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Report to Congressional Requesters

November 2016

PATIENT PROTECTION AND AFFORDABLE CARE ACT

Results of Enrollment Testing for the 2016 Special Enrollment Period

GAO-17-78

GAO Highlights

Highlights of GAO-17-78, a report to congressional requesters.

November 2016

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Results of Enrollment Testing for the 2016 Special Enrollment Period

Why GAO Did This Study

Under PPACA, consumers can enroll in health insurance coverage, or change from one qualified health plan to another, through the federal and state marketplaces either (1) during the annual open enrollment period or (2) outside of the open enrollment period, if they qualify for an SEP. A consumer may qualify for an SEP due to specific triggering events, such as a nonvoluntary loss of health-care coverage. CMS reported that 1.6 million individuals made a plan selection through an SEP in 2015.

GAO was asked to test marketplace enrollment and verification controls for applicants attempting to obtain coverage during an SEP.

This report describes the results of GAO attempts to obtain subsidized qualified health-plan coverage during the 2016 SEP in the federal marketplace and two selected state-based marketplaces—California and the District of Columbia.

To perform the undercover testing of enrollment verification, GAO submitted 12 new fictitious applications for subsidized health-insurance coverage outside of the open enrollment period in 2016. GAO's applications tested verifications related to a variety of SEP triggering events. The results cannot be generalized to all enrollees.

GAO provided a draft of this report to CMS and the selected state agencies. In their written comments, CMS and the states reiterated that they are not required to verify an SEP event and instead rely on self-attestation. However, prudent stewardship and good management practices suggest that fraud risks be understood and managed to protect public funds.

View GAO-17-78. For more information, contact Seto J. Bagdoyan at (202) 512-6722 or bagdoyans@gao.gov.

What GAO Found

The Patient Protection and Affordable Care Act (PPACA) requires that federal and state-based marketplaces verify application information—such as citizenship or immigration status—to determine eligibility for enrollment in a health plan, potentially including a subsidy. However, there is no specific legal requirement to verify the events that trigger a Special Enrollment Period (SEP), which is an opportunity period to allow an individual to apply for health coverage after events such as losing minimum essential coverage or getting married. Prior to the start of GAO's enrollment tests, the Centers for Medicare & Medicaid Services (CMS), which maintains the federal Health Insurance Marketplace (Marketplace), implemented a policy to request that federal Marketplace applicants provide supporting documentation for certain SEP triggering events. According to CMS, ensuring that only qualified applicants enroll during an SEP is intended to prevent people from misusing the system to enroll in coverage only when they become sick. However, relying on self-attestation without verifying documents submitted to support an SEP triggering event, such as those mentioned above, could allow actual applicants to obtain subsidized coverage they would otherwise not qualify for.

The federal and selected state-based marketplaces approved health-insurance coverage and subsidies for 9 of 12 of GAO's fictitious applications made during a 2016 SEP. The remaining 3 fictitious applicants were denied. The marketplaces instructed 6 of 12 applicants to provide supporting documentation, such as a copy of a recent marriage certificate, related to the SEP triggering event; the remaining 6 of 12 were not instructed to do so. For 5 applicants, GAO provided no documents to support the SEP triggering event, but coverage was approved anyway. Officials from the marketplaces explained that they do not require applicants to submit documentation to support certain SEP triggering events. For other SEP triggering events, CMS officials explained that the standard operating procedure in the federal Marketplace is to enroll applicants first, and verify documentation to support the SEP triggering event after enrollment. The officials also noted that all applicants must attest to their eligibility for enrollment.

GAO is not making any recommendations to the Department of Health and Human Services (HHS) in this report. However, GAO made eight recommendations to strengthen PPACA enrollment controls in a February 2016 report; these recommendations included conducting a fraud-risk assessment of the federal marketplace, consistent with the leading practices described in GAO's framework for managing fraud risks in federal programs. In formal comments on a draft of the February report, HHS concurred with the recommendations and outlined a number of steps it planned to take to implement them. In an April 2016 follow-up letter to GAO, HHS described a number of specific actions it had taken in response to the eight recommendations, such as creating an integrated project team to perform the Marketplace fraud-risk assessment. As of November 2016, GAO considers all eight recommendations to be still open, pending corroborating information, and will continue to monitor CMS's progress in implementing them. Implementing these recommendations by actions such as performing the fraud-risk assessment could help address the control vulnerabilities GAO identified during its most recent SEP tests.

Contents

Abbreviations

APTC	advance premium tax credit
CA	Covered California
CMS	Centers for Medicare & Medicaid Services
CSR	cost-sharing reduction
data hub	data services hub
HCERA	Health Care and Education Reconciliation Act of 2010
HHS	Department of Health and Human Services
Marketplace	Health Insurance Marketplace
PPACA	Patient Protection and Affordable Care Act
SEP	special enrollment period

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Congressional Requesters

The Patient Protection and Affordable Care Act (PPACA) provides subsidies to those eligible to purchase private health-insurance plans who meet certain income and other requirements.[1] With those subsidies and other costs, the act represents a significant, long-term fiscal commitment for the federal government.[2] While subsidies under the act are generally not paid directly to enrollees, participants nevertheless benefit financially through reduced monthly premiums or lower costs due at time of service, such as copayments.[3] Because subsidy costs are contingent on eligibility for coverage, enrollment controls that help ensure only qualified applicants are approved for coverage with subsidies are a key factor in determining federal expenditures under the act.

Under PPACA, states[4] may elect to operate their own health-care marketplaces, or may rely on the federally facilitated marketplace, or Health Insurance Marketplace (Marketplace), often known to the public as HealthCare.gov.[5] The Centers for Medicare & Medicaid Services (CMS), a unit of the Department of Health and Human Services (HHS), is responsible for overseeing the establishment of these marketplaces and maintaining the federally facilitated marketplace.

[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 report, references to PPACA include any amendments made by HCERA.

[2]According to the Congressional Budget Office, the estimated cost of subsidies and related spending under the act is $56 billion for fiscal year 2017, rising to $106 billion for fiscal year 2026, and totaling $866 billion for fiscal years 2017 through 2026.

[3]Enrollees can pay lower monthly premiums by virtue of a tax credit the act provides. They may elect to receive the tax credit in advance, to lower premium cost, or to receive it at time of income-tax filing, which reduces tax liability.

[4]The term “states” includes the District of Columbia.

[5]Specifically, the act required, by January 1, 2014, the establishment of health-insurance marketplaces in all states. In states not electing to operate their own marketplaces, the federal government was required to operate a marketplace. According to Centers for Medicare & Medicaid Services (CMS) data, as of March 31, 2016, about 11.1 million people had marketplace coverage—8.4 million through the 38 states using the HealthCare.gov platform and 2.7 million through 13 state-based marketplaces. Among the 11.1 million, about 85 percent were receiving the advance premium tax credit (APTC) subsidy, and about 57 percent were receiving the cost-sharing reduction (CSR) subsidy provided by the act.

Consumers can enroll in health-insurance coverage, or change from one qualified health plan to another,[6] through the federal and state-based marketplaces either (1) during the annual open enrollment period[7] or (2) outside of the open enrollment period, if they qualify for a special enrollment period (SEP). According to CMS, SEPs are an important way to ensure that people who lose health insurance during the year or who experience a major life event have the opportunity to enroll in coverage through the health-insurance marketplaces outside of the annual open enrollment period. A consumer may qualify for an SEP due to a major life event, including if he or she loses health-care coverage, or gains or becomes a dependent due to marriage, among other circumstances. CMS reported that, as of March 21, 2016, 1.6 million individuals made a plan selection through an SEP in 2015 through the HealthCare.gov platform.[8]

As described below, there is currently no specific legal requirement for federal or state-based marketplaces to verify the events that trigger an SEP.[9] However, federal and some state-based marketplaces have begun to request that applicants submit documents to verify certain SEP events, as described in greater detail later in this report. According to CMS, this development is in response to concerns that have been raised about whether marketplace rules and procedures are sufficient to ensure that only those who are eligible enroll through SEPs. In this regard, according

[6]In this report, we use "qualified health plan" to refer to coverage obtained from private insurers through a marketplace.

[7]The timing of each annual open enrollment period is determined by CMS and may vary each year, with exact dates specified in regulation. The open enrollment period for 2016 was from November 1, 2015, to January 31, 2016. According to CMS, during the 2016 open enrollment period, approximately 12.7 million consumers enrolled in a health-insurance plan through the marketplaces—with 9.6 million through HealthCare.gov and 3.1 million through state-based marketplaces.

[8]According to CMS, this population of 1.6 million does not include individuals who had paid their premiums and had an active policy as of that date (i.e., who had effectuated coverage). It is important to note that this includes consumers that enrolled in 2015 through a onetime tax season SEP for individuals and families who did not have health coverage in 2014 and were subject to the "shared responsibility payment" when they filed their 2014 taxes in states that used the federal marketplace. This population of 1.6 million individuals does not include consumers who selected a plan during the open enrollment period and then used an SEP to change plans.

[9]The Plan Verification and Fairness Act of 2016, H.R. 5589, would require exchanges to verify, through an HHS-approved verification process, that individuals seeking coverage during an SEP are qualified for the SEP. On June 28, 2016, the bill was introduced in the House of Representatives and referred to the House Committee on Energy and Commerce. As of October 2016, no further action has occurred.

to CMS officials, it is important to ensure that only eligible consumers can enroll in marketplace health-care coverage during an SEP as a way of preventing fraudulent access to the program and deterring potentially improper payments. Further, according to CMS, ensuring that only eligible applicants enroll during an SEP prevents people from misusing the system to enroll in coverage only if they become sick.

In light of the government's substantial financial commitment under PPACA, you asked us to examine and test marketplace enrollment and verification controls for an SEP for the 2016 coverage year. This report, which is the latest in a series of reports examining various PPACA enrollment-control issues,[10] describes results of undercover attempts to obtain subsidized qualified health-plan coverage outside the open enrollment period for 2016; that is, during an SEP.

To perform our undercover testing on obtaining new coverage during an SEP, we used 12 fictitious identities for the purpose of making applications to obtain subsidized qualified health-plan coverage offered through a marketplace by telephone and online.[11] PPACA requires marketplaces to verify application information to determine eligibility for enrollment and, if applicable, determine eligibility for the income-based subsidies or Medicaid. These verification steps include validating an applicant's Social Security number, if one is provided; verifying citizenship, status as a U.S. national, or lawful presence in the United States; and verifying household income. The 12 identities were designed to pass these verification steps by providing supporting documentation—albeit fictitious—such as a copy of the Social Security card, driver's license, and proof of income.

We selected states within the federal Marketplace and state-based marketplaces for our undercover applications, based on factors including state population and percentage of a state's population without health insurance, among other factors. Specifically, we selected two states—Virginia and Florida—that elected to use the federal Marketplace rather

[10]Additional details on our previous work examining various PPACA enrollment-control issues are described later in this report.

