



DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201



JUN 30 2014

TO: Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services

FROM: Daniel R. Levinson
Inspector General *Daniel R. Levinson*

SUBJECT: Not All Internal Controls Implemented by the Federal, California, and Connecticut Marketplaces Were Effective in Ensuring That Individuals Were Enrolled in Qualified Health Plans According to Federal Requirements (A-09-14-01000)

The attached final report provides the results of our reviews of internal controls implemented by the federally facilitated marketplace (the Federal marketplace), Covered California (the California marketplace), and Access Health CT (the Connecticut marketplace) to ensure that individuals were enrolled in qualified health plans (QHPs) according to Federal requirements. The Continuing Appropriations Act, 2014, mandated that the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services submit to Congress no later than July 1, 2014, a report regarding the effectiveness of the procedures and safeguards provided under the Patient Protection and Affordable Care Act for preventing submission of inaccurate or fraudulent information by applicants for enrollment in QHPs offered through the individual marketplace.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at <https://oig.hhs.gov>.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Kay L. Daly, Assistant Inspector General for Audit Services, at (202) 619-1157 or through email at Kay.Daly@oig.hhs.gov or Lori A. Ahlstrand, Regional Inspector General for Audit Services, Region IX, at (415) 437-8360 or through email at Lori.Ahlstrand@oig.hhs.gov. We look forward to receiving your final management decision within 6 months. Please refer to report number A-09-14-01000 in all correspondence.

Attachment



DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL



OFFICE OF AUDIT SERVICES, REGION IX
90 - 7TH STREET, SUITE 3-650
SAN FRANCISCO, CA 94103

JUN 30 2014

Report Number: A-09-14-01000

Mr. Kevin J. Counihan
Chief Executive Officer
Access Health CT
280 Trumbull Street, 15th Floor
Hartford, CT 06103

Dear Mr. Counihan:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled *Not All Internal Controls Implemented by the Federal, California, and Connecticut Marketplaces Were Effective in Ensuring That Individuals Were Enrolled in Qualified Health Plans According to Federal Requirements*. We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at <https://oig.hhs.gov>.

If you have any questions or comments about this report, please do not hesitate to call me, or contact George Nedder, Audit Manager, at (617) 565-3463 or through email at George.Nedder@oig.hhs.gov. Please refer to report number A-09-14-01000 in all correspondence.

Sincerely,

Lori A. Ahlstrand
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Mandy Cohen, M.D., M.P.H.
Acting Deputy Administrator and Director
Center for Consumer Information and Insurance Oversight
Centers for Medicare & Medicaid Services
200 Independence Avenue, SW
733H 02, HHH Building
Washington, DC 20201



DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL



OFFICE OF AUDIT SERVICES, REGION IX
90 - 7TH STREET, SUITE 3-650
SAN FRANCISCO, CA 94103

JUN 3 0 2014

Report Number: A-09-14-01000

Mr. Peter V. Lee
Executive Director
Covered California
1601 Exposition Boulevard
Sacramento, CA 95815

Dear Mr. Lee:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled *Not All Internal Controls Implemented by the Federal, California, and Connecticut Marketplaces Were Effective in Ensuring That Individuals Were Enrolled in Qualified Health Plans According to Federal Requirements*. We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at <https://oig.hhs.gov>.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Yun Kim, Audit Manager, at (323) 261-7218, extension 301, or through email at Yun.Kim@oig.hhs.gov. Please refer to report number A-09-14-01000 in all correspondence.

Sincerely,

Lori A. Ahlstrand
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Mandy Cohen, M.D., M.P.H.
Acting Deputy Administrator and Director
Center for Consumer Information and Insurance Oversight
Centers for Medicare & Medicaid Services
200 Independence Avenue, SW
733H 02, HHH Building
Washington, DC 20201

cc:

Ms. Juli Baker
Chief Technology/Information Officer

Ms. Desi Malone
Manager, Grant Management

Ms. Jennifer Lum
Supervisor, Internal Audits

Ms. Cynthia Hayden
Assistant Project Director, CalHEERS Project

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**NOT ALL INTERNAL CONTROLS
IMPLEMENTED BY THE FEDERAL,
CALIFORNIA, AND CONNECTICUT
MARKETPLACES WERE EFFECTIVE IN
ENSURING THAT INDIVIDUALS
WERE ENROLLED IN QUALIFIED HEALTH
PLANS ACCORDING TO FEDERAL
REQUIREMENTS**

*Inquiries about this report may be addressed to the Office of Public Affairs at
Public.Affairs@oig.hhs.gov.*



Daniel R. Levinson
Inspector General

June 2014
A-09-14-01000

Office of Inspector General

<https://oig.hhs.gov>

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at <https://oig.hhs.gov>

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

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

WHY WE DID THIS REVIEW

The Patient Protection and Affordable Care Act (ACA) established health insurance exchanges (commonly referred to as “marketplaces”) to allow individuals and small businesses to shop for health insurance in all 50 States and the District of Columbia. A marketplace offers individuals private health insurance plans, known as qualified health plans (QHPs), and enrolls individuals in those plans. QHPs must meet certain participation standards and cover a core set of benefits.

The Continuing Appropriations Act, 2014, mandated that the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services (HHS) submit to Congress no later than July 1, 2014, a report regarding the effectiveness of the procedures and safeguards provided under the ACA for preventing submission of inaccurate or fraudulent information by applicants for enrollment in QHPs offered through the individual marketplace.

In response to the mandate, we reviewed internal controls that selected marketplaces implemented to comply with the procedures and safeguards required by the ACA for determining the eligibility of applicants for enrollment in QHPs. Internal controls are intended to provide reasonable assurance that an organization’s objectives are being achieved, including effectiveness and efficiency of operations and compliance with applicable laws and regulations. We performed an internal control review because it enabled us to evaluate the effectiveness and efficiency of the selected marketplaces’ operations and the marketplaces’ compliance with applicable Federal requirements.

Because we reviewed the marketplaces’ internal controls in place during the first 3 months of the open enrollment period for applicants enrolling in QHPs (October to December 2013), our review provides an early snapshot of the effectiveness of these controls. A companion study (*Marketplaces Faced Early Challenges Resolving Inconsistencies with Applicant Data*, report number OEI-01-14-00180) focuses on the procedures used by marketplaces nationwide for resolving inconsistencies between self-attested applicant information and data sources used for verification. These are the first of several OIG reviews that will examine various aspects of marketplace operations, including additional eligibility verifications, payment accuracy, contractor oversight, and data security.

We selected three marketplaces for this review: (1) the federally facilitated marketplace (the Federal marketplace), which operated in 36 States as of October 1, 2013; (2) Covered California (the California marketplace); and (3) Access Health CT (the Connecticut marketplace). We selected these marketplaces on the basis of their type (federally operated or State-operated), coverage of States in different parts of the country, and size of the uninsured population.

OBJECTIVE

The objective of this review was to determine whether internal controls implemented by the Federal, California, and Connecticut marketplaces were effective in ensuring that individuals were enrolled in QHPs according to Federal requirements.

BACKGROUND

Health Insurance Marketplaces

A marketplace is designed to serve as a one-stop shop at which individuals get information about their health insurance options; are evaluated for eligibility for a QHP and, when applicable, eligibility for financial assistance through insurance affordability programs; and enroll in the QHP of their choice. For States that elected not to establish and operate a State-based marketplace (State marketplace), the ACA required the Federal Government to operate a marketplace (i.e., the Federal marketplace) in the State. A State was also able to establish a State-partnership marketplace, in which HHS and the State share responsibilities for core functions.

As of October 1, 2013, 36 States, including 7 State-partnership marketplaces, used the Federal marketplace, and 15 States had established State marketplaces. California and Connecticut are 2 of the 15 States that had established State marketplaces. The Centers for Medicare & Medicaid Services (CMS) operates the Federal marketplace and works with States to establish State and State-partnership marketplaces, including overseeing their operations.

Qualified Health Plans and Insurance Affordability Programs

QHPs are private health insurance plans that each marketplace recognizes and certifies as meeting certain participation standards and covering a core set of benefits. To lower individuals' insurance premiums or out-of-pocket costs for QHPs, the ACA provides for two types of insurance affordability programs: the premium tax credit and cost-sharing reductions. The premium tax credit reduces the cost of a plan's premium and is available at tax filing time or in advance. When paid in advance, the credit is referred to as the "advance premium tax credit." Cost-sharing reductions help individuals with out-of-pocket costs, such as deductibles, coinsurance, and copayments. Depending on an individual's income, he or she may be eligible for either or both types of insurance affordability programs.

To be eligible to enroll in a QHP, an individual must be a U.S. citizen, a U.S. national, or lawfully present in the United States; not be incarcerated; and meet applicable residency standards. To be eligible for an advance premium tax credit and cost-sharing reductions, the individual must meet additional requirements, such as annual household income and family size requirements.

Application and Enrollment Process for Qualified Health Plans and Insurance Affordability Programs

To enroll in a QHP, an applicant must complete an application and meet eligibility requirements defined by the ACA. An applicant can enroll in a QHP through the marketplace Web site (online), which is either HealthCare.gov (the Federal marketplace Web site) or the State marketplace Web site, depending on the applicant's State of residence; by phone; by mail; in person; or directly with a broker or agent of a health insurance company. For online and phone applications, the marketplace verifies the applicant's identity through an identity-proofing process. For paper applications, the marketplace requires the applicant's signature before the marketplace processes the application. When an applicant completes any type of application, the applicant attests that answers to all questions are true and is subject to the penalty of perjury.

After reviewing the applicant's information, the marketplace determines whether the applicant is eligible for a QHP and, when applicable, eligible for insurance affordability programs. To verify the information submitted by the applicant, the marketplace uses multiple electronic data sources, including sources available through the Federal Data Services Hub (Data Hub). These data sources include HHS, the Social Security Administration (SSA), the U.S. Department of Homeland Security (DHS), and the Internal Revenue Service (IRS). If the marketplace determines that the applicant is eligible, the applicant selects a QHP, and the marketplace transmits the enrollment information to the insurance company, i.e., the QHP issuer.

Generally, when a marketplace cannot verify information submitted by the applicant or the information is inconsistent with information available through the Data Hub or other sources, the marketplace must attempt to resolve the inconsistency. If the marketplace is unable to resolve an inconsistency through reasonable efforts, it must generally provide the applicant 90 days to submit satisfactory documentation to resolve the inconsistency (referred to as "the inconsistency period"). The marketplace may extend the inconsistency period if the applicant demonstrates that a good-faith effort has been made to submit required documentation. During the inconsistency period, the applicant may choose to enroll in a QHP and, when applicable, may choose to receive advance premium tax credits and cost-sharing reductions. After the inconsistency period, if the marketplace is unable to resolve the inconsistency, it determines the applicant's eligibility on the basis of available data sources and, in certain circumstances, the applicant's attestation.

HOW WE CONDUCTED THIS REVIEW

We reviewed the internal controls that were in place at the Federal, California, and Connecticut marketplaces from October to December 2013. We limited our review to those internal controls related to (1) verifying identity of applicants, (2) determining applicants' eligibility for enrollment in QHPs and eligibility for insurance affordability programs, and (3) maintaining and updating eligibility and enrollment data. These internal controls at each marketplace were not necessarily the same.

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

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

Our attribute sampling approach is commonly used to test the effectiveness of internal controls for compliance with laws, regulations, and policies. According to the Government Accountability Office and President's Council on Integrity and Efficiency's² *Financial Audit Manual* (July 2008), section 450, auditors may use a randomly selected sample of 45 items to perform a compliance review. If all sample items are determined to be in compliance with requirements, a conclusion that the controls are effective can be made. If one or more sample items are determined not to be in compliance with requirements, a conclusion that the controls are ineffective can be made. We tested the controls at each marketplace separately. Our sampling methodology was limited to forming an opinion about whether the internal controls at each marketplace were effective and was not designed to estimate the percentage of applicants for whom each marketplace did not perform the required eligibility verifications.

For the 45 sample applicants for each marketplace, we reviewed supporting documentation to evaluate whether the marketplace determined eligibility in accordance with Federal requirements. During our fieldwork, questions arose concerning OIG's access under the Internal Revenue Code to Federal taxpayer information that IRS provides to marketplaces. We sought authorization from IRS to access that information. Because the request was still pending when we had completed our data collection, we did not review supporting documentation for certain eligibility requirements, such as annual household income and family size, for the purpose of this report.³ As a result, we could not evaluate whether each marketplace determined the 45 sample applicants' eligibility for advance premium tax credits and cost-sharing reductions according to Federal requirements.⁴

¹ According to the enrollment data provided by the three marketplaces for all applicants who were determined eligible to enroll in QHPs with coverage effective January 1, 2014, the Federal marketplace had 1,112,411 applicants, the California marketplace had 453,401 applicants, and the Connecticut marketplace had 34,095 applicants.

² The President's Council on Integrity and Efficiency is now called the Council of the Inspectors General on Integrity and Efficiency (Inspector General Act § 11).

³ OIG plans to conduct additional audit work in this area.

⁴ We were able to evaluate the Connecticut marketplace's specific internal controls related to determining applicants' eligibility for advance premium tax credits and cost-sharing reductions according to Federal requirements by performing other audit procedures. The marketplace provided us with additional data that enabled us to evaluate the controls. The additional data did not contain Federal taxpayer information.

Further, we did not determine whether information submitted by the 45 sample applicants at each marketplace was inaccurate or fraudulent because we could not independently verify the accuracy of data stored at other Federal agencies, e.g., IRS and SSA. Instead, we focused our review on determining the effectiveness of internal controls for processing that data and addressing inconsistencies in eligibility data when identified by the marketplace.

Because the open enrollment period for applicants to enroll in QHPs ended after December 31, 2013, marketplaces may have received new information, which could have changed applicants' eligibility for enrollment in QHPs and, when applicable, eligibility for insurance affordability programs. We did not review the marketplaces' redeterminations of applicants' eligibility that resulted from verifications of information provided by applicants after December 31, 2013.

Our review of internal controls, which included reviewing 45 sample applicants and performing other audit procedures, would not necessarily have detected all internal control deficiencies because internal controls provide only reasonable assurance that each marketplace complied with Federal requirements.

WHAT WE FOUND

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

On the basis of our review of 45 sample applicants at each marketplace, we determined that certain controls were effective, e.g., verification of applicants' incarceration status at all 3 marketplaces. However, the internal controls were not effective for:

- validating Social Security numbers (one sample applicant) at the Federal marketplace,
- verifying citizenship (seven sample applicants) and lawful presence (one sample applicant) at the California marketplace, and
- performing identity proofing of phone applicants (one sample applicant) and verifying minimum essential coverage through non-employer-sponsored insurance (seven sample applicants) at the Connecticut marketplace.⁵

On the basis of performing other audit procedures, such as interviews with marketplace officials and reviews of supporting documentation, we determined that other controls were not effective. For example, the Federal and California marketplaces did not always resolve inconsistencies in

⁵ Connecticut marketplace officials stated that the marketplace planned to correct a system defect that prevented the marketplace from storing verification data for minimum essential coverage through non-employer-sponsored insurance for the seven applicants.

eligibility data, and the Connecticut marketplace did not always properly determine eligibility for insurance affordability programs.

The presence of an internal control deficiency does not necessarily mean that a marketplace improperly enrolled an applicant in a QHP or improperly determined eligibility for insurance affordability programs. Other mechanisms exist that may remedy the internal control deficiency, such as the resolution process during the inconsistency period. For example, if a marketplace did not have a control in place to verify an applicant's citizenship through SSA as required, the marketplace may still have been able to verify citizenship with satisfactory documentation provided by the applicant during the inconsistency period.

The table on the following page shows the deficiencies in internal controls identified at each marketplace, through both testing of controls by reviewing 45 sample applicants and performing other audit procedures.

Table: Deficiencies in Internal Controls Identified at the Three Marketplaces by Reviewing Sample Applicants and Performing Other Audit Procedures (October to December 2013)

Deficiencies Identified	Federal Marketplace	California Marketplace	Connecticut Marketplace
<i>Verifying Identity of Applicants and Entering Application Information</i>			
Identity proofing of applicants was not always performed			X
Information from paper applications was not always entered correctly into enrollment system		X	
<i>Determining Eligibility of Applicants</i>			
Social Security numbers were not always validated through the Social Security Administration	X		
Citizenship was not always verified through the Department of Homeland Security		X	
Lawful presence was not always verified through the Department of Homeland Security		X	
Eligibility for insurance affordability programs was not always determined properly			X
Inconsistencies in eligibility data were not always resolved	X ⁶	X	
<i>Maintaining and Updating Eligibility and Enrollment Data</i>			
Eligibility data were not always properly maintained		X	X
System functionality to allow enrollees to update enrollment information had not been developed	X		
NOTES			
<ul style="list-style-type: none"> • The absence of an “X” for a deficiency indicates that, on the basis of our review, nothing came to our attention to indicate that the marketplace had this deficiency. • Although we identified deficiencies at each marketplace, the magnitude of the deficiencies varied. For example, the California marketplace did not verify citizenship through DHS for seven sample applicants but did not verify lawful presence through DHS for only one sample applicant. 			

⁶ This deficiency was related to applicants for whom inconsistencies could not be resolved by the Federal marketplace for certain eligibility requirements as of February 2014.

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

In addition to deficiencies that we noted in our "Findings" section, we identified issues that may be of interest to stakeholders. The section "Other Issues Noted at the Three Marketplaces" in the body of the report provides information on these issues.

WHAT WE RECOMMEND

To address the specific deficiencies that we identified, we recommend that CMS, Covered California, and Access Health CT take action to improve internal controls related to (1) verifying identity of applicants and entering application information, (2) determining applicants' eligibility for enrollment in QHPs and eligibility for insurance affordability programs, and (3) maintaining and updating eligibility and enrollment data.

We also recommend that CMS work with Covered California and Access Health CT to implement our recommendations addressing deficiencies identified at the California and Connecticut marketplaces. The "Recommendations" section in the body of the report lists our specific recommendations for each of the three marketplaces.

MARKETPLACES' COMMENTS AND OUR RESPONSES

CMS, Covered California, and Access Health CT provided written comments on our draft report:

- CMS concurred with all of our recommendations and provided information on actions that it had taken or planned to take to address our recommendations. However, it stated that it did not believe that the recommendations to perform identity proofing of all applicants and fully develop system functionality to allow enrollees to report life changes needed to be included in the report. After reviewing additional supporting documentation that CMS provided after issuance of our draft report, we removed our recommendation and the related finding on identify proofing of applicants.
- Covered California agreed with our recommendation that it ensure that documentation is maintained to support the resolution of inconsistencies and provided information on actions that it had taken or planned to take to address our remaining recommendations. Covered California did not concur with our findings that identity proofing of applicants was not always performed and citizenship was not always verified through DHS. In addition, it stated that it could not concur or disagree with our finding that lawful presence was not always verified through DHS. After reviewing supporting documentation that Covered California provided after issuance of our draft report, we removed our finding and the related recommendation on identity proofing of applicants; however, we included the issue in the section "Other Issues Noted at the Three Marketplaces" in the body of the report.

- Access Health CT concurred with three of our recommendations, but it did not concur with our recommendation to ensure that identity proofing of phone applicants is performed and with our finding that it did not verify applicants' citizenship through DHS. After reviewing additional supporting documentation that Access Health CT provided after issuance of our draft report, we removed our finding and the related recommendation on citizenship verification.

CMS, Covered California, and Access Health CT also provided comments on the other issues noted at the marketplaces. We summarized these comments at the end of each issue in the body of the report. CMS's, Covered California's, and Access Health CT's comments are included in their entirety as appendixes to this report. CMS provided technical comments on our draft report, which we addressed as appropriate.

