HEARING ON THE INTEGRITY OF THE AFFORDABLE CARE ACT'S PREMIUM TAX CREDIT

HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT

OF THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRTEENTH CONGRESS

SECOND SESSION

July 23, 2014

SERIAL 113–OS10

Printed for the use of the Committee on Ways and Means

U.S. GOVERNMENT PUBLISHING OFFICE
94–428 WASHINGTON : 2016

For sale by the Superintendent of Documents, U.S. Government Publishing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
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CONTENTS

HEARING ON THE INTEGRITY OF THE AFFORDABLE CARE ACT'S PREMIUM TAX CREDIT

WEDNESDAY, JULY 23, 2014

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, DC.

The subcommittee met, pursuant to call, at 10:30 a.m., in Room 1100, Longworth House Office Building, the Honorable Charles Boustany [chairman of the subcommittee] presiding.

[The advisory of the hearing follows:]

HEARING ADVISORY

Boustany Announces Hearing on the Integrity of the Affordable Care Act's Premium Tax Credit

1100 Longworth House Office Building at 10:30 AM
Washington, Jul 16, 2014

Congressman Charles Boustany, Jr. MD (R–LA), Chairman of the Committee on Ways and Means Subcommittee on Oversight, today announced that the Subcommittee will hold a hearing on the integrity of the administration of the Affordable Care Act's Premium Tax Credit. **The hearing will take place on Wednesday, July 23, 2014, in Room 1100 of the Longworth House Office Building, beginning at 10:30 A.M.**

The Government Accountability Office (GAO) will be the only witness at the hearing. In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

BACKGROUND:

The Affordable Care Act (ACA) created tax credits and cost sharing subsidies for certain individuals purchasing health insurance through insurance exchanges. To ensure that payments only benefit those eligible and are made in the correct amount, the Federal Government must verify a number of pieces of information, including, identity of the applicant, date of birth, Social Security Number, income, lawful presence in the country, and other data. As the Congressional Budget Office projects that the Federal Government will distribute over $1 trillion in subsidies over the next decade, it is critical that adequate measures are in place to protect taxpayers. The hearing will explore the integrity of the premium tax credit verification system, and whether it is vulnerable to fraud, waste, and abuse.

In announcing the hearing, Chairman Boustany said, "**In recent years this Subcommittee has examined fraud, waste, and abuse in the execution of existing programs, such as the Earned Income Tax Credit. We know that the Federal Government wastes tens of billions of dollars each year in improper payments—what we don't know is how much more will be wasted under ObamaCare's new federal subsidies. We look forward to hearing from GAO and examining what is happening now that the subsidies are going out the door."**

FOCUS OF THE HEARING:

The hearing will focus on the Federal Government's ability protect premium tax credits from fraud, waste, and abuse.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit written comments for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, *http://waysandmeans.house.gov*, select "Hearings." Select the hearing for which you would like to submit, and click on the link entitled, "Click here to provide a submission for the record." Once you have followed the online instructions, submit all requested information. ATTACH your submission as a Word document, in compliance with the formatting requirements listed below, **by the close of business on August 6, 2014**. Finally, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225–3625 or (202) 225–5522.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be provided in Word format and MUST NOT exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, telephone, and fax numbers of each witness.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Note: All Committee advisories and news releases are available on the World Wide Web at *http://www.waysandmeans.house.gov/*.

Chairman BOUSTANY. This hearing will come to order. Good morning and welcome to this morning's hearing on the integrity of insurance premium subsidies under the healthcare law.

Last month, this subcommittee and the Subcommittee on Health held a hearing that showed the administration's failure to implement effective eligibility verification systems would result in billions of the dollars in improper payments going out the door and unexpected tax debts for families across America.

This morning, we turn to the question of whether the Federal exchange has sufficient controls in place to verify income and identity verification, including Social Security numbers, names and other information. On September 12th of last year, Chairman Camp, Senators Tom Coburn, Orrin Hatch and I wrote to Comptroller General Gene Dodaro asking that the Government Accountability Office conduct testing to determine whether the administration had in place appropriate internal controls to prevent fraud and abuse in health insurance exchanges. We asked that they do this through the GAO's forensic audits and investigative service, a team of forensic audit and investigative professionals who conduct special investigations and fraud assessments.

To test these internal controls, GAO went undercover, created 18 fictitious identities to apply for insurance subsidies online, over the phone and in person. When GAO applied for premium subsidies online or over the phone with fictitious names, Social Security numbers and documents, it succeeded over 91 percent of the time. When GAO went to seek help from taxpayer-funded assisters, five teams out of six, they were turned away or unable to find help.

When GAO sent in fake documents to support their applications, Federal contractors accepted thos

When GAO sent in fake documents to support their applications, Federal contractors accepted thos
When GAO sent in fake documents to support their applications, Federal contractors accepted those documents. Sadly, this is not terribly surprising, but it is really disturbing.

Time and again the administration has chosen to either ignore the law, or when it does implement the law, it does so with a level of incompetence. The administration decided the employer mandate would harm its political and electoral interests, so it delayed the mandate. The administration found that the words of the law would prevent it from implementing Federal subsidies in a way it preferred, it ignored the law, and as the D.C. Circuit ruled yesterday, when the administration sought to implement Federal exchange—implement the Federal exchange and created healthcare.gov, the Web site crashed spectacularly. So when the administration began issuing billions of dollars in subsidies, we found that it did so without regard to protecting those taxpayer dollars from improper payments.

This is not simply a question of whether one likes the President's health law or the way this administration has gone about implementing it. The question really is whether the administration is being a good steward of taxpayer dollars and putting in place adequate controls to protect those dollars from fraud, waste and abuse. This is about whether these subsidies are actually going to those who really need them and who have—who qualify them—qualify for them appropriately. The history of the healthcare law's implementation suggests that the answer has been no.

Today we hear from Seto Bagdoyan, the acting director of the Forensic Audits and Investigative Service on GAO's preliminary findings in this matter. I want to thank him and GAO for this work.

And look forward to your testimony, Mr. Bagdoyan, and also look forward to continuing to work with you on this issue.

Now I would—I am very pleased to yield to the distinguished ranking member from Georgia, Mr. Lewis, for the purposes of an opening statement.

Mr. LEWIS. Thank you for holding today's hearing, Mr. Chairman. I would like also to thank our witness for being here today. Thank you for being here, sir.

Mr. BAGDOYAN. My pleasure.

Mr. LEWIS. Let me begin by highlighting a simple and an important fact. The Affordable Care Act works. Last week, multiple reports from Gallup, the Commonwealth Fund and the Urban Institute provided Congress with a truth that cannot be denied, explained away or disputed. Today more Americans have health insurance than they did 1 year ago.

Many of my colleagues on the other side of the aisle said that no one would sign up for the Affordable Care Act; instead, 8 million people enrolled. There were claims that part of the law were too expensive, but last month HHS reported the average cost was only $82 per month for those receiving tax credits.

Let me highlight some more indisputable ACA successes. Today, more than 17 million children with pre-existing conditions can no longer be denied coverage, 3.1 million adults can be covered on

their parents' plan until age 26, and 105 million Americans will no longer face bankruptcy because insurance companies will stop paying their medical bills. That is what the ACA did and we should be proud of this work.

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ing their medical bills. That is what the ACA did and we should be proud of this work.

Despite constant attack, the prediction of disaster has simply failed to come true. Instead, the door to healthcare has opened for millions of Americans.

Mr. Chairman, I would like to ask unanimous consent to insert two articles into the record. One is from Politico, entitled, "The Verdict is in: Obamacare Lowers Uninsured." The second is from the New York Times, entitled, "Obamacare Fails to Fail."

Thank you, Mr. Chairman.

Chairman BOUSTANY. Without objection, they will be entered into the record.

[The information follows: Rep. John Lewis 1, Rep. John Lewis 2]

The New York Times http://nyti.ms/1yepQR5

Obamacare Fails to Fail

JULY 13, 2014

Paul Krugman

How many Americans know how health reform is going? For that matter, how many people in the news media are following the positive developments?

I suspect that the answer to the first question is "Not many," while the answer to the second is "Possibly even fewer," for reasons I'll get to later. And if I'm right, it's a remarkable thing — an immense policy success is improving the lives of millions of Americans, but it's largely slipping under the radar.

How is that possible? Think relentless negativity without accountability. The Affordable Care Act has faced nonstop attacks from partisans and right-wing media, with mainstream news also tending to harp on the act's troubles. Many of the attacks have involved predictions of disaster, none of which have come true. But absence of disaster doesn't make a compelling headline, and the people who falsely predicted doom just keep coming back with dire new warnings.

Consider, in particular, the impact of Obamacare on the number of Americans without health insurance. The initial debacle of the federal website produced much glee on the right and many negative reports from the mainstream press as well; at the beginning of 2014, many reports confidently asserted that first-year enrollments would fall far short of White House projections.

Then came the remarkable late surge in enrollment. Did the pessimists

face tough questions about why they got it so wrong? Of course not. Instead, the same people just came out with a mix of conspiracy theories and new predictions of doom. The administration was "cooking the books," said Senator John Barrasso of Wyoming; people who signed up wouldn't actually pay their premiums, declared an array of "experts"; more people were losing insurance than gaining it, declared Senator Ted Cruz of Texas.

But the great majority of those who signed up did indeed pay up, and we now have multiple independent surveys — from Gallup, the Urban Institute and the Commonwealth Fund — all showing a sharp reduction in the number of uninsured Americans since last fall.

I've been seeing some claims on the right that the dramatic reduction in the number of uninsured was caused by economic recovery, not health reform (so now conservatives are praising the Obama economy?). But that's pretty lame, and also demonstrably wrong.

For one thing, the decline is too sharp to be explained by what is at best a modest improvement in the employment picture. For another, that Urban Institute survey shows a striking difference between the experience in states that expanded Medicaid — which are also, in general, states that have done their best to make health care reform work — and those that refused to let the federal government cover their poor. Sure enough, the decline in uninsured residents has been three times as large in Medicaid-expansion states as in Medicaid-expansion rejecters. It's not the economy; it's the policy, stupid.

What about the cost? Last year there were many claims about "rate shock" from soaring insurance premiums. But last month the Department of Health and Human Services reported that among those receiving federal subsidies — the great majority of those signing up — the average net premium was only $82 a month.

Yes, there are losers from Obamacare. If you're young, healthy, and affluent enough that you don't qualify for a subsidy (and don't get insurance from your employer), your premium probably did rise. And if you're rich enough to pay the extra taxes that finance those subsidies, you have taken a financial hit. But it's telling that even reform's opponents aren't trying to

highlight these stories. Instead, they keep looking for older, sicker, middle-class victims, and keep failing to find them.

Oh, and according to Commonwealth, the overwhelming majority of the newly insured, including 74 percent of Republicans, are satisfied with their coverage.

You might ask why, if health reform is going so well, it continues to poll badly. It's crucial, I'd argue, to realize that Obamacare, by design, by and large doesn't affect Americans who already have good insurance. As a result, many peoples' views are shaped by the mainly negative coverage in the news media. Still, the latest tracking survey from the Kaiser Family Foundation shows that a rising number of Americans are hearing about reform from family and friends, which means that they're starting to hear from the program's beneficiaries.

And as I suggested earlier, people in the media -- especially elite pundits -- may be the last to hear the good news, simply because they're in a socioeconomic bracket in which people generally have good coverage.

For the less fortunate, however, the Affordable Care Act has already made a big positive difference. The usual suspects will keep crying failure, but the truth is that health reform is -- gasp! -- working.

A version of this op-ed appears in print on July 14, 2014, on page A19 of the New York edition with the headline: Obamacare Fails to Fail.

POLITICO

The verdict is in: Obamacare lowers uninsured

By: David Nather
July 10, 2014 09:20 PM EDT

The evidence is piling up now: Obamacare really does seem to be helping the uninsured.

Survey after survey is showing that the number of uninsured people has been going down since the start of enrollment last fall. The numbers don't all match, and health care experts say they're not precise enough to give more than a general idea of the trend.

But by now, the trend is unmistakable: Millions of people who didn't have health insurance before the Affordable Care Act have gained it since last fall. The law is not just covering people who already had health coverage, but adding new people to the ranks of the insured — which was the point of the law all along.

(Also on POLITICO: Employer mandate at heart of GOP-Obama suit)

There's still a lot of variation in the numbers, too much for health care experts to pin down an exact number with any confidence. But even health care analysts who think the law is a bad idea acknowledge that the evidence suggests the uninsured are being helped. Given the predictions of doom that accompanied the law's passage and launch, that's a sweet bit of vindication for the president and ACA supporters.

"It will be better when we've got a whole year behind us, so we can tell how much [in the surveys] was noise and how much was reality," said Douglas Holtz-Eakin of the conservative American Action Forum, a frequent critic of the law. "Having said that, it sure looks like there are more people covered, and that's a good thing."

A survey by the Commonwealth Fund found that 9.5 million fewer adults are uninsured now than at the beginning of the Obamacare enrollment season. The Urban Institute's Health Reform Monitoring Survey found a similar drop, with 8 million adults gaining coverage. And Gallup-Healthways survey reported that the uninsured rate has fallen to 13.4 percent of adults, the lowest level since it began tracking health coverage in 2008.

(Also on POLITICO: Obama on impeachment: 'Really?')

That was all on Thursday. In recent months, other surveys in the Gallup series have consistently found the same downward trend, and a RAND survey in April estimated that the law extended health coverage to 9.3 million Americans.

That's not going to end the fights over the health care law — not even close. Republicans say the debate isn't just about whether the law has helped uninsured people, but about all the side effects, like canceled health plans, higher premiums for some people with individual health insurance, reduced work hours for part-time employees, and the

long-term costs to the nation.

Sen. Ted Cruz (R-Texas), who led the battle to defund the law last fall and could fight it again on the presidential campaign trail in 2016, insists the new surveys don't change the debate at all — because the real issue, in his view, is still the disruption of the canceled plans and higher premiums.

(Also on POLITICO: Rove to GOP: Work with Obama)

"Four years ago, before the law was implemented, it was possible to have good-faith disagreements about whether the law would work," Cruz told POLITICO on Thursday. "Today, seeing the utter disaster that has played out ... to me, it is the essence of pragmatism to realize that the law isn't working, and to repeal it and start over."

And even though the law's performance has stabilized since the clumsy rollout last fall, there are plenty of ways the side effects could still flare up again — through big premium increases for next year (they've been modest so far), another possible round of canceled plans and the potential for angry customers next year if they've received too much in subsidies and have to pay them back.

"The Republican argument was never that a trillion or two dollars would never cover any more uninsured. It was that the cost of doing so in higher health care costs and premiums, cancelled policies, increased government control of health care, and a myriad other negatives—were not worth it," said Republican pollster Whit Ayres." That argument still holds."

But the latest surveys have been a huge morale boost for the Obama administration and congressional Democrats, who now have armfuls of statistics to prove that the law is doing what it's supposed to do: help the uninsured.

"No matter whose estimates you look at, the facts about the Marketplace's first year are this: Millions of people have gained coverage because of the ACA, and millions more could if the remaining states did the right thing and expanded Medicaid," said an Obama administration official.

Adam Jentleson, a spokesman for Senate Majority Leader Harry Reid, declared that "Republicans have constructed an alternate reality in which the sky is always falling on Obamacare, but the facts tell a different story."

The new surveys have taken a lot of the uncertainty out of the Affordable Care Act's impact on the uninsured. Earlier this year, it appeared that it could be **months, if not years,** before Americans would answer the most basic questions about whether the law had actually covered uninsured people, thanks to the lag time in official government surveys and the vague wording of the questions in Obamacare applications.

