202) 512-6722 or bagdoyans@gao.gov.

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What GAO Found

The Patient Protection and Affordable Care Act (PPACA) requires health-insurance marketplaces to verify application information to determine eligibility for enrollment and, if applicable, determine eligibility for income-based subsidies. Verification steps include validating the applicant's Social Security number, if one is provided; citizenship or immigration status; and household income. PPACA requires the marketplaces to grant eligibility while identified inconsistencies between the information provided by the applicant and by government sources are being resolved. The 2016 coverage year was the first year in which a key eligibility requirement—verification of whether applicants who previously received one type of federal subsidy under the act filed federal tax returns, as a requirement to retain that benefit—went into effect.

As previously reported for the 2014 and 2015 coverage years, GAO's undercover testing for the 2016 coverage year found that the health-care marketplaces' eligibility determination and enrollment processes remain vulnerable to fraud. The marketplaces initially approved coverage and subsidies for GAO's 15 fictitious applications. However, three applicants were unable to put their policies in force because their initial payments were not successfully processed. GAO focused its testing on the remaining 12 applications.

- For four applications, to obtain 2016 subsidized coverage, GAO used identities from its 2014 testing that had previously obtained subsidized coverage. Although none of the fictitious applicants filed a 2014 tax return, all were approved for 2016 subsidies. Marketplace officials told GAO that they allowed applicants to attest to filing taxes if information from the Internal Revenue Service (IRS) indicated that the applicant did not file tax returns. Marketplace officials said one reason they allow attestations is a time lag between when tax returns are filed and when they are reflected in IRS's systems. CMS officials said they are rechecking 2014 tax-filing status.
- For eight applications, GAO used new fictitious identities to test verifications related to identity or citizenship/immigration status and, in each case, successfully obtained subsidized coverage.

When marketplaces directed 11 of the 12 applicants to provide supporting documents, GAO submitted fictitious documents as follows:

- For five applications, GAO provided all documentation requested and the applicants were able to retain coverage.
- For three applications, GAO provided only partial documentation and the applicants were able to retain coverage. Two of these applicants were able to clear inconsistencies through conversations with marketplace phone representatives even though the information provided over the phone did not match the fictitious documentation that GAO previously provided.
- For three applications, GAO did not provide any of the requested documents, and the marketplaces terminated coverage for one applicant but did not terminate coverage for the other two applicants.

According to officials from the Department of Health and Human Services' (HHS) Centers for Medicaid & Medicare Services (CMS), some of GAO's application outcomes could be explained by decisions to extend document filing deadlines.

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Abbreviations

APTC	advance premium tax credit
CMS	Centers for Medicare & Medicaid Services
CSR	cost-sharing reduction
data hub	data services hub
HCERA	Health Care and Education Reconciliation Act of 2010
HHS	Department of Health and Human Services
IRS	Internal Revenue Service
Marketplace	Health Insurance Marketplace
PPACA	Patient Protection and Affordable Care Act
SSA	Social Security Administration

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September 12, 2016

Congressional Requesters

The Patient Protection and Affordable Care Act (PPACA), signed into law in March 2010, offers subsidized health-care coverage for qualifying applicants, expands the availability of Medicaid, and provides for the establishment of health-insurance exchanges, or marketplaces, to help consumers compare and select among plans offered by participating private issuers of health-care coverage.¹ In January 2016, the third open-enrollment season conducted under the act was completed. This period was the first year in which a key eligibility requirement—verification of whether applicants who previously received one type of federal subsidy under the act filed federal tax returns, as a requirement to retain that benefit—went into effect.

Under PPACA, states may elect to operate their own health-care marketplaces, or may rely on the federally facilitated marketplace, or Health Insurance Marketplace (Marketplace), often known to the public as HealthCare.gov.² The Centers for Medicare & Medicaid Services (CMS), a unit of the Department of Health and Human Services (HHS), is responsible for overseeing the establishment of these marketplaces, and the agency maintains the federally facilitated marketplace.

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 through 2026. While subsidies under the act are generally not paid

¹Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA), Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010). In this report, references to PPACA include any amendments made by HCERA.

²Specifically, the act required, by January 1, 2014, the establishment of health-insurance marketplaces in all states. In states not electing to operate their own marketplaces, the federal government was required to operate a marketplace.

directly to enrollees, participants nevertheless benefit financially through reduced monthly premiums or lower costs due at time of service, such as copayments.³ Because subsidy costs are contingent on eligibility for coverage, enrollment controls that help ensure only qualified applicants are approved for coverage with subsidies are a key factor in determining federal expenditures under the act.⁴ In addition, PPACA provided for the expansion of the Medicaid program.⁵

In light of the government's substantial financial commitment under the act, you asked us to examine marketplace enrollment and verification controls. In July 2014 and July 2015, we testified on results of undercover applications for the 2014 coverage year—the first under the act—for the federal Marketplace, including the maintenance of fictitious applicant identities and provision of coverage through 2014 and into 2015.⁶ In October 2015, we testified on preliminary results of fictitious undercover applications for the 2015 coverage year for the federal Marketplace and selected state-based marketplaces.⁷ In February 2016, we issued a report addressing CMS enrollment controls and the agency's

³Enrollees can pay lower monthly premiums by virtue of a tax credit the act provides. They may elect to receive the benefit of the tax credit in advance, to lower premium cost, or to receive it at time of income-tax filing, which reduces tax liability. See discussion of the advance premium tax credit (APTC) reconciliation process later in this report.

⁴According to CMS data, as of March 31, 2016, about 11.1 million people had marketplace coverage—8.4 million through the 38 states using the HealthCare.gov system and 2.7 million through state-based marketplaces. Among the 11.1 million, about 85 percent were receiving the APTC subsidy, and about 57 percent were receiving the cost-sharing reduction subsidy (both subsidies described later in this report) provided by the act.

⁵PPACA 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.

⁶Respectively, GAO, *Patient Protection and Affordable Care Act: Preliminary Results of Undercover Testing of Enrollment Controls for Health Care Coverage and Consumer Subsidies Provided Under the Act*, [GAO-14-705T](#) (Washington, D.C.: July 23, 2014); and *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).

⁷GAO, *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).

management of enrollment fraud risk. On the basis of our 2014 undercover testing and related work, that report included eight recommendations to CMS to strengthen its oversight of the federal Marketplace.⁸

This report describes potential vulnerabilities to fraud in the application, enrollment, and eligibility-verification controls of the federal Marketplace and a selected state marketplace for the act's third open-enrollment period and for 2016 coverage, based on undercover testing involving fictitious applicants.

To perform our undercover testing of the application, enrollment, and eligibility-verification controls for the 2016 open-enrollment season—which ran from November 1, 2015, to January 31, 2016—we used 15 fictitious identities for the purpose of making applications for individual health-care coverage and Medicaid by telephone and online.⁹ Because the federal government, at the time of our review, operated a marketplace on behalf of the state in about three-quarters of the states, we focused our work on those states.¹⁰ Specifically, we selected two states—Virginia and West Virginia—that elected to use the federal Marketplace rather than operate a marketplace of their own. We selected one additional state—California—that operates its own marketplace, known as Covered California.¹¹ The results obtained using our limited number of fictional

⁸GAO, *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). CMS concurred with our recommendations, and implementation is pending.

⁹For 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.

¹⁰Specifically, according to HHS, for the 2016 coverage year, there were 38 states using the HealthCare.gov system. Among all consumer health-plan selections, about 76 percent (8.4 million) were in states using the HealthCare.gov system.

¹¹These selections allowed us to include one state-based marketplace, one federal Marketplace state that expanded Medicaid eligibility, and one federal Marketplace state that did not expand Medicaid. In the case of our state marketplace selected for testing, we previously included the state in our 2015 undercover testing. By selecting it again for 2016, we would be in a position to compare application experiences over time. Likewise, Virginia and West Virginia were part of our 2014 testing. To preserve confidentiality of our applications, we do not disclose here any identifying information below the state level, such as location of our fictitious applicants.

applicants are illustrative and represent our experience with applications in the three states we selected. The results cannot, however, be generalized to the overall population of applicants or enrollees.

Our testing covered both individual health-care plans and Medicaid—specifically, 14 applications for individual plans, and 1 application for Medicaid. A portion of the applications focused on a requirement that applicants who previously received advance payment of tax credits to subsidize their monthly premium payments must file federal income-tax returns and account for those subsidies in order to continue receiving that benefit. In our 15 applicant scenarios, we chose to test controls related to (1) whether certain applicants had made required income-tax filings, and (2) the identity or citizenship/immigration status of the applicant. In general, our approach allowed us to test similar scenarios across different states. We made 10 of our applications online initially and 5 by phone. In some cases, we filed paper applications, as is permissible, after speaking with marketplace representatives. We set our applicants' income levels at amounts eligible for subsidies provided under the act, or to meet Medicaid eligibility requirements, as appropriate.

After conducting our undercover testing, we briefed officials from CMS, the California marketplace, and the West Virginia state Medicaid agency on our results.¹² To protect our fictitious identities, we did not disclose specific applicant identity information. CMS and state officials generally told us that without such information they could not fully research handling of our applicants. We also reviewed statutes, regulations, and other policy and related information. Appendix I provides a more detailed description of our scope and methodology.

We conducted this performance audit from November 2015 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 objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective. We conducted our related

¹²Because Virginia uses the federal Marketplace, we discussed results of our Virginia applications with CMS.

investigative work in accordance with investigative standards prescribed by the Council of the Inspectors General on Integrity and Efficiency.

Background

Under PPACA, health-insurance marketplaces were intended to provide a single point of access for individuals to enroll in participating private health plans, apply for income-based subsidies to offset the cost of these plans, and, as applicable, obtain an eligibility determination or assessment of eligibility for other health-coverage programs, such as Medicaid or the Children’s Health Insurance Program.¹³

To be eligible to enroll in a “qualified health plan” offered through a marketplace—that is, one providing essential health benefits and meeting other requirements under PPACA—an individual must be a U.S. citizen or national, or otherwise lawfully present in the United States; reside in the marketplace service area; and not be incarcerated (unless incarcerated while awaiting disposition of charges).¹⁴ 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.

