United States Government Accountability Office

Testimony
Before the Committee on Finance, U.S. Senate

For Release on Delivery
Expected at 10:00 a.m. ET
Thursday, July 16, 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

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July 2015

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GAO Highlights

Highlights of GAO-15-702T, a testimony before the Committee on Finance, U.S. Senate

### Why GAO Did This Study

PPACA provides for the establishment of health-insurance exchanges, or marketplaces, where consumers can compare and select private health-insurance plans. The act also expands the availability of subsidized health-care coverage. The Congressional Budget Office estimates the cost of subsidies and related spending under the act at $28 billion for fiscal year 2015. PPACA requires verification of applicant information to determine eligibility for enrollment or subsidies.

GAO was asked to examine controls for application and enrollment for coverage through the federal Marketplace. This testimony describes (1) the results of GAO's undercover testing of the Marketplace's eligibility and enrollment controls, including opportunities for potential enrollment fraud, for the act's first open-enrollment period; and (2) additional undercover testing in which GAO sought in-person application assistance.

This statement is based on GAO undercover testing of the Marketplace application, enrollment, and eligibility-verification controls using 18 fictitious identities. GAO submitted or attempted to submit applications through the Marketplace in several states by telephone, online, and in-person. Details of the target areas are not disclosed, to protect GAO's undercover identities. GAO's tests were intended to identify potential control issues and inform possible further work. The results, while illustrative, cannot be generalized to the full population of applicants or enrollees. GAO provided details to CMS for comment, and made technical changes as appropriate.

View GAO-15-702T. For more information, contact Seto J. Bagdoyan at (202) 512-6722 or BagdoyanS@gao.gov.

### What GAO Found

To assess the enrollment controls of the federal Health Insurance Marketplace (Marketplace), GAO performed 18 undercover tests, 12 of which focused on phone or online applications. During these tests, the Marketplace approved subsidized coverage under the Patient Protection and Affordable Care Act (PPACA) for 11 of the 12 fictitious GAO applicants for 2014. The GAO applicants obtained a total of about $30,000 in annual advance premium tax credits, plus eligibility for lower costs due at time of service. For 7 of the 11 successful fictitious applicants, GAO intentionally did not submit all required verification documentation to the Marketplace, but the Marketplace did not cancel subsidized coverage for these applicants. While these subsidies, including those granted to GAO's fictitious applicants, are paid to health-care insurers, and not directly to enrolled consumers, they nevertheless represent a benefit to consumers and a cost to the government. GAO's undercover testing, while illustrative, cannot be generalized to the population of all applicants or enrollees. GAO shared details of its observations with the Centers for Medicare & Medicaid Services (CMS) during the course of its testing, to seek agency responses to the issues raised. Other observations included the following:

- The Marketplace did not accurately record all inconsistencies. Inconsistencies occur when applicant information does not match information available from Marketplace verification sources. Also, the Marketplace resolved inconsistencies from GAO's fictitious applications based on fictitious documentation that GAO submitted. Overall, according to CMS officials, the Marketplace did not terminate any coverage for several types of inconsistencies, including Social Security data or incarceration status.
- Under PPACA, filing a federal income-tax return is a key control element, designed to ensure that premium subsidies granted at time of application are appropriate based on reported applicant earnings during the coverage year. GAO, however, found errors in information reported by the Marketplace for tax filing purposes for 3 of its 11 fictitious enrollees, such as incorrect coverage periods and subsidy amounts.
- The Marketplace automatically reenrolled coverage for all 11 fictitious enrollees for 2015. Later, based on what it said were new applications GAO's fictional enrollees had filed—but which GAO did not itself make—the Marketplace terminated coverage for 6 of the 11 enrollees, saying the fictitious enrollees had not provided necessary documentation. However, for five of the six terminations, GAO subsequently obtained reinstatements, including increases in premium tax-credit subsidies.

For an additional six applicants, GAO sought to test the extent to which, if any, in-person assisters would encourage applicants to misstate income in order to qualify for income-based subsidies during coverage year 2014. However, GAO was unable to obtain in-person assistance in 5 of the 6 undercover attempts. For example, an assister told GAO that it only provided help for those applying for Medicaid and not health-care insurance applications. Representatives of these organizations acknowledged the issues GAO raised in handling of the inquiries. CMS officials said that their experience from the first open-enrollment period helped improve training for the 2015 enrollment period.

Chairman Hatch, Ranking Member Wyden, and Members of the Committee:

I am pleased to be here today to discuss enrollment for health-care coverage obtained through the federal health-insurance exchange established under the Patient Protection and Affordable Care Act (PPACA),[1] and in particular, to discuss results of our undercover testing of eligibility and enrollment controls for the 2014 coverage year.[2] We presented preliminary results in July 2014.[3] Among other things, PPACA provides subsidies to those eligible to purchase private health-insurance plans who meet certain income and other requirements, and with those subsidies and other costs, represents a significant, long-term fiscal commitment for the federal government. According to the Congressional Budget Office, the estimated cost of subsidies and related spending under the act is $28 billion for fiscal year 2015, rising to $103 billion for fiscal year 2025, and totaling $849 billion for fiscal years 2016–2025. While subsidies under the act are not paid directly to enrollees, participants nevertheless benefit through reduced monthly premiums or lower costs due at time of service, such as copayments. Because subsidy costs are contingent on who obtains coverage, enrollment controls that help ensure only qualified applicants are approved for coverage with subsidies are a key factor in determining federal expenditures under the act.[4]

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

[2]Specifically, our review covered the first open-enrollment period, from October 1, 2013 to March 31, 2014, as well as follow-on work through 2014 and into 2015 after close of the open-enrollment period.

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

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

PPACA, signed into law on March 23, 2010, expands the availability of subsidized health-care coverage, 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.[5] Under PPACA, states may elect to operate their own health-care exchanges, or may rely on the federally facilitated exchange, known to the public as HealthCare.gov. These marketplaces were intended to provide a single point of access for individuals to enroll in private health plans, apply for income-based subsidies to offset the cost of these plans—which are paid directly to health-insurance issuers—and, as applicable, obtain an eligibility determination for other health coverage programs, such as Medicaid or the Children's Health Insurance Program. The Department of Health and Human Services' (HHS) Centers for Medicare & Medicaid Services (CMS) is responsible for overseeing the establishment of these online marketplaces, and the agency maintains the federally facilitated exchange. At the time we began the work described in this statement, CMS was operating HealthCare.gov, also known as the Health Insurance Marketplace (Marketplace) in about two-thirds of the states.[6]

To be eligible to enroll in a qualified health plan offered through a marketplace, an individual must be a U.S. citizen or national, or otherwise lawfully present in the United States; reside in the marketplace service area; and not be incarcerated (unless incarcerated while awaiting disposition of charges). Marketplaces, in turn, are required by law to verify application information to determine eligibility for enrollment and, if applicable, determine eligibility for the income-based subsidies.[7] These verification steps include validating an applicant's Social Security number, if one is provided;[8] verifying citizenship, status as a national, or lawful

[5]Specifically, the act required, by January 1, 2014, the establishment of health-insurance exchanges in all states. In states not electing to operate their own exchanges, the federal government was required to operate an exchange.

[6]Specifically, in 34 states, the federal government operated individual exchanges. Two states operated their own exchanges, but applicants applied through HealthCare.gov. As of March 2015, the number of states had grown to 37, according to HHS' Office of the Assistant Secretary for Planning and Evaluation, with the Marketplace accounting for 76 percent (8.8 million) of consumers' plan selections.

[7]42 U.S.C. § 18081(c); 45 C.F.R. §§ 155.310, 155.315, 155.320.

[8]An exchange must require an applicant who has a Social Security number to provide the number. 42 U.S.C. § 18081(b)(2) and 45 C.F.R. § 155.310(a)(3)(i).

presence with the Social Security Administration (SSA) or the Department of Homeland Security (DHS); and verifying household income and family size against tax-return data from the Internal Revenue Service (IRS), as well as data on Social Security benefits from the SSA.