[11]For all our fictitious 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 or to mail the application, we acted as instructed. As mentioned, in this report, we use "qualified health plan" to refer to coverage obtained from private insurers through a marketplace.

than operate a marketplace of their own. We also selected two state-based marketplaces—Covered California (California) and DC Health Link (District of Columbia).[12]

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

Our undercover testing included fictitious applicants claiming to have experienced an event that would trigger eligibility to enroll in health-insurance coverage during an SEP. Specifically, our 12 fictitious applicants claimed to have experienced one of the following selected events that may indicate eligibility, under certain circumstances, to enroll in health coverage under an SEP: (1) lost minimum essential health coverage; (2) gained access to new qualified health plans as a result of a permanent move; (3) gained a dependent through marriage; (4) experienced an exceptional circumstance, such as a serious medical condition that prevented the consumer from enrolling during the annual open enrollment period; (5) nonenrollment during the annual open enrollment period was unintentional and the result of misinformation or misrepresentation by a non-exchange entity providing enrollment assistance or conducting enrollment activities; and (6) Medicaid application filed during the annual open enrollment period was denied after the open enrollment period had closed. We tested the six selected triggering events in the federal Marketplace and the two selected state marketplaces. We submitted three applications in each state and the District of Columbia.

We made six of our applications online initially, and six by phone; however, if, during online applications, we were directed to make phone calls to complete the process or to mail or fax the application, we acted as instructed. We also self-attested that the information provided in the application was true, when instructed. In these tests, we also stated income at a level eligible to obtain both types of income-based subsidies

[12]Covered California, the qualified health plan marketplace for residents of California, is an independent public entity that may also do business as the California Health Benefit Exchange. DC Health Link, the qualified health-plan marketplace for residents of the District of Columbia, is managed by the District of Columbia Health Benefit Exchange Authority, an independent authority of the District of Columbia government.

available under PPACA—a premium tax credit and cost-sharing reduction (CSR).[13]

We designed the 12 fictitious applications to provide either no documentation or fictitious documentation related to the SEP triggering event, when instructed to do so.[14] As mentioned, for all 12 fictitious applicants, we submitted supporting documentation related to proof of identity and income, such as a copy of the Social Security card, driver's license, and self-employment ledger. We then observed the outcomes of the document submissions, such as any approvals received or requests received to provide additional supporting documentation. For the applications that were denied, we did not proceed with the appeals process.[15] A more detailed description of our scope and methodology is included in appendix I.

After conducting our undercover testing, we briefed officials from the federal and selected state-based marketplaces.[16] To protect our fictitious identities, we did not disclose specific applicant identity information. We

[13]To qualify for these income-based subsidies, an individual must be eligible to enroll in marketplace coverage; meet income requirements; and not be eligible to enroll in marketplace coverage under a qualifying plan or program, such as affordable employer-sponsored coverage, Medicaid, or the State Children's Health Insurance Program. 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 consumer of such subsidies can likewise vary.

[14]CMS announced that it would begin requesting supporting documentation from consumers who enroll or change plans using an SEP for selected triggering events on June 17, 2016. We started our testing after June 17, 2016. We used professional judgement to determine what type of documentation we would submit related to the SEP triggering event. According to officials from the federal and selected state-based marketplaces, the federal and selected state-based marketplaces generally provide an applicant 30 days to submit supporting documentation related to an SEP triggering event. If instructed to do so, and the scenario was designed to provide fictitious supporting documentation related to the SEP event, we provided the requested documentation within 30 days.

[15]When a consumer is denied, the consumer has the right to appeal the decision through the federal or state-based marketplace if the consumer disagrees with a decision related to eligibility for health coverage including Medicaid, the Children's Health Insurance Program, purchasing health coverage through the marketplace, tax credit, CSR, and enrollment period, among other things.

[16]Because Virginia and Florida use the federal Marketplace, we discussed results of our Virginia and Florida applications with CMS officials.

also reviewed statutes, regulations, and other policy and related information.

We conducted our performance audit from May 2016 to November 2016 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective. We conducted our related investigative work in accordance with investigative standards prescribed by the Council of the Inspectors General on Integrity and Efficiency.

Background

Enrolling and Obtaining Health-Care Coverage through an SEP

Consumers can enroll in a PPACA qualified health plan offered through a marketplace, or change their previously selected qualified health plan, after the annual open enrollment period concludes[17] if they qualify for an SEP.[18] Under CMS regulations, a consumer may qualify for an SEP due to a specific triggering event, and generally would have up to 60 days after the event to select and enroll in a qualified health plan. Examples of qualifying events include but are not limited to

- losing minimum essential health coverage of the individual or his or her dependent;[19]
- gaining a dependent or becoming a dependent through marriage, birth, adoption, placement for adoption, or placement in foster care, or through a child-support order or other court order;

[17]The 2016 open enrollment period ran from November 1, 2015, to January 31, 2016.

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

[19]Loss of minimum essential health coverage includes losing job-based coverage, such as when an employer stops offering coverage; losing individual health coverage from a plan or policy the consumer bought himself or herself; losing eligibility for Medicaid; losing eligibility for Medicare; or losing coverage through a family member. However, loss of coverage does not include voluntary termination of coverage or loss due to failure to pay premiums on a timely basis, among other reasons.

- gaining access to new qualified health plans as a result of a permanent move;[20]
- not enrolling during the annual open enrollment period, or other enrollment period for which the consumer qualified, was unintentional, inadvertent, or erroneous and is the result of error, misrepresentation, misconduct, or inaction by the Marketplace or its agents;[21]
- applying for Medicaid or the Children's Health Insurance Program during the open enrollment period, or other enrollment period for which the consumer qualified, and being determined ineligible after the enrollment period ended; and
- demonstrating to the marketplace that the individual meets other exceptional circumstances as the marketplace may provide.[22]

While PPACA requires marketplaces to verify application information to determine eligibility for enrollment and income-based subsidies—such as verifying U.S. citizenship, nationality, or lawful presence—there is no specific legal requirement to verify the events that trigger an SEP. Specifically, there is no specific legal requirement that federal or state marketplaces (1) request documents to support an SEP triggering event

[20]In such cases, the individual must have had minimum essential coverage for 1 or more days during the 60 days preceding the date of the permanent move, or must have been living outside of the United States or in a U.S. territory at the time of the move. According to CMS, the requirement to have had minimum essential coverage for 1 or more days during the 60 days preceding the date of a permanent move went into effect on July 11, 2016.

[21]According to HealthCare.gov, qualifying circumstances for the federal exchange include (1) misinformation, misrepresentation, misconduct, or inaction of someone working in an official capacity (i.e., insurance company, navigator, certified application counselor, agent, or broker) that kept the consumer from enrolling, enrolling in the right plan, or getting the premium tax credit or CSR that the consumer was eligible for; (2) a technical error or another Marketplace-related enrollment delay caused a consumer or his or her dependent's nonenrollment, or enrollment into the wrong plan; or (3) the wrong plan data were displayed on HealthCare.gov at the time that the consumer selected the health plan, such as benefit or cost-sharing information. Rather than the standard 60-day period after the triggering event to select and enroll in a qualified health plan, for these situations the exchange may define the length of the SEP as appropriate based on the circumstances of the SEP, up to a maximum of 60 days.

[22]According to HealthCare.gov, examples of qualifying exceptional circumstances for the federal exchange may include an unexpected hospitalization that prevented the individual from enrolling during the annual open enrollment period, or a natural disaster, such as an earthquake, massive flooding, or hurricane, that prevented enrollment during the open enrollment period. Rather than the standard 60 day period after the triggering event to select and enroll in a qualified health plan, for exceptional circumstances that trigger an SEP the exchange may define the length of the SEP as appropriate based on the circumstances of the SEP, up to a maximum of 60 days.

or (2) authenticate the documents submitted to support an SEP event to determine whether those documents are fictitious. According to CMS officials and state officials, consumers that claim eligibility to enroll during an SEP must attest under penalty of perjury that they meet the conditions of eligibility for an SEP.

In February 2016, however, CMS announced plans to begin requesting supporting documentation to verify certain events that would trigger an SEP. Specifically, CMS announced its intention to establish a Special Enrollment Confirmation Process in which consumers who enroll or change plans using an SEP through the federal Marketplace will be directed to provide documentation for any of the following triggering events: (1) loss of minimum essential coverage; (2) permanent move; (3) birth; (4) adoption, placement for adoption, placement for foster care or child support or other court order; or (5) marriage. According to the notice, CMS will provide consumers with lists of qualifying documents, such as a birth or marriage certificate. In June 2016, CMS announced that it would begin requesting some supporting documentation beginning on June 17, 2016.[23]

State-based marketplaces are not required to follow CMS's Special Enrollment Confirmation Process, but states may choose to follow this guidance or establish their own processes, according to CMS officials. States may also choose to accept a consumer's attestation of the SEP triggering event without further verification. For example, according to state officials from Covered California, the state-based marketplace accepts self-attestation and requests supporting documents for a random sample of eligible consumers for certain SEP triggering events.[24] According to officials from the DC Health Benefit Exchange Authority, the

[23]In September 2016, CMS announced its plan to implement a pilot program in 2017 to evaluate the effect of preenrollment verification of SEP eligibility on various aspects of the program. However, the CMS announcement indicates that the scope of this planned pilot had not been determined as of September 2016.

[24]According to officials from Covered California, beginning August 2016, Covered California conducts a statistically valid random sampling of individuals who have enrolled during an SEP. At the time of our review, the sample includes individuals who enrolled during an SEP based on two types of triggering events: (1) moves to and within California, and (2) loss of minimum essential health coverage. This random sample of consumers may include consumers who have selected a plan, but may or may not have subsequently paid the plan premium (i.e., effectuated), according to officials from Covered California.

state-based marketplace accepts self-attestation for three of the six SEP triggering events we tested.[25]

Prior GAO Reports, Testimonies, and Recommendations Regarding PPACA Enrollment-Fraud Risk Controls

We have previously testified and reported on various aspects of PPACA enrollment controls as part of our ongoing work in this area.[26] For example, in July 2014 we testified on our undercover attempts to obtain health-care coverage offered by the federal Marketplace for coverage-year 2014 using fictitious identities and false documentation. We were successful in 11 out of 12 attempts to do so. In October 2015, we testified on similar undercover testing for coverage-year 2015 where we were successful in 17 of 18 attempts. In February 2016 we issued a report addressing CMS enrollment controls and the agency's management of enrollment-fraud risk. The February 2016 report included eight recommendations, which are discussed below, to strengthen CMS oversight of the Marketplace. In September 2016, we issued two reports and testified about addressing the potential vulnerabilities to fraud in the application, enrollment, and eligibility-verification controls of the federal Marketplace and selected state marketplaces for PPACA's second and third open enrollment periods, for 2015 and 2016 coverage, respectively.

In our February 2016 report, we recommended that the Secretary of Health and Human Services direct the Acting Administrator of CMS to: (1) conduct a feasibility study and create a written plan on actions that CMS

[25]According to officials from the DC Health Benefit Exchange Authority, for an exceptional circumstance such as a serious medical condition that prevented an application during open enrollment, marketplace errors, and denial of Medicaid coverage during open enrollment, the marketplace does not allow consumers to enroll until after they undergo a manual review process that may involve document requests.

