United States Government Accountability Office

Report to Congressional Requesters

December 2017

FEDERAL HEALTH-INSURANCE MARKETPLACE

Analysis of Plan Year 2015 Application, Enrollment, and Eligibility-Verification Process

Accessible Version

GAO-18-169

December 2017

FEDERAL HEALTH-INSURANCE MARKETPLACE

Analysis of Plan Year 2015 Application, Enrollment, and Eligibility-Verification Process

GAO Highlights

Highlights of GAO-18-169, a report to congressional requesters

Why GAO Did This Study

The Patient Protection and Affordable Care Act (PPACA) offers subsidized health-care coverage for qualifying applicants. States may operate their own health-care marketplaces or rely on the FFM, maintained by CMS. In PY 2015, 37 states relied on the FFM and over 8 million plan selections were made through the FFM. PPACA represents a significant fiscal commitment for the federal government, which pays subsidies to issuers on participants' behalf.

GAO was asked to examine enrollment into the FFM for PY 2015, the most current data available at the time of GAO's review. This report examines the extent to which indications of potentially improper or fraudulent enrollments existed in the FFM's application, enrollment, and eligibility-verification process for the 2015 enrollment period.

GAO reviewed relevant federal statutes, regulations, and policies for PY 2015 and interviewed CMS officials. GAO analyzed eligibility and enrollment data for about 8.04 million applicants in PY 2015 to identify applicants (1) who had a citizenship, status as a national, or lawful presence inconsistency; (2) whose information did not match SSA records; or (3) who were reportedly deceased. GAO also reviewed a nongeneralizable sample of 45 applicants to more fully understand verification processes.

What GAO Recommends

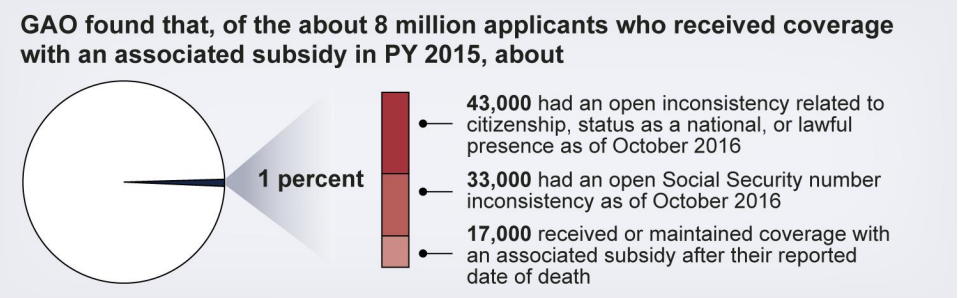
GAO recommends that CMS assess and document the feasibility of approaches to identify the deaths of individuals prior to automatic reenrollment. HHS concurred with GAO's recommendation.

View GAO-18-169. For more information, contact Seto Bagdoyan at (202) 512-6722 or bagdoyans@gao.gov.

What GAO Found

A small percentage—about 1 percent—of plan year (PY) 2015 enrollments were potentially improper or fraudulent. These applicants had unresolved inconsistencies related to citizenship, status as a national, lawful presence, or Social Security number (SSN), or received coverage while reportedly deceased, according to GAO's analysis of federally facilitated marketplace (FFM) eligibility and enrollment data. To verify applicant information, such as citizenship, status as a national, or lawful presence, and SSNs, the FFM uses data from the Department of Homeland Security (DHS) and Social Security Administration (SSA), among other sources. When an applicant's information does not match the available data sources, the FFM generates an inconsistency, and the FFM should take steps, such as requesting applicant documentation, to resolve it. Having an SSN is not a condition of eligibility; however, unresolved inconsistencies could indicate that an enrollment is potentially improper or fraudulent. The FFM did not actively resolve SSN inconsistencies for PY 2015, but the Centers for Medicare & Medicaid Services (CMS) has since completed system upgrades and established procedures for verifying SSNs with applicant-provided documentation, according to CMS officials.

About 1 Percent of Plan Year (PY) 2015 Enrollments Were Potentially Improper or Fraudulent



Source: GAO analysis of the Centers for Medicare & Medicaid Services data. | GAO-18-169

Note: Some applicants may be included in more than one category.

GAO found that applicants or enrollees may have received or maintained coverage with an associated subsidy after their reported death because the FFM did not always identify individuals as deceased in a timely manner, such as prior to automatic reenrollment. CMS relied on third parties, such as family members, to report the death of an enrollee to the FFM, but did not always receive adequate notification to verify the death. According to CMS officials, CMS is exploring approaches to identify enrollees who may be deceased and should therefore be unenrolled from coverage. The FFM checks applicants' information against death information from SSA before initial enrollment but does not recheck death information prior to reenrollment. According to CMS officials, the FFM does not reverify information, other than income, when automatically reenrolling applicants to help encourage individuals to maintain enrollment in coverage from one year to the next. Without rechecking SSA death information prior to automatic reenrollment, the FFM remains at risk of providing subsidized coverage to deceased individuals with related costs to the federal government.

Contents

Figures

Abbreviations

ACA	Affordable Care Act
APTC	advance premium tax credit
CMS	Centers for Medicare & Medicaid Services
CSR	Cost Sharing Reduction
data hub	federal data services hub
DHS	Department of Homeland Security
EVS	Enumeration Verification System
FFM	federally facilitated marketplace
HHS	Department of Health and Human Services
IRS	Internal Revenue Service
OBE	overcome by events
PPACA	Patient Protection and Affordable Care Act
PTC	premium tax credit
PY	plan year
SAVE	Systematic Alien Verification for Entitlements
SSA	Social Security Administration
SSN	Social Security number

U.S. GOVERNMENT ACCOUNTABILITY OFFICE
441 G St. N.W.
Washington, DC 20548

December 21, 2017

Congressional Requesters

The Patient Protection and Affordable Care Act (PPACA), signed into law on March 23, 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 assist consumers in comparing and selecting among insurance plans offered by participating private issuers of health-care coverage.[1] Under PPACA, states and the District of Columbia may elect to operate their own health-care marketplaces, or may rely on the federally facilitated marketplace (FFM), 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 online marketplaces, and the agency maintains the FFM.

Under PPACA, heath-care marketplaces are the mechanisms through which applicants enroll in qualified health plans. To help pay the cost of insurance premiums for taxpayers and their dependents, PPACA provides a premium tax credit (PTC) to individuals who meet certain income and other requirements. Individuals can have the federal government pay PTC to their issuers in advance on their behalf, known as advance premium tax credit (APTC), which lowers their monthly premium payments. APTC is based on estimates of household income.[3]

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

[2]In plan year 2015, which is the focus of this review, 13 states and the District of Columbia operated their own marketplace.

[3]Taxpayers who choose to have APTC must reconcile the amount of APTC paid to issuers on their behalf with PTC they are eligible for on their income-tax returns, which is computed based on the actual modified adjusted gross income calculated when filing their returns. PTC is a refundable tax credit in that, in addition to offsetting tax liability, any credit amounts in excess of tax liability are refunded to taxpayers. The Internal Revenue Service (IRS) is responsible for ensuring individuals, employers, and issuers comply with certain PPACA health-coverage and tax-filing requirements. GAO, *Improper Payments: Improvements Needed in CMS and IRS Controls over Health Insurance Premium Tax Credit*, GAO-17-467 (Washington, D.C.: July 13, 2017).

Subsidies and other costs to eligible individuals under PPACA represent a significant fiscal commitment for the federal government. As of January 2017, the Congressional Budget Office projected that the cost of coverage provisions to the federal government will increase to $51 billion for fiscal year 2017 for the FFM and state-based marketplaces. Subsidy costs are contingent on eligibility for coverage. Therefore, enrollment controls that help ensure only qualified applicants are approved for subsidized coverage are a key factor in determining federal expenditures under the act.

To enroll in health-insurance coverage offered through a marketplace created by PPACA, individuals must complete an application and meet certain eligibility requirements. For example, an individual must be a U.S. citizen or national, or be otherwise lawfully present in the United States. The marketplaces are required by law to take several steps to verify the information in individuals' applications to determine their eligibility to enroll in coverage and, if applicable, qualify for federal subsidies. Verification steps include validating an applicant's Social Security number (SSN), if one is provided; verifying citizenship, status as a U.S. national, or lawful presence; and verifying household income and family size.

In light of findings in our recent reports related to the FFM's application, enrollment, and eligibility-verification process, you asked that we examine PPACA enrollment into the FFM for plan year 2015 (the most current data available at the time of our review).[4] This report examines the extent to which indications of potentially improper or fraudulent enrollments existed in the FFM's application, enrollment, and eligibility-verification process for the 2015 enrollment period.[5]

To identify indications of potentially improper or fraudulent enrollments in the FFM's application, enrollment, and eligibility-verification process, we reviewed relevant federal statutes, HHS regulations, and CMS policies for plan year 2015; interviewed CMS officials; and analyzed eligibility and

[4]See the Related GAO Products section at the end of this report.

[5]An improper enrollment means any enrollment that should not have been made under statutory, administrative, or other legally applicable requirements and includes any enrollment of an ineligible recipient. A fraudulent enrollment involves willful misrepresentation. Whether conduct is in fact fraudulent is a determination to be made through the judicial or other adjudicative system. For purposes of this report, we did not attempt to differentiate between those enrollments that were potentially improper and those that were potentially fraudulent.

enrollment data for about 8.04 million applicants with effectuated enrollments in plan year 2015 with an associated APTC or Cost Sharing Reduction (CSR).[6] We focused our analyses on three areas based on the eligibility and verification requirements marketplaces must use to determine whether individuals are eligible to enroll and maintain coverage. Specifically, we identified and analyzed data for applicants receiving coverage with an associated subsidy (1) with inconsistencies related to citizenship, status as a national, or lawful presence;[7] (2) whose information, including SSN, did not match the Social Security Administration's (SSA) records; or (3) who were reportedly deceased. For the purposes of this report, we define applicants receiving coverage with an associated subsidy as applicants receiving coverage in plan year 2015 with an associated APTC or CSR. Because APTC is based on, among other things, estimates of household income, and taxpayers must reconcile the amount of APTC paid by the federal government to issuers on their behalf with the PTC they are eligible for on their tax returns, the number of applicants receiving coverage with an associated subsidy and the amount of associated subsidies identified through our analysis may differ from the number of applicants who ultimately received subsidized coverage and the amount of subsidies paid to issuers on their behalf.[8]

To complete our analysis of these three areas, we compared about 8.04 million applicants that received coverage with an associated subsidy for plan year 2015 to the Department of Homeland Security's (DHS) Systematic Alien Verification for Entitlements (SAVE) system from November 15, 2014, through December 31, 2015, to identify applicants with unresolved inconsistencies related to citizenship, status as a

[6]CSR is a discount that lowers the amount consumers pay for out-of-pocket charges for deductibles, coinsurance, and copayments. Because the benefit realized through the CSR subsidy can vary according to medical services used, the value to consumers of such subsidies can likewise vary. Applicants must be eligible for an APTC to be eligible for a CSR, but do not need to elect to receive the benefit of the PTC in advance. Therefore, our analysis included some applicants who had an associated CSR but did not have an associated APTC.

[7]Inconsistencies are generated by the FFM when an applicant's self-attested information does not match information contained in the data source used by the FFM, or if a data source is not available to verify the information.

[8]The reconciliation process was outside the scope of our review, which focused on the enrollment and eligibility-verification process. Therefore, we did not determine the extent to which the number of applicants who ultimately received subsidized coverage for plan year 2015 and the amount of associated subsidies paid in plan year 2015 differed from the numbers identified in our analyses.

national, or lawful presence;[9] SSA's Enumeration Verification System (EVS) from November 16, 2016, through December 29, 2016, and SSA's Affordable Care Act (ACA) batch file output from March 2017, to identify potentially invalid personal information;[10] and SSA's full death file from June 2016, to identify reportedly deceased individuals.[11] For reporting purposes, we present the results of our data-matching analyses as approximate whole numbers. Additionally, we selected a nongeneralizable sample of 45 applicants from our results to more fully understand the verification and inconsistency-resolution process.

To determine the reliability of the data used in our analysis, we performed electronic testing to determine the validity of specific data elements in the FFM and other federal data files that we used to perform our work. We also interviewed officials responsible for their respective databases, and reviewed documentation related to the databases and literature related to the quality of the data. On the basis of our own testing and our discussions with agency officials, we concluded that the data elements used for this report were sufficiently reliable for the purposes of our reporting objectives.

As discussed above, we focused our analyses on three areas. We did not perform analyses using independent data sources to verify other types of information required for applicants to enroll in qualified health plans and

[9]Inconsistencies are categorized as resolved if the applicant provides sufficient documentation to verify eligibility; expired, in most cases, if sufficient documentation has not been provided within 90–95 days; overcome by events (OBE) when no additional action is needed, such as when the application changes to a non-financial-assistance application, another inconsistency has expired, or an applicant self-corrects information on the application that allows for automatic verification with an external data source; or open if the inconsistency is not resolved, expired, or OBE. For the purposes of this report, we define "unresolved" inconsistencies as inconsistencies categorized as "open."

[10]The ACA batch file is a process developed by SSA specific for CMS to use when enrolling applicants into the FFM. The process is similar to EVS but does not provide the same response.