My statement today presents results and analysis from work originally requested by a number of congressional requesters.[9] Specifically, today's statement (1) describes the final results of our undercover testing of the federal Marketplace's application, enrollment, and eligibility verification controls, including opportunities for potential enrollment fraud, for the act's first open-enrollment period ending March 31, 2014; and (2) describes additional undercover testing in which we sought in-person consumer assistance for federal Marketplace applications. Our control testing began in January 2014 and concluded in April 2015.

Our July 2014 testimony, which described the results of our work up to that time, focused on application for, and approval of, coverage for fictitious applicants.[10] My statement today extends that work to the postapplication process, including our maintenance of the fictitious applicant identities throughout 2014 and into 2015, payment of subsidized premiums on policies we obtained, and the Marketplace's verification process for applicant documentation. Thus, taken together, our two statements now cover the entire process of first obtaining, and then continuing, coverage for our fictitious applicants, from early 2014 into 2015.

To perform our undercover testing of the Marketplace application, enrollment, and eligibility-verification process, we created 18 fictitious identities for the purpose of making applications for individual health-care coverage by telephone, online, and in-person.[11] Because the federal government, at the time of our review, operated a marketplace on behalf

[9]Our original requesters were: in the U.S. Senate, the then-ranking member of the Committee on Homeland Security and Government Affairs and the then-ranking member of the Committee on Finance; and in the U.S. House of Representatives, the then-chairman of the Committee on Ways and Means and the then-chairman of the Committee on Ways and Means, Subcommittee on Oversight.

[10]GAO-14-705T.

[11]For all our applicant scenarios, we sought to act as an ordinary consumer would in attempting to make a successful application. For example, if, during online applications, we were directed to make phone calls to complete the process, we acted as instructed.

of the state in about two-thirds of the states, we focused our work on those states. We selected three of these states for our undercover applications, and further selected target areas within each state.[12] To maintain independence in our testing, we created our applicant scenarios without knowledge of specific control procedures, if any, that CMS or other federal agencies may use in accepting or processing applications. We thus did not create the scenarios with intent to focus on a particular control or procedure.[13] The results obtained using our limited number of fictional applicants are illustrative and represent our experience with applications in the three states we selected. They cannot, however, be generalized to the overall population of all applicants or enrollees. In particular, our tests were intended to identify potential control issues and inform possible further work. We shared details of our work with CMS during the course of our testing, to seek agency responses to the issues we raised. We also provided details prior to this hearing, and made technical changes as appropriate.

For 12 of the 18 applicant scenarios, we chose to test controls for verifications related to the identity or citizenship/immigration status of the applicant.[14] This approach allowed us to test similar scenarios across different states. We made half of these applications online and half by phone. In these tests, we also stated income at a level eligible to obtain both types of income-based subsidies available under PPACA—a

[12]We based the state selections on factors including range of population size, mixture of population living in rural versus urban areas, and number of people qualifying for income-based subsidies under the act. We selected target areas within each state based on factors including community size. To preserve confidentiality of our applications, we do not disclose here the number or locations of our target areas. We generally selected our states and target areas to reflect a range of characteristics.

[13]We were aware of general eligibility requirements, however, from public sources such as websites.

[14]As noted earlier, to be eligible to enroll in a qualified health plan offered through a marketplace, an individual must be a U.S. citizen or national, or otherwise lawfully present in the United States; reside in the marketplace service area; and not be incarcerated (unless incarcerated while awaiting disposition of charges). Marketplaces, in turn, are required by law to verify application information to determine eligibility for enrollment and, if applicable, determine eligibility for the income-based subsidies.

premium tax credit and cost-sharing reduction.[15] Our tests included fictitious applicants who provided invalid Social Security identities, noncitizens claiming to be lawfully present in the United States, and applicants who did not provide Social Security numbers. As appropriate, in our applications for coverage and subsidies, we used publicly available information to construct our scenarios. We also used publicly available hardware, software, and materials to produce counterfeit or fictitious documents, which we submitted, as appropriate for our testing, when instructed to do so. We then observed the outcomes of the document submissions, such as any approvals received or requests to provide additional supporting documentation. We began this control testing in January 2014 and concluded it in April 2015. We also obtained data from CMS on applicant submission of required verification documentation. These data listed document submission status as of April 2015 for the act's first open-enrollment period, including for our undercover applications.

For the remaining 6 of our 18 applicant scenarios to examine enrollment through the Marketplace, we sought to test only income-verification controls. We randomly selected three "Navigator" and three non-Navigator in-person assisters in our target areas.[16] For half of these 6 applications, our applicant planned to state income slightly above the maximum amount allowable for income-based subsidies, while for the others, our applicant planned to state income slightly below the range eligible for these subsidies. We sought to determine the extent to which, if

[15]To qualify for these income-based subsidies, an individual must be eligible to enroll in marketplace coverage; meet income requirements; and not be eligible for coverage under a qualifying plan or program, such as affordable employer-sponsored coverage, Medicaid, or the Children's Health Insurance Program. Cost-sharing reduction (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.

[16]For the 2014 coverage year, CMS awarded $67 million in grants for "Navigators," which are individuals or organizations that are to provide, without charge, impartial health-insurance information to consumers, and to help them complete eligibility and enrollment forms. In addition, such aid is also to be available from other in-person assisters ("non-Navigators") who generally perform the same functions as Navigators, but are funded through separate grants or contracts. Navigators and non-Navigator assisters must complete comprehensive training, according to CMS. Through the HealthCare.gov website, CMS published a state-by-state list of where in-person assistance can be obtained.

any, in-person assisters might encourage our undercover applicants to misstate income in order to qualify for either of the income-based PPACA subsidies. We chose to limit our review of those providing in-person assistance to the extent we encountered these assisters as part of our enrollment control testing. A full examination of in-person assistance, including issues other than eligibility and enrollment, was beyond the scope of our work. Overall, our review covered the act's first open-enrollment period, from October 1, 2013 to March 31, 2014, as well as follow-on work through 2014 and into 2015 after close of the open-enrollment period.

We plan to issue a final report, with recommendations, on our undercover eligibility- and enrollment-controls testing. We are conducting our audit work 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 we obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. We conducted our related investigative work in accordance with investigative standards prescribed by the Council of the Inspectors General on Integrity and Efficiency.

## The Federal Marketplace Approved Subsidized Coverage for 11 of 12 Fictitious Applicants in 2014, with Coverage Continuing into 2015

## We Obtained Coverage for 11 of 12 Fictitious Applicants by Using the Telephone Application Process and Bypassing Online Identity Verification

As we described in our July 2014 testimony, the federal Marketplace approved subsidized coverage for 11 of 12 fictitious applicants who initially applied online or by telephone. For the 11 approved applications, we paid the required premiums to put health-insurance policies into force. We obtained the advance premium tax credit (APTC) in all cases, totaling about $2,500 monthly or about $30,000 annually for all 11 applicants. After receiving these premium subsidies, our 11 fictitious applicants paid premiums at a total annual rate of about $12,000. We also obtained eligibility for cost-sharing reduction (CSR) subsidies.[17] The APTC and CSR subsidies are not paid directly to enrolled consumers; instead, the federal government pays them to issuers of health-care policies on consumers' behalf. However, they represent a benefit to consumers—and a cost to the government—by reducing out-of-pocket costs for medical coverage.[18] To receive advance payment of the premium tax credit, applicants agree they will file a tax return for the coverage year, and must indicate they understand that the premium tax credits paid in advance are subject to reconciliation on their federal tax return.

As we also reported in July 2014, for each of our 6 online applications (among the group of 12 applications made online and by phone), we failed to clear a required identity-checking step, and thus could not complete the process online. For online applications, the Marketplace employs a process known as "identity proofing" to verify an applicant's identity.[19] It does so by using personal and financial history on file with a credit reporting agency contracted by the Marketplace. The Marketplace generates questions, based on information on file with the contractor, that

[17]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.

[18]Even if not obtaining subsidies, applicants can also benefit if they obtain coverage for which they would otherwise not qualify, such as by not being a U.S. citizen or national, or lawfully present in the United States.