[26]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); *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); *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); *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: Results of Undercover Testing of the Federal Marketplace and Selected State Marketplaces for the 2016 Coverage Year*, GAO-16-784 (Washington, D.C.: Sept. 12, 2016); and *Health Care: Results of Recent Undercover Testing for Patient Protection and Affordable Care Act Coverage, and Review of Market Concentration in the Private Insurance Markets*, GAO-16-882T (Washington, D.C.: Sept. 14, 2016).

can take to monitor and analyze the extent to which data hub queries provide requested or relevant applicant verification information;[27] (2) track the value of enrollee subsidies that are terminated or adjusted for failure to resolve application inconsistencies,[28] and use this information to inform assessments of program risks; (3) regarding cost-sharing subsidies that are terminated or adjusted for failure to resolve application inconsistencies, consider and document whether it would be feasible to create a mechanism to recapture those costs; (4) identify and implement procedures to resolve Social Security number inconsistencies where the Marketplace is unable to verify Social Security numbers or applicants do not provide them; (5) reevaluate CMS's use of certain incarceration status data and determine to either use these data or accept applicant attestation on status in all cases; (6) create a written plan and schedule for providing Marketplace call center representatives with access to information on the current status of eligibility documents submitted to CMS's documents processing contractor; (7) conduct a fraud-risk assessment, consistent with best practices described in GAO's framework for managing fraud risks in federal programs,[29] of the potential for fraud in the process of applying for qualified health plans through the federal Marketplace; and (8) fully document prior to implementation, and have readily available for inspection thereafter, any significant decision on qualified health-plan enrollment and eligibility matters, with such documentation to include details such as policy objectives, supporting analysis, scope, and expected costs and effects.

In formal comments on a draft of the report, HHS concurred with our recommendations and outlined a number of steps it plans to take to implement them. In an April 2016 letter, HHS described a number of specific actions it had taken in response to our eight recommendations,

[27]To implement its process for verifying certain applicant information, CMS created an electronic system called the "data services hub" (data hub), which, among other things, provides a single link to federal sources, such as the Internal Revenue Service and the Social Security Administration, to verify consumer application information. Additional information on the data hub and data hub queries is described in our February 2016 report, GAO-16-29.

[28]PPACA establishes a process to resolve "inconsistencies"—instances where individual applicant information does not match information from marketplace data sources. Additional information on the process for resolving inconsistencies is described in our February 2016 report, GAO-16-29.

[29]GAO, *A Framework for Managing Fraud Risks in Federal Programs*, GAO-15-593SP (Washington, D.C.: July 2015). The fraud framework identifies leading practices and presents them in risk-based format to aid program managers in managing fraud risks.

such as creating an integrated project team to perform the Marketplace fraud-risk assessment. In May 2016, we requested that CMS provide detailed documentation and other evidence to help corroborate the various actions described in the HHS letter. As of November 2016, CMS's response to this request was pending. Consequently, we consider all eight recommendations to remain open as of November 2016, pending corroborating information. We will continue to monitor HHS's progress in implementing them. Implementing these recommendations as intended, such as performing the fraud-risk assessment, could help address some of the control vulnerabilities we identified during our SEP tests as well.

Results of Undercover Attempts to Obtain Subsidized Coverage during an SEP

Concerning our current work, the federal or selected state-based marketplaces approved subsidized coverage for 9 of our 12 fictitious applicants seeking coverage during an SEP for 2016. Three of our 12 fictitious applicants were denied. Figure 1 summarizes the outcome of the 12 fictitious applications, which are discussed in greater detail below.

Figure 1: Summary of Outcomes for 12 Fictitious Applications for Subsidized Qualified Health-Plan Coverage during a Special Enrollment Period (SEP) as of October 2016

Marketplace	Scenario for testing	Obtained and maintained subsidized coverage?[a]
▸ Federal		
	Loss of minimum essential health coverage	✔ Yes
	Permanent move to another state	✔ Yes
	Marriage	✔ Yes
	Misinformation or misrepresentation given to an applicant by a non-Marketplace entity providing enrollment assistance	✘ No
	Medicaid application during open enrollment denied[b]	✔ Yes
	Experienced a serious medical condition that prevented application during open enrollment	✘ No
▸ State-based		
	Loss of minimum essential health coverage	✔ Yes
	Permanent move to another state	✔ Yes
	Marriage	✔ Yes
	Misinformation or misrepresentation given to an applicant by a nonmarketplace entity providing enrollment assistance	✘ No
	Medicaid application during open enrollment denied[b]	✔ Yes
	Experienced a serious medical condition that prevented application during open enrollment	✔ Yes

Source: GAO. | GAO-17-78

[a]"Obtained and maintained subsidized coverage" refers to our fictitious applicants' ability to enroll in a qualified health plan with subsidies and maintain coverage as of October 2016.

[b]"Medicaid application during open enrollment denied" was designed to test whether the federal and state-based marketplace had procedures in place to verify whether an applicant applied for Medicaid during open enrollment but was denied after open enrollment closed.

The federal and selected state-based marketplaces requested supporting documentation for 6 of our 12 fictitious applicants who initially applied online or by telephone seeking coverage during an SEP. On the basis of our design for the scenario, we provided the federal and selected state-

based marketplaces either no supporting documentation or fictitious documentation related to the SEP triggering event. As described below, in some instances we provided fictitious documents to the federal and selected state-based marketplaces to support the SEP triggering event and were able to obtain and maintain subsidized health coverage. Our applicant experiences are not generalizable to the population of applicants or marketplaces.

Results of Undercover Attempts to Obtain Subsidized Qualified Health-Plan Coverage from the Federal Marketplace and Selected State-Based Marketplaces during an SEP

The federal or selected state-based marketplaces approved coverage and subsidies for 9 of our 12 fictitious applicants who initially applied online or by telephone seeking coverage during an SEP, as of October 2016.[30] For these 9 applications, we were approved for APTC subsidies, which totaled about $1,580 on a monthly basis, or about $18,960 annually. These 9 applicants also each were approved for CSR subsidies,[31] putting them in a position to further benefit if they used medical services. However, in our tests, our fictitious applicants did not seek medical services.

The federal or state-based marketplaces denied coverage for 3 of our 12 fictitious applicants. Specifically:

- One applicant stated that the applicant did not receive any response from the marketplace after attempting to enroll in a health plan in a community center in January 2016. This fictitious applicant claimed that the applicant had applied for coverage to the federal Marketplace and that the applicant did not discover the applicant was not enrolled in a health plan until June 2016—about 6 months after the applicant's claimed initial contact with the marketplace. The marketplace representative stated that the applicant needed to follow up with the marketplace and select a health plan within 60 days of the SEP-triggering event, which in this case was misinformation or misrepresentation by a non-Marketplace entity providing enrollment

[30]We were unable to obtain coverage online for 6 fictitious applicants and submitted some applications over the phone. In other cases, we filed paper applications, as is permissible, after speaking with marketplace representatives. We subsequently paid premiums for the approved applicants to put the policies into force.

[31]As mentioned, a 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 consumer of such subsidies can likewise vary.

assistance in January of 2016.[32] Under CMS regulations, for this type of triggering event the marketplace may define the length of the SEP as appropriate based on the circumstances, up to a maximum of 60 days.

- The second fictitious applicant who applied for coverage to the state-based marketplace and was denied coverage claimed that the applicant initially tried to enroll in January 2016 and was told by a certified enrollment counselor that the applicant qualified for a high deductible plan, but did not qualify for a premium tax credit or CSR. When the applicant followed up with the state-based marketplace to obtain additional information, the marketplace representative requested the name of the enrollment counselor with whom the applicant initially applied for health coverage in January 2016.[33] The applicant provided the representative with a fictitious enrollment counselor name and location. The marketplace representative stated that the marketplace's application notes show that the applicant applied outside open enrollment and informed the applicant that the applicant could submit an appeal to further review the application. The applicant later received a letter from the selected state-based marketplace stating that, based on what the applicant told the marketplace about the event that occurred in June 2016, the applicant did not qualify for a special enrollment period at that time.
- The third fictitious applicant who was denied claimed an inability to apply for coverage during the open enrollment period because the applicant experienced a serious medical condition, had been hospitalized unexpectedly in January 2016, and needed rehabilitation through May 2016. The federal marketplace representative stated that the representative could not enroll the applicant in a health plan outside of open enrollment because the SEP event was an exceptional circumstance and CMS has to approve enrollment of these types of SEP triggering events. The representative explained that the representative would have to submit an escalation to CMS for our fictitious applicant to be approved to enroll during the SEP. After the application was escalated, the federal marketplace denied this

[32]The federal marketplace representative also asked for the original application identification number, location, and name of the enrollment counselor we claimed we initially spoke to when we attempted to enroll during open enrollment. We provided a fictitious name and location. We did not provide the federal Marketplace with the applicant identification numbers for this fictitious applicant.

[33]We did not provide the federal and state-based marketplaces with the application identification numbers for this fictitious applicant.

application, and a federal marketplace representative we spoke with stated that the applicant could have applied in November and December, before the unexpected hospitalization.[34] According to CMS officials, the federal marketplace makes eligibility determinations on a case-by-case basis for those applicants who experience an unexpected hospitalization that prevents them from enrolling during the open enrollment period.

Details of Supporting Documentation Requested and Verified for Fictitious Applicants Seeking to Enroll during an SEP

The federal and selected state-based marketplaces requested supporting documentation for 6 of our 12 fictitious applicants who initially applied online or by telephone seeking coverage during an SEP.[35] The 6 remaining fictitious applicants were not instructed to provide supporting documentation related to the SEP triggering event.[36] As previously mentioned, the federal or state-based marketplaces approved subsidized health-insurance coverage for 9 of our 12 fictitious applicants and denied coverage for 3 of our 12 fictitious applicants.

As mentioned, for all 12 fictitious applicants, we submitted supporting documentation related to proof of identity and income, such as a copy of the Social Security card, driver's license, and self-employment ledger. We designed the 12 fictitious applications to provide either no documentation or fictitious documentation related to the SEP event to note any differences in outcomes. As previously mentioned, we used professional

[34]As previously discussed, an individual may qualify for an SEP if the individual demonstrates to the Exchange, in accordance with guidelines issued by CMS, that the individual meets "other exceptional circumstances" as the Exchange may provide. According to HealthCare.gov, an example of such a qualifying exceptional circumstance is if the consumer faced a serious medical condition—such as an unexpected hospitalization or temporary cognitive disability—that kept him or her from enrolling during the annual open enrollment period. Further, under CMS's regulations, the marketplace may define the length of this type of SEP as appropriate based on the circumstances of the SEP, but in no event may the length of the SEP exceed 60 days.

[35]Four of those 6 fictitious applicants that were requested to provide documentation related to their SEP event successfully obtained subsidized health coverage. As mentioned, in two scenarios for the misinformation or misrepresentation by a nonmarketplace entity providing enrollment assistance in January of 2016, the federal and state-based marketplaces requested the original application identification number, location, and name of the enrollment counselor we claimed we initially spoke to when we attempted to enroll during open enrollment. These two applicants were denied enrollment.

[36]Five of those 6 fictitious applicants that were not requested to provide supporting documentation successfully obtained subsidized health coverage. The remaining 1 of 6 fictitious applicants that were not requested to provide supporting documentation related to their SEP was denied coverage.

judgement to determine what type of documentation we would submit related to the SEP triggering event.[37] For 9 of the 12 applications, GAO provided no documents or fictitious documents to support the SEP triggering event and was able to obtain and maintain subsidized health coverage. Figure 2 summarizes document submissions and outcomes for the 12 fictitious applications for subsidized qualified health-plan coverage during an SEP.

[37]For example, for a marriage scenario, we did not provide a marriage certificate or any documentation including the fictitious spouse's Social Security number. We did need to submit documentation related to the fictitious applicant's income in the form of a self-employment ledger and avoided providing information supporting a fictitious spouse. In another example, we had to submit proof of identity to pass the general eligibility requirements for a scenario in which we claimed the applicant permanently moved to another state within the past 60 days. Thus, to avoid submitting documentation related to the SEP triggering event, we submitted a driver's license, but we ensured it was from the original state and the issuance date was back-dated several years. We did not provide any documentation to support our permanent move to the new state. We did, however, self-attest to the permanent move.