TABLE OF CONTENTS

INTRODUCTION	1
Why We Did This Review	1
Objective	2
Background	2
Patient Protection and Affordable Care Act.....	2
Health Insurance Marketplaces	2
Qualified Health Plans and Insurance Affordability Programs.....	3
Application and Enrollment Process for Qualified Health Plans and Insurance Affordability Programs.....	6
Administration of the Federal, California, and Connecticut Marketplaces.....	9
How We Conducted This Review	10
FINDINGS	12
Deficiencies Related to Verifying Identity of Applicants and Entering Application Information.....	14
Identity Proofing of Applicants Was Not Always Performed by the Connecticut Marketplace.....	14
Information From Paper Applications Was Not Always Entered Correctly by the California Marketplace Into Its Enrollment System.....	15
Deficiencies Related to Determining Eligibility of Applicants.....	16
Social Security Numbers Were Not Always Validated Through the Social Security Administration by the Federal Marketplace.....	16
Citizenship Was Not Always Verified Through the Department of Homeland Security by the California Marketplace	17
Lawful Presence Was Not Always Verified Through the Department of Homeland Security by the California Marketplace.....	18
Eligibility for Insurance Affordability Programs Was Not Always Determined Properly by the Connecticut Marketplace	18
Inconsistencies in Eligibility Data Were Not Always Resolved by the Federal and California Marketplaces.....	19
Deficiencies Related to Maintaining and Updating Eligibility and Enrollment Data	22
Eligibility Data Were Not Always Properly Maintained by the California and Connecticut Marketplaces	22
System Functionality To Allow Enrollees To Update Enrollment Information Had Not Been Developed by the Federal Marketplace.....	23

CONCLUSION	24
RECOMMENDATIONS	25
Recommendations to CMS.....	25
Recommendations to Covered California	25
Recommendations to Access Health CT	26
MARKETPLACES’ COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSES	26
CMS Comments and Office of Inspector General Response	27
Covered California Comments and Office of Inspector General Response.....	27
Access Health CT Comments and Office of Inspector General Response	29
OTHER ISSUES NOTED AT THE THREE MARKETPLACES	30
Identity Proofing of Applicants Was Performed by the California Marketplace Only by Accepting Applicants’ Electronic Signatures or Verbal Attestations	30
Residency Was Verified by the Federal, California, and Connecticut Marketplaces Only by Accepting Applicants’ Attestation of Residency	31
Family Size Was Verified by the Federal, California, and Connecticut Marketplaces Only by Accepting Applicants’ Attestation of Family Size	32
Enrollment Records Were Not Always Promptly Sent to Qualified Health Plan Issuers by the Connecticut Marketplace.....	32
Appropriate Advance Premium Tax Credits Were Not Always Reported to Qualified Health Plan Issuers by the Connecticut Marketplace	33
Documentation Was Not Provided by the Federal Marketplace To Support That Required Monthly Reconciliations for Qualified Health Plans Were Performed	33
APPENDIXES.....	
A: Marketplace Type Used in Each State as of October 1, 2013	35
B: Federal Eligibility Requirements for Qualified Health Plans and Insurance Affordability Programs	38

C: Seven Steps in the Application and Enrollment Process for a Qualified Health Plan	48
D: Overview of Internal Controls.....	50
E: Audit Scope and Methodology	51
F: Results of Testing of Controls for 45 Sample Applicants at Each Marketplace for the Required Eligibility Verifications.....	55
G: CMS Comments	56
H: Covered California Comments.....	62
I: Access Health CT Comments	70

INTRODUCTION

WHY WE DID THIS REVIEW

The Patient Protection and Affordable Care Act (ACA)¹ established health insurance exchanges (commonly referred to as “marketplaces”) to allow individuals and small businesses to shop for health insurance in all 50 States and the District of Columbia.² A marketplace offers individuals private health insurance plans, known as qualified health plans (QHPs), and enrolls individuals in those plans. QHPs must meet certain participation standards and cover a core set of benefits.

The Continuing Appropriations Act, 2014, mandated that the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services (HHS) submit to Congress no later than July 1, 2014, a report regarding the effectiveness of the procedures and safeguards provided under the ACA for preventing submission of inaccurate or fraudulent information by applicants for enrollment in QHPs offered through the individual marketplace.³

In response to the mandate, we reviewed internal controls that selected marketplaces implemented to comply with the procedures and safeguards required by the ACA for determining the eligibility of applicants for enrollment in QHPs. Internal controls are intended to provide reasonable assurance that an organization’s objectives are being achieved, including effectiveness and efficiency of operations and compliance with applicable laws and regulations. We performed an internal control review because it enabled us to evaluate the effectiveness and efficiency of the selected marketplaces’ operations and the marketplaces’ compliance with applicable Federal requirements.

Because we reviewed the marketplaces’ internal controls in place during the first 3 months of the open enrollment period for applicants enrolling in QHPs (October to December 2013), our review provides an early snapshot of the effectiveness of these controls. A companion study (*Marketplaces Faced Early Challenges Resolving Inconsistencies with Applicant Data*, report number OEI-01-14-00180) focuses on the procedures used by marketplaces nationwide for resolving inconsistencies between self-attested applicant information and data sources used for verification. These are the first of several OIG reviews that will examine various aspects of marketplace operations, including additional eligibility verifications, payment accuracy, contractor oversight, and data security.

We selected three marketplaces for this review: (1) the federally facilitated marketplace (the Federal marketplace), which operated in 36 States as of October 1, 2013; (2) Covered California (the California marketplace); and (3) Access Health CT (the Connecticut marketplace). We

¹ P.L. No. 111-148 (Mar. 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010, P.L. No. 111-152 (Mar. 30, 2010), collectively referred to as “ACA.”

² Each State can have an individual marketplace and a Small Business Health Options Program (SHOP) marketplace, which enables small businesses to access health coverage for their employees. This report does not include a review of SHOP marketplaces.

³ P.L. No. 113-46, section 1001(c) (Oct. 17, 2013).

selected these marketplaces on the basis of their type (federally operated or State-operated), coverage of States in different parts of the country, and size of the uninsured population.

OBJECTIVE

The objective of this review was to determine whether internal controls implemented by the Federal, California, and Connecticut marketplaces were effective in ensuring that individuals were enrolled in QHPs according to Federal requirements.

BACKGROUND

Patient Protection and Affordable Care Act

A major goal of the ACA is to provide more Americans with access to affordable health care by creating new health insurance marketplaces; enforcing rights and protections for those individuals who apply for insurance (including preventing insurance companies, e.g., QHP issuers, from denying coverage because of preexisting conditions); and providing financial assistance through insurance affordability programs for people who cannot afford insurance.

Health Insurance Marketplaces

A marketplace is designed to serve as a one-stop shop at which individuals get information about their health insurance options; are evaluated for eligibility for a QHP and, when applicable, eligibility for insurance affordability programs; and enroll in the QHP of their choice.⁴ For States that elected not to establish and operate a State-based marketplace (State marketplace), the ACA required the Federal Government to operate a marketplace in the State.⁵

The three types of marketplaces operational as of January 1, 2014, were the Federal, State, and State-partnership marketplaces:

- **Federal marketplace:** HHS operates the Federal marketplace in States that did not establish their own marketplaces. Individuals in these States enroll in QHPs through the Federal marketplace.
- **State marketplace:** A State may establish and operate its own marketplace. The State marketplace may use Federal services (e.g., the system that provides Federal data) to assist with certain functions, such as eligibility determinations for insurance affordability programs.

⁴ An individual is considered to be enrolled in a QHP when he or she has been determined eligible and has paid the first monthly insurance premium. An individual may also obtain information from the marketplace about Medicaid and the Children's Health Insurance Program (CHIP) (ACA § 1413 and 45 CFR § 155.405).

⁵ ACA §§ 1311(b) and 1321(c).

- **State-partnership marketplace:** A State may establish a State-partnership marketplace, in which HHS and the State share responsibilities for core functions. For example, HHS may perform certain functions, such as eligibility determinations, and the State may perform other functions, such as insurance plan management and consumer outreach. A key distinction between a State-partnership and State marketplace is that the former uses the Federal marketplace Web site to enroll individuals in QHPs and the latter has its own Web site for that purpose.

As of October 1, 2013, 36 States, including 7 State-partnership marketplaces, used the Federal marketplace, and 15 States had established State marketplaces. Appendix A provides a map that shows the type of marketplace in each State as of October 1, 2013, as well as a list of the States and their marketplace types.

Qualified Health Plans and Insurance Affordability Programs

Qualified Health Plans

QHPs are private health insurance plans that each marketplace recognizes and certifies as meeting certain participation standards. QHPs are required to cover a core set of benefits (known as essential health benefits).⁶ QHPs are classified into “metal” levels: bronze, silver, gold, and platinum. These levels are determined by the percentage that each QHP expects to pay, on average, for the total allowable costs of providing essential health benefits.⁷

Insurance Affordability Programs

The ACA provides for two types of insurance affordability programs to lower individuals’ insurance premiums or out-of-pocket costs for QHPs:⁸

- **Premium tax credit:** The premium tax credit reduces the cost of a plan’s premium and is available at tax filing time or in advance. Generally, the premium tax credit is available on a sliding scale to individuals or families with incomes from 100 percent through 400 percent of the Federal poverty level. When paid in advance, the credit is referred to as the “advance premium tax credit.”⁹ The Federal Government pays the advance premium tax credit amount monthly to the QHP issuer on behalf of the taxpayer

⁶ ACA § 1301(a) and 45 CFR part 156, subpart B. Dental coverage for children must be available as part of a health plan or as a standalone plan. QHPs are not required to offer adult dental coverage.

⁷ An individual who is under 30 years old or qualifies for a hardship exemption may also choose a catastrophic plan, which requires the individual to pay all of his or her medical expenses until the deductible amount is met (ACA § 1302(e) and 45 CFR §§ 156.155 and 156.440). Hardship includes specific circumstances that prevent an individual from obtaining coverage under a QHP, such as the expense of purchasing a QHP causing serious deprivation of food, shelter, clothing, or other necessities (45 CFR § 155.605(g)).

⁸ We did not review other types of insurance affordability programs, such as Medicaid and CHIP.

⁹ ACA § 1401 and 45 CFR § 155.20 (definition of “advance payment of the premium tax credit”).

to offset a portion of the cost of the premium of any metal-level plan. For example, if an individual who selects an insurance plan with a \$500 monthly insurance premium qualifies for a \$400 monthly advance premium tax credit, the individual pays only \$100 to the QHP issuer. The Federal Government pays the remaining \$400 to the QHP issuer. Starting in January 2015, taxpayers must include on their tax returns the amount of any advance premium tax credit made on their behalf. The Internal Revenue Service (IRS) will reconcile the advance premium tax credit payments with the maximum allowable amount of the credit.¹⁰

- **Cost-sharing reductions:** Cost-sharing reductions help qualifying individuals with out-of-pocket costs, such as deductibles, coinsurance, and copayments.¹¹ For example, an individual who visits a physician may be responsible for a \$30 copayment. If the individual qualifies for a cost-sharing reduction of \$20 for the copayment, the individual pays only \$10. An individual must select a silver-level QHP to qualify for cost-sharing reductions.¹² Generally, cost-sharing reductions are available to an individual or family with income from 100 through 250 percent of the Federal poverty level. The Federal Government makes monthly payments to QHP issuers to cover estimated costs of cost-sharing reductions provided to individuals. At the end of the year, HHS reconciles with the QHP issuers the total amount of estimated payments of cost-sharing reductions made to QHP issuers with the actual costs of cost-sharing reductions incurred.

An individual may be eligible for either or both types of insurance affordability programs if he or she meets specified Federal requirements.

Federal Eligibility Requirements for Qualified Health Plans and Insurance Affordability Programs

To be eligible to enroll in a QHP, an individual must:

- be a U.S. citizen, a U.S. national, or lawfully present in the United States;¹³

¹⁰ The maximum allowable amount of the credit is the total amount of the premium tax credit for which an individual may be eligible in a benefit year (26 U.S.C. §§ 36B(a) and (b)).

¹¹ ACA § 1402 and 45 CFR § 155.20.

¹² Indians may receive cost-sharing reductions without selecting a silver-level plan if their income does not exceed 300 percent of the Federal poverty level (ACA §§ 1402 and 2901 and 45 CFR § 155.350). “Indian” is defined as an individual who meets the definition in section 4(d) of the Indian Self-Determination and Education Assistance Act (ISDEAA), P.L. No. 93-638. Under section 4(d), “Indian” is a person who is a member of an Indian tribe. The ISDEAA defines “Indian tribes” as “any Indian tribe, Band, nation, or other organized group or community, including any Alaska Native village or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act, which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians” (25 U.S.C. § 450b(e)).

¹³ An individual may be considered “lawfully present” if his or her immigration status meets any of the categories defined in 45 CFR § 152.2.

- not be incarcerated; and¹⁴
- meet applicable residency standards.¹⁵

To be eligible for insurance affordability programs, an individual must meet additional requirements for annual household income and family size.¹⁶ Additionally, an individual is not eligible for these programs if he or she is eligible for minimum essential coverage that is not offered through a marketplace.¹⁷

Marketplaces must verify up to 11 requirements, as appropriate, when determining eligibility for QHPs and insurance affordability programs:

1. Social Security number,
2. citizenship,
3. status as a national,¹⁸
4. lawful presence (e.g., if an individual is not a citizen),
5. incarceration status (e.g., whether an individual is in prison),
6. residency,
7. whether an individual is an Indian,
8. family size,
9. annual household income,

¹⁴ An individual must not be incarcerated, other than incarceration pending the disposition of charges (45 CFR § 155.305(a)(2)).

¹⁵ ACA §§ 1312(f) and 1411(b) and 45 CFR § 155.305(a)(3).

¹⁶ ACA §§ 1401 and 1402 and 45 CFR §§ 155.305(f) and (g).

¹⁷ 45 CFR § 155.20 and 26 U.S.C. § 5000A(f). Minimum essential coverage consists of employer-sponsored and non-employer-sponsored coverage. For the purpose of this report, we use the term “non-employer-sponsored coverage” to include government programs (e.g., Medicare and Medicaid), grandfathered plans, and other plans (e.g., State and tribal). Special circumstances apply for individuals who are eligible for TRICARE and U.S. Department of Veterans Affairs benefits. See 77 Fed. Reg. 30377, 30379 (May 23, 2012).

¹⁸ The term “national” may refer to a person who, though not a citizen of the United States, owes permanent allegiance to the United States. All U.S. citizens are U.S. nationals, but only a relatively small number of people acquire U.S. nationality without becoming U.S. citizens (8 U.S.C. § 1101(a)).

10. whether the individual is eligible for minimum essential coverage through employer-sponsored insurance, and
11. whether the individual is eligible for minimum essential coverage through non-employer-sponsored insurance.¹⁹

Appendix B has details on the Federal eligibility requirements for QHPs and insurance affordability programs.

Application and Enrollment Process for Qualified Health Plans and Insurance Affordability Programs

To enroll in a QHP, an applicant²⁰ must complete an application and meet eligibility requirements defined by the ACA. An applicant can enroll in a QHP through the marketplace Web site (online), which is either HealthCare.gov (the Federal marketplace Web site) or the State marketplace Web site, depending on the applicant's State of residence; by phone; by mail; in person; or directly with a QHP issuer's broker or agent. For online and phone applications, the marketplace verifies the applicant's identity through an identity-proofing process. For paper applications, the marketplace requires the applicant's signature before the marketplace processes the application.²¹ When an applicant completes any type of application, the applicant attests that answers to all questions are true and is subject to the penalty of perjury.²²

After reviewing the applicant's information, the marketplace determines whether the applicant is eligible for a QHP and, when applicable, eligible for insurance affordability programs.²³ To verify the information submitted by the applicant, the marketplace uses multiple electronic data sources, including sources available through the Federal Data Services Hub (Data Hub).²⁴ The Data Hub is a single conduit for marketplaces to send and receive electronic data from multiple Federal agencies; it does not store data. Federal agencies connected to the Data Hub include HHS, the Social Security Administration (SSA), the U.S. Department of Homeland Security

¹⁹ 45 CFR §§ 155.315 and 155.320.

²⁰ For the purpose of this report, the term "applicant" refers to both the person who completes the application (application filer) and the person who seeks coverage in a QHP. The application filer may or may not be an applicant seeking coverage in a QHP (45 CFR § 155.20). For example, an application filer may be a parent seeking coverage for a child, who is the applicant.

²¹ Centers for Medicare & Medicaid Services (CMS), *Guidance Regarding Identity Proofing for the Marketplace, Medicaid, and CHIP, and the Disclosure of Certain Data Obtained through the Data Services Hub*, dated June 11, 2013 (Identity Proofing Guidance).

²² Any person who fails to provide correct information may be subject to a civil monetary penalty (ACA § 1411(h)).

²³ An applicant can apply for enrollment in a QHP without applying for insurance affordability programs.

²⁴ State marketplaces can access additional sources of data to verify applicant information. For example, the California marketplace uses the California Franchise Tax Board to verify household income.

(DHS), and IRS (ACA § 1411(c)). If the marketplace determines that the applicant is eligible, the applicant selects a QHP, and the marketplace transmits the enrollment information to the QHP issuer.

Generally, when a marketplace cannot verify information submitted by the applicant or the information is inconsistent with information available through the Data Hub or other sources, the marketplace must attempt to resolve the inconsistencies. For these purposes, applicant information is considered to be consistent with information from other sources if they are reasonably compatible with each other.²⁵ Information is considered reasonably compatible if any difference between the applicant information and other sources does not affect the eligibility of the applicant. Inconsistencies do not necessarily indicate that an applicant provided inaccurate information or is enrolled in a QHP or receiving financial assistance through insurance affordability programs inappropriately.

The marketplace must first make a reasonable effort to identify and address the causes of an inconsistency by contacting the applicant to confirm the accuracy of the information on the application. If the marketplace is unable to resolve the inconsistency through reasonable efforts, it must generally provide the applicant 90 days to submit satisfactory documentation to resolve the inconsistency (referred to as “the inconsistency period”).²⁶ The marketplace may extend the inconsistency period if the applicant demonstrates that a good-faith effort has been made to submit required documentation.²⁷ Additionally, for enrollments occurring during 2014, the Secretary of HHS has the authority to extend the inconsistency period for all marketplaces. However, this extension does not apply to applicants with inconsistencies pertaining to citizenship and immigration status.²⁸

During the inconsistency period, the applicant may choose to enroll in a QHP and, when applicable, may choose to receive the advance premium tax credit and cost-sharing reductions.²⁹ An applicant may choose to enroll during the period only if the applicant is otherwise eligible to enroll in a QHP and may receive the advance premium tax credit and cost-sharing reductions if (1) the applicant meets other eligibility requirements and (2) the tax filer³⁰ attests that the advance premium tax credit is subject to reconciliation.³¹ After the inconsistency period, if the

²⁵ 45 CFR § 155.300(d). For purposes of determining reasonable compatibility, “other sources” include information obtained through electronic data sources, other information provided by the applicant, or other information in the records of the marketplace.

²⁶ See generally ACA § 1411(e)(4) and 45 CFR § 155.315(f).

²⁷ 45 CFR § 155.315(f)(3).

²⁸ ACA § 1411(e)(4).

²⁹ 45 CFR § 155.315(f)(4).

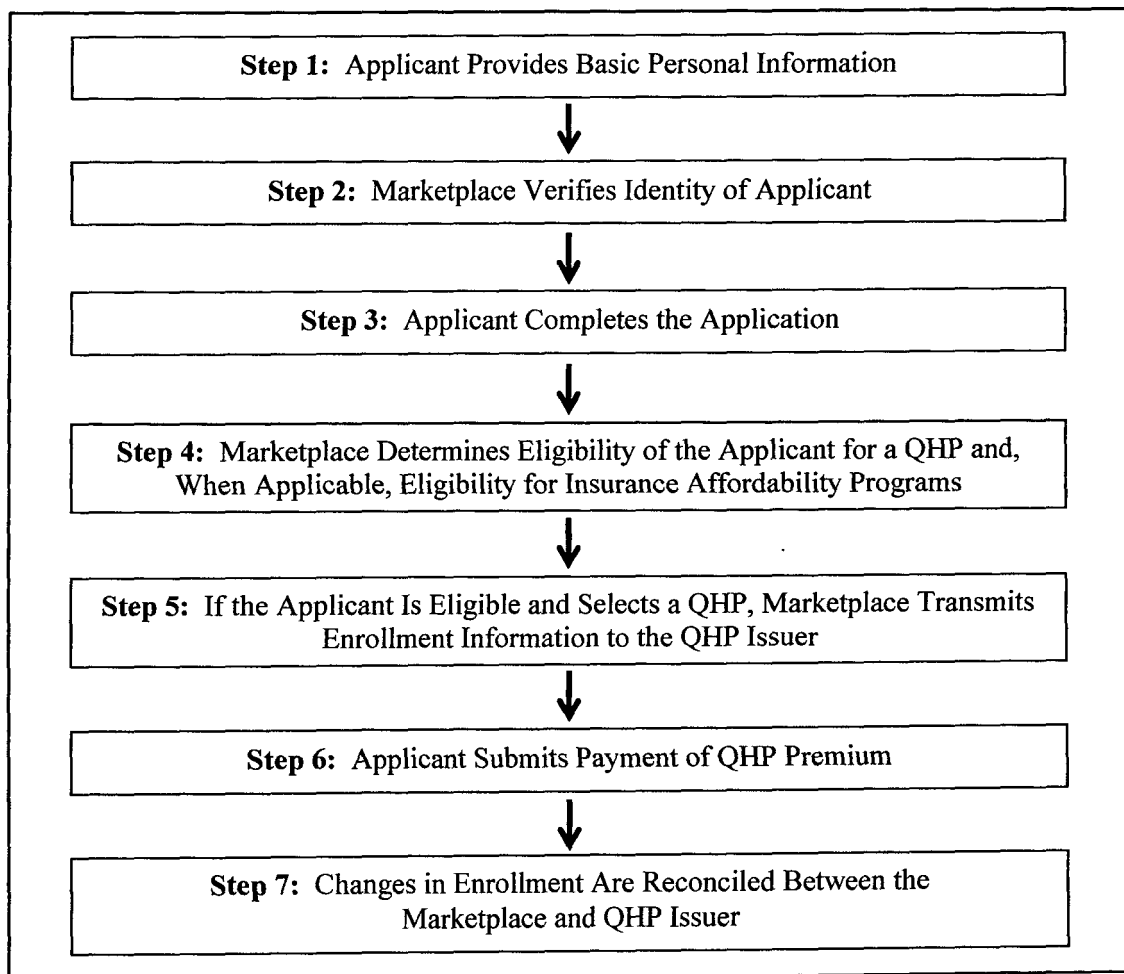
³⁰ Generally, a “tax filer” is an individual or a married couple who indicate that they are filing an income tax return for the benefit year (45 CFR § 155.300(a)).

