IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

FAULK COMPANY, INC.,	§	
	§	
Plaintiff,	§	
	§	
vs.	§	
	§	
UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, XAVIER BECERRA, in his official capacity as Secretary of HHS, and CHIQUITA BROOKS-LASURE, in her official capacity as Administrator of CMS,	§	**CIVIL ACTION NO. 4:24-CV-00609-P**
	§	
Defendants.	§	

PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT AND BRIEF IN SUPPORT

While certain facts are necessary for the establishment of jurisdiction, venue and standing, and while the harm caused to Faulk Company, Inc. ("Faulk Company") is factual and very real, the facts are not in dispute. Rather, as the Court has stated, the matters before it are legal in nature. Accordingly, Plaintiff Faulk Company, Inc. hereby moves the Court to enter summary judgment as follows:

1. Against Defendants HHS, CMS, Secretary Becerra (or his successor) and Administrator Brooks-Lasure (or her successor) (collectively, the "HHS Parties") on Count III:

   a. Setting aside HHS regulation 45 C.F.R. § 155.310(i) as being contrary to law and in excess of statutory authority under 5 U.S.C. § 706(2)(A) and (C).

   b. Declaring that HHS regulation 45 C.F.R. § 155.310(i) is void retroactive to its inception;

c. Finding that Faulk Company is the substantially prevailing party, that the HHS Parties were not substantially justified in their position, that Faulk Company satisfies the means test of 28 U.S.C. § 2412(d)(2)(B), and that due to the difficulty of the issues in this case (principally the unique intersection of health and welfare benefits law with tax law) Faulk Company's attorneys' fees should be awarded at the rates billed;

d. Awarding Faulk Company its attorneys' fees, expenses, and costs from the preparation of the Complaint through the final disposition of this case; and

e. Such other relief as the Court may deem just and proper.

2. Against the United States of America on Count I:

a. Awarding Faulk Company $205,621.71 as a refund for excise taxes illegally assessed and collected by IRS, plus interest at the applicable underpayment rate;

b. Finding that Faulk Company is the substantially prevailing party, that IRS was not substantially justified in its position, that Faulk Company satisfies the means test of 28 U.S.C. § 2412(d)(2)(B), and that due to the difficulty of the issues in this case (principally the unique intersection of health and welfare benefits law with tax law) Faulk Company's attorneys' fees should be awarded at the rates billed;

c. Awarding Faulk Company its attorneys' fees, expenses, and costs from the preparation of the Complaint through the final disposition of this case; and

d. Such other relief as the Court may deem just and proper.

STATEMENT OF FACTS

Faulk Company has attached to this motion certain government documents and agency/congressional records that have been referenced in this and prior briefing both for the convenience of the Court and in an abundance of caution due to the age of some of these records, which may be archived before the final resolution of this case. To the extent the Court relies upon these sources as adjudicative facts, Faulk Company invites the Court to take judicial notice of them sua sponte under Federal Rule of Evidence 201(c)(1).

Plaintiff Faulk Company performs janitorial services in and around Fort Worth, Texas. With less than 500 employees and a net worth of less than $7 million, the business operates on small profit in comparison to its revenue. Oswalt Decl. ¶ 3. Faulk Company has not received anything other than a Letter 226-J purporting to be a "Section 1411 Certification," which does so in a manner contrary to statute, as explained in detail below. *Id.* at ¶¶ 3, 6. Faulk Company has never been granted the opportunity to appeal any exchange subsidy determination, or to present information to any exchange for review of the determination either by the exchange or the person making the determination, or to provide evidence of any employer-sponsored plan Faulk Company may have or of employer contributions to such plan, or to have access to the data used to make any employee's subsidy eligibility determination, or to know the names of employees who received subsidies and whether or not those employees' incomes are above or below the threshold by which the affordability of an employer's health insurance coverage is measured. *Id.* at ¶ 5.

Faulk Company offered traditional group health insurance to its employees prior to 2019, but not one employee enrolled in it, so Faulk Company stopped promoting it. *Id.* at ¶ 8. If Faulk had notice or certification in reasonable proximity to an employee's determination of eligibility for subsidized exchange coverage that it may be liable for 4980H excise taxes, Faulk would have

continued to promote its insurance plan, despite Plaintiff's belief based on past pattern and practice that no employee would have enrolled in it. *Id.* at ¶ 9.

IRS's three (3) year delay in providing to Faulk Company its purported Section 1411 Certification through letter 226-J further denied Faulk Company access to real-time information regarding its excise tax liability, thus forcing it to act reactively rather than proactively.

Faulk Company first received a letter 226-J from IRS on December 1, 2021, paid the ESRP at issue December 28, 2021 (albeit under protest) in the amount of $205,621.71, and filed a claim for refund on Form 843 January 28, 2022. *Id.* at ¶ 10. More than six months after silence from IRS regarding the Form 843 or anything that could be considered a claim of disallowance from the IRS, Faulk Company filed this lawsuit.

ARGUMENTS AND AUTHORITIES

Plaintiff Faulk Company, Inc. does not, at this time, move the Court for summary judgment as to Count IV. Count IV is an Administrative Procedures Act challenge under 5 U.S.C. § 706(2)(A) alleging that HHS acted arbitrarily and capriciously or otherwise abused its discretion. Such challenges are based on the administrative record, which the defending agency is to certify and file with the reviewing court. HHS has not yet filed with this Court its certified administrative record for its issuance of HHS regulation 45 C.F.R. § 155.310(i), but neither do we need to wait. It is not necessary for this Court to reach the issue of whether HHS acted arbitrarily or capriciously or abused its discretion because the statutory language of Section 1411 of the Affordable Care Act (42 U.S.C. § 18081) and Internal Revenue Code Section 4980H are sufficient, as Faulk Company has demonstrated in Plaintiff's Response to Defendant's Motion to Dismiss and Brief in Support, ECF No. 24.

In reply to Faulk Company's response, HHS and the United States have continued to press for an interpretation of those statutes that would do material, injurious harm to the English

language, and it is simply untenable. The arguments presuppose the conclusion, and they ignore—or at least downplay—grammar, syntax and the very meaning of words Congress used.

HHS and the United States make a lot of hay over the 4980H excise tax being a monthly calculation and the fact that employees can claim subsidies on their tax returns after-the-fact versus the Section 1411 due process taking place only at an employee's initial application to an exchange, but those arguments miss the point. The Section 1411 certification element in Code Section 4980H(a)(2) and (b)(1)(B) is only a trigger; it is not the method of calculating an ESRP excise tax. The method of calculation is later in the clause that begins, "then there is hereby imposed…." The details needed to calculate an ESRP excise tax become relevant only after the clause establishing the trigger is satisfied. (Notice that the triggering language requires just a single employee, whereas the calculation methodology clause is per-employee.) Similarly, it is irrelevant that employees technically do not need to apply for subsidies on the exchange and can instead claim them on their tax returns. Again, the number of people receiving subsidies is part of the calculation of the tax, not its trigger. The trigger gives way to the effect; the effect does not define the trigger. It is quite conceivable that Congress understood that there might be a rare situation where an employer would not owe an ESRP excise tax if not even one employee applied to the exchange and only claimed subsidies on their individual tax returns. Imperfect solutions are a hallmark of representative government.

Perhaps more fatal to HHS' and the United States' interpretation is that it flies in the face of how Section 1411 and Code Section 4980H interact. Of the two elements in the excise tax statute, Code Section 4980H, the one pertaining to employees receiving subsidies merely states that one or more employees "has been certified to the employer under section 1411 of the Patient Protection and Affordable Care Act as having enrolled for such month in [exchange coverage] with respect to which [a subsidy] *is allowed or paid*." 26 U.S.C. § 4980H(a)(2), (b)(1)(B)

(emphasis supplied). The employee's eligibility for the subsidy is not an element, only allowance or payment of a subsidy, irrespective of whether that subsidy was paid or allowed based on inaccurate, false or misleading information from the employee. Because Code Section 4980H has no element of employee eligibility, it does not permit an employer to defend an ESRP excise tax assessment on the basis that any employee was ineligible for a subsidy, even though the payment or allowance of a subsidy is a key element.

The silence in 4980H concerning employee eligibility for subsidies speaks volumes. In crafting Code Section 4980H, Congress was clearly relying upon the employer notice and appeal process detailed in Section 1411(f)(2) to produce the certification referred to Code Section 4980H. Is it any wonder, then, why Congress felt it needed to pass a second law reiterating the importance of the Section 1411 process mere months after HHS issued its due-process-sidestepping regulation 45 C.F.R. § 155.310(i)?

> Notwithstanding any other provision of law, the Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall ensure that American Health Benefit Exchanges verify that individuals applying for premium tax credits under section 36B of the Internal Revenue Code of 1986 and reductions in cost-sharing under section 1402 of the Patient Protection and Affordable Care Act (42 U.S.C. 18071) are eligible for such credits and cost sharing reductions *consistent with the requirements of section 1411* of such Act (42 U.S.C. 18081).

Continuing Appropriations Act, 2014, 2014, Pub. L. 113-46 (Oct. 17, 2013), at § 1001(a) (emphasis supplied).[1]

[1] Plaintiff has located the certification to Congress required by Section 1001(a) of the Continuing Appropriations Act, 2014 that HHS was to provide before it could provide subsidies on the exchanges. Consistent with HHS' general failure to involve employers in the process, when it certified to Congress that the exchanges "verify that applicants for advance payments of the premium tax credit and cost-sharing reductions are eligible for such payments and reductions, consistent with the requirements of section 1411," HHS failed to include any process whatsoever for employer notices or appeals. *See* Letter from Kathleen Sebelius, Secretary of HHS, to The Honorable Joseph R. Biden, Jr., President of the Senate (Jan. 1, 2014), *available at* https://www.cms.gov/cciio/resources/letters/downloads/verifications-report-12-31-2013.pdf.