[11]SSA maintains two sets of death data. SSA shares its full death file with certain agencies, including CMS, that pay federally funded benefits. For other users of its death data, SSA shares the Death Master File. The Death Master File is a subset of the full death file, as it contains about 10 percent fewer death records than the full death file and does not include state-reported death data. Use of the term "full" is not meant to indicate that a file contains all deaths but rather that the file includes deaths reported by states. SSA does not have a death record for all deceased individuals (e.g., deaths not reported to SSA), and SSA does not guarantee the completeness or accuracy of its death data.

qualify for subsidies, which we have discussed in previous GAO reports. Specifically, we did not perform analysis on the following:

- *Income.* Internal Revenue Service (IRS) household income information is necessary in determining subsidy amounts, but can be up to 2 years old. Due to the age of the data, there may be discrepancies between applicants' attested information and what the marketplace obtains through the federal data services hub (data hub).[12] According to HHS regulations and CMS guidance, if electronic data are unavailable or an applicant's attestation of projected annual household income is more than 10 percent below the annual household income as computed using available data sources, the marketplace must follow inconsistency-resolution procedures. These procedures will accept differences of up to 20 percent of an applicant's attested income from what CMS is able to recalculate using supporting documentation.
- *Residency.* Individuals must intend to reside in the state in which they are applying for coverage and are not required to have a fixed address in the state. The marketplace can accept self-attestation unless the information provided by the applicant is not reasonably compatible with other information provided by the applicant or in the records of the marketplace. HHS has recently stated that its previous assessments of available sources did not identify any comprehensive data source for verifying residency. However, we previously reported that CMS did not document an evaluation of available external sources to determine the quality, relevance, and reliability of the data, and we recommended that it do so.[13]
- *Incarceration.* Individuals must not be incarcerated (unless incarcerated while awaiting disposition of charges). We have previously reported that there are many challenges associated with using incarceration data, including the risk of false positives.[14]

[12]The data hub is a portal developed by CMS for exchanging information between the FFM, state-based marketplaces, and Medicaid agencies, among other entities, and CMS's external partners, including other federal agencies such as SSA, DHS, and the IRS, among others. For further background, see GAO, *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), and *HeathCare.gov: Actions Needed to Address Weaknesses in Information Security and Privacy Controls*, GAO-14-730 (Washington, D.C.: Sept. 16, 2014).

[13]GAO-17-467. HHS concurred with our recommendation.

[14]GAO-16-29.

For more detailed information on our scope and methodology, see appendix I.

We conducted this performance audit from November 2015 to December 2017 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

CMS operates the FFM consistent with PPACA and relevant HHS regulations. In plan year 2015, 37 states relied on the FFM. The remaining 14 states, including the District of Columbia, operated their own state-based marketplaces. According to published HHS figures, the FFM accounted for about 76 percent, or approximately 8.8 million, of plan selections made via marketplaces from November 15, 2014, through February 22, 2015.[15] Overall, we found that about 8.04 million applicants selected a plan, effectuated enrollment, and received coverage with an associated subsidy for plan year 2015.[16] We discuss these 8.04 million applicants later in this report. More than half of the 8.8 million plans in plan year 2015 were applicants who did not have a plan via the FFM in plan year 2014, which was the FFM's first year. Of the 8.8 million total plans, 87 percent qualified for an APTC with an average APTC of $263 per application per month.[17]

[15]Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Health Insurance Marketplaces 2015 Open Enrollment Period: March Enrollment Report* (Mar. 10, 2015).

[16]The data for the plan selections made using HealthCare.gov include those who applied between November 15, 2014, and February 15, 2015, and those who enrolled during a special enrollment period on or before February 22, 2015. The final number of applicants who received coverage with an associated subsidy in plan year 2015 differs from the number of plan selections because not all applicants who selected a plan paid the premium to effectuate their policy, not all applicants qualified for subsidies, and some applicants enrolled during a special enrollment period after February 22, 2015.

[17]The amount of APTC also varies with changes in family size and the insurance premiums for the marketplace health plans offered in the area where a taxpayer resides.

All marketplaces, including the FFM, are required by PPACA to verify applicant information to determine eligibility for enrollment and income-based subsidies, if applicable.[18] Marketplaces, among other things, must

- check for Medicaid eligibility before determining eligibility for qualified health plans;
- validate an applicant's SSN, if one is provided, by comparing with SSA records;[19]
- verify citizenship, status as a U.S. national, or lawful presence by comparing with SSA or DHS records, respectively;[20] and
- verify household income and family size by comparing with tax-return data from the IRS, as well as data on Social Security benefits from SSA.[21]

If the information the applicant provided on the application does not match the information contained in the data source, or if a data source is not available to verify the information, the FFM generates an inconsistency. The FFM then sends a notification to the applicant, who generally has 90 days to present satisfactory documentary evidence to resolve the inconsistency, and grants the applicant conditional eligibility if the applicant is otherwise qualified.[22] While waiting for supporting documentation, the FFM attempts to review and resolve the

[18]CMS uses a document-processing contractor, which reviews documentation applicants submit, by mail or online upload, to resolve inconsistencies.

[19]A marketplace must require an applicant who has an SSN to provide the number. 42 U.S.C. § 18081(b)(2) and 45 C.F.R. § 155.310(a)(3)(i). However, having an SSN is not a condition of eligibility.

[20]DHS systems can also verify naturalized, or in some cases derived, citizenship based upon identification numbers on naturalization certificates and certificates of citizenship.

[21]We reported in July 2017 that CMS's control activities related to the accuracy of APTC calculations based on income and family size were not properly designed. Specifically, we found that CMS accepts applicant attestations of family size without further verification and we recommended that CMS design and implement procedures to verify family size with the IRS. GAO-17-467.

[22]For 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. Time periods may be extended under certain circumstances.

inconsistency, which can include looking for obvious errors on the application. The FFM will generally categorize inconsistencies as expired if the applicant was not able to provide the supporting documentation to resolve the inconsistency within the allotted time frame and the FFM was not able to resolve the inconsistency. Depending on the type of inconsistency and availability of data sources, an applicant with an expired inconsistency may have his or her coverage terminated, or the applicant's subsidy amount may be recalculated based on the trusted source information or eliminated. In other circumstances, the applicant's situation may change such that no additional action is required by the FFM to address the inconsistency. These inconsistencies are categorized as overcome by events (OBE) and can include situations where the application changes to a non-financial-assistance application or another inconsistency has expired. Inconsistencies that the FFM cannot resolve, expire, or categorize as OBE remain open.

We previously made recommendations to improve the FFM's enrollment and eligibility-verification process. Specifically, in 2016, we made eight recommendations, including that CMS consider analyzing outcomes of the verification system, take steps to resolve inconsistencies related to SSNs, and conduct a risk assessment of the potential for fraud in marketplace applications.[23] HHS concurred with our recommendations. In 2017, we made 10 recommendations to HHS involving the annual reporting of APTC improper-payments estimates, improving control activities related to eligibility determinations, and calculations of APTC based on incomes and family sizes.[24] HHS concurred with 7 of the recommendations and neither agreed nor disagreed with the remaining 3 recommendations, which related to improving control activities for verifying identities of individuals, preventing duplicate coverage of individuals receiving minimum essential coverage through their employers, and verifying household incomes and family sizes. As of November 2017, HHS has not provided us with documentation to support the implementation of recommendations made in 2016 or 2017. As a result, the 18 recommendations remain open.

[23]GAO-16-29.

[24]GAO-17-467.

Analyses Identified about 1 Percent of Enrollments during Plan Year 2015 as Potentially Improper or Fraudulent, with Challenges Remaining in the Identification and Reenrollment of Reportedly Deceased Individuals

About 1 Percent of Enrollments for Plan Year 2015 Were Identified as Potentially Improper or Fraudulent

Our analysis of plan year 2015 FFM enrollment and eligibility data identified a small percentage—about 1 percent—of enrollments that were potentially improper or fraudulent because they had an unresolved issue related to citizenship, status as a national, or lawful presence, or to SSN, or were reportedly deceased.[25] The presence of an unresolved data-matching inconsistency could indicate that an enrollment is potentially improper or fraudulent because an unresolved inconsistency indicates that the FFM could not verify information provided by the applicant. When a data-matching inconsistency is generated, HHS regulations require that the applicant provide supporting documentation generally within 90 days to resolve the inconsistency. If the applicant does not provide requested documentation within the time frame and the FFM cannot otherwise verify the information provided by the applicant, the inconsistency may be expired, which could lead to termination from coverage or a recalculation or elimination of subsidy amounts based on the trusted data source information, depending on the type of inconsistency. In addition, in our prior undercover work, we were able to obtain and maintain coverage for fictitious applicants by submitting fictitious or no documents to resolve a

[25]The 1 percent (about 87,000 applicants) represents unique applicants who at the end of plan year 2015 had open inconsistencies related to citizenship, status as a national, or lawful presence status, or to SSN, or received coverage with an associated subsidy while reportedly deceased. As discussed in the sections that follow, we identified about 43,000 applicants with an open inconsistency related to citizenship, status as a national, or lawful presence; about 33,000 applicants with an open SSN inconsistency; and about 17,000 applicants who received or maintained coverage with an associated subsidy after the date reported in SSA's full death file as their date of death. Some applicants fell into more than one of these categories.

data-matching inconsistency.[26] Our undercover work has also previously shown that the FFM did not verify the authenticity or accuracy of the documents we submitted to resolve inconsistencies. As part of our current analyses, we did not independently verify the instances where the FFM resolved inconsistencies when applicants provided the requested documentation during this engagement. However, if the FFM did not corroborate information on applicant-provided documentation with the appropriate agency, some applicants with resolved data-matching inconsistencies may have received coverage with an associated subsidy potentially improperly or fraudulently.

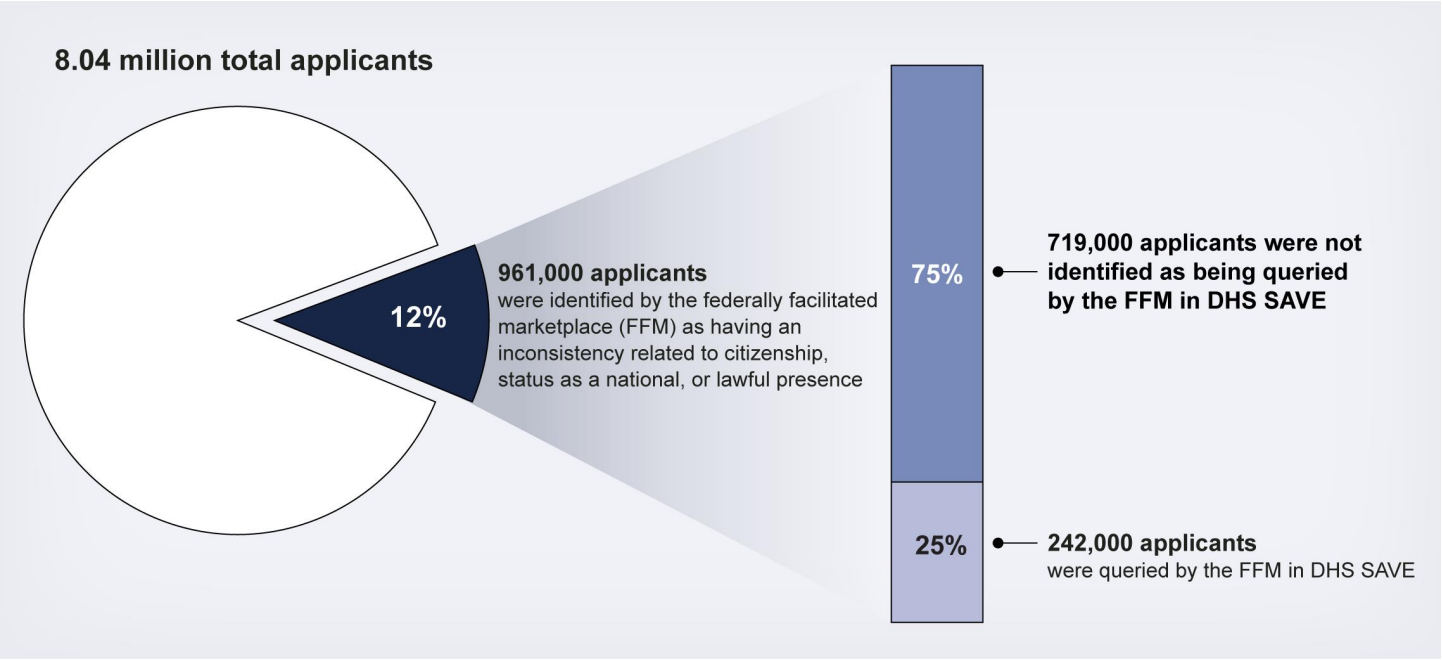
Verification of Citizenship, Status as a National, or Lawful Presence Status

Most of the about 8.04 million applicants who received coverage with an associated subsidy in plan year 2015 provided information that allowed the FFM to verify an applicant's status as a U.S. citizen or national, or lawfully present in the United States. Nevertheless, the FFM did identify some inconsistencies related to citizenship, status as a national, or lawful presence. The FFM flags applicants as having an inconsistency if they attested to being a citizen but their status as a citizen could not be verified—for example, because their SSN and other information does not match SSA records—or they attest to an eligible immigration status but their lawful presence could not be immediately verified. Specifically, based on our analysis of enrollment data provided by CMS, the FFM initially identified approximately 88 percent of about 8.04 million applicants as a U.S. citizen or national, or lawfully present in the United States. The FFM identified the remaining approximately 961,000 applicants (12 percent), as having inconsistencies related to citizenship, status as a national, or lawful presence.