Health care experts still want to see the official government surveys, but they say there are now enough unofficial surveys to prove that the law is reaching uninsured people. There are some people who are replacing old health coverage with new coverage, but it's now clear that millions of the law's customers didn't have health insurance before.

"One has to acknowledge that at this point, despite some continuing bumps in the road, the ACA is largely on track to accomplishing what it set out to do," said Larry Levitt of the Kaiser Family Foundation. "That, of course, doesn't mean that everyone is benefiting from

it or agrees with it. The law wasn't designed to create all winners and no losers."

Because of the variation in the surveys' numbers, "it could be a couple million more or less" than the Commonwealth estimates, Levitt said. And some of the reduction could be due to an improving economy, he added — but "the reductions we're seeing clearly swamp any effect from lower unemployment."

Still, Republicans aren't likely to give the Obama administration a lot of credit. Lately, they've been minimizing the significance of the big enrollment numbers by saying, hey, of course people are signing up — they'll have to pay fines under the individual mandate if they don't. "They made it illegal for it not to work. You have to be covered," Holtz-Eakin said.

But the Commonwealth Fund survey also suggested that most of the people who have signed up for the Affordable Care Act are happy with their coverage — and aren't just disgruntled people who were already insured and liked their own coverage better.

According to the survey, 58 percent of the Obamacare customers said they were better off under their new health coverage, and only 9 percent said they were worse off than they were before. Even among people who previously had health insurance — the ones who might resent having to switch — 52 percent liked the new coverage, while 16 percent said they were worse off.

Republicans on Capitol Hill, however, insisted they hear more from people who have had their own health insurance disrupted by the health care law -- not the ones who have gained coverage.

"The White House wants everyone to forget about the people who lost their insurance" because of canceled health plans, Cruz said. Even if most of those people have been able to replace it since then, he said, there are still many other Americans who have had their work hours reduced so their employers won't have to provide health coverage. And he predicted that "this fall, we're going to see premiums skyrocket again."

Sen. John Barrasso (R-Wyo.) dismissed the surveys, saying he is "hearing disproportionately from people who are unhappy with the way the law is affecting their own pocketbooks" — especially by "paying for more insurance than they need or want or will ever use."

The unspoken political reality is that Republican base voters aren't ready to let the GOP give up the fight, even if they wanted to. But there are also so many other issues in the fight — including the impact on other people's coverage and the cost of the law — that it was never likely to just go away, no matter how many uninsured people have been helped.

"I don't think it changes the debate, because the debate has so many dimensions," said Holtz-Eakin.

Mr. LEWIS. It is clear that it makes no sense to continue attacks to the fund and destroy the healthcare law. There should be no fear in a good faith, bipartisan effort to make the ACA stronger and better for future generations. This is why I look forward to the testimony of the GAO about ways to make commonsense improvements to the ACA. In fact, there are actions we can take right now to find and fight waste, fraud and abuse. For example, Congress can provide adequate funding for the IRS and HHS enforcement systems so that all taxpayers will be protected. We have an opportunity to be proactive and not rea

systems so that all taxpayers will be protected. We have an opportunity to be proactive and not rea
systems so that all taxpayers will be protected. We have an opportunity to be proactive and not reactive.

One thing is crystal clear, one thing is crystal clear: It is time for political stunts and baseless fear tactics to end. Success cannot and must not be dismantled. We will not go back to a time when Americans did not have access to affordable healthcare insurance. We will not destroy the ACA. I hope that all of my colleagues on both sides of the aisle will come together to strengthen and improve the historic benefits and protection of the ACA. It is time to move forward and do what is right, what is just, what is fair and what is responsible.

Again, thank you, Mr. Chairman, and I yield back my time.

Chairman BOUSTANY. Thank you, Mr. Lewis.

Chairman BOUSTANY. Now it is my pleasure to welcome our witness, Mr. Seto Bagdoyan, acting director of Forensic Audits and Investigative Services at the Government Accountability Office.

Thank you, sir. We really appreciate your time today. We appreciate the effort that you have put into this, along with your staff. The subcommittee has received your written statement. It will be made part of our formal hearing record. As is customary, you will have 5 minutes to give your oral remarks, and then we will open up for questions.

Sir, you may begin.

STATEMENT OF SETO BAGDOYAN, ACTING DIRECTOR, AUDIT SERVICES, FORENSIC AUDITS AND INVESTIGATIVE SERVICE, GOVERNMENT ACCOUNTABILITY OFFICE, WASHINGTON, D.C.

Mr. BAGDOYAN. Chairman Boustany, Ranking Member Lewis and Members of the Subcommittee, I am pleased to be here today to discuss at a high level preliminary observations from the undercover component of GAO's ongoing review of the Federal healthcare Marketplace to test its enrollment controls. This review is at the request of this subcommittee, as the chairman mentioned, and others in Congress.

In terms of preliminary results, Mr. Chairman, we used fictitious identities, false information and forged documents, as well as instructions from the Marketplace itself, to circumvent its front and back end controls.

Accordingly, we obtained actual coverage for which we are paying premiums, the government is paying premium tax credits on our behalf directly to insurers totaling about $2,500 a month, or about $30,000 a year.

At the outset, I would note that, one, observations are subject to change as we obtain and analyze additional information; two, enrollment test results can't be projected to the entire universe of applicants; and three, since our work is ongoing and involves the use of certain investigative techniques, I am precluded from discussing many details about this and future work in this setting.

That said, the results in the two main components of our undercover work are as follows: First, in 12 fictitious applications, which

were made by phone and online, we tested the Marketplace's front-end controls for verifying an applicant's identity or citizenship or immigration status. Marketplace applications require attestations that information provided is neit

immigration status. Marketplace applications require attestations that information provided is neit
immigration status. Marketplace applications require attestations that information provided is neither false nor untrue. The applications also stated income at a level to qualify for income-based subsidies to offset premium costs for tax credits and reduce expenses, such as co-pays.

For 11 of the 12 applications, we obtained subsidized coverage. For the 12th application, the Marketplace did not allow us to proceed, because the applicant declined to provide a Social Security number as part of our test.

In terms of back-end controls, the healthcare law requires the Marketplace to provide eligibility while any identified inconsistencies between information submitted by the applicant and what resides in government databases is being resolved through submission and verification of supplementary documentation. For each of the 11 approved applications, we were directed to submit supporting documents, such as proof of income or citizenship, but we found the document submission and review process to be inconsistent regarding similar applications. As of July of this year, we had received notification that some of the forged documentations submitted for two applicants had been verified, thus clearing the back-end controls for these three documents.

According to CMS and its document processing contractor, this contractor is not required to look for or detect fraud and accepts documents as authentic unless they are obvious alterations. We continue to receive subsidized coverage for all 11 successful applications, including those where we did not provide any of the requested supporting documents.

Second, in six other fictitious applications, we attempted to test the extent to which, if any, in-person assisters would encourage our applicants to misstate income in order to qualify for income-based subsidies. However, we were unable to obtain in-person assistance in five of six attempts. For example, one in-person assister said that he does not provide assistance—he provides assistance only after people already have an application in progress. The assister was not able to help us, because the healthcare.gov Web site was down at the time, and he did not respond to several follow-up phone calls. One in-person assister correctly advised the applicant that he—that the stated income would not qualify for subsidy.

Collectively, our undercover and audit work to date has highlighted key areas of inquiry about the Marketplace's controls, which we plan to pursue in depth during our remaining work.

Mr. Chairman, this concludes my remarks. I look forward to the subcommittee's questions.

Chairman BOUSTANY. Thank you, Mr. Bagdoyan.

[The prepared statement of Mr. Bagdoyan follows:]

United States Government Accountability Office

GAO

Testimony

Before the Subcommittee on Oversight, Committee on Ways and Means, House of Representatives

For Release on Delivery
Expected at 10:30 a.m. ET
Wednesday, July 23, 2014

PATIENT PROTECTION AND AFFORDABLE CARE ACT

Preliminary Results of Undercover Testing of Enrollment Controls for Health Care Coverage and Consumer Subsidies Provided Under the Act

Statement of Seto J. Bagdoyan, Acting Director,
Forensic Audits and Investigative Service

GAO Highlights

Highlights of GAO-14-705T, a testimony before the Subcommittee on Oversight, Committee on Ways and Means, House of Representatives

Why GAO Did This Study

PPACA provides for the establishment of health insurance exchanges, or marketplaces, where consumers can compare and select private health insurance plans. The act also expands the availability of subsidized health care coverage. The Congressional Budget Office estimates the net federal cost of coverage provisions at $36 billion for fiscal year 2014, with subsidies and related spending accounting for a large portion. PPACA requires marketplaces to verify application information to determine enrollment eligibility and, if applicable, eligibility for subsidies.

GAO was asked to examine issues related to controls for application and enrollment for coverage through the federal marketplace. This testimony discusses preliminary observations on (1) results of undercover testing in which we obtained health care coverage; (2) additional undercover testing, in which we sought to obtain consumer assistance with our applications; and (3) delays in the development of a system needed to analyze enrollment.

This statement is based on preliminary analysis from GAO's ongoing review for this subcommittee and other congressional requesters. GAO created fictitious identities to make applications through the federally facilitated exchange in several states by telephone, online, and in-person. The number and locations of the target areas are not disclosed because of ongoing testing. The results, while illustrative, cannot be generalized to the overall applicant or enrollment populations. GAO expects to issue a final report next year.

View GAO-14-705T. For more information, contact Seto Bagdoyan at (202) 512-6722 or bagdoyans@gao.gov.

July 2014

PATIENT PROTECTION AND AFFORDABLE CARE ACT

Preliminary Results of Undercover Testing of Enrollment Controls for Health Care Coverage and Consumer Subsidies Provided Under the Act

What GAO Found

Centers for Medicare & Medicaid Services (CMS) officials told us they have internal controls for health care coverage eligibility determinations. GAO's undercover testing addressed processes for identity- and income-verification, with preliminary results revealing questions as follows:

- For 12 applicant scenarios, GAO tested "front-end" controls for verifying an applicant's identity or citizenship/immigration status. Marketplace applications require attestations that information provided is neither false nor untrue. In its applications, GAO also stated income at a level to qualify for income-based subsidies to offset premium costs and reduce cost sharing. For 11 of these 12 applications, which were made by phone and online using fictitious identities, GAO obtained subsidized coverage. For one application, the marketplace denied coverage because GAO's fictitious applicant did not provide a Social Security number as part of the test.
- The Patient Protection and Affordable Care Act (PPACA) requires the marketplace to provide eligibility while identified inconsistencies between information provided by the applicant and by government sources are being resolved through submission of supplementary documentation from the applicant. For its 11 approved applications, GAO was directed to submit supporting documents, such as proof of income or citizenship; but, GAO found the document submission and review process to be inconsistent among these applications. As of July 2014, GAO had received notification that portions of the fake documentation sent for two enrollees had been verified. According to CMS, its document processing contractor is not required to authenticate documentation; the contractor told us it does not seek to detect fraud and accepts documents as authentic unless there are obvious alterations. As of July 2014, GAO continues to receive subsidized coverage for the 11 applications, including 3 applications where GAO did not provide any requested supporting documents.
- For 6 applicant scenarios, GAO sought to test the extent to which, if any, in-person assisters would encourage applicants to misstate income in order to qualify for income-based subsidies. However, GAO was unable to obtain in-person assistance in 5 of the 6 initial undercover attempts. For example, one in-person assister initially said that he provides assistance only after people already have an application in progress. The in-person assister was not able to assist us because HealthCare.gov website was down and did not respond to follow-up phone calls. One in-person assister correctly advised the GAO undercover investigator that the stated income would not qualify for subsidy.

A key factor in analyzing enrollment is to identify approved applicants who put their policies in force by paying premiums. However, CMS officials stated that they do not yet have the electronic capability to identify such enrollees. As a result, CMS must rely on health insurance issuers to self-report enrollment data used to determine how much CMS owes the issuers for the income-based subsidies. Work is underway to implement such a system, according to CMS, but the agency does not have a timeline for completing and deploying it. GAO is continuing to look at these issues and will consider recommendations to address them.

Chairman Boustany, Ranking Member Lewis, and Members of the Subcommittee:

I am pleased to be here today to discuss enrollment for health care coverage under the Patient Protection and Affordable Care Act (PPACA).[1] Among other things, the act provides subsidies to those eligible to purchase private health insurance plans, and with those subsidies and other costs, represents a significant, long-term fiscal commitment for the federal government. According to the Congressional Budget Office, the estimated net cost of coverage provisions to the federal government are $36 billion for fiscal year 2014 and $1.4 trillion for fiscal years 2015–2024, with subsidies and related spending accounting for a large portion of the total.[2] Because subsidy costs arising from the act are contingent on who obtains coverage, enrollment controls that help ensure only qualified applicants are approved for coverage or subsidies are a key factor in determining federal expenditures under the act.

PPACA, signed into law on March 23, 2010, provides for the establishment of health insurance exchanges, or marketplaces, to assist consumers in comparing and selecting among insurance plans offered by participating private issuers of health care coverage.[3] These marketplaces were intended to provide a single point of access for individuals to enroll in private health plans, apply for income-based subsidies to offset the cost of these plans—which are paid directly to health insurance issuers—and, as applicable, obtain an eligibility determination for other health coverage programs, such as Medicaid or the State Children's Health Insurance Program. The Department of Health and Human Services' (HHS) Centers for Medicare & Medicaid

[1]Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA), Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010). In this testimony, references to PPACA include any amendments made by HCERA. Future citations to PPACA will identify the applicable section of law without providing a full citation, as set forth here.

[2]Net costs are gross costs, including items such as income-based subsidies, minus revenue produced, such as through penalties paid by employers and uninsured people. See Congressional Budget Office, *Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act* (April 2014).

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

Services (CMS) is responsible for overseeing the establishment of these online marketplaces. CMS has worked with a variety of contractors to develop, test, and maintain the federally facilitated marketplace known to the public as HealthCare.gov. At the time we conducted the work described in this statement, CMS was operating HealthCare.gov, also known as the Health Insurance Marketplace (Marketplace), in 36 states.

To be eligible to enroll in a qualified health plan offered through a marketplace, an individual must be a U.S. citizen or national, or otherwise lawfully present in the United States; reside in the marketplace service area; and not be incarcerated (unless jailed while awaiting disposition of the charges). Marketplaces, in turn, are required by law to take several steps to verify application information to determine eligibility for enrollment and, if applicable, determine eligibility for the income-based subsidies.[4] These verification steps include validating an applicant's Social Security number, if one is provided;[5] verifying citizenship, status as a national, or lawful presence with the Social Security Administration (SSA) or the Department of Homeland Security; and verifying household income and family size against tax-return data from the Internal Revenue Service, as well as data on Social Security benefits from the SSA.[6]

My statement today is based on preliminary results and analysis from ongoing work we are conducting at the request of the subcommittee and others. Specifically, today's statement (1) assesses, by means of undercover testing in which we obtained health care coverage, the Marketplace application and enrollment processes, including opportunities for potential enrollment fraud, during the act's first open enrollment period, which ran from October 2013 to April 2014;[7] (2) describes additional undercover testing, in which we sought to obtain

[4]PPACA, § 1411(c), 124 Stat. at 226-227; 45 C.F.R. §§ 155.310, 155.315, 155.320.

[5]An exchange must require an applicant who has a Social Security number to provide the number. 45 C.F.R. § 155.310(a)(3)(i).

[6]For a fuller discussion of the act's provisions related to eligibility determinations for enrollment in coverage and related subsidies, see app. I.

[7]Fraud involves obtaining something of value through willful misrepresentation. Whether conduct is in fact fraudulent is a determination to be made through the judicial or other adjudicative system. See GAO, *Standards for Internal Control in the Federal Government, 2013 Exposure Draft*, GAO-13-830SP (Washington, D.C.: September 2013), 40.

consumer assistance with our applications; and (3) describes delays in the development of the system needed to analyze enrollment.