Section 1411 and Code Section 4980H are sequential; the due process required by Section 1411 is a statutory prerequisite to the assessment of any ESRP excise tax. IRS has no authority to issue any certification under Section 1411, and HHS cannot delegate it. The due-process-sidestepping HHS regulation 45 C.F.R. § 155.310(i) is completely contrary to the language of the statute, and it must be set aside. Moreover, IRS cannot issue any Section 1411 certification, so Faulk Company is entitled to a refund.

REQUEST FOR ORAL ARGUMENT

Plaintiff Faulk Company, Inc. respectfully requests that the Court permit the parties an opportunity to present oral argument on the matters before it.

Respectfully submitted,

/s/ David L. LeFèvre

David LeFevre
Texas Bar No.: 24072202
Christine Vanderwater
Texas Bar No.: 24137259
LeFevre Law PC
Mail: 1302 Waugh Dr #189
Houston, TX 77019
Office: 4201 Main St, Ste 200-153
Houston, TX 77002
(713) 581-1987
david@erisefire.com
christine@erisafire.com

Taylor J. Winn
Texas Bar No. 24115960
Christopher Howe
Texas Bar No. 10089400
Kelly Hart & Hallman LLP
201 Main Street, Suite 2500
Fort Worth, TX 76102
Telephone (817) 332-2500
Facsimile (817) 878-9280
christopher.howe@kellyhart.com
taylor.winn@kellyhart.com

ATTORNEYS FOR PLAINTIFF FAULK COMPANY, INC.

CERTIFICATE OF SERVICE

On March 7, 2025, I electronically submitted the foregoing document with the clerk of court for the U.S. District Court, Northern District of Texas, using the electronic case filing system of the court. I hereby certify that I have served all counsel and/or pro se parties of record electronically or by another manner authorized by Federal Rule of Civil Procedure 5(b)(2).

/s/ Taylor J. Winn
Taylor J. Winn

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

FAULK COMPANY, INC.,	§	
	§	
Plaintiff,	§	
	§	
vs.	§	
	§	
UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, XAVIER BECERRA, in his official capacity as Secretary of HHS, and CHIQUITA BROOKS-LASURE, in her official capacity as Administrator of CMS,	§	**CIVIL ACTION NO. 4:24-CV-00609-P**
	§	
Defendants.	§	

APPENDIX IN SUPPORT OF PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT

NOW COMES, Plaintiff Faulk Company, Inc. and files this Appendix in Support of Its Motion for Summary Judgment.

EX. NO.	DESCRIPTION	APP. PAGES
A	Dawson Oswalt Declaration	1-5
B	Frequently Asked Questions Regarding The Federally-Facilitated Marketplace's1 (FFM) 2016 Employer Notice Program	6-8
C	Verification of Household Income and Other Qualifications for the Provision of Affordable Care Act Premium Tax Credits and Cost-Sharing Reductions	9-24
D	Amendment to Reconciliation Act of 2010	25-60
E	OIG Report: Not All Internal Controls Implemented by the Federal, California, and Connecticut Marketplaces were Effective in Ensuring that Individuals were Enrolled in Qualified Health Plans According to Federal Requirements	61-152
F	Federal Health Insurance Exchange 2019 Open Enrollment	153-160

Respectfully submitted,

/s/ David L. LeFèvre

David LeFevre
Texas Bar No.: 24072202
Christine Vanderwater
Texas Bar No.: 24137259
LeFevre Law PC
Mail: 1302 Waugh Dr #189
Houston, TX 77019
Office: 4201 Main St, Ste 200-153
Houston, TX 77002
(713) 581-1987
david@erisefire.com
christine@erisafire.com

Taylor J. Winn
Texas Bar No. 24115960
Christopher Howe
Texas Bar No. 10089400
Kelly Hart & Hallman LLP
201 Main Street, Suite 2500
Fort Worth, TX 76102
Telephone (817) 332-2500
Facsimile (817) 878-9280
christopher.howe@kellyhart.com
taylor.winn@kellyhart.com

ATTORNEYS FOR PLAINTIFF
FAULK COMPANY, INC.

CERTIFICATE OF SERVICE

On March 7, 2025, I electronically submitted the foregoing document with the clerk of court for the U.S. District Court, Northern District of Texas, using the electronic case filing system of the court. I hereby certify that I have served all counsel and/or pro se parties of record electronically or by another manner authorized by Federal Rule of Civil Procedure 5(b)(2).

/s/ Taylor J. Winn
Taylor J. Winn

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

FAULK COMPANY, INC.,	§	
	§	
Plaintiff,	§	
	§	
	§	
vs.	§	
	§	
UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, XAVIER BECERRA, in his official capacity as Secretary of HHS, and CHIQUITA BROOKS-LASURE, in her official capacity as Administrator of CMS,	§	**CIVIL ACTION NO. 4:24-CV-00609-P**
	§	
	§	
Defendants.		

DECLARATION OF DAWSON OSWALT IN SUPPORT OF PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT

1. "My name is Dawson Oswalt. I am over twenty-one (21) years of age and am legally competent to make this Declaration. After review of relevant company documents and due inquiry with relevant company personnel and its former owner and Vice President Tony Faulk, I have corporate knowledge of the facts stated below, and upon knowledge and belief each fact is true and correct.

2. I am currently the President of Faulk Company, Inc. (hereinafter referred to as "Faulk Company"). Faulk Company has been in the janitorial services business since 1981; we clean schools. During the COVID-19 pandemic, our employees were deemed "essential workers," and we worked tirelessly to ensure, to the best of our ability, that the places where American children go to learn were clean and safe. Even though school district contracts are not particularly lucrative and our business would fairly be described as "low-margin," Faulk Company continues that work today.

Faulk v. USA
Exhibit
A

3. Faulk Company is a small business. Its net worth is less than $7 million; and at all times relevant to these proceedings, Faulk Company has had fewer than 500 employees.

4. Faulk Company has never received any document from the United States Department of Health and Human Services ("HHS") for any tax year that purports to be a "Section 1411 Certification" or that references Section 1411 of the Patient Protection and Affordable Care Act or that certifies in any way that any employee of Faulk Company enrolled for any particular month in a health plan from a federal- or state-run health insurance exchange.

5. Faulk Company has never been offered any opportunity by HHS to appeal any exchange subsidy determination, or to present information to any exchange for review of the determination either by the exchange or the person making the determination, or to provide evidence of any employer-sponsored plan Faulk Company may have or of employer contributions to such plan, or to have access to the data used to make any employee's subsidy eligibility determination, or to know the names of employees who received subsidies and whether or not those employees' incomes are above or below the threshold by which the affordability of an employer's health insurance coverage is measured. In fact, Faulk Company has never been offered any opportunity by any federal agency to appeal anything related to employee exchange subsidies or Employer Shared Responsibility Payment ("ESRP") excise taxes, apart from the Internal Revenue Service ("IRS") process for appealing the assessment of ESRP excise taxes.

6. The only documents received by Faulk Company that purport to certify anything with respect to any potential exposure to ESRP excise taxes are letters from IRS with the designation "Letter 226-J." For the 2019 tax year, Faulk Company received a Letter 226-J from IRS on or about December 13, 2021, which includes a statement, "This letter certifies, under Section 1411 of the Affordable Care Act, that for at least one month in the year, one or more of your full-time employees was enrolled in a qualified health plan for which a PTC was allowed."

The names of employees who received subsidized exchange coverage are provided in a table included with the letter, but nothing suggests whether those employees' incomes are above or below the threshold by which the affordability of an employer's health insurance coverage is measured. For the 2020 tax year, Faulk Company received a similar letter in or around November or early December of 2022. For the 2021 tax year, Faulk Company received a similar letter in January of 2024. To my knowledge, the only documents received by Faulk Company from any agency of the United States government bearing any reference to Section 1411 or purporting to certify anything with respect to employees who received exchange subsidies are these.

7. Before receiving the initial IRS Letter 226-J from IRS on or about December 31, 2021, Faulk Company had no notice of potential ESRP excise tax exposure or opportunity for appeal, whether from HHS or otherwise.

8. Prior to 2019, Faulk Company had offered traditional group health insurance to its employees, but not one employee enrolled in it, so Faulk Company stopped promoting it.

9. Had Faulk Company been given notice or certification in reasonable proximity to an employee's determination of eligibility for subsidized exchange coverage that it "may be liable for a tax imposed by section 4980H of title 26 with respect to an employee because of a determination that the employer does not provide minimum essential coverage through an employer-sponsored plan or that the employer does provide that coverage but it is not affordable coverage with respect to an employee," Faulk Company would have continued to promote the insurance plan, despite the very high likelihood that no employee would ever enroll in it.

10. The IRS's delay of its purported Section 1411 Certification—Letter 226-J—which was provided to Faulk Company more than three (3) years after open enrollment began for 2019 Exchange coverage, and two (2) years after December 2019 when the last employee could

theoretically have sought 2019 Exchange coverage, denied Faulk Company access to real-time information in advance of assessment of excise taxes by IRS.

11. This denial of our ability to gauge potential tax liabilities in near real-time forced Faulk Company to take a reactive rather than proactive approach to ESRP excise taxes.