³¹ 45 CFR § 155.315(f)(4).

marketplace is unable to resolve the inconsistency, it determines the applicant’s eligibility on the basis of available data sources and, in certain circumstances, the applicant’s attestation.³² For more information on how marketplaces may resolve inconsistencies, see Chart 1: Steps and Outcomes for Resolving Inconsistencies in the companion study report *Marketplaces Faced Early Challenges Resolving Inconsistencies with Applicant Data*, (report number OEI-01-14-00180).

Generally, an applicant must pay the first month’s QHP premium for the insurance coverage to be effective. If a change to the enrollee’s³³ coverage occurs after the coverage becomes effective, the marketplace and the QHP issuer must reconcile the revised enrollment records (45 CFR § 155.400). Figure 1 provides a summary of the steps in the application and enrollment process, and Appendix C provides a detailed description of each step.

Figure 1: Seven Steps in the Application and Enrollment Process for a Qualified Health Plan



³² 45 CFR §§ 155.315(f)(5), (f)(6), and (g).

³³ For the purpose of this report, the term “enrollee” refers to an applicant who completed an application, was determined eligible, and selected a QHP and whose enrollment information was sent to a QHP issuer.

An applicant may submit an application to enroll in a QHP during an open enrollment period. An applicant may also enroll in a QHP during a special enrollment period outside of the open enrollment period if the applicant experiences certain life changes, such as marriage or birth of a child.³⁴ For calendar year (CY) 2014, the open enrollment period was October 1, 2013, through March 31, 2014.³⁵

Administration of the Federal, California, and Connecticut Marketplaces

CMS oversees implementation of certain ACA provisions related to the marketplaces.³⁶ CMS also works with States to establish State and State-partnership marketplaces, including oversight functions such as performing onsite reviews of system functionality for eligibility determinations, enrollment of applicants, and consumer assistance.³⁷

Federal Marketplace

CMS established the Federal marketplace and is responsible for implementing many ACA provisions governing all marketplaces, including verification of applicant information to determine eligibility for enrollment in a QHP and insurance affordability programs. CMS operates HealthCare.gov, the official Web site for the Federal marketplace.

California Marketplace

California was the first State to enact legislation creating a State marketplace. The public entity known as Covered California established the California marketplace and is responsible for operating it.³⁸ For CY 2014, the California marketplace has contracts with 11 health insurance companies to offer QHPs to individuals.

The California marketplace created a centralized eligibility and enrollment system known as the California Healthcare Eligibility, Enrollment, and Retention Systems (CalHEERS). CalHEERS determines applicants' eligibility for enrollment in QHPs and, when applicable, eligibility for insurance affordability programs. CalHEERS also assesses applicants' eligibility for Medicaid and CHIP.

³⁴ ACA § 1311(c)(6) and 45 CFR § 155.410.

³⁵ The Federal and California marketplaces created a special enrollment period to allow applicants to finish the application and enrollment process by April 15, 2014. The special enrollment period was open to applicants who started their applications by March 31, 2014, and could not complete them because of high consumer traffic on the marketplaces' Web sites.

³⁶ The Center for Consumer Information and Insurance Oversight, within CMS, oversees implementation of the ACA with respect to marketplaces.

³⁷ See generally 45 CFR §§ 155.110 and 155.1200.

³⁸ California Government Code, Title 22, §§ 100500–100521.

Connecticut Marketplace

Connecticut enacted legislation to create a State marketplace. The public entity known as Access Health CT established and operates the Connecticut marketplace.³⁹ For CY 2014, the Connecticut marketplace has contracts with three insurance companies to offer QHPs to individuals.

The Connecticut marketplace uses its enrollment system (Connecticut enrollment system) to determine applicants' eligibility for enrollment in QHPs and, when applicable, eligibility for insurance affordability programs; the system also assesses the eligibility of most Medicaid-eligible and CHIP applicants.

HOW WE CONDUCTED THIS REVIEW

We reviewed the internal controls that were in place at the Federal, California, and Connecticut marketplaces from October to December 2013. We limited our review to those internal controls related to (1) verifying identity of applicants, (2) determining applicants' eligibility for enrollment in QHPs and eligibility for insurance affordability programs, and (3) maintaining and updating eligibility and enrollment data. These internal controls at each marketplace were not necessarily the same. Appendix D provides general information on internal controls.

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

- tested controls by reviewing a sample of 45 applicants randomly selected at each marketplace from all applicants who were determined eligible to enroll in QHPs with coverage effective January 1, 2014,⁴⁰ and
- performed other audit procedures, which included interviews with marketplace management, staff, and contractors; observation of staff performing tasks related to eligibility determinations; and reviews of supporting documentation and enrollment records.

Our attribute sampling approach is commonly used to test the effectiveness of internal controls for compliance with laws, regulations, and policies. According to the Government Accountability Office and President's Council on Integrity and Efficiency's⁴¹ *Financial Audit Manual* (July 2008), section 450, auditors may use a randomly selected sample of 45 items to perform a compliance review. If all sample items are determined to be in compliance with

³⁹ Connecticut General Statute, §§ 38a-1080–1092.

⁴⁰ According to the enrollment data provided by the three marketplaces for all applicants who were determined eligible to enroll in QHPs with coverage effective January 1, 2014, the Federal marketplace had 1,112,411 applicants, the California marketplace had 453,401 applicants, and the Connecticut marketplace had 34,095 applicants.

⁴¹ The President's Council on Integrity and Efficiency is now called the Council of the Inspectors General on Integrity and Efficiency (Inspector General Act § 11).

requirements, a conclusion that the controls are effective can be made. If one or more sample items are determined not to be in compliance with requirements, a conclusion that the controls are ineffective can be made. We tested the controls at each marketplace separately. Our sampling methodology was limited to forming an opinion about whether the internal controls at each marketplace were effective and was not designed to estimate the percentage of applicants for whom each marketplace did not perform the required eligibility verifications.

For the 45 sample applicants for each marketplace, we reviewed supporting documentation to evaluate whether the marketplace determined eligibility in accordance with Federal requirements. During our fieldwork, questions arose concerning OIG's access under the Internal Revenue Code to Federal taxpayer information that IRS provides to marketplaces. We sought authorization from IRS to access that information. Because the request was still pending when we had completed our data collection, we did not review supporting documentation for certain eligibility requirements, such as annual household income and family size, for the purpose of this report. As a result, we could not evaluate whether each marketplace determined the 45 sample applicants' eligibility for advance premium tax credits and cost-sharing reductions according to Federal requirements.⁴²

Further, we did not determine whether information submitted by the 45 sample applicants at each marketplace was inaccurate or fraudulent because we could not independently verify the accuracy of data stored at other Federal agencies, e.g., IRS and SSA. Instead, we focused our review on determining the effectiveness of internal controls for processing that data and addressing inconsistencies in eligibility data when identified by the marketplace.

Because the open enrollment period ended after December 31, 2013, marketplaces may have received new information, which could have changed applicants' eligibility for enrollment in QHPs and, when applicable, eligibility for insurance affordability programs. We did not review the marketplaces' redeterminations of applicants' eligibility that resulted from verifications of information provided by applicants after December 31, 2013.

Our review of internal controls, which included reviewing 45 sample applicants and performing other audit procedures, would not necessarily have detected all internal control deficiencies because internal controls provide only reasonable assurance that each marketplace complied with Federal requirements.

We performed fieldwork from November 2013 to May 2014 at the CMS offices in Bethesda and Baltimore, Maryland; at the Covered California office in Sacramento, California; and at the Access Health CT office in Hartford, Connecticut. We also performed fieldwork at selected marketplace contractor offices in various locations.

⁴² We were able to evaluate the Connecticut marketplace's specific internal controls related to determining applicants' eligibility for advance premium tax credits and cost-sharing reductions according to Federal requirements by performing other audit procedures. The marketplace provided us with additional data that enabled us to evaluate the controls. The additional data did not contain Federal taxpayer information.

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

Appendix E contains the details of our audit scope and methodology.

FINDINGS

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

On the basis of our review of 45 sample applicants at each marketplace, we determined that certain controls were effective, e.g., verification of applicants' incarceration status at all 3 marketplaces. However, the internal controls were not effective for:

- validating Social Security numbers (one sample applicant) at the Federal marketplace,
- verifying citizenship (seven sample applicants) and lawful presence (one sample applicant) at the California marketplace, and
- performing identity proofing of phone applicants (one sample applicant) and verifying minimum essential coverage through non-employer-sponsored insurance (seven sample applicants) at the Connecticut marketplace.⁴³

On the basis of performing other audit procedures, such as interviews with marketplace officials and reviews of supporting documentation, we determined that other controls were not effective. For example, the Federal and California marketplaces did not always resolve inconsistencies in eligibility data, and the Connecticut marketplace did not always properly determine eligibility for insurance affordability programs.

The presence of an internal control deficiency does not necessarily mean that a marketplace improperly enrolled an applicant in a QHP or improperly determined eligibility for insurance affordability programs. Other mechanisms exist that may remedy the internal control deficiency, such as the resolution process during the inconsistency period. For example, if a marketplace did not have a control in place to verify an applicant's citizenship through SSA as required, the marketplace may still have been able to verify citizenship with satisfactory documentation provided by the applicant during the inconsistency period.

⁴³ Connecticut marketplace officials stated that the marketplace planned to correct a system defect that prevented the marketplace from storing verification data for minimum essential coverage through non-employer-sponsored insurance for the seven applicants.

Table 1 shows the deficiencies in internal controls identified at each marketplace, through both testing of controls by reviewing 45 sample applicants and performing other audit procedures.

Table 1: Deficiencies in Internal Controls Identified at the Three Marketplaces by Reviewing Sample Applicants and Performing Other Audit Procedures (October to December 2013)

Deficiencies Identified	Federal Marketplace	California Marketplace	Connecticut Marketplace
<i>Verifying Identity of Applicants and Entering Application Information</i>			
Identity proofing of applicants was not always performed			X
Information from paper applications was not always entered correctly into enrollment system		X	
<i>Determining Eligibility of Applicants</i>			
Social Security numbers were not always validated through the Social Security Administration	X		
Citizenship was not always verified through the Department of Homeland Security		X	
Lawful presence was not always verified through the Department of Homeland Security		X	
Eligibility for insurance affordability programs was not always determined properly			X
Inconsistencies in eligibility data were not always resolved	X ⁴⁴	X	
<i>Maintaining and Updating Eligibility and Enrollment Data</i>			
Eligibility data were not always properly maintained		X	X
System functionality to allow enrollees to update enrollment information had not been developed	X		
NOTES			
<ul style="list-style-type: none"> The absence of an “X” for a deficiency indicates that, on the basis of our review, nothing came to our attention to indicate that the marketplace had this deficiency. Although we identified deficiencies at each marketplace, the magnitude of the deficiencies varied. For example, the California marketplace did not verify citizenship through DHS for seven sample applicants but did not verify lawful presence through DHS for only one sample applicant. 			

⁴⁴ This deficiency was related to applicants for whom inconsistencies could not be resolved by the Federal marketplace for certain eligibility requirements as of February 2014.

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

Appendix F lists the required verifications for eligibility determinations and the number of sample applicants for whom the marketplaces did not perform the required verifications.

DEFICIENCIES RELATED TO VERIFYING IDENTITY OF APPLICANTS AND ENTERING APPLICATION INFORMATION

Identity Proofing of Applicants Was Not Always Performed by the Connecticut Marketplace

The Connecticut marketplace did not always perform identity proofing of applicants. Identity proofing helps to ensure the privacy of personal information and to prevent an unauthorized individual from submitting an online or phone application. On the basis of the information we reviewed, nothing came to our attention to indicate that the Federal and California marketplaces had this deficiency.⁴⁵

Federal Requirements

Marketplaces must establish and implement operational, technical, administrative, and physical safeguards to ensure the confidentiality, integrity, and availability of personally identifiable information that they create, collect, use, or disclose and to ensure that personally identifiable information is used by or disclosed to only those authorized to receive or view it (45 CFR § 155.260(a)(4)).

According to CMS's Identity Proofing Guidance for State marketplaces, before a marketplace accepts an online or telephone application for enrollment in a QHP, it must conduct identity proofing sufficient to provide assurance that only the appropriate individual has access to restricted data. The guidance explains that identity proofing involves the (1) collection of core attributes, including the applicant's name, birth date, Social Security number (optional), address, phone number, and email address; (2) validation of core attributes with a trusted data source; and (3) for some applicants, collection and validation of responses to questions about the applicant's personal history, e.g., the names of current and past employers. CMS allows States to use Federal identity-proofing services.

⁴⁵ The California marketplace did not perform identity proofing in accordance with CMS guidance. However, the California marketplace obtained approval from CMS to delay implementing identity proofing. See the section "Other Issues Noted at the Three Marketplaces."

The Connecticut Marketplace Did Not Always Perform Identity Proofing of Phone Applicants

For one of the three sample applicants who applied by phone, the Connecticut marketplace did not perform identity proofing in accordance with CMS guidance.⁴⁶ The applicant completed an application by phone to enroll in a QHP and never accessed her application through the Web site.⁴⁷ Although the marketplace performed identity proofing of applicants who applied for QHPs using the marketplace's Web site, it did not do so for applicants who applied by phone through the call center. However, if a phone applicant later accessed his or her application through the Web site, the marketplace performed identity proofing at that time. The Connecticut marketplace did not have a procedure to perform identity proofing of applicants who applied by phone.

Information From Paper Applications Was Not Always Entered Correctly by the California Marketplace Into Its Enrollment System

The California marketplace did not ensure that information included on paper applications was always entered correctly into CalHEERS. If application information is not correctly entered, a marketplace may incorrectly determine an applicant's eligibility for enrollment in a QHP and, when applicable, eligibility for insurance affordability programs. On the basis of the information we reviewed, nothing came to our attention to indicate that the Federal and Connecticut marketplaces had this deficiency.

Federal Requirements

Marketplaces must establish and implement privacy and security standards that are consistent with certain principles. One of these principles is data integrity and quality. Under this principle, a marketplace should take reasonable steps to ensure that personally identifiable information is complete, accurate, and up to date to the extent necessary for the marketplace's intended purposes and has not been altered or destroyed in an unauthorized manner (45 CFR § 155.260(a)(3)(vi)).

The California Marketplace Did Not Ensure That Its Staff Correctly Entered Some Information From Paper Applications Into CalHEERS

The California marketplace did not ensure that its staff correctly entered some information from applicants' paper applications into CalHEERS.⁴⁸ The California marketplace had a procedure to ensure that its staff correctly entered basic personal information, such as name, date of birth, and Social Security number, into CalHEERS. However, the marketplace did not have a procedure,

⁴⁶ Marketplaces perform identify proofing of application filers. If a sample applicant was not the application filer, we reviewed supporting documentation for identity proofing of the application filer.

⁴⁷ For the remaining two sample applicants, the marketplace performed identity proofing when the applicants had completed their applications online.

⁴⁸ We identified this deficiency by performing audit procedures other than reviewing the 45 sample applicants.

such as supervisory review, to ensure that other application information, such as annual household income and citizenship, was entered correctly into CalHEERS.

For example, an applicant submitted a paper application listing household income of \$450 per week.⁴⁹ The applicant's monthly income should have been entered into CalHEERS as \$1,948.50, by using the correct conversion factor of 4.33 for converting weekly to monthly income ($\$450 \times 4.33$). However, California marketplace staff incorrectly entered the applicant's monthly income as \$1,800 by using the incorrect conversion factor of 4 ($\$450 \times 4$). The staff did not follow the marketplace's manual, which instructed the staff to select an income frequency (e.g., weekly or monthly) in the system instead of directly entering a total monthly income amount. Without procedures to ensure that application information is correctly entered into CalHEERS, the marketplace may incorrectly determine eligibility for insurance affordability programs. According to California marketplace officials, the marketplace is developing a quality control process for reviewing other paper application information, such as annual household income and citizenship.

DEFICIENCIES RELATED TO DETERMINING ELIGIBILITY OF APPLICANTS

Social Security Numbers Were Not Always Validated Through the Social Security Administration by the Federal Marketplace

The Federal marketplace did not always validate applicants' Social Security numbers through SSA. Without validating an applicant's Social Security number, a marketplace cannot ensure that the applicant meets eligibility requirements for enrollment in a QHP. On the basis of information we reviewed, nothing came to our attention to indicate that the California and Connecticut marketplaces had this deficiency.

Federal Requirements

A marketplace must validate an applicant's Social Security number through SSA if the applicant provides the Social Security number (ACA § 1411(c)(2) and 45 CFR § 155.315(b)).

The Federal Marketplace Did Not Always Validate Social Security Numbers Through the Social Security Administration

For 1 of 44 sample applicants who submitted Social Security numbers,⁵⁰ the Federal marketplace did not validate the applicant's Social Security number through SSA.⁵¹ The data provided by the Federal marketplace showed that the applicant included a Social Security number on the

⁴⁹ We selected three paper applications to understand the paper application process at the California marketplace.

⁵⁰ We reviewed 44 of the 45 sample applicants for this deficiency because 1 sample applicant did not provide a Social Security number.

⁵¹ For the sample applicant who provided a Social Security number that was not validated, the eligibility verification data provided by the Federal marketplace showed that the applicant attested to being a U.S. citizen, but the data did not show that the marketplace verified the applicant's citizenship through SSA as required.

application; however, the marketplace did not have data demonstrating that it validated the Social Security number through SSA. As of April 8, 2014, CMS had not provided an explanation of why the applicant's Social Security number was not validated.

Citizenship Was Not Always Verified Through the Department of Homeland Security by the California Marketplace

The California marketplace did not always verify applicants' citizenship through DHS when SSA could not verify citizenship. Without verifying citizenship in this manner, a marketplace may place an applicant in an inconsistency period even though the applicant may be a U.S. citizen. On the basis of the information we reviewed, nothing came to our attention to indicate that the Federal and Connecticut marketplaces had this deficiency.⁵²

Federal Requirements

Marketplaces must verify an applicant's citizenship through SSA. If SSA cannot verify an applicant's citizenship, the marketplace must verify citizenship through DHS if the applicant provides documentation that can be verified through DHS and attests to citizenship. If the marketplace cannot verify citizenship through DHS, the marketplace must make a reasonable effort to identify and address the causes of the inconsistency (ACA § 1411(c)(2) and 45 CFR § 155.315(c)). If it is unable to resolve the inconsistency, the marketplace must notify the applicant and generally provide the applicant with a period of 90 days to present satisfactory documentary evidence of citizenship (ACA § 1411(e)(3) and 45 CFR § 155.315(c)(3)). During the inconsistency period, the applicant may choose to enroll in a QHP and, when applicable, may choose to receive advance premium tax credits and cost-sharing reductions (45 CFR § 155.315(f)(4)).

The California Marketplace Did Not Verify Citizenship Through the Department of Homeland Security When Social Security Administration Information Was Inconsistent With Application Information or Was Unavailable

For 7 of 10 sample applicants who attested that they were U.S. naturalized citizens⁵³ and provided documentation that could be verified through DHS,⁵⁴ the California marketplace did not verify citizenship through DHS when (1) the SSA system indicated that the applicant was not

⁵² For one sample applicant, the Federal marketplace provided updated eligibility verification data instead of the original data. Because the updated data did not include information on whether the marketplace verified the applicant's citizenship, we could not determine whether the marketplace verified citizenship.

⁵³ A U.S. naturalized citizen is a foreign citizen or national who has been granted U.S. citizenship after fulfilling the requirements established by Congress in the Immigration and Nationality Act.

⁵⁴ The 10 sample applicants provided either naturalization or citizenship certificate numbers. A naturalization certificate number is issued to a person who became a U.S. citizen through the naturalization process. A certificate of citizenship is issued to a person born outside the United States who derived or acquired U.S. citizenship through a parent who was a U.S. citizen.

a U.S. citizen or (2) SSA information was unavailable⁵⁵ to verify citizenship. The California marketplace placed six of the seven applicants in an inconsistency period when it should have verified citizenship through DHS according to the Federal requirements.⁵⁶

The California marketplace's process for verifying citizenship was incomplete. According to California marketplace officials, CalHEERS was not designed to verify an applicant's citizenship through DHS when (1) the applicant attested to being a U.S. citizen and (2) the application information did not match SSA information or SSA information was unavailable to verify citizenship.

Lawful Presence Was Not Always Verified Through the Department of Homeland Security by the California Marketplace

The California marketplace did not always verify applicants' lawful presence through DHS. Without verifying lawful presence in this manner, a marketplace may place an applicant in an inconsistency period even though he or she is lawfully present. On the basis of the information we reviewed, nothing came to our attention to indicate that the Federal and Connecticut marketplaces had this deficiency.

Federal Requirements

A marketplace must verify an applicant's lawful presence through DHS if the applicant attests to not being a U.S. citizen but being lawfully present (ACA § 1411(c)(2)(B) and 45 CFR § 155.315(c)(2)).

The California Marketplace Did Not Always Verify Lawful Presence Through the Department of Homeland Security

For one of three sample applicants who attested that they were not U.S. citizens but were lawfully present, the California marketplace did not verify lawful presence through DHS. The data provided by the California marketplace showed that the applicant entered information to prove lawful presence; however, the marketplace did not have data demonstrating that it had verified lawful presence through DHS.