Figure 2: Summary of Documentation Requested for 12 Applications for Subsidized Qualified Health-Plan Coverage during a Special Enrollment Period (SEP) as of October 2016

Marketplace	Scenario for testing	Type of verification	GAO document submission category	Documentation requested by marketplace related to SEP	Documentation submitted by GAO to marketplace related to SEP[a]	Obtained and maintained subsidized coverage?
▶ Federal	Loss of minimum essential health coverage	CMS verification[b]	Fictitious	Proof of lost health coverage	Employer letter with date employer-coverage benefits stopped	✔ Yes
	Permanent move to another state	CMS verification[b]	None	Proof of lost health coverage	N/A	✔ Yes
	Marriage	CMS verification[b]	None	Proof of marriage	N/A	✔ Yes
	Misinformation or misrepresentation given to an applicant by a non-Marketplace entity providing enrollment assistance	No verification[c]	None	Initial application ID number, location, and name of the enrollment counselor	Location	✘ No
	Medicaid application during open enrollment denied	No verification[c]	None	None	N/A	✔ Yes
	Experienced a serious medical condition that prevented application during open enrollment	No verification[c]	None	None	N/A	✘ No
▶ State-based	Loss of minimum essential health coverage	State selective verification[d]	None	None	N/A	✔ Yes
	Permanent move to another state	State selective verification[d]	Fictitious	None	Driver's license	✔ Yes
	Marriage	No verification[c]	Fictitious	None	Marriage certificate	✔ Yes
	Misinformation or misrepresentation given to an applicant by a nonmarketplace entity providing enrollment assistance	No verification[c]	None	Location and name of initial certified enrollment counselor	Location and name	✘ No
	Medicaid application during open enrollment denied	State selective verification[d]	None	None	N/A	✔ Yes[e]
	Experienced a serious medical condition that prevented application during open enrollment	State selective verification[d]	Fictitious	Doctor's letter stating nature of medical condition	Doctor's letter stating dates and type of medical condition	✔ Yes

Source: GAO. | GAO-17-78

Notes: N/A = not applicable. The scenarios were designed to pass the identity verification steps for online and telephone accounts and provide supporting income documentation on the fictitious applications by providing a copy of the driver's license, proof of income, and Social Security card.

There is no legal requirement that either the federal or state-based marketplaces must verify the events that trigger an SEP.

[a]Any documentation we submitted was fictitious.

[b]"CMS verification" refers to SEP triggering events that are subject to the CMS Special Enrollment Confirmation Process. CMS announced that consumers who enroll using an SEP through the federal marketplace for certain triggering events would be directed to provide documentation as part of the CMS Special Enrollment Confirmation Process.

[c]For the federal marketplace, "No verification" refers to triggering events that are not subject to the CMS Special Enrollment Confirmation Process announcement. For one of the selected state-based marketplaces, "No Verification" refers to instances where the marketplace is not required and elected not to request documentation to verify the specific SEP scenario we used for testing. While the federal and selected state-based marketplaces did not request documentation to support the applicants that claimed misinformation or misrepresentation by a nonmarketplace entity providing enrollment assistance as a SEP triggering event, the marketplaces did request information about the initial application made during open enrollment.

[d]"State selective verification" refers to the instances in which the state-based marketplaces we selected, even though not required to verify SEP events, nonetheless may elect to request documentation to support an SEP event.

[e]On the basis of our applicant's communication with the marketplace, it is not clear whether the applicant was approved for subsidized qualified health coverage based on this SEP triggering event or a different SEP triggering event.

Officials from the marketplaces explained that they do not require applicants to submit documentation to support certain SEP triggering events. For other SEP triggering events, CMS officials explained that the standard operating procedure in the federal marketplace is to enroll applicants first, and verify documentation to support the SEP triggering event after enrollment.

As previously mentioned, there is no specific legal provision that requires federal and state-based marketplaces to verify the events that trigger an SEP, but in February 2016 CMS announced plans to begin a Special Enrollment Confirmation Process, which involves requesting supporting documentation to verify certain events that would trigger an SEP. CMS announced that it would begin requesting supporting documentation from consumers who enroll or change plans using an SEP for selected triggering events on June 17, 2016. We started our testing after June 17, 2016. State-based marketplaces are not required to participate in the CMS Special Enrollment Confirmation Process and may establish their

own processes.[38] According to state and federal officials, all applicants that apply for enrollment during an SEP must attest under penalty of perjury that they meet the conditions of eligibility for the SEP. However, relying on self-attestation without verifying documents submitted to support a SEP triggering event could allow actual applicants to obtain subsidized coverage they would otherwise not qualify for.

Documents Requested for Applicants to the Federal Marketplace

Three of our six fictitious applicants to the federal Marketplace claimed eligibility based on an SEP triggering event covered by the CMS Special Enrollment Confirmation Process and were instructed by the federal marketplace to provide supporting documentation to prove eligibility to enroll through the SEP. As of October 2016, the three fictitious applicants that claimed eligibility based on an SEP triggering event covered by the CMS Special Enrollment Confirmation Process are currently enrolled in a subsidized qualified health plan. Two of these three fictitious applicants were asked to submit documents to support their SEP event, but obtained and maintained subsidized health coverage without providing any documentation to support their SEP event.[39] The third of these three individuals submitted fictitious documents supporting the SEP event in response to the federal Marketplaces' request and subsequently obtained and maintained subsidized health coverage.

The remaining three of six applicants to the federal Marketplace claimed eligibility based on SEP events that were not covered by the CMS Special Enrollment Confirmation Process and (as such) were not instructed to provide supporting documentation to prove eligibility to enroll through the SEP. For example, one of these three applicants to the federal marketplace claimed to have applied for Medicaid during the annual open

[38]For example, according to state officials from Covered California, the state-based marketplace accepts self-attestation and then performs a random sample for certain SEP triggering events. According to Covered California officials, the results of the random sample are ongoing. According to officials from the DC Health Benefit Exchange Authority, for serious medical conditions that prevented an application during open enrollment, marketplace errors, and post-open-enrollment denial of Medicaid coverage applied for during open enrollment, the marketplace does not allow consumers to enroll until after they undergo a manual review process that may involve document requests.

[39]For one of these two applicants, we requested a 30-to-60 day extension to provide the supporting documentation related to the SEP. This 30-to-60 day period has expired. For the other applicant, the marketplace asked that we provide the supporting documentation related to the SEP within 60 days of the SEP triggering event. As mentioned, this scenario was designed not to provide supporting documentation related to the SEP. As of October 2016, the federal marketplace has not followed up requesting the supporting documentation for either applicant.

enrollment but was subsequently denied Medicaid after open enrollment had closed—which is not an event covered by the process. This applicant did not provide documentation to support this claim, and the applicant obtained subsidized coverage.[40] The remaining two applicants to the federal marketplace were denied, as described previously in this report.[41]

Documents Requested for Applicants to Selected State-Based Marketplaces

Two of the six fictitious applicants to the selected state-based marketplaces were instructed by the state-based marketplace to provide supporting documentation proving eligibility to enroll through the SEP. For one of the two fictitious applicants, we did so, and the fictitious applicant is currently enrolled in a qualified health plan. The other applicant was denied, as described previously in this report.[42]

The remaining four of our six fictitious applicants to the selected state-based marketplaces were not instructed by the state marketplace to provide supporting documentation to prove eligibility to enroll through the SEP. Two of these four fictitious applicants were able to obtain and maintain subsidized health insurance through the marketplace without providing supporting documentation related to the SEP and are currently enrolled in a qualified health plan.

[40]According to CMS officials, CMS accepts self-attestation to verify eligibility for an applicant who claims he or she applied for Medicaid during open enrollment and was subsequently denied after open enrollment had closed; however, there are no other policies and processes in place to verify whether applicants who apply through a federal marketplace are eligible for this SEP, according to CMS officials. Consumers that claim eligibility to enroll during an SEP as a result of this situation must attest under penalty of perjury that they meet the conditions of eligibility for the SEP.

[41]As mentioned, in one of the two scenarios, the federal marketplace asked for the original application identification number, location, and name of the enrollment counselor we claimed we initially spoke to when we attempted to enroll during open enrollment. We provided a fictitious name and location. The marketplace representative stated that the fictitious applicant needed to follow up with the marketplace and select a health plan within 60-days of the SEP-triggering event. It is unclear whether the response we provided—a fictitious name of the enrollment counselor and fictitious location—is the reason the applicant was denied.

[42]As mentioned, while the marketplace did not request documentation to support the applicant's SEP triggering event, the marketplace requested the name of the representative and location where the applicant initially attempted to enroll in the state-based marketplace during open enrollment. It is unclear whether the response we provided—a fictitious name of the enrollment counselor and fictitious location—is the reason the applicant was denied.

Fictitious Documents Submitted to Support SEP Triggering Events

As mentioned, in some instances, we provided fictitious documents to the federal and selected state-based marketplaces to support the SEP triggering event and were able to obtain and maintain subsidized health coverage.[43] After the conclusion of our undercover testing, when we spoke with federal and selected state-based marketplace officials about the outcomes of our fictitious applicants, the federal and selected state-based marketplace officials told us that unless a document appeared visibly altered, they accepted it. For example, one of our fictitious applicants claimed that we were eligible to enroll during the SEP because the applicant recently lost health coverage. In response to our application, the federal marketplace required us to submit documentation to support this SEP triggering event, such as submitting a letter from an employer stating that coverage was terminated and the date the coverage ended. We submitted a fictitious letter from a fictitious employer with a fictitious telephone number indicating our coverage was terminated on a certain date. A marketplace representative later told us that the marketplace had received and verified the fictitious supporting documentation we submitted. The fictitious applicant obtained subsidized health coverage and has continued to maintain subsidized coverage to date.

In another example, one of our fictitious applicants claimed that the applicant was eligible to enroll during the SEP because the applicant experienced a serious medical condition that prevented the applicant from enrolling in a plan during open enrollment. In response, the marketplace required us to submit documentation to establish our SEP triggering event. Specifically, the marketplace requested a letter from the doctor explaining the nature of the condition that kept us from enrolling during open enrollment. We submitted a fictitious doctor's note with a fictitious doctor's name and address, as well as a fake phone number that we could monitor. We were later notified that we had been approved. On the basis of our records, no one called the fake number we provided before we were approved for coverage. The fictitious applicant obtained subsidized health coverage and has continued to maintain subsidized coverage to date.

[43]As mentioned, while the federal and selected stated-based marketplaces did not request documentation to support the applicants that claimed misinformation or misrepresentation by a nonmarketplace entity providing enrollment assistance SEP triggering event, the marketplace requested the name of the representative and location where the applicants initially attempted to enroll in the marketplace during open enrollment. It is unclear whether the response we provided—a fictitious name of the enrollment counselor and fictitious location—is the reason both applicants were denied.

As mentioned, there is no specific legal requirement that federal or state-based marketplaces authenticate the documents submitted to support an SEP event to determine whether those documents are fictitious. However, according to federal and state officials, all applicants that apply for enrollment during an SEP must attest under penalty of perjury that they meet the conditions of eligibility for the SEP.