[19]According to CMS, the purpose of identity proofing is to prevent someone from creating an account and applying for health coverage based on someone else's identity and without their knowledge. Although intended to counter such identity theft involving others, identity proofing thus also serves as an enrollment control for those applying online.

only the applicant is believed likely to know.[20] If an applicant's identity cannot be verified online, applicants are directed to call the credit reporting agency for assistance.[21] If the credit reporting agency then cannot verify identity, applicants are typically told to contact the federal Marketplace or their state-based exchange, credit-reporting agency officials told us.

We subsequently were able to obtain coverage for all six of these applications that we began online by completing them by phone. By following instructions to make telephone contact with the Marketplace, we circumvented the initial identity-proofing control that had stopped our online applications. When we later asked CMS officials about this difference between online and telephone applications, they told us that unlike with online applications, the Marketplace allows phone applications to be made on the basis of verbal attestations by applicants, given under penalty of perjury, who are directed to provide supporting documentation.

For our 6 phone applications, we successfully completed the application process, with the exception of one applicant who declined to provide a Social Security number and was not allowed to proceed.[22] After being approved for coverage, we received enrollment material from insurers for

[20]According to executives of the contractor that performs the identity proofing, about 78 percent of applicants overall that have attempted identity proofing online for the 2014 and 2015 application cycles were successful, across the federal Marketplace and state exchanges combined. The contractor officials said that the 78 percent success rate is marginally lower than the general success rate for identity-proofing services the contractor provides. This lower rate, the contractor told us, is likely due to the health-care exchange population being less likely to have an "electronic footprint" upon which identity proofing is based. The contractor executives said that the remaining 22 percent did not necessarily fail the identity proofing. In many cases, the contractor was not able to locate the applicant in its records, or the applicant did not respond to the questions for identity verification.

[21]According to the contractor, about 560,000 telephone inquiries were made to the contractor from October 2013 to April 1, 2015, after applicants did not pass the online identity proofing. In about 35 percent of those cases, identity could be verified.

[22]As shown in app. I, three of our applicants did not provide Social Security numbers. While one of them was not allowed to proceed, the other two were allowed to complete applications. Our purported rationale for not providing the numbers was concern about personal privacy.

each of our 11 successful fictitious applicants. Appendix I summarizes outcomes for all 12 of our phone and online applications.[23]

The Marketplace is required to seek postapproval documentation in the case of certain application "inconsistencies." Inconsistencies occur in instances in which information an applicant has provided does not match information contained in data sources that the Marketplace uses for eligibility verification at time of application, or such information is not available. For example, an applicant might state income at a particular amount, but his or her federal tax return lists a different amount, or the applicant has no tax return on file. Likewise, the applicant may provide a Social Security number, but it does not match information on file with the SSA. If there is such an application inconsistency, the Marketplace is to determine eligibility using attestations of the applicant, and ensure that subsidies are provided on behalf of the applicant, if he or she is eligible to receive them, while the inconsistency is being resolved using "back-end" controls. Thus, the Marketplace was required to approve eligibility to enroll in health-care coverage and to receive subsidies for each of our 11 fictitious applicants while the inconsistencies were being addressed.[24] At the time of our July 2014 testimony, we had begun to receive notifications from the Marketplace on the outcomes of our fictitious document submissions. As discussed later in this statement, we continued to receive additional notices about our applicants through 2014 and into 2015.

## Federal Marketplace Communications with Our 11 Successful Fictitious Enrollees about Their Applications Were Unclear or Incomplete

In all 11 cases in which we obtained coverage, the Marketplace directed us, either orally or in writing, to send supporting documentation. However, the Marketplace did not always provide clear and complete communications. As a result, during our testing, we did not always know the current status of our applications or specific documents required in support of them. Examples include the following:

- **Unclear correspondence.** Rather than stating a message directly, correspondence instead was conditional or nonspecific, stating the

[23]We shared with CMS details on our successfully obtaining coverage, during the course of our review, in March 2015.

[24]According to CMS officials, the federal Marketplace makes eligibility determinations. Private insurers, also called "issuers," provide coverage.

applicant may be affected by something, and then leaving it to the applicant to parse through details to see if they were indeed affected.

- **Inaccurate guidance.** The Marketplace directed 8 of our 11 successful applicants to submit additional documentation to prove citizenship and identity—but an accompanying list of suitable documents that could be sent in response consisted of items for proving income.

- **Lack of Marketplace notice on document submissions.** In five cases, we did not receive any indication on whether information sent in response to Marketplace directives was acceptable. As a result, we had to call the Marketplace to obtain status information. According to CMS, after documents are processed, consumers will receive a written notice.

- **Lack of written notice.** In one case, the Marketplace did not provide us with any written correspondence directing we submit additional documentation. The Marketplace only requested documentation for the initial enrollment during our phone application for coverage. According to the Marketplace, applicants are to receive written notice of documentation required.[25]

CMS officials told us they are working to improve communication with consumers, and will make improvements in consumer notices. According to the officials, they are soliciting feedback from consumer advocates, call-center representatives, and application assisters to improve such communications. According to the officials, CMS has already made significant improvements that include adding a complete list of acceptable documents to resolve citizenship and immigration status inconsistencies, and consolidating warning notices to include all inconsistency issues. CMS is currently working on further improvements in notices, including those for eligibility and instances of insufficient documentation, according to the officials.

[25]We shared with CMS details on communication issues we encountered, during the course of our review, in March 2015.

## Our 11 Fictitious Enrollees Maintained Subsidized Coverage throughout 2014, Even Though We Sent Fictitious Documents, or No Documents, to Resolve Application Inconsistencies

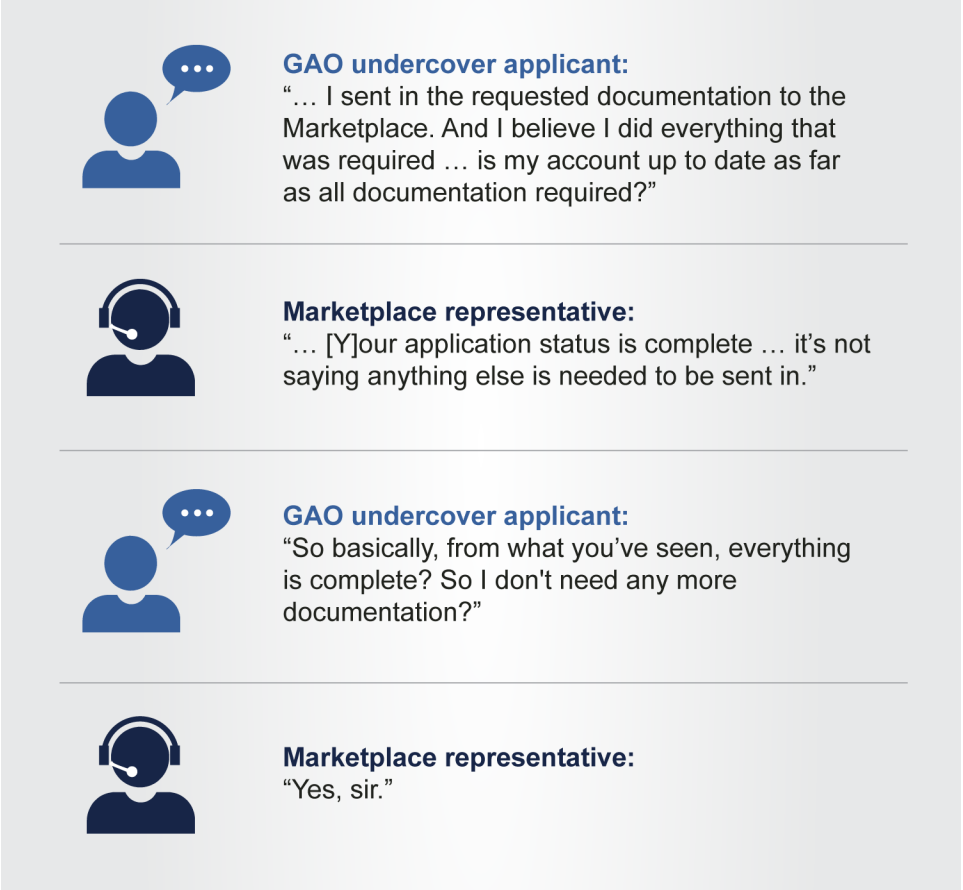
As part of our testing, and in response to Marketplace directives, we provided follow-up documentation, albeit fictitious.[26] Overall, as shown in appendix II, we varied what we submitted by application—providing all, none, or only some of the material we were told to send—in order to test controls and note any differences in outcomes. Among the 11 applications for which we were directed to send documentation, we submitted