Eligibility for Insurance Affordability Programs Was Not Always Determined Properly by the Connecticut Marketplace

The Connecticut marketplace determined applicants to be eligible for insurance affordability programs when they were not eligible. They were not eligible because they were Medicaid-eligible or had not selected a silver-level QHP. On the basis of the information we reviewed,

⁵⁵ SSA information was unavailable because of Data Hub outages or the SSA system was offline.

⁵⁶ For one sample applicant, the California marketplace could not provide the eligibility verification data because the applicant terminated her enrollment in a QHP. Without these data, we could not determine whether the California marketplace placed the applicant in an inconsistency period.

nothing came to our attention to indicate that the Federal and California marketplaces had this deficiency.

Federal Requirements

An applicant eligible for non-employer-sponsored insurance,⁵⁷ including Medicaid, is not eligible for the advance premium tax credit (45 CFR §§ 155.20 and 155.305(f) and 26 U.S.C. § 5000A(f)). Further, an applicant requesting cost-sharing reductions must select a silver-level QHP (ACA § 1402(b)(1) and 45 CFR § 155.305(g)(1)(ii)).

The Connecticut Marketplace Improperly Determined Applicants Who Were Medicaid-Eligible or Did Not Select Silver-Level Health Plans To Be Eligible for Insurance Affordability Programs

The Connecticut marketplace improperly determined Medicaid-eligible applicants to be eligible for advance premium tax credits and applicants who did not select silver-level QHPs to be eligible for cost-sharing reductions.⁵⁸ Of the 34,095 applicants whose eligibility information was transmitted to QHP issuers, 223 Medicaid-eligible applicants who selected QHPs instead of Medicaid were determined eligible for advance premium tax credits, and 619 applicants who did not select silver-level QHPs were determined eligible for cost-sharing reductions.

A system programming error allowed some Medicaid-eligible applicants who selected QHPs to be determined eligible for advance premium tax credits. Because of additional system programming errors related to catastrophic plans offered by two QHP issuers, applicants who selected these plans were automatically determined eligible for cost-sharing reductions. Connecticut marketplace officials stated that they had corrected these programming errors in December 2013 and March 2014, respectively, and had contacted applicants to correct applications. We did not verify that the Connecticut marketplace had corrected these programming errors and had contacted the applicants to correct the applications.

Inconsistencies in Eligibility Data Were Not Always Resolved by the Federal and California Marketplaces

The Federal and California marketplaces did not always resolve inconsistencies in applicants' eligibility data. Without resolving inconsistencies in an applicant's eligibility data, a marketplace cannot ensure that the applicant meets each of the eligibility requirements for enrollment in a QHP and, when applicable, for insurance affordability programs. On the basis of the information we reviewed, nothing came to our attention to indicate that the Connecticut marketplace had this deficiency.

⁵⁷ Non-employer-sponsored insurance includes government programs, grandfathered plans, and other plans.

⁵⁸ We identified this deficiency by performing audit procedures other than reviewing the 45 sample applicants.

Federal Requirements

Marketplaces must make a reasonable effort to identify and address the causes of inconsistencies. If a marketplace is unable to resolve an inconsistency, it must notify the applicant of the inconsistency and generally must provide the applicant with a period of 90 days from the date on which the notice was sent to either present satisfactory documentary evidence or otherwise resolve the inconsistency.⁵⁹ The marketplace may extend the inconsistency period when an applicant demonstrates a good-faith effort to obtain sufficient documentation to resolve the inconsistency (45 CFR § 155.315(f)(3)). During the inconsistency period, an applicant who is otherwise qualified is eligible to enroll in a QHP and, when applicable, eligible for insurance affordability programs (45 CFR § 155.315(f)(4)).

Marketplaces must maintain and ensure that their contractors, subcontractors, and agents maintain for 10 years documents and records that are sufficient to enable HHS or its designees to evaluate the marketplaces' compliance with Federal requirements (45 CFR § 155.1210(a)). The records must include data and records related to the marketplaces' eligibility verifications and determinations and enrollment transactions (45 CFR § 155.1210(b)(4)).

The Federal Marketplace Resolved Less Than 1 Percent of Inconsistencies Related to Certain Eligibility Requirements as of February 2014

Information provided by CMS officials showed that the Federal marketplace system resolved less than 1 percent of approximately 2.9 million inconsistencies in applicant data for the 11 eligibility requirements as of February 2014.^{60, 61} The Federal marketplace was able to resolve inconsistencies related to validation of an applicant's Social Security number and verification of incarceration status, whether the applicant was an Indian, and whether the applicant was eligible for minimum essential coverage through non-employer-sponsored insurance. However, the Federal marketplace was not able to resolve inconsistencies related to:

- citizenship,
- status as a national,
- lawful presence,
- residency,

⁵⁹ ACA § 1411(e)(4) and 45 CFR § 155.315(f).

⁶⁰ We identified this deficiency by performing audit procedures other than reviewing the 45 sample applicants.

⁶¹ CMS stated that an applicant may have more than one inconsistency.

- family size,⁶²
- annual household income, and
- whether the applicant was eligible for minimum essential coverage through employer-sponsored insurance.

Although the Federal marketplace received documentary evidence from applicants related to inconsistencies, it could not resolve the inconsistencies because the system functionality to resolve inconsistencies had not been fully developed. According to CMS officials, as of February 23, 2014, the Federal marketplace had resolved approximately 10,000 of the 2.9 million inconsistencies (less than 1 percent). We did not validate the accuracy of CMS's figures.

The California Marketplace Did Not Resolve All Inconsistencies in Eligibility Data or Maintain Documentation To Support Resolution of Inconsistencies

For 19 of the 25 sample applicants who had inconsistencies in their eligibility data, the California marketplace did not resolve the inconsistencies.⁶³ For example, on November 30, 2013, the marketplace determined that an applicant was eligible for a QHP and the advance premium tax credit and notified the applicant of an inconsistency related to household income. The marketplace requested that the applicant provide supporting documentation; however, it did not resolve these inconsistencies by February 28, 2014, which was the end of the 90-day inconsistency period. After that date, the California marketplace allowed the applicant to remain enrolled in a QHP and eligible to receive an advance premium tax credit.⁶⁴ According to California marketplace officials, the marketplace did not have the resources to resolve all inconsistencies as required.

For two sample applicants, the California marketplace did not maintain documentation to support the resolution of inconsistencies. The California marketplace provided case notes from county eligibility workers. However, the case notes did not support that the inconsistencies were resolved. For example, documentation provided by California showed that one sample applicant had inconsistencies related to annual household income and citizenship, but the case notes supported the resolution of the inconsistency for only annual household income. Although the

⁶² Because of the lack of electronic data sources for verifying both residency and family size, marketplaces generally may accept attestation without further verification as the basis for eligibility (45 CFR §§ 155.315(d) and 155.320(c)(3)(i)(C)). See the section "Other Issues Noted at the Three Marketplaces."

⁶³ We identified this deficiency by performing other audit procedures in addition to reviewing the 45 sample applicants.

⁶⁴ As of March 31, 2014, the California marketplace had not resolved these inconsistencies for the 19 sample applicants. According to a marketplace official, the marketplace had continued to use the attested information of applicants until completing a review of all documents submitted by applicants to resolve inconsistencies and determining whether applicants had made a good-faith effort to provide requested documentation.

California marketplace had a procedure for county eligibility workers to maintain supporting documentation, the procedure was not followed.

DEFICIENCIES RELATED TO MAINTAINING AND UPDATING ELIGIBILITY AND ENROLLMENT DATA

Eligibility Data Were Not Always Properly Maintained by the California and Connecticut Marketplaces

The California and Connecticut marketplaces did not always properly maintain applicants' eligibility data. If a marketplace does not maintain all eligibility data, it cannot sufficiently demonstrate that applicants are eligible for enrollment in QHPs and, when applicable, eligible for insurance affordability programs. On the basis of the information we reviewed, nothing came to our attention to indicate that the Federal marketplace had this deficiency.

Federal Requirements

Marketplaces should take reasonable steps to ensure that personally identifiable information is complete, accurate, and up to date to the extent necessary for the marketplace's intended purposes and has not been altered or destroyed in an unauthorized manner (45 CFR § 155.260(a)(3)(vi)).

Marketplaces must maintain and ensure that their contractors, subcontractors, and agents maintain for 10 years documents and records that are sufficient to enable HHS or its designees to evaluate the marketplaces' compliance with Federal requirements (45 CFR § 155.1210(a)). The records must include data and records related to the marketplaces' eligibility verifications and determinations and enrollment transactions (45 CFR § 155.1210(b)(4)).

The California Marketplace Maintained Conflicting Application and Eligibility Data

For 30 of 45 sample applicants, the California marketplace maintained conflicting application and eligibility data.⁶⁵ The following are examples:

- When we observed one sample applicant's information on the CalHEERS computer screen, the information showed that the applicant was a U.S. citizen; however, the data that the California marketplace provided to support the eligibility verification showed that the applicant was not a U.S. citizen. The California marketplace subsequently provided satisfactory documentation that this applicant was a U.S. citizen.
- For another sample applicant, the data that the California marketplace provided to support the eligibility verification had multiple data fields, one of which showed that the

⁶⁵ We identified this deficiency by performing other audit procedures in addition to reviewing the 45 sample applicants. Although the California marketplace initially provided conflicting application and eligibility data, it later provided additional data that we used to determine whether the required verifications were performed for the 45 sample applicants.

applicant was a U.S. citizen; however, another data field showed that the Data Hub was unavailable. Therefore, the California marketplace could not have verified the applicant's citizenship through the Data Hub. The California marketplace subsequently provided satisfactory documentation that this applicant was a U.S. citizen.

According to California marketplace officials, CalHEERS stored the same information for an applicant in multiple places; however, because of system defects within CalHEERS, the application and eligibility data did not match in all places. The officials also stated that they had corrected some of the system defects and planned to correct additional system defects in CalHEERS.

The Connecticut Marketplace Did Not Always Store Eligibility Verification Data Confirming Ineligibility for Non-Employer-Sponsored Insurance

For 7 of the 31 sample applicants who applied for financial assistance through insurance affordability programs, the Connecticut marketplace could not provide eligibility verification data confirming that the applicants were ineligible for minimum essential coverage through non-employer-sponsored insurance. The Connecticut marketplace performed the verification and demonstrated that it successfully received verification data through the Data Hub. However, Connecticut marketplace officials explained that a system defect prevented the marketplace from storing verification data for the seven applicants. The officials stated that they planned to correct the system to ensure that it maintained these data.

System Functionality To Allow Enrollees To Update Enrollment Information Had Not Been Developed by the Federal Marketplace

During our review period, the Federal marketplace had not developed system functionality to allow enrollees to update enrollment information. If an enrollee cannot update enrollment information because of life changes, he or she must submit a new application, resulting in multiple records for the same enrollee. On the basis of the information we reviewed, nothing came to our attention to indicate that the California and Connecticut marketplaces had this deficiency.

Federal Requirements

In accordance with 45 CFR § 155.330(b), an enrollee in a QHP is required to report a life change, such as marriage, child birth, or placement of a child for adoption or in foster care, with respect to the eligibility standards specified in 45 CFR § 155.305 within 30 days of such a change. In addition, a marketplace must redetermine the eligibility of an enrollee in a QHP if it receives and verifies new information reported by the enrollee or identifies updated information through the data-matching process in accordance with 45 CFR § 155.330.

Marketplaces should take reasonable steps to ensure that personally identifiable information is complete, accurate, and up to date to the extent necessary for the marketplace's intended purposes and has not been altered or destroyed in an unauthorized manner (45 CFR § 155.260(a)(3)(vi)).

The Federal Marketplace Did Not Have System Functionality To Allow Enrollees To Report Life Changes Affecting Eligibility

During the first 3 months of the open enrollment period (October to December 2013), the Federal marketplace did not have system functionality to allow enrollees to report life changes affecting their eligibility for enrollment in QHPs and, when applicable, eligibility for insurance affordability programs.⁶⁶ If an enrollee had a life change, such as a marriage or birth of a child, the enrollee had to complete a new application through the marketplace. The enrollment records provided by CMS showed that 2,651 enrollees had a total of 6,674 enrollment records.⁶⁷ According to CMS, as of February 2014, this system functionality had been implemented; however, we did not verify that this functionality was implemented.

CONCLUSION

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

On the basis of our review of 45 sample applicants at each marketplace, we determined that certain controls were effective, e.g., verification of applicants' incarceration status at all 3 marketplaces. However, we also determined that other controls were not effective. For example, the Federal marketplace did not always validate Social Security numbers through SSA, and the California marketplace did not always verify applicants' citizenship through DHS when required.

On the basis of performing other audit procedures, such as interviews with marketplace officials and reviews of supporting documentation, we determined that additional controls were not effective. For example, the Federal and California marketplaces did not always resolve inconsistencies in eligibility data, and the Connecticut marketplace did not always properly determine eligibility for insurance affordability programs.

Overall, we identified deficiencies in internal controls related to (1) verifying identity of applicants and entering application information, (2) determining applicants' eligibility for enrollment in QHPs and eligibility for insurance affordability programs, and (3) maintaining and updating eligibility and enrollment data.

These deficiencies occurred because (1) the marketplaces did not have procedures or did not follow existing procedures to ensure that applicants were enrolled in QHPs according to Federal

⁶⁶ We identified this deficiency by performing audit procedures other than reviewing the 45 sample applicants.

⁶⁷ The enrollment records showed that each of these enrollees was enrolled in only one health plan or one dental plan or both. The enrollment records included 1,112,411 applicants for enrollment in QHPs with coverage effective January 1, 2014.

requirements or (2) the marketplaces' eligibility or enrollment systems had defects or lacked functionality.

RECOMMENDATIONS

Our specific recommendations to CMS, Covered California, and Access Health CT are listed below.

RECOMMENDATIONS TO CMS

We recommend that CMS address the deficiencies that we identified and continue to improve internal controls at the Federal marketplace by:

- ensuring that Social Security numbers, when provided by applicants, are validated through SSA;
- fully developing system functionality to resolve all inconsistencies in eligibility data; and
- ensuring that the system functionality is fully developed to allow enrollees to report life changes affecting eligibility for enrollment in QHPs and, when applicable, eligibility for insurance affordability programs.

We also recommend that CMS redetermine, if necessary, the eligibility of the sample applicant for whom we determined that the Federal marketplace did not validate the applicant's Social Security number through SSA as required.

In addition, we recommend that CMS work with Covered California and Access Health CT to implement our recommendations listed below, which address deficiencies identified at the California and Connecticut marketplaces.

RECOMMENDATIONS TO COVERED CALIFORNIA

We recommend that Covered California address the deficiencies that we identified and continue to improve internal controls at the California marketplace by:

- implementing a procedure to ensure that all information from applicants' paper applications is correctly entered into CalHEERS;
- designing a process to verify applicants' citizenship through DHS when required;
- ensuring that applicants' lawful presence is verified through DHS;
- ensuring that it resolves all inconsistencies in eligibility data;
- ensuring that it maintains documentation to support the resolution of inconsistencies; and

- correcting the system defects in CalHEERS to ensure that eligibility data are complete, accurate, and up to date.

We also recommend that Covered California redetermine, if necessary, the eligibility of the sample applicants for whom we determined that verifications were not performed according to Federal requirements.

RECOMMENDATIONS TO ACCESS HEALTH CT

We recommend that Access Health CT address the deficiencies that we identified and continue to improve internal controls at the Connecticut marketplace by:

- developing and implementing a procedure to ensure that it performs identity proofing of phone applicants,
- ensuring that it corrected the system programming errors related to applicants' eligibility for advance premium tax credits and cost-sharing reductions, and
- ensuring that it corrected a system defect related to maintaining eligibility verification data for minimum essential coverage through non-employer-sponsored insurance.

We also recommend that Access Health CT redetermine, if necessary, the eligibility of the sample applicants for whom we determined that verifications were not performed according to Federal requirements.

MARKETPLACES' COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSES

CMS, Covered California, and Access Health CT provided written comments on our draft report:

- CMS concurred with all of our recommendations and provided information on actions that it had taken or planned to take to address our recommendations. However, it stated that it did not believe that the recommendations to perform identity proofing of all applicants and fully develop system functionality to allow enrollees to report life changes needed to be included in the report. After reviewing additional supporting documentation that CMS provided after issuance of our draft report, we removed our recommendation and the related finding on identify proofing of applicants.
- Covered California agreed with our recommendation that it ensure that documentation is maintained to support the resolution of inconsistencies and provided information on actions that it had taken or planned to take to address our remaining recommendations. Covered California did not concur with our findings that identity proofing of applicants was not always performed and citizenship was not always verified through DHS. In addition, it stated that it could not concur or disagree with our finding that lawful presence was not always verified through DHS. After reviewing supporting documentation that Covered California provided after issuance of our draft report, we

removed our finding and the related recommendation on identity proofing of applicants; however, we included the issue in the section “Other Issues Noted at the Three Marketplaces.”

- Access Health CT concurred with three of our recommendations, but it did not concur with our recommendation to ensure that identity proofing of phone applicants is performed and with our finding that it did not verify applicants’ citizenship through DHS. After reviewing additional supporting documentation that Access Health CT provided after issuance of our draft report, we removed our finding and the related recommendation on citizenship verification.

The sections below provide more detail on the three marketplaces’ comments and our responses. CMS’s, Covered California’s, and Access Health CT’s comments are included in their entirety as Appendixes G, H, and I, respectively. CMS also provided technical comments on our draft report, which we addressed as appropriate.

CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, CMS concurred with all of our recommendations and provided information on actions that it had taken or planned to take to address our recommendations. However, it stated that it did not believe that two recommendations in our draft report needed to be included. Regarding our recommendation to ensure that identity proofing of all applicants is performed, CMS maintained that it had performed identity proofing of all 45 sample applicants and provided OIG with additional supporting documentation after issuance of our draft report. Regarding our recommendation to ensure that system functionality is fully developed to allow enrollees to report life changes, CMS stated that it had already implemented this functionality. CMS’s comments are included in their entirety as Appendix G.

After reviewing the additional supporting documentation that CMS provided, we removed our recommendation and the related finding on identify proofing of applicants. Because CMS implemented the system functionality to allow enrollees to report life changes after our audit period, we did not verify the implementation. Therefore, we maintain that our recommendation is valid.

COVERED CALIFORNIA COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, Covered California agreed with our recommendation that it ensure that documentation is maintained to support the resolution of inconsistencies and provided information on actions that it had taken or planned to take to address our remaining recommendations. Covered California also provided information on its concurrence and nonconcurrence with our findings. Covered California’s comments are included in their entirety as Appendix H.

Covered California Comments

Covered California concurred with our findings that (1) paper applications were not always entered correctly into the enrollment system, (2) inconsistencies in eligibility data were not always resolved, and (3) eligibility data were not always properly maintained. However, regarding our finding on maintenance of eligibility data, Covered California stated that it did not believe that maintaining conflicting application and eligibility data (which it referred to as “inconsistencies within the internal tables”) degraded the accuracy of the eligibility process or outcomes or both.

Covered California did not concur with our findings that identity proofing of applicants was not always performed and citizenship was not always verified through the DHS and stated that it could not concur or disagree with our finding that lawful presence was not always verified through DHS:

- Regarding our finding and related recommendation on identity proofing, Covered California stated that it planned to implement remote identity proofing before November 15, 2014.⁶⁸ It stated that, for the first open enrollment period, with CMS’s approval, it had implemented an identity proofing process, which included accepting applicants’ electronic signatures (for online applications) and verbal attestations to identity made under penalty of perjury (for phone applications). After issuance of our draft report, Covered California provided OIG with supporting documentation of CMS’s approval. The documentation showed that CMS had approved Covered California’s interim solution for the identity-proofing process, which allowed Covered California to accept applicants’ electronic signatures and verbal attestations.
- Regarding our finding on verification of citizenship through DHS, Covered California stated that CMS had approved its citizenship verification process of using SSA data to electronically verify applicants’ citizenship. Covered California also stated that during the early months of open enrollment, the Data Hub was frequently offline, which had “impacted Covered California’s ability to verify some cases as noted in the audit.”
- Regarding our finding on verification of lawful presence through DHS, Covered California stated that it had consistently verified lawful presence with DHS. It also stated that verification of lawful presence for 1 of the 45 sample applicants “was not apparent in the data field of the record due to some form of technical error” and that it was conducting an analysis to determine whether this error resulted in any cases of lawful presence not being verified. Covered California stated that, until that analysis was complete, it could not concur or disagree with our finding.

⁶⁸ Remote identity proofing is a type of identity proofing that is performed electronically and provides immediate feedback (i.e., whether an individual passed or failed the identity proofing) using information contained in Federal data sources.

Office of Inspector General Response

Although Covered California stated that not properly maintaining eligibility data did not degrade the accuracy of the eligibility process or outcomes, we did not validate its assertion. Without reviewing all eligibility data affected by this deficiency, there is no assurance that the accuracy of eligibility data was not affected.