Agency Comments and Our Evaluation

We provided a draft of this report to HHS, Covered California, and the District of Columbia (DC) Health Benefit Exchange Authority. Written comments from HHS, Covered California, and the DC Health Benefit Exchange Authority are summarized below and reprinted in appendixes II–IV, respectively. In their written comments, in terms of overall context, these agencies reiterated that they are not required to verify the events that trigger an SEP and instead rely on self-attestation and the associated penalties, which we acknowledge and state in this report. However, prudent stewardship and good management practices suggest that fraud risks be understood and managed to protect public funds. In addition to their formal written comments, all three agencies provided us with technical comments, which we incorporated, as appropriate, in this report.

In its written comments, HHS stated that SEPs are a critical way for qualified consumers to obtain health coverage and that it is important that SEPs are not misused or abused. HHS also described several actions it is taking to better understand SEPs, including its efforts as part of the agency's Special Enrollment Confirmation Process, which we also describe in this report. For example, according to HHS, beginning June 18, 2016, all consumers who complete a Marketplace application for an SEP included in the Special Enrollment Confirmation Process will read in their Eligibility Determination Notice next steps that they must take to prove their SEP eligibility along with a list of examples of documents they may submit. HHS noted that consumers who do not respond to requests for documentation or do not provide sufficient documentation could be found ineligible for their SEP and may lose coverage. In addition, HHS stated that it is implementing steps to improve program integrity, such as by conducting a fraud risk assessment of the Marketplace consistent with GAO's fraud risk framework.[44] As mentioned, we believe that performing a fraud-risk assessment consistent with our prior recommendations to

[44]GAO-15-593SP. The fraud framework identifies leading practices and presents them in risk-based format to aid program managers in managing fraud risks.

HHS in this area could help address the control vulnerabilities we identified during our SEP tests.

In its written comments, Covered California also stated that it is important to ensure that consumers who enroll in health coverage during an SEP have, in fact, experienced a qualifying life event. Covered California explained that its controls are in compliance with federal standards. Covered California also described processes it has in place to verify certain SEP events, such as the random sample of consumers who experience two qualifying life events: (1) loss of minimum essential coverage and (2) permanent move to and within California, as we describe in this report. Covered California also suggested that any requirement for marketplaces to authenticate documents provided by applicants for an SEP should also consider the burden that document authentication may impose on marketplaces, consumers, and the sources of such documents, such as doctors and insurers. In this regard, we did not evaluate the cost of authenticating such documents as part of our work because it was outside the scope of our review.

In its written comments, the DC Health Benefit Exchange Authority described its policies and processes for verifying SEP eligibility by relying on self-attestation or reviewing information provided by consumers and others. Additionally, in its written comments, the DC Health Benefit Exchange Authority also raised concerns about our methodology. First, the agency stated that the DC marketplace is too different from other marketplaces to be an informative part of our review. Specifically, the comments state that the age of individuals enrolled in health insurance coverage in the DC marketplace – and enrolled through SEPs in particular – suggests that there is no evidence that consumers are waiting to get sick before enrolling in coverage. We did not evaluate the DC marketplace's data on its population of enrollees and did not evaluate the DC marketplace's conclusion that the age of its enrollee population shows that there is no systemic abuse of SEPs. Rather, our work focused on testing whether our fictitious applicants could obtain and maintain health coverage during an SEP by submitting fictitious documents or no documents to support our SEP triggering event. The DC marketplace is similar to the federal Marketplace and the other state-based marketplace we selected in that it relies on self-attestation to verify certain SEP events.

The written comments from the DC Health Benefit Exchange Authority also expressed concern that the results of our testing are not useful to help improve the agency's processes because we did not provide specific

details of our undercover testing scenarios to the states included in our review. As we noted in our meetings with HHS and both of the state agencies included in our review, we did not provide certain details on our undercover testing scenarios to maintain the integrity of our undercover tests. Specifically, we did not provide details about our undercover tests that could risk inappropriately revealing the identities of our fictitious applicants and preclude the use of such identities in any future reviews. However, we did provide HHS and both of the state agencies with details of the scenarios, including the type of application submitted; the type of documentation we submitted; and the interaction with the marketplace representatives, among other things. Providing additional, specific details about our fictitious identities would not help the agency address any systemic vulnerabilities stemming from their reliance on self-attestation to verify eligibility for an SEP.

Further, the DC Health Benefit Exchange Authority commented that our undercover tests are unrealistic because we produced fictitious documents to support our SEP events; that lying under penalty of perjury is a unique ability of our undercover investigators; and that our work assumes a significant number of individuals perjure themselves to access federal funds. These statements represent a misunderstanding of our methodology. First, as stated in our report, we used publicly available hardware, software, and materials to produce the counterfeit documents that we submitted for our testing. Using these same tools, potential fraudsters may realistically produce similarly counterfeit documents to support an SEP triggering event. Second, potential fraudsters have the ability—and very possibly the inclination—to lie under penalty of perjury to perpetrate their illegal schemes. Finally, our report makes no statements or assumptions about the number of individuals who perjure themselves to access federal funds. Rather, our report focuses on the results of our undercover testing of enrollment verification for 12 fictitious applications for subsidized health-insurance coverage during an SEP in 2016 to identify potential vulnerabilities in enrollment-verification controls. As mentioned above, prudent stewardship and good management practices suggest that fraud risks be understood and managed to protect public funds.

The DC Health Benefit Exchange Authority's written comments additionally stated that relying on self-attestation is a well-accepted practice in the federal government. The DC Health Benefit Exchange Authority also suggested that any requirement for marketplaces to authenticate documents provided by applicants for an SEP should consider the burden on both the marketplace and consumers. In this

regard, we did not evaluate the cost of authenticating such documents as part of our work because it was outside the scope of our review. Further, while federal agencies may rely on self-attestation for certain aspects of their programs, such as those noted in the DC Health Benefit Exchange Authority's written comments, federal agencies also take steps to verify information needed to determine eligibility for programs and benefits. For example, in compliance with the requirements of PPACA and CMS regulations, the federal and state-based marketplaces (including DC Health Link) verify information on applicant citizenship, nationality, or legal presence status by matching applicant data with data from federal agencies rather than relying on self-attestation for this information.[45] Additionally, our prior work has found that relying on self-reported information can leave agencies vulnerable to fraud in some programs.[46] Thus, it would be misleading to characterize reliance on self-attestation for conducting program integrity activities as a generally well-accepted practice in the federal government.

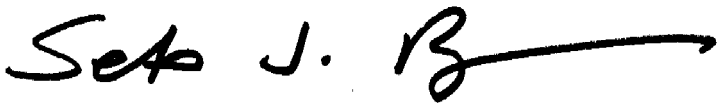
Finally, the DC Health Benefit Exchange Authority's written comments stated that its approach to verifying SEP events is consistent with the best practices in our fraud risk framework. For example, the DC Health Benefit Exchange Authority stated that it has reviewed the characteristics of the DC marketplace, consistent with the principles of our fraud risk framework, and assessed risk to develop appropriate verification procedures. However, we did not review, and are thus not able to corroborate, the DC Health Benefit Exchange Authority's claim that its enrollment verification controls are consistent with our fraud risk framework.

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

[45]For more information on this process, see GAO-16-29.

[46]For example, see GAO, *Actions Needed to Help Prevent Potential Overpayments to Individuals Receiving Concurrent Federal Workers' Compensation*, GAO-15-531 (Washington, D.C.: Aug. 3, 2015).

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 V.



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

List of Requesters

The Honorable Orrin Hatch
Chairman
Committee on Finance
United States Senate

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

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

The Honorable Tim Murphy
Chairman
Subcommittee on Oversight and Investigation
Committee on Energy and Commerce
House of Representatives

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

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

Appendix I: Objective, Scope, and Methodology

We were asked to examine and test health-care marketplace enrollment and verification controls for a special enrollment period (SEP) for the 2016 coverage year. This report describes results of undercover attempts to obtain subsidized qualified health-plan coverage outside the open enrollment period for 2016; that is, during an SEP. To perform our undercover testing and describe the results of our undercover attempts to obtain new coverage during an SEP, we used 12 fictitious identities for the purpose of making applications to obtain subsidized qualified health-plan coverage offered through a marketplace by telephone and online.[1] The Patient Protection and Affordable Care Act (PPACA) requires marketplaces to verify application information to determine eligibility for enrollment and, if applicable, determine eligibility for the income-based subsidies or Medicaid. These verification steps include validating an applicant's Social Security number, if one is provided; verifying citizenship, U.S. nationality, or lawful presence in the United States; and verifying household income. The 12 identities were designed to pass these verification steps by providing supporting documentation—albeit fictitious—such as a copy of the Social Security card, driver's license, and proof of income.

We selected states within the federal Health Insurance Marketplace (Marketplace) and state-based marketplaces for our undercover applications, based on factors including state population, percentage of state's population without health insurance, whether the state was selected for testing as part of our prior work, whether the state participates in the state-based marketplace or federal marketplace, and whether the states make the eligibility determination or assessment for other health-coverage programs, including Medicaid. Specifically, we selected two states—Virginia and Florida—that elected to use the federal marketplace rather than operate a marketplace of their own. We also selected two state-based marketplaces—Covered California (California) and DC Health Link (District of Columbia).

The results obtained using our limited number of fictional applicants are illustrative and represent our experience with applications in the federal and state marketplaces we selected. The results cannot, however, be

[1]For all our fictitious 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 or to mail the application, we acted as instructed. In this report, we use "qualified health plan" to refer to coverage obtained from private insurers through a marketplace.

generalized to the overall population of applicants, enrollees, or marketplaces.

Our undercover testing included fictitious applicants claiming to have experienced an event that would trigger eligibility to enroll in health-insurance coverage during an SEP. Specifically, our 12 fictitious applicants claimed to have experienced one of the following selected events that may indicate eligibility, under certain circumstances, to enroll in health coverage under an SEP: (1) loss of minimum essential health coverage; (2) gained access to new qualified health plans as a result of a permanent move to another state; (3) gained a dependent through marriage; (4) experienced an exceptional circumstance, such as a serious medical condition that prevented the consumer from enrolling during the annual open enrollment period; (5) nonenrollment during the annual open enrollment period was unintentional and the result of misinformation or misrepresentation by a non-exchange entity providing enrollment assistance or conducting enrollment activities; and (6) Medicaid application filed during the annual open enrollment period was denied after the open enrollment period had closed. We tested the six selected triggering events in the federal marketplace. We also tested the six selected triggering events in the two selected state-based marketplaces. We submitted three applications in each state and the District of Columbia.

We selected these six SEP triggering events to create a balance between three events that are subject to the Centers for Medicare & Medicaid Services (CMS) Special Enrollment Confirmation Process and three events that are not subject to this process.[2] In February 2016, CMS announced plans to begin requesting supporting documentation to verify certain events that would trigger an SEP. CMS announced that it would begin requesting supporting documentation from consumers who enroll or change plans using an SEP for selected triggering events on June 17, 2016. We started our testing after June 17, 2016. State-based marketplaces are not required to follow CMS's Special Enrollment

[2]The three events we selected that are subject to the CMS Special Enrollment Confirmation Process are (1) loss of minimum essential coverage; (2) permanent move to another state; and (3) gaining a dependent through marriage. The three events we selected that are not subject to this CMS process are (1) an exceptional circumstance, such as a serious medical condition that prevented the consumer from enrolling during the open enrollment period; (2) unintentional nonenrollment caused by misinformation or misrepresentation by a nonexchange entity; and (3) Medicaid application filed during open enrollment was denied after open enrollment closed.