Under the Medicaid 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 fiscal year 2016 for the Medicaid expenditures of “newly eligible” individuals who gained Medicaid eligibility through the expansion.¹⁵ According to the CMS Office of the Actuary, federal expenditures for the

¹³Individuals may also continue to apply for Medicaid coverage or the Children’s Health Insurance Program through direct application to their respective state agencies.

¹⁴In this report, we use “qualified health plan” to refer to coverage obtained from private insurers through a marketplace, as distinguished from enrollment in a public health program such as Medicaid.

¹⁵The “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.

Medicaid expansion are estimated at \$430 billion from 2014 through 2023.¹⁶

PPACA requires marketplaces 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;¹⁷ verifying citizenship, status as a U.S. national, or lawful presence by comparison with Social Security Administration (SSA) or Department of Homeland Security records; and verifying household income by comparison with tax-return data from the Internal Revenue Service (IRS), data on Social Security benefits from SSA, and other available current income sources.¹⁸

In particular, 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 (data 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.¹⁹ The Marketplace uses the data hub in

¹⁶According to the CMS Office of the Actuary, newly eligible adult enrollment is projected to reach 12.0 million people by 2023, representing 15 percent of total projected program enrollment. Expenditures for newly eligible adults are projected to total \$460 billion for 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.

¹⁷A 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.

¹⁸For 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).

¹⁹For our evaluation of the data hub from an enrollment and eligibility-verification perspective, see [GAO-16-29](#).

an attempt to verify that applicant information necessary to support an eligibility determination is consistent with external data sources.

For qualifying applicants, the act provides two possible forms of subsidies for consumers enrolling in individual health plans, both of which are generally paid directly to insurers on consumers' behalf. One is a federal income-tax credit, which enrollees may elect to receive in advance, and which reduces a consumer's monthly premium payment.²⁰ When taken in advance, this benefit is known as the advance premium tax credit (APTC). The other, known as cost-sharing reduction (CSR), is a discount that lowers the amount consumers pay for out-of-pocket charges for deductibles, coinsurance, and copayments.²¹

Under PPACA, an applicant's filing of a federal income-tax return, including a required additional form, is a significant eligibility requirement for continued receipt of federal subsidies. When applicants apply for coverage, they report family size and the amount of projected income. On the basis, in part, of that information, the Marketplace will calculate the maximum allowable amount of APTC. An applicant can then decide whether 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.

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 income-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

²⁰If enrollees do not choose to receive the income-tax credit in advance, they may claim it later when filing tax returns.

²¹In certain circumstances, receipt of the premium tax credit subsidy could effectively result in a payment directly to an enrollee. For example, a person could be eligible for the premium tax credit; could elect not to receive the credit in advance, but instead claim it at the time of filing a federal income-tax return; and could have an overall tax liability such that the credit produces a refund that otherwise would not have been due. In such cases, receiving the subsidy would be akin to a direct payment from the government. As noted, however, when the credit is taken in advance, payments are made to an insurer on the consumer's behalf.

size.²² Reconciliation is accomplished using IRS Form 8692, Premium Tax Credit (PTC). To receive advance payment of the tax credit at time of application, applicants must attest they will file a tax return for the year for which they receive APTC. CMS announced that, beginning with the open-enrollment period for 2016 coverage, APTC and CSR subsidies will be discontinued for 2016 coverage for enrollees who received APTC in 2014, but did not comply with the requirement to file a federal income-tax return and reconcile receipt of their APTC subsidy.²³

Under PPACA's application process, "inconsistencies" are generated when individual applicant information does not match information from federal data sources—either because information an applicant provided does not match information contained in data sources that a marketplace uses for eligibility verification at the time of application, or because 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. Under the marketplace process, applicants will be asked to provide additional information or documentation for the marketplaces to review to resolve the inconsistency.

²²The actual premium tax credit due for the year will differ from the advance tax-credit amount calculated by the Marketplace if family size and income as estimated at the time of application are different from family size and household income reported on the tax return. If the actual allowable credit is less than the advance payments, the difference, subject to certain caps, will be subtracted from the applicant's tax refund or added to the applicant's balance due. On the other hand, if the allowable credit is more than the advance payments, the difference is added to the tax refund or subtracted from the balance due.

²³For more information on IRS implementation of the APTC reconciliation process, see [GAO-15-540](#). That report detailed, among other things, that as of July 2015 incomplete and delayed marketplace data limited IRS's ability to match taxpayer premium tax-credit claims to marketplace data at the time of tax-return filing. In addition, IRS did not know the total amount of APTC payments made to insurers for 2014 marketplace policies, because marketplace data were incomplete. Without this information, IRS did not know the aggregate amount of APTC that taxpayers should have reported on 2014 tax returns or the extent of noncompliance with the requirement for APTC recipients to accurately report those amounts on their tax returns.

The Marketplaces Approved Subsidized Coverage for All 15 of Our Fictitious Applicants, Including Those Who Had Not Filed Required Tax Returns

Our undercover testing for the 2016 coverage year found that the eligibility determination and enrollment processes of the federal and state marketplaces we reviewed remain vulnerable to fraud, as we previously reported for the 2014 and 2015 coverage years. For each of our 15 fictitious applications, the marketplaces approved coverage, including for 6 fictitious applicants who had previously obtained subsidized coverage but did not file the required federal income-tax returns. Although IRS provides information to marketplaces on whether health-care applicants have filed required returns, the federal Marketplace and our selected state marketplace allowed applicants to instead attest that they had filed returns, saying the IRS information was not sufficiently current. The marketplaces we reviewed also relaxed documentation standards or extended deadlines for filing required documentation. After initial approval, all but one of our fictitious enrollees maintained subsidized coverage, even though we sent fictitious documents, or no documents, to resolve application inconsistencies. Marketplace officials told us that without specific identities of our fictitious applicants—which we declined to provide, to protect the identities—they could not comment on individual outcomes. In general, however, they told us our results indicate their marketplace processes worked as designed.

Results of Applications

For each of our 15 fictitious applications, the federal or state-based marketplaces approved coverage at time of application—specifically, 14 applications for qualified health plans, and 1 application for Medicaid.²⁴ Each of the 14 applications for qualified health plans was also approved for APTC subsidies. These subsidies totaled about \$5,000 on a monthly basis, or about \$60,000 annually. These 14 qualified-health-plan applications also each obtained CSR subsidies, putting the applicants in a position to further benefit if they used medical services. However, our successful applicants did not seek medical services. These subsidies are not paid directly to enrolled consumers; instead, the federal government pays them to health-plan issuers on consumers' behalf.

²⁴According to CMS officials, when individuals apply through a marketplace for coverage with financial assistance, they complete a single application that is an application for all insurance-affordability programs; that is, people 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 application" throughout this report. The application is signed under penalty of perjury, the officials noted.

For the first time in our three rounds of undercover application testing since the 2014 coverage year, we successfully cleared an online identity-checking step for one fictitious applicant. Known as “identity proofing,” the process uses personal and financial history on file with a credit-reporting agency. The marketplace generates questions that only the applicant is believed likely to know. According to CMS, the purpose of identity proofing is to prevent someone from creating an account and applying for health coverage based on someone else’s identity and without the other person’s knowledge. Although intended to counter such identity theft involving others, identity proofing also serves as an enrollment control for those applying online.

For our 2014 and 2015 undercover testing, we failed to clear identity proofing in each online application we made.²⁵ In this latest round of testing, we cleared identity proofing in one online application by successfully answering the identity questions presented: (1) name the county for the applicant address provided, (2) identify the high school from which the applicant graduated, and (3) identify the last four digits of a cellular phone number.²⁶ Although our applicant’s identity was fictitious, the eligibility system may still have been able to generate questions based on a “likely” match, CMS officials told us.

For our state marketplace applications, in four of five cases, marketplace representatives were unable to verify our applicants’ identities and, as a result, suggested that we visit enrollment counselors to present identification in person. As a representative said to one of our applicants, “I can’t look at your picture ID” and, “I have to be able to confirm that you are who you say you are ... in case you were an impostor calling us.” We avoided such in-person visits, however, by filing paper applications (which under PPACA must be an option available to applicants). In such cases, an applicant signature is provided under penalty of perjury and threat of civil or criminal penalty. In our paper applications, we provided signatures for our fictitious identities and filed the forms. In another of the state

²⁵In our first round of testing, for 2014 coverage, we failed to clear the online identity checking step for six fictitious online applicants. In the second round, for 2015, we failed to clear the online identity check in eight cases.

²⁶Because all of our applicants were fictitious, our answers, when provided, were fictitious as well.

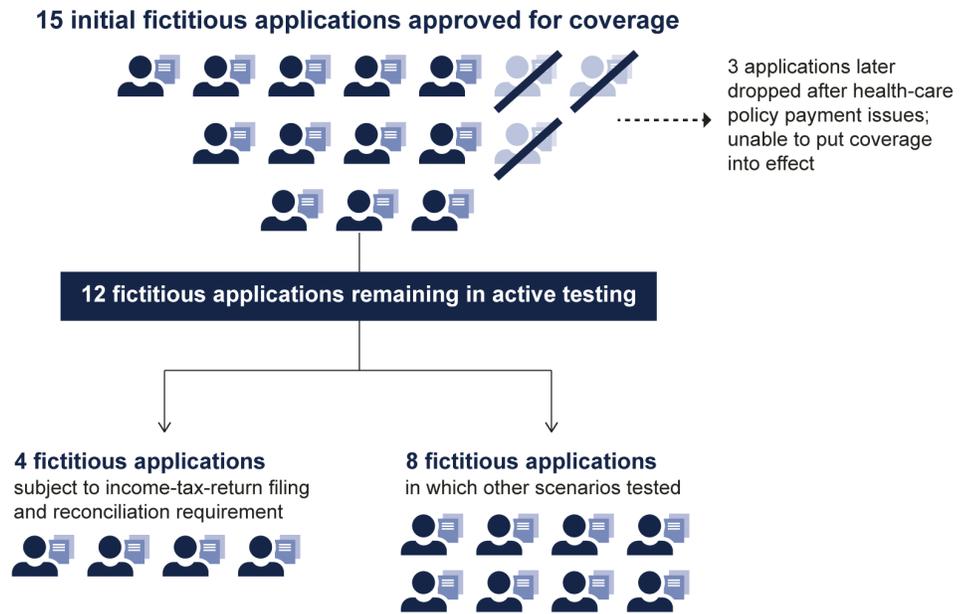
marketplace cases, we were able to complete the application over the phone, without being asked identity-proofing questions. Our federal Marketplace applicants received no similar instructions on visiting enrollment counselors or submitting paper applications.