Regarding the findings with which Covered California did not concur, we have the following responses:

- After reviewing the supporting documentation that Covered California provided, we removed our finding and the related recommendation on identity proofing of applicants.
- We acknowledge that CMS approved Covered California's eligibility verification plan, which allowed use of SSA data to verify citizenship. However, this verification process did not meet the Federal requirements that marketplaces verify applicants' citizenship through DHS when (1) SSA cannot verify citizenship and (2) applicants provide documentation that can be used to verify citizenship through DHS.
- Covered California did not provide data that demonstrated that it had verified lawful presence through DHS. Therefore, we maintain that our finding and the related recommendation are valid.

ACCESS HEALTH CT COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, Access Health CT concurred with three of our recommendations. However, it did not concur with our recommendation to ensure that identity proofing of phone applicants is performed and with our finding that it did not verify citizenship through DHS. Access Health CT's comments are included in their entirety as Appendix I.

Access Health CT Comments

Access Health CT did not concur with our recommendation and the related finding on identity proofing of phone applicants. Access Health CT commented that a new phone applicant's identity was validated through the Data Hub when an application was submitted but before being transferred to the QHP issuer. Access Health CT provided documentation showing that it submitted to SSA an applicant's name, Social Security number, and date of birth through the Data Hub to verify an applicant's identity. Access Health CT stated that if an applicant called back after submitting an application, a call center representative would ask identity questions to confirm that the applicant should be granted access to his or her account.

Access Health CT did not concur with our finding related to verification of applicants' citizenship through DHS when SSA information was inconsistent with application information. It stated that it had a process to verify applicants' naturalized citizenship status through DHS and that DHS cannot verify citizenship for individuals born in the United States.

Office of Inspector General Response

The Connecticut marketplace's process of validating a new phone applicant's identity through the Data Hub did not meet the requirements for the identity-proofing process described in CMS's guidance. According to CMS guidance, to submit an application, the phone applicant must first complete identity proofing. However, the Connecticut marketplace did not perform identity proofing of a phone applicant until the applicant had called back after the application had been submitted. Also, CMS guidance requires collecting core attributes, validating those core attributes with a trusted data source, and collecting and validating responses to identity-proofing questions for some applicants. The Connecticut marketplace's process of validating information through SSA for phone applicants did not meet these requirements. Therefore, we maintain that our recommendation that Access Health CT develop and implement a procedure to ensure that it performs identity proofing of phone applicants is consistent with CMS guidance.

After reviewing additional supporting documentation that Access Health CT provided after issuance of our draft report, we removed our finding and the related recommendation on verification of applicants' citizenship through DHS.

OTHER ISSUES NOTED AT THE THREE MARKETPLACES

In addition to deficiencies that we noted in our "Findings" section, we identified issues that may be of interest to stakeholders. In written comments on our draft report, CMS, Covered California, and Access Health CT provided comments on these issues, which are summarized in the sections below.

IDENTITY PROOFING OF APPLICANTS WAS PERFORMED BY THE CALIFORNIA MARKETPLACE ONLY BY ACCEPTING APPLICANTS' ELECTRONIC SIGNATURES OR VERBAL ATTESTATIONS

Marketplaces must establish and implement operational, technical, administrative, and physical safeguards to ensure the confidentiality, integrity, and availability of personally identifiable information that they create, collect, use, or disclose and to ensure that personally identifiable information is used by or disclosed to only those authorized to receive or view it (45 CFR § 155.260(a)(4)).

According to CMS's Identity Proofing Guidance for State marketplaces, before a marketplace accepts an online or telephone application for enrollment in a QHP, it must conduct identity proofing sufficient to provide assurance that only the appropriate individual has access to restricted data. The guidance explains that identity proofing involves the (1) collection of core attributes, including the applicant's name, birth date, Social Security number (optional), address, phone number, and email address; (2) validation of core attributes with a trusted data source; and (3) for some applicants, collection and validation of responses to questions about the applicant's personal history, e.g., the names of current and past employers. CMS allows States to use Federal identity-proofing services.

The California marketplace enrolled applicants without performing identity proofing in accordance with CMS's guidance because the marketplace obtained approval from CMS to adopt an interim solution. Specifically, on September 23, 2013, the California marketplace obtained approval that would allow it to accept electronic signatures for online applicants and verbal attestations for phone applicants as proof of applicants' identities. At the time of approval, CMS required the California marketplace to fully implement remote identity proofing of applicants by December 1, 2013. On December 2, 2013, the California marketplace sent CMS a letter acknowledging that CMS had approved of a change in the implementation date of remote identity proofing from December 1, 2013, to January 2014. On January 30, 2014, the California marketplace sent CMS a letter stating that it planned to implement remote identity proofing on May 1, 2014, or 30 days after the end of the open enrollment period, whichever was later.

In written comments on our draft report, Covered California stated that it planned to implement remote identity proofing before November 15, 2014.

RESIDENCY WAS VERIFIED BY THE FEDERAL, CALIFORNIA, AND CONNECTICUT MARKETPLACES ONLY BY ACCEPTING APPLICANTS' ATTESTATION OF RESIDENCY

A marketplace must verify an applicant's attestation regarding residency by accepting the attestation without further verification or by examining data sources that are available to the marketplace and that have been approved by HHS for this purpose. However, if information that the applicant provides regarding residency is not reasonably compatible with other information provided by the applicant or in the records of the marketplace, the marketplace must examine information in data sources that are available to the marketplace and that have been approved by HHS for this purpose. If the information in such data sources is not reasonably compatible with the information provided by the applicant, the marketplace must follow procedures for resolution of inconsistencies (45 CFR § 155.315(d)).

The Federal, California, and Connecticut marketplaces accepted the applicants' attestation of residency in accordance with Federal requirements, which do not call for further verification. The marketplaces informed us that data sources were not available to them to verify residency. Therefore, the marketplaces could accept only an applicant's attestation to verify residency.

In written comments on our draft report, CMS stated that it did not believe that the marketplaces' verification of residency by accepting applicants' attestations needed to be a noted issue. CMS stated that the marketplaces followed Federal requirements and there were not comprehensive, national electronic data sources for residency verification available to the Federal marketplace. In written comments on our draft report, Access Health CT stated that HHS had not identified an approved source to verify residency.

FAMILY SIZE WAS VERIFIED BY THE FEDERAL, CALIFORNIA, AND CONNECTICUT MARKETPLACES ONLY BY ACCEPTING APPLICANTS' ATTESTATION OF FAMILY SIZE

A marketplace may verify an applicant's family size by accepting an applicant's attestation of a tax filer's family size for determining advance premium tax credits and cost-sharing reductions (45 CFR § 155.320(c)(3)(i)(C)). However, if the marketplace finds that an applicant's attestation of a tax filer's family size is not reasonably compatible with other information provided by the applicant or in the records of the marketplace, the marketplace must examine income data obtained through other electronic data sources to verify the attestation. If the information in such data sources is not reasonably compatible with the applicant's attestation, the marketplace must follow procedures for resolution of inconsistencies (45 CFR § 155.320(c)(3)(i)(D)).

According to Federal, California, and Connecticut marketplace officials, the marketplaces received IRS information on applicants' family sizes during the eligibility determination process. The marketplaces did not make IRS family-size data available to applicants or require them to attest that these data were accurate.⁶⁹ The marketplaces accepted the applicants' attestation of family size in accordance with Federal requirements.

According to CMS, it initially planned to use IRS tax data to verify family size. However, it determined that the number of exemptions on a tax return does not necessarily correspond to actual family size, and there was not an efficient way to reconcile the tax return exemption data with an individual's family size attestation. Further, the Federal marketplace had no other data source for family size. Therefore, CMS proceeded with accepting applicant attestations rather than relying on IRS information or other electronic data sources.

In written comments on our draft report, CMS stated that it did not believe that the marketplaces' verification of family size by accepting applicants' attestation needed to be a noted issue. CMS stated that the marketplaces followed Federal requirements and there were not comprehensive, national electronic data sources for verification of family size available to the Federal marketplace. In written comments on our draft report, Access Health CT stated that "IRS data for dependent determination may not be accurate as of the time of enrollment with respect to determining an applicant's household size."

ENROLLMENT RECORDS WERE NOT ALWAYS PROMPTLY SENT TO QUALIFIED HEALTH PLAN ISSUERS BY THE CONNECTICUT MARKETPLACE

Marketplaces must send eligibility and enrollment information to QHP issuers and HHS "promptly and without undue delay" (45 CFR § 155.400(b)(1)).

Before January 1, 2014, the Connecticut marketplace did not promptly send to QHP issuers the enrollment records for 139 of the 34,095 applicants who had been determined eligible and had selected QHPs. This occurred because marketplace staff identified issues with the applications

⁶⁹ The IRS family-size data is considered Federal taxpayer information that is protected from disclosure by Internal Revenue Code § 6103.

but did not inform other staff who were responsible for correcting these issues. When some of these applicants reported to the Connecticut marketplace that QHP issuers had not received their information, the marketplace successfully resolved the issues for 121 applicants and transmitted their information to the issuers. However, as of April 2, 2014, the marketplace had not been able to contact 18 applicants to resolve the application issues.

In written comments on our draft report, Access Health CT stated that it was not able to contact the 18 applicants after 3 attempts. It stated that it did not enroll those applicants in QHPs and did not send their enrollment data to the QHP issuers.

APPROPRIATE ADVANCE PREMIUM TAX CREDITS WERE NOT ALWAYS REPORTED TO QUALIFIED HEALTH PLAN ISSUERS BY THE CONNECTICUT MARKETPLACE

Marketplaces must calculate advance premium tax credits in accordance with IRS regulations. These regulations require an applicant's maximum monthly advance premium tax credit to be the lesser of the applicant's monthly insurance premium or one-twelfth of the applicant's projected premium tax credit.⁷⁰ The marketplaces must ensure that the correct amounts of advance premium tax credits are reported to QHP issuers.

Of the 34,095 applicants whose eligibility information was transmitted to QHP issuers, 8 applicants had monthly advance premium tax credits amounts that were greater than their monthly insurance plan premiums. After a QHP issuer alerted the Connecticut marketplace to the problem, the marketplace implemented a system change to prevent advance premium tax credit amounts from exceeding insurance premium amounts.

This issue at the Connecticut marketplace is an example of the challenges that marketplaces may have in ensuring accurate reporting of advance premium tax credits to QHP issuers.

In written comments on our draft report, Access Health CT stated that a system correction had been released to ensure that, going forward, the advance premium tax credits selected would always be less than the total premium on all applications.

DOCUMENTATION WAS NOT PROVIDED BY THE FEDERAL MARKETPLACE TO SUPPORT THAT REQUIRED MONTHLY RECONCILIATIONS FOR QUALIFIED HEALTH PLANS WERE PERFORMED

Marketplaces are required to reconcile enrollment information with QHP issuers and HHS no less frequently than monthly (45 CFR § 155.400(d)). According to a preamble of the Federal Register, CMS expects that marketplaces will work to minimize enrollment discrepancies, automate reconciliation where possible, and streamline any manual reconciliation activities that remain necessary.⁷¹

⁷⁰ 45 CFR § 155.305(f)(5) and 26 CFR § 1.36B-3.

⁷¹ 77 Fed. Reg. 18310, 18385 (Mar. 27, 2012).

Although the Federal marketplace obtained the services of a contractor to reconcile enrollment information transmitted to and received from QHP issuers monthly, the marketplace did not provide documentation to support that the contractor performed the required monthly reconciliations for enrollment information exchanged between QHP issuers and the Federal marketplace. CMS officials stated that the system to support the reconciliations had yet to be developed. Without monthly QHP reconciliations, CMS cannot effectively monitor the current enrollment status of applicants, such as applicants' selection of QHPs and QHPs' termination of plans.

In written comments on our draft report, CMS stated that the automated payment and reporting system between QHP issuers and CMS was not complete or fully tested. CMS also stated that it had an interim process, which allowed QHP issuers to submit aggregate information on a monthly basis to receive financial assistance payments.

**APPENDIX A: MARKETPLACE TYPE USED IN EACH STATE
AS OF OCTOBER 1, 2013**

**Figure 2: Map Showing Type of Marketplace in Each State
as of October 1, 2013**

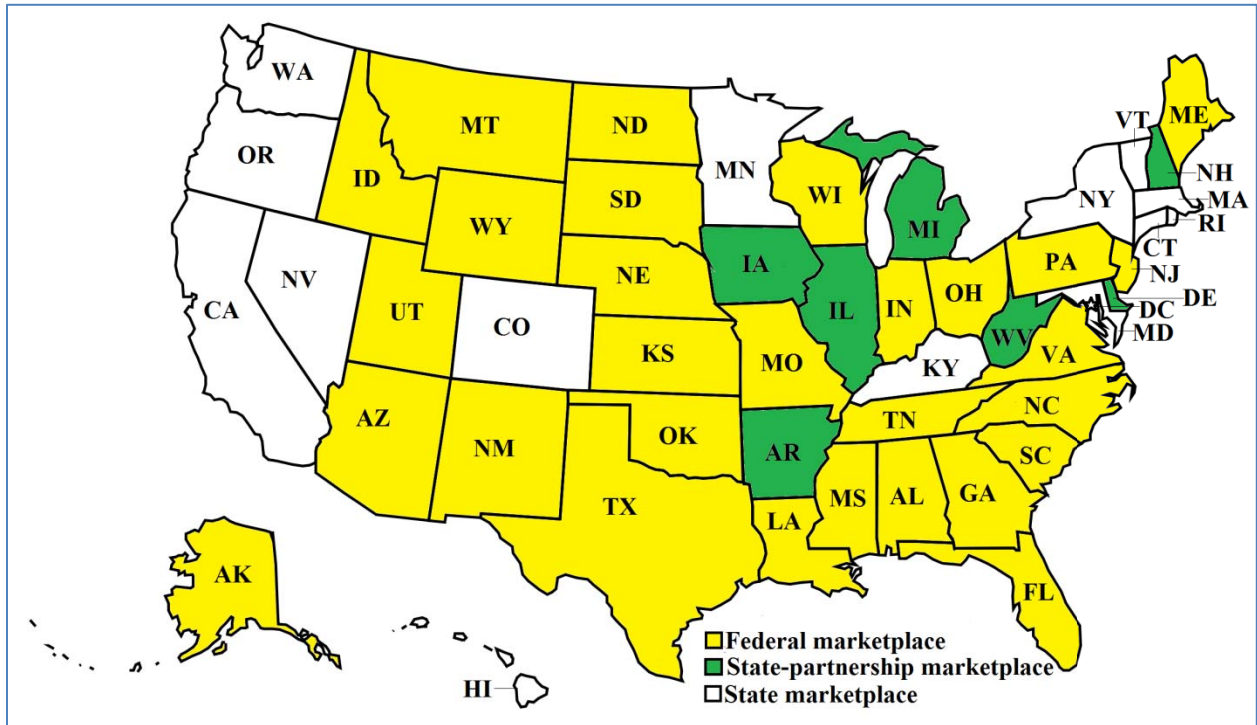


Table 2: Type of Marketplace in Each State as of October 1, 2013

State	Type of Marketplace
Alabama	Federal
Alaska	Federal
Arizona	Federal
Arkansas	State-partnership
California	State
Colorado	State
Connecticut	State
Delaware	State-partnership
District of Columbia	State
Florida	Federal
Georgia	Federal
Hawaii	State
Idaho*	Federal
Illinois	State-partnership
Indiana	Federal
Iowa	State-partnership
Kansas	Federal
Kentucky	State
Louisiana	Federal
Maine	Federal
Maryland	State
Massachusetts	State
Michigan	State-partnership
Minnesota	State
Mississippi	Federal
Missouri	Federal
Montana	Federal
Nebraska	Federal
Nevada	State
New Hampshire	State-partnership
New Jersey	Federal
New Mexico*	Federal
New York	State

* Idaho and New Mexico had begun to establish State marketplaces; however, they used the Federal marketplace as of October 1, 2013.

Table 2 (cont.): Type of Marketplace in Each State as of October 1, 2013

State	Type of Marketplace
North Carolina	Federal
North Dakota	Federal
Ohio	Federal
Oklahoma	Federal
Oregon	State
Pennsylvania	Federal
Rhode Island	State
South Carolina	Federal
South Dakota	Federal
Tennessee	Federal
Texas	Federal
Utah	Federal
Vermont	State
Virginia	Federal
Washington	State
West Virginia	State-partnership
Wisconsin	Federal
Wyoming	Federal

APPENDIX B: FEDERAL ELIGIBILITY REQUIREMENTS FOR QUALIFIED HEALTH PLANS AND INSURANCE AFFORDABILITY PROGRAMS

ELIGIBILITY REQUIREMENTS FOR APPLICANTS

Eligibility Requirements for Enrollment in a Qualified Health Plan

45 CFR § 155.305(a)

To be eligible for enrollment in a QHP through a marketplace, the applicant must:

- be a citizen, national, or noncitizen who is lawfully present in the United States;
- not be incarcerated, other than pending the disposition of charges; and
- meet applicable residency standards.

Eligibility Requirements for Advance Premium Tax Credits

45 CFR § 155.305(f)

To be eligible for the advance premium tax credit, the applicant must:

- expect to have household income from 100 through 400 percent of the Federal poverty level;
- meet the requirements for eligibility for enrollment in a QHP;
- not be eligible for minimum essential coverage, with the exception for coverage in the individual market,⁷² and
- be enrolled in a QHP that is not a catastrophic plan.

A lawfully residing noncitizen with income below 100 percent of the Federal poverty level and who is not eligible for Medicaid may also be eligible for the advance premium tax credit.

The marketplace authorizes the advance premium tax credit on behalf of a tax filer only if the filer attests to complying with certain tax requirements.⁷³

⁷² Minimum essential coverage is defined in 26 U.S.C. § 5000A(f) and regulations issued under that section. As described in section 5000A(f), government-sponsored programs, eligible employer-sponsored plans, grandfathered health plans, and certain other health benefits coverage are minimum essential coverage (26 CFR § 1.36B-2(c)).

⁷³ 45 CFR § 155.310(d)(2)(ii).

Eligibility Requirements for Cost-Sharing Reductions

45 CFR § 155.305(g)

To be eligible for cost-sharing reductions, the applicant must:

- meet the eligibility requirement for enrollment in a QHP through the marketplace,
- meet the requirements for the advance premium tax credit,
- have household income from 100 through 250 percent of the Federal poverty level, and
- be enrolled in a silver-level plan through the marketplace.

A lawfully residing noncitizen with income below 100 percent of the Federal poverty level and who is not eligible for Medicaid may also be eligible for cost-sharing reductions.

VERIFICATION REQUIREMENTS FOR MARKETPLACES

Enrollment in a Qualified Health Plan

ACA § 1411(b)

An applicant for enrollment in a QHP offered through the individual marketplace must provide the name, address, and date of birth of each individual who is to be covered by the QHP and the following information for each individual covered by the QHP:

- Social Security number, citizenship, or immigration status;
- income and family size for the coverage year or within 2 preceding years for an applicant claiming the premium tax credit or reduced cost-sharing; and
- employer-sponsored coverage for an applicant claiming the premium tax credit or reduced cost-sharing.

ACA § 1411(c)(1)

A marketplace must submit the information provided by an applicant under ACA § 1411(b) to HHS for verification in accordance with the requirements of ACA §§ 1411(c) and (d).

ACA § 1411(d)

In the case of information provided under ACA § 1411(b) that is not required under ACA § 1411(c) to be submitted to another person for verification, HHS must verify the accuracy of such information in such manner as HHS determines appropriate, including delegating responsibility for verification to the marketplace.

Insurance Affordability Programs

ACA § 1411(c)(3)

For determination of eligibility for the premium tax credit and cost-sharing reductions, HHS must submit household income and family size information to IRS for verification.

Social Security Number

45 CFR § 155.315(b)

For any applicant who provides his or her Social Security number to the marketplace, the marketplace must transmit the Social Security number and other identifying information to HHS, which will submit it to SSA.

If the marketplace is unable to validate an applicant's Social Security number through SSA or SSA indicates that the applicant is deceased, the marketplace "must follow the procedures specified in paragraph (f) of this section, except that the [marketplace] must provide the applicant with a period of 90 days from the date on which the notice described in paragraph (f)(2)(i) of this section is received for the applicant to provide satisfactory documentary evidence or resolve the inconsistency" with SSA. The date on which the notice is received means 5 days after the date on the notice, unless the applicant demonstrates that he or she did not receive the notice within the 5-day period.

Citizenship, Status as a National, or Lawful Presence

ACA § 1411(c)(2)

For citizenship, HHS must submit to SSA the following information for a determination as to whether the information provided is consistent with the information in the records of SSA: name, date of birth, and Social Security number of each individual covered by the QHP and the attestation of an applicant that he or she is a U.S. citizen.

If an applicant attests that he or she is (1) an alien lawfully present in the United States or (2) a citizen, but SSA notifies HHS that the attestation to citizenship is inconsistent with information in the records maintained by SSA, HHS must submit to DHS the following information: name, date of birth, and any identifying information with respect to the applicant's immigration status; attestation that the applicant is an alien lawfully present in the United States; or attestation that the applicant is a citizen. DHS then determines whether the information provided is consistent with the information in the records of DHS.