[26]GAO, *Patient Protection and Affordable Care Act: Results of Enrollment Testing for the 2016 Special Enrollment Period*, GAO-17-78 (Washington, D.C.: Nov. 17, 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-16-784 (Washington, D.C.: Sept. 12, 2016); *Patient Protection and Affordable Care Act: Final Results of Undercover Testing of the Federal Marketplace and Selected State Marketplaces for Coverage Year 2015,* GAO-16-792 (Washington, D.C.: Sept. 9, 2016); *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); 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).

The FFM was able to obtain information from the DHS SAVE program to address some inconsistencies related to citizenship, status as a national, or lawful presence, but issues with applicant-provided information precluded the FFM from querying all of the inconsistencies. The FFM queried DHS SAVE records for about 242,000 of the 961,000 applicants with inconsistencies (25 percent), but we were not able to identify queries for about 719,000 (75 percent). See figure 1 below for a comparison of FFM inconsistencies related to citizenship, status as a national, or lawful presence to DHS SAVE records.

Figure 1: Federally Facilitated Marketplace Use of the Department of Homeland Security (DHS) Systematic Alien Verification for Entitlements (SAVE) Program during Plan Year 2015



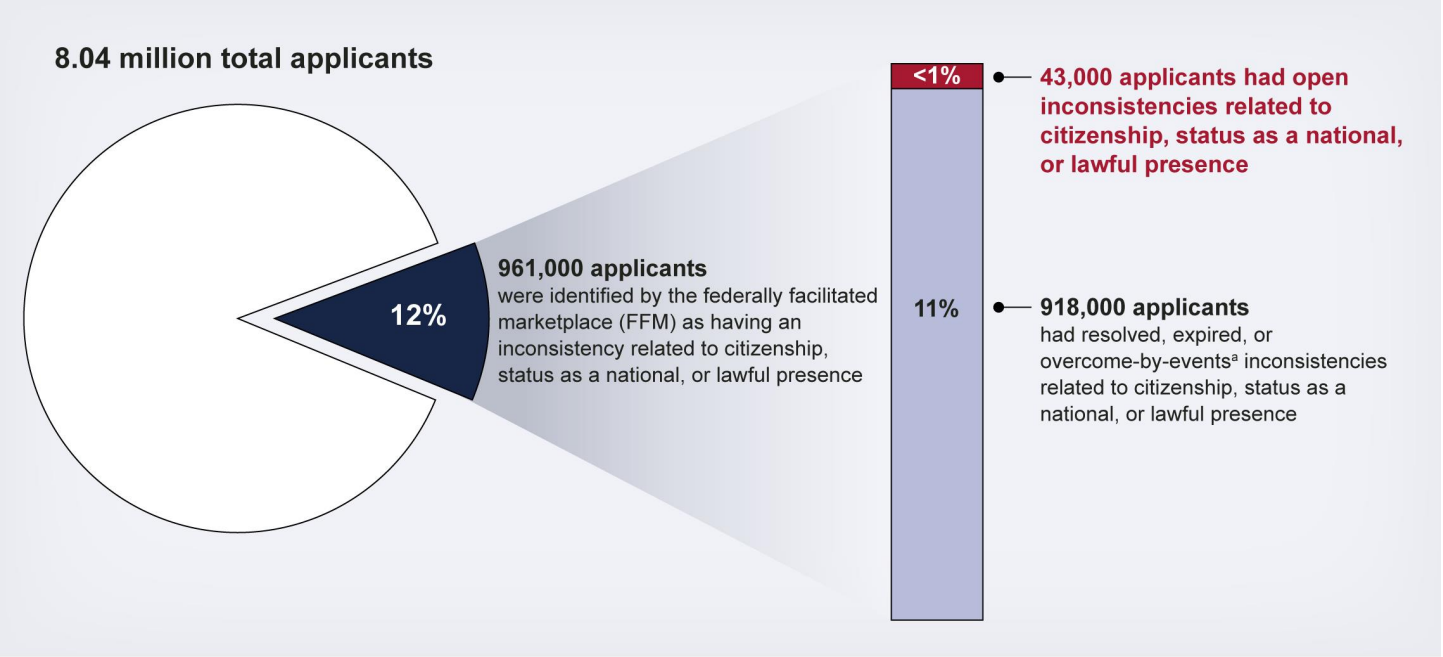
Source: GAO analysis of the Centers for Medicare & Medicaid Services data. | GAO-18-169

We found that the FFM could not query these 719,000 applicants mostly because of the quality of information submitted by applicants. Specifically, many of the applicants the FFM could not query were missing information such as immigration numbers that the DHS SAVE program requires. For example, we found applicants who provided their name and date of birth but did not provide an immigration number, which prevented the FFM from using the DHS SAVE program to verify citizenship or lawful

presence status. Such cases required the FFM to request supporting documentation from the applicant.[27]

After the initial comparison to the DHS SAVE program, the FFM attempts to resolve remaining inconsistencies by first looking for obvious errors and then by using additional documentation requested from the applicant. See figure 2 below for an overview of inconsistencies related to citizenship, status as a national, or lawful presence that remained unresolved (i.e., open), as of December 31, 2015.[28]

Figure 2: Federally Facilitated Marketplace Unresolved Inconsistencies Related to Citizenship, Status as a National, or Lawful Presence for Plan Year 2015



Source: GAO analysis of the Centers for Medicare & Medicaid Services data. | GAO-18-169

Note: Numbers do not sum due to rounding. Graphic is not to scale.

[27]Per PPACA, an applicant need not be a U.S. citizen or national to be eligible, but does need to be legally present. Therefore, an immigration-related inconsistency can be resolved via documentation of lawful presence.

[28]According to CMS officials, the plan year 2015 inconsistencies were not updated after December 31, 2015. Instead, this information was carried forward and new inconsistencies were generated for plan year 2016.

[a]Overcome by events indicates that no additional action is required by the FFM to address the inconsistency, and can include situations where the application changes to a non-financial-assistance application or an applicant updates information on his or her application.

As shown in figure 2, CMS addressed some, but not all, inconsistencies. Specifically, about 43,000 inconsistencies related to citizenship, status as a national, or lawful presence (less than 1 percent of total applicants) remained in an open status as of December 31, 2015. An open status indicates that CMS was unable to resolve or obtain documentation to clarify the issues that led to the inconsistency. In some cases, an inconsistency generated late in the year may have remained open but, according to CMS officials, would have carried forward and generated a new inconsistency for plan year 2016. Inconsistencies that remained open because they were not resolved within the required time frame represent potentially improper or fraudulent applicants who retained coverage without providing sufficient supporting documentation to resolve their inconsistency. However, the number of potentially improper or fraudulent applicants may be understated since we only took into consideration those with inconsistencies in an open status and not applicants with expired inconsistencies who may have continued to receive coverage and had subsidies paid to issuers on their behalf before CMS was able to terminate their coverage and subsidies.

To examine steps taken by the FFM when processing inconsistencies related to citizenship, status as a national or lawful presence, we selected a nongeneralizable sample of 15 of the 961,000 applicants that the FFM identified. For 13 out of the 15, the FFM verified the applicant's information through supporting documentation or DHS SAVE and resolved or expired the inconsistency in accordance with its standard operating procedures, or the FFM categorized the applicant as OBE because of an application update that made the inconsistency no longer relevant. We did note that in 2 of the 13 cases, the FFM did not perform a DHS SAVE program query to corroborate the supporting documentation. However, this was not required at the time the applicants enrolled, which was prior to June 2015 when CMS established that procedure.

In the remaining cases, the FFM did not verify the applicants' information in plan year 2015, but the applicants received coverage beyond the 95-day inconsistency-resolution period. For example, in one case we found that the applicant obtained multiple policies for different periods during the year without ever providing sufficient information to verify his or her status as a U.S. citizen or national, or being lawfully present in the United States. As a result, the applicant was able to obtain coverage for two-thirds of the coverage year. According to CMS, this inconsistency was

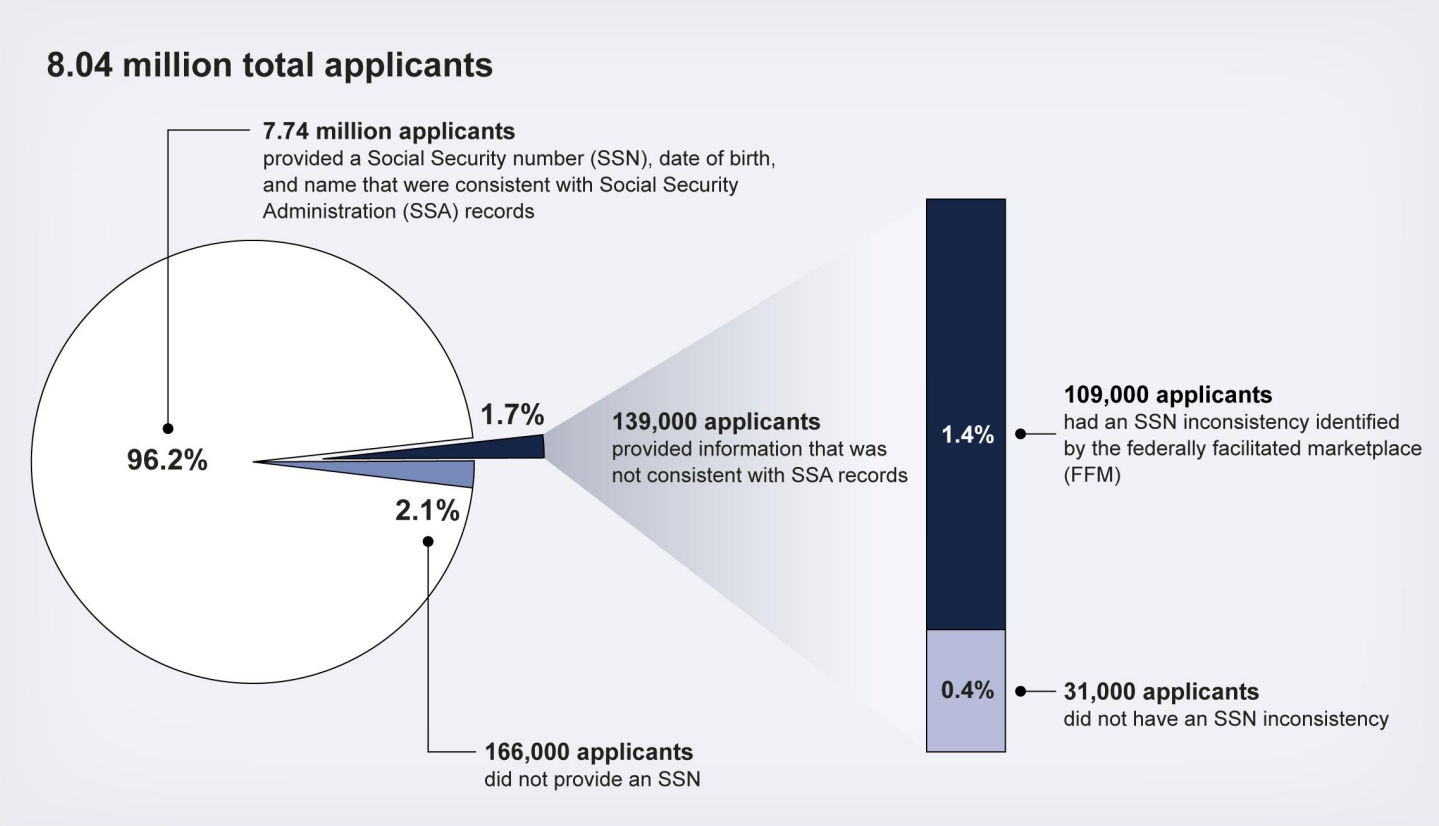
carried over to plan year 2016, when the inconsistency was expired and the applicant's coverage was terminated.

Verification of Social Security Numbers

Most applicants for plan year 2015 who received coverage with an associated subsidy submitted SSNs and other information that matched SSA records, and the FFM identified SSN inconsistencies for most of the applicants whose information did not match SSA records. As shown in figure 3, our analysis found that over 96 percent of applicants (7.74 million out of about 8.04 million) submitted information that was consistent with SSA records, but about 139,000 (1.7 percent of total applicants) did not. The other 166,000 applicants (2.1 percent) did not provide an SSN on their application.[29]

[29]The FFM must require applicants who have an SSN to provide the number. 42 U.S.C. § 18081(b)(2) and 45 C.F.R. § 155.310(a)(3)(i). However, having an SSN is not a condition of eligibility. We did not verify whether any of the 166,000 applicants who did not provide an SSN had an SSN.

Figure 3: Federally Facilitated Marketplace Applicants Receiving Subsidized Qualified Health Coverage for Plan Year 2015 Whose Personal Information Did Not Match the Social Security Administration's Records



Source: GAO analysis of the Centers for Medicare & Medicaid Services data. | GAO-18-169

Note: Numbers and percentages do not sum due to rounding. Figure is not to scale.

Of the approximately 139,000 applicants (1.7 percent) whose information did not match SSA records in our analysis, we found that the FFM identified an SSN inconsistency for about 109,000 (1.4 percent of total applicants).[30] The FFM did not designate the remaining applicants whose information did not match SSA records in our analysis (about 31,000 of 139,000 applicants) as having an SSN inconsistency for plan year 2015, indicating that the FFM did not flag the applicant's information as not

[30]The 109,000 applicants with an SSN inconsistency may overlap with the 961,000 applicants with an inconsistency related to citizenship, status as a national, or lawful presence because applicants can have multiple inconsistencies. As discussed later in this section, according to CMS officials, most applicants with an SSN inconsistency also had an inconsistency related to citizenship, status as a national, or lawful presence.