Confirmation Process, but states may choose to follow this guidance or establish their own processes, according to CMS officials.

We made 6 of our applications online initially, and 6 by phone; however, for all our fictitious 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 or mail or fax the application, we acted as instructed. We also self-attested that the information provided in the application was true when instructed. In these tests, we also stated income at a level eligible to obtain both types of income-based subsidies available under PPACA—a premium tax credit, to be paid in advance, and cost-sharing reduction (CSR).

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 material to produce counterfeit documents, which we submitted, as appropriate for our testing, when instructed to do so. We designed the 12 fictitious applications to provide either no documentation or fictitious documentation related to the SEP triggering event.[3] We used professional judgement to determine what type of documentation we would submit related to the SEP triggering event. For example, for a marriage scenario, we did not provide a marriage certificate or any documentation including the fictitious spouse's Social Security number. We did need to submit documentation related to the fictitious applicant's income in the form of a self-employment ledger and avoided providing information supporting a fictitious spouse. In another example, we had to submit proof of identity to pass the general eligibility requirements for a scenario in which we claimed the applicant permanently moved to another state within the past 60 days. Thus, to avoid submitting documentation related to the SEP triggering event, we submitted a driver's license, but we ensured it was from the original state and the issuance date was back-dated several years. We did not provide any documentation to support our permanent move to the new state. We did, however, self-attest to the permanent move. We then observed the outcomes of the document submissions, such as any approvals received

[3]In the scenarios that were designed to provide fictitious documentation, the marketplace generally provided the fictitious applicant 30 days to submit supporting documentation related to the SEP event. If instructed to do so, and the scenario was designed to provide fictitious supporting documentation related to the SEP event, we provided the requested documentation within 30 days.

or requests received to provide additional supporting documentation. For the applications that we were denied, we did not proceed with the appeals process.[4]

We conducted our performance audit from May 2016 to November 2016 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective. We conducted our related investigative work in accordance with investigative standards prescribed by the Council of the Inspectors General on Integrity and Efficiency.

[4]When a consumer is denied, the consumer has the right to appeal the decision through the federal or state marketplace if the consumer disagrees with a decision related to eligibility for health coverage including Medicaid, the Children's Health Insurance Program, purchasing health coverage through the marketplace, tax credit, CSR, and enrollment period, among other things.

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

NOV 0 4 2016

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

Dear Mr. Bagdoyan:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, *"Patient Protection and Affordable Care Act: Results of Enrollment Testing for the 2016 Special Enrollment Period"* (GAO-17-78).

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

Sincerely,

Jim R. Esquea
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: PATIENT PROTECTION AND AFFORDABLE CARE ACT: RESULTS OF ENROLLMENT TESTING FOR THE 2016 SPECIAL ENROLLMENT PERIOD (GAO-17-78)

The Department of Health and Human Services (HHS) appreciates the opportunity to review and comment on this Government Accountability Office (GAO) draft report. HHS takes seriously its commitment to ensuring the program integrity of the Marketplaces established by the Affordable Care Act.

Special enrollment periods (SEPs) are an important way to make sure that people who lose health insurance during the year or who experience major life changes, like getting married or having a child, have the opportunity to enroll in coverage through the Marketplaces outside of the annual Open Enrollment period. SEPs are a longstanding feature of health insurance, and without them, many people would lack options to maintain continuous coverage.

While SEPs provide a critical pathway to coverage for qualified individuals who experience qualifying events, it's equally important that SEPs are not misused or abused. HHS is continually monitoring the health and operations of the Marketplace and has taken several steps to analyze and strengthen current rules and procedures to ensure that only those who are eligible enroll through SEPs.

As GAO notes in its report, Federal and state marketplaces are not required to verify the qualifying events that trigger an SEP. However, in order to better understand whether current rules and procedures are sufficient, HHS established the Special Enrollment Confirmation Process for the Federally-facilitated Marketplace. As part of this process, all consumers enrolling through the most common SEPs need to submit documentation to verify their eligibility to receive an SEP. The SEPs included in the Special Enrollment Confirmation Process are loss of minimum essential coverage; change in primary place of living; gaining or becoming a dependent due to a birth, adoption, foster care placement, or child support or other court order; and marriage. These SEPs represent two thirds of Federal Marketplace consumers who enrolled in or changed plans using an SEP in the second half of 2015.

Beginning in March 2016, all consumers who applied for coverage through a Federally-facilitated Marketplace were required to acknowledge, via attestation on the Marketplace application, that they might be asked to provide documentation to verify eligibility for an SEP.

Beginning June 18, 2016, consumers who completed a Marketplace application for coverage and qualified for an SEP saw a flag on their Eligibility Results page within their online accounts, which explained they were eligible for an SEP, but may need to send the Marketplace more information. Consumers were also directed to read their Eligibility Determination Notice (EDN) to find out if they need to submit documents.

Currently, all consumers who qualify for these SEPs subject to verification saw in their EDN detailed next steps that they must take to prove their SEP eligibility, along with a list of examples of documents they may submit. Consumers who don't respond to requests for documentation or don't provide sufficient documentation could be found ineligible for their SEP and may lose coverage. Consumers who qualify for SEPs, but whose SEP eligibility is not verified through this

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: PATIENT PROTECTION AND AFFORDABLE CARE ACT: RESULTS OF ENROLLMENT TESTING FOR THE 2016 SPECIAL ENROLLMENT PERIOD (GAO-17-78)

process must attest under penalty of perjury that the information they submit on their application for an SEP is true and correct.

In addition, in order to better protect consumers and taxpayer dollars, HHS is implementing a number of initiatives to enhance operations with a focus on program integrity. As recommended by the GAO,[1] HHS is conducting a Marketplace Fraud Risk Assessment, leveraging the GAO's fraud risk framework.[2] The GAO's framework identifies leading practices for managing fraud risks and was developed to help managers combat fraud and preserve integrity in government agencies and programs. HHS is using this framework to identify and prioritize key areas for potential risk in the Marketplace.

HHS looks forward to continuing to benefit from suggestions from our partners in the GAO and HHS OIG on ways to improve our operations so eligible consumers can gain coverage through the Marketplaces in a way that prevents consumer harm and protects taxpayer money. When provided with specific findings and recommendations from our partners in the GAO and the HHS OIG, HHS uses that information to improve its programs. While the GAO has not provided details on the fictitious persons they used nor made recommendations to address the findings in this report, HHS continues to make ongoing improvements to strengthen program integrity efforts and Marketplace controls.

[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)

Appendix III: Comments from Covered California

November 4, 2016

Jonathon Oldmixon
Assistant Director
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Mr. Oldmixon,

Thank you for providing Covered California the opportunity to review and comment on the U.S. Government Accountability Office's (GAO) draft report entitled, "*Patient Protection and Affordable Care Act: Results of Enrollment Testing for the 2016 Special Enrollment Period (GAO-17-78)*." This performance audit (undercover testing) was conducted in response to a congressional request to examine and test marketplace enrollment and verifications controls for the 2016 coverage year Special Enrollment Period (SEP). The GAO's examination included testing whether the federal marketplace and state marketplace's rules and procedures are sufficient to ensure that only those who have experienced a qualifying life event are enrolling in coverage.

For California, the GAO used three fictitious identities to apply for subsidized qualified health plan coverage offered through a marketplace by telephone and online during SEP. Specifically, the fictitious applicants claimed to have experienced one of the following selected events that may indicate eligibility, under certain circumstances, to enroll in health coverage under an SEP: (1) lost minimum essential health coverage; (2) gained access to new qualified health plans as a result of a permanent move; (3) gained a dependent through marriage; (4) experienced an exceptional circumstance; (5) non-enrollment during the annual open enrollment period was unintentional and the result of misinformation or misrepresentation by a non-Exchange entity providing enrollment assistance or conducting enrollment activities; and (6) Medicaid application filed during the annual open enrollment period was denied after the open enrollment period had closed.

Covered California concurs that it is very important that consumers who enroll during an SEP have, in fact, experienced a qualifying life event. From day one of the first open enrollment period, we have established controls and business systems that are in compliance with applicable federal and state regulations regarding identity verification and eligibility determination. And while we cannot comment on specific outcomes of this audit since the detailed information regarding the fictitious applicants that applied to

Covered California was not provided to us, we can state that the protocols we have in place to process applicants during an SEP are compliant with federal standards. Additionally, the GAO report itself states, the results of this report cannot be generalized to our overall SEP enrollment population. We are committed to continuous process improvements, and have put in place many process controls to minimize the potential for fraud similar to those recommended by the GAO to the Secretary of Health and Human Services in a February 2016 report addressing enrollment and verification controls and the management of fraud risks.

As the GAO states in this report, "there is no specific legal requirement that federal or state marketplaces (1) request documents to support an SEP triggering event or (2) authenticate the documents submitted to support an SEP event to determine whether those documents are fictitious." Consistent with federal regulations, Covered California allows consumers to self-attest to their qualifying life event under penalty of perjury without further verification during an SEP. However, in recognizing the risk of consumer fraud, Covered California's state regulations specifies that when a consumer self-attests to a qualifying life event, they could be held liable to penalty fines of either $25,000 or $250,000 if the information they provided regarding their qualifying life event was found to be fraudulent.

As part of Covered California's efforts to improve its policies and procedures for verifying that only those who are eligible enroll through SEP, Covered California implemented a statistically valid random sampling SEP verification process in August 2016. Covered California's guiding principles for its SEP verification process includes ensuring that eligible individuals are enrolled; preserving the risk mix of the individual market and supporting long-term affordability; and ensuring the special enrollment policy will not be overly burdensome to members. Collaboration with Qualified Health Plans and stakeholders has been integral in identifying options and developing potential new policies and process as well as considerations of technological capabilities. Consumers are notified in advance that they may be required to provide supporting documentation that verifies their qualifying life event during the SEP application process. In addition, the application process informs the consumer about the penalty fines.

In addition to accepting a consumer's self-attestation, under penalty of perjury, to a qualifying life event for an SEP, we have taken additional steps to focus on two qualifying life events, which include loss of minimum essential coverage and permanent move to and within California. We focused on the loss of minimum essential coverage and permanent move to and within California because both qualifying life events represent a large percentage of qualifying life events for consumer enrollments during the SEP. We obtain a statistically valid random sample of SEP enrollments and verify the consumer's qualifying life event by requesting supporting documentation of the event. Consumers have a 30-day period to respond with sufficient documentation that demonstrates their eligibility under an SEP. In the event the consumer does not provide acceptable documentation, Covered California has the authority to terminate the consumer from our program.

Covered California would like to note that although we do not authenticate documents, we do inspect documents for obvious fraudulent activities and refer suspicious

documents to the Office of Consumer Protection for further review and formal investigation. The implication that there should be a requirement on marketplaces to "authenticate" documents should be considered with great care. There is no indication that actual consumers are using fraudulent documentation in the face of substantial fines. The burden of authentication on both marketplaces, consumers, and the sources of documentation (e.g. employers, doctors, insurers) should be considered before such significant change were implemented.

Covered California has formed an enterprise-wide internal SEP workgroup to discuss priorities, future policies, and process improvements related to the SEP. Additionally, a Request for Information was published on September 12, 2016, to determine technological solutions that may be available to provide electronic verification of all qualifying life events.