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

Although our documentation was fictitious, and in some cases we submitted none, or only some, of the documentation we were directed to send, we retained our coverage for all 11 applicants through the end of the 2014 coverage year. As described earlier, APTC subsidies our applicants received totaled about $30,000 annually, and further financial benefit would have been available through CSR subsidies if we had obtained qualifying medical services. Following our document submissions, the Marketplace told us, either in writing or in response to phone calls, that the required documentation for all our approved applicants had been received and was satisfactory. In one case, when we called the Marketplace to inquire about the status of our documentation submission—but where we had not actually submitted any documents—a representative told our applicant that documents had been reviewed and processed, and, “There is nothing else to do at this time.” Figure 1 shows a portion of a call in which a Marketplace representative said our documentation was complete, even though we did not submit any documents.

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

**Figure 1: Excerpts of Transcript of Telephone Conversation with the Federal Marketplace, Confirming Submission of Satisfactory Documentation**




Source: GAO. | GAO-15-702T

For one applicant, the Marketplace did subsequently state in a November 2014 letter that we would lose our subsidies, beginning in December 2014. However, there was no follow-up communication regarding the loss of our subsidies, and the subsidies were not terminated in December 2014.

On the basis of applicant data we obtained from CMS, the Marketplace cleared inconsistencies for some of our 11 fictitious applications in

instances where we submitted bogus documents.[27] Appendix III contains a summary of our document requests and submissions. We also noted instances where the Marketplace either did not accurately capture all inconsistencies, or resolved inconsistencies based on suspect documentation, including the following:

- **Did not capture all inconsistencies.** For 3 of the 11 applicants, while the Marketplace at the outset directed our applicants to provide documentation of citizenship/immigration status, the CMS applicant data we later received for these applicants do not reflect inconsistencies for the items initially identified.

- **Disqualifying income.** For 2 of the 11 applicants, we reported income substantially higher than the amount we initially stated on our applications, and at levels that should have disqualified our applications from receiving subsidies. However, according to the CMS data, the Marketplace resolved our income inconsistencies and, as noted, our APTC and CSR subsidies for both applicants continued.

In addition to having fictitious documentation approved, two of our applicants also received notices in early 2015 acknowledging receipt of documents recently submitted, when we had not sent any such documents. We do not know why we received these notices.

## The CMS Document-Verification Process Is Not Designed to Identify Fraudulent Applications

We found that the CMS document-processing contractor is not required to seek to detect fraud.[28] It is only required to inspect for documents that have obviously been altered. According to contractor executives we spoke with, the contractor personnel involved in the document-verification process are not trained as fraud experts and do not perform antifraud duties. In particular, the executives told us, the contractor does not certify the authenticity of submitted documents, does not engage in fraud

[27]The inconsistency data we obtained listed status as of April 2015 for all inconsistencies generated during the first open-enrollment period, including those for our undercover applications. For this statement, we examined only inconsistency information for our applications, but we plan to make a broader analysis as part of ongoing work.

[28]Fraud involves obtaining something of value through willful misrepresentation. Whether conduct is in fact fraudulent is a determination to be made through the judicial or other adjudicative system. For information generally on fraud controls, see GAO, *Individual Disaster Assistance Programs: Framework for Fraud Prevention, Detection, and Prosecution*, GAO-06-954T (Washington, D.C.: July 12, 2006).

detection, and does not undertake investigative activities. In the contractor's standard operating procedures for its work for CMS, document-review workers are directed to "determine if the document image is legible and appears unaltered by visually inspecting it." Further, according to the contractor, it is not equipped to attempt to identify fraud, and does not have the means to judge whether documents submitted might be fraudulent.

CMS officials told us there have been no cases of fraudulent applications or documentation referred to the U.S. Department of Justice or the HHS Office of Inspector General, because its document-processing contractor has not identified any fraud cases to CMS. However, as noted earlier, the contractor is not required to detect fraud, nor is it equipped to do so. According to the CMS officials, there has been "no indication of a meaningful level of fraud."

According to CMS officials, it would not be practical to have applicants show original documents at time of application. With the HealthCare.gov website, the agency decided to move away from in-person authentication, in order to avoid burden on consumers, the officials told us. They also said in-person presentation of documentation is not possible in the current structure, as there are insufficient resources to establish a system to do so.

Overall, according to CMS officials, the agency has limited ability to respond to attempts at fraud. They told us CMS must balance consumers' ability to "effectively and efficiently" select Marketplace coverage with "program-integrity concerns." CMS places a strong emphasis on program integrity and builds program integrity features into all aspects of implementation of the law, according to CMS officials. In any case, the CMS officials said the design of the program does not allow for direct consumer profit from fraud, because APTC and CSR subsidies are paid to policy issuers, not consumers. We note, however, that even so, the subsidies nevertheless can produce direct financial benefits to consumers. For example, if consumers elect to receive the premium tax credit in advance, that lowers the cost of monthly coverage. A consumer could also receive the advance premium tax credit and not file a federal tax return, as required to ensure proper treatment of the credit. Likewise, CSR subsidies mean smaller out-of-pocket expenses when obtaining medical services. Accordingly, although subsidies may be paid directly to issuers, they still result in a cost to the government and a benefit to enrollees.

CMS officials told us the agency plans to conduct an assessment of the Marketplace's eligibility determination process, including the application process and the inconsistency resolution process. They did not provide a firm date for completion, saying the review would depend on obtaining IRS information for use as a reference.

## Four of Our 11 Applicants Continued to Receive Subsidized Coverage for 2014, Likely Because CMS Waived Documentation Requirements

According to the applicant data we obtained from CMS, most of our applications had unresolved inconsistencies—indicating either that the Marketplace did not receive requested documentation or the documentation was not satisfactory. Specifically, as shown in appendix III, the CMS data indicate that, as of April 2015, 7 of our 11 applications had at least one inconsistency that remained unresolved.

Because we did not disclose the specific identities of our fictitious applicants, CMS officials said they could not explain our findings on handling of inconsistencies for our applications.[29] However, in general, they said our subsidized policies may have remained in effect during 2014 because CMS waived certain document filing requirements. Specifically, CMS directed its document contractor not to terminate policies or subsidies if an applicant submitted any documentation to the Marketplace. That is, if an applicant submitted at least one document, whether it resolved an inconsistency or not, that would be deemed sufficient so that the Marketplace would not terminate either the policy or subsidies of the applicant, even if other documentation had initially been required.[30] For example, for one of our applicants, the Marketplace requested citizenship, income, and identity documents, but our applicant submitted only identity information. Under the CMS directive, the applicant's policy and subsidies continued through 2014 because our applicant submitted at least one document to the Marketplace, but not all documents required. Thus, in the case of our four applicants that submitted partial documentation to the Marketplace, we likely were

[29]GAO's standard practice is to not disclose identifiers associated with undercover identities and operatives, in order to protect use of this sensitive investigative technique, which can yield results not obtainable through other means.

[30]For example, in the case of an income inconsistency, contractor procedures stated there will not be action taken "if the consumer or anyone in the household has sent any supporting document … regardless of the relevance of the document to the Annual Income inconsistency." For instance, there will be no action on the income issue "if the consumer or household member has sent a document relating to immigration, even though that document cannot be used to resolve the Annual Income inconsistency."

relieved of the obligation for submitting all documents for the 2014 plan year.