To perform our undercover testing of the Marketplace application and enrollment processes, we created 18 fictitious identities for the purpose of making applications for individual health care coverage by telephone, online, and in-person.[8] Because of the federal government's role in operating marketplaces in the 36 states, we targeted our work on the federal Marketplace. We selected several states within the federal Marketplace for our undercover applications, based on factors including population size, mixture of population living in rural versus urban areas, and number of people qualifying for income-based subsidies under the act. We further selected target areas within each state, based on factors including community size. Because our testing work is ongoing, we do not disclose here the number or locations of our target areas. We generally selected our states and target areas to reflect a range of characteristics. To maintain independence in our testing, we created our applicant scenarios without knowledge of specific control procedures that CMS or other federal agencies may use in accepting or processing applications. We thus did not create the scenarios with intent to focus on a particular control or procedure.[9] Because the number of fictitious applications we made was limited, and the applications do not reflect a sample of actual applications, the results of our testing, while illustrative, cannot be generalized to the overall applicant or enrollment population.

For 12 of the 18 applicant scenarios, we tested "front-end" controls for verifications related to the identity or citizenship/immigration status of the applicant.[10] We made half of these applications online and half by phone. In these tests, we also stated income at a level eligible to obtain both

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

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

[10]Among other things, these tests simulated "identity theft," where a person misuses the identity information of another. We distinguish between "front-end" controls, which are preventative in nature and seek to diminish the opportunity for fraudulent access into a system, and "back-end" controls, which occur after an applicant has entered a system. See GAO, *Individual Disaster Assistance Programs: Framework for Fraud Prevention, Detection, and Prosecution*, GAO-06-954T (Washington, D.C.: July 12, 2006).

types of income-based subsidies available under PPACA—a premium tax credit and cost-sharing reduction.[11] Our tests included fictitious applicants who provided invalid Social Security numbers, noncitizens claiming to be lawfully present in the United States, and applicants who did not provide Social Security numbers. As appropriate, in our applications for coverage and subsidies, we used publicly available information to construct our scenarios. We also used publicly available hardware, software, and materials to produce counterfeit documents, which we submitted, as appropriate for our testing, when instructed to do so. We then observed the outcomes of the document submissions, such as any approvals received or requests received to provide additional supporting documentation.

For the remaining 6 of our 18 applicant scenarios to examine enrollment in the Marketplace, we sought to test only income-verification controls. We randomly selected three "Navigator" and three non-Navigator in-person assisters in our target areas.[12] For half of these 6 applications, our applicant planned to state income slightly above the maximum amount allowable for income-based subsidies, while for the others, our applicant planned to state income slightly below the range eligible for these subsidies. We sought to test the extent to which, if at all, any of the in-person assisters would encourage applicants to misstate income in order to qualify for either of the individual PPACA subsidies.

For all three objectives, we also reviewed laws, regulations, and other policy and related information. In addition, we also interviewed CMS officials to obtain an understanding of the application data that CMS maintains and reports.

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

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

We are conducting our 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. We are conducting our related investigative work in accordance with investigative standards prescribed by the Council of the Inspectors General on Integrity and Efficiency.

We Obtained Coverage in 11 of 12 Applications Made through Undercover Testing

The federal Marketplace approved coverage for 11 of our 12 fictitious applicants who initially applied online, or by telephone.[13] We later received notices in 10 of 11 of these cases that failure to submit documentation needed to verify eligibility could lead to loss of coverage or subsidies we received.[14] For 1 of the 11 approvals, we initially were denied coverage, but were successful when we subsequently reattempted the application. Applicants for coverage are required to attest that they have not intentionally provided false or untrue information. Applicants who provide false information are subject to penalties under federal law, including fines and imprisonment.[15] For each of the approved applications, we were ultimately directed to submit supporting documentation to the Marketplace, such as proof of income, identity, or citizenship.

[13]In the one application in which we failed to obtain coverage, our fictitious phone applicant declined to provide what was a valid Social Security number, citing identity theft concerns.

[14]Where the marketplace identifies certain inconsistencies in an application that it cannot resolve through reasonable effort, the marketplace must undertake an "inconsistency process," under which the applicant is typically given 90 days to present satisfactory evidence to resolve the identified inconsistencies. During this time, the marketplace must allow the applicant to enroll in a qualified health plan, and, if applicable, receive premium tax credit and cost-sharing reduction subsidies.

[15]In addition to penalties under federal criminal law, PPACA imposes civil penalties up to $25,000 for failure to provide correct information due to negligence or disregard of applicable rules, and up to $250,000 for knowingly and willfully providing false or fraudulent information.

Preliminary Results of Front-End Controls Testing

For each of our 11 approved applications, we paid the required premiums to put policies into force, and are continuing to pay the premiums. For the 11 applications that were approved for coverage, we obtained the advance premium tax credit in all cases.[16] The total amount of these credits for the 11 approved applications is about $2,500 monthly or about $30,000 annually. We also obtained cost-sharing reduction subsidies, according to Marketplace representatives, in at least 9 of the 11 cases.[17] As noted, these advance premium tax credits and cost-sharing reductions are not paid directly to enrolled consumers; instead, the federal government pays them to issuers on consumers' behalf. To receive advance payment of the premium tax credit, applicants agree that they will file a tax return for the benefit year, and applicants receiving premium tax credits during the inconsistency period must indicate their understanding that premium tax credits are subject to reconciliation on their federal tax return.[18]

For each of our 6 online applications that were among the total group of 12, we failed to clear an identity checking step during the front end of the

[16] Thus, as of July 2014, GAO continues to receive subsidized coverage for the 11 applications.

[17] Income requirements for the tax credits and cost-sharing reduction subsidies are as follows:

- Those earning from 100 percent to 400 percent of the federal poverty level (adjusted for family size) are eligible for premium tax credits. These are federal income-tax credits, which eligible enrollees may elect to have paid in advance to health insurance issuers to offset premium costs. The federal poverty level varies by location. For the 2013–2014 open enrollment period, for example, the federal poverty level for the 48 contiguous states and the District of Columbia ranged from income of $11,490 for a single-person household to $39,630 for a household of eight.
- Those earning from 100 percent to 250 percent of the federal poverty level are also eligible for cost-sharing reduction subsidies. This is a reduction in a policyholder's nonpremium costs of coverage, such as for deductibles or copayments for covered services.

The number of our applications receiving cost-sharing reduction subsidies is likely higher because we stated our income at a level to obtain these subsidies. Marketplace representatives to whom we spoke did not always state whether our applicant had qualified for this subsidy. In addition, because the value realized through the cost-sharing reduction subsidy varies according to medical services used, value for such subsidies can likewise vary.

[18] Cost-sharing reduction subsidies are not subject to reconciliation on the taxpayer's federal income-tax return.

online application process, and thus could not complete the process online.[19] However, we subsequently were able to obtain coverage for all 6 of these applications begun online by completing them by phone. In 5 of these 6 cases, the online system directed us to contact a Marketplace contractor that handles identity checking. The contractor was unable to resolve the identity issues. According to a CMS public information website, if the contractor cannot resolve the issue, applicants may be asked to provide identity documents, by online upload or by mail. In such cases, according to CMS officials, applications are to be put on hold until identity proofing is completed. For this group of 5 applications, however, contractor representatives did not ask us to submit identity documents but instead directed us to call the Marketplace. We did, and after speaking with Marketplace representatives as instructed, we were able to successfully proceed with our applications by phone and obtain coverage for the 5 applications. In the sixth case, the online system directed us to call the Marketplace directly, without contacting the contractor. In that case, too, we proceeded to successfully complete the application by phone and obtained coverage.[20] According to CMS officials and executives of the Marketplace's call center contractor, an identity discrepancy must be cleared and identity verified before an application can proceed to completion.

For our 6 phone applications, we successfully completed the application process, with the exception of one applicant who declined to provide a Social Security number and was not allowed to proceed.

In the course of follow-up dealings with the Marketplace, call-center representatives in at least four cases could not locate our existing applications and, as a result, began new applications, according to our

[19]For online applications, the Marketplace employs a process known as identity proofing to verify an applicant's identity. This is done by using personal and financial history on file with a credit reporting agency. The Marketplace generates questions, based on information on file, that only the applicant is believed likely to know. If an applicant's identity cannot be verified, applicants are directed to call a credit reporting agency that is CMS's contractor for completing the identity-proofing process, for assistance in completing the proofing process.

[20]We were unaware of what procedure, if any, the Marketplace representatives used in clearing our applications for completion and submission. Because we were on the phone with Marketplace representatives, we could not observe how our applications were handled, and the Marketplace representatives did not otherwise indicate on what basis the applications were allowed to continue.

conversations with the representatives. According to CMS call-center and document-processing contractors, multiple electronic applications have been common.

Preliminary Results of Back-End Controls Testing

The Marketplace is required to seek postapproval documentation in the case of certain application "inconsistencies"—instances in which information an applicant has provided does not match information contained in data sources that the Marketplace uses for eligibility verification at time of application, or such information is not available. If there is an application inconsistency, the Marketplace is to provide eligibility while the inconsistency is being resolved using "back-end" controls.[21] Under these controls, applicants will be asked to provide additional information or documentation for a Marketplace contractor to review in order to resolve the inconsistency.

Among the 11 of our 12 undercover applications that successfully obtained coverage, the Marketplace initially directed that we submit supplementary documentation in 10 cases, with a request for supplementary documentation in the 11th case coming a few months after approval of coverage. Among the Marketplace communications were the following:

- The Marketplace asked two of three applicants with inactive Social Security numbers to submit proof of citizenship, identity, and income, but it asked a third only for income information.
- In four cases, the Marketplace asked for additional documentation a few months after initial document requests were made.
- The Marketplace directed two applicants to log into online accounts for messages—but these applicants had no such online accounts.
- The Marketplace sent unclear reminders to three applicants to file supplementary documentation, with a cover letter directing applicants to submit one type of document to resolve a particular inconsistency (for example, income), but then in an enclosure to be returned to the Marketplace requesting that another type of document be sent (for example, citizenship).

As part of our testing and in response to Marketplace requests, we provided counterfeit follow-up documentation, but varied what we

[21]PPACA, §§ 1411(e)(3)-(4), 124 Stat. at 228-229; 45 C.F.R. § 155.315(f)(4).

submitted by application—providing all, none, or only some of the material requested—in order to note any differences in outcomes. Specifically, among the 10 applications for which we were directed to send documentation at the time of approval, we submitted

- all requested documentation for 3 of the 10 applications,
- partial documentation for 4 applications, and
- no documentation for the remaining 3 applications.[22]

In addition, in 2 cases in which we were directed to submit income information, we reported income substantially higher than the amount we initially stated on our applications, and at levels that should disqualify our applications from obtaining subsidies.

CMS officials told us that a CMS contractor evaluates follow-up documentation on a rolling basis as it receives submissions. If the contractor deems the information submitted to be complete, a decision on eligibility is typically made within 1 to 2 days, according to the officials.[23] Otherwise, applicants may be directed to submit additional information as deemed necessary. In all cases, CMS officials told us, applicants are to be notified of the outcome of the review of their submitted documentation.

For the seven applications for which we elected to submit full or partial follow-up documentation, approximately 3 months have elapsed since we submitted the requested information. As of July 17, 2014, we had received notifications indicating the Marketplace had reviewed portions of the counterfeit documentation sent for two applications. Specifically, the Marketplace notified both these applicants that their proof of citizenship/immigration status had been verified and no further action is

[22]As noted, any documentation we supplied was, like our initial applications, fictitious, having been fabricated using commercially available hardware, software, and materials.

[23]CMS officials referred to this process as "adjudication" of the filings.

necessary.[24] One of them also had identity verified. We are awaiting notice on other documents filed for these two applicants.[25]

In the time since we filed documents requested at time of approval, we have received a number of follow-up communications from the Marketplace, which, as noted earlier, include requests for documentation not originally requested. In response, we have submitted a second round of documents, which responds to the requests but also maintains our testing methodology of submitting all, none, or some of the items requested. As of July 17, 2014, outcomes were still pending for these applications. Regardless of the status of any postapproval communications, our coverage remains in effect for all 11 approved applications.

Overall, among all applications for the federal Marketplace, about 4.3 million application inconsistencies have been identified, representing about 3.5 million people, according to the CMS contractor handling receipt and evaluation of submitted materials. Of the total inconsistencies, about 2.6 million are for applicants who took the step of selecting health care plans after completing their applications. As of mid-July 2014, about 650,000 inconsistencies had been cleared. However, according to contractor executives, due to system limitations, processing of income and citizenship/immigration status inconsistencies—which together account for 75 percent of inconsistency volume—began in May and June

[24]For both applications, the Marketplace also sent additional letters following verification. In these letters, the Marketplace requested we send supporting documentation to clear the inconsistencies, unless we had already received notification that the inconsistencies had been cleared—which we had received. We called the Marketplace to inquire about these postverification letters. For both applications, the marketplace representatives advised us to resend the supporting documentation. In addition, for one application, the Marketplace representative stated a representative would call the applicant to provide an explanation for this issue. As of July 17, 2014, we had not received such a call from the Marketplace.

[25]We are awaiting notice on the other documents because according to the CMS contractor handling document submissions, supporting documents are processed individually, rather than being considered all together for a particular application.

2014.[26] In some cases, according to the CMS contractor, documents cannot be matched to their respective applications, and become "orphans." As of mid-July 2014, the contractor said, there had been about 227,000 such documents. According to the contractor executives, unmatched documents are retained and reconsidered every 21 days to see if new information is available that can enable a match to be made.

As noted, applicants attest at the time of application that information they provide is not false or untrue. According to CMS officials, its document processing contractor is not required under its contract to authenticate documentation or to conduct forensic analysis. Executives of the contractor concurred, and told us the review standard the contractor uses is that it accepts documents as authentic unless there are obvious alterations. According to the executives, the contractor does not certify authenticity, does not engage in fraud detection, and does not undertake investigative activities. Specifically, in the contractor's standard operating procedures for its work for CMS, document review workers are directed under "general verification guidance" to "determine if the document image is legible and appears unaltered by visually inspecting it." Further, the contractor is not equipped to attempt to identify fraud, the contractor executives told us, and the contractor does not have the means to judge whether documents submitted might be fraudulent. The standard of accepting authenticity unless there is obvious alteration originated from CMS, the executives said.

According to the contractor executives, when consumers send copies of documents, as directed, rather than originals, there inevitably is a loss of image quality such that the contractor could not closely examine whether a document is authentic.[27] Costs would increase by several times to thoroughly analyze document authenticity, the CMS contractor executives

[26]The HHS Office of Inspector General recently reported on applicant inconsistencies, noting that the Marketplace was unable to resolve a high fraction of inconsistencies because the CMS eligibility system was not fully operational. Noting that each applicant can have multiple inconsistencies, the report said that inconsistencies do not necessarily indicate an applicant provided inaccurate information or is enrolled in a plan or receiving subsidies inappropriately. The report also addresses inconsistency resolution among state-based exchanges. See Department of Health and Human Services, Office of Inspector General, *Marketplaces Faced Early Challenges Resolving Inconsistencies With Applicant Data*, OEI-01-14-00180 (Washington, D.C.: June 2014).

[27]Incoming documents are also scanned, which means copies are made of the copies submitted.

told us. Even if such an effort was attempted, they said, it would be difficult to say if anti-fraud measures would be effective, because that is not the company's business.

The contractor also does not currently make use of outside data sources in its document review; instead, it inspects what documents are received.[28] Overall, the contractor executives told us, the contractor is not aware of any fraudulent applications and that, based on its practices, it also is not in a position to know whether fraud is being attempted. CMS officials similarly told us they did not know the extent of any attempts at application or enrollment fraud, but said that to date, there is no evidence of applicants defrauding the federal Marketplace.