12. Faulk Company paid the ESRP excise tax due at issue in this case on December 28, 2021, under protest, in the amount of $205,621.71, as evidenced in the Exhibits to this declaration.

13. Faulk Company duly filed a claim for refund on Form 843 on January 28, 2022, which was received by IRS on February 1, 2022, as evidenced in the Exhibits to this declaration.

14. More than six (6) months had elapsed since Faulk Company's Form 843 refund request when it filed the current suit.

15. Faulk Company has not received anything that could be construed as a notice of disallowance from IRS, nor has it filed a written waiver of the requirement that we be notified of such a step through a notice of disallowance.

16. Included with this declaration are true and accurate copies of various documents referenced or relied upon herein:

A. Exhibit A: IRS Letter 226-J dated December 1, 2021, received on or about December 13, 2021, which purports to "certif[y], under Section 1411 of the Affordable Care Act, that for at least one month in the year, one or more of your full-time employees was enrolled in a qualified health plan for which a PTC was allowed."

B. Exhibit B: Response to IRS dated December 30, 2021, via Form 14764, wherein Faulk Company represented to IRS that it disagreed with the assessment of the aforementioned ESRP excise tax, and that, notwithstanding such disagreement, full payment was made under protest.

C. Exhibit C: Form 843 dated January 19, 2022, wherein Faulk Company once again represented to IRS that it disagreed with the assessment of the ESRP excise tax, and requested a refund.

D. Exhibit D: IRS Letter 227-M dated March 28, 2022, wherein IRS advised that the amount due (and already paid previously on December 31, 2021) was unchanged, that IRS disagreed with Faulk Company's position, and stated that the "Letter 226J is the ALE's certification under section 1411 of the Affordable Care Act," citing HHS regulation 45 C.F.R. § 155.310(i).

Dawson Oswalt

Date: 3/7/2025

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR CONSUMER INFORMATION & INSURANCE OVERSIGHT

Frequently Asked Questions Regarding The Federally-Facilitated Marketplace's[1] (FFM) 2016 Employer Notice Program

Q. What is the employer notice program?
The Affordable Care Act and implementing regulations require each Health Insurance Marketplace to notify any employer whose employee was determined eligible for advance premium tax credits (APTC) and cost sharing reductions (CSRs) because the employee attested that he or she was neither enrolled in employer sponsored coverage nor eligible for employer coverage that is affordable and meets the minimum value standard.

Starting in 2016, the FFM will notify certain employers whose employees enrolled in Marketplace coverage with APTC. The FFM will send notices to employers if the employee received APTC for at least one month in 2016 and if the FFM has an address for the employer.

Q. How is the FFM implementing the employer notice program in 2015?
The FFM is phasing-in the employer notice program to improve operational efficiency and minimize confusion for employers and employees. In 2015, the FFM has been focusing on educating the public about the employer notice and appeals requirements, as well as conducting outreach to stakeholders to ensure effective implementation of the program. The FFM will begin sending notices to certain employers in 2016, and will expand to more employers in later years.

As part of its efforts at public education in 2015, the FFM has used assister channels and consumer outreach to explain to consumers the importance of attesting correctly to eligibility for or enrollment in an employer sponsored plan. We have emphasized the benefit of using the employer coverage tool and continue to examine ways to make it a more useful tool for consumers.

Additionally, CMS representatives have met with various employer groups and large- and small-business stakeholders to discuss their concerns related to the employer notice and appeals process. These meetings have helped shape the program we will implement in 2016.

Q. Will employers be liable for the employer shared responsibility payment for 2015 if a full-time employee receives a premium tax credit for coverage received through a Marketplace in that year?
Yes. The IRS will independently determine any liability for the employer shared responsibility payment without regard to whether the Marketplace issued a notice or the employer engaged in any appeals process. More information on the IRS process can be found at www.irs.gov.

Q. Which employers will be notified through the employer notice program in 2016?
In 2016, the FFM will send notices to employers whose employees received APTC in 2016 and whose employees provided the Marketplace with a complete employer address.

[1] The guidance describes the process that will be used for all states operating on HealthCare.gov, including FFM states and SBMs using the federal platform.

Faulk v. USA
Exhibit
B

The notice will identify the specific employee and include a statement that the employee is enrolled in Marketplace coverage with APTC. The notices will not contain the employee's personal health information or federal tax information.

For 2016, the FFM will not notify employers when an employee who was benefiting from APTC or CSRs terminates Marketplace coverage.[2]

Q. How does this affect SBMs?
SBMs have the same flexibility to phase in their employer notices process in an effort to enhance operational efficiency and improve stakeholder engagement. SBMs will continue to have the option to refer employer appeals to the HHS appeals entity.

Q. When can employers expect to receive notices?
The FFM will send notices in batches. We expect to send the first batch in spring of 2016, following the close of Open Enrollment for the 2016 coverage year. This will likely be the largest batch of notices as it will include employers whose employees enrolled in Marketplace coverage with APTC during Open Enrollment which ends on January 31, 2016. The FFM will send additional batches of notices throughout 2016.

Q. Can employers receive notices by email or to a designated address?
For 2016, the FFM will send notices to the mailing address of the employer provided by the employee on his or her application for Marketplace coverage. As the FFM continues implementation of the employer notice program, it will consider alternative ways of contacting employers.

Q. What happens if the employer wants to appeal an employer notice from the FFM?
An employer may appeal an employer notice and assert that it provides its employee access to affordable, minimum value employer sponsored coverage or that its employee is enrolled in employer coverage, and therefore that the employee is ineligible for APTC. If the employer is successful, the FFM will send a notice to the employee encouraging the employee to update his or her Marketplace application to reflect that he or she has access to or is enrolled in other coverage. The notice will also explain that failure to update the application may result in a tax liability.

Q. How does an employer submit an appeal of an employer notice to the FFM?
A. An employer has 90 days from the date of the notice it receives from the FFM to request an appeal. An employer appeal request form will be available on https://www.healthcare.gov/marketplace-appeals/ . An employer must mail an appeal request to:

Health Insurance Marketplace
465 Industrial Blvd.
London, KY 40750-0061

They may also fax their appeal request to a secure fax line: 1-877-369-0129.

Q. When will CMS implement the process for all employers?

[2] *See* 155.340(b)(3)(ii).

We intend to evaluate the employer notice program phase-in for 2016, and determine the best means of expanding and improving that process in subsequent years. We will keep all relevant stakeholders aware of our plans and progress as it develops.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

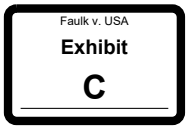
The Honorable Joseph R. Biden, Jr.
President of the Senate
Washington, DC 20510

January 1, 2014

Dear Mr. President:

I am respectfully submitting the enclosed report entitled *Verification of Household Income and Other Qualifications for the Provision of Affordable Care Act Premium Tax Credits and Cost-Sharing Reductions* in accordance with the Continuing Appropriations Act 2014, Pub. L. No. 113-46, Division B, 127 Stat. 558 (2013). I certify that the American Health Benefit Exchanges (Marketplaces) verify that applicants for advance payments of the premium tax credit and cost-sharing reductions are eligible for such payments and reductions, consistent with the requirements of section 1411 of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010) (collectively, the Affordable Care Act). I am providing this certification before the first advance payments of the premium tax credit are made; these payments will begin in mid-January and will include enrollments from the past three months. As required by the Affordable Care Act and implementing regulations, when a consumer applies for insurance affordability programs, including advance payments of the premium tax credit and cost-sharing reductions, the Marketplace verifies application information provided by the consumer when making an eligibility determination. The Department of Health and Human Services has issued regulations that detail these procedures, and the Marketplaces have implemented numerous systems and processes to carry out these verifications, including access to the Federal data services hub, State-level data sources, and policies and procedures to resolve inconsistencies between information provided by applicants and information contained in verification data sources.

Enclosed please find a report that describes the statutory, regulatory, and policy requirements that both State-based Marketplaces and Federally-facilitated Marketplaces must follow. This



report discusses each verification requirement and describes the operational processes used for each verification.

Sincerely,

Kathleen Sebelius

Verification of Household Income and Other Qualifications for the Provision of Affordable Care Act Premium Tax Credits and Cost-Sharing Reductions

Introduction

The Continuing Appropriations Act 2014, Pub. L. No. 113-46, Division B, 127 Stat. 558 (2013) requires the Secretary of Health and Human Services ("Secretary") to submit a report to Congress no later than January 1, 2014 which details the procedures employed by the Exchanges to verify eligibility for premium tax credit (PTC) and cost-sharing reductions (CSRs). Under regulations adopted by the Secretary to implement section 1411 of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010) (collectively, the Affordable Care Act (ACA)), Exchanges make eligibility determinations for advance payments of the premium tax credit using these verification procedures; those advance payments are later reconciled based on a determination of PTC eligibility made by the Department of the Treasury. The Secretary is issuing this report to provide Congress with a description of the statutory and regulatory requirements that Exchanges must follow to verify eligibility for advance payments of the premium tax credit (APTC) and CSRs. This report also provides descriptions of the operational processes Exchanges use to carry out eligibility-related verification of information provided by applicants.

In accordance with statute and applicable implementing regulations, when a consumer submits an application for insurance affordability programs (which include APTCs, CSRs, Medicaid, the Children's Health Insurance Program (CHIP), and the Basic Health Program (BHP)), the Exchange verifies information provided by the consumer on the application as a component of making an eligibility determination. The processes for verifying information in order to determine eligibility for enrollment in a qualified health plan (QHP) through the Exchange and for APTC under section 36B of the Internal Revenue Code (the Code) and CSRs under section 1402 of the ACA are specified in the ACA and its implementing regulations. Pursuant to both statute and applicable regulations, the Exchanges have implemented numerous processes to carry out the verification of information provided by applicants.

