



U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES  
OFFICE OF INSPECTOR GENERAL

Testimony of:  
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Hearing Title:  
"Failure To Verify: Concerns Regarding PPACA's Eligibility  
System"

House Committee on Energy and Commerce  
Subcommittee on Health

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Good morning, Mr. Chairman and other distinguished Members of the Committee. Thank you for the opportunity to testify about the Department of Health and Human Services (HHS) Office of Inspector General's (OIG) recently released reports related to the new health insurance marketplaces established under the Patient Protection and Affordable Care Act (ACA).

OIG provides oversight of HHS programs to fight fraud, waste, and abuse and ensure efficiency, economy, and effectiveness. Because of the size and scope of HHS programs and outlays (almost \$1 trillion in 2014), in essence, we are responsible for overseeing 25 cents of every Federal dollar and programs that touch the lives of virtually all Americans.

The new health insurance marketplaces are among those important programs. Our two new reports provide a first look at a critical component of marketplace operations: verification of enrollee eligibility. One report (mandated report) responded to a congressional mandate to examine the effectiveness of enrollment procedures and safeguards;<sup>1</sup> the second report (companion report) addressed a specific risk area – the inconsistency resolution process – that we identified as meriting additional attention.<sup>2</sup>

Specifically, the Continuing Appropriations Act of 2014, Pub. L. No. 113-46, directed HHS OIG to examine and report to Congress by July 1, 2014, regarding:

...the effectiveness of procedures and safeguards provided under the Patient Protection and Affordable Care Act (ACA) for preventing the submission of inaccurate or fraudulent information by applicants for enrollment in a qualified health plan offered through an American Health Benefit Exchange (marketplace).

Our mandated work examined and directly tested internal controls in place from October 1 through December 31, 2013, at the Federal, California, and Connecticut marketplaces with

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<sup>1</sup> *Not All Internal Controls Implemented by the Federal, California, and Connecticut Marketplaces Were Effective in Ensuring That Individuals Were Enrolled in Qualified Health Plans According to Federal Requirements*, OAS-09-14-01000, issued July 2014. Available online at <http://oig.hhs.gov/oas/reports/region9/91401000.pdf>.

<sup>2</sup> *Marketplaces Faced Early Challenges Resolving Inconsistencies With Applicant Data*, OEI-01-14-00180, issued July 2014. Available online at <http://oig.hhs.gov/oei/reports/oei-01-14-00180.pdf>.

respect to (1) verifying the identity of applicants and entering application information, (2) determining eligibility of applicants for enrollment in a Qualified Health Plan (QHP) and for receipt of the advance premium tax credits and cost-sharing reductions, and (3) maintaining and updating enrollment data.

We concluded that the Federal, Connecticut, and California marketplaces had certain procedures in place to verify an applicants' information, but not all internal controls implemented by the three marketplaces were effective in ensuring that individuals were enrolled in QHPs according to Federal requirements. The deficiencies in internal controls that we identified may have limited the marketplaces' ability to prevent the use of inaccurate or fraudulent information when determining eligibility of applicants for enrollment in QHPs.

The presence of an internal control deficiency does not necessarily mean that a marketplace improperly enrolled an applicant in a QHP or improperly determined eligibility for insurance affordability programs. Other mechanisms exist that may remedy the internal control deficiency.

For the companion report, we analyzed nationally whether and how marketplaces resolved inconsistencies between applicants' self-attested information and the data received through the Federal Data Hub and other data sources. We obtained data from the State marketplaces from October through December, 2013; for the Federal marketplace, we were able to analyze data through February 2014.

We found that during those time periods, marketplaces were unable to resolve most inconsistencies, which they reported most commonly as citizenship and income. Specifically, the Federal marketplace was unable to resolve 2.6 million of 2.9 million inconsistencies because the CMS eligibility system was not fully operational. One application may include multiple inconsistencies. Inconsistencies do not necessarily indicate that an applicant provided inaccurate information or is enrolled in a QHP inappropriately or is receiving financial assistance through insurance affordability programs inappropriately. The ability to resolve inconsistencies varied across the marketplaces, and seven State-based marketplaces reported that they were able to resolve inconsistencies without delay.