To ensure that only eligible consumers enroll in Covered California's health benefits, our service center representatives, navigators, certified application counselors, certified insurance agents, etc., are provided with annual and refresher trainings that include courses on SEP enrollments. Additionally, task guides and job aids are continually updated with additional clarification regarding the SEP processes. The service center is in the process of implementing additional quality assurance processes, which include additional evaluations of service center representatives and whether Covered California's SEP policies and procedures are being followed. As a part of those efforts, there will be additional program monitoring and oversight in all areas of service center performance, including SEP enrollments. We continue to emphasize promotion of a positive consumer experience and effective customer service, but it is equally important that consumers who enroll in Covered California actually qualify for our program and the benefits offered to them through the Affordable Care Act.

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

In 2015, Covered California built upon existing internal controls to further ensure effective consumer support and fraud controls by establishing the Program Integrity Division to help improve program compliance with federal and state regulations. The Program Integrity Division is a mission critical section within Covered California that is responsible for program integrity functions that include, but are not limited to, the Consumer Protection and Fraud Risk Management Program and a comprehensive Oversight and Monitoring Program.

To ensure program integrity and strategically mitigate the likelihood and impact of fraud, the Office of Consumer Protection and Fraud Risk Management manages an integrated fraud prevention program within Covered California. The program supports an organizational culture that is committed to program integrity and combatting fraud. This

is a combined effort made by the Covered California Board, the Audit Committee, independent internal and external auditors, risk assessment staff, management at all levels, investigators, operations personnel and others to manage the risk of fraud. We make it a priority to take the opportunity to consider, enact and improve measures to detect, deter and prevent fraud before it occurs. We have designed and implemented an anti-fraud strategy to address potential fraud, waste, and abuse activities of employees, external stakeholders, consumers, and others. Our focus on fraud strategies includes prevention, which mitigates the risk of fraud occurring; detection, which helps identify potential fraud that has already occurred; and response, which includes taking corrective actions to remedy the harm caused by fraud. These fraud prevention and detection strategies are vital to combating fraud before it occurs and are necessary to preserve the sustainability and the integrity of Covered California's operations.

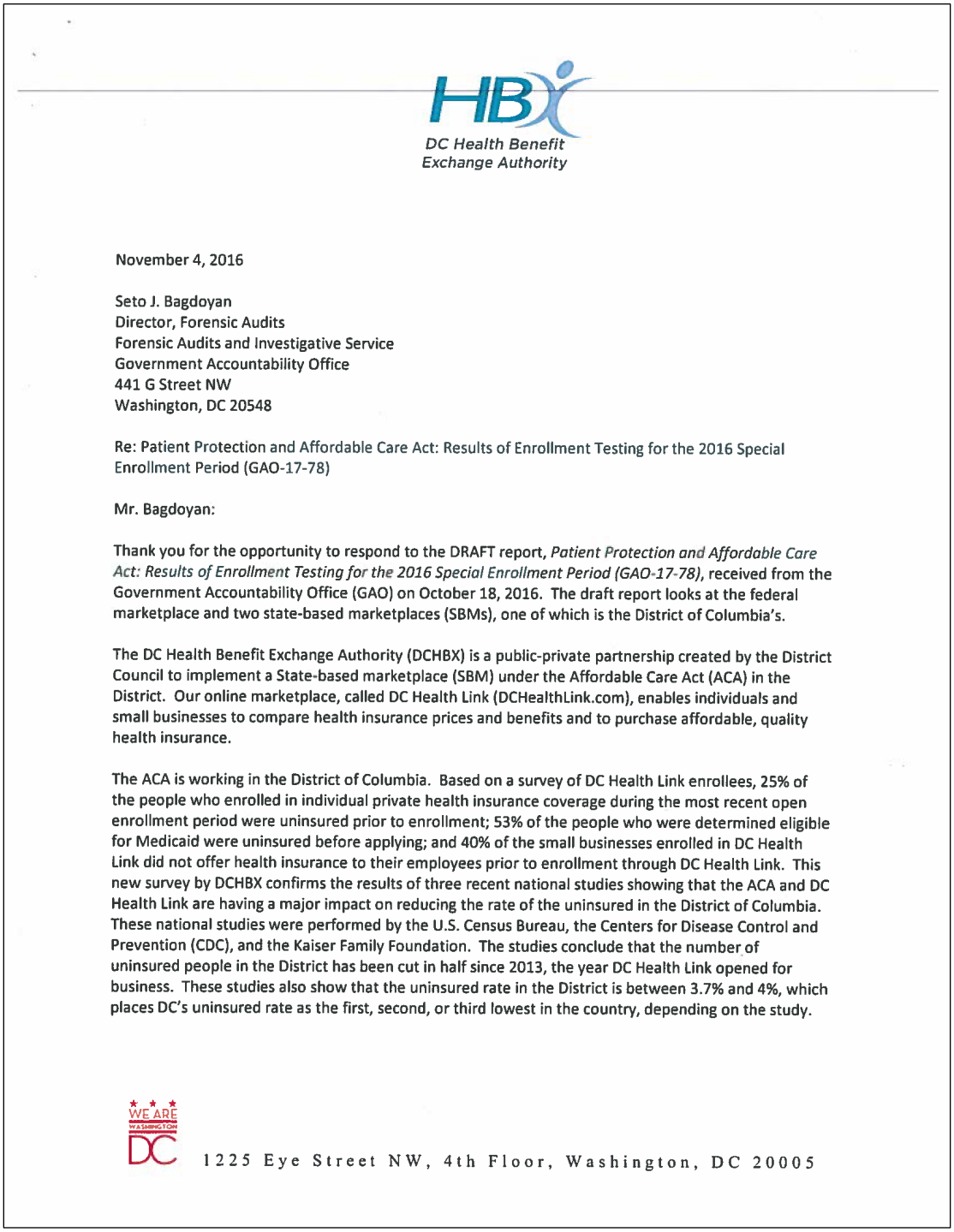
The Oversight and Monitoring Program, as prescribed by the Center for Consumer Information & Insurance Oversight, and Centers for Medicare & Medicaid Services, consists of oversight and monitoring activities of both financial and programmatic areas to ensure compliance with the Affordable Care Act. The Oversight and Monitoring Program's function is to support the following components of Covered California's operations: written policies and procedures; defined roles and responsibilities of individuals and organizations responsible for oversight and monitoring activities; effective training of employees and stakeholders; mechanisms for reporting instances of suspected fraud, waste, and abuse violations and the results of investigations or results of oversight and monitoring activities; defined enforcement standards for employees and stakeholders; routine monitoring and auditing; and tools or systems to assist Covered California with internal oversight and monitoring. Covered California's Oversight and Monitoring Program fosters accountability and transparency, and mitigates the risk of systematic vulnerabilities being undetected to ensure a well-functioning, secured, and compliant marketplace.

As Covered California continues to build upon its successes, we thank the engagement team in their efforts to effect continuous improvement.

Sincerely,

Peter V. Lee
Executive Director

Appendix IV: Comments from the District of Columbia Health Benefit Exchange Authority



DC Health Benefit Exchange Authority

November 4, 2016

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

Re: Patient Protection and Affordable Care Act: Results of Enrollment Testing for the 2016 Special Enrollment Period (GAO-17-78)

Mr. Bagdoyan:

Thank you for the opportunity to respond to the DRAFT report, *Patient Protection and Affordable Care Act: Results of Enrollment Testing for the 2016 Special Enrollment Period (GAO-17-78)*, received from the Government Accountability Office (GAO) on October 18, 2016. The draft report looks at the federal marketplace and two state-based marketplaces (SBMs), one of which is the District of Columbia's.

The DC Health Benefit Exchange Authority (DCHBX) is a public-private partnership created by the District Council to implement a State-based marketplace (SBM) under the Affordable Care Act (ACA) in the District. Our online marketplace, called DC Health Link (DCHealthLink.com), enables individuals and small businesses to compare health insurance prices and benefits and to purchase affordable, quality health insurance.

The ACA is working in the District of Columbia. Based on a survey of DC Health Link enrollees, 25% of the people who enrolled in individual private health insurance coverage during the most recent open enrollment period were uninsured prior to enrollment; 53% of the people who were determined eligible for Medicaid were uninsured before applying; and 40% of the small businesses enrolled in DC Health Link did not offer health insurance to their employees prior to enrollment through DC Health Link. This new survey by DCHBX confirms the results of three recent national studies showing that the ACA and DC Health Link are having a major impact on reducing the rate of the uninsured in the District of Columbia. These national studies were performed by the U.S. Census Bureau, the Centers for Disease Control and Prevention (CDC), and the Kaiser Family Foundation. The studies conclude that the number of uninsured people in the District has been cut in half since 2013, the year DC Health Link opened for business. These studies also show that the uninsured rate in the District is between 3.7% and 4%, which places DC's uninsured rate as the first, second, or third lowest in the country, depending on the study.

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We are proud of our success and appreciate the federal government's regulations giving SBMs flexibility related to SEPs to craft policies that serve local needs and markets. DCHBX has a stakeholder-driven process for SEP policies. Health plans, brokers, consumer and patient advocates, and other members of the DC community participate. The stakeholder-driven policies balance the goal of enabling our customers to access affordable quality private health insurance coverage with the need to ensure that there are cost-effective reasonable processes in place to safeguard against improper use of special enrollment periods. The risk that qualified people would be deterred from enrolling by an over-burdensome process is real. The Department of Health & Human Services (HHS) acknowledged this risk in its recent request for comment in the HHS Notice of Benefit and Payment Parameters for 2018.[1]

DCHBX verifies that a customer seeking a SEP meets applicable criteria either through attestation under penalty of perjury or through review of information/documentation from the customer, the carrier, or our own systems--with the goal of eliminating unnecessary barriers to coverage.

The purpose of this letter is to express our profound disappointment with the utility of this report for the following reasons:

- The characteristics of DC Health Link are too different to be useful in this case study.
- The study is not useful to help improve our current approach and processes because the GAO chose to generalize information instead of providing specific details pertaining to each state.
- Unlike other reports where GAO created plausible fictitious scenarios, here GAO used fictitious cases that are highly unrealistic, manufacturing phony employer documents and phony medical documents. Furthermore, GAO failed to provide evidence or data to support the assumption that consumers are likely to manufacture phony employer documents or phony medical documents.[2]
- GAO's position to oppose self-attestation is contrary to well accepted practices by federally funded programs.
- DCHBX's approach to SEPs and acceptance of self-attestation is consistent with the GAO's Cost-Benefit Approach to fraud control.
- There are no findings and no recommendations specific to DCHBX. Neither the report nor discussions with GAO staff suggested that DCHBX should have processed any case differently than we did.

Unlike other GAO reports and case studies that enabled us to examine our approach and processes with the goal of always looking for ways to improve, this report lacks actionable information.

We appreciate GAO's explicit admission of the report's shortcoming in part by stating, "in some instances we provided *fictitious documents* to the federal and selected state-based marketplaces to support the SEP triggering event and were able to obtain and maintain subsidized health coverage. Our applicant experiences are *not generalizable* to the population of applicants or marketplaces."[3] (Emphasis added.)

[1] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2018, 81 Fed. Reg. 61456, 61502-61503 (proposed Sept. 6 2016).
[2] An illuminating and relevant experience is to look at HIPAA and whether there was wide spread fraud related to HIPAA certificates of coverage, which were necessary to access private health insurance when leaving job-based coverage. GAO does not reference any such data.
[3] GAO DRAFT Report at page 13.