Section 1411 of the ACA requires the Secretary to establish a program for determining whether an applicant meets the citizenship or lawful presence requirements for eligibility for enrollment in a QHP through the Exchange, and, if the applicant is seeking eligibility for APTC or CSRs, whether the applicant meets the income and coverage requirements for eligibility for APTC and

CSRs.[1] Section 1411(b) specifies minimum information required to be provided by an applicant, including name, address, date of birth, social security number (if applicable, based on the applicant's citizenship or immigration status), and immigration status. For applicants seeking eligibility for APTC or CSR, section 1411(b) also specifies that the applicant must provide information regarding income and family size, and information regarding employer sponsored coverage. Section 1411(c) requires that some of this information (specifically, citizenship and lawful presence attestations and household income) must be verified against specified Federal records. In addition, section 1411(d) provides authority for the Secretary to determine the method through which other information provided by an applicant, for which the verification process is not otherwise specified in section 1411, is to be verified.

All Exchanges, including both State-based Exchanges (SBEs) and Federally-facilitated Exchanges (FFEs), must follow the applicable statutory and regulatory requirements to carry out the verification process. The individual verifications that Exchanges are required to perform as part of the eligibility determination process and the statutory and regulatory requirements pursuant to which these processes are performed are identified in the next section of this report. In addition, the operational processes that Exchanges use to perform the verifications are also described in the next section. CMS developed the Federal Data Services Hub (FDSH) and the FFEs' eligibility and enrollment system consistent with Federal statutes, regulations, and guidelines as well as industry standards that ensure the security, privacy, and integrity of systems and the data that flows through them. CMS also has security and privacy agreements with all Federal agencies, SBEs, and other state agencies connecting to the Hub.

While all Exchanges are required by statute and regulation to perform the eligibility verifications outlined in this report, including the required usage of available Federal data sources to perform eligibility verifications, there is some flexibility in how Exchanges can implement and perform these verifications. For example, the operational processes that SBEs employ may differ somewhat from those the FFEs employ. In addition to the Federal data sources available through the FDSH, which is being used by SBEs as the primary data source for performing eligibility verifications, SBEs in some cases have access to State data sources that can be utilized as an additional data source for performing the eligibility verifications, in coordination with those

[1] Note: Pursuant to section 1402(d) of the ACA and 45 CFR 155.350, an Exchange must determine individuals who are members of Federally recognized tribes, as defined in section 4(d) of 25 U.S.C. 450b(d), eligible for CSRs if household income is at or below 300 percent of the Federal Poverty Level, and issuers shall eliminate any cost-sharing for covered services under a QHP. Additionally, an Exchange must determine such individuals eligible for CSRs regardless of income for covered services that are furnished through an Indian health care provider, and the issuer shall eliminate any cost-sharing for covered services under a QHP.

available at the Federal level. The ability for States to use additional data sources for purposes of conducting verifications of certain eligibility information is specified in 45 CFR 155.315 and 155.320, and the additional data sources are approved by HHS as part of the Exchange Blueprint, as specified in 45 CFR 155.315(h) and 45 CFR 155.105(d) and (e).

In order to oversee and validate the processes that SBEs use to perform eligibility-related verifications, the Department of Health and Human Services (HHS) has developed several tools. These oversight tools ensure that SBEs meet all statutory and regulatory requirements and also ensure that the operational processes that the SBEs employ appropriately verify applicant information and determine eligibility for enrollment. The tools and methods that HHS uses for oversight and validation of SBE processes are described in the third section of this report.

Section II: Statutory and regulatory requirements for verifications and operational processes for verifications[2]

The following paragraphs describe each verification that an Exchange is required to carry out to verify eligibility for APTC and CSRs. Certain attestations or other information provided by either the applicant, or application filer in cases where the application filer is applying on behalf of others in the household, are required to be verified by the Exchange. Attestations about tax filing associated with receipt of APTCs are required to be made by the tax filer. Each subsection below describes the statutory and regulatory requirements for a specific verification, as well as the operational processes that Exchanges use to perform that verification.

Verification of Social Security number

Section 1411(c)(2) of the ACA states that for citizenship or immigration status, the Secretary shall submit specified information to the Commissioner of Social Security to determine whether the information provided by the applicant or application filer is consistent with the information in the records of the Commissioner. The information provided to the Social Security Administration (SSA) includes the applicant's name, date of birth, Social Security number, and an attestation that the individual is a citizen, if applicable. 45 CFR 155.315 describes the verification process related to eligibility for enrollment in a QHP through the Exchange, and section 155.315(b) describes the process for validation of Social Security number. It states that, for any individual who provides his or her Social Security number to the Exchange, the

[2] Except for certain tax-filing related attestations from the tax filer (who may or may not be the applicant), the attestations discussed in the verification process may be provided by the applicant or the application filer who submits the application on behalf of the applicant.

Exchange must transmit the Social Security number and other identifying information to HHS, which will submit it to SSA. If the Exchange is unable to verify the Social Security number through SSA or SSA indicates that the individual is deceased, the Exchange must provide the applicant with a 90 day inconsistency period as provided in 45 CFR 155.315(b)(2) and (f) to provide documentary evidence or otherwise resolve the inconsistency.

FFEs and SBEs use the operational process of electronic data matching with SSA to carry out the validation of Social Security numbers (SSNs).

Verification of citizenship, status as a national, or lawful presence

Section 1411(c)(2)(B) of the ACA states that for an individual who attests that he or she is an alien lawfully present in the United States or is a citizen but with respect to whom the Commissioner of Social Security has notified the Secretary that the individual's attestation of citizenship is inconsistent with the information in the Commissioner's records, the Secretary shall submit specified information to the Secretary of Homeland Security for verification of citizenship or lawful presence. The information submitted to the Department of Homeland Security (DHS) includes the individual's name, date of birth, identifying information with respect to the individual's immigration status, and the attestation that the individual is a non-citizen lawfully present or an attestation that the individual is a citizen, as applicable. 45 CFR 155.315(c)(1) describes the process required for verification of citizenship, status as a national, or lawful presence. It states that for an applicant for whom an attestation is provided that attests to citizenship and the applicant's SSN, the Exchange must transmit the SSN and other identifying information to HHS, which will submit the information to SSA. Section 155.315(c)(2) states that for an applicant who attests to lawful presence or attests to citizenship and for whom the Exchange cannot verify the claim of citizenship through SSA, and who has documentation that can be verified through DHS, the Exchange must transmit information from the applicant's documentation and other identifying information to HHS, which will submit the information to DHS.

FFEs and SBEs use the operational process of electronic data matching with SSA and DHS to carry out the verification of citizenship, status as a national, or lawful presence. For an applicant for whom an attestation as to citizenship is provided and for whom the Exchange cannot verify the claim of citizenship through SSA, the applicant is asked if he or she is a naturalized or derived citizen, and if so whether he or she has naturalization or citizenship documentation verifiable by DHS. If the applicant does, the Exchange must transmit the information to HHS, which will submit the information to DHS. For an applicant for whom an attestation of citizenship, status as a national, or lawful presence is provided and for whom the Exchange

cannot verify the attestation through SSA or DHS, the Exchange must provide the applicant with a 90 day inconsistency period as specified in 45 CFR 155.315(c)(3) and (f) to provide documentary evidence or otherwise resolve the inconsistency.

Verification of Residency

Section 1411(b)(1)(A) of the ACA requires an applicant for enrollment in a qualified health plan offered through an Exchange to provide the name, address, and date of birth of each individual applying for coverage. 45 CFR 155.305(a)(3) specifies the eligibility standards for residency and states that an applicant must meet the following standards: if he or she is an individual who is age 21 and over, is not living in an institution as defined in 42 CFR 435.403(b), is capable of indicating intent, and is not receiving an optional State supplementary payment as addressed in 42 CFR 435.403(f), then the service area of the Exchange of the individual is the service area of the Exchange in which he or she is living and intends to reside or has entered with a job commitment or is seeking employment; or if he or she is an individual who is under the age of 21, is not living in an institution as defined in 42 CFR 435.403(b), is not eligible for Medicaid based on receipt of assistance under title IV-E of the Social Security Act as addressed in 42 CFR 435.403(g), is not emancipated, is not receiving an optional State supplementary payment as addressed in 42 CFR 435.403(f), then the Exchange service area of the individual is the service area of the Exchange in which he or she resides or is the service area of the Exchange of a parent of caretaker.

45 CFR 155.315(d) specifies the verification of residency required for an eligibility determination for enrollment in a QHP through the Exchange. Section 155.315(d) states that the Exchange must verify the attestation of an applicant's residency, which is made subject to penalty of perjury and other applicable penalties, including those specified in section 1411(h) of the ACA, by doing the following: examining electronic data sources that are available to the Exchange and which have been approved by HHS for this purpose and accepting the attestation except under specified circumstances. If the information provided about an applicant's residency is not reasonably compatible with other information provided by the applicant, the Exchange must examine electronic data sources available to the Exchange that have been approved by HHS for this purpose. If the information in these data sources is not reasonably compatible with the information provided by the applicant, the Exchange must provide the applicant with a 90 day inconsistency period as specified in 45 CFR 155.315(f) to provide documentary evidence to resolve the inconsistency.