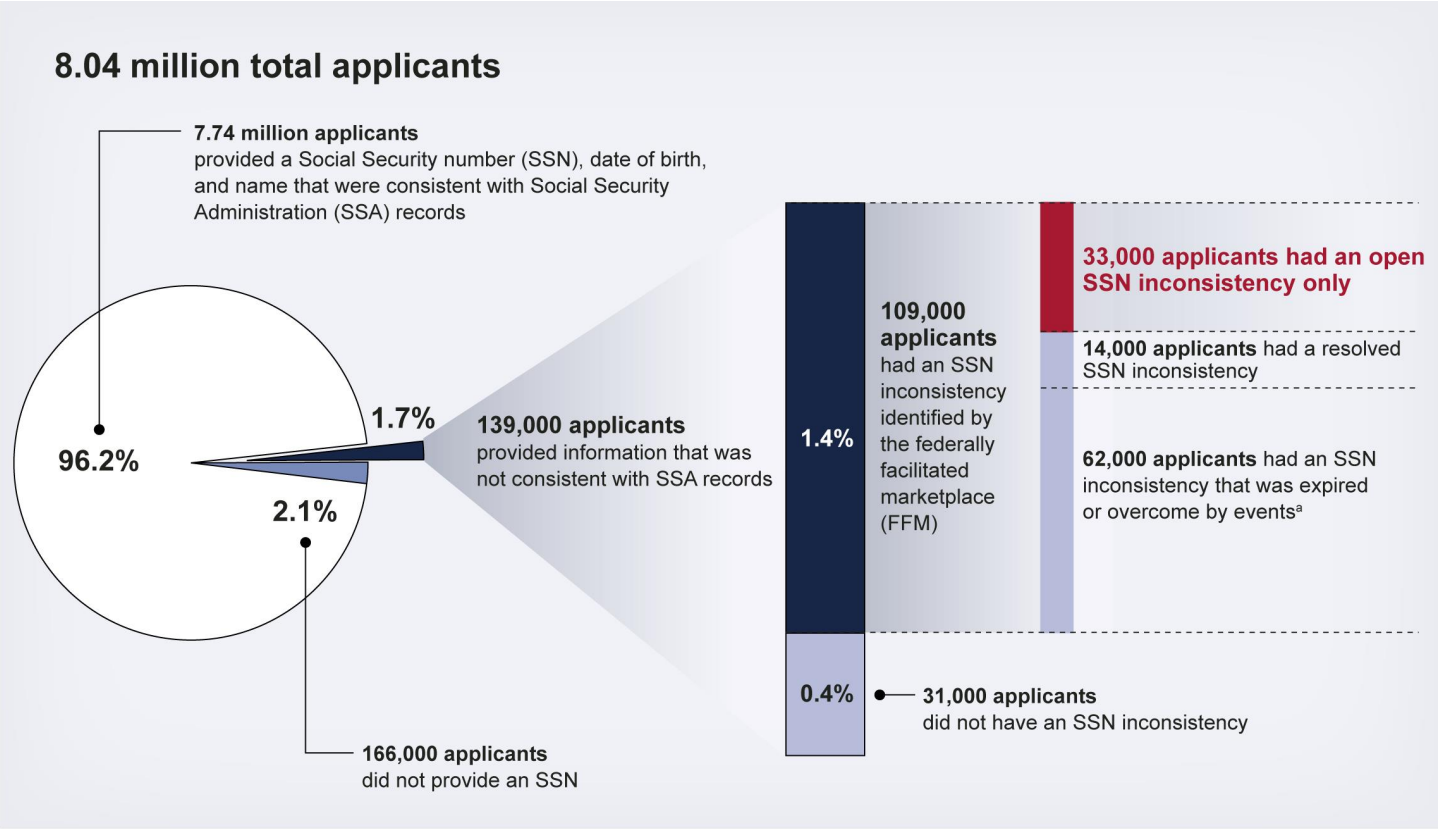
matching SSA records.[31] The FFM may not have flagged an applicant's information for plan year 2015 as not matching SSA records if the applicant's information matched SSA records at the time of enrollment but the applicant later changed his or her name with SSA.

The FFM did not address all SSN inconsistencies for plan year 2015. Specifically, about 33,000 of the 109,000 applicants for whom the FFM identified an SSN inconsistency for plan year 2015 (less than 1 percent of total applicants) had an open SSN inconsistency only (see fig. 4).[32]

[31]The number of applicants with an SSN inconsistency and the number of applicants without an SSN inconsistency does not equal the number of applicants whose information did not match SSA records because of rounding.

[32]The 33,000 applicants with an open SSN inconsistency may overlap with the 43,000 applicants with an open inconsistency related to citizenship, status as a national, or lawful presence because applicants can have multiple inconsistencies.

Figure 4: Federally Facilitated Marketplace Unresolved Social Security Number Inconsistencies for Plan Year 2015



Source: GAO analysis of the Centers for Medicare & Medicaid Services data. | GAO-18-169

Note: Numbers and percentages do not sum due to rounding. Figure is not to scale.

[a]Overcome by events indicates that no additional action is required by the FFM to address the inconsistency, and can include situations where the application changes to a non-financial-assistance application or an applicant updates information on his or her application.

An open SSN inconsistency may indicate a potentially improper or fraudulent enrollment because it indicates that the FFM did not verify the applicant's identity information but the applicant retained coverage. Applicants may have had open SSN inconsistencies in plan year 2015 because the FFM did not take steps to actively resolve SSN inconsistencies at that time. In some cases, an inconsistency generated late in the year may have remained open but, according to CMS officials, would have carried forward and generated a new inconsistency for plan year 2016. According to CMS officials, the FFM did not actively take steps to resolve SSN inconsistencies in plan year 2015 primarily because the FFM could not update SSNs in the data system at the time, as discussed in more detail later in this section. We previously reported that open SSN

inconsistencies are indicators of potentially fraudulent applications.[33] Specifically, we reported that we had successfully enrolled and received coverage with an associated subsidy in plan year 2015 for eight undercover identities that either did not provide an SSN or had an invalid Social Security identity.[34] Further, HHS regulations state that the FFM must follow its standard inconsistency procedures if it is unable to validate an individual's SSN through SSA.[35] To address this issue we recommended that CMS design and implement procedures to resolve SSN inconsistencies. In May 2017, CMS established written procedures for verifying SSNs with documents submitted by applicants, as discussed in more detail later in this report.[36]

The remaining applicants with an SSN inconsistency for plan year 2015 had either a resolved SSN inconsistency (14,000 applicants) or an SSN inconsistency that was expired or OBE (62,000 applicants). Although the FFM was not actively resolving SSN inconsistencies in plan year 2015, according to CMS officials, most applicants with an SSN inconsistency also had an inconsistency related to citizenship, status as a national, or lawful presence, and documentation submitted to resolve those inconsistencies may also resolve SSN inconsistencies.[37] For example, according to CMS officials, if an applicant submitted a Social Security card to the FFM, an SSN inconsistency could be resolved based on that documentation. If an inconsistency related to citizenship, status as a national, or lawful presence expired, the FFM automatically expired the SSN inconsistency, according to CMS procedures. According to CMS officials, the FFM closed SSN inconsistencies as OBE if no action needed to be taken on the inconsistency because it was no longer relevant to the application, such as in cases where the applicant corrected his or her SSN on the application.

[33]GAO-16-29.

[34]GAO-15-702T and GAO-16-29.

[35]45 C.F.R. § 155.315(b).

[36]We reviewed documentation describing these procedures but did not independently verify that the procedures had been implemented because the changes were outside the scope of our review.

[37]However, we previously reported that applicants can have SSN inconsistencies without a corresponding inconsistency related to citizenship, status as a national, or lawful presence. See GAO-16-29.

To examine steps taken to verify SSNs and process SSN inconsistencies, we reviewed a nongeneralizable sample of 15 applicants of the 139,000 applicants who received coverage with an associated subsidy in plan year 2015 whose information did not match SSA records in our analysis. In 3 of the 15 cases, additional information provided by CMS indicates that the FFM verified that the SSN on the application was correct. Specifically, in two of the cases, our analysis found that the applicant's information did not match SSA records but the FFM verified the applicant's information and did not generate an SSN inconsistency. As previously discussed, the FFM may not have identified an SSN inconsistency if the applicant's information matched SSA records at the time of enrollment but the applicant later changed his or her name with SSA. In both of these cases, we found that the applicant's date of birth matched SSA records but the name did not, indicating that the applicant may have changed his or her name. In the third case, the FFM resolved the SSN inconsistency in plan year 2015 when the applicant submitted a Social Security card showing the same name and SSN as the application.[38]

In 5 of the 15 cases, the applicant had an SSN inconsistency in plan year 2015 that was not resolved. Specifically, in two of the five cases, the SSN inconsistency expired when an inconsistency related to citizenship, status as a national, or lawful presence was expired, in accordance with CMS procedures. In one case, the SSN inconsistency remained open because, as previously noted, the FFM did not take direct action to resolve SSN inconsistencies in plan year 2015, according to CMS officials. In two cases, the SSN inconsistency was OBE. According to CMS officials, an inconsistency status may be changed to OBE when the inconsistency no longer needs to be addressed as a result of changes to the application, such as when an applicant updates information on his or her application or the application changes to a non-financial-assistance application. CMS officials did not specify what circumstances resulted in the status of these two SSN inconsistencies being changed to OBE; however, one of the applicants had a subsequent health-insurance policy that did not provide financial assistance.

We found that in 5 of the 15 cases, the FFM either resolved an SSN inconsistency in plan year 2015 when the applicant submitted a Social Security card or did not generate an SSN inconsistency for plan year

[38]We determined that the applicant name and SSN matched SSA records, but the SSN inconsistency was generated because the date of birth provided by the applicant did not match SSA records.

2015 because the applicant had provided a Social Security card in plan year 2014, but information on the applicant-provided Social Security card did not match information in CMS's data system. CMS officials did not indicate that the FFM had verified the name and SSN on the applicant-provided Social Security cards in these five cases with SSA records. The SSN on applicant-provided documentation may not have matched the SSN in CMS's data because, as discussed previously, system limitations existed prior to March 2017. Specifically, even if the FFM received a Social Security card to resolve an inconsistency, the FFM did not reflect this change in CMS's data system because the system did not have the capability to modify or update SSN information at the time, according to CMS officials. For example, if an applicant mistyped his or her SSN, the inconsistency may have been subsequently resolved if the applicant submitted a Social Security card, but CMS's data system would continue to reflect the incorrect SSN that had been originally submitted.

Finally, we found that in 2 of the 15 cases, the FFM resolved the SSN inconsistency in plan year 2015 or the FFM did not generate an SSN inconsistency in 2015 because it resolved an SSN inconsistency in plan year 2014, but information provided by CMS did not support the resolution of the SSN inconsistency. Specifically, in one case in which the FFM resolved an SSN inconsistency for plan year 2015, we could not determine how the SSN inconsistency was resolved because, according to CMS officials, the applicant did not provide documentation of his or her SSN. In another case, the FFM automatically reenrolled an applicant for plan year 2015 without an SSN inconsistency after identifying an SSN inconsistency in plan year 2014 because, according to CMS officials, the applicant submitted a passport to resolve a citizenship inconsistency. While submission of a U.S. passport can be used to verify citizenship, CMS procedures do not permit using a passport to resolve an SSN inconsistency, and the applicant's passport did not contain an SSN. Because the applicant did not provide any other documentation to resolve the SSN inconsistency in plan year 2014 and the FFM did not generate an SSN inconsistency in plan year 2015, even though the applicant's information did not match SSA records, we could not determine whether CMS's data system reflects the correct SSN for this applicant.

According to CMS officials, having an incorrect SSN on the application does not affect eligibility, since having an SSN is not a requirement for eligibility. However, as previously discussed, resolving data-matching inconsistencies without corroborating information with the appropriate agency puts the FFM at risk of approving potentially fraudulent or improper applications for subsidized coverage. We identified

approximately $59 million in APTC for plan year 2015 associated with the applications of the 14,000 applicants who provided SSNs and other information that did not match SSA records and had a resolved SSN inconsistency. The $59 million may include APTC associated with applicants whose SSN inconsistencies were resolved without sufficient documentation, applicants who had SSN inconsistencies that were resolved based on applicant-submitted documentation that does not match the SSN in CMS's data system, and applicants whose SSN inconsistencies were resolved appropriately.[39] We identified $112 million in APTC associated with the applications of applicants who did not have an SSN inconsistency flagged in plan year 2015, although some information did not match SSA records in our analysis.[40] We could not associate APTC subsidies with individual applicants because applications may include more than one person.[41]

Further, inaccurate SSNs in CMS's system potentially impede the IRS's ability to reconcile APTC. The IRS is responsible for processing tax returns to determine the final amount of PTC to which taxpayers are entitled and for recovering APTC overpayments. To enable the IRS to reconcile APTC, PPACA requires marketplaces to report certain information on individuals with marketplace coverage, including the name, address, and taxpayer-identification number—an SSN in cases where the individual has one—to the IRS.[42] The IRS compares information provided

[39]As discussed previously, we identified sample cases in which applicants had resolved SSN inconsistencies in each of these categories. However, we cannot determine the portion of this amount attributable to cases in each of these categories because the sample of cases we reviewed was nongeneralizable.