We also found that data on inconsistencies were limited. For example, the Federal marketplace could not determine the number of applicants who had at least one inconsistency. Marketplaces faced challenges resolving inconsistencies despite having policies and procedures in place.

These are the first two reports in a series relating to operations of the marketplaces. OIG's other marketplace-related work and the work of our oversight partners will provide a detailed collection of data for policymakers and stakeholders.<sup>3</sup>

Following are additional details about our two new reports.

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<sup>3</sup> For a description of some additional ongoing audits and evaluations, consult Appendix A to our *Work Plan*, found at <http://oig.hhs.gov/reports-and-publications/archives/workplan/2014/Work-Plan-2014.pdf>. HHS OIG continues to plan and start new work focused on the marketplaces.

## **MANDATED REPORT: Not All Internal Controls Implemented by the Federal, California, and Connecticut Marketplaces Were Effective in Ensuring That Individuals Were Enrolled in Qualified Health Plans According to Federal Requirements**

### *Audit Scope and Methodology*

In response to the mandate, we reviewed internal controls that the selected marketplaces implemented to comply with the procedures and safeguards required by the ACA for determining the eligibility of applicants for enrollment in QHPs. We performed an internal control review because it enabled us to evaluate the effectiveness of the selected marketplaces' operations and the marketplaces' compliance with applicable Federal requirements. Internal controls are safeguards and procedures that ensure that programs work as intended.

Because we reviewed the marketplaces' internal controls in place during the first 3 months of the open enrollment period for applicants enrolling in QHPs (October through December 2013), our review provides an early snapshot of the effectiveness of these controls. We selected three marketplaces for this review: (1) the federally facilitated marketplace (the Federal marketplace), which operated in 36 States as of October 1, 2013; (2) Covered California (the California marketplace); and (3) Access Health CT (the Connecticut marketplace). We selected these marketplaces on the basis of their type (federally operated or State-operated), coverage of States in different parts of the country, and size of the uninsured population.

To determine the effectiveness of the internal controls at each marketplace, we:

- tested controls by reviewing a sample of 45 applicants randomly selected at each marketplace from all applicants who were determined eligible to enroll in QHPs during the period from October 1 through December 31, 2013, with coverage effective January 1, 2014; and<sup>4</sup>
- performed other audit procedures, which included interviews with marketplace management, staff, and contractors; observation of staff performing tasks related to eligibility determinations; and reviews of supporting documentation and enrollment records.

We did not review supporting documentation for certain eligibility requirements, such as annual household income and family size, for the purpose of this report because we did not have access to needed Federal taxpayer data at the time of our data collection period.<sup>5</sup>

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<sup>4</sup> Our attribute sampling approach is commonly used to test the effectiveness of internal controls for compliance with laws, regulations, and policies. According to the Government Accountability Office and the President's Council on Integrity and Efficiency's *Financial Audit Manual* (July 2008), section 450, auditors may use a randomly selected sample of 45 items to perform a compliance review. If all sample items are determined to be in compliance with requirements, a conclusion that the controls are effective can be made. If one or more sample items are determined not to be in compliance with requirements, a conclusion that the controls are ineffective can be made. We tested the controls at each marketplace separately. Our sampling methodology was limited to forming an opinion about whether the internal controls at each marketplace were effective and was not designed to estimate the percentage of applicants for whom each marketplace did not perform the required eligibility verifications.

<sup>5</sup> OIG plans to conduct additional audit work in this area.

## *Audit Findings*

Not all internal controls implemented by the Federal, California, and Connecticut marketplaces were effective in ensuring that individuals were enrolled in QHPs according to Federal requirements. The deficiencies in internal controls that we identified may have limited the marketplaces' ability to prevent the use of inaccurate or fraudulent information when determining eligibility of applicants for enrollment in QHPs.