Please note that there are separate residency verification rules for Medicaid and CHIP.

Verification of incarceration status

Section 1312(f)(1)(B) of the ACA states that an individual shall not be treated as a qualified individual if, at the time of enrollment, the individual is incarcerated, other than incarceration pending the disposition of charges. A qualified individual is defined in section 1312(f)(1)(A) of the ACA with respect to an Exchange as: an individual who is seeking to enroll in a QHP in the individual market offered through the Exchange and who resides in the State that established the Exchange, but excluding individuals who are incarcerated other than pending the disposition of charges. 45 CFR 155.315(e) specifies the requirements for verification of incarceration status. It states that the Exchange must verify the attestation, which is made subject to penalty of perjury and other applicable penalties, including those specified in section 1411(h) of the ACA, that an applicant is not incarcerated by: relying on electronic data sources that are available to the Exchange and which have been approved by HHS for this purpose, or if an approved data source is unavailable, accepting the attestation; however, if the attestation provided by the applicant or application filer is not compatible with information from approved data sources or other information from the applicant or in the records of the Exchange, the Exchange must provide the applicant with a 90 day inconsistency period as specified in 45 CFR 155.315(f) to provide documentary evidence to resolve the inconsistency.

Verification of minimum essential coverage (MEC) other than through employer sponsored insurance (ESI)

45 CFR 155.320 describes the verification process related to additional eligibility criteria for insurance affordability programs. Section 36B(c)(2)(B) of the Code makes APTC and CSR available to enrollees for coverage months for which they are eligible. Section 36B(c)(2)(B) specifies that a coverage month shall not include any month with respect to an individual if, for such month, the individual is eligible for minimum essential coverage (as defined in section 5000A(f) of the Code) other than through the individual market. Accordingly, 45 CFR 155.320(b) specifies the Exchange must verify whether an applicant is eligible for MEC other than through an eligible employer-sponsored plan, Medicaid, CHIP or the BHP, using information obtained by transmitting specified identifying information to HHS for verification purposes. When the Exchange transmits identifying information to HHS, this information is used to verify whether the applicant is eligible for coverage through Medicare, the Veterans Health Administration, TRICARE (Department of Defense), and the Peace Corps. The Exchange must also verify whether an applicant has already been determined eligible for coverage through Medicaid, CHIP, or the BHP using information obtained from the agencies administering such programs. The process by which the Exchanges verify eligibility for MEC through an employer-sponsored plan is discussed below.

FFEs and SBEs use the operational process of electronic data matching for verification of MEC other than ESC.[3]

Verification of household income and family size

Section 1411(b)(3) of the ACA specifies information that must be provided for all applicants claiming APTC or CSRs. Such applicants are required to provide information regarding income and family size described in section 6103(l)(21) of the Code for the taxable year ending with or within the second calendar year preceding the calendar year in which the plan year begins. In addition, applicants are required to provide information regarding changes in circumstances that may occur with respect to the eligibility information specified in section 1412(b)(2) of the ACA. This includes information with respect to individuals who were not required to file an income tax return for the taxable year ending with or within the second calendar year preceding the calendar year in which the plan year begins or individuals who experience changes in marital status or family size or significant reductions in income.

45 CFR 155.320(c) specifies the requirements for verification of household income and family/household size as related to eligibility for insurance affordability programs. Section 155.320(c)(1) requires tax return data regarding modified adjusted gross income (MAGI) and family size to be requested for all individuals whose income is counted in calculating a tax filer's household income and for whom the Exchange has an SSN.

45 CFR 155.320(c)(3)(i) specifies the requirements for the family size verification process for eligibility for APTC and CSRs. The Exchange must require an attestation identifying the number and names of the individuals that comprise a tax filer's family; such attestations are provided under penalty of perjury and other applicable penalties, including those specified in section 1411(h) of the ACA. To the extent the applicant or application filer attests that tax return data regarding MAGI-based income represents an accurate projection of a tax filer's family size for the benefit year for which coverage is requested, the Exchange must determine the tax filer's eligibility for APTC and CSRs based on the family size data in the tax return data. To the extent that tax return data are not available, or an applicant attests that a change in circumstances has occurred or is reasonably expected to occur such that the tax return data does not represent an accurate projection of a tax filer's family for the benefit year for which coverage is requested, the

[3] Electronic data matching with Medicaid and CHIP agencies is subject to the State agency's ability to provide data at this time. Exchanges verify Medicaid and CHIP eligibility using data from the Medicaid and CHIP agency in the State in which the Exchange is operating, in those States in which the Medicaid and CHIP agency is able to provide data at this time. Section 1411 explicitly addresses verification of employer-sponsored coverage but does not address verification of existing enrollment/eligibility in Medicaid and CHIP programs. Note that each new applicant will also have at least an assessment of Medicaid and CHIP eligibility as part of the APTC and CSR eligibility determination.

Exchange will accept the attestation of the tax filer's family size unless the Exchange finds that an attestation of a tax filer's family size is not reasonably compatible with other information provided by the application filer for the family or in the records of the Exchange. With the exception of tax return data, the Exchange must use data obtained through other electronic data sources to verify the attestation. If such data sources are unavailable or information in such data sources is not reasonably compatible with the applicant's attestation, the Exchange must request additional documentation in accordance with the procedures specified in 45 CFR 155.315(f).

The FFEs and SBEs currently do not have access to a data source with information that could be used to verify an applicant's attestation regarding family size, such as prior eligibility records, and are therefore accepting applicant attestations at this time. HHS will continue to evaluate whether electronic data sources may be available to verify family size in the future.

45 CFR 155.320(c)(3)(ii) specifies the requirements for the annual household income verification process for eligibility for APTC and CSRs. The Exchange must compute annual household income based on tax return data and must require an applicant to attest regarding the tax filer's projected annual household income, which is done under penalty of perjury and other applicable penalties, including those specified in section 1411(h) of the ACA. To the extent the attestation indicates the tax return income represents an accurate projection of the tax filer's household income for the benefit year for which coverage is requested, the Exchange must determine eligibility for APTC and CSRs based on the tax return information. To the extent tax return data are not available or an applicant attests that a change in circumstances has occurred or is reasonably expected to occur, and the tax return data therefore does not represent an accurate projection of the tax filer's household income for the benefit year for which coverage is requested, the Exchange must require the applicant to attest to the tax filer's projected household income for the year for which coverage is requested.

FFEs and SBEs use the operational process of electronic data matching with IRS, SSA, and current sources of income to verify annual household income.

Section 155.320(c)(3)(iii) describes the requirements for the verification process for increases in household income and states the following: if an applicant's attestation of projected household income, which is made under penalty of perjury and other applicable penalties, including those specified in section 1411(h) of the ACA, indicates a tax filer's income has increased or is reasonably expected to increase from the income reflected in tax return data for the benefit year for which coverage is requested and the Exchange has not verified the applicant's MAGI-based income to be within the applicable Medicaid or CHIP MAGI-based income standards, the Exchange must accept the applicant's attestation for the tax filer's family. However, if MAGI-

based income sources available to the Exchange indicate that the applicant's projected annual household income is in excess of his or her attestation by a significant amount, or if other information provided by the applicant indicates that his or her projected annual household income is in excess of his or her attestation by a significant amount and information from MAGI-based income sources is not available or is not reasonably compatible with the applicant's attestation, then the Exchange must request additional documentation to support the attestation in accordance with the procedures specified in 45 CFR 155.315(f)(1) through (4).

FFEs and SBEs use the operational process of electronic data matching with current income sources including, for the FFEs and some SBEs, data matching with Equifax Workforce Solutions. For SBEs, another common data source used to verify current income is state wage data from the State Wage Information Collection Agency (SWICA).

Section 155.320(c)(3)(iv) specifies the requirements for the alternate verification process for decreases in annual household income and situations in which tax return data are unavailable. It states that a tax filer qualifies for the alternate verification process if an applicant attests to projected annual income in accordance with section 155.320(c)(3)(ii)(B); the tax filer does not meet the criteria for the verification process for increases in household income; the applicants in the tax filer's family have not established MAGI-based income to be within the applicable Medicaid or CHIP MAGI-based income standards; and one of the following criteria is met: the Department of the Treasury does not have tax return data that may be disclosed for the tax filer that is at least as recent as the calendar year two years prior to the calendar year for which APTC or CSRs would be effective; the applicant attests that the applicable family size has changed or is reasonably expected to change for the benefit year; the applicant attests that a change in circumstances has occurred or is reasonably expected to occur and so the tax filer's annual household income has decreased or is reasonably expected to decrease; the applicant attests that the tax filer's tax filing status has changed or is reasonably expected to change; or an applicant in the tax filer's family has filed an application for unemployment benefits.