For the 14 qualified-health-plan applications, we attempted to pay the required premiums to put policies into force, as we did in both of our previous rounds of testing. For 11 applicants, we successfully made premium payments. However, for three applicants, our initial premium payments—made to insurers we selected—were unsuccessful, and we were unable to resolve the issue. While we believed we had received confirmation of premium payments, insurers said payments were not received on a timely basis.²⁷ As a result, our coverage was not put into effect in these three cases. At that point, because these cases had experienced different treatment than our other applications and no longer matched our original testing profile, we elected to discontinue them from further testing.²⁸ Thus, the remainder of our discussion centers on the 12 cases for which we did not encounter payment issues—11 applications for qualified health plans, and 1 for Medicaid. As discussed in following sections, we divided the remaining 12 cases into those involving reconciliation of APTC subsidies and those involving other issues. Figure 1 shows a breakdown of our applications, from the original group of 15 down to the division into the tax-filing and other-issue groups.

²⁷Specifically, we made payments by telephone, and received confirmation numbers for the transactions. Later, our applicants received notices stating that payment processing was unsuccessful. We subsequently contacted the marketplace and insurers, but were unable to resolve the issue.

²⁸Specifically, when we learned of the difficulties with the payments we believed had been made, we made inquiries to marketplace representatives and attempted to restore coverage. The representatives, however, told our applicants that to seek restoration they must go through a formal appeals process. On the basis of that information, we elected to discontinue further testing with these applications, because the focus of our work was the eligibility and enrollment process, and not other matters, such as the appeals process.

Figure 1: Summary of GAO’s Fictitious Applications for 2016 Open-Enrollment Testing for PPACA Coverage through the Marketplaces



Source: GAO. | GAO-16-784

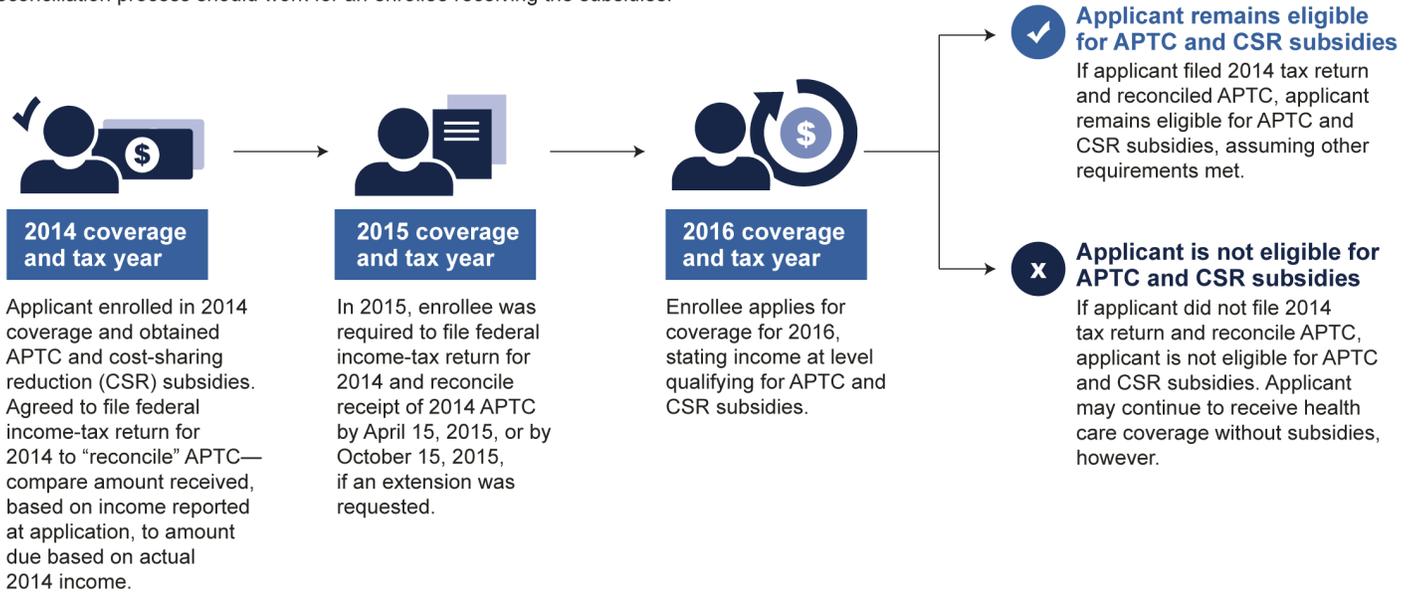
Marketplaces Approved Subsidies for Fictitious Applicants Who Had Previously Obtained Subsidized Coverage but Did Not File Required Tax Returns

CMS announced that beginning with the open-enrollment period for 2016 coverage, APTC and CSR subsidies would be discontinued for 2016 coverage for enrollees who received APTC in 2014 but did not comply with the requirement to file a 2014 federal income-tax return and reconcile APTC received.²⁹ Figure 2 illustrates how the reconciliation process is designed to work, and how failing to reconcile is to affect the ability to retain subsidized coverage. As discussed later, IRS tax-return processing time, and taxpayer-requested extension of the filing deadline, can affect the timeliness of tax-filing data that IRS reports to marketplaces.

²⁹Eligibility for income-based CSRs for most applicants is tied to eligibility for APTC. Thus, according to CMS, enrollees who do not file and reconcile APTC for 2014 would be determined ineligible for APTC for the 2016 plan year and therefore also ineligible for income-based CSRs.

Figure 2: Reconciling Receipt of Prior APTC Subsidies to Obtain Current Plan Year Subsidies under PPACA

According to the Centers for Medicare & Medicaid Services, beginning with 2016 open enrollment, the federal Health Insurance Marketplace is enforcing a requirement that, to continue to receive income-based subsidies, enrollees must file an income-tax return and “reconcile” receipt of previous advance premium tax credits (APTC). Shown below is an example of how the reconciliation process should work for an enrollee receiving the subsidies:



Source: GAO. | GAO-16-784

Notes: In general, individuals and families may be eligible for APTC if household income is at least 100 percent but no more than 400 percent of the federal poverty level for their family size. In addition, APTC and CSR are available for those selecting “Silver” qualified health plans and with income from 100 percent to 250 percent of the federal poverty level. However, a consumer who is ineligible for APTC is generally ineligible for income-based CSRs.

Because reconciliation is a key requirement for receipt of subsidies, and CMS announced that loss of subsidy would be enforced for the first time in 2016, we focused a number of our undercover applicant scenarios on this process. At the outset of our testing, we made 6 of our 15 applications using identities from our 2014 testing, when we obtained

subsidized coverage for them.³⁰ After the payment-processing issue noted earlier, four of these six identities remained in active testing.

In addition to obtaining coverage, each of the four remaining fictitious applicants was also approved for APTC subsidies. For these four applicants, these subsidies totaled about \$1,100 on a monthly basis, or about \$13,000 annually. They also obtained CSR subsidies. Figure 3 summarizes results by scenario.

Figure 3: Summary of Outcomes for Four Fictitious Applicants Who Had Not Filed Required 2014 Federal Income-Tax Return, as of August 2016

Marketplace type	State	Applicant asked whether filed 2014 income-tax return?	Obtained subsidized qualified health-plan coverage?	Maintained subsidized coverage?
▶ Federal	West Virginia	Yes	✓ Yes	✓ Yes
▶ Federal	West Virginia	Yes	✓ Yes	✓ Yes
▶ State	California	No	✓ Yes	✓ Yes
▶ State	California	No	✓ Yes	✓ Yes

Source: GAO. | GAO-16-784

Notes: These applicants used fictitious identities created for our 2014 undercover testing. At the time of our 2014 testing, these applicants employed various scenarios, such as citizenship/immigration status or invalid Social Security identity, where applicant information did not match Social Security Administration records. At the time, we submitted fictitious documentation to the Marketplace in a fashion similar to that described later in this report for the remainder of our 2016 undercover applicants. See [GAO-15-702T](#) for a full description of the 2014 testing from which these identities were drawn.

In two of the four cases, Marketplace representatives asked our applicants if they had filed the requisite income-tax return, to which they replied falsely that they had done so. For one of these applicants, a federal Marketplace representative initially told us that we were not

³⁰See [GAO-15-702T](#). Although we used identities from our 2014 testing, we did not maintain coverage continuously from 2014 to 2016. Notwithstanding that break in coverage, the reconciliation requirement remained for our applicants who had received APTC in 2014.

approved for subsidies, for tax-related reasons.³¹ However, when we provided the representative with verbal assurances that we had filed the necessary tax return, the representative dropped the matter, and we were approved for subsidized coverage. In May 2016, we received a Marketplace notice stating that if we do not file a 2014 tax return and reconcile APTC, our subsidies would end. As of August 2016, our subsidized coverage remained in force.

In the two other of the four cases, our fictitious state marketplace applicants were not asked whether they received APTC subsidies in 2014 or whether they filed income-tax returns. As noted earlier, for our state marketplace applicants, we filed some applications by paper form. The state marketplace's paper application form, however, did not ask whether we had filed a 2014 tax return, or otherwise require us to demonstrate that we had filed the return.

About \$4 Billion in 2014 APTC
Has Not Been Reconciled,
According to IRS

To support the tax-reconciliation requirement, IRS began reporting to federal and state-based marketplaces, in response to 2016 queries made to the data hub, cases in which an applicant or a member of the applicant's tax household received APTC subsidies for 2014 but had not filed a 2014 income-tax return.³² IRS reports subsidy-recipient tax-return filing status based on information received from marketplaces on who received APTC subsidies. It matches the marketplace-provided information against records of who has filed tax returns, to identify those

³¹ Although we called marketplace representatives about various issues associated with our applications, we were not in a position to know what specific information the representatives may have had access to in their respective systems.