On the basis of our reviews of sampled applicants, we determined that certain controls were effective, e.g., verification of applicants' incarceration status, at all three marketplaces. However, the internal controls were not effective for:

- validating Social Security numbers (one sample applicant) at the Federal marketplace,
- verifying citizenship (seven sample applicants) and lawful presence (one sample applicant) at the California marketplace, and
- performing identity proofing of phone applicants (one sample applicant) and verifying minimum essential coverage through non-employer-sponsored insurance (seven sample applicants) at the Connecticut marketplace.<sup>6</sup>

On the basis of performing other audit procedures, such as interviews with marketplace officials and reviews of supporting documentation, we determined that other controls were not effective. For example, the Federal and California marketplaces did not always resolve inconsistencies in eligibility data, and the Connecticut marketplace did not always properly determine eligibility for insurance affordability programs. Further, the California and Connecticut marketplaces did not maintain all eligibility data needed to sufficiently demonstrate that applicants are eligible for enrollment, and the Federal marketplace lacked the system functionality to allow enrollees to update enrollment information. The presence of an internal control deficiency does not necessarily mean that a marketplace improperly enrolled an applicant in a QHP or improperly determined eligibility for insurance affordability programs.

These deficiencies occurred because (1) the marketplaces did not have procedures or did not follow existing procedures to ensure that applicants were enrolled in QHPs according to Federal requirements or (2) the marketplaces' eligibility or enrollment systems had defects or lacked functionality. For example, the Federal marketplace's system functionality to resolve inconsistencies in eligibility data had not been fully developed.

## *OIG Recommendations and CMS's and Marketplaces' Responses*

OIG recommends that CMS, Covered California, and Access Health CT take action to improve internal controls related to (1) verifying identity of applicants and entering application information, (2) determining applicants' eligibility for enrollment in QHPs and eligibility for

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<sup>6</sup> Connecticut marketplace officials stated that the marketplace planned to correct a system defect that prevented the marketplace from storing verification data for minimum essential coverage through non-employer-sponsored insurance for the seven applicants.

insurance affordability programs, and (3) maintaining and updating eligibility and enrollment data.

We also recommend that CMS work with Covered California and Access Health CT to implement OIG's recommendations addressing deficiencies identified at these marketplaces.

CMS concurred with all of our recommendations and provided information on actions that it had taken or planned to take to address them. California and Connecticut agreed with some of our findings and recommendations. CMS's, California's, and Connecticut's comments (full text) are included in our final report.<sup>7</sup>

## **COMPANION REPORT: Marketplaces Faced Early Challenges Resolving Inconsistencies With Applicant Data**

### *Evaluation Scope and Methodology*

This evaluation, which offers a nationwide snapshot of marketplaces, examined specifically whether and how the Federal and 15 State health insurance marketplaces resolved inconsistencies between applicants' self-attested information and the data received through the Federal Data Hub or from other data sources.

We obtained data from the State marketplaces (except for four States that did not provide the requested data) from October through December, 2013; for the Federal marketplace, we were able to analyze data through February 2014. We conducted interviews or site visits with the staffs at the Federal marketplace and all 15 State marketplaces between January and March 2014. We reviewed each marketplace's policies and procedures for resolving inconsistencies.

### *Evaluation Findings*

During the period of our review, marketplaces were unable to resolve most inconsistencies, which they reported most commonly as citizenship and income. Specifically, the Federal marketplace was unable to resolve 2.6 million of 2.9 million inconsistencies because the CMS eligibility system was not fully operational.

Each applicant can have multiple inconsistencies. Inconsistencies do not necessarily indicate that an applicant provided inaccurate information or is enrolled in a QHP inappropriately or is receiving financial assistance through insurance affordability programs inappropriately. However, marketplaces must resolve inconsistencies to ensure that eligibility determinations for enrollment in QHPs and for insurance affordability programs are accurate.

The abilities of State marketplaces to resolve inconsistencies varied:

- four State marketplaces reported that they were unable to resolve inconsistencies;

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<sup>7</sup> Available online at <http://oig.hhs.gov/oas/reports/region9/91401000.pdf>.