[40]This amount may include cases in which the FFM verified the SSN but our analysis did not, such as cases in which the applicant changed his or her name after initial enrollment.

[41]The CMS data provided the APTC amounts at the policy level, but inconsistencies occur at the individual level. As a result, we could not associate subsidies with a specific individual and subsidy amounts associated with applicants with resolved SSN inconsistencies and applicants whose information did not match SSA records but did not have an SSN inconsistency may not be mutually exclusive. We do not report the amount of CSR associated with these applications because the benefit realized through the CSR subsidy can vary according to medical services used and therefore the value of such subsidies to enrollees can likewise vary. However, we note that because, in plan year 2015, the federal government made advance payments of CSRs to issuers of health-care policies on enrollees' behalf, there may have been costs associated with individuals who improperly or fraudulently received coverage and eligibility for CSRs even if such individuals did not obtain medical services, if excess CSR payments were not identified and recovered.

[42]26 U.S.C. § 36B(f)(3).

by the marketplace on the APTC paid to issuers on taxpayers' behalf to the amount for which taxpayers qualify based on actual household income and family size reported on their tax returns.

In March 2017, system functionality upgrades were completed and deployed to enable the FFM to modify or update SSNs, according to CMS officials. In addition, as noted previously, CMS established procedures in May 2017 for verifying SSNs with documents submitted by applicants. These procedures require the FFM to take steps to update and verify SSNs by (1) obtaining documentation of the SSN or processing previously received SSN documents, (2) entering the SSN shown on documentation into CMS's data system, and (3) trying to verify the newly entered or corrected SSN with SSA records. Further, the procedures direct the FFM to escalate cases for CMS review if the SSN cannot be verified, or documentation submitted to verify the SSN matches the information originally provided by the applicant that could not be verified with SSA records, as this may indicate potential fraud. We did not independently verify that the procedures have been implemented because the changes occurred outside the scope of our review; however, if properly implemented, these changes may help reduce the risk that potentially improper or fraudulent applicants could obtain subsidized coverage by helping to ensure that SSNs are appropriately verified and corrected in CMS's data system.

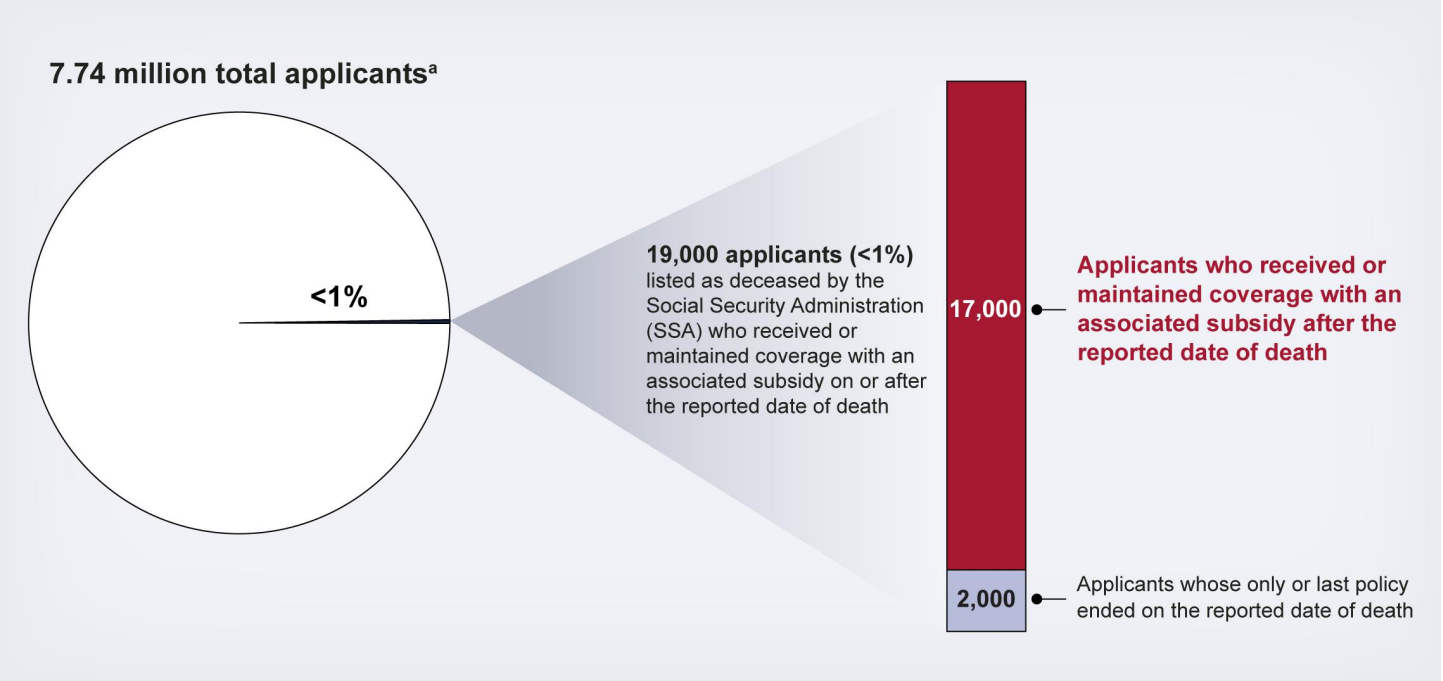
Relatively Few Reportedly Deceased Individuals Received Coverage with an Associated Subsidy, but Challenges Remain with Identifying Deceased Individuals before Automatic Reenrollment

We found relatively few indicators that reportedly deceased individuals received coverage with an associated subsidy during plan year 2015. Specifically, we identified about 19,000 out of the approximately 7.74 million applicants who provided SSNs and other information that matched SSA records (about 0.24 percent) who received coverage with an associated subsidy on or after the date listed in the full death file as their date of death.[43] HHS regulations state that in the case of termination of coverage due to death, the last day of enrollment in a qualified health plan through the FFM is the date of death.[44] However, the FFM did not always terminate the enrollment of individuals through the exchange as of the date reported in the full death file as their date of death. Specifically, we found that the coverage for about 2,000 of the 19,000 reportedly deceased individuals ended on their reported date of death, but the remaining approximately 17,000 received or maintained coverage with an associated subsidy—APTC or CSR, which the federal government pays to issuers on behalf of enrollees—after their reported date of death (see fig. 5).

[43]For purposes of this report, we refer to individuals whose name and SSN were listed in SSA's full death file as reportedly deceased, and we refer to the date of death listed in the full death file as the reported date of death. It is not possible to determine from data matching alone whether these matches definitively identify individuals receiving coverage with an associated subsidy who were deceased because individuals can be erroneously listed in the full death file.

[44]45 C.F.R. § 155.430(d)(7).

Figure 5: Federally Facilitated Marketplace Applicants Receiving Subsidized Qualified Health Coverage Who Were Reportedly Deceased While Receiving Coverage in Plan Year 2015



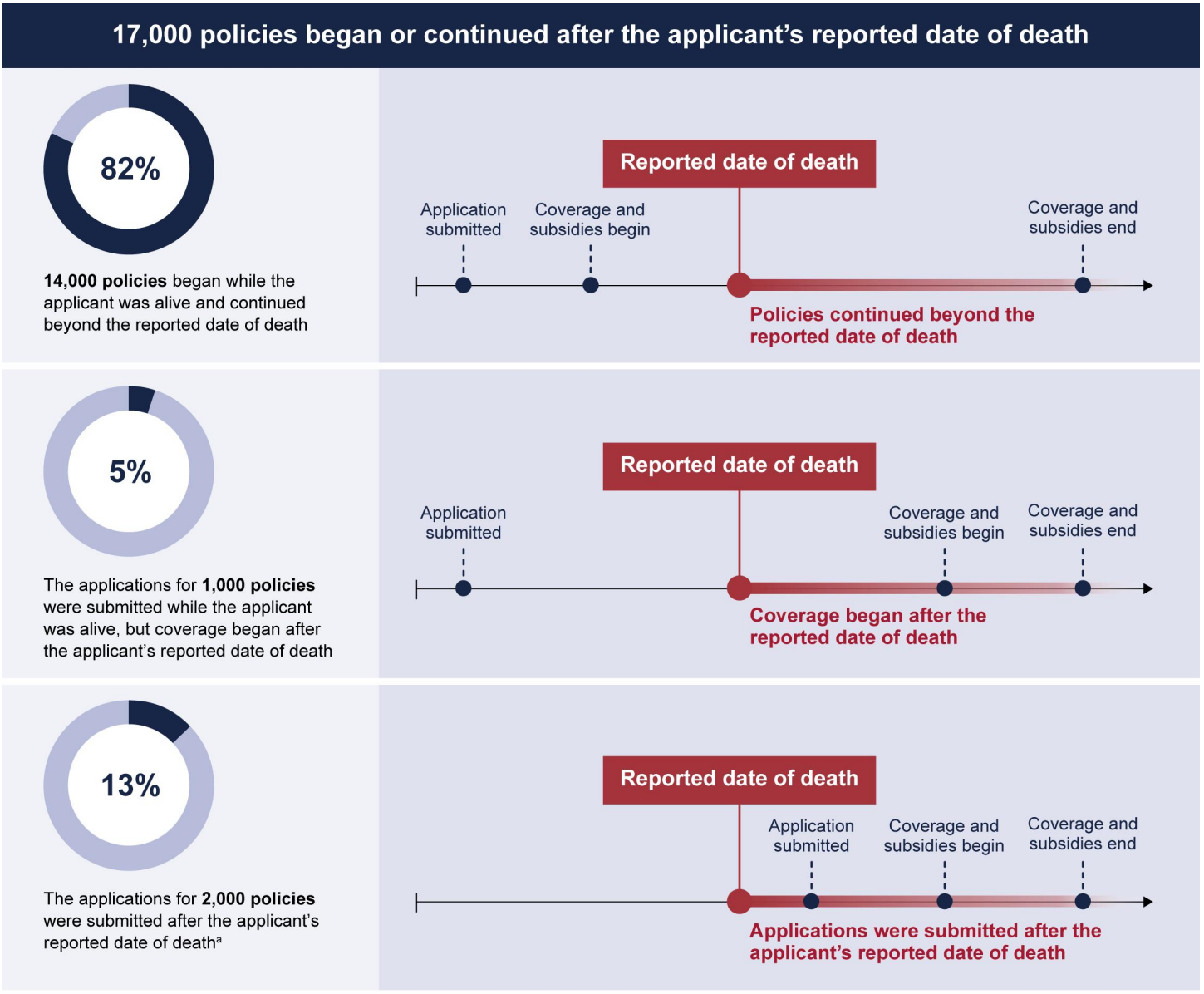
Source: GAO analysis of the Centers for Medicare & Medicaid Services data. | GAO-18-169

Note: Figure is not to scale. Numbers are rounded to the nearest thousand.

[a]A total of about 8.04 million applicants received coverage with an associated subsidy— Advance Premium Tax Credit or Cost Sharing Reduction—in plan year 2015. We compared 7.74 million applicants to the Social Security Administration's (SSA) full death file to identify applicants who received coverage with an associated subsidy after the date reported in the full death file as their date of death. We could not match the remaining 307,000 applicants to the full death file because their information could not be verified with SSA records.

Most insurance policies associated with reportedly deceased applicants began when they were alive and continued after their deaths, but in some cases the date of submission of the application for coverage occurred after the individual's reported date of death. Specifically, through our analysis, we found about 14,000 (82 percent) of the 17,000 policies that continued beyond the applicant's reported date of death began while the individual was alive (see fig. 6). However, the remaining policies began after the applicant's reported date of death, including about 1,000 policies (5 percent) for which the applicant reportedly died after the application was submitted but before coverage started and about 2,000 policies (13 percent) in which the applicant died before the application was submitted.

Figure 6: Application and Coverage Dates of Policies of Applicants Who Received Subsidized Qualified Health Coverage beyond Their Reported Date of Death in Plan Year 2015



Source: GAO analysis of the Centers for Medicare & Medicaid Services data. | GAO-18-169

Note: Numbers are rounded to the nearest thousand.

[a]In about 1,700 of the 2,000 policies in which the applicant reportedly died before the application was submitted, we found that the federally facilitated marketplace had automatically submitted the application to reenroll the applicant.

We identified about $23.0 million in APTC—which the federal government pays to issuers on behalf of enrollees—after the date of death of the applicant associated with the 17,000 policies that started or continued after the applicant's reported date of death, of which about a fifth (about $4.7 million) was associated with the 2,000 policies of applicants who were reported as deceased before their application was submitted.[45] We could not determine the portion of APTC associated with each individual on a policy or the extent to which the total APTC amount would have changed if the policy had been terminated as of the reportedly deceased individual's date of death.[46] As previously discussed, taxpayers who choose to have APTC must reconcile the amount of APTC paid to issuers on their behalf with PTC they are eligible for on their income-tax returns. Therefore, the final PTC amount may differ from the amount of APTC paid to issuers because changes in circumstances, such as the death of an enrollee, may affect the amount of PTC for which an enrollee is eligible. We did not determine the extent to which APTC paid on behalf of reportedly deceased individuals was reconciled with PTC for which these individuals were ultimately eligible as the reconciliation process was outside the scope of our review. However, we previously found that not all individuals correctly filed their federal income-tax returns, as required, and the federal government is missing opportunities to recover overpayments of APTC as part of the reconciliation process.[47] As a result, APTC overpayments that the federal government improperly provides to issuers on behalf of deceased enrollees may not be fully recovered through the reconciliation process.