³² The full requirement for subsidy recipients is to *file* a tax return, and as part of that return, include IRS form 8962 to *reconcile* receipt of the subsidy. As indicated in table 1, some subsidy recipients file a return, but do not perform the required APTC reconciliation. For the 2016 open-enrollment period, the data IRS provided to marketplaces for subsidy recipients identified only those failing to file a return. Beginning with 2017 open enrollment, IRS officials said the agency plans to report more refined information to marketplaces, for applicants: (1) not filing a tax return at all, (2) not filing by virtue of having obtained an extension of the normal filing deadline, or (3) filing a tax return but failing to complete the form that provides for reconciliation. However, even though IRS provided marketplaces only with failure-to-file information for 2016 open enrollment, taxpayers still remain obligated to file returns and reconcile APTC subsidies, IRS officials told us.

reported as receiving subsidies but who did not file a return.³³ As shown in table 1, about one-quarter of 2014 APTC—totaling about \$4 billion—had not been reconciled as of December 2015, according to summary information provided by IRS.

Table 1: Unreconciled and Reconciled 2014 APTC as of December 2015, as Reported by IRS

	Number of filers	Sum of advance premium tax credit (APTC) (dollars)
Unreconciled APTC		
Nonfilers with tax-filing extension	88,419	287,861,129
Nonfilers without tax-filing extension	290,015	524,605,457
Filers with no Form 8962 for reconciliation	1,027,222	3,182,979,767
Total	1,405,656	3,995,446,363
Reconciled APTC		
Reconciled with IRS Form 8962	3,273,515	11,439,663,631
Total unreconciled and reconciled APTC	4,679,171	15,435,109,984

Source: IRS, Compliance Data Warehouse. | GAO-16-784

As table 1 indicates, the largest category for unreconciled APTC, both in number of filers and value of APTC, is those who filed tax returns, but did not, as part of their filing, complete the necessary form for reconciliation. Although IRS reports to marketplaces whether an applicant has filed a tax return, it does not make eligibility determinations for APTC on applications for coverage. Instead, it passes the filing information to marketplaces, which then make the determinations. As IRS officials noted to us, reporting that an applicant has not filed a required tax return ends IRS's role.

³³IRS's determinations of applicant tax-filing status likely understate the true number of people who have not filed as required. As we have described previously, information IRS receives from marketplaces does not always contain information that is complete enough—such as including a Social Security number—for IRS to match marketplace-supplied health-coverage data against its tax-filing records. See [GAO-16-29](#) for details. As a result, IRS may not identify all applicants who received 2014 APTC subsidies but did not file a 2014 tax return.

The Federal Marketplace Generally Chose Not to Rely on IRS Failure-to-File Data

In the case of the federal Marketplace, CMS generally elected not to rely on the IRS data identifying 2014 subsidy recipients who failed to file income-tax returns when making federal Marketplace eligibility determinations for 2016. Instead, if IRS reported that applicants had not filed a tax return, CMS chose to offer applicants the opportunity to attest they had made the proper tax filing, to be followed by CMS postapproval checks of IRS data.³⁴

CMS officials told us they chose to allow applicant attestations of tax filing, rather than rely solely on IRS failure-to-file data, for two reasons:

- Time lag between when tax returns are filed and when filings are reflected in information IRS provides to marketplaces. This is due to: normal IRS processing time; additional time required to update tax-return-filing status in information provided to marketplaces; and because taxpayers can request a tax-filing deadline extension, to October 15, beyond the normal filing date of April 15. IRS officials told us that assuming a return is complete, normal processing time is typically 3 to 12 weeks. They also confirmed that the IRS status updates, which occur monthly, can add additional time.
- Enrollees receiving the APTC subsidy had not previously been required to reconcile the credit as part of their taxes and were unfamiliar with the reconciliation process.

CMS officials told us that in May 2016, seeking to check individuals who received APTC after attesting to filing a 2014 tax return, the agency began a postapplication approval process for tax-filing verification. Under this process, the officials said, the federal Marketplace would first check IRS tax-filing-requirement data for applicants who attested on their applications that they had filed a tax return; next, would notify remaining

³⁴All affected applicants have the opportunity to attest to filing required tax returns, CMS officials told us. Those contacting the Marketplace directly can attest when making that contact, they said. Those who do not contact the Marketplace, and thus are in line for automatic reenrollment as provided by CMS regulations, are sent notices stating they may contact the Marketplace to attest. Those who do not respond to the notices, however, can lose eligibility for APTC and CSR. For example, according to CMS, in October 2015, ahead of the 2016 coverage year, there were approximately 171,000 applications from federal Marketplace enrollees for which IRS reported it had not processed a 2014 tax return. In December 2015, approximately 37,000 of the 171,000 applications were reenrolled in 2016 coverage without APTC, due to the IRS information and there being no applicant attestation to having filed a 2014 tax return.

APTC recipients who have not filed of the obligation to do so; and then would conduct a final IRS check of tax-filing status for those who had received warning notices. After that, nonfilers will lose APTC and income-based CSR subsidies.³⁵ According to the officials, this process will be complete, with subsidies terminated, by October 2016.³⁶ If such a determination is made to end subsidies, on the schedule CMS identified, those losing financial assistance for failure to file may have received subsidized coverage for January to September, or 9 months of the 2016 coverage year, according to CMS officials. IRS officials said subsidy recipients would still be responsible for reconciling APTC provided. As noted, that could increase or decrease tax liability depending on the individual situation.

According to CMS officials, the tax-filing recheck process—done following applicant attestations on tax-filing earlier—began in May 2016, 4 months after the close of 2016 open enrollment. The CMS officials told us this timing was chiefly because the federal Marketplace did not have the system capability earlier to both first determine on a large-scale basis whether applicants had made required tax filings, and then also to subsequently end subsidies for those who had not done so. The process of both comprehensively checking tax-return-filing status and also taking action against those not making the required filings is a difficult, complex task, CMS officials told us, due to coordination required with IRS and restrictions on disclosure of protected federal taxpayer information. Although building a system to do so has been a priority, they said, competing priorities, coupled with complexity of building a new system, meant system capability to remove APTC on a large-scale basis following a recheck process would not be available until August or September 2016 at the earliest. CMS officials said that among enrollees in Marketplace coverage with APTC subsidies who had attested to filing a 2014 tax return, there were about 19,000 applications for which IRS indicated no 2014 return had been processed at the start of the recheck process in May 2016. CMS officials said they do not have information on the value of APTC and CSR subsidies associated with this coverage. Although the recheck process began 4 months after the end of 2016 open enrollment, the Marketplace hopes to begin the tax-filing check-and-termination

³⁵There is an appeal process for those losing subsidies, CMS officials told us.

³⁶Although losing subsidies, applicants can retain full-cost, unsubsidized coverage.

process earlier for the upcoming 2017 coverage year, because the system will already be in place, the officials said. But a timetable has not been set, they said.

For our 2016 fictitious applicants, because they did not file a tax return and reconcile APTC subsidies they received, IRS could have reported the failure to file in response to marketplace queries if the applicant had a valid Social Security number, CMS officials told us.³⁷ Since the federal Marketplace process allowed applicant attestation instead, that is likely what accounted for our fictitious applicants successfully gaining coverage despite not having filed tax returns, according to the officials.³⁸

IRS officials told us they expressed concerns to CMS about CMS's attestation approach. Allowing applicants to attest to tax filing, without making some validation attempt at the time of application, raises the possibility that improper APTC payments would be made, in the case that it is determined later that an applicant in fact did not make the required filing. The issue arises because the APTC is paid before reconciliation status is ultimately known, the officials told us. From IRS's perspective, if someone has not reconciled, the person has not met the obligation necessary to continue to receive APTC, they said.³⁹ IRS officials said they have had ongoing discussions with CMS about this issue, but noted that CMS has the decision-making authority in the matter.

Tax Reconciliation for the State Marketplace

In the case of the state marketplace we tested, Covered California similarly opted for applicant attestation rather than relying on IRS tax-filing data, marketplace officials told us. State officials told us that for 2016

³⁷One of our two applicants did not have a valid Social Security identity. CMS officials told us the federal Marketplace obtains information from IRS via the data hub only if SSA successfully validates the applicant's Social Security number.

³⁸For the two federal Marketplace cases at issue here, we did attest to having filed and reconciled.

³⁹The specific issue is *advance* payment of the premium tax credit, IRS officials said. It could be true that an applicant is ineligible for APTC, due to failure to reconcile, but that upon filing a tax return, the applicant is nevertheless entitled to a premium tax credit, based on his or her specific circumstances. As for those who receive APTC but then lose it for failure to reconcile, subsidies received in the interim do not necessarily give rise to a tax liability, depending on individual circumstances, the officials said. Assuming such a consumer files a tax return and reconciles APTC received, any necessary recapture of subsidies paid is accomplished, they said.

enrollment, the marketplace added an attestation form to its online application system for those who had received subsidized coverage for 2014 and were renewing their coverage.⁴⁰ In November 2015, the marketplace conducted an outreach campaign, sending notices to consumers who were reported by IRS as not having filed, warning that they were at risk of losing subsidies if they did not file tax returns. Covered California followed up with a reminder notice in January 2016, the officials said. Then, in May 2016, the marketplace rechecked IRS tax-filing data, officials told us, for those reported by IRS as not having filed, plus those who had not attested earlier that they had filed tax returns. On the basis of that check, the marketplace then ended subsidized coverage for those still showing as not having filed, officials told us.