If a tax filer qualifies for an alternate verification process and the applicant's attestation to projected household income is greater than ten percent below the annual household income computed by the Exchange based on the tax return data, or if tax return data are unavailable, then the alternate verification procedures are specified in 45 C.F.R. 155.320(c)(3)(vi). That section states that, for an applicant in this situation, the Exchange must attempt to verify the applicant's attestation of the tax filer's projected annual household income by using annualized data from the MAGI-based income sources and other electronic data sources approved by HHS, based on evidence showing that such data sources are sufficiently accurate and offer less administrative complexity than paper verification. If an applicant's attestation regarding a tax filer's projected

annual household income indicates that the tax filer's annual household income has increased or is reasonably expected to increase from the data regarding MAGI-based income for the benefit year for which coverage is requested, and the Exchange has not verified the applicant's MAGI-based income through the verification process for Medicaid and CHIP for MAGI-based household income to be within the applicable Medicaid or CHIP MAGI-based income standard, the Exchange must accept the applicant's attestation, unless the Exchange finds that the applicant's attestation of the tax filer's annual household income is not reasonably compatible with other information provided by the application filer or available to the Exchange through MAGI-based income data sources, in which case the Exchange must request additional documentation using the procedures specified in 45 C.F.R. 155.315(f). If electronic data are not available or the applicant attests to a projected annual household income that is more than ten percent below the annual household income computed using MAGI-based income sources, the Exchange must follow the inconsistency process specified in 45 C.F.R. 155.315(f)(1) through (4). If following a 90 day inconsistency period, an applicant has not provided additional information and data sources indicate that an applicant in the tax filer's family is eligible for Medicaid or CHIP, the Exchange must not provide the applicant with eligibility for APTC, CSRs, Medicaid, CHIP, or the BHP. If following a 90 day inconsistency period the Exchange is unable to verify the applicant's attestation, the Exchange must determine the applicant's eligibility based on the Exchange's computation of annual household income based on tax return data. If following a 90 day inconsistency period the Exchange is unable to verify the applicant's attestation and the tax return data are unavailable, the Exchange must determine the tax filer ineligible for APTC and CSRs.

FFEs and SBEs use the operational process of electronic data matching with current income sources and additional documentation requested from the applicant.

Verification related to enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer sponsored plan

For applicants who are applying for APTC or CSRs on the basis that the applicant's (or related individual's) employer is not treated under section 36B(c)(2)(C) of the Internal Revenue Code as providing minimum essential coverage (MEC) or affordable MEC, section 1411(b)(4) of the ACA specifies the information that must be provided regarding employer sponsored coverage. This information includes the name, address, employer identification number (if available) of the employer; whether the applicant (or related individual) is a full-time employee and whether the employer provides minimum essential coverage; if the employer provides minimum essential coverage, the lowest cost option for the applicant (or related individual) and the applicant's (or related individual's) required contribution under the employer-sponsored plan; and if the

applicant claims an employer's minimum essential coverage is unaffordable, the information regarding income and family size specified in section 1411(b)(3) of the ACA and discussed above.

45 CFR 155.320(d) specifies the verification related to enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan. The Exchange must verify whether an applicant reasonably expects to be enrolled in an eligible employer-sponsored plan or eligible for qualifying coverage in an eligible employer-sponsored plan for the benefit year for which coverage is requested. The Exchange must obtain data about enrollment in and eligibility for an eligible employer-sponsored plan from any electronic data sources available to the Exchange and which have been approved by HHS, based on evidence showing that such data sources are sufficiently current, accurate, and minimize administrative burden. Additionally, the Exchange must obtain any data regarding enrollment in an employer-sponsored plan or eligibility for qualifying coverage in an eligible employer-sponsored plan based on Federal employment by transmitting identifying information to HHS to provide the necessary verification, and must obtain any available data from the SHOP that corresponds to the state in which the Exchange is operating. Data from the SHOP are not currently available for this purpose, but will be used for verification once the data are available. The Exchange accepts the applicant's attestation regarding the employer-sponsored coverage verification unless the applicant's attestation is not reasonably compatible with the foregoing verification information obtained by the Exchange, other information provided by the applicant, or other information in the records of the Exchange. If the attestation is not reasonably compatible with this information, the Exchange must follow the inconsistency procedure specified in 45 CFR 155.315(f). Additionally, for applicants for whom the Exchange does not have any of the foregoing verification information, the Exchange must select a statistically significant random sample of applicants and verify the attestation regarding employer-sponsored coverage by following the procedures specified in 45 CFR 155.320(d)(3)(iii) to contact the employer(s) listed on the application. If the Exchange receives relevant information from an employer, the Exchange must determine the applicant's eligibility based on such information. If, after a 90 day period, the Exchange has not obtained the necessary information from an employer, the Exchange must determine eligibility based on the attestation provided with the application. The Exchange has the option to perform verifications using this statistically significant random sample method for the first year of operations, and must use this method for eligibility determinations for APTC and CSRs that are effective on and after January 1, 2015. Alternatively, for the first year of operations, the Exchange may accept the applicant's attestation regarding enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan for the benefit year for which coverage is requested.

To support employer-sponsored coverage verification, the application for APTC or CSRs must include information regarding the applicant's access to employer-sponsored coverage on the application.

Section III: Procedures Employed by CMS to Ensure Appropriate Verifications of Eligibility Performed by State-based Exchanges

Under 45 CFR 155.105, in order for a State to receive approval from HHS to operate a State-based Exchange (SBE), a State must complete and submit an Exchange Blueprint that documents how the Exchange meets, or will meet, all applicable requirements, and must demonstrate operational readiness to operate an SBE. The Exchange Blueprint application, published in May 2012, identifies the set of discrete requirements that an SBE must meet in order to receive this approval. These requirements include the capacity to determine eligibility for APTC and CSRs, to conduct verifications of eligibility pursuant to 45 CFR 155, Subpart D, and to electronically connect to data sources to conduct such verifications.

Under the Exchange Blueprint, SBEs must be able to perform required eligibility verifications by matching applicant data against the Federal data sources discussed above through an automated connection with the FDSH. SBEs must provide supporting documentation to demonstrate their ability to meet these requirements in order to receive Blueprint approval from CMS. SBEs were required to submit their Blueprint applications to HHS by December 15, 2012 and, as provided under 45 CFR 155.105, HHS granted SBEs approval of their Blueprint applications on a conditional basis on January 1, 2013. Conditional approval means that each SBE has a set of conditions with timelines that must be met in order to receive full approval as an SBE. The conditional approval of the SBE Blueprint applications was based on the evidence of progress towards meeting the Blueprint requirements, along with assurances each SBE provided that they would meet the requirements in areas where they had not yet achieved operational readiness as of January 1, 2013. CMS took this approach towards granting approval by the required January 1, 2013 date on the basis that all SBEs were still actively in the process of completing implementation of information systems functionality and operational processes to perform Blueprint-required activities when the Blueprint applications were due to CMS on December 15, 2012.

As part of demonstrating their ability to perform Blueprint-required activities correctly and in an automated manner, SBEs were required to perform a set of CMS-defined end-to-end information system tests. To this end, CMS developed 23 test scenarios, representing 75 test cases, for SBEs to conduct. Each test scenario is designed to test the ability to meet a particular requirement in the Exchange Blueprint and contains a set of 3 to 4 test cases. Each set of test cases that are

associated with a test scenario vary in degree of difficulty from more basic test cases to more complex test cases. These tests, known as "Blueprint tests," allow SBEs to complete a standard set of tests using CMS-specified data inputs to arrive at CMS-specified outcomes. This approach standardizes the testing and evaluation of results by CMS. Among the 23 Blueprint test scenarios are 10 test scenarios (listed below and representing 30 test cases) that address the ability of an SBE to correctly verify and determine eligibility for QHP coverage through the Exchange, both with and without eligibility for APTC and CSRs.

3.3b	The Marketplace has the capacity to accept and process applications, updates, and responses to redeterminations from applicants and enrollees online.
3.4b	The Marketplace has the capacity to conduct periodic data matching pursuant to 45 CFR 155, subpart D and act on the results of the data matching
3.4c	The Marketplace has the capacity to conduct annual redeterminations and process responses through all channels pursuant to 45 CFR 155, subpart D.
3.5	The Marketplace has the capacity to conduct verifications pursuant to 45 CFR 155, subpart D, and is able to connect to data sources, such as the Data Services Hub, and other sources as needed.
3.7a	The Marketplace has the capacity to determine individual eligibility for QHP coverage through the Marketplace.
3.7b1-2	The Marketplace has the capacity to determine eligibility for Medicaid and CHIP based on MAGI or The Marketplace has the capacity to assess eligibility for Medicaid and CHIP based on MAGI.
3.8	The Marketplace has the capacity to determine eligibility for Advance Payments of the Premium Tax Credit (APTC) and Cost Sharing Reductions (CSRs), including calculating maximum APTC, independently or through the use of a Federally-managed service.
3.10	The Marketplace has the capacity to accept applications and updates, conduct verifications, and determine eligibility for individual responsibility requirement and payment exemptions independently or through the use of Federally-managed services.
3.12a*	The Marketplace has the capacity to process QHP selections and terminations using electronic enrollment transaction standards in coordination with issuers and CMS.
3.12b	The Marketplace has the capacity to compute actual APTC.

CMS defined the input data for states to use in performing these 10 Blueprint test scenarios such that SBEs would produce certain a certain set of eligibility verification and determination outcomes if the tests was performed correctly. These 10 Blueprint test scenarios also required states to make calls to the FDSH verification services so that the FDSH could respond to the verification calls by providing the appropriate Blueprint test input data to states so they could complete the Blueprint test. Thus, in order to complete these 10 Blueprint tests, SBEs needed to have first gone through the step of establishing connectivity to the FDSH. This step was completed by all SBEs by October 1, 2013. Therefore, since October 1, 2013, SBEs have been

able to utilize the FDSH to perform eligibility verifications as part of their Exchange operations. Both the CMS Blueprint tests and establishment of FDSH connectivity were intended to supplement and occur in conjunction with each SBE's own internal testing of eligibility verification and eligibility determination functionality.