In following through on our applications, we also identified a potential challenge to consumers obtaining information about review of documentation submitted. In communications we received from the Marketplace about our document submissions, we were directed to call the Marketplace with questions. When we called to inquire about the status of our document filings, representatives could not answer our questions. They told us they were not able to confirm receipt of requested documentation and were not able to provide information on whether requested documentation has been reviewed. The CMS contractors handling consumer calls and document verification each confirmed to us that the call centers cannot access document-submission information. Hence, it is currently not possible for a call-center representative, fielding an inquiry such as ours, to obtain document status information in order to provide that information to the consumer.

Overall, CMS officials told us that they have internal controls for the eligibility-determination process, and that experience has not shown the need for any changes in that process. They said that thus far, the focus has been on stabilizing processes being implemented for the first time.

Our work continues on the postapproval verification process. In particular, we are tracking whether we receive any additional adjudication notices

[28]At the time of our review, contractor executives told us they were soon to begin accessing a U.S. Department of Homeland Security data system for the limited purpose of checking documents submitted that had expired during the review process. They said, however, this does not constitute "external verification" and instead is a means to access updated versions of documents already received.

from the CMS verification contractor, or whether the contractor identifies supporting documentation we submitted as fictitious or inconsistent with information submitted at time of application. We will continue to assess CMS's management of the application and approval process through our ongoing work and consider any recommendations needed to address these issues.[29]

We Were Unable to Obtain In-Person Assistance in Five of Six Undercover Attempts to Test Income-Verification Controls

We attempted six in-person applications, in order to test income-verification controls only. Specifically, we sought to determine the extent to which, if any, in-person assisters would encourage our applicants to misstate income in order to qualify for either of the income-based PPACA subsidies.[30] According to CMS, in-person assistance is to be available for those seeking assistance in filing applications.[31] For these six in-person applications, we randomly chose three Navigators and three non-Navigators in the target areas of our selected states. For the in-person applications, because our sole interest was any potential advice on reporting income, we did not seek or obtain policies, as we did with our phone and online applications.

During our testing, we visited one in-person assister and obtained information on whether our stated income would qualify for subsidy. In that case, a Navigator correctly told us that our income would not qualify for subsidy. However, for the remaining five in-person applications, we were unable to obtain such assistance. We encountered a variety of situations that prevented us from testing our planned scenarios, including the following:

[29]Our work in this area may not be complete for a number of months, given flexibility provided under the act for CMS to extend the postapproval verification period. PPACA, § 1411(e)(4), 124 Stat. at 228.

[30]In these in-person applications, our planned approach was not to lead the assisters toward encouraging applicants to misstate income, but instead, as applicable, to discuss concerns about policy costs and to inquire if there were ways to reduce the expenses.

[31]According to a CMS website: "No matter what state they live in, consumers are able to get live in-person help as they go through the process of applying for and choosing new coverage options in the Marketplace." See Centers for Medicare & Medicaid Services, *Assistance Roles to Help Consumers Apply & Enroll in Health Coverage Through the Marketplace*, CMS Product No. 11647-P (January 2014).

- One of the three Navigators required that we make an appointment in advance by phone. When we were unable to reach the Navigator by phone, we made an in-person visit. The Navigator declined to provide assistance, or to schedule an appointment, saying instead we would need to phone to schedule an appointment to return.
- One of the three non-Navigators initially said it provides assistance only after people already have an application in progress. The non-Navigator did offer to assist us with an application, but the HealthCare.gov website was down. He directed us to call later for assistance. After we did so, this non-Navigator did not respond to three follow-up phone calls.
- Another of the three non-Navigators, a health care services company, told us it only handles applications from those having a medical bill at its medical facility.
- The third non-Navigator did not provide assistance, telling us it handles only applications for Medicaid.

In two of the five instances in which we were unable to obtain assistance at our originally selected locations, we proceeded to seek assistance at other randomly selected locations in our target areas. In these follow-up attempts, we again encountered difficulty in obtaining assistance for our applicants, including the following:

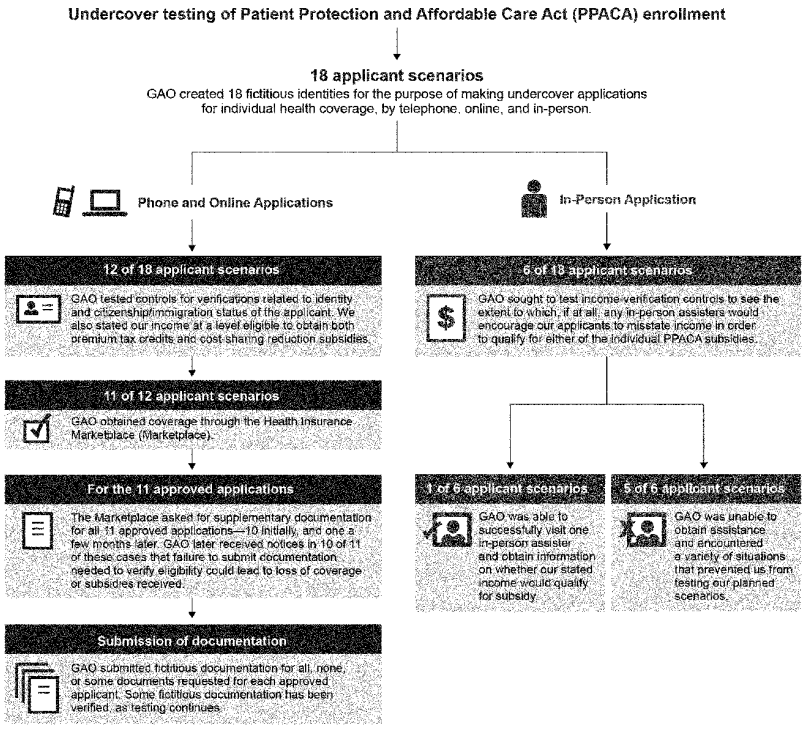
- For one test, we visited two additional locations beyond the initial location before finding an in-person assister at a third who correctly told us our income was insufficient to qualify for subsidy. At the first two locations, we were told, among other things, that appointments were necessary.
- For another test, which occurred late in the open-enrollment period, non-Navigator representatives declined to provide help, telling us they were uncomfortable doing so and planned to take a seminar on enrollment.

We further pursued, by phone calls to the Marketplace, the applications for which we could not get explicit in-person guidance on income and qualification for subsidy. In these calls, we were correctly advised that our income was outside the range eligible for income-based subsidy.[32]

[32]We believe, however, that as an investigative technique, a telephone interaction is qualitatively different from an in-person interaction, the former of which offers less personal contact between the parties and more difficulty in developing rapport. For that reason, we originally designed our testing for in-person contact.

Figure 1 summarizes our process and results for each of the groups of applicants—the 12 phone and online applications, and the six in-person attempts.

Figure 1: Preliminary Results of GAO Undercover Testing of Patient Protection and Affordable Care Act (PPACA) Application Process



Source: GAO. | GAO-14-705T

CMS Does Not Yet Have the Capability to Identify Those Who Have Paid for Policies, Limiting Our Ability to Analyze Enrollment

The federal government, in administering the two income-based subsidies, makes payments to issuers of health insurance on behalf of eligible consumers who have enrolled in a qualified health plan. According to CMS officials, individuals are considered to be enrolled in a plan after they pay the initial premium.[33] Thus, a key factor in analyzing enrollment in Marketplace coverage—and federal expenditures and subsidies that follow—is the ability to identify which applicants approved for coverage have subsequently paid premiums and put policies in force.

According to HHS, more than 8 million people selected a plan for coverage during the initial open-enrollment period that ended in April. CMS officials, however, told us they are thus far unable to identify individuals who have made premium payments. Issuers have reported this information to CMS, but the agency has not yet created a system to process the information, according to CMS officials.

In May 2014, CMS officials told us that work is underway to implement such a system. However, CMS does not have a timeline for completing and deploying this work. As a result, under current operations, CMS must rely on health insurance issuers to self-report enrollment data reflecting individuals for whom CMS owes the issuers the income-based subsidies arising from obtaining coverage through the Marketplace. We plan to continue examining this issue, among others, as part of our ongoing work, and to consider any recommendations needed to address it.

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

GAO Contact and Staff Acknowledgments

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

[33]For subsidy-eligible individuals, this means payment of any portion of the premium not covered by the subsidies.

Individuals making key contributions to this statement include: Wayne A. McElrath, Director; Matthew Valenta, Gary Bianchi, and Kristi Peterson, Assistant Directors; Carrie Davidson; Paul Desaulniers; Sandra George; Robert Graves; Barbara Lewis; Maria McMullen; George Ogilvie; Shelley Rao; Ramon Rodriguez; Christopher H. Schmitt; Julie Spetz; Cherié Starck, Helina Wong; Elizabeth Wood; and Michael Zose.

Appendix I: Legal Appendix

This appendix provides background on certain requirements related to the submission of applications and eligibility-verification procedures to enroll in qualified health plans and qualify for income-based subsidies under the Patient Protection and Affordable Care Act (hereafter PPACA).[1]

To be eligible to enroll in a qualified health plan offered through a marketplace established under PPACA, an individual must be a U.S. citizen or national, or otherwise be lawfully present in the United States; reside in the marketplace service area; and not be incarcerated (unless pending disposition of the charges).[2] In addition, certain low- and moderate-income individuals and families may be eligible for income-based subsidies authorized by PPACA to make coverage more affordable: (1) a refundable tax credit, generally paid on an advance basis, to reduce premium costs for marketplace coverage (referred to as premium tax credits) and (2) reductions in cost-sharing associated with such coverage (known as cost-sharing reductions) for items such as copayments for physician visits or prescription drugs.[3] To qualify for either subsidy, an individual must meet applicable income requirements and must not be eligible for coverage under another qualifying plan or program, such as affordable employer-sponsored coverage, Medicaid, or the State Children's Health Insurance Program.[4] Subsidy payments are made to the issuer of the qualified health plan to offset the cost of the plan to the individual.[5]

Individuals seeking coverage under a qualified health plan offered through a marketplace may apply via the Internet, by telephone through a call center, by mail, or in person, using a single application that collects information necessary to determine enrollment eligibility and, if applicable,

[1]PPACA, Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA), Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010). In this appendix, references to PPACA include any amendments made by HCERA. Future citations to PPACA will identify the applicable section of law without providing a full citation, as set forth here.

[2]PPACA, § 1312(f)(1), (3),124 Stat. at 183-184; 45 C.F.R. § 155.305(a).

[3]PPACA, § 1401(a), 124 Stat. at 213-219 (adding 26 U.S.C. § 36B); *id.* at § 1402, 124 Stat. at 220-224.

[4]*Id.*, 45 C.F.R. § 155.305(f)-(g).

[5]PPACA, § 1412(c), 124 Stat. at 232-233.

subsidy eligibility.[6] Applicants for coverage are to attest that they have not intentionally provided false or untrue information. Applicants who provide false information are subject to penalties under federal law, including fines and imprisonment.[7]

Marketplaces are required by law to take several steps to verify application information to assess eligibility for enrollment in a qualified health plan and, if applicable, to qualify for an income-based subsidy. These verification steps include validating an applicant's Social Security number, if one is provided;[8] verifying an applicant's citizenship, status as a national, or lawful presence with the Social Security Administration (SSA) and/or the Department of Homeland Security; verifying household income and family size against the most recent tax-return data from the Internal Revenue Service (IRS), as well as data on Social Security benefits from the SSA; and verifying whether the applicant is eligible for health coverage under another qualifying plan or program that would preclude eligibility for subsidy purposes.[9]

Where the marketplace identifies certain inconsistencies in an application that it cannot resolve through reasonable effort, the marketplace must undertake an "inconsistency process," under which the applicant is given 90 days to present satisfactory evidence to resolve the identified

[6]45 C.F.R. § 155.405. An individual who applies via the Internet must first complete identity proofing, a step instituted by CMS to prevent someone from applying for health coverage without the named applicant's knowledge. According to CMS guidance, individuals who seek to apply for coverage through the federal Marketplace by submitting an online application and are unable to complete the electronic identity proofing process may be asked to submit satisfactory documentation of identity to the marketplace. CMS, *FAQ on Remote Identity Proofing, Remote Identity Proofing Failures and Application Inconsistencies (Federally-facilitated Marketplace)*, (May 21, 2014).

[7]In addition to any applicable penalties for perjury under federal criminal law, PPACA imposes civil penalties up to $25,000 for failure to provide correct information due to negligence or disregard of applicable rules, and up to $250,000 for knowingly and willfully providing false or fraudulent information. PPACA, § 1411(h)(1), 124 Stat. at 230. CMS recently issued a final rule, in which it specified how it intends to impose such penalties. Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond. 79 Fed. Reg. 30,240, 30,290 (May 27, 2014) (to be codified at 45 C.F.R. § 155.285).

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

[9]PPACA, § 1411(c), 124 Stat. at 226-227; 45 C.F.R. §§ 155.315(b)-(c), 155.320(b)-(c).

inconsistencies.[10] For example, the inconsistency process applies when the marketplace is unable to validate an individual's Social Security number or attestation regarding citizenship or immigration status.[11] It also applies when the marketplace is unable to verify eligibility for income-based subsidies, including, for example, if an applicant indicates a change in circumstances, such as substantial changes in income compared with the most recent tax return available, or IRS does not have recent tax-return data.[12] During the inconsistency period, the marketplace must allow the applicant to enroll in a qualified health plan and, if applicable, authorize the advance payment of any premium tax credit or cost-sharing reduction to the applicant's issuer on the basis of the applicant's attestations.[13]

In general, if a marketplace is unable to resolve the inconsistency after 90 days, it is required to determine eligibility based on the information contained in federal and other electronic data sources.[14] However, for applicants who do not have documentation to resolve an inconsistency (e.g., due to homelessness or natural disaster), a marketplace is required to provide an exception, on a case-by-case basis, to accept an applicant's attestation and approve eligibility.[15] To receive advance payment of the premium tax credit—during the inconsistency period and for the benefit year—an applicant must agree to file a tax return for the benefit year.[16] To receive advance payment of the premium tax credit during the

[10]PPACA, § 1411(e)(4)(A)(ii), 124 Stat. at 228; 45 C.F.R. § 155.315(f)(2).

[11]PPACA, § 1411(e)(3), 124 Stat. at 228; 45 C.F.R. § 155.315(b), (c), (f).

[12]PPACA, § 1411(e)(4), 124 Stat. at 228-229; 45 C.F.R. § 155.320(c)(3).

[13]PPACA, § 1411(e)(3)-(4), 124 Stat. at 228-229; 45 C.F.R. § 155.315(f)(4).

[14]PPACA authorizes the Department of Health and Human Services to extend the 90-day period for enrollments occurring during 2014. PPACA, § 1411(e)(4)(A)(ii), 124 Stat. at 228. CMS regulations also generally permit the marketplaces to extend the 90-day period if the applicant has made a good faith effort to obtain documentation required to resolve the inconsistency. 45 C.F.R. § 155.315(f)(3).

[15]45 C.F.R. § 155.315(g). This exception applies only to inconsistencies unrelated to citizenship or immigration status.

[16]45 C.F.R. § 155.310(d)(2)(ii)(A). If an individual who receives advance payment of the premium tax credit fails to file a federal income tax return for the benefit year, a marketplace is not permitted to approve eligibility for premium tax credits or cost-sharing reduction subsidies for the individual in a subsequent benefit year. 45 C.F.R. § 155.305(f)(4), (g)(1)(i)(B).

inconsistency period, an applicant also must attest to understanding that any advance payments of premium tax credits received during this period are subject to reconciliation.[17] Marketplaces are required to permit applicants to receive less than the full amount of advance payments of the premium tax credits in order to minimize the possibility of having to repay such credits if their actual income for the benefit year is higher.[18]

[17]45 C.F.R. § 155.315(f)(4)(ii).