For the 2014 plan year, PPACA authorized CMS to extend the period for applicants to resolve inconsistencies unrelated to citizenship or lawful presence.[31] Additionally, regulations state that CMS may extend the period for an applicant to resolve any type of inconsistency when the applicant demonstrates a "good faith effort" to submit documentation.[32] CMS officials told us they relied upon these authorities to make a policy decision to broadly extend the period for resolving all types of inconsistencies in 2014. Under the policy, the officials told us, the submission of a single document served as evidence of a good faith effort by the applicant to resolve all inconsistencies, and therefore extended the resolution period through the end of 2014.[33] As such, CMS did not terminate any applicant who "demonstrated a good faith effort" in 2014. The officials told us that CMS is enforcing the full submission requirement for 2015, and that any good-faith extensions granted in 2015 would be decided on a case-by-case basis and be limited in length. All consumers, regardless of whether they benefitted from the good-faith effort extension in 2014, will still be subject to deadlines for filing sufficient documentation, they said. In particular, according to the officials, those who made a good-faith effort by submitting documentation, but failed to clear their inconsistencies in 2014, were among the first terminations in 2015, which they said took place in February and early March. We are continuing to seek further information from CMS officials on their good-faith effort policy, as well as any 2015 terminations, as part of ongoing work.

Although the good-faith effort policy could explain the handling of some of our applications, CMS officials could not provide a general explanation for the three applications for which we submitted no documentation but our subsidized coverage remained. However, based on our examination of applicant files at the CMS document contractor, this could be due to an error in the CMS enrollment system. Specifically, we found instances in which records we reviewed showed that applicants had not enrolled in a plan, when they actually had done so. Contractor officials told us that in

[31]42 U.S.C. § 18081(e)(4)(A).

[32]45 C.F.R. § 155.315(f)(3).

[33]We did not find any public announcement of CMS's decision to apply the good-faith provision.

such cases, they did not terminate the plans or subsidies because the applicants were shown as not enrolled. We plan to address this issue of tracking of inconsistencies in our ongoing work.

Also included among the unresolved inconsistencies for our applicants were four for Social Security numbers. According to CMS officials, inconsistencies for Social Security numbers occur when an applicant's name, date of birth, and Social Security number cannot be validated in an automated check with SSA. The officials told us that systems capability has not allowed CMS's document contractor to make terminations for such inconsistencies. They also said the agency has done no analysis of the fiscal effect of not making such terminations. We plan to address this issue in ongoing work.[34] In addition, CMS officials told us that although it checks applicants or enrollees against SSA's Death Master File, it currently does not have the systems capability to change coverage if a death is indicated. Instead, the officials told us, the Marketplace has established a self-reporting procedure for individuals to report a consumer's death in order to remove the consumer from coverage. The number of reported deaths from SSA is "very minimal," according to CMS officials.

## The Marketplace Automatically Reenrolled Coverage for All 11 Fictitious Applicants for 2015

The coverage we obtained for our 11 fictitious applicants contained an automatic reenrollment feature—both insurers and the Marketplace notified us that if we took no action, we would automatically be enrolled in the new coverage year (2015).[35] In all 11 of our cases, we took no action and our coverage was automatically reenrolled in January 2015. We continued to make premium payments, in order to demonstrate

[34]CMS officials also told us the agency did not pursue terminations for inconsistencies involving American Indian status and presence of employer-sponsored or minimum essential coverage. For incarceration status (incarcerated individuals are generally not eligible for coverage), CMS officials said the agency accepted applicant attestations after determining that the SSA prisoner database was unreliable.

[35]Under a CMS policy adopted in September 2014 for the 2015 coverage year, generally, if consumers do nothing, they will be automatically enrolled in the same plan with the same premium tax credit and other financial assistance. Consumers whose 2013 tax return indicates they had very high income, or who did not give the Marketplace permission to check updated tax information for annual eligibility redetermination purposes, were to be automatically enrolled but without financial assistance if they do not return to HealthCare.gov. CMS said this process provides continuity of coverage and safeguards public funds. See http://cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2014-Fact-sheets-items/2014-09-02.html?DLPage=1&DLSort=0&DLSortDir=descending, accessed July 8, 2015.

continuation of subsidized coverage, which meant continuing costs for the federal government. Appendix IV summarizes our automatic reenrollments.

Although we obtained automatic reenrollments, we found communications from the Marketplace leading up to the end of 2014 to be contradictory or erroneous. Examples include the following:

- As noted earlier, our applicants were notified they would automatically be reenrolled for the new coverage year. But most of the applicants also received, to varying degrees, notices to reapply or to take some type of action. For example, we received notices stating: “Official Notice: Your 2015 application is ready,” “Action Needed: Your 2015 health coverage,” and “Follow these steps to re-enroll by December 15.” The message and frequency of these notices could create uncertainty among applicants who believed they need not take any action to remain enrolled.

- In correspondence to our applicants, the Marketplace referred to things that could not have happened. In four cases in the latter part of 2014, Marketplace correspondence referred to the filing of federal tax returns of our applicants, even though our applicants never filed a tax return.

- In four cases, our enrollees received notices directing them to send additional information in order to continue coverage, saying they could lose coverage if they did not—but the deadline for submission was a date that had passed months earlier. For example, one enrollee received such a notice in December 2014, advising that coverage might be lost six months earlier, in June 2014.

As mentioned previously, CMS officials told us they are working to improve communication with consumers, and will make improvements in consumer notices.

## CMS Provided Inaccurate Tax Information for 3 of 11 Fictitious Applicants

Under PPACA, an applicant’s filing of a federal income-tax return is a key element of back-end controls. When applicants apply for coverage, they report family size and the amount of projected income. Based, in part, on that information, the Marketplace will calculate the maximum allowable amount of advance premium tax credit. An applicant can then decide if he or she wants all, some, or none of the estimated credit paid in advance, in the form of payment to the applicant’s insurer that reduces the applicant’s monthly premium payment.

If an applicant chooses to have all or some of his or her credit paid in advance, the applicant is required to "reconcile" on his or her federal tax return the amount of advance payments the government sent to the applicant's insurer on the applicant's behalf with the tax credit for which the applicant qualifies based on actual reported income and family size.[36]

To facilitate this reconciliation process, the Marketplace sends enrollees Form 1095-A, which reports, among other things, the amount of advance premium tax credit paid on behalf of the enrollee. This information is necessary for enrollees to complete their tax returns. The accuracy of information reported on this form, then, is important for determining an applicant's tax liability, and ultimately, government revenues.

We found errors with the information reported on 1095-A forms for 3 of our 11 fictitious applicants.[37] In two cases, we received multiple forms containing different information for the same applicant. In all three cases, the forms did not accurately reflect the number of months of coverage, thus misstating the advance premium tax credits received. In one of the cases, for instance, the form did not include a couple of months of advance premium tax credit that was received and, as a result, understated the advance premium tax credit received by more than $600. Appendix V shows complete results for tax forms we received. Because we did not provide CMS with detailed information about the specific cases, CMS officials said they could not conduct research and explain

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

[37]The errors we encountered were of a different type than those announced by CMS in February 2015, when the agency said about 800,000 tax filers had received Forms 1095-A that listed incorrect benchmark plan premium amounts. For details, see http://blog.cms.gov/2015/02/20/what-consumers-need-to-know-about-corrected-form-1095-as/, accessed on June 30, 2015.

why these errors occurred. In general, CMS officials told us the agency made quality checks on tax information before mailings to consumers.[38]

During our testing work, we also identified that unlike advance premium tax credits, CSR subsidies are not subject to a recapture process such as reconciliation on the taxpayer's federal income-tax return. In discussions with CMS and IRS officials, we found that the federal government has not established a process to identify and recover the value of CSR subsidies that have been provided to our fictitious enrollees improperly. These subsidies increase government costs; and, according to IRS, excess CSR payments, if not recovered by CMS, would be taxable income to the individual for whom the payment was made. We are continuing to seek information from CMS on any efforts to recover costs associated with subsidy reductions or eliminations due to unresolved inconsistencies.