45 CFR § 155.315(c)

The marketplace must verify an applicant's citizenship, status as a national, or lawful presence with records from SSA. For an applicant who attests to citizenship and has a Social Security

number, the marketplace must transmit the applicant's Social Security number and other identifying information to HHS, which will submit it to SSA.

For an applicant who has documentation that can be verified through DHS and who attests to lawful presence, or who attests to citizenship and for whom the marketplace cannot substantiate a claim of citizenship through SSA, the marketplace must transmit information from the applicant's documentation and other identifying information to HHS, which will submit necessary information to DHS for verification.

For an applicant who attests to citizenship, status as a national, or lawful presence and for whom the marketplace cannot verify such attestation through SSA or DHS, the marketplace "must follow the procedures specified in paragraph (f) of this section, except that the [marketplace] must provide the applicant with a period of 90 days from the date on which the notice described in paragraph (f)(2)(i) of this section is received for the applicant to provide satisfactory documentary evidence or resolve the inconsistency" with SSA or DHS, as applicable. The date on which the notice is received means 5 days after the date on the notice, unless the applicant demonstrates that he or she did not receive the notice within the 5-day period.

Incarceration Status

ACA § 1312(f)(1)(B)

An individual must not be treated as a qualified individual if, at the time of enrollment, the individual is incarcerated, other than incarceration pending the disposition of charges.

45 CFR § 155.315(e)

The marketplace must verify an applicant's attestation, which is made subject to penalty of perjury and other penalties under § 1411(h) of the ACA that he or she is not incarcerated by:

(1) Relying on any electronic data sources that are available to the [marketplace] and which have been approved by HHS for this purpose, based on evidence showing that such data sources are sufficiently current, accurate, and offer less administrative complexity than paper verification; or

(2) Except as provided in paragraph (e)(3) of this section, if an approved data source is unavailable, accepting his or her attestation without further verification.

(3) To the extent that an applicant's attestation is not reasonably compatible with information from approved data sources described in paragraph (e)(1) of this section or other information provided by the applicant or in the records of the [marketplace], the [marketplace] must follow the procedures specified in § 155.315(f).

Residency

45 CFR § 155.315(d)

The marketplace must verify an applicant's attestation that he or she meets the standards of § 155.305(a)(3) as follows:

- (1) Except as provided in paragraphs (d)(3) and (4) of this section, accept his or her attestation without further verification; or
- (2) Examine electronic data sources that are available to the [marketplace] and which have been approved by HHS for this purpose, based on evidence showing that such data sources are sufficiently current and accurate, and minimize administrative costs and burdens.
- (3) If information provided by an applicant regarding residency is not reasonably compatible with other information provided by the individual or in the records of the [marketplace] the [marketplace] must examine information in data sources that are available to the [marketplace] and which have been approved by HHS for this purpose, based on evidence showing that such data sources are sufficiently current and accurate.
- (4) If the information in such data sources is not reasonably compatible with the information provided by the applicant, the [marketplace] must follow the procedures specified in paragraph (f) of this section. Evidence of immigration status may not be used to determine that an applicant is not a resident of the [marketplace] service area.

Indian Attestation

45 CFR § 155.350(c)

To the extent that an applicant attests that he or she is an Indian, the marketplace must verify such attestation by:

- (1) Utilizing any relevant documentation verified in accordance with § 155.315(f);
- (2) Relying on any electronic data sources that are available to the [marketplace] and which have been approved by HHS for this purpose, based on evidence showing that such data sources are sufficiently accurate and offer less administrative complexity than paper verification; or
- (3) To the extent that approved data sources are unavailable, an individual is not represented in available data sources, or data sources are not reasonably compatible with an applicant's attestation, the [marketplace] must follow the

procedures specified in § 155.315(f) and verify documentation provided by the applicant in accordance with the standards for acceptable documentation provided in section 1903(x)(3)(B)(v) of the Social Security Act.

Family Size

ACA §§ 1411(c)(1) and (3)

The marketplace must verify family size information submitted by applicants with information from IRS.

45 CFR § 155.320(c)(3)(i)

(A) The [marketplace] must require an applicant to attest to the individuals that comprise a tax filer's family for advance payments of the premium tax credit and cost-sharing reductions.

(B) To the extent that the applicant attests that the information described in paragraph (c)(1)(i) of this section represents an accurate projection of a tax filer's family size for the benefit year for which coverage is requested, the [marketplace] must determine the tax filer's eligibility for advance payments of the premium tax credit and cost-sharing reductions based on the family size data in paragraph (c)(1)(i) of this section.

(C) To the extent that the data described in paragraph (c)(1)(i) of this section is unavailable, or an applicant attests that a change in circumstances has occurred or is reasonably expected to occur, and so it does not represent an accurate projection of a tax filer's family size for the benefit year for which coverage is requested, the [marketplace] must verify the tax filer's family size for advance payments of the premium tax credit and cost-sharing reductions by accepting an applicant's attestation without further verification, except as specified in paragraph (c)(3)(i)(D) of this section.

(D) If the [marketplace] finds that an applicant's attestation of a tax filer's family size is not reasonably compatible with other information provided by the application filer for the family or in the records of the [marketplace], with the exception of the data described in paragraph (c)(1)(i) of this section, the [marketplace] must utilize data obtained through other electronic data sources to verify the attestation. If such data sources are unavailable or information in such data sources is not reasonably compatible with the applicant's attestation, the [marketplace] must request additional documentation to support the attestation within the procedures specified in § 155.315(f).

Annual Household Income

45 CFR § 155.320(c)(1)(i)

For all individuals whose income is counted in calculating a tax filer's household income, or an applicant's household income and for whom the marketplace has a Social Security number, the marketplace must request tax return data from IRS regarding modified adjusted gross income and family size and data regarding Social Security benefits from SSA.

45 CFR § 155.320(c)(3)(ii)

(A) The [marketplace] must compute annual household income for the family described in paragraph (c)(3)(i)(A) of this section based on the data described in paragraph (c)(1)(i) of this section.

(B) The [marketplace] must require the applicant to attest regarding a tax filer's projected annual household income.

(C) To the extent that the applicant's attestation indicates that the information described in (c)(3)(ii)(A) of this section represents an accurate projection of the tax filer's household income for the benefit year for which coverage is requested, the [marketplace] must determine the tax filer's eligibility for advance payments of the premium tax credit and cost-sharing reductions based on the household income data in paragraph (c)(3)(ii)(A) of this section.

(D) To the extent that the data described in paragraph (c)(1)(i) of this section is unavailable, or an applicant attests that a change in circumstances has occurred or is reasonably expected to occur, and so it does not represent an accurate projection of the tax filer's household income for the benefit year for which coverage is requested, the [marketplace] must require the applicant to attest to the tax filer's projected household income for the benefit year for which coverage is requested.

Minimum Essential Coverage Through Employer-Sponsored Insurance

ACA § 1411(b)(4)

The marketplace must verify whether an applicant is eligible for employer-sponsored coverage for the purposes of determining eligibility for advance premium tax credits and cost-sharing reductions. The applicant is required to provide the name, address, and employer identification number (if available) of the employer; whether the applicant is a full-time employee and whether the employer provides minimum essential coverage; if the employer provides minimum essential coverage, the lowest cost option for the applicant or the applicant's required contribution under the employer-sponsored plan; and if the applicant claims an employer's minimum essential coverage is unaffordable, information regarding income and family size.

45 CFR § 155.320(d)

The marketplace must verify whether an applicant reasonably expects to be enrolled in an eligible employer-sponsored plan or is eligible for qualifying coverage in an eligible employer-sponsored plan for the benefit year for which coverage is requested.

The marketplace must:

- (i) Obtain data about enrollment in and eligibility for an eligible employer-sponsored plan from any electronic data sources that are available to the [marketplace] and which have been approved by HHS, based on evidence showing that such data sources are sufficiently current, accurate, and minimize administrative burden.
- (ii) Obtain any available data regarding enrollment in employer-sponsored coverage or eligibility for qualifying coverage in an eligible employer-sponsored plan based on federal employment by transmitting identifying information specified by HHS to HHS for HHS to provide the necessary verification using data obtained by HHS.
- (iii) Obtain any available data from the SHOP that corresponds to the State in which the [marketplace] is operating.

Minimum Essential Coverage Through Non-Employer-Sponsored Insurance

45 CFR § 155.320(b)(1)

- (i) The [marketplace] must verify whether an applicant is eligible for minimum essential coverage other than through an eligible employer-sponsored plan, Medicaid, CHIP, or the [Basic Health Program], using information obtained by transmitting identifying information specified by HHS to HHS for verification purposes.
- (ii) The [marketplace] must verify whether an applicant has already been determined eligible for coverage through Medicaid, CHIP, or the [Basic Health Program], if a [Basic Health Program] is operating in the service area of the [marketplace], within the State or States in which the [marketplace] operates using information obtained from the agencies administering such programs.

Resolution of Inconsistencies in Eligibility Data

ACA § 1411(e)

If the information provided by an applicant is inconsistent with information in the records maintained by the Federal agencies that the marketplaces must verify applicant information with,

HHS must notify the marketplace, and the marketplace must make a reasonable effort to identify and address the causes of such inconsistency.

In the case the inconsistency or inability to verify is not resolved, the marketplace must notify the applicant of such fact and provide the applicant an opportunity to either present satisfactory documentary evidence or resolve the inconsistency during the 90-day period beginning on the date on which the notice is sent to the applicant. HHS may extend the 90-day period for enrollments occurring during CY 2014 (except for citizenship and immigration status).

45 CFR § 155.315(f)

For an applicant for whom the marketplace cannot verify information required to determine eligibility for enrollment in a QHP, the advance premium tax credit, and cost-sharing reductions, the marketplace:

- must make a reasonable effort to identify and address the causes of such inconsistency, including through typographical or other clerical errors, by contacting the applicant to confirm the accuracy of the information submitted;
- must provide notice to the applicant regarding the inconsistency and provide the applicant with a period of 90 days from the date when the notice is sent to the applicant to present satisfactory documentary evidence to the marketplace, if the marketplace is unable to resolve the inconsistency through reasonable efforts; and
- may extend the 90-day period for an applicant if the applicant demonstrates that a good-faith effort has been made to obtain the required documentation during the period.

During the 90-day inconsistency period, a marketplace must:

- proceed with all other elements of eligibility determination using the applicant's attestation and provide eligibility for enrollment in a QHP to the extent that an applicant is otherwise qualified and
- ensure that advance payments of the premium tax credit and cost-sharing reductions are provided on behalf of an applicant within this period who is otherwise qualified for such payments and reductions, as described in § 155.305, if the tax filer attests to the marketplace that he or she understands that any advance payments of the premium tax credit paid on his or her behalf are subject to reconciliation.

If, after a 90-day inconsistency period, a marketplace remains unable to verify the attestation, a marketplace must determine the applicant's eligibility on the basis of the information available from the data sources, unless the applicant qualifies for the exception provided under paragraph (g) of § 155.315.

When electronic data to support the verifications for residency or minimum essential coverage other than through an eligible employer-sponsored plan is required but it is not reasonably

expected that data sources will be available within 1 day of the initial request to the data source, a marketplace must accept the applicant's attestation regarding the factor of eligibility for which the unavailable data source is relevant.

Redetermination of Eligibility

45 CFR § 155.330(a)

The marketplace must redetermine the eligibility of an enrollee in a QHP through the marketplace during the benefit year if it receives and verifies new information reported by an enrollee or identifies updated information through the data matching described in paragraph (d) of this section.

45 CFR § 155.330(b)

The marketplace must require an enrollee to report any change with respect to the eligibility standards specified in § 155.305 within 30 days of such change, except that the marketplace:

- must not require an enrollee who did not request an eligibility determination for insurance affordability programs to report changes that affect eligibility for those programs;
- may establish a reasonable threshold for changes in income, such that an enrollee who experiences a change in income that is below the threshold is not required to report such a change; and
- must allow an enrollee to report changes via the channels available for the submission of an application, as described in § 155.405(c).

APPENDIX C: SEVEN STEPS IN THE APPLICATION AND ENROLLMENT PROCESS FOR A QUALIFIED HEALTH PLAN

Step 1: Applicant Provides Basic Personal Information

The applicant provides basic personal information, such as name, birth date, and Social Security number.

Step 2: Marketplace Verifies Identity of Applicant

Before an applicant can submit an online or phone application, the marketplace must verify the applicant's identity through identity proofing. The purpose of identity proofing is to prevent an unauthorized individual from creating a marketplace account for another individual and applying for health coverage without the individual's knowledge and to safeguard personally identifiable information created, collected, and used by the marketplace. Before an applicant can create an online account and complete an application, the marketplace's Web site lists questions and asks the applicant to answer them to verify his or her identity. For an applicant applying by phone, marketplace staff complete an online application on behalf of the applicant; a staff member asks questions based on public records about the individual and selects the answers the applicant chooses.⁷⁴

For the Federal marketplace, CMS uses a contractor to perform identity-proofing services and makes these services available to State marketplaces. The contractor verifies the identity of the applicant using a process that is similar to the one it uses to verify the identities of consumers performing certain online commercial transactions.

Step 3: Applicant Completes the Application

The applicant completes the application by providing information such as citizenship or immigration status. If applying for insurance affordability programs, the applicant provides additional information, such as family size and household income. For a paper application, a marketplace's staff or contractor manually enters the information into the eligibility or enrollment system.

Step 4: Marketplace Determines Eligibility of the Applicant for a Qualified Health Plan and, When Applicable, Eligibility for Insurance Affordability Programs

On the basis of the information provided on the application and obtained from electronic data sources, such as IRS, the marketplace determines the applicant's eligibility to enroll in the selected QHP and eligibility for insurance affordability programs in accordance with Federal requirements. The marketplace verifies these items through multiple electronic data sources, including sources available through the Data Hub.

⁷⁴ CMS's Identity Proofing Guidance. For paper applications, the marketplace accepts the applicant's written or electronic signature under the penalty of perjury. An individual who submits a paper application must complete identity verification steps to access application and QHP information electronically.

Steps 5, 6, and 7: Marketplace Transmits Enrollment Information to the Qualified Health Plan Issuer, Applicant Finalizes Enrollment by Submitting Payment, and Marketplace Reconciles Enrollment Information

If the applicant is determined to be eligible to enroll in a QHP, the marketplace is required to transmit the enrollment information to the QHP issuer for the QHP that the applicant selected (45 CFR § 155.400). This information includes applicant information, the plan selection, and financial assistance information, if applicable. The applicant must submit his or her premium payment to finalize the enrollment and obtain health coverage. The marketplace is also required to reconcile enrollment information with the QHP issuer each month.

APPENDIX D: OVERVIEW OF INTERNAL CONTROLS

INTERNAL CONTROLS IN THE GOVERNMENT⁷⁵

Internal controls are an integral component of an organization's management that provides reasonable, not absolute, assurance that the following objectives of an agency are being achieved: (1) effectiveness and efficiency of operations, (2) reliability of financial reporting, and (3) compliance with applicable laws and regulations.

Internal controls are composed of the plans, policies, methods, and procedures used to meet the organization's mission, goals, and objectives. They include the processes and procedures for planning, organizing, directing, and controlling program operations and management's system for measuring, reporting, and monitoring program performance.

A deficiency in an internal control exists when the design, implementation, or operation of a control does not allow management or personnel, in the normal course of performing their assigned functions, to achieve control objectives and address related risks.

FIVE COMPONENTS OF INTERNAL CONTROL⁷⁶

Internal control consists of five interrelated components:

- **Control Environment:** The set of standards, processes, and structures that provide the basis for carrying out internal control across the organization. The control environment includes factors such as the organizational structure, assignment of authority and responsibilities, and ethical value.
- **Risk Assessment:** The process for identifying and assessing risks to achieve objectives, which is a basis for determining how the risks should be managed.
- **Control Activities:** The actions established through policies and procedures that help ensure management's directives to mitigate risks to the achievement of objectives are carried out. These activities include authorizations and approvals, verifications, and reconciliations.
- **Information and Communication:** Management uses relevant and quality information to support functioning of other internal control components. Communication is the process of providing, sharing, and obtaining necessary information.
- **Monitoring:** Ongoing or separate evaluations or both to ascertain whether the components are present and functioning.

⁷⁵ Government Accountability Office's *Standards for Internal Control in the Federal Government: 1999 and Government Auditing Standards: 2011 Revision*.

⁷⁶ Committee of Sponsoring Organizations of the Treadway Commission: *Internal Control – Integrated Framework*, Executive Summary (May 2013).

APPENDIX E: AUDIT SCOPE AND METHODOLOGY

SCOPE

In response to the reporting requirement in the Continuing Appropriations Act, 2014, we reviewed the internal controls that were in place at the Federal, California, and Connecticut marketplaces from October to December 2013. We limited our review to those internal controls related to (1) verifying identity of applicants, (2) determining applicants' eligibility for enrollment in QHPs and eligibility for insurance affordability programs, and (3) maintaining and updating eligibility and enrollment data. These internal controls at each marketplace were not necessarily the same. In our review, we focused on control activities, which is one of the five components of internal controls as described in Appendix D.

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

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

Our attribute sampling approach is commonly used to test the effectiveness of internal controls for compliance with laws, regulations, and policies. According to the Government Accountability Office and President's Council on Integrity and Efficiency's⁷⁷ *Financial Audit Manual* (July 2008), section 450, auditors may use a randomly selected sample of 45 items to perform a compliance review. If all sample items are determined to be in compliance with requirements, a conclusion that the controls are effective can be made. If one or more sample items are determined not to be in compliance with requirements, a conclusion that the controls are ineffective can be made. We tested the controls at each marketplace separately. Our sampling methodology was limited to forming an opinion about whether the internal controls at each marketplace were effective and was not designed to estimate the percentage of applicants for whom each marketplace did not perform the required eligibility verifications.

For the 45 sample applicants for each marketplace, we reviewed supporting documentation to evaluate whether the marketplace determined eligibility in accordance with Federal requirements. During our fieldwork, questions arose concerning OIG's access under the Internal Revenue Code to Federal taxpayer information that IRS provides to marketplaces. We sought authorization from IRS to access that information. Because the request was still pending when we had completed our data collection, we did not review supporting documentation for certain eligibility requirements, such as annual household income and family size, for the purpose of this

⁷⁷ The President's Council on Integrity and Efficiency is now called the Council of the Inspectors General on Integrity and Efficiency (Inspector General Act § 11).

report. As a result, we could not evaluate whether each marketplace determined the 45 sample applicants' eligibility for advance premium tax credits and cost-sharing reductions according to Federal requirements.⁷⁸

After our data collection period, IRS determined that OIG could receive Federal taxpayer information maintained by the Federal marketplace under section 6103(l)(21)(C) of the Internal Revenue Code for purposes of this report. OIG is consulting with IRS to determine our access to Federal taxpayer information for additional work and planning that work accordingly.

Further, we did not determine whether information submitted by the 45 sample applicants at each marketplace was inaccurate or fraudulent because we could not independently verify the accuracy of data stored at other Federal agencies, e.g., IRS and SSA. Instead, we focused our review on determining the effectiveness of internal controls for processing that data and addressing inconsistencies in eligibility data when identified by the marketplace. This review meets the mandate because internal controls are a type of safeguard or procedure that may prevent the use of inaccurate or fraudulent information submitted by applicants who are enrolling in QHPs. We also did not determine whether the 45 sample applicants at each marketplace were properly determined eligible for enrollment in QHPs or for insurance affordability programs.

Because the open enrollment period ended after December 31, 2013, marketplaces may have received new information, which could have changed applicants' eligibility for enrollment in QHPs and, when applicable, eligibility for insurance affordability programs. We did not review the marketplaces' redeterminations of applicants' eligibility that resulted from verifications of information provided by applicants after December 31, 2013.

Our review of internal controls, which included reviewing 45 sample applicants and performing other audit procedures, would not necessarily have detected all internal control deficiencies because internal controls provide only reasonable assurance that each marketplace complied with Federal requirements.

We performed fieldwork from November 2013 to May 2014 at the CMS offices in Bethesda and Baltimore, Maryland; at the Covered California office in Sacramento, California; and at the Access Health CT office in Hartford, Connecticut. We also performed fieldwork at selected marketplace contractor offices in various locations.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State laws, regulations, and guidance;

⁷⁸ We were able to evaluate the Connecticut marketplace's specific internal controls related to determining applicants' eligibility for advance premium tax credits and cost-sharing reductions according to Federal requirements by performing other audit procedures. The marketplace provided us with additional data that enabled us to evaluate the controls. The additional data did not contain Federal taxpayer information.