[18]45 C.F.R. §155.310(d)(2)(i). Cost-sharing reductions are not subject to reconciliation on the taxpayer's federal income tax return.

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Chairman BOUSTANY. I want to thank you and your team for this first look at what appears to be a pretty significant problem with process and implementation with regard to these subsidies.

And these findings, although preliminary, are quite troubling. Eleven out of 12 applications with false identities were approved and are receiving subsidies. Applications that falsified citizenship information were also approved. And then, on the back end, five out of six navigators and assisters are failing to help taxpayers. Federal contractors seem unable to uncover fraudulent documents. CMS is either unaware or unable to screen out fraudulent applications nationwide with regard to premiums and subsidies.

This is all very troubling, and I am glad you are going to continue taking a more in depth look at this, because we look forward to revisiting the issue, but from your work so far, you know, in your official capacity, but also as an American citizen, are you really worried, are you really concerned about the total lack of effective controls that might result in significant fraud and more improper payments in this system as it stands?

Mr. BAGDOYAN. Thank you for your question, Mr. Chairman.

I would speak only on my—in my official capacity, of course, in this setting, but as I mentioned earlier, our investigative work and our audit work thus far has identified certain areas of concern that we plan to pursue as our work unfolds, as well as areas, such as the database of applicants itself, which will be at the core of our work.

So I would say in summary that what we have so far is a number of questions that are fundamental regarding the effectiveness of controls, especially at the front end, where the preventative controls are paramount, as well as the back end, where traditionally they are relatively less effective, where you have a situation of a pay and chase, as we discussed earlier. So we are absolutely committed to focusing on controls in this regard.

Chairman BOUSTANY. And we know that if we have—if we fall back into a pay-and-chase situation, it is very difficult to recover those dollars. Is that correct?

Mr. BAGDOYAN. Well, according to GAO's fraud prevention framework, back-end controls are relatively less effective than strong preventative controls, so I would just respond in that context.

Chairman BOUSTANY. Thank you. And your work also included interesting findings regarding two contractors and numerous grant recipients. One concerned a contractor hired to resolve identity verification and a second concerned a contractor hired to process paperwork that is unable to verify whether the document is actually authentic. Another finding concerned navigators and other assisters who were unable or unwilling to help your undercover applicants despite the fact that they had received tens of millions of dollars in Federal grants.

Again, I know this is still a preliminary finding, but can you describe in greater detail GAO's experience with these groups? What—you know, what are we—what is your recommendation at this point, or do you have one, to correct these problems? This is troubling, because a lot of money has gone out the door in the form of grants to these—you know, these navigators. I have deep concerns about this.

Mr. BAGDOYAN. Certainly. In all three instances, we have had an initial touch with these entities, so it would be premature to reach a judgment about effectiveness or not or certainly what needs to be done about them, but in terms of the contractor who was—who has been tasked with verifying identity, they did attempt to assist us during the call process after we were directed by the online system to do so. And when they were unable to verify our identity, they suggested that we call the call center, and as my statement alludes to, we were able to get coverage that way.

Regarding the contractor who is tasked with verifying documentation at the back end, there is no provision to look for fraud in the contract itself. And we confirmed this with CMS officials as well as the contractor officials at our site visit in their facility in Kentucky, so——

And then in terms of the navigators, again, it is a—it is an initial contact, and one person made the correct call on our application scenario, but the other five, for various reasons, were unable or unwilling to assist us.

Chairman BOUSTANY. Okay. Do you have any more—can you shed any more light on why they were unable or——

Mr. BAGDOYAN. In one instance, one assister said they didn't have sufficient training to do so. Another one said we needed to make an appointment, because we essentially were a walk-in at that—in that case and—but would not pick up the phone to make an appointment. And another two instances, I believe, there might have been a willingness to do so, but the Web site itself was unavailable at the time.

Chairman BOUSTANY. Okay. Well, I appreciate that. This subcommittee and the Ways and Means Committee as a whole is taking our oversight function very, very seriously. We know this is a first look. We appreciate the work you have done, and we know this work is ongoing, and so we will look forward to revisiting these issues as you get more data and hopefully get to a point where you can make some specific recommendations to us.

I have to say, the initial findings are deeply troubling to me. We know we are dealing with fraud and abuse in a number of other areas where tax credits and especially refundable tax credits are being utilized, which undermines the integrity of these programs and the intent of the programs to help those who really need help. And I think we are at a point now, clearly, we are at a point where this—these kinds of situations are intolerable. Whether you are a Republican or a Democrat, we cannot tolerate this level of fraud, abuse, taxpayer waste, and we need to root these things out, so we will look forward to continuing to work with you on these issues. Thank you.

I will now yield to my friend, Mr. Lewis.

Mr. LEWIS. Mr. Chairman, my friend, I want to thank you for yielding.

Mr. Chairman, I want to ask you a question. Can you share with the Democratic Members of the Committee a copy of the letter that you sent to GAO? It is my understanding that GAO does not make public ongoing investigation.

Chairman BOUSTANY. Yeah. We will be happy to share that letter with you. I was under the assumption that you had seen it.

Mr. LEWIS. Well, thank you very much, Mr. Chairman.

That will be most helpful.

Mr. Director, let's get right to the heart of the matter. Have you drawn any conclusion at this point in your investigation?

Mr. BAGDOYAN. No, sir, we have not. Our work is ongoing. As I mentioned earlier, this is our first touch-through looking at the controls, and we have identified certain areas for further audit and investigation as appropriate, but we can't draw any conclusions based on our current status.

Mr. LEWIS. What is your time frame for concluding this investigation?

Mr. BAGDOYAN. It is difficult to say at this point. It could be several months, but our work is very active, and we are receiving new information as we speak from CMS, and we will have a chance to analyze and follow up that, but we are looking at at least several more months, sir.

Mr. LEWIS. What areas are subject to further review?

Mr. BAGDOYAN. Sure. In general terms, I think there are various types of controls where they are at along the process, how they interact with each other, who is responsible for them, how they might benchmark against best practice, that sort of thing.

Mr. LEWIS. And the false income information that the GAO gave, would that not be caught up during a true process? Can you explain this process?

Mr. BAGDOYAN. I am sorry. Could you restate the question?

Mr. LEWIS. Yeah. The false information that the GAO gave, would that be caught up during the true-up process?

Mr. BAGDOYAN. I think what we used was part of the overall investigative plan, but the identities we employed, the information and the documents were all fictitious.

Mr. LEWIS. The income process, how do you go about getting this information? Are you free, at liberty?

Mr. BAGDOYAN. Well, in a general sense, we set our income levels within the range of eligibility to obtain subsidies, and that is pretty much all I can discuss at this time.

Mr. LEWIS. Okay. Over the past year, a lot has been made of the problem with the Web site. Tell me how many fraudulent applications were you able to get past the Web site.

Mr. BAGDOYAN. Our online applications, as I state in my formal statement, our applications were flagged for identity verification. We were referred to the contractor, who is tasked with resolving those identity questions. They were unable to do so. They referred us to the Marketplace's call center, and through the call center, we were able to bypass the initial flag and obtain coverage.

Mr. LEWIS. Could you tell Members of the Committee, what are the benefits of cheating the ACA system? The money goes to the insurance company, not the individuals.

Mr. BAGDOYAN. Yes. I mean, we are not receiving the subsidies directly to our accounts. They are paid by the government to the insurers directly upon presentation of what I would imagine would be some sort of an invoice on a monthly basis.

Mr. LEWIS. Thank you very much, Mr. Director.

I yield back my time.

Chairman BOUSTANY. I thank the gentleman.

Mr. Reed, you are recognized for questioning.

Mr. REED. Thank you, Mr. Chairman.

Thank you for the testimony today, sir. One of the pieces of information I found intriguing in your preliminary work is as you went through this work, my understanding is you talked with the officials of CMS that handle this situation, and they indicated to you that—the CMS officials told you that their experience has not shown the need for any changes in the eligibility determination process. So CMS is working with you throughout this investigation, correct?

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correct?

Mr. BAGDOYAN. Yes. We have been in touch with CMS officials and obtained documents and other information.

Mr. REED. Very, very frustrating to me as a member of this oversight committee that the officials that are responsible for trying to implement this program are sending you and sending this body a message that they are not interested in making any changes to improve the situation, even though you have given them examples of clear, egregious violations of the procedures. Am I misunderstanding the response of CMS?

Mr. BAGDOYAN. Well, I think that has been their position at the time. I believe in press reports regarding this hearing, the public statement that CMS made was their willingness to continue to work with GAO and identify areas where improvements were made. So I would have to reconcile those two statements during the course of our work.

Mr. REED. Well, I would hope this oversight process and this public spotlight does do its job and gets CMS on the ball to not send a message that they don't want to work with you and others to clear up this clearly egregious behavior that you have discovered and that you continue to discover as you go forward with this investigation.

There is another interesting thing in your written testimony that I read, and it is that you indicated that CMS is currently unable to identify who has made a premium payment and who has not. Is that accurate? I mean, did I read your testimony correctly?

Mr. BAGDOYAN. Yes. That is our understanding, that that part of the back-end system, that is part of the broader data hub, I believe, has not been constructed, but there is a plan to do so, we just don't have a timeline for that to happen.

Mr. REED. Okay. So there is a plan that CMS has advised to you that they have in order to verify that information?

Mr. BAGDOYAN. That is our understanding at this time, yes.

Mr. REED. But they can't give you a timeline as to when they are going to get that done or implemented or——

Mr. BAGDOYAN. That's correct as of this date.

Mr. REED. What are the details of that plan?

Mr. BAGDOYAN. I can't comment on them. We can check back and see with my staff to determine. If we have appropriate documentation, we can get back to you on that.

Mr. REED. So just say you don't know, and there is probably information out there that you could check?

Mr. BAGDOYAN. There might be in our work papers set, but I am just not familiar with that plan specifically. So I don't want to give you a wrong answer. We will get back to you.

Mr. REED. And am I correct in your testimony, though, too, that the insurers have given the information to CMS on the payment?

Mr. BAGDOYAN. Again, that is our understanding, that the insurers provide a list and an amount of subsidy owed, and the government takes that self-attestation and reimburses the insurers for

the subsidies directly without touching the enrollee, which is an important point to make.

Mr. REED. So just so the American people understand that may be enrolled in these situations, what happens if the government doesn't catch the fact that they are not paying their premiums anymore with the individual's responsibility to repay back these premiums that may be erroneously or fraudulently issued to them?

Mr. BAGDOYAN. Well, I think the requirement is that the applicant or the enrollee continue to make payments to be eligible for the subsidy, but that is a determination that I wouldn't be able to make in terms of what exactly the process would be for the government to follow up with that particular enrollee and determine why the payments are not being made, whether there would be a grace period to restart the payments.

Mr. REED. Okay. But maybe I am not being clear. So if an enrollee doesn't make the premium payment and the subsidy continues to be provided to the insurer, correct?

Mr. BAGDOYAN. I—that is a possibility, yes.

Mr. REED. And then, subsequently, it is discovered that the premiums weren't made, isn't there an obligation on CMS' part or the government's part to go after the enrollee to say, Hey, we gave you a premium subsidy that you are not entitled to, because the premiums weren't made? Is that—that is my understanding of it.

Mr. BAGDOYAN. Thank you for your clarification. We are aware of situations like that, but so far, the audit part of our work has not focused on it, and we will be focusing on that area going forward.

Mr. REED. Well, I appreciate that, because I am very concerned about the fraud and everything that you have uncovered in this preliminary report, but I am also very concerned that enrollees don't understand what is coming down the pipeline, because if CMS doesn't do its job, if the government doesn't do its job, if they continue to engage in this fraudulent behavior, then premiums are going out. That is one thing. That is wrong. That is illegal. That is a clear violation. But also if the premiums go out and the enrollees have pay back those premiums because of some type of mistake that the government made, I hope the American people understand they are the ones who are going to be on the hook to have to pay this back, and not the insurer.

I yield back, Mr. Chairman.

Chairman BOUSTANY. Thank the gentleman.

Mr. Crowley, you are recognized for 5 minutes.

Mr. CROWLEY. I thank you, Mr. Chairman.

I am interested in hearing about the concern for the enrollees. That is very interesting. My friend from New York spoke so eloquently about concern for the enrollees. I would just add for the record that 52 times my colleagues on the other side of the aisle have voted to repeal the Affordable Care Act, 52 times. I am not asking you to comment on that, but just to state for the record that 52 attempts by my colleagues on the Republican side of the aisle have been to repeal the entire act itself, so it is interesting to hear about the concerns for the enrollees.

Quite frankly, Mr. Bagdoyan, I think that this hearing is premature. You have stated yourself that you have not finished your investigation. Is that correct?

Mr. BAGDOYAN. Yes. The work is ongoing on the investigative and the audit front, yes.

Mr. CROWLEY. And I would suggest that possibly part of that investigation, as Mr. Lewis was referring to, was seeing this through. Have any of your undercover investigators actually accessed any healthcare through these plans?

Mr. BAGDOYAN. They have not.

Mr. CROWLEY. They have not. And they are paying a premium—they are paying a premium, and the government is giving a subsidy directly to the insurance companies, correct?

Mr. BAGDOYAN. That is correct. As part of the investigative scenarios, that is correct.

Mr. CROWLEY. So it appears as though you have operated a very sophisticated criminal operation here, not that your intention is criminal. In other words, if someone is thinking in terms of a criminal mindset to actually exploit the system, you are kind of working in that—that mode in an honest way, I guess you could say, right?

Mr. BAGDOYAN. Well, that is part of our tasking, to investigate and——

Mr. CROWLEY. And I appreciate that.

Mr. BAGDOYAN. And it is the authority of the GAO to do that, sure.

Mr. CROWLEY. And it is important from an accounting point of view in understanding and saving taxpayers. This is not accusatory towards you and what——

Mr. BAGDOYAN. I understand.

Mr. CROWLEY. [continuing]. You are doing. I want to make that clear.

Mr. BAGDOYAN. No worries.

Mr. CROWLEY. But what is the ultimate price here for the criminal? Is it a free colonoscopy? What is the ultimate benefit to the criminal who is taking these risks to do this? You know, this isn't like Medicare fraud where the doctor is actually cooking the books to put more money into his or her pocket. Why would a noncitizen, for instance, risk discovery by applying for health insurance, or a fraudster with an illegal Social Security Number use them for this purpose when there are other obviously more lucrative ways in which to exploit those things? Why would they do that?

Mr. BAGDOYAN. I am afraid I wouldn't be able to comment on the intent of anyone attempting fraud.

Mr. CROWLEY. Let me ask you this question, then: in addition to the penalties in the Federal criminal law, the ACA has civil penalties for providing false information. Is that correct?

Mr. BAGDOYAN. I believe that is my understanding.

Mr. CROWLEY. So, in a perfect world, if people—again, if these were real criminals, if they were attempting to do this, they would probably be—they would have some knowledge that possibly there would be some penalties if this were uncovered. Is that correct?

Mr. BAGDOYAN. I can't speak for individuals. There is, I think, sufficient information.

Mr. CROWLEY. And, in fact, the two penalties are as stiff as $25,000 for failure to provide information and $250,000 for providing false information. That is a substantial amount. Is that not enough, or do you think we shou

viding false information. That is a substantial amount. Is that not enough, or do you think we shou
viding false information. That is a substantial amount. Is that not enough, or do you think we should maybe increase those penalties? Do you think that those penalties would have some impact on the criminal's intent to pursue this?