[45]We do not report the amount of CSR associated with these policies because the benefit realized through the CSR subsidy can vary according to medical services used and therefore the value of such subsidies to enrollees can likewise vary. However, we note that because, in plan year 2015, the federal government made advance payments of CSRs to issuers of health-care policies on enrollees' behalf, there may be costs to the federal government associated with reportedly deceased individuals who receive or maintain coverage and eligibility for CSRs, even if such individuals do not obtain medical services, if excess CSR payments are not identified and recovered.

[46]A single policy may include more than one person. The CMS data provided the APTC amounts at the policy level. In cases in which coverage is terminated because of death, the marketplace redetermines eligibility for coverage and APTC for the remaining members of the household. Eligibility for and amount of APTC for remaining household members depends on a variety of factors that may be affected by the death of a member of the household, such as income and family size. As a result, we could not determine the portion of subsidies associated with each individual on a policy or the extent to which the total subsidy amount would have changed if the policy had been terminated as of the reportedly deceased individual's date of death.

[47]See GAO-17-467.

In the majority of cases in which the applicant reportedly died before the application was submitted (about 1,700 out of 2,000 policies), we found that the FFM had automatically submitted the application to reenroll the applicant. We reviewed five sample cases in which the date of the application submission occurred after the individual's reported date of death. For all five cases, the individual had received coverage with an associated subsidy in plan year 2014 and the FFM automatically reenrolled the individual for plan year 2015 after the reported date of death. According to additional information provided by CMS officials, the federal government paid APTC to issuers on behalf of all five of these individuals in plan year 2015 after their reported date of death.

Deceased individuals may receive coverage with an associated subsidy beyond their reported date of death—or the FFM may automatically reenroll deceased individuals after their reported date of death—because the FFM does not always identify applicants as deceased after their initial enrollment in a qualified health plan. The FFM checks applicants' information against SSA's full death file to identify reportedly deceased individuals before enrolling them for coverage and subsidies. However, we previously found that the FFM does not conduct periodic checks during the year to determine whether any individuals have subsequently died.[48] Further, according to CMS officials, the FFM does not recheck the full death file before automatically reenrolling applicants for subsequent plan years or reverify information, but rather only rechecks income, to help encourage individuals to maintain enrollment in coverage from one year to the next and align with the process for individuals with employer-sponsored health insurance. HHS regulations require marketplaces to periodically examine certain available data sources to identify changes—such as the enrollee's death—to determine whether individuals receiving coverage with an associated subsidy remain eligible.[49]

CMS does not always identify deaths of enrollees in time to terminate enrollment through the exchange as of the date of death or to prevent automatic reenrollment, because CMS relies on third parties, such as family members, to report the death of an enrollee to the FFM. The FFM has procedures in place for individuals to report an enrollee's death in

[48]GAO-17-467.

[49]45 C.F.R. § 155.330(d)(1)(i).

order to remove the enrollee from coverage.[50] We reviewed a nongeneralizable sample of 15 of the 17,000 reportedly deceased individuals who received coverage with an associated subsidy after the date reported in the full death file as their date of death, including the five cases we reviewed in which the FFM automatically reenrolled the individuals after their reported date of death. In 8 of the 15 sample cases we reviewed, a family member or other individual contacted the FFM and reported the enrollee's death.[51] In two of these cases, the individual reporting the death did not provide sufficient documentation of the death, as required by CMS.[52] In three cases, the FFM received notification and a death certificate to verify the death, but did not terminate the policy as of the date of death. The FFM did not receive the death certificates for two of the three cases until 2016—after the 2015 plan year had ended. In the other case, the deceased individual received coverage and subsidies for 3 months in 2015 after the reported date of death but the FFM did not receive the death certificate to verify the death until almost 2 months after the coverage was terminated.[53] We could not determine the reason the individual's coverage had been terminated. According to CMS officials, in plan year 2015, the FFM received notification of policy termination and policy end dates from plan issuers but did not always receive information on the reason coverage was terminated.

[50]HHS regulations require the marketplaces to establish a process to permit individuals, including enrollees' authorized representatives, to report the death of an enrollee for purposes of initiating termination of the enrollee's marketplace enrollment. The marketplace may require the reporting party to submit documentation of the death. 45 C.F.R. § 155.430(b)(1)(iii). If the consumer reporting the death is not the application filer, or anyone in the household at least 18 years of age who was included in the initial application for marketplace coverage, CMS guidance states that he or she must submit documentation of death to the marketplace.

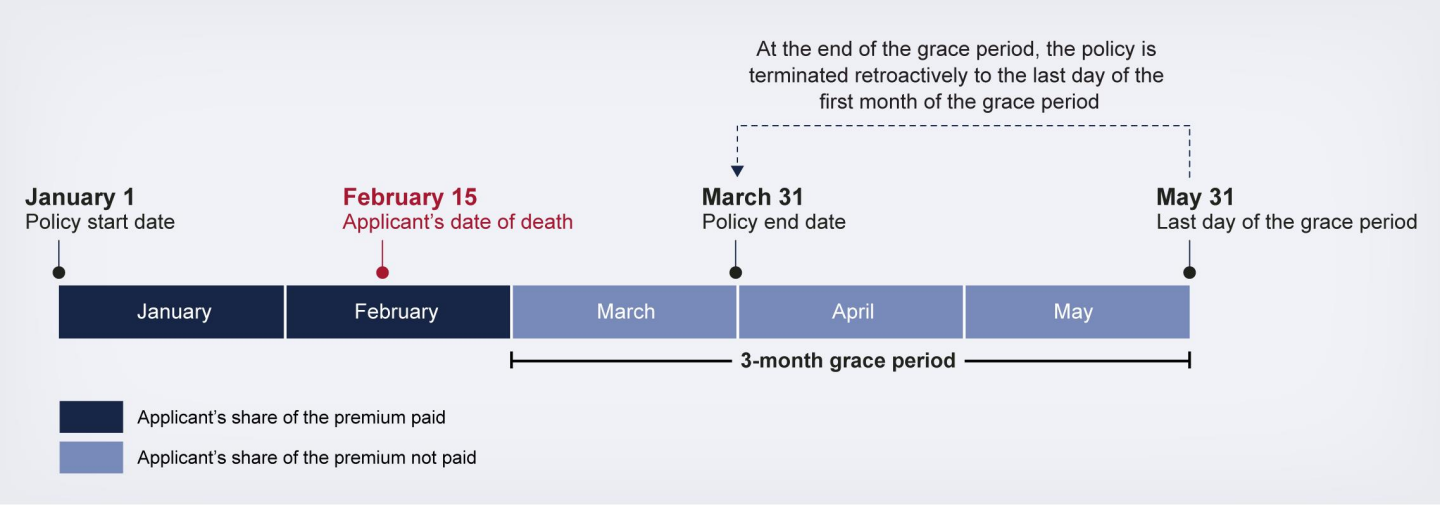
[51]CMS officials did not indicate that an individual had notified the FFM of the death in the other seven cases.

[52]In one of these cases, the individual reporting the death was not on the application for coverage. In the other case, an individual submitted information on the death in response to an inconsistency related to income, rather than through the normal death notification process, according to CMS officials.

[53]In the other three cases in which an individual reported the death to the FFM, the individuals had been automatically reenrolled for plan year 2015 after their deaths in 2014 and their deaths were reported to the FFM in January 2015. The policies for all three individuals ended in January 2015 and may have been terminated for nonpayment of premium.

When the FFM does not receive sufficient notification of a death, the policy may be terminated by the issuer for nonpayment, according to CMS officials. According to HHS regulations, when individuals stop paying their premiums, such as in the case of death, there is a 3-month grace period, after which the individuals' policies would be terminated for failure to pay premiums retroactively to the last day of the first month of the grace period.[54] For example, as shown in figure 7, if an individual dies on February 15 and the premium for the policy is not paid for months after the individual's death, the individual would enter a 3-month grace period covering March, April, and May. The issuer would terminate the policy for nonpayment on May 31, with a policy end date set retroactively to March 31—the last day of the first month of the grace period. As a result, in cases in which the policy for a deceased individual is not paid for months occurring after the individual's date of death, the deceased individual may still receive subsidized coverage for 1 full month after the month of death.

Figure 7: Example of Termination of Coverage and Subsidies for Nonpayment of Premium after an Applicant's Death When the Marketplace Is Not Notified of the Death



Source: GAO analysis of Health and Human Services regulations and Centers for Medicare & Medicaid Services guidance. | GAO-18-169

[54]Thus, under the grace period, an issuer may receive up to 3 months of additional APTC on behalf of a marketplace enrollee that has died, unless the death is otherwise reported to the issuer. If the grace period is exhausted, the issuer is required to return 2 of the 3 months of excess APTC.

However, deceased individuals may receive subsidized coverage beyond the end of the first month after their date of death if the policy is not terminated by the issuer for nonpayment of premium. According to CMS officials, the plan issuer may continue to report a deceased individual as covered if the premium continues to be paid. For example, another individual may be authorized to make payments on the policy, such as a spouse who is also covered by the policy. We identified instances in which policies continued beyond the end of the first month after the date of death reported in the full death file, with some policies continuing until the end of the plan year. In 7 of our 15 sample cases—including one case in which the applicant was automatically reenrolled for plan year 2015 after his reported date of death in October 2014—the policy continued for more than 1 complete month in 2015 after the individual's reported date of death.[55] In four of the seven sample cases in which coverage continued beyond the end of the first month after the individual's death, the policy also covered the deceased individual's spouse.[56] In other instances, an individual may have set up payments covering future months prior to death. For example, in the case in which the applicant had been receiving coverage with an associated subsidy in 2014 and was then automatically reenrolled for plan year 2015 after his reported date of death in October 2014, the individual received subsidized coverage for the entirety of plan year 2015. According to CMS officials, the individual may have set up automated payments to pay the premium.[57]

We recommended in July 2017 that CMS assess and document the feasibility of approaches for periodically verifying individuals' continued eligibility by working with other government agencies to identify changes in life circumstances that affect APTC eligibility, such as death, that may occur during the plan year and, if appropriate, design and implement these verification processes.[58] The agency agreed with the

[55]As previously discussed, the FFM received notification of policy terminations and policy end dates from plan issuers but, according to CMS officials, did not always receive information on the reason for the policy termination, such as whether the individual stopped paying the premium. Therefore, we could not determine whether a policy was terminated for nonpayment of premium or for another reason.

[56]As previously noted, in cases in which coverage is terminated because of death, the FFM redetermines eligibility for coverage and APTC for the remaining members of the household.

[57]The individual was the only person covered on the policy.

[58]GAO-17-467.

recommendation and stated that it was exploring approaches to identify enrollees who may be deceased and should therefore be unenrolled from coverage. Effectively addressing this recommendation is necessary to help ensure that the FFM does not provide coverage with associated subsidies to deceased individuals. However, as of September 2017, CMS officials could not confirm whether the approaches CMS was exploring would include rechecking the full death file prior to automatically reenrolling individuals. Without rechecking the full death file prior to automatic reenrollment to identify individuals who died during the plan year, the FFM remains at risk of providing coverage to deceased individuals, potentially for prolonged periods of time following their deaths, and of paying APTC to issuers on their behalf that may not be fully recovered through the reconciliation process.

Conclusions

Effective implementation of PPACA eligibility and enrollment provisions is a complex undertaking. As subsidies for insurance coverage through the FFM cost billions of dollars to the federal government annually, effective controls to ensure that only qualified applicants receive subsidized coverage under the act are especially important. For plan year 2015, the FFM generally verified citizenship, status as a national, or lawful presence and SSN information appropriately, with few indications that individuals received coverage with an associated subsidy fraudulently or improperly. However, in some instances, applicant-submitted documentation used to verify applicant information did not match CMS data. CMS has taken steps since 2015 to improve verification of applicant information, including taking steps to improve verification of SSNs using documentation submitted by applicants and adding capability to modify or update SSNs in its data system. These procedures and system upgrades, if properly implemented, should help improve verification of applicant SSNs that initially did not match SSA records.

Further, while relatively few enrollees reportedly died prior to or during plan year 2015, some individuals received or maintained coverage with an associated subsidy after their reported deaths and some individuals were automatically reenrolled for the 2015 plan year after their reported death. The FFM checks the full death file prior to initial enrollment, but does not recheck the full death file to identify enrollee deaths during the plan year or prior to reenrolling individuals for the following plan year. Without processes to identify the deaths of enrollees in a timely manner, including prior to reenrollment for the following plan year, CMS is at risk of

providing additional months of subsidized coverage improperly with related costs to the federal government. In 2017, we recommended that CMS assess the feasibility of approaches for periodically verifying changes, such as death, that affect eligibility for subsidies. Implementing our 2017 recommendation, and taking the additional step of assessing whether to check the full death file prior to automatically reenrolling individuals for the following plan year, could help ensure the FFM is not paying APTC on behalf of deceased individuals, especially for prolonged periods following their deaths.

Recommendation for Executive Action

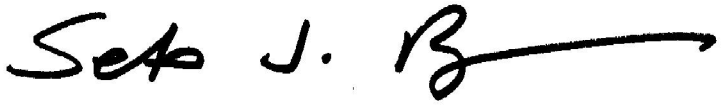
As part of its efforts to assess and document the feasibility of approaches to identify the deaths of enrollees that may occur during the plan year, the Administrator of CMS should specifically assess and document the feasibility of approaches—including rechecking the full death file—to identify the deaths of individuals prior to automatic reenrollment for subsequent plan years and, if appropriate, design and implement these verification processes. (Recommendation 1)

Agency Comments

We provided a draft of this product to HHS for comment. In its written comments, which are reprinted in appendix II, HHS concurred with our recommendation. HHS also provided technical comments, which we incorporated as appropriate.