Covered California also allowed an opportunity to regain subsidized coverage, however. The state marketplace sent a notice of loss of subsidy, explaining that the change was based on failure to file. But the marketplace also told those losing subsidized coverage that if they believed the determination was wrong, they could attest to having filed. If consumers made that attestation, subsidized coverage would be restored, officials told us. Thus, a consumer could have attested (at renewal, when submitting a new application, or while reporting a change) that he or she had filed, or would file; next, have had subsidized coverage end when IRS data did not support the attestation; but then have the subsidized coverage reestablished through another attestation. The reason for this ultimate reliance on attestation is that officials were “very mindful” that IRS data being reported to marketplaces may not be current. While relying on attestation, the marketplace does not have information on the extent to which people who attested to filing have actually done so, the officials said. The officials also could not provide information on the number of applications where the IRS non-filing code was received, but the marketplace relied on attestation. As of May 2016, among 14,000 consumers that had not attested, 5,000 lost APTC during the redetermination process, Covered California officials told us.⁴¹

⁴⁰As provided by the officials, this was a general description of the process. Our fictitious applicants did not encounter the attestation form during our testing.

⁴¹Covered California officials said they did not have information on the number of people losing subsidies who had them restored after subsequent attestation.

After subsidized coverage is restored following a postcutoff attestation, there are no further checks of IRS data for the coverage year, officials told us. This practice is because they deemed a new round of checks for the 2017 coverage year, beginning in about October 2016, as an opportune time to make the next check. However, the officials said the October check would not distinguish between failure to file for the first year subject to the reconciliation requirement—2014—or instead for the second year for which the requirement was in effect, 2015.⁴²

Nevertheless, if a consumer has the IRS nonfiling code at that time, her or she will not be renewed with a subsidy, the officials said. In general, Covered California only takes action on the most recent tax-filing status code returned from the data hub, the officials said, which currently does not distinguish between years.

In our California work we also identified that the state marketplace used a paper application that did not include a tax-filing query, which means that applicants filing by paper would not have to attest to tax-filing status. As a result, two of our fictitious applicants that submitted paper applications were not asked whether they filed taxes (as noted in fig. 3). Covered California officials confirmed the form has been in use since the first PPACA open-enrollment period began in 2013. The state marketplace is seeking to revise its paper application, with CMS to review the changes, Covered California officials told us.

The state marketplace has limited ability to know whether applicants received subsidies in prior years, the Covered California officials told us, and thus are subject to the reconciliation requirement. Those who obtained previous coverage through Covered California can readily be identified, they said. But the state marketplace generally does not receive information on whether its applicants have ever had previous coverage elsewhere. An exception is for applicants flagged by IRS for failure to file. For non-Covered California enrollees, that flag indicates previous coverage elsewhere, the officials said. Otherwise, the state marketplace has no way to determine such previous coverage.

⁴²Even so, taxpayers remain obligated to reconcile APTC received in any year, IRS officials told us.

Remaining Fictitious Applicants, Using Testing Scenarios Similar to Those Employed Previously, Likewise Were Approved for Coverage and Awarded Subsidies

At the outset of our testing, we made 9 of our 15 applications using new fictitious identities to test scenarios similar to those tested in our previous undercover testing—citizenship / lawful presence, Social Security identity, and duplicate enrollment in more than one state. After the payment-processing issue noted earlier, eight of these nine applications remained in active testing—seven for qualified-health-plan coverage and one for Medicaid.

For all seven of the qualified-health-plan coverage cases that remained active, our fictitious applicants were approved for coverage with APTC and CSR subsidies. However, as discussed later, one fictitious applicant did not maintain subsidized coverage. For these seven successful applicants, we obtained APTC subsidies totaling about \$2,700 on a monthly basis, or about \$33,000 annually. In the eighth case, our applicant was approved for Medicaid coverage.⁴³ Figure 4 summarizes our testing results by scenario.

⁴³We made our application through the federal Marketplace, with the eligibility determination made by the state Medicaid agency.

Figure 4: Summary of Outcomes for Eight Fictitious Applications with Identity, Legal Status, and Duplicate-Enrollment Issues, as of August 2016

Marketplace type	State	Scenario for testing	Obtained subsidized coverage? ^a	Maintained subsidized coverage?
▶ State	California	Lawfully present	✓ Yes	✓ Yes
▶ State	California	Invalid Social Security identity	✓ Yes	✓ Yes
▶ State	California	Duplicate enrollment	✓ Yes	✓ Yes
▶ Federal	Virginia	Lawfully present	✓ Yes	✓ Yes
▶ Federal	Virginia	Duplicate enrollment	✓ Yes	✓ Yes
▶ Federal	West Virginia	Lawfully present	✓ Yes	✗ No
▶ Federal	West Virginia	Invalid Social Security identity	✓ Yes	✓ Yes
▶ Federal	West Virginia	Duplicate enrollment	✓ Yes (Medicaid)	✓ Yes

Source: GAO. | GAO-16-784

Note: Invalid Social Security identity is where applicant information did not match Social Security Administration records.

^aUnless otherwise noted, coverage obtained was for qualified health plans. Our Medicaid application was included for the purpose of testing for duplicate enrollment concurrent with enrollment in other qualified health plans.

As previously noted, citizenship/lawful presence is an explicit eligibility criterion under PPACA. In the case of Social Security identity, the information our applicants submitted did not match information on file with SSA. In the case of duplicate enrollment, we used a single identity to apply for coverage in each of the three states—a situation consistent with identity theft.

According to Officials, Federal Marketplace Outcomes Appear to Be as Expected

CMS officials told us that for the federal Marketplace there generally appeared to be reasons to explain the outcomes our fictitious applicants experienced. For example, in the case of the applicant who passed online identity proofing (described earlier), the eligibility system may still have been able to generate identity-proofing security questions even if our applicant’s identity was fictitious, the officials told us. This could be possible through use of probable or likely matching criteria, rather than exact matching of the phony applicant information, officials explained. That is, the system that seeks to identify a person and then generate

corresponding security questions may have made a match based on some applicant information, rather than on a one-for-one match with information the applicant provided. The federal Marketplace uses a risk-based system for applicant identification, CMS officials told us, based on the preponderance of data available, as opposed to a single identity element. Because there is no universal source for applicant information, the risk-based approach is best, they said. Meanwhile, the identity-proofing process used in online applications is not used in the telephone application process, the officials said. This is due in part to resource limits, CMS officials told us, but is chiefly attributable to a policy decision that call center representatives not have access to applicants' credit histories, in order to protect personally identifiable information.⁴⁴

Likewise, according to CMS officials, some of our applicants' treatment could likely be explained by an extension of document-submission deadlines granted by the Marketplace. CMS regulations authorize the Marketplace to extend the standard 90-day inconsistency resolution period if the applicant demonstrates a good-faith effort to obtain the required documentation during the period.⁴⁵ In 2014, the Marketplace had statutory authority to extend for any reason the period to resolve inconsistencies unrelated to citizenship or lawful presence, as well as the good-faith-effort regulatory authority to extend the submission period for resolving any type of inconsistency. Using its authority, the Marketplace effectively waived document-submission requirements for many applicants.⁴⁶

⁴⁴To protect applicant personal information generally, CMS officials told us, the Marketplace takes steps including preemployment screening and background checks of call-center representatives; monitoring of representatives' phone and computer activity; and barring items such as portable electronic devices, paper, and personal belongings in call-center workspaces.

⁴⁵For most types of inconsistencies, the standard resolution period is 90 days from the date a notice is sent to the applicant. However, for inconsistencies related to citizenship, status as a U.S. national, or lawful presence, the inconsistency period is 90 days from the date the notice is received by the applicant. To accommodate mail delivery time, for these inconsistencies CMS generally applies a standard resolution period of 95 days from the date the notice is sent to the applicant.

⁴⁶In 2014, CMS officials told us that submission of a single document, of any kind, served as sufficient evidence of a good-faith effort by the applicant to resolve all inconsistencies the applicant might have had; this extended the inconsistency-resolution period through the end of calendar year 2014.

For 2015 and 2016, however, the statutory authority had expired, and the Marketplace took a different approach in implementing its good-faith-effort regulatory authority. CMS told us as part of our 2014 testing work that use of the good-faith-effort authority would be limited to a case-by-case basis after 2014.⁴⁷ Under good-faith-effort extensions for 2016, documentation requirements are not waived, but applicants are provided additional time to submit documents, CMS officials said.

According to CMS officials, a good-faith-effort extension can be triggered for these reasons:

1. An applicant has not received standard reminder notices warning of an unresolved inconsistency and the deadline for submitting documentation. In such cases, a 90-day extension is provided.
2. The Marketplace has not called the applicant to warn that he or she needs to submit documents by the deadline. A 30-day extension is provided.
3. The consumer requests an extension. A 60-day extension is provided.⁴⁸

Each extension based on these factors is onetime only, the CMS officials told us. Other than granting these extensions, the Marketplace did not apply good-faith-effort authority in any other way for 2016 enrollment, officials told us.⁴⁹ CMS also did not otherwise waive, amend, or extend verification or eligibility controls in 2016, officials told us. We asked CMS

⁴⁷For details, see [GAO-16-29](#).

⁴⁸According to CMS, the specific triggers for applicant-requested extensions are: (1) the applicant requests assistance in resolving an inconsistency; (2) Marketplace attempts to send warning notices were returned as undeliverable mail; (3) the applicant provides documents that were on the acceptable list for citizenship, lawful presence, or income inconsistencies, but they are found to be insufficient; (4) the Marketplace gets written notice the applicant has requested documents from a government or official entity, but the records have not yet been provided; (5) the Marketplace gets written notice the applicant did not understand the need to provide documents, for reasons such as mental, educational, or language limitations; and (6) the Marketplace gets written notice that a personal hardship prevents the applicant from providing documents.

⁴⁹In the case of our fictitious applicants, one applicant requested an extension and was granted it, while another applicant was granted an extension without requesting one. It was not apparent from our conversations with marketplace representatives whether good-faith effort was a consideration.

officials for details on the number of applications that benefited from good-faith-effort extensions for 2016, including the reason for granting the extensions and types of inconsistencies at issue, and as of August 2016 officials had yet to respond.⁵⁰

In the case of duplicate enrollments, our fictitious applicant was first approved for subsidized coverage in the California marketplace and then—using the same identity—applied and was approved for a qualified health plan in Virginia and for Medicaid in West Virginia. When our applicant made the Medicaid application, a federal Marketplace representative flagged the applicant as potentially fraudulent. Nonetheless, the applicant was told that he was eligible for coverage. CMS officials told us they consider it highly unlikely, and thus low risk, that individuals would apply for multiple plans for themselves, given the cost of paying premiums on more than one plan. But they also acknowledged they are interested in the possibility that multiple enrollments could represent identity theft, and said they are working on approaches to identify such situations.