Mr. BAGDOYAN. Again, Mr. Crowley, I would be hesitant to comment on that.

Mr. CROWLEY. I appreciate that. I see that—I know that I am running out of time, but I see that my colleagues once again on the other side of the aisle are using this as an opportunity, I think, to exploit their dislike of the Affordable Care Act, and I know that they don't like it, I get that, but today, I guess the theatrical selection is much ado about nothing, because there is really nothing here yet until we see what happens in the true-up what the follow-up of the IRS would be in terms of determining whether or not that individual was eligible for those credits. And I know that they haven't helped in terms of making that even more helpful to the recipient of the credits themselves, so I appreciate that. It is just another attempt to try to smear, I think, the Affordable Care Act.

More people are getting coverage, as my colleague from Georgia has said, and they are liking it. All the doomsday predictions haven't come true, and they are now trying to trump up new accusations that ignore the reality of it that people are actually accessing healthcare and enjoying it.

Yes, there are instances where people misstate or wrongly estimate their income, and for those inconsistencies, they are later verified and corrected, and if not, they have to pay it back.

So I think, you know, Mr. Bagdoyan, as I mentioned before, I do appreciate your work and you needing to do this and it is important work that you are engaged in, but I think it has been premature. It is like having an investigation of organized crime, and talking about an investigation that is going on before you have gotten to the conclusion. It tips off a lot of people that we may not want to be tipping off.

With that, I will yield back.

Chairman BOUSTANY. I thank the gentleman.

Which underscores why we are taking a serious look at oversight early in this process, to avert problems and taxpayer dollars going out to waste, fraud and abuse, rather than letting this linger on for years on end and taxpayers being caught up in this trap.

With that, I will now yield to Mr. Roskam.

Mr. ROSKAM. Thank you, Mr. Chairman.

Mr. Bagdoyan, the gentleman from New York, Mr. Crowley, said that this is an attempt to smear the Affordable Care Act, and I would argue just the opposite. I think the Affordable Care Act, to use his adjective—or his verb, is smearing itself, and he posed a number of hypotheticals to you. Let me move out of the hypothetical and into the actual.

So, actually, based on this investigation, there were 12 attempts to defraud the system, and 11 of those attempts were successful. That is right, isn't it?

Mr. BAGDOYAN. That is correct, Mr. Roskam.

Mr. ROSKAM. That is not hypothetical. Those are actual 11 attempts that came up where the bad actor rang the bell and got a benefit that they weren't supposed to get. That is right, isn't it?

Mr. BAGDOYAN. That is correct in these 11 instances.

Mr. ROSKAM. I find that number, 11 out of 12, shocking, jarring, troubling; you know, pick your descriptor. Have you come to an opinion based on your experience as to how you would characterize the robustness of the program? I recognize your admonition at the beginning that you don't want to overlay, but for example, accept this hypothetical: if this trend were to continue and 11 out of 12 were to continue to be the trend and you were to lay that out over this entire program, how would you describe that net result?

Mr. BAGDOYAN. Well, again, I would be reluctant to project based on this very limited sample.

Mr. ROSKAM. I accept that at face value.

Mr. BAGDOYAN. But as I mentioned, again, and I will underscore it in this instance, is that we have identified several areas of control that need attention, and our audit work will focus on that and benchmark against appropriate standards for us to make any kind of judgment in terms of forward looking in this regard.

Mr. ROSKAM. Have you come to an opinion about the robustness of the Internal Revenue Service and their role in the 11 cases that you came across?

Mr. BAGDOYAN. Our work has not touched the IRS as yet, but they are part of the overall scope of our work.

Mr. ROSKAM. So the IRS inquiry is ongoing?

Mr. BAGDOYAN. It is, yes. It is—it is active work as we speak, and that is one of the agencies we will be touching on in terms of their roles in controlling enrollment.

Mr. ROSKAM. And this GAO report, this investigation came about as a result of a specific congressional inquiry. Is that right?

Mr. BAGDOYAN. That is correct, at the request of Chairman Boustany and others.

Mr. ROSKAM. I think that we are going to continue to have these episodic insights into the weakness of some of these things. And what we need to be doing and what Congress needs to be doing is advocating an overall structure for oversight.

I have introduced H.R. 4158, which would create a special inspector general to monitor the Affordable Care Act, or SIGMA. Congress has appointed special inspectors general for things like the Troubled Access Recovery Program, TARP, Afghanistan, Iraq and elsewhere, where literally billions of dollars in waste have been uncovered.

And if you think about the scope of what we are talking about here, CBO projects that over a trillion dollars in Affordable Care Act subsidies are going to be paid out over 10 years. Those types of numbers just absolutely take your breath away. Even if a portion of the trend that you uncovered continues, these numbers are really jarring.

The special inspector general approach that I have advocated would have a similar role with jurisdiction that spans all implementing agencies, and the ability to bring important data to light and hold the administration accountable. And in the case of subsidies, it is given specific oversight over the IRS and its implementation of the law more broadly, but also its subsidy verification and overpayment recapture process. So I think that there is a real opportunity here.

Your insight is incredibly helpful. I want to join my colleagues in thanking you for the work that you are doing. We are not overcharacterizing it, but we are really concerned about the depth and the problems that you have identified and articulated. Thank you for your time.

And I yield back. Thank very much.

Chairman BOUSTANY. Thank the gentleman.

Mr. Paulsen, you are recognized for 5 minutes.

Mr. PAULSEN. Thank you, Mr. Chairman.

And I thank you for taking the time to be with us this morning. You know, we already knew that we were unable to verify income and eligibility information. We have had that discussion in this committee as the law has been put into practice, for those that are applying for health insurance, but this review, the review that you provide today, calls into question whether the government is even able to verify that these people who are applying for insurance are who they say they are. I mean, just those folks, it is just—you know, the 11 out of the 12 cases that you mentioned earlier as a part of this review.

And just to follow up a little bit on what Mr. Roskam had said, it is troubling to follow on the heels of your report, knowing full well that the inspector general for tax administration has already found seriously inadequate controls available in administering their part of the law. HHS, the Office of the Inspector General has already found their internal controls are deficient. And now we have this report where you have laid out 11 of 12 successful cases in defrauding, essentially defrauding the system. So we know that improper payments in other Federal programs have cost money. You look at the EITC over a 10-year period, costing taxpayers $132 billion. If you apply that percentage to what would be transpired into this extensive, expensive program with the Affordable Care Act, Obamacare, we are talking real money here, real money that can be prevented.

But let me ask you this. I want to just follow up on a little different line of questioning, Mr. Bagdoyan. You stated that six of your 18 applicant scenarios included in-person applications through the navigators and those in-person assisters, but you tested—your testing had one problem. In five of the six scenarios, they were either unable to find these individuals or they were turned away, correct?

Mr. BAGDOYAN. Well, the six cases are independent of the other 12, because they focused on testing the income control. And the five who were unable to assist us was done, as I mentioned earlier, for a variety of reasons. They said they didn't have sufficient training to do so, they focused on a narrow part of the applicant population, two of them were experiencing some Web site access

problems at the times, and another one told us that we needed to make an appointment. When we attempted to do so onsite, we were advised to call, but our calls were unsuccessful.

Mr. PAULSEN. Okay. So you have worked through this scenario. We know that CMS awarded these navigators that you were approaching $67 million in grants to help consumers complete their eligibility applications and the enrollment forms, and then other in-person assisters received this money as well, but your testimony, then, is suggesting that many of these groups may be pocketing that money, taxpayer money, witho

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then, is suggesting that many of these groups may be pocketing that money, taxpayer money, without providing the services.

Can you just describe a little bit about what your experience and GAO's experience was at trying to obtain in-person assistance in your applications?

Mr. BAGDOYAN. Yes. I would refer you to my answer earlier. There was a mix of having to make appointments, we were not able to make them on the spot, and we didn't get our phone calls returned, and there were also Web site problems. Someone said that they didn't have sufficient training, so they were uncomfortable in performing the service.

Mr. PAULSEN. So there is insufficient training, the Web sites, you know, may be inaccurate or not working correctly. Do you expect that later, GAO, through your ongoing investigation, is going to name those entities where you sought assistance but you were unable to obtain it? In other words, is there going to be a trail of accountability here? Is that going to be part of your recommendation? Do you see that happening?

Mr. BAGDOYAN. Well, we will have to look at the assister issue in the broadest context possible within the controls focus of our work. I can't really comment beyond what the implications are to the entire assister population, because this was, again, a very narrow slice of that population that we looked at. So we will take a variety of factors into consideration, but in terms of naming names, I don't think that at this time or in the future, we would necessarily go that route.

Mr. PAULSEN. Well, and let me just ask this, then. So knowing 5 of 6 or 11 of 12, we are talking high percentages here, right, 80 to 90 percent of issues here. Is a part of the investigation, I would expect, accountability, right, as a part of your investigation, maybe not naming names, but naming those that—where the contracts were let, where the navigators were supposed to be providing these services, where there is no accountability in essence, correct?

Mr. BAGDOYAN. I think from the perspective of looking at the controls in their totality, that is an area that we will take a look at, but, again, I would emphasize the narrowness and the smallness of our sample, and the percentages would be out of whack if we had something that would be projected to those populations.

Mr. PAULSEN. Thank you, Mr. Chairman.

Yield back.

Chairman BOUSTANY. Thank the gentleman.

Mr. Davis, you are recognized for 5 minutes.

Mr. DAVIS. Thank you very much, Mr. Chairman.

And thank you, Mr. Director.

It seems to me that this is a very interesting investigation, that we are investigating what we think might happen. And I guess from watching television, I am of the opinion that much of the forensic work relative to investigations are about things that have occurred, and we are trying to find out how and why. It is interesting to me that the focus of the investigation is on individuals who would qualify for a subsidy, yet that there isn't anything that we can project they are going to benefit; that the beneficiaries become the insurance companies. It certainly does not become them. So if we can't establish any intent relative to fraud, then we can establish that maybe somebody who was helping them or somebody who was giving them information ha

lish that maybe somebody who was helping them or somebody who was giving them information ha

lish that maybe somebody who was helping them or somebody who was giving them information had not been trained as well as they should have been and, as a result of that, mistakes occur, and yet we still focus on them.

Let me ask you, is the 11 out of 12, is that really accurate? I mean, it is hard to determine the accuracy of projections sometimes. Anyway, things don't always go as it looks as though they would, but is the 11 of 12, is that a firm level of accuracy that we really could expect?

Mr. BAGDOYAN. Thank you for your question. The intent of this sample was not to project in any way. It is too small of a sample to do so, anyway. The intent of this phase of our work, the investigative undercover phase, is basically to identify areas for potential focus for our future work in terms of the overall controls and then the specific controls and tools and how they interact, where they are in the process and how they might work or not work depending on their application. So it was not intentional on our part to say, Well, 11 out of 12 we can project to the entire universe of applicants. And that is one of the limitations that I identified in my oral comments.

Mr. DAVIS. I have always thought and felt that a bit of prevention is worth much more than the cure, and so surely if we can prevent things from happening, but I guess I am wondering, where would the money come from since we have not passed an HHS appropriation bill, since "cut, cut, cut" has been the theme of our colleagues on the other side? Where would the money come from to do this broad investigatory work that related across the board to these individuals who could get a subsidy, but it wouldn't go to them? I mean, what is——

Mr. BAGDOYAN. Well, certainly, sir, I can't comment on the budget necessarily to do this work, but I would concur with your earlier comment about the importance of preventative controls, what we call the front-end controls. That is part of GAO's fraud prevention framework. So I would agree to that extent, that that is where the action has to happen, because the back-end controls traditionally are less effective.

Mr. DAVIS. Well, thank you very much.

I yield back.

Chairman BOUSTANY. I thank the gentleman.

Before we go to the next questioner, I also want to make the point, and I think you—it is highlighted in your report, that you—even though the sample size is small, you sampled diverse areas of the country, rural and urban. So it sort of gives us, even with a small number, kind of a broad snapshot of—within the confines of those small numbers, that we have a trillion dollar program over 10 years, we are very concerned about the integrity of the program, and safeguards on the front end, which we know are more effective than trying to go through pay and chase, which as we know from other programs, that is not effective in recouping and protecting taxpayers. And so I just wanted to make that point, and if—and I want you also to state for the record a little bit about the fact that you looked at diverse areas, both urban and rural.

Mr. BAGDOYAN. Certainly we tried to have a representation of different geographic locations in the country, and within those geographic locations, we attempted to represent urban and rural settings so that we had, given, again,

graphic locations, we attempted to represent urban and rural settings so that we had, given, again,
graphic locations, we attempted to represent urban and rural settings so that we had, given, again, our limited sample, as diverse coverage as possible.

Chairman BOUSTANY. And you will continue the investigation along those same lines, so——

Mr. BAGDOYAN. Right. As more information becomes available, the more we analyze, we will identify, as appropriate, additional steps in that regard, yes.

Chairman BOUSTANY. Thank you.

Mr. Marchant, you are recognized for 5 minutes.

Mr. MARCHANT. Thank you, Mr. Chairman.

And thank you, Director, for this report.

I guess the word is out to America that what we have suspected all along is true. Wall Street Journal says fictitious applicants get to U.S. health insurance tax credits. The Washington Post says, Federal uncover investigation signs up fake applicants for ACA coverage and subsidies. And then NBC comes out and says, GAO sting finds it easy to fake it. Get Obamacare premiums.

So what we have suspected since we passed this law and it began to be implemented is that it is another Federal program that is going to be easily scammed and easily accessed by someone willing to commit fraud. We have several programs in the Federal Government that we find out daily that that is happening to.

I guess we also found out what the new definition of a navigator is. The new definition of a navigator is a fraud assistant agent. It is something that we have suspected since the first TV and news stories came out when we found people in these agencies not being able to answer questions, some of them had criminal backgrounds. From the very beginning, we suspected that the people that were going to be assisting people to sign up to this program were not qualified to do so. This report, this preliminary report completely ratifies that.

In one of these stories, it says that 4.3 million of the applicants have some inconsistency in their application, 4.3 million, and the agents and the contractors that are supposed to be vetting these

inconsistencies are so far behind, they will never catch up, never catch up to verifying these inconsistencies.

This last year, this year, we will have spent $17 billion on this program, another Federal program. Where did the money come from? The money came from taxpayers. In the last year, millions of taxpayers in the United States have found out that they are paying for Obamacare; they are paying in extra taxes. So it is the responsibility of this committee, it is the responsibility of this Congress to make sure that those taxpayers, those hardworking taxpayers do not have their money wasted, and so I think that your preliminary report has done a great service to this Congress and this committee, because it is giving us some direction now in finding out exactly how to address this problem.

When you gave the navigators the information, did you provide income information?

Mr. BAGDOYAN. Yes. I would refer you to my opening statement where I said that the one person who did assist us, correctly identified our income, which we gave this person, as being outside the boundaries of qualifying for a subsidy. So we did provide a number, and this assister assessed that number and correctly told us that it was outside of that bo

number, and this assister assessed that number and correctly told us that it was outside of that bo
number, and this assister assessed that number and correctly told us that it was outside of that bound.

Mr. MARCHANT. So your—in these 11 to 12 cases—in all 12 cases, you provided the IRS with income that was verifiable and you provided them with a Social Security Number that was verifiable?

Mr. BAGDOYAN. We provided a series of data points as part of the application, but I will remind you that the six navigator scenarios are not intended to seek coverage like the other 12 were. So it is a technical nuance, but it is a very important one to make. But we did provide information online during our online application process, and then when we switched over to the telephone process, we were submitting various bits of information, yes.

Mr. MARCHANT. So you could draw the conclusion that, as flawed as the Web site started and as flawed as it is and as flawed as it is, and now on the back end as you described, catching those fraud and catching those inconsistencies, the Web site, you found you—it was much more difficult on the Web site to give them false information and sign up than it was if you would switch to a navigator?