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

If you or your staff have any questions about this report, please contact me at (202) 512-6722 or bagdoyans@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix III.



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 Greg Walden
Chairman
Committee on Energy and Commerce
House of Representatives

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

The Honorable Michael Burgess
Chairman
Subcommittee on Health
Committee on Energy and Commerce
House of Representatives

The Honorable Vern Buchanan
Chairman
Subcommittee on Oversight
Committee on Ways and Means
House of Representatives

The Honorable Peter Roskam
House of Representatives

The Honorable Fred Upton
House of Representatives

Appendix I: Objectives, Scope, and Methodology

The objective of this review was to examine the extent to which indications of potentially improper or fraudulent enrollments exist in the federally facilitated marketplace's (FFM) application, enrollment, and eligibility-verification process for the 2015 enrollment period.

To identify indications of potentially improper or fraudulent enrollments in the FFM's application, enrollment, and eligibility-verification process, we reviewed relevant federal statutes, Department of Health and Human Services (HHS) regulations, and Centers for Medicare & Medicaid Services (CMS) policies for plan year 2015. We also met with CMS officials that oversee enrollment into the FFM.

In addition, we obtained and analyzed eligibility and enrollment data for applicants enrolled from November 15, 2014, through December 31, 2015, and identified about 8.04 million applicants with an associated subsidy who effectuated enrollments in plan year 2015.[1] For the purposes of this report, we define applicants receiving coverage with an associated subsidy as applicants receiving coverage in plan year 2015 with an associated advance premium tax credit (APTC)[2] or Cost Sharing

[1]We did not include stand-alone dental plans in our review, as these plans are not eligible for subsidies.

[2]To help pay the cost of insurance premiums for taxpayers and their dependents, the Patient Protection and Affordable Care Act (PPACA) provides a premium tax credit (PTC) to individuals who meet certain income and other requirements. Individuals can have the federal government pay PTC to their issuers in advance on their behalf, known as APTC, which lowers their monthly premium payments. The APTC is based on, among other things, estimates of household income. Taxpayers who choose to have APTC must reconcile the amount of APTC paid to issuers on their behalf with PTC they are eligible for on their income-tax returns, which is computed based on the actual modified adjusted gross income calculated when filing their returns. PTC is a refundable tax credit in that, in addition to offsetting tax liability, any credit amounts in excess of tax liability are refunded to taxpayers. The Internal Revenue Service (IRS) is responsible for ensuring individuals, employers, and issuers comply with certain PPACA health-coverage and tax-filing requirements. GAO, *Improper Payments: Improvements Needed in CMS and IRS Controls over Health Insurance Premium Tax Credit*, GAO-17-467 (Washington, D.C.: July 13, 2017).

Reduction (CSR).[3] The number of applicants receiving coverage with an associated subsidy and the amount of associated subsidies identified through our analysis may differ from the number of applicants who ultimately received subsidized coverage and the amount of subsidies received. In addition, we obtained and analyzed information on inconsistencies associated with these applicants as of December 31, 2015.

We focused our analyses on three areas based on the eligibility and verification requirements the FFM must use to determine whether individuals are eligible to enroll and maintain coverage. Specifically, we identified and analyzed data for applicants receiving coverage with an associated subsidy (1) with inconsistencies related to citizenship, status as a national, or lawful presence;[4] (2) whose information, including Social Security number (SSN), did not match the Social Security Administration's (SSA) records, and (3) who were reportedly deceased.

- **Applicants who had inconsistencies related to citizenship, status as a national, or lawful presence.** To review applicants with inconsistencies, we used data from the Department of Homeland Security's (DHS) Systematic Alien Verification for Entitlements (SAVE) system. Specifically, we obtained queries made by the FFM from November 15, 2014, through December 31, 2015, and compared them to approximately 961,000 applicants the FFM identified as having inconsistencies related to citizenship, status as a national, or lawful presence. For the purposes of this report, we considered applicants with open inconsistencies related to citizenship, status as a national, or lawful presence, or SSN, to be potentially improper or

[3]CSR is a discount that lowers the amount consumers pay for out-of-pocket charges for deductibles, coinsurance, and copayments. Because the benefit realized through the CSR subsidy can vary according to medical services used, the value to consumers of such subsidies can likewise vary. Applicants must be eligible for an APTC to be eligible for a CSR, but do not need to elect to receive the benefit of the PTC in advance. Therefore, our analysis included some applicants who had an associated CSR but did not have an associated APTC.

[4]Inconsistencies are categorized as resolved if the applicant provides sufficient documentation to verify eligibility; expired, in most cases, if sufficient documentation has not been provided within 90–95 days; overcome by events (OBE) when no additional action is needed such as when the application changes to a non-financial-assistance application, another inconsistency has expired, or an applicant self-corrects information on the application that allows for automatic verification with an external data source; or open if the inconsistency is not resolved, expired, or OBE. For the purposes of this report, we define "unresolved" inconsistencies as inconsistencies categorized as "open."

fraudulent. However, the number of potentially improper or fraudulent applicants may be understated since we did not take into consideration applicants with expired inconsistencies who may have continued to receive coverage and had subsidies paid to issuers on their behalf before CMS was able to terminate their coverage and subsidies.

- **Applicants whose information, including SSN, did not match SSA's records.** To identify applicants whose personal information—name, date of birth, or SSN—did not match SSA's records, we used the SSA Enumeration Verification System (EVS) from November 16, 2016, through December 29, 2016, and SSA's Affordable Care Act (ACA) batch file from March 2017. Specifically, we processed the approximately 7.9 million applicants who provided an SSN of the about 8.04 million total applicants through SSA EVS and the SSA ACA batch file and analyzed the output codes to determine whether the information matched SSA's records. To determine whether the FFM had also identified an SSN-related inconsistency, we compared the SSA EVS analysis results to the FFM eligibility information. Although having an SSN is not a condition of eligibility, we consider applicants with open SSN inconsistencies to be potentially improper or fraudulent because open SSN inconsistencies indicate that the FFM was not able to verify the applicant's identity information, but the applicant retained coverage.
- **Applicants who were reportedly deceased.** To identify applicants who were reportedly deceased prior to or during plan year 2015, we compared the approximately 7.74 million applicants whose information matched SSA records of the about 8.04 million total applicants in the eligibility and enrollment data to the SSA full death file from June 2016.[5] We matched records using the SSN, name, and date of birth. We limited our review to those applicants already verified through SSA EVS. We considered applicants to be potentially improper or fraudulent if they received or maintained coverage with an associated subsidy after the date reported in SSA's full death file as their date of death.

[5]SSA maintains two sets of death data. SSA shares its full death file with certain agencies, including CMS, that pay federally funded benefits. For other users of its death data, SSA shares the Death Master File. The Death Master File is a subset of the full death file, as it contains about 10 percent fewer death records than the full death file and does not include state-reported death data. Use of the term "full" is not meant to indicate that a file contains all deaths but rather that the file includes deaths reported by states. SSA does not have a death record for all deceased individuals (e.g., deaths not reported to SSA), and SSA does not guarantee the completeness or accuracy of its death data.

To determine the reliability of the data used in our analysis, we performed electronic testing to determine the validity of specific data elements in the FFM and other federal data files that we used to perform our work. We also interviewed officials responsible for their respective databases, and reviewed documentation related to the databases and literature related to the quality of the data. On the basis of our own testing and our discussions with agency officials, we concluded that the data elements used for this report were sufficiently reliable for our purposes. For reporting purposes, we present the results of our data-matching analyses as approximate whole numbers.

To review the results of our matches, we selected a nongeneralizable sample of 45 applicants that contained

- 15 cases with inconsistencies related to citizenship, status as a national, or lawful presence;[6]
- 15 cases where the applicant SSN information did not match SSA records;[7] and
- 15 cases where the applicant's information matched the SSA full death file.[8]

For all 45 cases, we requested and reviewed copies of available supporting documentation from CMS. Our review of applicant cases provides illustrative examples, and the results are not projectable to the entire population of applicants to the FFM.

As discussed above, we focused our analyses on three areas. We did not perform analyses using independent data sources to verify other types of information required for applicants to enroll in qualified health plans and

[6]The sample of 15 cases related to citizenship, status as a national, or lawful presence included 5 cases that were not found in DHS SAVE data, 5 cases that were categorized as resolved, and 5 cases categorized as open, expired, or overcome by events (OBE).

[7]The sample of 15 SSN cases included 5 cases that were not flagged by CMS in 2015, 5 cases that were categorized as resolved, and 5 cases categorized as open, expired, or OBE.

[8]The sample of 15 reportedly deceased applicants included 5 cases in which the application for coverage was submitted after the applicant's reported date of death, 5 cases in which the applicants' reported date of death occurred after the application for coverage but before their coverage started, and 5 cases in which the applicant reportedly died while receiving coverage.

qualify for subsidies, which we have discussed in previous GAO reports. Specifically, we did not perform analysis on the following:

- *Income.* Internal Revenue Service (IRS) household income information is necessary in determining subsidy amounts, but can be up to 2 years old. Due to the age of the data, there may be discrepancies between applicants' attested information and what the marketplace obtains through the federal data services hub (data hub).[9] According to HHS regulations and CMS guidance, if electronic data are unavailable or an applicant's attestation of projected annual household income is more than 10 percent below the annual household income as computed using available data sources, the marketplace must follow inconsistency-resolution procedures. These procedures will accept differences of up to 20 percent of an applicant's attested income from what CMS is able to recalculate using supporting documentation.
- *Residency.* Individuals must intend to reside in the state in which they are applying for coverage and are not required to have a fixed address in the state. The marketplace can accept self-attestation unless the information provided by the applicant is not reasonably compatible with other information provided by the applicant or in the records of the marketplace. HHS has recently stated that its previous assessments of available sources did not identify any comprehensive data source for verifying residency. However, we previously reported that CMS did not document an evaluation of available external sources to determine the quality, relevance, and reliability of the data, and recommended that it do so.[10]
- *Incarceration.* Individuals must not be incarcerated (unless incarcerated while awaiting disposition of charges). We have previously reported that there are many challenges associated with using incarceration data, including the risk of false positives.[11]

[9]The data hub is a portal developed by CMS for exchanging information between the FFM, state-based marketplaces, and Medicaid agencies, among other entities, and CMS's external partners, including other federal agencies such as SSA, DHS, and the IRS, among others. For further background, see GAO, *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), and *HeathCare.gov: Actions Needed to Address Weaknesses in Information Security and Privacy Controls*, GAO-14-730 (Washington, D.C.: Sept. 16, 2014).

[10]GAO-17-467.

[11]GAO-16-29.

We conducted this performance audit from November 2015 to December 2017 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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

DEC 0 7 2017

Seto Bagdoyan
Director, Forensic Audits and Investigations
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, "*Federal Health-Insurance Marketplace: Analysis of Plan Year 2015 Application, Enrollment, and Eligibility-Verification Process*" (GAO-18-169).

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

Sincerely,

Barbara Pisaro Clark

Barbara Pisaro Clark
Acting 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 - FEDERAL HEALTH-INSURANCE MARKETPLACE: ANALYSIS OF PLAN YEAR 2015 APPLICATION, ENROLLMENT, AND ELIGIBILITY-VERIFICATION PROCESS (GAO-18-169)

The U.S. Department of Health and Human Services (HHS) appreciates the opportunity from the Government Accountability Office (GAO) to review and comment on this draft report. HHS takes seriously its responsibilities to protect taxpayer funds while reducing the burden on consumers, employers, and other individuals and entities involved in the Exchange and other insurance affordability programs.

Exchange Program Integrity

Instituting strong program safeguards to ensure that only individuals who are eligible are enrolled in Exchange coverage, and that they are only receiving the amount of financial assistance they are eligible for, is essential to ensuring that the Exchanges operate as intended. 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 in its other programs and is applying program integrity best practices to the Exchange. In addition, 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 an Exchange Fraud Risk Assessment, leveraging GAO's fraud risk framework.[2] 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 Exchange.

The Exchange Eligibility Verification Process

To determine whether an applicant is eligible for qualified health plan enrollment through the Exchange and/or insurance affordability programs, HHS uses technology that allows the federal government to provide individuals with real-time, electronic eligibility verification via data sources available through the Federal Data Services Hub (Hub). The Hub provides a secure electronic connection between Exchanges and Medicaid/CHIP agencies with federal and private databases. These databases are used to verify eligibility and include 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 (VA), Medicare, Peace Corps, the Office of Personnel Management (OPM), TRICARE, and State Medicaid Agencies. The Hub supported tens of millions of data verifications during the first four open enrollment periods. For example, as GAO reported in previous work, HHS' control activities for verifying citizenship and lawful presence with SSA or DHS were properly designed and implemented and are operating as designed.