As evidence that SBEs performed the Blueprint tests correctly, each SBE was required to provide evidence and supporting documentation demonstrating their usage of the CMS-specified input data and how they achieved the CMS-specified test outcomes. As part of this evidence and supporting documentation, each SBE was also required to submit a certification of the Blueprint test results from the SBE's Independent Verification and Validation (IV&V) entity. These are entities that each SBE contracts with to perform independent oversight of the SBE's information system implementation effort.

Blueprint testing began in the summer of 2013. Blueprint testing by SBEs will continue through the end of December 31, 2013 and into 2014, so that SBEs can perform tests using certain enhancements to the FDSH verification services that are not yet available. This would include testing an SBE's ability to conduct eligibility re-determinations using the FDSH quarterly eligibility verification service, as well as testing an SBE's ability to correctly submit monthly and annual eligibility reports to CMS and IRS which are required of SBEs beginning in 2014.

Conclusion

We note that application filers must attest, under penalty of perjury, that they are not providing false or fraudulent information when completing an application. In addition to the existing penalties for perjury, section 1411(h) of the ACA applies penalties when an individual fails to provide correct information based on negligence or disregard of program rules, or knowingly and willfully provides false or fraudulent information. Moreover, the IRS will reconcile APTC to actual PTC eligibility when consumers file their annual tax returns, and it will recoup overpayments and provide refunds when appropriate, subject to statutory limits. These safeguards all apply no matter which type of Exchange is operating in a State.

CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Douglas W. Elmendorf, Director

March 20, 2010

Honorable Nancy Pelosi
Speaker
U.S. House of Representatives
Washington, DC 20515

Dear Madam Speaker:

The Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation (JCT) have completed an estimate of the direct spending and revenue effects of an amendment in the nature of a substitute to H.R. 4872, the Reconciliation Act of 2010. The amendment discussed in this letter (hereafter called "the reconciliation proposal") is the one that was made public on March 18, 2010, as modified by subsequent changes incorporated in a proposed manager's amendment that was made public on March 20.

This estimate differs from the preliminary estimate that CBO issued on March 18 in that it reflects CBO and JCT's review of the legislative language of the earlier amendment and the manager's amendment, as well as modest technical refinements of the budgetary projections.[1] This estimate is presented in two ways:

- An estimate of the budgetary effects of the reconciliation proposal, in combination with the effects of H.R. 3590, the Patient Protection and Affordable Care Act (PPACA), as passed by the Senate; and

- An estimate of the *incremental* effects of the reconciliation proposal, over and above the effects of enacting H.R. 3590 by itself.[2]

[1] For the preliminary estimate by CBO and JCT of the direct spending and revenue effects of the reconciliation proposal, see Congressional Budget Office, letter to the Honorable Nancy Pelosi providing a preliminary analysis of the reconciliation proposal (March 18, 2010).

[2] For the estimate by CBO and JCT of the direct spending and revenue effects of H.R. 3590 as passed by the Senate, see Congressional Budget Office, cost estimate of H.R. 3590, Patient Protection and Affordable Care Act (March 11, 2010). JCT's detailed table of revenue effects is available at www.jct.gov.

Faulk v. USA
Exhibit
D

CBO and JCT have not yet updated their preliminary and partial estimate of the budgetary impact of the reconciliation proposal under the assumption that H.R. 3590 is not enacted—that is, the reconciliation proposal's impact under current law.

H.R. 3590 would, among other things, establish a mandate for most residents of the United States to obtain health insurance; set up insurance exchanges through which certain individuals and families could receive federal subsidies to substantially reduce the cost of purchasing that coverage; significantly expand eligibility for Medicaid; substantially reduce the growth of Medicare's payment rates for most services (relative to the growth rates projected under current law); impose an excise tax on insurance plans with relatively high premiums; and make various other changes to the federal tax code, Medicare, Medicaid, and other programs. The reconciliation proposal includes provisions related to health care and revenues, many of which would amend H.R. 3590. (The changes with the largest budgetary effects are described below.) The reconciliation proposal also includes amendments to the Higher Education Act of 1965, which authorizes most federal programs involving postsecondary education. (Those provisions and their budgetary effects are described below as well.)

Estimated Budgetary Impact of the Legislation

CBO and JCT estimate that enacting both pieces of legislation—H.R. 3590 and the reconciliation proposal—would produce a net reduction in federal deficits of $143 billion over the 2010–2019 period as result of changes in direct spending and revenues (see Table 1). That figure comprises $124 billion in net reductions deriving from the health care and revenue provisions and $19 billion in net reductions deriving from the education provisions. Approximately $114 billion of the total reduction would be on-budget; other effects related to Social Security revenues and spending as well as spending by the U.S. Postal Service are classified as off-budget. CBO has not completed an estimate of the potential impact of the legislation on discretionary spending, which would be subject to future appropriation action.

CBO and JCT previously estimated that enacting H.R. 3590 by itself would yield a net reduction in federal deficits of $118 billion over the 2010–2019 period, of which about $65 billion would be on-budget. The incremental effect of enacting the reconciliation proposal—assuming that H.R. 3590 had already been enacted—would be the difference between the estimate of their combined effect and the previous estimate for H.R. 3590. That

incremental effect is an estimated net reduction in federal deficits of $25 billion during the 2010–2019 period over and above the savings from enacting H.R. 3590 by itself; almost all of that reduction would be on-budget.[3]

Additional details on the budgetary effects of the reconciliation proposal and H.R. 3590 are provided in Tables 2 through 7 attached to this letter:

- Table 2 shows budgetary cash flows for direct spending and revenues associated with the two pieces of legislation combined.

- Table 3 summarizes the incremental changes in direct spending and revenues resulting from the reconciliation proposal, assuming that H.R. 3590 had already been enacted.

- For the two pieces of legislation combined, Table 4 provides estimates of the changes in the number of nonelderly people in the United States who would have health insurance and presents the primary budgetary effects of the provisions related to health insurance coverage.

- For the two pieces of legislation combined, Table 5 displays detailed estimates of the costs or savings from the health care provisions that are not related to health insurance coverage (primarily involving the Medicare program). The table does not include the effects of revenue provisions; those effects are reported separately by JCT in JCX-17-10 at www.jct.gov.

- Table 6 presents details on the incremental effects of the health care and revenue provisions of the reconciliation proposal—that is, the difference between the effects of those provisions in the two pieces of legislation combined and the effects of H.R. 3590 by itself (as shown in CBO's cost estimate of March 11, 2010).

- Table 7 summarizes the incremental effects of the health care, revenue, and education provisions of the reconciliation proposal, also assuming that H.R. 3590 had been enacted.

[3] As originally introduced, the reconciliation proposal would require transfers from on-budget general funds to the off-budget Social Security trust funds to offset any reduction in the balances of those trust funds resulting from other provisions of the proposal. The effects of that provision were reflected in CBO's preliminary estimate. However, the manager's amendment to the reconciliation proposal strikes that provision, so its effects are not included in this estimate.

The estimate provided here covers the 2010–2019 period to be consistent with the budget horizon used under S. Con. Res. 13, the Concurrent Resolution on the Budget for Fiscal Year 2010. The Congress has not yet adopted a new budget resolution that would extend the House and Senate budget enforcement periods through 2020.

Because the reconciliation proposal and H.R. 3590 would affect direct spending and revenues, pay-as-you-go procedures would apply. The time periods used for pay-as-you-go calculations under the new Statutory Pay-As-You-Go Act extend from 2010 through 2015 and from 2010 through 2020. Although CBO and JCT have not conducted a detailed analysis of the effects of the reconciliation proposal and H.R. 3590 in 2020, enacting that legislation would probably reduce the budget deficit modestly in that year. Reflecting that assessment, CBO and JCT estimate that enacting that legislation would reduce projected on-budget deficits both through 2015 and through 2020.[4]

The remainder of this letter discusses the major components of the education provisions contained in the reconciliation proposal; reviews the main changes that the reconciliation proposal would make to the health care and revenue provisions of H.R. 3590; describes the effects of the legislation on health insurance coverage; presents information about the effects of the legislation on discretionary spending; provides CBO's analysis of the legislation's impact on the federal budget beyond the first 10 years; and analyzes certain other effects of the legislation.

[4] Pay-as-you-go procedures do not apply to off-budget effects, which include changes to Social Security or the U.S. Postal Service. Under the Statutory Pay-As-You-Go Act, estimated changes in the on-budget deficit from direct spending and revenues are recorded on 5-year and 10-year "scorecards" by the Office of Management and Budget, which is required to order a sequestration (cancellation) of certain direct spending if either scorecard reflects a net cost in the budget year at the end of a Congressional session.

Table 1. Estimate of the Effects on the Deficit of the Reconciliation Proposal Combined with H.R. 3590, as Passed by the Senate

	By Fiscal Year, in Billions of Dollars											
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
NET CHANGES IN THE DEFICIT FROM INSURANCE COVERAGE PROVISIONS [a,b]												
Effects on the Deficit	3	7	9	10	49	87	132	154	164	172	78	788
NET CHANGES IN THE DEFICIT FROM OTHER PROVISIONS AFFECTING DIRECT SPENDING [c]												
Effects on the Deficit of Changes in Outlays	3	3	-7	-28	-50	-60	-70	-86	-101	-116	-79	-511
NET CHANGES IN THE DEFICIT FROM OTHER PROVISIONS AFFECTING REVENUES [d]												
Effects on the Deficit of Changes in Revenues	*	-9	-12	-38	-50	-48	-59	-65	-69	-71	-109	-420
NET CHANGES IN THE DEFICIT [a]												
Net Increase or Decrease (-) in the Budget Deficit	6	1	-10	-56	-51	-20	3	4	-5	-15	-109	-143
On-Budget	6	1	-10	-55	-50	-18	8	10	2	-6	-108	-114
Off-Budget [e]	*	*	1	-1	-1	-2	-5	-6	-7	-9	-1	-29
Memorandum:												
Incremental Effects on the Deficit of H.R. 4872 Incorporating the Manager's Amendment, Relative to H.R. 3590 as Passed by the Senate												
Net Increase or Decrease	2	4	4	-3	-13	-4	-7	-3	-2	-3	-5	-25
On-Budget	2	4	4	-6	-14	-7	-11	-7	-6	-7	-10	-48
Off-Budget [e]	0	*	*	4	1	3	4	4	4	4	5	23
Effects on the Deficit of Provisions of the Reconciliation Proposal Combined with H.R. 3590												
Health Care and Revenue Provisions	6	1	-13	-50	-48	-16	7	6	-4	-13	-104	-124
Education Provisions	*	*	4	-6	-3	-5	-4	-2	-2	-2	-5	-19

Continued

Table 1. Continued.