Mr. BAGDOYAN. Well, we were flagged on the online process. We were referred to the contractor, who was intended to clarify or verify our identity. When they weren't able to do so, they directed us to the call center, and that is where we got through in terms of obtaining coverage.

Now, I would say that when we did provide information as part of the application process, there were inconsistencies that were flagged, and we subsequently received requests to submit documentation which would be—to substantiate the information we were providing, and that is the documentation that is now at the back end with the contractor, who processes that documentation.

And as I mentioned earlier, in several instances regarding two of our applicants, those documents have been verified as authentic.

Mr. MARCHANT. Thank you, Director.

Chairman BOUSTANY. I thank the gentleman.

Ms. Jenkins, you have 5 minutes.

Ms. JENKINS. Thank you, Mr. Chairman. Thank you for having this important hearing.

Mr. Director, thank you for being here. We are very concerned about this GAO report and your findings that the premium tax credit offered by enrollment in the exchange is vulnerable to abuse. In particular, it is concerning to me. This subcommittee has held two similar hearings on this topic this year. And your findings have confirmed our fears.

When Commissioner Koskinen of the IRS testified on this subject back in May, he told this subcommittee that he hoped, he hoped taxpayers would do certain things, such as notifying the exchange of life events, so that their subsidies would be adjusted, but acknowledged that more public outrage might be necessary to ensure that the enrollees are compliant.

In June, a panel of tax experts told this subcommittee that it was very unlikely that taxpayers would notify the exchange of their life events. I am afraid that this will leave those receiving premium tax credits on the hook for thousands of dollars in penalties in the future.

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Now this GAO report highlights the broader problem of intentional waste, fraud, and abuse of premium tax credits by providing that these agencies simply do not have the infrastructure necessary to verify this information before handing taxpayer dollars to bad actors. Instead of doubling down on the investigating wrongful premium tax credits, CMS issued a proposed rule in late June that will automatically reenroll participants in the exchange for 2015.

So I have several questions for you. First, do you believe that the administration currently has the ability to accurately verify eligibility for these premium tax credits? And do you believe that it will be possible for CMS to accurately verify eligibility for the current enrollees in time for open season in November?

Mr. BAGDOYAN. Thank you for your question. At this point, we haven't touched those areas, but they are within the scope of our work. And as appropriate, we will follow up vigorously. And again, within the broad context of looking at all the controls, that would be part of the picture, definitely.

Ms. JENKINS. Okay. But you saw nothing that indicated that these——

Mr. BAGDOYAN. Not at this point. We narrowly focused on our investigation at the beginning of our overall work to, again, touch several controls and see which areas were candidates, if you will, for additional focus.

Ms. JENKINS. Okay. Fair enough. Could you just comment on whether you believe automatically reenrolling exchange participants is a good idea?

Mr. BAGDOYAN. I can't comment. That is really not part of our scope right now. So I can't comment on that.

Ms. JENKINS. Okay. Thank you.

I yield back.

Mr. BAGDOYAN. My pleasure.

Chairman BOUSTANY. I thank the gentlelady.

We will next go to Ms. Black for 5 minutes.

Mrs. BLACK. Thank you, Mr. Chairman.

I want to thank you for having this very important hearing. These are subject matters that we have been talking about for quite some time, at least since I have been here for the last 3 and a half years and ones that are close to my heart.

I want to reiterate the fact that this is so important, as you said, Mr. Chairman, that these dollars do not go out the door and then us try to retrieve them. We know from other tax credits that have been given, that there is billions of dollars that go out and we never receive those back. So this is so important that we get this right now and take care of this, because those dollars are precious, and they need to be used for people that truly need the assistance. So thank you again. Let me ask you about something that is not in your report and has not been mentioned here today, and that is there were two major planks to the ACA. One is the verification of an income to make sure that someone qualified for those subsidies. But the second was that if you had employer-sponsored insurance, you would not be eligible for those subsidies. And I don't see anything here to show that that is one of the major planks that we should be looking for. Are you looking at that major plank in the work that you are doing?

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we should be looking for. Are you looking at that major plank in the work that you are doing?

Mr. BAGDOYAN. I am not familiar with that particular aspect. It is a big plan. But we would be happy to get back to you on that particular point.

Mrs. BLACK. Well, I know that the data hub was supposed to do a lot. And we looked at that data hub from the beginning and knew that it was very complicated. As a matter of fact, a number of people who are experts in the industry said it was so complicated they didn't believe that it ever could be done. So the data hub was supposed to be one of the mechanisms to be used, but I am just really curious, because I don't know that we know how many people currently are applying for these subsidies that potentially would not be eligible because of their employer-sponsored insurance. So I would really love to hear back from you on what your thoughts are on that because it is a major plank. And I think that we have got to make sure that that one is covered as well.

As far as the income verification goes, again, the data hub was supposed to be the mechanism to be used that it would then ping into the IRS. The IRS would then get that information back to say whether that was good information or not. But would it make sense in your opinion that they would be using something, say, like Equifax that is being used by the SNAP program to verify income?

Mr. BAGDOYAN. I believe Equifax does have a role, but I would have to, again, check and confirm that and get back to you.

Mrs. BLACK. Do you also know in your investigation whether this administration has provided any deadline for these contractors to complete the remaining inconsistencies? Because I understand there is a large number of those. So, in the meantime, people potentially are getting the subsidies, but it seems that it is going to take a long time to have those inconsistencies verified. Do you have any information to share with us on where this administration is going?

Mr. BAGDOYAN. Based on our visit to the document processing contractor's facility, they are actively trying to clear out the backlog of inconsistencies. But in terms of timing, I would have to again get back to you on that if there is a specific end date for that process. But as you can imagine, there are hundreds of thousands of application-related documents that need to be vetted and cleared. And there are also, as my statement alludes to, a number of documents which cannot be matched against applications as well.

Mrs. BLACK. And then my final comments, really more comments than anything, but when we looked at the navigators, and I read all of the rules and regulations related to the navigators, and noted at that time that it would be pretty difficult for a navigator with a small amount of training that they received to even be able to help somebody work through a very complicated system, especially if that individual had a complicated application process. So I would be very interested to see what additional information you get back about what navigators are able to do for those who come to get assistance. And there certainly is a difference between the navigators and the navigator assistants, the assistant navigators, because there is a big difference in their training. So I would be very interested to see, as you complete your report, on the kind of information and help that are given to people, given the amount or the lack of education that the

of information and help that are given to people, given the amount or the lack of education that the
of information and help that are given to people, given the amount or the lack of education that they really have in order to take on that role.

Thank you, Mr. Chairman.

Chairman BOUSTANY. I thank the gentlelady.

Mr. Kelly, you are recognized for 5 minutes.

Mr. KELLY. I thank the chairman.

Mr. Bagdoyan, thanks for being here today. I was reading through your testimony last night. United States Government Accountability Office. That is who you represent. What is your job? I mean, why even create a GAO?

Mr. BAGDOYAN. Well, GAO exists to serve the Congress in its investigative and oversight capacity in its broadest term.

Mr. KELLY. Okay. So, I mean, it is kind of an early detection, right? I mean, if you were in the private sector—I got to tell you, I came out of the private sector. If I had the ability to go to an agency before I made an investment, kind of the look-before-you-leap type of philosophy, because in the private sector you are not allowed to make a mistake. You go out of business. To have the ability to look ahead and see what the total cost of this program was going to be; where are the traps on this? Where were the downfalls on this? What could possibly go wrong? When you look

at the numbers, these are staggering. There is nobody in the private sector that would look at this model and say you know what, I think that is acceptable. My God, you just can't do those things, not in the private sector.

Now, in government, it is kind of fun because we work with OPM. And for those of you that aren't in the private sector, that means other people's money, in this case hardworking American taxpayers' money. So it is easy to throw those dollars around and say you know what, unintended consequences. Doggone it, we did it again. And we are going to have the GAO do a study. And then you do a study, and we say, well, wait a minute that is too limbed. You can't tell me that and expect me to believe that somehow down the road this has a happy ending. What do you see coming? And I am just talking about from a practical everyday American's outlook on life. People that get up every morning, throw their feet out over the bed, go to work so that they can put a roof over their children's heads, spoons on the table, clothes on their backs, and keep giving money to a government who they are trusting to spend it the right way, and we are finding out that they don't even trust us any more than that because we have wasted so much of it. The district that I come in, you know what people watch? They don't watch dollars, they watch pennies. And the old adage is if you watch pennies, you pay attention to pennies, the dollars will add up. My God, $17 trillion and climbing in the red ink here, and we are still saying, you know what, this is all hypothetical. Come on, if we can't do these wonderful things. But it comes down to this. Our job in this body is to protect the hardworking American taxpayers' investment, their tax dollars, and make sure that they are being spent the right way. And if we find something wrong, early detection is always the best way to get a correction. Certainly in your health it is much better to find out early on that you are on the wrong trajectory and you have to change your lifestyle or you have got to do something.

the wrong trajectory and you have to change your lifestyle or you have got to do something.
the wrong trajectory and you have to change your lifestyle or you have got to do something.

So just tell me, the GAO, the job that you are doing, you are looking at things right now, and there has got to be bells and whistles going off everywhere. And it is my understanding that the administration was told, you know what, light is not green. It is yellow, and it is about at the end of its yellow term. It is going to turn red real quick. You better look before you leap. You better make sure that you are spending this money the right way because you are collecting it from people who go to work every day and put that money in this furnace. That is where the revenue comes from. It does not come from Congress. It comes from the American taxpayer.

So I just wonder, as you go on with this study, is there anything that you look at and think, well, my gosh, I think if we keep going the way we are going, things are going to be all right because this is all hypothetical. And I got to tell you I am fed up with every issue that involves policy that affects the American people to be about politics. Really? Really. If you came here for a political career and you didn't come here for the people that you represent, then

my God, take a look at the mirror and say, am I still doing what they sent me to do? So you are sitting there every day. You are watching this go on. You got to sit there and just pull your hair out and say, you know, I keep telling them that it is not working. I keep telling them that they are wasting dollars. And they keep saying to me, too early. Too early. This is too partisan. You are seeing this coming. Where does this lead as we go forward?

Mr. BAGDOYAN. Mr. Kelly, our work is definitely ongoing. In the next several months, we will be looking again, as I mentioned earlier, at a wide range of issues. And when we issue our report, we are likely to have recommendations to address the issues we have identified and direct those recommendations to the relevant agencies. And they are supposed to get back to us with their specific plans within 60 days of how to begin implementing those.

Mr. KELLY. I hope it works better for you than for me, because the people I have talked to said, you know what, Kelly, you got to get reelected. I have just got to get through this cycle. The people I talk to, the bureaucrats, the problem is that you folks don't understand, this is our career. And we will keep doing what we have to do. There is something drastically wrong here. And I would hope that you are able to stay on line and keep doing what you do best.

I just think that sometimes you try to help people, and they turn a deaf ear and a blind eye to what you have offered them. And I see that happening here. And at the end of the day, it is the American taxpayer who foots the bill for every single thing that comes out of their pockets. And they have co-signed a note for the future that includes their children, their grandchildren, and their great grandchildren. And we sit here with our eyes covered and our ears plugged and say, no, no, no, this is just politics. It is not politics. This is about people, and it is about the American people. I thank you for your work. And please keep doing what you are doing. God bless you.

Mr. BAGDOYAN. Thank you.

Chairman BOUSTANY. I thank the gentleman. I think he made a very eloquent case for early and aggressive oversight because he certainly made clear that the American people do want accountability.

Thank you, Mr. Bagdoyan. Thank you to you and your staff for appearing before us today, and the important work that you are doing. Please be advised that members may have additional questions they may submit in writing to you.

Mr. BAGDOYAN. Absolutely.

Chairman BOUSTANY. And we expect answers to be made part of the record.

And with that, this subcommittee now stands adjourned.

[Whereupon, at 11:42 a.m., the subcommittee was adjourned.]

Member Submissions For The Record

The New York Times http://nyti.ms/1yepQR5

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Obamacare Fails to Fail

JULY 13, 2014

Paul Krugman

How many Americans know how health reform is going? For that matter, how many people in the news media are following the positive developments?

I suspect that the answer to the first question is "Not many," while the answer to the second is "Possibly even fewer," for reasons I'll get to later. And if I'm right, it's a remarkable thing — an immense policy success is improving the lives of millions of Americans, but it's largely slipping under the radar.

How is that possible? Think relentless negativity without accountability. The Affordable Care Act has faced nonstop attacks from partisans and right-wing media, with mainstream news also tending to harp on the act's troubles. Many of the attacks have involved predictions of disaster, none of which have come true. But absence of disaster doesn't make a compelling headline, and the people who falsely predicted doom just keep coming back with dire new warnings.

Consider, in particular, the impact of Obamacare on the number of Americans without health insurance. The initial debacle of the federal website produced much glee on the right and many negative reports from the mainstream press as well; at the beginning of 2014, many reports confidently asserted that first-year enrollments would fall far short of White House projections.

Then came the remarkable late surge in enrollment. Did the pessimists

face tough questions about why they got it so wrong? Of course not. Instead, the same people just came out with a mix of conspiracy theories and new predictions of doom. The administration was "cooking the books," said Senator John Barrasso of Wyoming; people who signed up wouldn't actually pay their premiums, declared an array of "experts"; more people were losing insurance than gaining it, declared Senator Ted Cruz of Texas.

But the great majority of those who signed up did indeed pay up, and we now have multiple independent surveys — from Gallup, the Urban Institute and the Commonwealth Fund — all showing a sharp reduction in the number of uninsured Americans since last fall.

I've been seeing some claims on the right that the dramatic reduction in the number of uninsured was caused by economic recovery, not health reform (so now conservatives are praising the Obama economy?). But that's pretty lame, and also demonstrably wrong.

For one thing, the decline is too sharp to be explained by what is at best a modest improvement in the employment picture. For another, that Urban Institute survey shows a striking difference between the experience in states that expanded Medicaid — which are also, in general, states that have done their best to make health care reform work — and those that refused to let the federal government cover their poor. Sure enough, the decline in uninsured residents has been three times as large in Medicaid-expansion states as in Medicaid-expansion rejecters. It's not the economy; it's the policy, stupid.

What about the cost? Last year there were many claims about "rate shock" from soaring insurance premiums. But last month the Department of Health and Human Services reported that among those receiving federal subsidies — the great majority of those signing up — the average net premium was only $82 a month.

Yes, there are losers from Obamacare. If you're young, healthy, and affluent enough that you don't qualify for a subsidy (and don't get insurance from your employer), your premium probably did rise. And if you're rich enough to pay the extra taxes that finance those subsidies, you have taken a financial hit. But it's telling that even reform's opponents aren't trying to

highlight these stories. Instead, they keep looking for older, sicker, middle-class victims, and keep failing to find them.

Oh, and according to Commonwealth, the overwhelming majority of the newly insured, including 74 percent of Republicans, are satisfied with their coverage.

You might ask why, if health reform is going so well, it continues to poll badly. It's crucial, I'd argue, to realize that Obamacare, by design, by and large doesn't affect Americans who already have good insurance. As a result, many peoples' views are shaped by the mainly negative coverage in the news media. Still, the latest tracking survey from the Kaiser Family Foundation shows that a rising number of Americans are hearing about reform from family and friends, which means that they're starting to hear from the program's beneficiaries.

And as I suggested earlier, people in the media -- especially elite pundits -- may be the last to hear the good news, simply because they're in a socioeconomic bracket in which people generally have good coverage.

For the less fortunate, however, the Affordable Care Act has already made a big positive difference. The usual suspects will keep crying failure, but the truth is that health reform is -- gasp! -- working.