## The Marketplace Later Terminated Subsidized Coverage for 6 of Our 11 Applicants in Early 2015, but We Restored Coverage for 5 of These Applicants—with Larger Subsidies

In December 2014, the Marketplace sent notifications to 5 of our 11 applicants, indicating that we had filed new applications for subsidized coverage. In four of these notices, the Marketplace stated our subsidies or coverage, or both, would be terminated if we failed to provide supporting documentation. However, we had not filed any such applications, nor, as described earlier, had we sought any redetermination of subsidies. Because each of our fictitious applicants earlier received either written or verbal assurances from the Marketplace that documentation had been received and no further action was necessary, we did not respond to these requests to submit supporting documentation.

A few months later, the Marketplace terminated coverage or subsidies for six applicants, including four applicants who had received notice of new applications in December 2014, and two applicants who had not received notice of a new application. The termination notices cited failure to respond to requests to submit documentation in support of what were claimed to be the new applications we submitted. Our remaining five applicants continued receiving subsidized coverage without interruption.[39]

[38]We shared with CMS details on errors in our applicants' 1095-A forms, during the course of our review, in March 2015.

[39]We shared with CMS details of our purported new applications, during the course of our review, in May 2015.

Following the termination notices, we elected to pursue continued coverage for the six cases as part of our testing, even though we had not filed the claimed new applications. Each of our six fictitious applicants that lost coverage or subsidies made phone inquiries to the Marketplace for an explanation of the terminations. In three of these inquiries, the Marketplace representatives told our applicants that they were required to file a new application or supporting documentation each year. However, as described earlier, notifications we received earlier from the Marketplace and insurers told us that no actions were needed to automatically reenroll in our plans other than to continue to pay premiums. In addition, as noted, other applicants did not receive notices of new applications being filed.[40] We are continuing to seek from CMS information on this treatment of our applicants.[41]

Next, for each of these six fictitious applicants, we requested in Marketplace phone conversations reinstatement of coverage or subsidies. For five of the six applicants, the Marketplace approved reinstatement of subsidized coverage, while in the process also increasing total premium tax credit subsidies for all these applicants combined by a total of more than $1,000 annually.[42] For the sixth applicant, a Marketplace representative said a caseworker must evaluate our situation. We were

[40]Although our other applicants did not receive notices of new applications being filed, CMS officials told us that each year, a new application for the upcoming coverage year is created for those who have coverage through the Marketplace. To lessen consumer burden, the Marketplace pre-populates a new application using existing information, they said. According to the officials, CMS encourages applicants who wish to continue Marketplace coverage to update their application information during open-enrollment and decide what coverage they will need for the next year. If applicants do not contact the Marketplace to choose coverage by December 15th, the Marketplace will automatically re-enroll them in their current plan or a similar one, the CMS officials told us.

[41]For the general situation for reenrollment, see Centers for Medicare & Medicaid Services, *Bulletin #14: Guidance for Issuers on 2015 Reenrollment in the Federally-facilitated Marketplace (FFM)*, available at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Bulletin14_Reenrollment_120114.pdf, accessed July 2, 2015.

[42]In seeking restoration of coverage, we did not request any change in subsidies. The Marketplace provided us with new subsidy amounts in approving our restored coverage. According to CMS officials, factors that could affect subsidy amounts include use of updated federal poverty level income information; a change in plans available in the market, which affects calculation of subsidies; and a consumer aging. We did not make premium payments for these five applicants following reinstatement because the reinstatements occurred at the end of our undercover testing period.

told we could not speak with the caseworker, and it could take the caseworker up to 30 days to resolve the issue. This applicant's case was still pending at the time we concluded our undercover activity in April 2015. Appendix VI summarizes outcomes for the unknown applications and terminations that followed for six of our applicants.

For three of the five applicants for whom we obtained reinstatement of subsidized coverage, we had open inconsistencies related to citizenship/immigration status remaining from our initial applications for 2014, according to CMS data. For each of these three applications, we had never submitted any citizenship or immigration documentation to the Marketplace for resolution. Nonetheless, we had subsidized coverage restored. We are continuing to seek from CMS any information on whether procedures allow repeated applications as a way to avoid document-filing requirements.

## We Were Unable to Obtain In-Person Assistance in Five of Six Undercover Attempts to Test Income-Verification Controls, and Application Assisters Subsequently Acknowledged Errors

As described earlier, CMS has awarded grants for "Navigators," which are to provide free, impartial health-insurance information to consumers. In addition, such aid is also to be available from other in-person assisters ("non-Navigators") who generally perform the same functions as Navigators, but are funded through separate grants or contracts.

As described in our July 2014 statement, in addition to the 12 online and telephone applications, we also attempted an additional 6 in-person applications, seeking to test income-verification controls only.[43] During our testing, we visited one in-person assister and obtained information on whether our stated income would qualify for subsidy. In that case, as shown in Figure 2, a Navigator correctly told us that our income would not qualify for subsidy. However, for the remaining five in-person applications, we were unable to obtain such assistance. We encountered a variety of situations that prevented us from testing our planned scenarios.[44] We later returned to the locations, seeking explanations on why we could not

[43]In these in-person applications, our planned approach was to discuss concerns about policy costs and to inquire whether there were ways to reduce the expenses, such as through income-based PPACA subsidies.

[44]For these six in-person applications, we randomly chose three Navigators and three non-Navigators in the target areas of our selected states. For the in-person applications, because our sole interest was any potential advice on reducing policy costs, we did not seek or obtain policies, as we did with our phone and online applications.

obtain the advertised assistance, which are also shown in figure 2.[45] Representatives of these organizations generally acknowledged the issues we raised in handling of our application inquiries.

[45]These subsequent visits were not undercover, and we identified ourselves as being with GAO.

**Figure 2: Results of Attempts to Obtain In-Person Assistance in Completing Applications**

| Type of in-person assister | Outcome of initial undercover inquiry, 2014 | Explanation offered by organization officials, 2015 |
|---|---|---|
| ▶ **Navigator** | Applicant asked during application process whether we wished to volunteer for service in the labor union organization. | Organization should not have asked whether the applicant wished to volunteer. |
| | After discussion with assister that our income did not qualify for subsidy, assister suggested we call the Marketplace to delete our application and "make sure that you know the specific number" for the income. | Organization improperly suggested the applicant delete the application. |
| ▶ **Non-Navigator** | Assister told us it provided assistance only to those who have been patients and owe money to the health-care facility. | Organization erred and did not treat the applicant properly. Those seeking assistance under the act need not be a patient at the facility and thus should not be turned away. |
| ▶ **Navigator** | Assister required appointment in advance by phone, but we were unable to make phone contact. We next made in-person visit, at which time assister declined to provide assistance, or to schedule appointment, saying instead we must phone to make appointment to return. | Organization did not properly treat the applicant, likely due to not having full-time staffer to handle Navigator inquiries. Organization has subsequently recognized issues with its services and taken steps including hiring a full-time staffer and implementing an online system for making appointments. |
| ▶ **Non-Navigator** | Assister initially said he provides assistance only after people already have application in progress. Offered to assist with application, but HealthCare.gov website was unavailable. Directed us to call later for assistance, but then did not respond to three follow-up calls. | Organization official apologized for the experience. Organization provides service on a volunteer basis, and providing application assistance is difficult, given time required for single application. |
| ▶ **Navigator** | Assister correctly advised that our income would not qualify for subsidy. | N/A |
| ▶ **Non-Navigator** | Assister did not provide us assistance, saying it did not provide assistance for health-care insurance applications under the act and instead only provides help for those applying for Medicaid. | Organization does not provide assistance for health-care insurance applications and did not know how it was listed on the federal website for providing such assistance. |

Source: GAO. | GAO-15-702T

Note: N/A = not applicable. Information is from Navigator and non-Navigator responses to GAO inquiries.

We shared these results with CMS officials, who said they could not comment on the specifics of our cases without knowing details of our undercover applications. CMS officials said Navigators are required to accept all applicants, even if an organization's mission is to work with specific populations. If Navigators cannot provide timely help themselves, they must refer applicants to someone who can give assistance. CMS officials also said that they can terminate grant agreements, among other enforcement actions, if Navigators do not comply with terms of their awards. They cited as an example a corrective action taken in March 2015 against a Navigator grantee operating in several states for not providing the full range of activities it promised. CMS officials stressed to us Navigator training and experience from the first open-enrollment period helped improve training for the second enrollment period ending in February 2015. As noted earlier, our review of in-person assistance was limited to the extent we encountered Navigators and non-Navigators as part of our enrollment control testing. A full examination of in-person assistance was beyond the scope of our work.