- reviewed the Secretary of HHS’s report on the eligibility verifications for advance premium tax credits and cost-sharing reductions (submitted to Congress on December 31, 2013);
- assessed internal controls by:
 - interviewing officials from CMS, Covered California, and Access Health CT and their contractors and reviewing documentation provided by them to understand how the marketplaces (1) verify the identity of applicants, (2) verify information submitted on enrollment applications and make eligibility determinations, and (3) maintain and update eligibility and enrollment data;
 - observing marketplace staff performing tasks related to eligibility determinations at the three marketplaces; and
 - reviewing documents and records at the three marketplaces;
- obtained enrollment records from the Federal, California, and Connecticut marketplaces for applicants for enrollment in a QHP with coverage effective January 1, 2014, representing:
 - 1,112,411 applicants (Federal marketplace),
 - 453,401 applicants (California marketplace), and
 - 34,095 applicants (Connecticut marketplace);
- analyzed the enrollment records to obtain an understanding of information that was sent to QHP issuers;
- performed tests, such as matching records to the marketplaces’ eligibility or enrollment systems, to determine whether the enrollment data were reliable;
- performed testing of internal controls used by the Federal, California, and Connecticut marketplaces for eligibility determinations by:
 - randomly selecting 45 applicants who enrolled in a QHP effective January 1, 2014, at each marketplace using the OIG, Office of Audit Services, statistical software and
 - obtaining and reviewing eligibility data for each sample applicant to determine whether the marketplace performed the required eligibility verification and determination according to Federal requirements; and

- discussed the results of our review with CMS, Covered California, and Access Health CT officials.

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

APPENDIX F: RESULTS OF TESTING OF CONTROLS FOR 45 SAMPLE APPLICANTS AT EACH MARKETPLACE FOR THE REQUIRED ELIGIBILITY VERIFICATIONS

Table 3 shows the number of sample applicants for whom the marketplaces did not perform the required eligibility verifications.

Table 3: Number of Sample Applicants for Whom Required Verifications Were Not Performed According to Federal Requirements

Required Eligibility Verification	Number of Sample Applicants		
	Federal Marketplace	California Marketplace	Connecticut Marketplace
Social Security number	1	0	0
Citizenship	0	7	0
Status as a national	0	0	0
Lawful presence	0	1	0
Incarceration status	0	0	0
Residency	Accepted attestation ⁷⁹	Accepted attestation	Accepted attestation
Indian	Not reviewed ⁸⁰	0	0
Family size	Not tested ⁸¹	Not tested	Not tested
Annual household income	Not tested	Not tested	Not tested
Minimum essential coverage through employer-sponsored insurance	Not reviewed	0	0
Minimum essential coverage through non-employer-sponsored insurance	Not reviewed	0	7
NOTE			
The table does not include the number of sample applicants for whom the eligibility data showed an inconsistency that was not resolved.			

⁷⁹ The three marketplaces accepted self-attestation in accordance with Federal requirements.

⁸⁰ “Not reviewed” indicates that data were not available to OIG for the required eligibility verifications during our review.

⁸¹ “Not tested” indicates that we were unable to test the required eligibility verifications because we did not have access to Federal taxpayer information during our fieldwork.

APPENDIX G: CMS COMMENTS



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

Date: May 27, 2014

To: Gloria L. Jarmon
Deputy Inspector General for Audit Services

From: Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services

Subject: OIG Draft Report: *Not All Internal Controls Implemented by the Federal, California, and Connecticut Marketplaces Were Effective in Ensuring that Individuals Were Enrolled in Qualified Health Plans According to Federal Requirements (A-09-14-01000)*

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of the Inspector General (OIG) draft report. CMS is committed to verifying the eligibility of consumers who apply for enrollment in qualified health plans (QHPs) through the Marketplace or for insurance affordability programs. As part of that effort, and as noted in the OIG's draft report, CMS has implemented several internal controls to prevent the use of inaccurate or fraudulent information when determining eligibility of applicants for enrollment or for insurance affordability programs. To date, there has been no evidence of an applicant defrauding the federally-facilitated Marketplace (FFM) or a state-based Marketplace (SBM) in order to unlawfully enroll in a QHP or take advantage of an insurance affordability program for which the applicant is not eligible. Additionally, CMS notes that none of the OIG's findings in this draft report showed that the FFM inappropriately determined eligibility for enrollment in a QHP or for insurance affordability programs.

Besides the internal controls examined by the OIG in this report, CMS and its federal partners have implemented other mechanisms to verify an applicant's eligibility both on the front-end and the back-end of the enrollment process. On the front-end, CMS verifies the FFM applicant's eligibility data through multiple electronic data sources in accordance with Federal requirements. SBMs are responsible for verifying their own applicants, using data available from the Hub and any other data sources available to them as approved by the Secretary. The FFM has successfully processed tens of millions of pieces of data through this process.

On the back-end, CMS works to expeditiously resolve inconsistencies between eligibility information provided by application filers and the data obtained through the electronic data sources to ensure that applicants receive the proper eligibility determination for participation in a QHP through the Marketplace or for insurance affordability programs. It is important to note that an inconsistency between eligibility information provided by an application filer and that

1

contained in electronic data sources does not mean that the eligibility information attested to by the application filer is incorrect or that the applicant is ineligible.

Additionally, at the end of the tax year, every tax filer, on whose behalf advance payments of the premium tax credits (APTC) were paid, must file a federal income tax return and claim the Premium Tax Credit. The Internal Revenue Service (IRS), through the tax filing process, will reconcile the difference between the APTC paid to the QHP issuer on the tax filer's behalf and the actual amount of the premium tax credit that the tax filer was entitled to claim for the enrollee. Through these layered controls, CMS ensures that the provision of APTC meets federal eligibility requirements on the front-end, while IRS works to ensure that requirements are met on the back-end.

OIG Recommendation

The OIG recommends that CMS should ensure that it performs identity proofing of all applicants.

CMS Response

CMS concurs with this recommendation, and will continue to ensure that it performs identity proofing on all applicable FFM applicants (for example, we do not identity proof paper applications). However, CMS does not believe this recommendation needs to be included in the report. CMS maintains that it identity proofed the 45 sample applicants, and has provided OIG with additional supporting documentation showing that the applicants were identity proofed.

CMS's robust identity proofing process is a key piece of our comprehensive privacy and security framework that protects sensitive federal and state data. Identity verification is used to provide assurance that application filers are who they say they are for purposes of applying for enrollment in a QHP through the Marketplace and for insurance affordability programs, and for obtaining and using eligibility data from third-party data sources. It is important to note that identity proofing is distinct from the eligibility verification process for determining eligibility for enrollment in a QHP through the Marketplace or for insurance affordability programs.

OIG Recommendation

The OIG recommends that CMS should ensure that Social Security numbers, when provided by applicants, are validated through the Social Security Administration.

CMS Response

CMS concurs with this recommendation and will work to ensure that Social Security Numbers (SSNs), when provided by applicants, are validated through the Social Security Administration (SSA).

As noted in the draft report, although the SSN was not validated through the SSA in one selected case for an FFM applicant, this does not necessarily mean that the Marketplace improperly determined eligibility for enrollment in a QHP through the Marketplace or for insurance affordability programs. The Marketplace application asks application filers to provide an applicant's SSN as a tool for verifying eligibility data, such as citizenship or lawful presence, and income, against the electronic data sources.

An applicant's SSN is used to verify citizenship status with the SSA and, if applicable, lawful presence with the Department of Homeland Security (DHS). With respect to citizenship, if the attestation of an applicant's citizenship cannot be verified by SSA or DHS using the applicant's SSN, then an inconsistency is generated. When an inconsistency regarding citizenship is generated, the applicant must provide the Marketplace with appropriate documentation, or otherwise resolve the inconsistency, such as by contacting SSA to correct that agency's records.

For applicants for APTC and Cost-Sharing Reduction (CSR), the SSN is also used to verify income, by comparing the eligibility information provided by the application filer to data contained in the records of the IRS for the most recent taxable year on file and in the records of the SSA. In instances where income cannot be verified through the use of IRS and SSA data (either because the data does not match or because it was not available), then the FFM checks current income sources (CMS has a contract with Equifax Workforce Solutions to provide current wage data, as reported to Equifax by employers). An inconsistency is then generated if the income cannot be verified through the use of current income data sources.

OIG Recommendation

The OIG recommends that CMS fully develop system functionality to resolve all inconsistencies in eligibility data.

CMS Response

CMS concurs with this recommendation. CMS is working to expeditiously resolve inconsistencies between eligibility information provided by application filers and the data obtained through the electronic data sources to ensure that applicants receive proper eligibility determinations for enrollment in a QHP through the Marketplace and for insurance affordability programs.

As the OIG report noted, during the time of the OIG's review, the FFM was able to resolve inconsistencies related to SSNs, non-employer sponsored minimum essential coverage, incarceration status, and whether the applicant is a member of a federally recognized tribe or a shareholder of an Alaska Native Corporation. The FFM continues to resolve inconsistencies within these categories, and has found that, so far, the vast majority of the cases have been reconciled positively by verifying the eligibility information provided by the application filer with the supporting documentation provided through the inconsistency process. This aligns with the requirement that application filers must attest, under penalty of perjury, that they are not providing untrue, false, or fraudulent information as part of the application for coverage.

Additionally, since the drafting of this report, the FFM now has in place an interim manual process that allows it to reconcile inconsistencies in the remaining categories, which are citizenship, status as a U.S. national, lawful presence, income, and employer-sponsored minimum essential coverage. Of course, this depends on having the appropriate supporting documents submitted by the consumer. Now that open enrollment is over, CMS has prioritized the development and implementation of full automated functionality. CMS plans to replace the interim manual process for clearing these inconsistencies categories with the automated functionality later this summer. CMS expects to have a similar experience as the seven SBMs

that reported that, with full automated functionality, they resolved inconsistencies without unnecessary delay and that the inconsistency process ran smoothly with minimal problems. The automated functionality for the FFM to resolve inconsistencies was deprioritized during the initial open enrollment period in order to focus resources necessary in that limited window for consumer enrollment.

The FFM continues to resolve inconsistencies every day, and CMS is working with consumers to encourage them to provide the supporting documentation needed to resolve their inconsistencies. Most applicants with inconsistencies are still within the standard 90-day window to send the FFM supporting documentation to resolve their inconsistencies. Additionally, the Affordable Care Act allows the Secretary to extend the 90-day inconsistency period for applications for coverage for 2014.

OIG Recommendation

The OIG recommends that CMS ensure that the system functionality is fully developed to allow enrollees to report life changes affecting eligibility for QHPs and, when applicable, eligibility for insurance affordability programs

CMS Response

CMS concurs with this recommendation, but does not believe this recommendation needs to be included in the report. CMS has already implemented the system functionality to allow enrollees to report life changes affecting eligibility for enrollment in a QHP through the Marketplace or for insurance affordability programs, and has provided the OIG with additional supporting documentation showing that functionality. Additionally, the OIG could visit HealthCare.gov to view the tool that allows an enrollee to report a change in income or household status that affects eligibility for income affordability programs. Including this recommendation in this report could confuse the public about what tools are available. CMS is willing to work with the OIG to demonstrate this functionality, if necessary.

OIG Recommendation

The OIG recommends that CMS redetermine, if necessary, the eligibility of the sample applicants for whom we determined that verifications were not performed according to Federal requirements.

CMS Response

CMS concurs with this recommendation. The only FFM sample applicant whom the OIG singled out was the applicant whose SSN and attestation of citizenship was not successfully verified against SSA records. This did not impact the veracity of the applicant's eligibility determination. The Marketplace application asks application filers to provide an applicant's SSN only as a tool for verifying eligibility data, such as citizenship or lawful presence, and income, against the electronic data sources.

CMS examined the application in question. The applicant is in an inconsistency period for both citizenship and income. Accordingly, for this applicant, CMS will follow the process for resolving inconsistencies, which will result in a final eligibility determination that will take into account whether the applicant sufficiently establishes the relevant eligibility criteria.

OIG Recommendation

The OIG recommends the CMS work with Covered California and Access Health CT to implement the OIG's recommendations, which address deficiencies identified at the California and Connecticut Marketplaces.

CMS Response

CMS concurs with this recommendation. SBMs are required to comply with all applicable legal requirements related to eligibility and enrollment. CMS will continue to monitor SBMs through technical assistance and financial assessments. CMS will work with the California and Connecticut Marketplaces to address the deficiencies identified in this draft OIG report.

CMS is currently monitoring Connecticut's compliance for identity proofing requirements and eligibility determination requirements. The identity proofing issue in Connecticut impacts only those application filers completing an application through the call center who do not subsequently access the application online. Connecticut officials have reported to CMS that this lack of system functionality is being addressed. Additionally, Connecticut has informed CMS that it has implemented system corrections for the eligibility issues identified in the draft OIG report, and has contacted any affected applicants to correct their eligibility determinations. Connecticut will continue to identify and resolve system errors and plans to develop a Quality Assurance Program for its eligibility processes.

CMS is currently monitoring California's compliance for identity proofing requirements. Although California did not implement the Federal Remote Identity Proofing Solution to conduct online identity proofing, California did perform identity proofing of application filers via electronic signature under penalty of perjury, in-person proof of identity, or recorded attestation of consumer's identity for phone applications, as a contingency for plan year 2014. California officials have committed to implementing the Federal Remote Identity Proofing Solution for plan year 2015.

OIG Noted Issues Outside the Scope of the Review

The OIG noted that the Federal, California, and Connecticut Marketplaces verify residency by accepting applicants' attestation of residency and family size.

CMS Response

CMS does not believe that this needs to be a noted issue. The FFM and state-based Marketplaces follow the federal requirements regarding verifying an applicant's attestation of residency and family size. There are not comprehensive, national electronic data sources for residency verification or for family size available to the FFM.

OIG Noted Issues Outside the Scope of the Review

The OIG noted that documentation was not provided by the Federal Marketplace to support that required monthly reconciliations for Qualified Health Plans were performed.

CMS Response

As CMS has said, the automated payment and reporting system between issuers and CMS is not complete or fully tested. CMS has an interim process for paying issuers that are owed Marketplace financial assistance in the form of APTC or CSR payments. Under this interim process, issuers who are owed payments submit initial, aggregate information on a monthly basis in order to receive Marketplace financial assistance payments. This data includes preliminary total effectuated enrollments, enrollees receiving Marketplace financial assistance, and the estimated amount owed to the issuer, all of which are subject to change and unconfirmed by CMS. On a monthly basis, CMS compares the effectuated enrollment counts submitted by the issuers to the enrollment counts generated from the FFM for individual market medical issuers. These data and payments will be further reconciled once the automated payment and reporting system is in place.

APPENDIX H: COVERED CALIFORNIA COMMENTS



May 29, 2014

Lori A. Ahlstrand
Office of Inspector General
Office of Audit Services, Region IX
90 – 7th Street, Suite 3-650
San Francisco, CA 94103

Re: Report A-09-14-01000 – Audit of ACA Enrollment Safeguards Mandate

Dear Ms. Ahlstrand:

Covered California has reviewed the U.S. Department of Health and Human Services, Office of Inspector General (OIG) draft report titled Not All Internal Controls Implemented by the [redacted] California, [redacted] Marketplaces Were Effective in Ensuring That Individuals Were Enrolled in Qualified Health Plans According to Federal Requirements dated May 14, 2014.

In responding to the OIG's draft report, we note the OIG's findings are based on an attribute sample of 45 enrollments for the 1.4 million who enrolled through Covered California. Further, this sample was taken very early in the first open enrollment period and improvements have been ongoing to ensure program integrity. In addition, every procedure that Covered California has implemented was reviewed and approved by the Centers for Medicare and Medicaid Services (CMS), during regular and ongoing Design Review Evidence and Criteria for Assessments (Design Reviews). Systems and processes have been, and continue to be refined and improved.

Covered California's IT systems and operational processes are designed to ensure all eligible consumers receive coverage through Covered California's Exchange. Covered California's IT system (CalHEERS) and operational processes are large and complex and ongoing refinements are part of our process of continuous improvement. Throughout the first open enrollment process and into the special enrollment period, Covered California closely monitored and conducted oversight of existing early stage activities, staff development training and internal policies and procedures. While Covered California does not entirely agree with the OIG findings, we appreciate OIG's offer to submit comments to the report. Comments are submitted for each finding and recommendation.

Sincerely,

Peter V. Lee
Executive Director

Attachment: OIG Audit #A-09-14-01000 – ACA Enrollment Safeguards Mandate

COVERED CALIFORNIASM

1501 EXPOSITION BOULEVARD, SACRAMENTO, CA 95815

WWW.COVEREDCA.COM

BOARD MEMBERS: Diana S. Drake, DBCU, Kathleen Bunker, Paul Perez, Susan Kennedy, Robert Ross, MD, EXEC DIRECTOR: Peter V. Lee

Covered California Comments on
Office of Inspector General
Audit of Affordable Care Act Enrollment Safeguards Mandate

May 28, 2014

Per the Office of Inspector General (OIG) request for comments, Covered California respectfully submits the following:

Covered California's IT systems and operational processes are designed to ensure all eligible consumers receive coverage through Covered California's Exchange. Covered California's IT system (CalHEERS) and operational processes are large and complex and ongoing refinements are part of our process of continuous improvement. Throughout the first open enrollment process and into the special enrollment period, Covered California closely monitored and conducted oversight of existing early stage activities, staff development training and internal policies and procedures.

The OIG's findings are based on an attribute sample of 45 enrollments for the 1.4 million who enrolled through Covered California. Further, the sample was taken very early in the first open enrollment period. Every business process and system procedure that Covered California implemented was reviewed and approved by the Centers for Medicare and Medicaid Services (CMS), via ongoing and numerous Design Reviews. Systems and processes have been, and continue to be, refined and improved. In particular, process and system refinements occurred during the early months of the open enrollment period, and improvements, are ongoing.

Covered California offers the following comments for each the six findings and eight recommendations.

Office of Inspector General Findings:

OIG Finding 1: Identity proofing of applicants was not always performed.

Covered California does not concur with this finding.

Covered California has utilized a federally approved identity proofing process since the opening of the Exchange on October 1, 2013. Covered California plans to

implement a remote identity proofing (RIDP) third party service, and will do so prior to November 15, 2014 (open enrollment).

Marketplaces must establish and implement operational, technical, administrative, and physical safeguards to ensure the confidentiality, integrity, and availability of personally identifiable information that they create, collect, use, or disclose and to ensure that personally identifiable information is used by or disclosed to only those authorized to receive or view it, per 45 CFR 155.260 (a)(4). At the same time, under the CFR, Exchanges have an obligation to confirm the identity of all applicants (identify proofing). Beginning in January 2013, Covered California engaged in extensive dialogue with CMS regarding appropriate identity proofing processes.

In June 2013, CMS provided Identify Proofing Guidance indicating that Exchanges would use a third party RIDP. Covered California discussed the guidance with CMS, as the policy designed and prepared to be implemented by California already met identity proofing regulations. With CMS approval, Covered California implemented the following identify proofing process for the first open enrollment period, which includes in-person and remote identity proofing:

- a. Paper: The consumer provides a signature attesting to his/her identify under penalty of perjury.
- b. Online: The consumer provides an electronic signature attesting to his/her identity under penalty of perjury.
- c. In-Person: In-person enrollment assistance personnel must verify applicant's identities.
- d. Phone: The consumer provides a recorded verbal attestation that the consumer is who he/she says he/she is under penalty of perjury.

CMS authorized Covered California to implement RIDP in 2014 after the close of the initial open enrollment.

OIG Finding 2: Information from paper applications was not always entered correctly into enrollment system.

Covered California concurs with this finding in that all data entry is subject to key-data error.

During the sample period, Covered California had fully trained all data-entry staff on protocols for data entry, and provided job aids to promote process accuracy.

Covered California had a Quality Assurance/Quality Control (QA/QC) processes in place that included sampling, oversight, tracking and trending and continually updated job aids for several operational areas, but not in the area of data entry for paper applications. Covered California is adding a similar QA/QC process specific to the paper application process. Covered California continues to improve its QA/QC processes to ensure information is as accurately entered for paper applications as possible.

OIG Finding 3: Citizenship was not always verified through the Department of Homeland Security.

Covered California does not concur with this finding.

CMS approved Covered California's citizenship verification process during the Design Reviews. Specifically, in Covered California's verification plan, we use the Social Security Administration data to electronically verify a consumer's U.S. citizenship attestation for eligibility. During the early months of open enrollment, the Federal Services Data Hub (data hub) was frequently offline, which impacted Covered California's ability to verify some cases as noted in the audit. However, Covered California's verification process supports consumers that cannot be verified through the data hub in that they can self-attest, under penalty of perjury, as to being a U.S. citizen, a national or lawfully present. In these instances, they are considered conditionally eligible to enroll under the 90-day reasonable opportunity period.

CalHEERS now has the capability to discern when the data hub is offline and accepts an attestation in lieu of immediate verification through the data hub. In these instances, CalHEERS captures this group of consumers and automatically re-runs verifications through the data hub when the data hub is back online, usually the next day. If it's discovered that a consumer did not meet eligibility criteria, the consumer receives a CalHEERS generated notice with contact and resolution options.

OIG Finding 4: Lawful presence was not always verified through the Department of Homeland Security.

Covered California consistently verifies lawful presence with the Department of Homeland Security (DHS). One out of the 45 sampled applicants' verification of lawful presence was not apparent in the data field of the record due to some form of technical error. In this particular case, where the result was not stored in the record, Covered California is conducting an analysis to determine if this technical error

resulted in any cases of lawful presence not being verified. Until that analysis is complete, Covered California cannot concur or disagree with the finding.

OIG Finding 5: Inconsistencies in eligibility data were not always resolved.

Covered California concurs with this finding in that Covered California relies on consumers' attestation, under penalty of perjury, to conduct eligibility determinations, and at the time of the audit Covered California had not completed all verifications subject to review. In the event the attested information cannot be electronically verified through Federal and/or state electronic data resources, the consumers are given 90 days to provide paper source documents to demonstrate eligibility.