- seven reported that they resolved inconsistencies without delay;
- one reported that it resolved only some inconsistencies; and
- three reported that their State Medicaid offices resolved inconsistencies.

We also found that data on inconsistencies are limited. For example, the Federal marketplace could not determine the number of applicants who had at least one inconsistency. Some marketplaces reported that failures with eligibility systems allowed applicants to submit multiple applications. In these instances, each application could be processed and cause the same inconsistencies to occur and be counted multiple times. Other marketplaces reported that when the Data Hub was experiencing an outage, additional inconsistencies may have occurred because the Data Hub could not be accessed to verify applicant information.<sup>8</sup>

Finally, marketplaces faced challenges resolving inconsistencies despite having policies and procedures in place. Marketplaces reported challenges with their Web sites, their information systems, and the Data Hub that they viewed as hindering their ability to resolve inconsistencies.

### *OIG Recommendations and CMS Response*

OIG recommends that CMS develop and make public a plan on how and by what date the Federal marketplace will resolve inconsistencies. This plan should specify, at a minimum, (1) the steps that CMS and the Federal marketplace will take to clear the current backlog of inconsistencies and to ensure that the CMS eligibility system can resolve inconsistencies and (2) the methods that CMS will use to monitor, track, and measure the Federal marketplace's progress in resolving inconsistencies. OIG also recommends that CMS conduct additional oversight of State marketplaces to ensure that they are resolving inconsistencies according to Federal requirements.

CMS concurred with both of our recommendations. CMS responded that since the time of our review, the Federal marketplace has in place an interim manual process to resolve inconsistencies pertaining to citizenship and immigration status, income, and employer-sponsored minimum essential coverage. CMS also reported that it plans to replace that manual process with an automated system later this summer. The full text of CMS' response is included in our report.

### **Conclusion**

OIG's vision is to drive positive change to ensure that HHS programs operate efficiently and effectively, prevent waste and fraud, and provide safe and appropriate care and services to eligible beneficiaries. OIG advances this vision and furthers our commitment to protecting the

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<sup>8</sup> Federal regulations require that marketplaces not place applicants in an inconsistency period if the marketplace expects data from the Data Hub to be available within 1 day. 45 CFR § 155.315(f). One marketplace reported that when the Data Hub was inoperable, its system attempted to access the Data Hub several times before considering the applicant's information "inconsistent" with Federal data sources. However, not all marketplaces described their specific procedures when data from the Data Hub were unavailable.

integrity of HHS programs by conducting work that is relevant, innovative, customer focused, and high impact. The findings and recommendations that we described today are intended to do just that.

New and changing HHS programs, like the marketplaces and others, offer opportunities to improve health and welfare, prevent waste and fraud, and increase the value realized from Federal investments. They also raise challenges for efficient and effective implementation; therefore, close oversight is essential. With respect to oversight of the marketplaces and related programs, OIG has a substantial body of work underway and planned to ensure that taxpayer dollars are spent for their intended purposes in a system that operates efficiently and is secure. This work will examine critical issues, such as payment accuracy, eligibility systems, contract oversight, data security, and consumer protection.

Funding of OIG's FY 2015 budget request would enable us to continue and enhance our focus on core risk areas associated with the marketplaces, as well as HHS's other public health and human service programs, and Medicare and Medicaid.<sup>9</sup>

Thank you for your interest in and support for OIG's mission and for the opportunity to discuss our work. We are happy to answer any questions you may have.

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<sup>9</sup> For more details on OIG's impact, the essential work we have planned, and the resources needed to fulfill these mission-critical activities, see OIG's FY 2015 congressional budget justification, available online at [http://oig.hhs.gov/reports-and-publications/archives/budget/files/FY2015\\_HHSOIG\\_Congressional\\_Justification.pdf](http://oig.hhs.gov/reports-and-publications/archives/budget/files/FY2015_HHSOIG_Congressional_Justification.pdf).