CMS officials told us there is no formal policy or specific guidance for situations such as the one we encountered in a case described in figure 2, in which an applicant is asked if he or she wishes to perform a service, such as volunteering for union activities, at the time the applicant seeks assistance. Still, CMS officials said Navigators would be discouraged from such activities while applicants seek help.

CMS officials told us it is reasonable for consumers to think that if an assister is listed on the federal website as providing help—as were the assisters we selected—that assistance should be available as indicated. CMS officials told us the agency recognizes challenges with its online tool to find local assistance, and has been working to make changes. We are continuing to seek written documentation on these planned improvements.

Chairman Hatch, Ranking Member Wyden, and Members of the Committee, this concludes my statement. I would be pleased to respond to any questions that you may have.

# GAO Contact and Staff Acknowledgments

## GAO Contacts

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

## Staff Acknowledgements

Individuals making key contributions to this statement, or our 2014 statement reporting preliminary results, include: Matthew Valenta and Gary Bianchi, Assistant Directors; Maurice Belding; Mariana Calderón; Marcus Corbin; Carrie Davidson; Paul Desaulniers; Colin Fallon; Suellen Foth; Sandra George; Robert Graves; Barbara Lewis; Maria McMullen; James Murphy; George Ogilvie; Shelley Rao; Ramon Rodriguez; Christopher H. Schmitt; Julie Spetz; Helina Wong; and Elizabeth Wood.

# Appendix I: Undercover Application Results

Figure 3 summarizes outcomes for all 12 of the undercover phone and online applications we made for coverage to the Health Insurance Marketplace (Marketplace) under the Patient Protection and Affordable Care Act, as part of our testing of eligibility and enrollment controls.

**Figure 3: Summary of Outcomes for Applications for Coverage**


| Case number | Applicant scenario | Initial type of application | Outcome |
|---|---|---|---|
| 1 | Lawfully present | Phone | The Health Insurance Marketplace (Marketplace) approved health-care insurance enrollment, with advance premium tax credit (APTC) and cost-sharing reduction (CSR) subsidies. |
| 2 | No Social Security number provided | Phone | Marketplace approved health-care insurance enrollment, with APTC and CSR subsidies. |
| 3 | Invalid Social Security identity | Online | Marketplace approved health-care insurance enrollment, with APTC and CSR subsidies. |
| 4 | Invalid Social Security identity | Online | Marketplace approved health-care insurance enrollment, with APTC and CSR subsidies. |
| 5 | Lawfully present | Phone | Marketplace approved health-care insurance enrollment, with APTC and CSR subsidies. |
| 6 | No Social Security number provided | Phone | Marketplace approved health-care insurance enrollment, with APTC and CSR subsidies. |
| 7 | Invalid Social Security identity | Online | Marketplace approved health-care insurance enrollment, with APTC and CSR subsidies. |
| 8 | Invalid Social Security identity | Online | Marketplace approved health-care insurance enrollment, with APTC and CSR subsidies. |
| 9 | Lawfully present | Phone | Marketplace approved health-care insurance enrollment, with APTC and CSR subsidies. |
| 10 | No Social Security number provided | Phone | Marketplace did not allow application to proceed without Social Security number; applicant had declined to provide number, citing privacy concerns. |
| 11 | Invalid Social Security identity | Online | Marketplace approved health-care insurance enrollment, with APTC and CSR subsidies. |
| 12 | Invalid Social Security identity | Online | Marketplace approved health-care insurance enrollment, with APTC and CSR subsidies. |

Source: GAO. | GAO-15-702T

# Appendix II: Fictitious Applicant Documentation Submitted

Figure 4 shows, by application, the documentation we submitted in support of the 11 undercover applications that were successful. As part of our eligibility- and enrollment-controls testing, we varied what we submitted by application—providing all, none, or only some of the material we were told to send.

**Figure 4: Summary of Marketplace Documentation Requests and Submissions, by Category of Response**


| Case number | Applicant scenario | Documentation requested by Marketplace | Fictitious items GAO submitted to Marketplace | GAO document submission category | Subsidized premiums provided through end of 2014 coverage year? |
|---|---|---|---|---|---|
| 1 | Lawfully present | Citizenship/Immigration | | Partial | Yes |
| | | Income | ✓ | | |
| | | Identity document (ID) | ✓ | | |
| 2 | No Social Security number provided | Citizenship/Immigration | | None | Yes |
| | | Income | | | |
| 3 | Invalid Social Security identity | Citizenship/Immigration | ✓ | Partial | Yes |
| | | Income | ✓ | | |
| | | ID | | | |
| 4 | Invalid Social Security identity | Citizenship/Immigration | ✓ | All | Yes |
| | | Income | ✓ | | |
| | | ID | ✓ | | |
| 5 | Lawfully present | Citizenship/Immigration | ✓ | All | Yes |
| | | Income | ✓ | | |
| | | ID | ✓ | | |
| 6 | No Social Security number provided | Citizenship/Immigration | ✓ | Partial | Yes |
| | | Income | | | |
| | | ID | ✓ | | |
| 7 | Invalid Social Security identity | Citizenship/Immigration | ✓ | All | Yes |
| | | Income | ✓ | | |
| | | ID | ✓ | | |
| 8 | Invalid Social Security identity | Income | | None | Yes[a] |
| 9 | Lawfully present | Citizenship/Immigration | ✓ | All | Yes |
| | | Income | ✓ | | |
| | | ID | ✓ | | |
| 10 | Application not allowed | | | | |
| 11 | Invalid Social Security identity | Citzenship/Immigration | | None | Yes |
| | | Income | | | |
| | | ID | | | |
| 12 | Invalid Social Security identity | Citzenship/Immigration | | Partial | Yes |
| | | Income | | | |
| | | ID | ✓ | | |

Source: GAO. | GAO-15-702T

[a]Federal Marketplace notified applicant in November 2014 that subsidies would be terminated the following month, but no such termination occurred.

# Appendix III: Marketplace Consideration of Documentation Submitted

Figure 5 shows, by application, a summary of our document requests and submissions, with Marketplace communications on adequacy of the submissions, for the 11 undercover applications that were successful.

**Figure 5: Summary of Marketplace Documentation Submission Outcomes**

Application | Documents submitted | 2014 outcomes | 2015 auto-reenrollment | Tax forms | Terminations and restoration

| Case number | GAO document submission category | Documentation requested by Marketplace | Fictitious items GAO submitted to Marketplace | Centers for Medicare & Medicaid Services (CMS)-reported status of inconsistencies, April 2015 | Did the Marketplace report to applicant that all documentation was successfully submitted? |
|---|---|---|---|---|---|
| 1 | Partial | Citizenship/Immigration | | Open | Yes (Marketplace letter) "No action needed: The Health Insurance Marketplace verified your information." |
| | | Income | ✓ | Resolved | |
| | | Identity document (ID) | ✓ | —[a] | |
| 2 | None | Citizenship/Immigration | | Open | Yes (call to Marketplace) "Your application status is complete." |
| | | Income | | Open | |
| 3 | Partial | Citizenship/Immigration | ✓ | Resolved | Yes (call to Marketplace) "Everything's complete." |
| | | Income | ✓ | Resolved | |
| | | ID | | —[a] | |
| | | | | Social Security number: Open[b] | |
| 4 | All | Citizenship/Immigration | ✓ | —[c] | Yes (Marketplace letter) "No action needed: The Health Insurance Marketplace verified your information." |
| | | Income | ✓ | Resolved[d] | |
| | | ID | ✓ | —[a] | |
| 5 | All | Citizenship/Immigration | ✓ | —[c] | Yes (call to Marketplace and letter) "No action needed: The Health Insurance Marketplace verified your information." (letter) |
| | | Income | ✓ | Resolved[d] | |
| | | ID | ✓ | —[a] | |
| 6 | Partial | Citizenship/Immigration | ✓ | Resolved | Yes (call to Marketplace and letter) "You don't need to take any further action at this time." (letter) |
| | | Income | | Open | |
| | | ID | ✓ | —[a] | |
| 7 | All | Citizenship/Immigration | ✓ | Resolved | Yes (call to Marketplace and letter) "Your information has been confirmed." (call) |
| | | Income | ✓ | Resolved | |
| | | ID | ✓ | —[a] | |
| | | | | Social Security number: Open[b] | |
| 8 | None | Income | | Applicant reported as terminated/subsidy adjusted[e] | Yes (call to Marketplace) "Everything's good in your account." |
| 9 | All | Citizenship/Immigration | ✓ | —[c] | Yes (call to Marketplace and letter) "No action needed: The Health Insurance Marketplace verified your information." (letter) |
| | | Income | ✓ | Resolved | |
| | | ID | ✓ | —[a] | |
| 10 | Application not allowed | | | | |
| 11 | None | Citzenship/Immigration | | Open | Yes (call to Marketplace) "Documents were reviewed and processed …. There is nothing else to do at this time." |
| | | Income | | Open | |
| | | ID | | —[a] | |
| | | | | Social Security number: Open[b] | |
| 12 | Partial | Citzenship/Immigration | | Open | Yes (call to Marketplace) "Your information has been confirmed." |
| | | Income | | Open | |
| | | ID | ✓ | —[a] | |
| | | | | Social Security number: Open[b] | |