The processing/review of consumers' supporting documentation is the point at which a determination is made as to whether or not the consumer legitimately meets eligibility standards. If the consumer demonstrates eligibility, he/she remains enrolled. If, the documentation submitted does not support eligibility, the consumer does not qualify and would enter the disenrollment process, which includes reimbursement of any Federal subsidies they may have received.

Covered California has a high volume of pending paper verifications that must be linked to the individual's case number. Staff is diligently working to conduct that reconciliation during the 90-day reasonable opportunity period and in some cases that review is extending past 90 days. However, Covered California won't begin the disenrollment process until all of the associated documents can be sorted, reviewed and processed according to business procedures.

OIG Finding 6: Eligibility data were not always properly maintained.

Covered California concurs that some internal data tables within CalHEERS were inconsistent with each other.

While various data elements displayed inconsistently, Covered California does not believe the inconsistencies within the internal tables degrade the accuracy of the eligibility process and/or outcomes.

During the early open enrollment period, five flaws were discovered within the CalHEERS system relating to how data is stored in different data tables. Four of those defects were resolved in March and April 2014 and the remaining flaw is on schedule for resolution in early June. The repair of these five system defects will resolve data discrepancies. To the extent the data flaws would potentially impact

eligibility, Covered California would conduct another eligibility determination for impacted enrollments.

OIG RECOMMENDATIONS for COVERED CALIFORNIA

Covered California was responsible for quickly designing a very large and complex IT system and operational processes in which we anticipated ongoing refinements would be needed and planned accordingly. Throughout the open enrollment process and into the special enrollment period, Covered California closely monitored and conducted oversight of existing early stage QA/QC activities, staff development training and internal policies and procedures. Covered California recognizes that all the aforementioned activities would need ongoing refinement as Covered California became fully operational.

OIG's recommendations mirror Covered California's expected quality improvements with the system rollout.

OIG Recommendation 1: Develop and implement a procedure to ensure that it performs identity proofing of all applicants.

Covered California has utilized a federally approved identity proofing process since the opening of the Exchange. Covered California plans to implement a remote identity proofing third party service (RIDP), and will do so prior to November 15, 2014 (open enrollment).

OIG Recommendation 2: Implement a procedure to ensure that all information from applicants' paper applications is correctly entered into CalHEERS.

Covered California continues to refine training and procedures, and will be bolstering its QA/QC process for all staff involved in the data-entry of paper applications to improve accuracy.

OIG Recommendation 3: Design a process to verify applicants' citizenship through DHS when required by Federal regulations.

Covered California continues to use the data hub and remains in compliance with Federal guidance.

OIG Recommendation 4: Ensure that applicants' lawful presence is verified through DHS.

Covered California consistently verifies lawful presence with DHS. Covered California is still researching a single anomalous case identified in the audit to determine the type and source of the apparent technical error.

OIG Recommendation 5: Ensure that it resolves all inconsistencies in eligibility data.

Due to the high volume of pending paper verifications that must be linked to the individual's case number, Covered California is diligently working to process the volume of paper documents submitted during the 90-day reasonable opportunity period. Covered California won't begin the disenrollment process until all of the associated documents can be sorted, reviewed and process according to business procedures.

OIG Recommendation 6: Ensure that it maintains documentation to support the resolution of inconsistencies.

In so far as this recommendation relates to the finding regarding Covered California's processes for confirming eligibility information that is submitted to validate consumer's self-attestation, Covered California agrees and has processes in place to support its ultimate decisions.

OIG Recommendation 7: Correct the system defects in CalHEERS to ensure that eligibility data are complete, accurate, and up to date.

As stated earlier in the response to OIG Finding #6, the four system defects have already been resolved and the remaining flaw is on schedule for resolution in early June (subsequent to the deadline for comments).

OIG Recommendation 8: Covered California re-determine, if necessary, the eligibility of the sample applicants for whom we determined that verifications were not performed according to Federal requirements.

To the extent any data flaws would potentially impact eligibility, Covered California would conduct another eligibility determination for enrollments.

APPENDIX I: ACCESS HEALTH CT COMMENTS



Connecticut's Health Insurance Marketplace

June 2, 2014

Lori A. Ahlstrand
Regional Inspector General for Audit Services
Office of Audit Services, Region IX
90 – 7th Street
Suite 3-650
San Francisco, CA 94103

RE: Draft Report Number: A-09-14-01000, "Not all internal controls implemented by the . . . Connecticut Marketplaces were effective in ensuring that individuals were enrolled in Qualified Health Plans according to Federal requirements"

Dear Ms. Ahlstrand:

This letter provides Connecticut's response to your May 2014 draft report # A-09-14-01000, as referenced above. I wish to thank you and your staff for the thorough eligibility and enrollment review completed on Access Health CT, Connecticut's state based marketplace. The work by you and your staff validated eligibility and enrollment issues we had already addressed or had already identified and were addressing. Further, we appreciated your identification of one additional finding we had not yet encountered. The examination and analysis continues in the post open enrollment period and we remain vigilant in resolving issues as they are identified.

Because of the ongoing work of Access Health CT personnel, mitigating actions are undertaken to address any issues identified until a system enhancement is implemented or a business process is developed. The responses to OIG recommendations and findings that follow reflect mitigating actions and/or resolution of issues, as appropriate. Overall, Access Health CT concurs with 3 of the 5 recommendations OIG has made for Connecticut in this report, and has provided rationales for the remaining 2 non concurrences which are explained in the attached responses.

However, given our examination and analysis process, we believe that these efforts ensured all individuals enrolled in a Qualified Health Plan in Connecticut by Access Health CT were done so in accordance with Federal requirements.

Please direct any questions regarding this report to Mr. Steve Sigal, Chief Financial Officer for AHCT. He can be reached at (860)757-5314 or steven.sigal@ct.gov. Thank you again for your assistance and support.

Sincerely,

/Kevin J. Counihan/
Chief Executive Officer
Access Health CT

280 Trumbull Street, 15th Floor
Hartford, CT 06103
(P) 860-757-5302 (F) 860-757-5330

Finding 1: AHCT Did Not Always Perform Identity Proofing of Phone Applicants

Condition:

Identity proofing helps to ensure the privacy of personal information and prevents an unauthorized individual from initiating an online application.

For one of the three sample applicants who applied by phone within our sample of 45, AHCT did not perform identity proofing. The applicant completed an application by phone to enroll in a QHP and never accessed their application through AccessHealthCT.com. Although AHCT performed identity proofing of applicants who applied for QHPs using AccessHealthCT.com, it did not do so for applicants who applied by phone through the call center. However, if a phone applicant later accessed his or her application through AccessHealthCT.com, the marketplace performed identity proofing at that time.

Criteria:

Marketplaces must establish and implement operational, technical, administrative, and physical safeguards to ensure the confidentiality, integrity, and availability of personally identifiable information that they create, collect, use, or disclose and to ensure that personally identifiable information is used by or disclosed to only those authorized to receive or view it (45 CFR § 155.260(a)(4)).

According to CMS's Guidance Regarding Identity Proofing for the Marketplace, Medicaid, and CHIP, and the Disclosure of Certain Data Obtained through the Data Services Hub, dated June 11, 2013, before a marketplace accepts an online or telephone application for enrollment in a QHP, it must conduct identity proofing sufficient to provide assurance that only the appropriate individual has access to restricted data. The guidance explains that identity proofing involves the (1) collection of core attributes, including the applicant's name, birth date, Social Security number (optional), address, phone number, and email address; (2) validation of core attributes with a trusted data source; and (3) for some applicants, collection and validation of responses to questions about the applicant's personal history, e.g., the names of current and past employers. CMS allows States to use Federal identity-proofing services.

Effect:

AHCT's internal controls were not effective in ensuring that applicants who applied by phone were enrolled identity proofed according to Federal requirements.

OIG Recommendation:

Develop and implement a procedure to ensure that it performs identity proofing of phone applicants.

AHCT Response:

AHCT does not concur with the Effect or OIG Recommendation that internal controls were not effective, and as a result, also does not concur with the finding. A new phone applicant's identity is validated by the data hub once the application has been submitted but before it's transferred to the carrier. Any discrepancies require paper verification, which are generated automatically through the eligibility system (these include identity, as well as citizenship, income, immigration status etc.) and are mailed to the client within 24 hours. This verification process (45 CFR § 155.315(f)(4)) acts as a mitigating control. If a consumer calls back after an initial application, identity

AHCT Response to Report # A-09-14-01000 Recommendations

questions are asked by call center representatives to confirm that they should be granted access to the account. As a further control, additional data sources at the Connecticut Department of Labor are going to be available prior to the next open enrollment period to validate identity for applicants that seek to participate in an affordability program.

Finding 2: AHCT Did Not Verify Citizenship through the Department of Homeland (DHS) Security When Social Security Administration (SSA) Information Was Inconsistent with Application Information

Condition:

AHCT did not always verify applicants' citizenship through DHS when SSA could not verify citizenship. Without verifying citizenship in this manner, a marketplace may place an applicant in an inconsistency period even though the applicant may be a U.S. citizen.

For 1 of 42 sample applicants who attested that they were U.S. citizens, AHCT did not verify citizenship through DHS when the SSA system indicated that the applicant was not a U.S. citizen. AHCT placed the applicant in an inconsistency period when it should have verified citizenship through DHS according to Federal requirements. AHCT provided satisfactory documentation submitted by the applicant during the inconsistency period indicating that the applicant was a U.S. citizen.

Criteria:

Marketplaces must verify an applicant's citizenship through SSA. If SSA cannot verify an applicant's citizenship, the marketplace must verify citizenship through DHS. If the marketplace cannot verify citizenship through DHS, the marketplace must make a reasonable effort to identify and address the causes of the inconsistency. If it is unable to resolve the inconsistency, the marketplace must notify the applicant and generally provide the applicant with 90 days to present satisfactory documentary evidence of citizenship (ACA § 1411(c)(2) and 45 CFR § 155.315(c)(3)). During the inconsistency period, an applicant who is otherwise qualified is provided conditional eligibility to enroll in a QHP and for insurance affordability programs (45 CFR § 155.315(f)(4)).

Effect:

AHCT's internal controls were not effective in ensuring that applicants who could not be verified as citizens by SSA were first verified by DHS prior to placing the applicant in an inconsistency period. Without verifying citizenship in this manner, AHCT may place applicants in an inconsistency period unnecessarily creating system and process inefficiencies.

OIG Recommendation:

Design a process to verify applicants' citizenship through the DHS when required by Federal regulations

AHCT Response:

AHCT does not concur with the OIG finding. AHCT does have a process and has consistently employed that process to verify applicants' naturalized citizenship status through the Department of Homeland Security (DHS). However, DHS is unable to verify US citizenship when the citizen is US born not naturalized. Since this information is not

AHCT Response to Report # A-09-14-01000 Recommendations

available in their database, AHCT can only verify "legally present" and "naturalized citizenship" through DHS. Since the DHS database cannot verify US born citizens, AHCT could not use both the SSA and DHS in the scenario outlined by the OIG finding. Additionally, the 90 day inconsistency period (45 CFR § 155.315(f)(4)) acts as a mitigating control to allow an applicant to verify their information. The 1 exception noted in the finding was verified through the paper verification process in accordance with federal regulations.

Finding 3: AHCT Improperly Determined Applicants Who Were Medicaid-Eligible or Did Not Select Silver-Level Health Plans To Be Eligible for Insurance Affordability Programs

Condition:

AHCT determined applicants to be eligible for insurance affordability programs when they were not eligible. They were not eligible because they were Medicaid-eligible or had not selected a silver-level QHP.

AHCT improperly determined Medicaid-eligible applicants to be eligible for advance premium tax credits and applicants who did not select silver-level QHPs to be eligible for cost-sharing reductions. Of the 34,095 applicants whose eligibility information was transmitted to QHP issuers, 223 Medicaid-eligible applicants who selected QHPs instead of Medicaid were determined eligible for advance premium tax credits, and 619 applicants who did not select silver-level QHPs were determined eligible for cost-sharing reductions.

Criteria:

An applicant eligible for non-employer-sponsored insurance, including Medicaid, is not eligible for the advance premium tax credit (45 CFR §§ 155.20 and 155.305 and 26 U.S.C. § 5000A(f)). Further, an applicant requesting cost-sharing reductions must select a silver-level QHP (ACA § 1402(b)(1) and 45 CFR § 155.305(g)(1)(ii)).

Effect:

AHCT's internal controls were not effective in ensuring that Medicaid-eligible applicants were not determined to be eligible for advance premium tax credits and applicants who did not select silver-level QHPs were not determined to be eligible for cost-sharing reductions.

OIG Recommendation:

Ensure the exchange corrects the system programming errors related to applicants' eligibility for advance premium tax credits and cost sharing reductions.

AHCT Response:

AHCT concurs with the OIG recommendation. Soon after open enrollment began, AHCT determined that the enrollment system was determining some applicants eligible for both APTCs and Medicaid when application changes were made after it was submitted. This system issue was corrected on December 21, 2013. With respect to cost sharing reductions being given to individuals who had not selected a silver plan, this issue was brought to light as a result of the audit. After reviewing the issue it was determined that consumers were not impacted, since the data was not coded by the carriers to accept CSR's on catastrophic plans. Controls have since been put in place to ensure that only eligible applicants receive CSRs on the 834. Additional controls include periodic reviews of transactions, and updated testing scripts to review rates. Since the go-live testing did not discover this issue with the existing test scripts, revised APTC and CSR test scripts have been added to regression testing.

Finding 4: AHCT Did Not Always Store Eligibility Verification Data Confirming Ineligibility for Non-Employer-Sponsored Insurance

Condition:

AHCT did not always properly maintain applicants' eligibility data. If a marketplace does not maintain all eligibility data, it cannot sufficiently demonstrate that applicants are eligible for enrollment in QHPs and, when applicable, eligible for insurance affordability programs.

For 7 of the 31 sample applicants who applied for financial assistance through insurance affordability programs, AHCT could not provide eligibility verification data confirming that the applicants were ineligible for minimum essential coverage through non employer-sponsored insurance. However, AHCT performed the verification and demonstrated that it successfully received verification data through the Data Hub.

Criteria:

Marketplaces must maintain and ensure that their contractors, subcontractors, and agents maintain for 10 years documents and records that are sufficient to enable HHS or its designees to evaluate the marketplaces' compliance with Federal standards (45 CFR § 155.1210(a)). The records must include data and records related to the marketplaces' eligibility verifications and determinations and enrollment transactions (45 CFR § 155.1210(b)(4)).

Effect:

AHCT's internal controls were not effective in ensuring it maintains all eligibility data to sufficiently demonstrate that applicants are eligible for enrollment in QHPs and, when applicable, eligible for insurance affordability programs.

OIG Recommendation:

Ensure that the exchange corrected a system defect related to maintaining eligibility verification data for minimum essential coverage through non-employer-sponsored insurance.

AHCT Response:

AHCT concurs with the OIG recommendation and a system enhancement was put into production on April 11, 2014. Although earlier testing resulted in exceptions, as stated above, AHCT demonstrated that all verification data was successfully received. This was only an issue because of a lack of maintaining the data for these few samples after eligibility was determined. Internal quality review procedures are being developed to allow AHCT the ability to provide more assurance that data is being maintained per federal regulations. These quality review procedures include periodic sampling, additional system testing, and enhanced training sessions for our data analysts.

OIG Recommendation:

Re-determine, if necessary, the eligibility of sample applicants that OIG determined were not performed according

to Federal requirements.

AHCT Response:

AHCT concurs with the OIG recommendation and completed necessary redeterminations.

Other issues outside the OIG audit scope:

Other Issue 1: Residency Was Verified by the Marketplaces Only by Accepting Applicants' Attestation of Residency

Condition:

The marketplaces accepted the applicants' attestation of residency without further verification in accordance with Federal requirements.

Criteria:

A marketplace must verify an applicant's attestation regarding residency by accepting the attestation without further verification or by examining data sources that are available to the marketplace and that have been approved by HHS for this purpose. However, if information that the applicant provides regarding residency is not reasonably compatible with other information provided by the applicant or in the records of the marketplace, the marketplace must examine information in data sources that are available to the marketplace and that have been approved by HHS for this purpose. If the information in such data sources is not reasonably compatible with the information provided by the applicant, the marketplace must follow procedures for resolution of inconsistencies (45 CFR § 155.315(d)).

AHCT Response:

As of this date, HHS has not identified an approved source for the exchange marketplaces to verify residency. AHCT is committed to addressing this issue and is moving forward with enhancing our verification process by including the Connecticut Department of Labor as an additional data source for the next open enrollment period.

However, AHCT does confirm that an applicant's attested address is in fact a Connecticut address. An applicant who lists an address that is not a verified Connecticut address is not allowed to proceed further with the enrollment process.

Other Issue 2: Family Size Was Verified by the Marketplaces Only by Accepting Applicants' Attestation of Family Size

Condition:

According to marketplace officials, the marketplaces received IRS information on applicants' family sizes during the eligibility determination process. Although the marketplaces did not make IRS family-size data available to applicants or require them to attest that these data were accurate, the marketplaces accepted the applicants' attestation of family size in accordance with Federal requirements.

Criteria:

AHCT Response to Report # A-09-14-01000 Recommendations

A marketplace may verify an applicant's family size by accepting an applicant's attestation of a tax filer's family size for determining advance premium tax credits and cost-sharing reductions (45 CFR § 155.320(c)(3)(i)(A)). However, if the marketplace finds that an applicant's attestation of a tax filer's family size is not reasonably compatible with other information provided by the applicant or in the records of the marketplace; the marketplace must examine income data obtained through other electronic data sources to verify the attestation. If the information in such data sources is not reasonably compatible with the applicant's attestation, the marketplace must follow procedures for resolution of inconsistencies (45 CFR § 155.320(c)(3)(i)(D)).

AHCT Response:

IRS data for dependent determination may not be accurate as of the time of enrollment with respect to determining an applicant's household size. An applicant is required to submit identifying information, such as social security number or legally present identifying number, during the course of enrollment. Such information is validated through the Federal data services hub. When such applicant's attested information cannot be verified, AHCT follows the procedures for resolution of inconsistencies as stated in 45 CFR § 155.320(c)(3)(i)(D). If an applicant fails to correct such inconsistencies within the 90 day period, such persons not identified will be disenrolled from coverage.

Other Issue 3: Insurance Enrollment Information Not Provided to Insurance Carriers

Condition:

Of the 34,095 records that AHCT transmitted to health insurance carriers, 139 records for applicants who were determined eligible and selected a QHP were not forwarded to the appropriate health insurance carrier timely.

Criteria:

Marketplaces must send eligibility and enrollment information to QHP issuers and HHS "promptly and without undue delay" (45 CFR § 155.400(b)(1)).

Effect:

Eligible applicants receive coverage in a QHP after health insurance exchanges forward applicants' data to health insurance carriers. Delays in submitting applicants' data could lead to delays in insurance coverage or eligible applicant's not receiving coverage.

AHCT Response:

AHCT identified some production issues early in our operation which resulted in the need to correct data prior to transferring to the carriers. Filters were put in place to catch transactions prior to the transaction being sent incorrectly to the carriers so that AHCT staff could correct the information. The applicants impacted were then personally contacted by AHCT via an outbound call campaign (up to 3 subsequent calls per household). The AHCT call center representatives were able to reach 121 of those individuals with the application issue, and those successful enrollments were transmitted to the carriers via an 834 file at a later date. The remaining 18 applicants were not able to be contacted by AHCT after 3 repeated attempts, and were not enrolled by AHCT. As a result, 834 files containing the 18 applicants appropriately have not been sent to the carriers.

Other Issue 4: APTC Amount Exceeds Total Plan Premium

Condition:

Of the 34,095 records that AHCT transmitted to health insurance carriers, 8 records included applicants whose monthly APTC amounts were greater than their monthly insurance plan premiums.

Criteria:

26 CFR § 1.36B-3 - Computing the premium assistance credit amount

(d) Premium assistance amount. The premium assistance amount for a coverage month is the lesser of—

- (1) The premiums for the month for one or more qualified health plans in which a taxpayer or a member of the taxpayer's family enrolls; or
- (2) The excess of the adjusted monthly premium for the applicable benchmark plan over 1/12 of the product of a taxpayer's household income and the applicable percentage for the taxable year.

Effect:

Because the Federal government pays health insurance premium subsidies to health insurance carriers based on the APTC information supplied by State health insurance exchanges, APTC calculations in excess of allowable amounts could result in the Federal government overpaying premium subsidies.

AHCT Response:

Originally, 4 applicants were identified on December 9, 2013 with this specific issue. As a follow-up, a total of 8 applicants were identified with this specific issue, and all eight applications have been corrected. As a result of the problem, a system correction was immediately released that ensures that the APTC selected would always be less than the total premium on all applications going forward.

The 4 additional impacted records were identified by AHCT after a thorough review of the EDI report spreadsheet. The correction was made to the system, and the information was then shared with the applicable carrier to update their records. AHCT has implemented periodic reviews of sent transactions to ensure that the APTCs provided to enrollees are not greater than the premiums. Further, AHCT has introduced scenarios within the regression test suite to confirm that newly implemented system changes do not reintroduce this issue.