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Characteristics of DC Health Link Too Different to be Useful in a GAO study

The GAO report focuses on enrollment controls as a means of controlling federal spending on subsidies. The report states,"[b]ecause subsidy costs are contingent on eligibility for coverage, enrollment controls that help ensure only qualified applicants are approved for coverage with subsidies are a key factor in determining federal expenditures under the act."[4]

DCHBX's SEP customer base is: 93% full pay and 7% APTC. Because DC Health Link subsidized enrollment is so different from enrollment in all other SBMs and the federal marketplace, the DC Health Link experience is neither instructive nor informative to other marketplaces.

DC Health Link enrollment demographics and key differences are as follows:

- 35% of currently enrolled private individual marketplace customers are 26 to 34 years old (Table 1).
- Approximately 7% of enrollees currently covered by private health insurance receive Advance Premium Tax Credit (APT), and fewer than 2% are eligible for cost sharing.[5]
- Customers who enrolled through a ***SEP are younger*** than those who enrolled during the last open enrollment (Table 2).
- 81% of SEP enrollees are under the age of 45 (2016), age being a proxy for health (Table 2).

TABLE 1: DC Health Link Individual Marketplace Current Enrollees by Age as of 10/2/2016

AGE GROUP	PERCENT
< 18	9.8%
18-25	5.8%
26-34	35%
35-44	20.3%
45-54	15%
55-64	13.5%
65+	0.6%

Table 2: DC Health Link People by Age Enrolled in Private Individual Health Insurance as of 10/2/2016

Age	3rd Open Enrollment %	2016 SEP %
< 18	8%	10%
18-25	9%	8%
26-34	38%	45%
35-44	19%	18%
45-54	14%	10%
55-64	12%	9%
65+	1%	0%

[4] GAO DRAFT Report at page 1.

[5] This is due to two factors: 1) Young people are less likely to qualify for APTC because of age rating and 2) DC's Medicaid program covers single adults with incomes up to 215% of the federal poverty level (FPL). Most residents who otherwise would qualify for APTC instead qualify for Medicaid coverage.

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What the data shows is important for two reasons. First, DC Health Link has a stable and young risk pool and does not have the issues that some markets have with low enrollment of younger people. A mix of younger and older people is important to keep the insurance pool stable. Age is a proxy for health, and if a risk pool only insures older people, premiums would reflect high claims and would be unaffordable for many. Second, DC Health Link's SEP population is younger than the open enrollment population. This means that there is no evidence of systemic abuse of SEPs. In other words, there is no evidence that people are waiting to get sick to enroll in coverage, abusing a SEP. It also means that DCHBX' current process works well, balancing the need to make it easy for all age groups (and especially younger people) to enroll in affordable, quality health insurance with the need to mitigate fraud and abuse.

There is no evidence of systemic abuses of SEPs and DC Health Link's percent of full pay customers compared to federal subsidy eligible customers makes inclusion of DC Health Link in the GAO report of little use.

DCHBX Special Enrollment Period Policy and Process

DCHBX's SEP rules are based on federal law. Where the law allows states to have different standards, DCHBX's Executive Board adopts policies based on recommendations of its Standing Advisory Board, which represents views of health plans, consumer advocates, brokers, small businesses, and others.

Consumers can request a SEP online at DCHealthLink.com or by calling the DC Health Link Contact Center. As acknowledged by GAO repeatedly in its report[6], under federal law, states are permitted to choose when to accept self-attestation[7] and when to request documentation. For SEPs requiring attestation, after attesting to the triggering event and timing for the event, an eligible consumer is allowed to select a health plan for enrollment.

For SEP–triggering events where DCHBX requires additional verification, there is a multi-layer review process. The customer must first request the SEP through the DC Health Link Contact Center. If the customer began the process through his or her online account, the system prompts him/her to contact the DC Health Link Contact Center. There, a customer service representative asks further questions to gather relevant information and requests documentation if applicable.

The DC Health Link Contact Center then refers the request to the DCHBX Member Services team for the first level of review. In this process, a case manager reviews the facts presented and the customer's eligibility and/or enrollment record, including the dates the customer applied for coverage and made plan selections, and/or his/her prior history of seeking assistance, including call history as applicable. The case manager may contact the customer, the insurance carrier, the Medicaid agency, an Assister, a Navigator, or a broker for more information. If the SEP can be verified in this review, the case manager can approve the SEP request. Only after a SEP approval can a customer enroll in coverage or change current coverage. A customer cannot shop for a plan unless and until a SEP is approved.

All denials or cases requiring further review are sent for a second level of review to the SEP Review Committee. This Committee is chaired by DCHBX's Deputy Director of Marketplace Innovation, Policy & Operations and includes senior-level representatives from Plan Management, Member Services, and the

[6] Acknowledged by GAO in the DRAFT Report at pages 2, 7-8, and 22.
[7] Acknowledged by GAO in the DRAFT Report at page 8.

Office of General Counsel. The SEP Review Committee considers the entire record to date and may gather additional information to complete its evaluation. If the SEP can be verified in this review, the SEP request is approved, and the customer may enroll in coverage or change current coverage.

After review by the SEP Review Committee, denial cases are sent for a final third layer of review by the DCHBX General Counsel and/or Executive Director. Following this final review, customers with an approved SEP are permitted to enroll in coverage or change current coverage. Those not approved are sent a denial letter that explains their right to appeal the decision to the DC Office of Administrative Hearings.

DCHBX works closely with the health plans on many SEP cases. This includes performing a close review, including gathering facts on certain types of cases.

GAO's Opposition to Self-Attestation Is Unfounded

GAO asserts that self-attestation is ineffective in stopping inappropriate SEP enrollments.[8] This assertion rests on a false premise reflected in GAO's methodology. GAO investigators lied to get SEPs through: They attested under penalty of perjury to facts they knew to be false. GAO investigators have a unique ability to act in a way not representative of the average consumer, such as lying—by attesting summarily to facts under penalty of perjury, when they know those facts are false. Importantly, GAO did not provide data from the ACA or other federal programs to support the assumption that a significant portion of people perjure themselves to access federal funds.

The GAO position is contrary to a well-established and accepted practice in federal government programs.

The Accepted Use of Self-Attestation in Federal Programs

Other federal programs recognize that consumers generally do not lie under penalty of perjury, and thus have long allowed self-attestation.

For example, the Internal Revenue Service relies on tax filers to self-attest to income and deductions and does not receive verification forms from third parties for all income sources and deductions, particularly for several categories of itemized deductions[9] or self-employment income/deductions. Similarly, when administering the federal student loan program, the U.S. Department of Education expects educational institutions to verify information on the Free Application for Federal Student Aid forms for only those forms specifically selected for verification by the Secretary or the institution itself.[10] Notably, if the applicant was determined eligible to receive only unsubsidized student financial assistance, his/her form is specifically excluded from verification.[11]

[8] GAO DRAFT Report at page 18-19.
stating, "[h]owever, relying on self-attestation without verifying documents submitted to support a SEP triggering even could allow actual applicants to obtain subsidized coverage they would otherwise not qualify for."
[9] *See* IRS Form 1040, Schedule A; *see e.g.* 26 C.F.R. 1.170-1 (charitable deductions); 26 C.F.R. §1.212-1(g) (investment advisory fees); 26 C.F.R. §1.212-1(h) (rental property expenses); 26 C.F.R. §1.212-1(l) (tax form preparation fees); 26 C.F.R. §1.213-1 (medical and dental expenses).
[10] 34 C.F.R. §668.54(a).
[11] 34 C.F.R. §668.54(b).

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Not only do SEP self-attestations reflect a well-accepted practice of self-attestation in federal programs. SEPs have their origin in the Health Insurance Portability and Accountability Act (HIPAA)[12]. The long-established SEP provisions under HIPAA do not include mandatory verification processes and permit the acceptance of self-attestation.[13] State-based marketplaces should not be held to higher standards than those that apply to the federal government.

DCHBX's Approach Is Consistent with the GAO's Cost-Benefit Approach to Fraud Control

DCHBX's approach to SEP verification is consistent with GAO's accepted practices. In its "Framework for Managing Fraud Risks in Federal Programs",[14] which GAO specifically recommends to the federal marketplace, GAO identified guiding principles with the overarching goal of developing a "strategic, risk-based approach to managing fraud risks."[15] The framework calls on managers to take steps such as determining the risk profile of the program[16] and using the characteristics of the program, along with risk tolerance, to conduct a cost-benefit analysis[17] of any proposed fraud control activity. GAO instructs that, as with any cost-benefit analysis, "managers may decide not to implement certain control activities for which the estimated benefits do not exceed the costs."[18] This analysis is not simply monetary; non-monetary factors may be considered when deciding whether to implement a control activity.[19]

DCHBX has reviewed the characteristics of the marketplace, consistent with the principles embraced in GAO's Framework, and assessed risk to develop appropriate verification procedures. Factors considered in the risk assessment included the fact that customers may not proceed with an application through DCHealthLink.com or our Contact Center without successfully passing ID proofing.[20] There is no conditional eligibility for people whose identity cannot be verified. People must come in person for ID proofing by HBX staff. Further, because over 93% of our customers pay full price for coverage, in most cases, federal dollars are not at risk. Also, the age of the SEP population shows no systemic abuse of SEPs.

We balance this low risk profile against both the financial and non-financial costs of an overly burdensome documentation requirement for all SEP requests. We consider the impact on the marketplace if healthy SEP eligible customers forgo enrolling because of the hurdles and burdens imposed. We also consider our own resources and authority when constructing a verification plan.

DCHBX has concluded it is neither an efficient use of resources to review and verify, nor worth the burden on the customer, to require documentation in many SEP scenarios such as recent marriage, birth, or move to the District. Instead, DCHBX permits customers to attest to these facts under penalty of perjury. For other SEPs, such as a marketplace or carrier error, additional information or verification is required. When additional information is required, DCHBX recognizes that third parties, such as

[12] 42 U.S.C §300gg-3(f) (including loss of other coverage or Medicaid, marriage, birth, or adoption or placement for adoption).
[13] 45 C.F.R. §146.117..
[14] GAO-15-593SP (July 2015).
[15] Id. at 2.
[16] Id. at 11.
[17] Id. at 21.
[18] Id.
[19] Id.
[20] Very few people use paper applications. Federal guidance exempts paper applications from ID proofing.

medical providers and employers, may face legal constraints, such as limitations under the HIPAA Privacy Rule, which would prevent them from responding to DCHBX requests to validate documents that customers submit.

Ultimately, any residual risk produced -- although none has been definitively demonstrated by the GAO, the insurance carriers, or DCHBX internal efforts -- is within appropriate risk tolerance. Also, as a health insurance marketplace supported by an assessment on health carriers which is passed on to consumers, there is no evidenced-based case to justify the cost of an extensive verification framework.

Conclusion

Thank you to the professional GAO staff who worked with the DCHBX staff. DCHBX welcomes fact-based reviews and concrete feedback to help improve our processes. Unfortunately, this report falls short on both fronts.

Sincerely,

Mila Kofman
Executive Director
DC Health Benefit Exchange Authority

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Appendix V: GAO Contact and Staff Acknowledgments

GAO Contact

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Staff Acknowledgments

In addition to the contact named above, Marcus Corbin; Ranya Elias; Colin Fallon; Suellen Foth; Georgette Hagans; Barbara Lewis; Olivia Lopez; Maria McMullen; James Murphy; Jonathon Oldmixon; Gloria Proa; Christopher Schmitt; Julie Spetz; and Elizabeth Wood made key contributions to this report.