Sometimes an applicant's eligibility information cannot be verified in real time by a 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 most recent data contained within the trusted data sources; however, the nature of the application information that is verified may

[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 - FEDERAL HEALTH-INSURANCE MARKETPLACE: ANALYSIS OF PLAN YEAR 2015 APPLICATION, ENROLLMENT, AND ELIGIBILITY-VERIFICATION PROCESS (GAO-18-169)

change frequently, and the information contained in the trusted data sources 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 Affordable Care Act (ACA), and it may be up to two years old depending on the most recent tax return filed by the applicant. When submitting the application information required by the ACA, individuals attest, under penalty of perjury, that the information they submit is accurate. Knowingly and willfully providing false or fraudulent information is a violation of federal law and subject to a fine of up to $250,000.

If an applicant provides information that cannot be verified by the trusted data sources, this does not necessarily mean the individual is ineligible for coverage and/or insurance affordability programs. In these cases, the statute requires the Exchanges make a reasonable effort to identify and address the cause of the inconsistency (otherwise known as a data matching issue) between the trusted data source and the information provided by the applicant. During this inconsistency resolution period, the ACA provides the applicant with eligibility for coverage through the Exchanges or for an insurance affordability program based on the information they attested to in their application.

Consistent with law and regulations, to resolve such an inconsistency, the Exchange provides the applicant the opportunity to submit documentary evidence to prove eligibility within 90 or 95 days (as applicable, depending on the category of inconsistency). 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 issue. If an applicant does not provide satisfactory documentation within the required time to resolve their inconsistency, the Exchange will subsequently determine the applicant's eligibility based on the information contained within the trusted data sources, as required by the law and, if necessary, will end enrollment through the Exchange and/or adjust the advance premium tax credit (APTC) as appropriate.

Tax Filing Requirement

To further protect the integrity of the Exchange 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 based on the tax filer's final actual income for the year, since APTC provided to qualified health plan issuers is based on a consumer's estimated projected income for the coverage year. The IRS, through the tax filing process, reconciles the difference between the APTC paid to the qualified health plan 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 Exchange consumers do not file their tax return and reconcile APTC previously paid on their behalf, they are not eligible to continue to receive APTC. The IRS provides information to Exchanges on consumers who received APTC in the prior coverage year but have not taken the necessary steps to file a tax return and reconcile APTC.

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED - FEDERAL HEALTH-INSURANCE MARKETPLACE: ANALYSIS OF PLAN YEAR 2015 APPLICATION, ENROLLMENT, AND ELIGIBILITY-VERIFICATION PROCESS (GAO-18-169)

Improving our Programs
HHS looks forward to continuing to benefit from suggestions from GAO on ways to improve our operations so eligible consumers can gain coverage through the Exchanges and insurance affordability programs in a way that prevents consumer harm and protects taxpayer money. GAO's recommendation and HHS' response is below.

Recommendation
Assess and document the feasibility of approaches—including rechecking the full death file—to identify the deaths of individuals prior to automatic reenrollment for subsequent plan years and, if appropriate, design and implement these verification processes.

HHS Response
HHS concurs with GAO's recommendation. HHS will assess and document the feasibility of identifying Exchange enrollees who may be deceased prior to automatic reenrollment and should thus be unenrolled from coverage.

3

Appendix III: 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, the following staff members made key contributions to this report: Philip Reiff, Assistant Director; Colin Fallon; Suellen Foth; Kristen Juskiewicz; Maria McMullen; Madeline Messick; James Murphy; Ariel Vega; Erin McLaughlin Villas; and Elizabeth Wood.

Appendix IV: Accessible Data

Data Tables

Accessible Data for About 1 Percent of Plan Year (PY) 2015 Enrollments Were Potentially Improper or Fraudulent

GAO found that, of the about 8 million applicants who received coverage with an associated subsidy in PY 2015, about 1 percent were associated with one of the three following categories:

- 43,000 had an open inconsistency related to citizenship, status as a national, or lawful presence as of October 2016
- 33,000 had an open Social Security number inconsistency as of October 2016
- 17,000 received or maintained coverage with an associated subsidy after their reported date of death

Accessible Data for Figure 6: Application and Coverage Dates of Policies of Applicants Who Received Subsidized Qualified Health Coverage beyond Their Reported Date of Death in Plan Year 2015

17,000 policies began or continued after the applicant's reported date of death

- 14,000 policies began while the applicant was alive and continued beyond the reported date of death
- The applications for 1,000 policies were submitted while the applicant was alive, but coverage began after the applicant's reported date of death
- The applications for 2,000 policies were submitted after the applicant's reported date of death

Agency Comment Letter

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

Page 1

DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation

Washington, DC 20201

Seto Bagdoyan

Director, Forensic Audits and Investigations

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, *"Federal Health-Insurance Marketplace: Analysis of Plan Year 2015 Application, Enrollment, and Eligibility-Verification Process*" (GAO-18-169).

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

Barbara Pisaro Clark

Acting Assistant Secretary for Legislation

Attachment

Page 2

GENERAL COMMENTS OF THE DEPA RTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED - FEDERAL HEALTH-INSURANCE MARKETPLACE: ANALYSIS OF PLAN YEAR 2015 APPLICATION, ENROLLMENT, AND ELIGIBILITY-VERIFICATION PROCESS (GAO-18-169)

The U.S. Department of Health and Human Services (HHS) appreciates the opportunity from the Government Accountability Office (GAO) to review and comment on this draft report. HHS takes seriously its responsibilities to protect taxpayer funds while reducing the burden on consumers, employers, and other individuals and entities involved in the Exchange and other insurance affordability programs.

Exchange Program Integrity

Instituting strong program safeguards to ensure that only individuals who are eligible are enrolled in Exchange coverage, and that they are only receiving the amount of financial assistance they are eligible for, is essential to ensuring that the Exchanges operate as intended. 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 in its other programs and is applying program integrity best practices to the Exchange. In addition, 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 an Exchange Fraud Risk Assessment, leveraging GAO's fraud risk framework.[2] 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 Exchange.

The Exchange Eligibility Verification Process

To determine whether an applicant is eligible for qualified health plan enrollment through the Exchange and/or insurance affordability programs, HHS uses technology that allows the federal government to provide individuals with real-time, electronic eligibility verification via data sources available through the Federal Data Services Hub (Hub). The Hub provides a secure electronic connection between Exchanges and

Medicaid/CHIP agencies with federal and private databases. These databases are used to verify eligibility and include 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 (VA), Medicare, Peace Corps, the Office of Personnel Management (OPM), TRICARE, and State Medicaid Agencies. The Hub supported tens of millions of data verifications during the first four open enrollment periods. For example, as GAO reported in previous work, HHS' control activities for verifying citizenship and lawful presence with SSA or DHS were properly designed and implemented and are operating as designed.

Sometimes an applicant's eligibility information cannot be verified in real time by a 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 most recent data contained within the trusted data sources however, the nature of the application information that is verified may

[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)

Page 3

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED - FEDERAL HEALTH-INSURANCE MARKETPLACE: ANALYSIS OF PLAN YEAR 2015 APPLICATION, ENROLLMENT, AND ELIGIBILITY-VERIFICATION PROCESS (GAO-18-169)

change frequently, and the information contained in the trusted data sources may be out of date when a consumer submits an application . For example, IRS data is the primary source of income info1mation as required by the Affordable Care Act (ACA), and it may be up to two years old depending on the most recent tax return filed by the applicant. When submitting the application information required by the ACA, individuals attest, under penalty of perjury, that the information they submit is accurate. Knowingly and willfully providing false or fraudulent information is a violation of federal law and subject to a fine of up to $250,000.

If an applicant provides information that cannot be verified by the trusted data sources, this does not necessarily mean the individual is ineligible for coverage and/or insurance affordability programs. In these cases, the statute requires the Exchanges make a reasonable effort to identify and address the cause of the inconsistency (otherwise known as a data matching issue) between the trusted data source and the information provided by the applicant. During this inconsistency resolution period, the ACA provides the applicant with eligibility for coverage through the Exchanges or for an insurance affordability program based on the information they attested to in their application.

Consistent with law and regulations, to resolve such an inconsistency, the Exchange provides the applicant the opportunity to submit documentary evidence to prove eligibility within 90 or 95 days (as applicable, depending on the category of inconsistency). 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 issue. Ifan applicant does not provide satisfactory documentation within the required time to resolve their inconsistency, the Exchange will subsequently determine the applicant's eligibility based on the information contained within the trusted data sources, as required by the law and, if necessary, will end enrollment through the Exchange and/or adjust the advance premium tax credit (APTC) as appropriate.

Tax Filing Requirement

To further protect the integrity of the Exchange 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 based on the tax filer's final actual income for the year, since APTC provided to qualified health plan issuers is based on a consumer's estimated projected income for the coverage year. The IRS, through the tax filing process, reconciles the difference between the APTC paid to the qualified health plan 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 Exchange consumers do not file their tax return and reconcile APTC previously paid on their behalf, they are not eligible to continue to receive APTC. The IRS provides information to Exchanges on consumers who received APTC in the prior coverage year but have not taken the necessary steps to file a tax return and reconcile APTC.

Page 4

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED - FEDERAL HEALTH-INSURANCE MARKETPLACE: ANALYSIS OF PLAN YEAR 2015 APPLICATION, ENROLLMENT, AND ELIGIBILITY- VERIFICATION PROCESS (GAO-18-169)

Improving our Programs

HHS looks forward to continuing to benefit from suggestions from GAO on ways to improve our operations so eligible consumers can gain coverage through the Exchanges and insurance affordability programs in a way that prevents consumer harm and protects taxpayer money.

GAO's recommendation and HHS' response is below.

Recommendation

Assess and document the feasibility of approaches—including rechecking the full death file—to identify the deaths of individuals prior to automatic reenrollment for subsequent plan years and, if appropriate, design and implement these verification processes.

HHS Response

HHS concurs with GAO's recommendation. HHS will assess and document the feasibility of identifying Exchange enrollees who may be deceased prior to automatic reenrollment and should thus be unenrolled from coverage.

Related GAO Products

Stated Health-Insurance Marketplaces: Three States Used Varied Data Sources for Eligibility and Had Few Indications of Potentially Improper Enrollments. GAO-17-694. Washington, D.C.: September 7, 2017.

Improper Payments: Improvements Needed in CMS and IRS Controls over Health Insurance Premium Tax Credit. GAO-17-467. Washington, D.C.: July 13, 2017.

Patient Protection and Affordable Care Act: Results of Enrollment Testing for the 2016 Special Enrollment Period. GAO-17-78. Washington, D.C.: November 17, 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-16-784. Washington, D.C.: September 12, 2016.

Patient Protection and Affordable Care Act: Most Enrollees Reported Satisfaction with Their Health Plans, Although Some Concerns Exist. GAO-16-761. Washington, D.C.: September 12, 2016.

Patient Protection and Affordable Care Act: Final Results of Undercover Testing of the Federal Marketplace and Selected State Marketplaces for Coverage Year 2015. GAO-16-792. Washington, D.C.: September 9, 2016.

Patient Protection and Affordable Care Act: CMS Should Act to Strengthen Enrollment Controls and Manage Fraud Risk. GAO-16-29. Washington, D.C.: February 23, 2016.

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.: October 23, 2015.

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.

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.

Patient Protection and Affordable Care Act: Status of CMS Efforts to Establish Federally Facilitated Health Insurance Exchanges. GAO-13-601. Washington, D.C.: June 19, 2013.

GAO's Mission

The Government Accountability Office, the audit, evaluation, and investigative arm of Congress, exists to support Congress in meeting its constitutional responsibilities and to help improve the performance and accountability of the federal government for the American people. GAO examines the use of public funds; evaluates federal programs and policies; and provides analyses, recommendations, and other assistance to help Congress make informed oversight, policy, and funding decisions. GAO's commitment to good government is reflected in its core values of accountability, integrity, and reliability.

Obtaining Copies of GAO Reports and Testimony

The fastest and easiest way to obtain copies of GAO documents at no cost is through GAO's website (http://www.gao.gov). Each weekday afternoon, GAO posts on its website newly released reports, testimony, and correspondence. To have GAO e-mail you a list of newly posted products, go to http://www.gao.gov and select "E-mail Updates."

Order by Phone

The price of each GAO publication reflects GAO's actual cost of production and distribution and depends on the number of pages in the publication and whether the publication is printed in color or black and white. Pricing and ordering information is posted on GAO's website, http://www.gao.gov/ordering.htm.

Place orders by calling (202) 512-6000, toll free (866) 801-7077, or TDD (202) 512-2537.

Orders may be paid for using American Express, Discover Card, MasterCard, Visa, check, or money order. Call for additional information.

Connect with GAO

Connect with GAO on Facebook, Flickr, LinkedIn, Twitter, and YouTube. Subscribe to our RSS Feeds or E-mail Updates. Listen to our Podcasts. Visit GAO on the web at www.gao.gov and read The Watchblog.

To Report Fraud, Waste, and Abuse in Federal Programs

Contact:

Website: http://www.gao.gov/fraudnet/fraudnet.htm
E-mail: fraudnet@gao.gov
Automated answering system: (800) 424-5454 or (202) 512-7470

Congressional Relations

Orice Williams Brown, Managing Director, WilliamsO@gao.gov, (202) 512-4400,
U.S. Government Accountability Office, 441 G Street NW, Room 7125,
Washington, DC 20548

Public Affairs

Chuck Young, Managing Director, youngc1@gao.gov, (202) 512-4800
U.S. Government Accountability Office, 441 G Street NW, Room 7149
Washington, DC 20548

Strategic Planning and External Liaison

James-Christian Blockwood, Managing Director, spel@gao.gov, (202) 512-4707
U.S. Government Accountability Office, 441 G Street NW, Room 7814,
Washington, DC 20548