As CMS has reported to us previously, officials during this review also said the agency is unaware of any fraud in individual consumer applications for federal Marketplace coverage. Apart from individual-consumer-level fraud, instances have occurred in which agents or brokers have submitted applications for people without their knowledge, for financial gain, such as if the agent/broker is working for an organization and is paid on commission based on the number of people enrolled, CMS officials told us. The officials said some consumers have reported to the agency that they have been enrolled without their knowledge. CMS officials declined to provide other details, saying work in this area is law-enforcement sensitive. In responding to consumer complaints, CMS has recently developed a capability for service-center representatives to direct complaint information to a program-integrity office for investigation into

⁵⁰CMS also told us the federal Marketplace granted good-faith-effort extensions in 2015, but similarly did not provide details.

waste, fraud, or abuse, CMS officials told us. They likewise said further details were unavailable.⁵¹

Overall, according to CMS officials, the federal Marketplace has made a number of improvements to the eligibility and enrollment process, as well as the process for resolving application inconsistencies. In particular, CMS officials said the agency has focused on providing applicants with specific details of what documentation is required, and that notices sent to consumers have been improved. As a result, more consumers are sending proper documentation with appropriate information in response to Marketplace requests, and applicant inconsistencies are down. As an illustration of improvements in document filing, CMS officials cited a 40 percent increase in the number of documents consumers have submitted to resolve inconsistencies.⁵²

According to CMS officials, the Marketplace has also relaxed the income-inconsistency resolution-threshold standard beginning with applications for 2016 coverage. Under this change, the acceptable variance for applicants submitting documentation to resolve income inconsistencies has increased, and the inconsistency can be resolved if the new income information meets one of two standards. First, there can now be up to a 25 percent difference, up from 20 percent, between what an applicant initially reported in income and the amount submitted later when providing income documentation to resolve an income inconsistency, for that inconsistency to be officially resolved. Or second, he or she can resolve the inconsistency if the income difference is within \$6,000. CMS officials said the federal Marketplace made the change in recognition that many applicants experience variations in earnings, making it hard to project

⁵¹CMS officials told us that in a rule published in March 2016 it finalized standards for agent and broker conduct, including a requirement that agents and brokers obtain the consent of an individual, employer, or employee before assisting with enrollment. See 45 C.F.R. § 155.220(j).

⁵²Overall, for policies for 2016 coverage that had APTC or CSR subsidies, as of May 1, 2016, about 280,000 households had subsidy adjustments due to unresolved income inconsistencies, according to CMS officials. In addition, about 71,000 consumers had coverage terminated due to unresolved citizenship / lawful-presence inconsistencies, the agency said.

income. They said that for lower-income households a small difference in income, measured in dollars, can result in a large percentage change.⁵³

In the case of our Medicaid application, as noted, we applied through the federal Marketplace and were told our applicant may be eligible for Medicaid and that the West Virginia state Medicaid agency would contact us with a final determination. When we later called the West Virginia state Medicaid agency, we were told our applicant was approved for Medicaid. When we shared the results of our testing with West Virginia Medicaid officials, they told us that without a specific identity for our fictitious applicant, they could not comment authoritatively on the outcome. However, the officials said that because our applicant was not directed to produce any documentation, it is likely that the federal Marketplace did not pass along any application inconsistencies, assuming the application was processed properly. As noted, for this fictitious applicant a federal Marketplace representative said the case would be flagged as a “fraud issue,” because applicant identifying information was already present in the Marketplace system. However, West Virginia officials said the Marketplace does not pass along to the state any information suggesting fraud.

The West Virginia officials told us that this experience illustrates why the federal Marketplace should make a greater effort to verify identity before sending Medicaid applicant information to the state. West Virginia is a “determination state,” meaning it delegates eligibility determinations to the federal Marketplace. That underscores the importance of the federal Marketplace making accurate determinations, the officials said. The officials told us West Virginia’s experience with Medicaid applicant data from the federal Marketplace has been that for 2014, the first coverage year for the program, data quality was not good overall. For example, the state would receive applicant information showing income exceeding Medicaid limits; or, the state would not receive Medicaid application information that should have passed from the federal Marketplace to the

⁵³Thus, the variance for income-inconsistency *resolution* changed. According to CMS officials, the process for income-inconsistency *generation* remained unchanged. Under that standard, income inconsistencies are generated if no household income data are available from Marketplace data sources; or, if an applicant’s self-reported income is more than 10 percent below the amount reported by Marketplace data sources.

According to Officials, State
Marketplace Outcomes Also
Appear to Be as Expected

state.⁵⁴ But since the first year, data quality has improved significantly, the officials said, although quality issues such as blank data fields or incorrect Social Security numbers remain. Data quality is important because if applicant information cannot be verified electronically, a Medicaid case worker must review it manually, the officials said. Had our West Virginia Medicaid applicant been directed to send documentation, a case worker would have examined it with the level of scrutiny applied varying according to the particular situation, the officials told us.

Although Covered California officials also told us that without specific identities they could not comment on individual outcomes, in general they said the results of our undercover testing indicate their marketplace processes worked as designed. For example, they said, when our applicants could not clear online identity proofing and contacted Covered California representatives by phone, the representatives were correct in first seeking to direct the applicants to visit enrollment counselors, so they could verify identities in person. While in-person presentation of identity documentation is never required, the officials said, an in-person visit provides an opportunity to examine identity documents. When our applicants indicated they would have difficulty in doing so, the representatives were also correct in offering the opportunity to file a paper application, the officials said. Likewise, applicants were treated correctly in being granted eligibility with the directive to provide supporting documentation.

The state officials noted that under PPACA the marketplace is required to accept paper applications. While our applicants could not establish their identity through the standard online process, the officials said, they could file a paper application in which the signature on the paper application is done under penalty of perjury. The same paper process is available for those originally applying by telephone, they said. Obtaining an eligibility determination then becomes possible—an option precluded by failure to

⁵⁴In making undercover applications for Medicaid coverage as part of our 2015 testing, we likewise experienced issues with the exchange of information between the federal Marketplace and determination states. See [GAO-15-159T](#) for details.

confirm an identity in the online process, the officials said.⁵⁵ The state marketplace does not have any information on the extent to which the threat of a penalty for perjury actually compels applicants to provide truthful answers.

Like the federal Marketplace, Covered California made use of a good-faith-effort extension policy for applicant documentation.⁵⁶ According to state officials, consumers must affirmatively request such an extension by contacting the state marketplace. They can be granted a maximum of 60 additional days to file required documentation, beyond the 90-day period initially provided. According to the officials, there has been a low volume of such requests—about 10 percent to 15 percent of consumers required to submit documentation to retain coverage.⁵⁷

Covered California officials also told us they have eased documentation requirements in several other ways:

- **Income:** Covered California is not taking steps to resolve income inconsistencies. Even though it requested applicants to submit income documentation, it is not taking action in cases in which they do not. The reason is a policy decision that the issue of whether amount of subsidies received was proper will be addressed through the tax reconciliation process. The marketplace provides consumers with multiple notices, alerting them to possible tax consequences of income inconsistencies, officials said. In addition, Covered California decided to give higher priority to other inconsistencies that can lead to

⁵⁵Covered California officials also told us the marketplace has staff dedicated to processing paper applications. Some staff key in applicant data submitted by paper application. If additional information is needed, the application is passed to other staff, who contact consumers. Once necessary information has been obtained, a query is made to the federal data hub, as is true for other forms of application. Thus, all applications end up passing through the marketplace's online portal, regardless of how they start, the officials told us.

⁵⁶According to CMS officials, California was among eight state-based marketplaces that allowed applicants to attest to having filed tax returns and reconciled APTC when flagged by IRS as not having filed. The others were: Colorado, the District of Columbia, Kentucky, Massachusetts, Minnesota, Rhode Island, and Vermont.

⁵⁷According to Covered California officials, as of June 2016, 2,023 of 17,202 individuals on a list to have their coverage terminated, for citizenship/legal status or incarceration inconsistencies, were granted a good-faith-effort extension.

termination of coverage, such as citizenship / lawful presence, rather than adjustment of subsidies, they said. We note that under PPACA, even if reconciliation is made, the amount of excess APTC that can be recovered can be limited, based on household income and tax-filing status. CSR subsidies, however, are not subject to reconciliation.

- Minimum essential coverage: The marketplace is not taking action to verify applicants' claims that they do not have access to "minimum essential coverage" and hence can apply for subsidized coverage through the marketplace.⁵⁸ While important, such cases account for a very low percentage of all applications, the officials said.
- Incarceration: Rather than rely on documentation, the marketplace accepts applicant attestation on incarceration status. Under PPACA, those who are incarcerated are not eligible for coverage, unless they are incarcerated awaiting disposition of charges.⁵⁹ The officials said they did not have information on the number of such attestations provided.

Otherwise, Covered California officials told us the state marketplace has made a number of improvements. In May 2016, it implemented a system check to guard against use of impossible Social Security numbers; we used such numbers in our 2015 undercover testing, which included California.⁶⁰ The marketplace is more consistently reminding people when documents are due and warning of loss of coverage if the material is not provided, they said. Consumer notices overall are more readable, following work with focus groups, according to the officials, and efforts are under way to address cases in which applicant-supplied Social Security

⁵⁸According to the federal Marketplace, under PPACA, "minimum essential coverage" provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements.

⁵⁹The federal Marketplace also relies on applicant attestation on incarceration status. See [GAO-16-29](#) for details.

⁶⁰See [GAO-16-159T](#). According to the SSA Program Operations Manual System, SSA 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."

numbers cannot be verified through the data hub.⁶¹ Such applicants, too, are being warned about loss of subsidy or coverage.

On the issue of identity theft and duplicate enrollment, Covered California officials said that while it can check the state marketplace's own records it would be helpful if CMS could supply data on those obtaining plans through the federal Marketplace. That way the state marketplace could check those obtaining coverage against coverage obtained elsewhere.