Source: GAO. | GAO-15-702T

[a]CMS officials said that any ID documents requested and submitted are reported under the citizenship status inconsistency. They said this is because ID information is not a distinct inconsistency, and that any such information is used as part of evaluating citizenship inconsistencies. As a result, CMS-reported status of inconsistencies, as shown in the table, does not include a separate item for ID status. We note, however, that Marketplace representatives specifically cited ID documents to our applicants, and that CMS online information, as well as letters sent to applicants, likewise refer to ID or documents that can be submitted to resolve an ID issue.

[b]Although GAO applicants were not specifically requested at time of application to provide confirmation of Social Security number, data obtained from CMS listed separately a Social Security number inconsistency.

[c]CMS data did not show an inconsistency for this category.

[d]Indicates case where GAO submitted income at a level substantially higher than the amount initially stated on fictitious applications, and at levels making the applicant ineligible for income-based subsidies.

[e]Notwithstanding the status as reported by CMS, the applicant continued to receive coverage and subsidies.

# Appendix IV: Automatic Reenrollments

Figure 6 summarizes automatic reenrollment activity at the end of the 2014 coverage year for the 11 undercover applications that were successful.

**Figure 6: Automatic Reenrollment Instructions Received by Applicants from Marketplace and Insurers**


| Case number | Applicant scenario | First notice received from Marketplace on auto-reenrollment | First notice received from insurer on auto-reenrollment | Excerpt from notices from Marketplace and insurers |
|---|---|---|---|---|
| 1 | Lawfully present | December 2014 | November 2014 | "To keep your current plan: Do nothing." |
| 2 | No Social Security number provided | December 2014 | November 2014 | "To keep your current plan: Do nothing." |
| 3 | Invalid Social Security identity | December 2014 | November 2014 | "To keep your current plan: Do nothing." |
| 4 | Invalid Social Security identity | December 2014 | October 2014 | "On January 01, 2015, you will be automatically re-enrolled and can keep your current coverage." |
| 5 | Lawfully present | December 2014 | November 2014 | "Unless you take action by December 15, 2014, you will be automatically enrolled to continue this coverage next year." |
| 6 | No Social Security number provided | December 2014 | November 2014 | "Unless you take action by December 15, 2014, you will be automatically enrolled to continue this coverage next year." |
| 7 | Invalid Social Security identity | December 2014 | October 2014 | "On January 1, 2015, you will be automatically re-enrolled and can keep your current coverage." |
| 8 | Invalid Social Security identity | December 2014 | November 2014 | "Unless you take action by December 15, 2014, you will be automatically enrolled to continue this coverage next year." |
| 9 | Lawfully present | December 2014 | December 2014 | "Your current plan with us is scheduled to automatically renew on January 1, 2015." |
| 10 | Application not allowed | | | |
| 11 | Invalid Social Security identity | December 2014 | December 2014 | "Your current plan with us is scheduled to automatically renew on January 1, 2015." |
| 12 | Invalid Social Security identity | December 2014 | December 2014 | "Your current plan with us is scheduled to automatically renew on January 1, 2015." |

Source: GAO. | GAO-15-702T

# Appendix V: Accuracy of Tax Forms Received

Figure 7 summarizes receipt of Forms 1095-A, for reconciliation of advance premium tax credits received, for the 11 undercover applications that were successful.

**Figure 7: Summary of 1095-A Forms Received**


| Case number | Applicant scenario | 1095-A form received? | 1095-A form contained errors? | Type of error |
|---|---|---|---|---|
| 1 | Lawfully present | ✓ | No | N/A |
| 2 | No Social Security number provided | ✓ | Yes | Incorrect coverage period and understated advance premium tax credit (APTC) received. |
| 3 | Invalid Social Security identity | ✓ | No | N/A |
| 4 | Invalid Social Security identity | ✓ | No | N/A |
| 5 | Lawfully present | ✓ | Yes | Received two forms, each with incorrect coverage period and understated APTC received. |
| 6 | No Social Security number provided | ✓ | No | N/A |
| 7 | Invalid Social Security identity | ✓ | No | N/A |
| 8 | Invalid Social Security identity | ✓ | Yes | Received three forms, each with incorrect coverage period and understated APTC received. |
| 9 | Lawfully present | ✓ | No | N/A |
| 10 | Application not allowed | | | |
| 11 | Invalid Social Security identity | ✓ | No | N/A |
| 12 | Invalid Social Security identity | ✓ | No | N/A |

Source: GAO. | GAO-15-702T

Note: N/A = not applicable.

# Appendix VI: Restoration of Subsidized Coverage

Figure 8 summarizes outcomes for the six applicants for whom the Marketplace terminated subsidies or coverage in early 2015. Prior to termination, four of these applicants had received notices of new applications filed, although we did not file any such applications. Following notice of the terminations, we restored subsidized coverage in five of six cases, with one case pending at the time we concluded our undercover activity.

**Figure 8: Marketplace Outcomes for Cases with Terminations Following Filing of Unknown Applications**


| Case number | Applicant scenario | Marketplace said new application filed? | Coverage/ benefit terminated | Outcome after seeking reinstatement | Change in monthly advance premium tax credit (APTC) (percent) |
|---|---|---|---|---|---|
| 1 | Lawfully present | ✓ Yes | Overall policy, including subsidies | Coverage and subsidies restored | ↑ 12 |
| 2 | No Social Security number provided | x No[a] | Overall policy, including subsidies | Caseworker review pending | N/A |
| 3 | Invalid Social Security identity | ✓ Yes | Subsidies only, coverage remained | Subsidies restored | ↑ 4 |
| 4 | Invalid Social Security identity | ✓ Yes | N/A—Notice of new application received, but coverage and subsidies continued without interruption | | |
| 5 | Lawfully present | x No | N/A | N/A | N/A |
| 6 | No Social Security number provided | ✓ Yes | Subsidies only, coverage remained | Subsidies restored | ↑ 8 |
| 7 | Invalid Social Security identity | x No | N/A | N/A | N/A |
| 8 | Invalid Social Security identity | x No | N/A | N/A | N/A |
| 9 | Lawfully present | x No | N/A | N/A | N/A |
| 10 | Application not allowed | | | | |
| 11 | Invalid Social Security identity | ✓ Yes | Overall policy, including subsidies | Coverage and subsidies restored | ↑ 11 |
| 12 | Invalid Social Security identity | x No[a] | Overall policy, including subsidies | Coverage and subsidies restored | ↑ 13 |

Source: GAO. | GAO-15-702T

Note: N/A = not applicable.

[a]The applicant's termination notice from the Marketplace referenced a new application, but we did not receive notice of a new application prior to termination.