A version of this op-ed appears in print on July 14, 2014, on page A19 of the New York edition with the headline: Obamacare Fails to Fail.

Rep. John Lewis 2

POLITICO

The verdict is in: Obamacare lowers uninsured

By: David Nather
July 10, 2014 08:20 PM EDT

The evidence is piling up now: Obamacare really does seem to be helping the uninsured.

Survey after survey is showing that the number of uninsured people has been going down since the start of enrollment last fall. The numbers don't all match, and health care experts say they're not precise enough to give more than a general idea of the trend.

But by now, the trend is unmistakable: Millions of people who didn't have health insurance before the Affordable Care Act have gained it since last fall. The law is not just covering people who already had health coverage, but adding new people to the ranks of the insured — which was the point of the law all along.

(Also on POLITICO: Employer mandate at heart of GOP-Obama suit)

There's still a lot of variation in the numbers, too much for health care experts to pin down an exact number with any confidence. But even health care analysts who think the law is a bad idea acknowledge that the evidence suggests the uninsured are being helped. Given the predictions of doom that accompanied the law's passage and launch, that's a sweet bit of vindication for the president and ACA supporters.

"It will be better when we've got a whole year behind us, so we can tell how much [in the surveys] was noise and how much was reality," said Douglas Holtz-Eakin of the conservative American Action Forum, a frequent critic of the law. "Having said that, it sure looks like there are more people covered, and that's a good thing."

A survey by the Commonwealth Fund found that 9.5 million fewer adults are uninsured now than at the beginning of the Obamacare enrollment season. The Urban Institute's Health Reform Monitoring Survey found a similar drop, with 8 million adults gaining coverage. And Gallup-Healthways survey reported that the uninsured rate has fallen to 13.4 percent of adults, the lowest level since it began tracking health coverage in 2008.

(Also on POLITICO: Obama on impeachment: 'Really?')

That was all on Thursday. In recent months, other surveys in the Gallup series have consistently found the same downward trend, and a RAND survey in April estimated that the law extended health coverage to 9.3 million Americans.

That's not going to end the fights over the health care law — not even close. Republicans say the debate isn't just about whether the law has helped uninsured people, but about all the side effects, like canceled health plans, higher premiums for some people with individual health insurance, reduced work hours for part-time employees, and the

long-term costs to the nation.

Sen. Ted Cruz (R-Texas), who led the battle to defund the law last fall and could fight it again on the presidential campaign trail in 2016, insists the new surveys don't change the debate at all — because the real issue, in his view, is still the disruption of the canceled plans and higher premiums.

(Also on POLITICO: Rove to GOP: Work with Obama)

"Four years ago, before the law was implemented, it was possible to have good-faith disagreements about whether the law would work," Cruz told POLITICO on Thursday. "Today, seeing the utter disaster that has played out ... to me, it is the essence of pragmatism to realize that the law isn't working, and to repeal it and start over."

And even though the law's performance has stabilized since the clumsy rollout last fall, there are plenty of ways the side effects could still flare up again — through big premium increases for next year (they've been modest so far), another possible round of canceled plans and the potential for angry customers next year if they've received too much in subsidies and have to pay them back.

"The Republican argument was never that a trillion or two dollars would never cover any more uninsured. It was that the cost of doing so in higher health care costs and premiums, cancelled policies, increased government control of health care, and a myriad other negatives—were not worth it," said Republican pollster Whit Ayres." That argument still holds."

But the latest surveys have been a huge morale boost for the Obama administration and congressional Democrats, who now have armfuls of statistics to prove that the law is doing what it's supposed to do: help the uninsured.

"No matter whose estimates you look at, the facts about the Marketplace's first year are this: Millions of people have gained coverage because of the ACA, and millions more could if the remaining states did the right thing and expanded Medicaid," said an Obama administration official.

Adam Jentleson, a spokesman for Senate Majority Leader Harry Reid, declared that "Republicans have constructed an alternate reality in which the sky is always falling on Obamacare, but the facts tell a different story."

The new surveys have taken a lot of the uncertainty out of the Affordable Care Act's impact on the uninsured. Earlier this year, it appeared that it could be **months, if not years,** before Americans would answer the most basic questions about whether the law had actually covered uninsured people, thanks to the lag time in official government surveys and the vague wording of the questions in Obamacare applications.

Health care experts still want to see the official government surveys, but they say there are now enough unofficial surveys to prove that the law is reaching uninsured people. There are some people who are replacing old health coverage with new coverage, but it's now clear that millions of the law's customers didn't have health insurance before.

"One has to acknowledge that at this point, despite some continuing bumps in the road, the ACA is largely on track to accomplishing what it set out to do," said Larry Levitt of the Kaiser Family Foundation. "That, of course, doesn't mean that everyone is benefiting from

it or agrees with it. The law wasn't designed to create all winners and no losers."

Because of the variation in the surveys' numbers, "it could be a couple million more or less" than the Commonwealth estimates, Levitt said. And some of the reduction could be due to an improving economy, he added — but "the reductions we're seeing clearly swamp any effect from lower unemployment."

Still, Republicans aren't likely to give the Obama administration a lot of credit. Lately, they've been minimizing the significance of the big enrollment numbers by saying, hey, of course people are signing up — they'll have to pay fines under the individual mandate if they don't. "They made it illegal for it not to work. You have to be covered," Holtz-Eakin said.

But the Commonwealth Fund survey also suggested that most of the people who have signed up for the Affordable Care Act are happy with their coverage — and aren't just disgruntled people who were already insured and liked their own coverage better.

According to the survey, 58 percent of the Obamacare customers said they were better off under their new health coverage, and only 9 percent said they were worse off than they were before. Even among people who previously had health insurance — the ones who might resent having to switch — 52 percent liked the new coverage, while 16 percent said they were worse off.

Republicans on Capitol Hill, however, insisted they hear more from people who have had their own health insurance disrupted by the health care law -- not the ones who have gained coverage.

"The White House wants everyone to forget about the people who lost their insurance" because of canceled health plans, Cruz said. Even if most of those people have been able to replace it since then, he said, there are still many other Americans who have had their work hours reduced so their employers won't have to provide health coverage. And he predicted that "this fall, we're going to see premiums skyrocket again."

Sen. John Barrasso (R-Wyo.) dismissed the surveys, saying he is "hearing disproportionately from people who are unhappy with the way the law is affecting their own pocketbooks" — especially by "paying for more insurance than they need or want or will ever use."

The unspoken political reality is that Republican base voters aren't ready to let the GOP give up the fight, even if they wanted to. But there are also so many other issues in the fight — including the impact on other people's coverage and the cost of the law — that it was never likely to just go away, no matter how many uninsured people have been helped.

"I don't think it changes the debate, because the debate has so many dimensions," said Holtz-Eakin.

Public Submissions For The Record

Tim Albright

Submission for Oversight Subcommittee Hearing titled

"Hearing on the Verification of Income and Insurance Information Under the Affordable Care Act" on June 10, 2014

Tim Albright
West Branch MI

Recommendations for simplifying the verification of income for Obamacare applicants and for improving customer service for Obamacare:.

- Give Medicare cards to those affected by churning until issues are resolved especially if an appeal or an investigation is pending. http://obamacarerundown.blogspot.com/ describes a possible plan
- Avoid using estimated income and Base Obamacare subsidies and Medicaid entitlement on previous year earnings when we know the exact amount. This would mirror the income rules used for the Extra Help with Medicare Prescription Costs which is another program based on need.
- HHS/CMS must establish a physical presence in communities across the nation, just like Social Security does. http://whitecollargreenspace.blogspot.com/ describes a possible plan

On The Last Word on 1/6/14, Lawrence O'Donnell discussed churning with his guests, Jenni Bergal of Kaiser Health News and Ezra Klein. Re: WashPost article titled: "Churning between Medicaid and exchanges could leave gaps in coverage, experts warn" http://www.washingtonpost.com/national/health-science/churning-between-medicaid-and-exchanges-could-leave-gaps-in-coverage-experts-warn/2014/01/05/cf858d7e-73fa-11e3-8def-a33011492df2_story.html

On 1/5/14, I was on the phone for 90 minutes talking to a service rep at the Obamacare 800#. I have a friend who had earning just below the federal poverty level (FPL)in 2013. The benefit estimators on healthcare.gov tell him he must apply for Medicaid if expects to earn the same income in 2014. He just started a new job where he should earn about a $1,000 more or around $16,000. Since that figure is above the FPL and the estimators tell him that he qualifies for a monthly subsidy toward his premium of $488 per month. We ask the rep what happens if he estimates $16,000 and signs up for a Silver plan with a premium around $488/mo but then when he files his taxes at the end of 2014 his earnings total only $15,000. Since this is below the FPL, does he owe IRS back the $488/mo or about

$6,000.00 since the subsidy is a tax credit? He won't have that kind of money. Will he get Medicaid retroactively for 2014. It took her a long time to look it up and the only thing she could say was that if he earns more than his estimate he might owe some of the subsidy back but if he earns less, he should not owe any of the subsidy back. She could not give us a reference to a regulation, a pamphlet, or a web page at cms.gov. She also explain exactly what would happen if he calls in July to let HHS know is earnings will be less. Will his subsidy stop? If so, what month? And what if it takes his state 90 days to process a Medicaid application? Will there be a gop in coverage? Will he owe the first 6 months of subsidy money to IRS at the end of the year? Very Confusing?

Questions about the implementation of ACA regulations published at:

https://www.federalregister.gov/articles/2013/01/22/2013-00659/medicaid-childrens-health-insurance-programs-and-exchanges-essential-health-benefits-in-alternative#h-6

1 - Eligibility to expanded Medicaid and for ACA subsidies are based on estimated income for 2014. A person living in a state that did not expand Medicaid could estimate 2014 income a few hundred dollars over 133% of the federal poverty level (FPL) and be given an ACA subsidy for 2014 totaling several thousand dollars. 12 months later he finds that his income for 2014 is only 132% of FPL. Will he have to pay back $2,000 to $3,000 in ACA subsidies even though his income was a few hundred dollars less than he estimates? And he still does not qualify for Medicaid. Eligibility for ACA subsidies should be based on 2013 income which is already known and not an estimate. This is how SSA determines eligibility for Extra Help with Medicare Prescription Drug Costs where the govt pays the Medicare Part D premiums and gives low income people lower co-pays and deductibles.

2 - ACA regulations change Medicaid rules and neither program looks at a persons assets or lump sum payments like lottery winnings to determine eligibility. People could be rich and have millions of dollars assets and have his own corporation but not pay himself a wage and could get Medicaid or ACA subsidies. It was a big news item in Michigan a few years ago when a major lottery winner bragged about still being on Medicaid.

3 - Medicaid counts income on a monthly basis and ACA counts income on an annual basis. This can lead to a phenomenon called churning where a person can go back and forth between being eligible for Medicaid and then an ACA subsidy.

Go to this link and search for the word churning, This link includes comments that HHS received about the ACA regulations and what several commenters thought about the problem of churning.

https://www.federalregister.gov/articles/2012/03/23/2012-6560/medicaid-program-eligiblity-changes-under-the-affordable-care-act-of-2010#h-28

4- Exempting the dis-insured from penalties and allowing them to sign up for crappy catastrophic plans or keep their old and non-compliant plans seems to go against the whole principal of providing universal coverage.

5 - Miscellaneous Miscellaneous Questions

What efforts are made to help applicants that have limited abilities due to medical mental health issues. This should include trying to find advocates, guardians, or relatives that assist applicants.
Has HHS or their contractors run Obamacare applicants against Social Security, SSI, VA, etc not just to confirm income but to confirm which claimant's have fiduciaries, representative payees, guardians, or conservators that are responsible for their business.
Social Security has procedures for paying fees to attorneys that represent claimants that appeal subsidy decisions. Will Obamacare have similar procedures?

Possible Solution to items 1 through 5

Since:
Obamacare will remain complex and ever-changing and

1. It involves tax returns
2. Citizens will need a place to report changes and/or discrepancies in income
3. Citizens will need a place to go to resolve disputes with insurance companies

It will be imperative for Obamacare to have a presence on the community.

I worked for the Social security Administration for 34 years and for the last several years we were tasked with contacting 10's of thousands of citizens to verify income and assets for the Medicare Part D prescription program. Claimants filed initial applications and redetermination online or by mailing paper forms to a scanning facility. The call center would try resolve simple discrepancies. For more complex cases lists would be sent to one of the 1300 field offices to call, write, or have face-to-face interviews and accept documents. These list were monitored constantly by management and we were supposed to resolve issues within 30 days. We also got lists of cases to work when claimants failed to return redertermination forms or they lost Medicaid coverage. Let me know and can identify the agency instructions on SocialSecurity.gov. And we had always handled enrollments in Parts A and Part B. We have over 1300 offices nationwide. See my submission to the house ways and means committee below for a plan to roll-out ACA customer service and verification quickly and cheaply. It would take HHS significant time and money to do it on their own.

I also believe that HHS/CMS will need a physical presence in all communities in order to reach their goal of 7 million enrollees. There may be close to a million people who have started the process but it may be weeks before we know how accurate and timely the enrollment data is that HHS/CMS sends electronically to insurance companies. With hundreds of insurance companies it may take a month or more to know how well their software and staff are operating. Their software is new too.

CMS/HHS will need to have face-to-face interviews if claimants appeal subsidy decisions &/or overpayments or ask for waivers of overpayments. Video conferencing units are available in many field offices and CMS could add more. Face-to-face interviews will also be needed when guardians or representatives have disagreements with claimants or for developing fraud cases.

On October 29, 2013, I submitted a plan to the House Ways and Means committee that asks SSA to partner with HHS and all state Obamacare exchanges to allow ACA navigators and application helpers to use the empty workstations in all 1300 SSA offices nationwide. There are between 5,000 and 15,000 desks and computers available. This office space available is worth close to $200 million and they are unused due to staffing losses. There would be little to know costs since SSA has lost 15% of its staff in the last 6 years.

Making Obamacare enrollment campaign successful will be a long slog, especially, after all the negative publicity. We must put pressure on HHS and SSA to put Navigators and application helpers in all 1300 SSA offices. It could be done within 30 days. This would rebuild confidence in Obamacare. It will help people believe that it will be just as good as Medicare. The following plan could help make up for the confusion and frustration citizens are experiencing when trying to use Healthcare.gov

My plan is to have 5,000 to 10,000 Obamacare Application Helpers use the 5,000 to 10,000 empty workstations in the 1300 Social Security Offices nationwide. These organizations received grants to develop the roll-out of Obamacare. This would be a win-win for HHS and SSA as SSA is paying for office space they are not using and managers do not want to see dozens of local SSA offices shut down. Having Navigators in all 1300 SSA offices would make more efficient use of office space and equipment that has already been paid for and it would give HHS one simple location in most communities that is more trusted than any other agency.

POSSIBLE SAVINGS:
SSA has office space for 5000 people times annual overhead cost of $24,000 each/year = $120 million per year wasted if not used by ACA navigators. SSA has office space for over 25,000 available in evenings times $24,000 per year = another $600 million wasted if not used ACA navigators. Total savings if ACA workers use space already paid for by Social Security Offices = $720million/yr times 10yrs= $7 BILLION. If federal government saves this much it might pay for a single payer plan.

Possible Solution to Item 4 Give Temporary Medicare coverage for those with actions pending that have medical emergencies.

The dis-insured would be helped a lot more if they were given the option of enrolling in Medicare with HHS subsidizing the Medicare premiums:
http://www.medicare.gov/your-medicare-costs/costs-at-a-glance/costs-at-glance.html
Monthly premiums are:
$426 for Medicare Part A (inpatient)
$105 for Medicare Part B (outpatient)
$31 for Medicare Part D (prescriptions)
$562 total

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