All But One of Our Fictitious Enrollees Maintained Subsidized Coverage, Even Though We Sent Fictitious Documents, or No Documents, to Resolve Application Inconsistencies

We retained subsidized coverage for 10 of the 11 qualified-health-plan applicants through August 2016, even though supporting documentation we submitted was fictitious, and in some cases we submitted none or only some of the documentation we were directed to send.

As noted, we focused our testing on 12 fictitious applicants. For all 11 of our applicants approved for qualified-health-plan coverage with subsidies, we were directed to provide supporting documentation. Our applicant approved for Medicaid received no direction to provide supporting documentation.

In response to the marketplace directives to the 11 subsidized qualified-health-plan applicants, we provided follow-up documentation, albeit fictitious.⁶² Overall, we varied what we submitted by application—providing all, none, or only some of the material we were told to send—to test controls and note any differences in outcomes. Among the 11 applications for which we were directed to send documentation, we submitted

- all requested documentation for five applications,
- partial documentation for three applications, and
- no documentation for the remaining three applications.

⁶¹This is a manual process where marketplace staff work through individual unverified Social Security numbers, marketplace officials told us.

⁶²Any documentation we supplied was, like our initial applications, fictitious, having been fabricated by us using commercially available hardware, software, and materials.

Figure 5 summarizes document submissions and outcomes for the 11 qualified-health-plan applicants, plus the Medicaid application for which, as noted, we were not directed to send documentation.

Figure 5: Summary of Marketplace Documentation Requests and Submissions, by Category of Response, for GAO’s Fictitious Applications

Marketplace type	State	Scenario for testing	Documentation requested by marketplace	Fictitious items GAO submitted to marketplace	GAO document submission category	Maintained subsidized coverage?
▶ State	California	Lawfully present	Citizenship/immigration	●	Partial	Yes
			Income	●		
			Minimum essential coverage	○		
▶ State	California	Invalid Social Security identity	Income	○	None	Yes
▶ State	California	2014 identity: lawfully present	Income	●	All	Yes
▶ State	California	2014 identity: invalid Social Security identity	Citizenship/immigration	●	All	Yes
			Income	●		
			Identity document	●		
			Minimum essential coverage	●		
			Incarceration status	●		
▶ State	California	Duplicate enrollment	Income	●	All	Yes
▶ Federal	Virginia	Lawfully present	Citizenship/immigration	○	None	Yes
			Income	○		
▶ Federal	Virginia	Duplicate enrollment	Income	●	All	Yes
▶ Federal	West Virginia	Lawfully present	Citizenship/immigration	○	None	No
			Income	○		
▶ Federal	West Virginia	Invalid Social Security identity	Citizenship/immigration	●	Partial	Yes
			Income	●		
			Identity document	○		
▶ Federal	West Virginia	2014 identity: invalid Social Security identity	Citizenship/immigration	○	Partial	Yes
			Income	●		
			Identity document	●		
▶ Federal	West Virginia	2014 identity: Lawfully present	Citizenship/immigration	●	All	Yes
			Income	●		
▶ Federal	West Virginia	Duplicate enrollment (Medicaid)	None	○	None	Yes

Legend: ● = yes; ○ = no

Source: GAO. | GAO-16-784

Notes: Unless otherwise indicated, coverage obtained was for qualified health plans. The Medicaid application was included for the purpose of testing for duplicate enrollment—that is, concurrent with enrollment in other qualified health plans. “Minimum essential coverage” documentation refers to evidence that applicant did not otherwise have access to a health-care plan offering required minimum coverage.

In two of the cases, in which we provided only partial documentation, our applicants were nevertheless able to clear inconsistencies through conversations with marketplace phone representatives. For example, in one case we called the federal Marketplace to discuss notices received about application inconsistencies. A representative told our applicant that the applicant needed to submit documentation on citizenship status and Social Security number. However, our applicant told the representative that the applicant had a name change, and provided the former name.⁶³ The representative appeared to enter this information into the Marketplace system before saying the documentation issues had been cleared, and no other information was required. The information our applicant provided over the phone, however, did not match documentation our applicant had filed previously. Without a specific identity, CMS officials could not say conclusively what happened with our application. Generally, however, they told us that under certain circumstances, such as an applicant providing new information, a previously recorded inconsistency may become inactive.

In one of the 11 qualified-health-plan cases, as shown in figure 5, our fictitious applicant’s coverage was terminated after the document-submission period, after we failed—by design—to provide any documentation to clear an inconsistency, in this case regarding immigration status.

We also noted other issues with marketplace-requested documentation:

- In one case involving Social Security identity, one of our applicants was directed to supply proof of a valid Social Security number at the time of initial eligibility determination. A subsequent Marketplace notice in early 2016, however, omitted that directive. We believe this could be confusing to an applicant. Further, to the extent it might cause an applicant to not submit necessary documentation, the discrepancy could lead to loss of coverage. CMS officials told us that

⁶³This former name would have matched SSA records.

the Marketplace initially requests a Social Security number, because having a Social Security number can help to clear other inconsistencies. The Marketplace does not, however, make it a practice to resolve Social Security inconsistencies alone.⁶⁴ In another of our applications involving Social Security identity, a Marketplace representative noted a discrepancy with our applicant's Social Security number, and inquired about the possibility of identity theft. Based on our applicant's assurances, however, the representative cleared the discrepancy and made no request for the applicant's Social Security card.

- In some cases, our applicants presented identical information, but marketplace handling of their applications was different. For example, in each of two federal Marketplace applicant scenarios, we claimed to be lawfully present and with income at a level qualifying for a subsidy. In each case, we were directed to provide proof of immigration status and income, and in both cases, we did not provide any documentation. In one case we lost coverage, while in the other we retained it.
- As noted, we elected not to continue testing with three scenarios after encountering premium-payment issues. Even though our coverage was canceled in these cases, we continued to receive marketplace notices directing us to provide supporting documentation or risk losing coverage. Such a situation could cause consumer confusion. CMS officials told us this practice is by design, because if consumers reapply later, they would still need to resolve inconsistencies previously identified.

As noted in the case of our one successful Medicaid application, we were not directed to submit any supporting documentation.

In discussing these outcomes for our fictitious applicants, federal and state marketplace officials reaffirmed, as we have reported previously, that the marketplaces do not seek to identify fraudulent document submissions. Federal Marketplace officials said document-review standards—in which CMS's documents-processing contractor is not required to examine documents for fraud—remain unchanged. Unless

⁶⁴In [GAO-16-29](#), we recommended that CMS develop a process for resolving Social Security number inconsistencies, because Social Security numbers are important to subsequent IRS tax-compliance efforts.

documents show signs of being visibly altered, they are accepted as authentic.⁶⁵ Covered California officials likewise told us marketplace service-center representatives do not authenticate documents. As with the federal Marketplace, the standard for review is visible alteration and whether a document presented appears as it should be; that is, for example, that a permanent-resident card submitted conforms to established design of such a card. If documents do look suspicious, they can be referred to a consumer-protection office for investigation, the officials said. Thus far, the office has not received any such referrals, they said.

In addition, as noted earlier, federal officials cited good-faith-effort extensions as possibly contributing to our outcomes. California officials said the state marketplace does not take action in cases when applicants fail to submit requested income documentation, thereby leaving income inconsistencies unresolved, which could account for our results.

For overall handling of inconsistency resolution, we asked CMS about the number of unresolved inconsistencies and the value of associated APTC and CSR subsidies. As of August 2016, the agency had yet to respond. Covered California officials provided some information on the state marketplace's experience with inconsistency resolution. Since January 1, 2016, the marketplace eliminated APTC for failure to resolve citizenship / lawful-presence inconsistencies in 10,043 cases; and likewise for 875 cases with unresolved incarceration inconsistencies. Covered California did not have information on value of subsidies for these groups. As of June 2016, Covered California's largest categories of unresolved inconsistencies were income (190,693 cases), Social Security number (9,247 cases), and citizenship / lawful presence (7,717 cases). Values of associated subsidies were likewise unavailable, officials told us.

Agency Comments and Our Evaluation

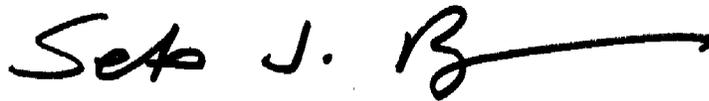
We provided a draft of this report to HHS, IRS, Covered California, and the West Virginia state Medicaid agency for their review and comment. HHS, IRS, and Covered California provided technical comments, which we incorporated as appropriate. HHS provided us with written comments,

⁶⁵CMS officials told us that although contractor staff are not trained in fraud detection, there is an escalation process if staff believe there is a discrepancy between a document filed and examples provided in CMS guidance.

which are reprinted in appendix II. Covered California's comments, along with our responses, are reprinted in appendix III. The West Virginia Medicaid agency did not provide comments.

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 of this report to the Secretary of Health and Human Services, the Acting Administrator of CMS, the Commissioner of Internal Revenue, 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.

A handwritten signature in black ink that reads "Seto J. Bagdoyan". The signature is written in a cursive style with a long horizontal stroke extending to the right.

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 Timothy Murphy
Chairman
Subcommittee on Oversight and Investigations
Committee on Energy and Commerce
House of Representatives

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

Appendix I: Objective, Scope, and Methodology

The objective of this report is to describe, by means of undercover testing and related work, potential vulnerabilities to fraud in the application, enrollment, and eligibility-verification controls of the federal Health Insurance Marketplace (Marketplace) and a selected state marketplace, for the third open-enrollment period under the Patient Protection and Affordable Care Act, for 2016 coverage. Our testing covered both individual health-care plans and Medicaid, with a portion focusing on a requirement that applicants who previously received advance payment of tax credits to subsidize their monthly premium payments must file federal income-tax returns and account for those credits, in order to continue receiving subsidies in future years.

To perform our undercover testing of the application, enrollment, and eligibility-verification process for the 2016 open enrollment season—which ran from November 1, 2015, to January 31, 2016—we used fictitious identities for the purpose of making 15 applications. Specifically, we made 14 applications for individual plans, and 1 application for Medicaid. In these 15 applicant scenarios, we chose to test controls for verifications related to the following:

1. Whether applicants had made required income-tax filings. We made six such fictitious applications. For qualifying applicants, the act provides two possible forms of subsidies for consumers enrolling in individual health plans, both of which are generally paid directly to insurers on consumers' behalf. One is a federal income-tax credit, which enrollees may elect to receive in advance, which reduces a consumer's monthly premium payment.¹ This is known as the advance premium tax credit.² 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 income-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

¹If enrollees do not choose to receive the income-tax credit in advance, they may claim it later when filing tax returns.

²The other, known as cost-sharing reduction, is a discount that lowers the amount consumers pay for out-of-pocket charges for deductibles, coinsurance, and copayments.

qualifies based on actual reported income and family size.³ Our group of six fictitious applicants tested this reconciliation requirement.

2. The identity or citizenship/immigration status of the applicant, or whether the applicant had sought enrollment in multiple plans. We made nine such fictitious applications.

In general, our testing approach allowed us to test similar scenarios across different states. We made 10 of our applications online initially, and 5 by phone.⁴ In some cases, we filed paper applications, as is permissible, after speaking with marketplace representatives. We set our applicants' income levels at amounts eligible for subsidies provided under the act, or to meet Medicaid eligibility requirements, as appropriate.

Because the federal government, at the time of our review, operated a marketplace on behalf of the state in about three-quarters of the states, we focused our work on those states.⁵ Specifically, we selected two states—Virginia and West Virginia—that elected to use the federal Marketplace rather than operate a marketplace of their own. We selected one additional state—California—that operates its own marketplace.⁶ The

³The actual premium tax credit due for the year will differ from the advance tax-credit amount calculated by a marketplace if family size and income as estimated at the time of application are different from family size and household income reported on the tax return. If the actual allowable credit is less than the advance payments, the difference, subject to certain caps, will be subtracted from the applicant's refund or added to the applicant's balance due. On the other hand, if the allowable credit is more than the advance payments, the difference is added to the refund or subtracted from the balance due.

⁴For 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.

⁵Specifically, according to the Department of Health and Human Services, for the 2016 coverage year, there were 38 states using the HealthCare.gov system. Among all consumer health-plan selections, about 76 percent (8.4 million) were in states using the HealthCare.gov system.

⁶These selections allowed us to include one state-based marketplace, one federal Marketplace state that expanded Medicaid eligibility, and one federal Marketplace state that did not expand Medicaid. In the case of our state marketplace selected for testing, we previously included the state in our 2015 undercover testing. By selecting it again for 2016, we would be in a position to compare application experiences over time. Likewise, Virginia and West Virginia were part of our 2014 testing. To preserve confidentiality of our applications, we do not disclose here any identifying information below the state level, such as location of our fictitious applicants.

results obtained using our limited number of fictional applicants are illustrative and represent our experience with applications in the three states we selected. The results cannot, however, be generalized to the overall population of applicants or enrollees.

For all 15 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. In responding to marketplace directives to submit documentation, we adopted an approach of submitting all requested documentation in some cases, partial documentation in other cases, or no documentation in the remaining cases, in order to note any differences in outcomes. We observed any approvals received, and responded as appropriate for our testing to any directions to provide additional supporting documentation.

Fourteen of our 15 applicant scenarios involved qualified individual health plans. For these 14 plans, we attempted to pay the required premiums to put policies into force. For 11 of these 14 applicants, we successfully made premium payments. However, for three applicants, our initial premium payments—made to insurers we selected—were unsuccessful, and we were unable to resolve the issue. While we believed we had received confirmation of premium payments, insurers said payments were not received on a timely basis.⁷ As a result, our coverage was not put into effect in these three cases. At that point, because these cases had experienced different treatment than our other applications and no longer matched our original testing profile, we elected to discontinue them from further testing.⁸

⁷Specifically, we made payments by telephone, and received confirmation numbers for the transactions. Later, our applicants received notices stating that payment processing was unsuccessful. We subsequently contacted the marketplace and insurers, but were unable to resolve the issue.

⁸Specifically, when we learned of the difficulties with the payments we believed had been made, we made inquiries to marketplace representatives and attempted to restore coverage. The representatives, however, told our applicants that to seek restoration, they must go through a formal appeals process. On the basis of that information, we elected to discontinue further testing with these applications, because the focus of our work was the eligibility and enrollment process, and not other matters, such as the appeals process.

To protect our undercover identities, we did not provide the marketplaces with specific applicant identity information. Centers for Medicare and Medicaid Services (CMS) and state officials generally told us that without such information they could not fully research handling of our applicants.

We also reviewed statutes, regulations, and other policy and related information. Overall, our review covered the act's third open-enrollment period, for 2016 coverage, as well as follow-on work after close of the open-enrollment period. After conducting our undercover testing, we briefed officials from CMS, the Internal Revenue Service, the California marketplace, and the West Virginia state Medicaid agency on our results and sought their views on the outcomes.⁹

We conducted this performance audit from November 2015 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 objective. We conducted our related investigative work in accordance with investigative standards prescribed by the Council of the Inspectors General on Integrity and Efficiency.

⁹Because Virginia uses the federal Marketplace, we discussed results of our Virginia applications with CMS.

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 25 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: Results of Undercover Enrollment Testing for the Federal Marketplace and a Selected State Marketplace for the 2016 Coverage Year*" (GAO-16-784).

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: RESULTS OF UNDERCOVER ENROLLMENT TESTING FOR THE FEDERAL MARKETPLACE AND A SELECTED STATE MARKETPLACE FOR THE 2016 COVERAGE YEAR (GAO-16-784)

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. 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: RESULTS OF UNDERCOVER ENROLLMENT TESTING FOR THE FEDERAL MARKETPLACE AND A SELECTED STATE MARKETPLACE FOR THE 2016 COVERAGE YEAR (GAO-16-784)

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, the Children's Health Insurance Program (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.

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.

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.

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: RESULTS OF UNDERCOVER ENROLLMENT TESTING FOR THE FEDERAL MARKETPLACE AND A SELECTED STATE MARKETPLACE FOR THE 2016 COVERAGE YEAR (GAO-16-784)

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.

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.

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>

**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: RESULTS OF
UNDERCOVER ENROLLMENT TESTING FOR THE FEDERAL MARKETPLACE AND A
SELECTED STATE MARKETPLACE FOR THE 2016 COVERAGE YEAR (GAO-16-784)**

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

Note: A GAO comment appears at the end of this appendix.



August 30, 2016

Ranya Elias
Analyst
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Ms. Elias,

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: Results of Undercover Enrollment Testing for the Federal Marketplace and a Selected State Marketplace for the 2016 Coverage Year* (GAO-16-784). This performance audit (undercover testing) was conducted in response to a congressional request to continue to examine enrollment and verification controls for the 2016 coverage year. Specifically, GAO's applications tested applicant verifications related to (1) required income-tax filings, and (2) identity or citizenship/immigration status.

For California, five fictitious identities were used to examine verification controls for subsidized qualified health-plan coverage. Covered California would like to note that the findings are based on an attribute sample of five enrollments out of 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 the report notes, for two of the five California applications submitted to test income-tax filing and reconciliation requirements, the GAO used identities from its 2014 testing of the Federal Marketplace and filed paper applications. Among the various scenarios employed for the 2014 testing, these two fictitious applicants either provided invalid Social Security identities, which would not match Social Security Administration records, or did not provide any Social Security numbers at all.

Covered California would like to emphasize that the GAO's fictitious applicants would not have encountered an attestation because, as the report notes, they submitted paper applications, which do not ask applicants whether a 2014 tax return was filed. Under the Patient Protection and Affordable Care Act, the marketplace is required to accept paper applications. Covered California is in the process of drafting a revised paper application to include attestation relating to tax-return filing and reconciliation.

See comment 1.

Covered California relies on applicant attestation from consumers. In November 2015, Covered California conducted a noticing campaign for individuals who had an IRS flag for failure to reconcile (007 code), but had not attested to filing their taxes. In January 2016, Covered California followed up with a reminder notice. Then, in May 2016, among the 14,000 consumers that had not attested, Covered California terminated eligibility for 5,000 consumers who had a 007 code and had not attested to filing their taxes. After subsequent attestation, 1,541 consumers then had their coverage restored.

The report further notes that, for non-Covered California enrollees, the 007 code indicates *previous* coverage elsewhere. Covered California would like to highlight that this is an assumption based on the rules surrounding the 007 code. In response to *concurrent*, duplicate enrollment amongst more than one marketplace, there currently is no method to identify enrollment elsewhere. Furthermore, it should be noted that consumers with an invalid Social Security number or no Social Security number would not have been assigned a 007 code by the IRS, and therefore would not have been part of our initial noticing campaign or redetermination efforts.

As stated in the report, Covered California does not authenticate documents. In the event that a submitted document appears visibly altered or suspicious, the case can be referred to a consumer protection office for investigation. GAO's fictitious applicants likely fell into an "inconsistency" period. Currently, system functionality is not available for automatic discontinuance of consumers that fail to clear inconsistencies during the reasonable opportunity period (ROP). However, Covered California plans to implement system functionality in late 2016 for the automatic processing of cases exceeding the 95-day ROP. This automated process will discontinue enrollment for those individuals with outstanding verifications for citizenship, lawful presence, incarceration, and residency status. In the meantime, Covered California has established a manual process for enforcing the ROP.

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.

See comment 1.

August 30, 2016
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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

GAO Comment

1. For the two California applications that were submitted to test income-tax filing and reconciliation requirements, we did provide a valid Social Security number. This means that our applicants could have been flagged by the Internal Revenue Service for failure to file tax returns. As Covered California noted, if the Social Security number is invalid or is not provided, the Internal Revenue Service does not return a failure-to-file code to the marketplace.

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, Philip Reiff, Gary Bianchi, and Helina Wong, Assistant Directors; Evelyn Calderón; Paul Desaulniers; Ranya Elias; Robert Graves; Olivia Lopez; Maria McMullen; James Murphy; George Ogilvie; Ramon Rodriguez; Christopher H. Schmitt; Julie Spetz; and Elizabeth Wood made key contributions to this report.

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