Sources: Congressional Budget Office and staff of the Joint Committee on Taxation (JCT).

Notes: Positive numbers indicate increases in the deficit, and negative numbers indicate reductions in the deficit.

Components may not sum to totals because of rounding; * = between $0.5 billion and -$0.5 billion.

a. Does not include effects on spending subject to future appropriations.

b. Includes excise tax on high-premium insurance plans.

c. These estimates reflect the effects of provisions affecting Medicare, Medicaid, and other federal health programs, and include the effects of interactions between insurance coverage provisions and those programs; they also reflect the effects of education provisions.

d. The changes in revenues include effects on Social Security revenues, which are classified as off-budget. The 10-year figure of $420 billion includes $406 billion in revenues from tax provisions (estimated by JCT) apart from receipts from the excise tax on high-premium insurance plans and $14 billion in revenues from certain provisions affecting Medicare, Medicaid, and other programs (estimated by CBO and JCT). (For JCT's estimates, see JCX-17-10.)

e. Off-budget effects include changes in Social Security spending and revenues as well as U.S. Postal Service spending.

Education Provisions Contained in the Reconciliation Proposal

Subtitle A of title II of the reconciliation proposal would amend the Higher Education Act of 1965, which authorizes most federal postsecondary education programs. The reconciliation proposal would eliminate the federal program that provides guarantees for student loans and replace those loans with direct loans made by the Department of Education. It would also increase direct spending for the Pell Grant program and other education grant programs. CBO estimates that those provisions would reduce direct spending by $5 billion over the 2010–2014 period and $19 billion over the 2010–2019 period (see Table 7).

Federal Student Loan Programs. On net, CBO estimates that the reconciliation proposal would reduce direct spending in the federal student loan programs by $28 billion over the 2010–2014 period and $58 billion over the 2010–2019 period.

In the Federal Family Education Loan (FFEL) program, private lenders originate loans to postsecondary students; the federal government makes payments to those lenders, guarantees them against significant loss in the case of default, and provides funds to guaranty agencies to help administer those loans. In the direct loan program, eligible borrowers receive nearly identical loans that are administered by the Department of Education and funded through the U.S. Treasury.

The reconciliation proposal would eliminate new loans in the FFEL program beginning in July 2010. Under the proposal, CBO expects that all of the guaranteed loans that would have been made under current law—estimated to be roughly $500 billion through 2019—would instead be made through the direct loan program.

The Federal Credit Reform Act specifies that the cost of new federal loans and loan guarantees be recorded in the budget in the year that the loans are disbursed, and that the cost be calculated as the net present value of the government's expected cash flows over the lifetime of a loan or guarantee, using interest rates on Treasury securities of comparable maturity to discount the estimated cash flows.[5] Using this methodology, CBO estimates that eliminating new guaranteed loans and replacing them with direct loans would yield reductions in direct spending of $61 billion over the 2010–2019 period. CBO also estimates that the expanded program for direct loans would incur about $5 billion in additional administrative costs during that period. However, those additional costs are classified as discretionary spending and are subject to future appropriation; they are not incorporated in the estimates of changes in direct spending and revenues reported in this letter.

The legislation would also make other changes to federal loan programs for education. CBO estimates that those changes would increase direct spending by $1 billion over the 2010–2014 period and $3 billion over the 2010–2019 period—partially offsetting the gross savings from eliminating new guaranteed loans in the FFEL program.

Federal Pell Grant Program. The reconciliation proposal would alter the structure of the Pell Grant program and provide additional funding for that program. CBO estimates that those changes would increase direct spending by $21 billion over the 2010–2014 period and $36 billion over the 2010–2019 period.

Under current law, Pell grants are funded through both discretionary and mandatory funding. The annual discretionary appropriation sets a base award level, and a mandatory account provides additional funding to

[5] An alternative approach to estimating the cost of federal loans and loan guarantees is to estimate what a private entity would need to be paid to assume the costs and risks to the government from providing such loans or guarantees. For further discussion of that so-called "fair-value" methodology, and for estimates of the cost of replacing guaranteed loans with direct loans based on different methodologies, see Congressional Budget Office, letter to the Honorable Judd Gregg regarding the budgetary impact of the President's proposal to alter federal student loan programs (March 15, 2010).

students eligible for the program. The dollar amount of the additional mandatory awards is determined by the amount directly appropriated in the Higher Education Act.

Beginning in fiscal year 2010, the reconciliation proposal would appropriate the amounts necessary to cover the cost of specified award levels in the Pell Grant program. For academic years through 2012–2013, the proposal would maintain the additional mandatory award at $690, as specified in current law for 2010–2011 and 2011–2012. (Under current law, however, there are not sufficient funds to cover all the costs of providing that $690 add-on to all Pell grant recipients; the proposal would provide the incremental funds necessary to do so.) Beginning in academic year 2013–2014, the mandatory award would increase according to a formula specified in the legislation. CBO estimates that the add-on would reach $1,115 for academic year 2017–2018 and subsequent years.

CBO estimates that the increase in the mandatory add-on for Pell grants would raise direct spending by $23 billion over the 2010–2019 period. In addition, the legislation would provide roughly $14 billion in further mandatory funds to the Pell Grant program; CBO expects that most of that additional funding would be spent in fiscal years 2011 and 2012.

Other Education Grant Programs. Finally, the education subtitle would appropriate $255 million per year through 2019 for grants to Historically Black Colleges and Universities and other Minority Serving Institutions. It would also appropriate $150 million per year through 2014 for College Access Challenge Grants. CBO estimates that those provisions would increase direct spending by $2 billion over the 2010–2014 period and by $3 billion over the 2010–2019 period.

Changes to H.R. 3590 Contained in the Reconciliation Proposal
The reconciliation proposal would make a variety of changes to H.R. 3590, as passed by the Senate. The changes with the largest budgetary effects over the 2010–2019 period include these:

- Increasing the subsidies for premiums and cost sharing that would be offered through the new insurance exchanges;

- Increasing the penalties for employers that do not offer health insurance and modifying the penalties for individuals who do not obtain insurance;

- Increasing the federal share of spending for certain Medicaid beneficiaries;

- Changing eligibility for Medicaid in a way that effectively increases the income threshold from 133 percent of the federal poverty level to 138 percent for certain individuals;

- Reducing overall payments to insurance plans under the Medicare Advantage program;

- Expanding Medicare's drug benefit by phasing out the "doughnut hole" in that benefit;

- Modifying the design and delaying the implementation of the excise tax on insurance plans with relatively high premiums; and

- Increasing the rate and expanding the scope of a tax that would be charged to higher-income households.

Effects of the Legislation on Insurance Coverage

CBO and JCT estimate that by 2019, the combined effect of enacting H.R. 3590 and the reconciliation proposal would be to reduce the number of nonelderly people who are uninsured by about 32 million, leaving about 23 million nonelderly residents uninsured (about one-third of whom would be unauthorized immigrants). Under the legislation, the share of legal nonelderly residents with insurance coverage would rise from about 83 percent currently to about 94 percent.

Approximately 24 million people would purchase their own coverage through the new insurance exchanges, and there would be roughly 16 million more enrollees in Medicaid and the Children's Health Insurance Program than the number projected under current law. Relative to currently projected levels, the number of people purchasing individual coverage outside the exchanges would decline by about 5 million.

Under the legislation, certain employers could allow all of their workers to choose among the plans available in the exchanges, but those enrollees would not be eligible to receive subsidies via the exchanges (and thus are shown in Table 4 as enrollees in employment-based coverage rather than as exchange enrollees). Approximately 5 million people would obtain coverage in that way in 2019, bringing the total number of people enrolled in exchange plans to about 29 million in that year.

On balance, the number of people obtaining coverage through their employer would be about 3 million lower in 2019 under the legislation, CBO and JCT estimate. The net change in employment-based coverage under the proposal would be the result of several flows, which can be illustrated using the estimates for 2019:

- Between 6 million and 7 million people would be covered by an employment-based plan under the proposal who would not be covered by one under current law (largely because the mandate for individuals to be insured would increase workers' demand for coverage through their employers).

- Between 8 million and 9 million other people who would be covered by an employment-based plan under current law would not have an offer of such coverage under the proposal. Firms that would choose not to offer coverage as a result of the proposal would tend to be smaller employers and employers that predominantly employ lower-wage workers—people who would be eligible for subsidies through the exchanges—although some workers who would not have employment-based coverage because of the proposal would not be eligible for such subsidies. Whether those changes in coverage would represent the dropping of existing coverage or a lack of new offers of coverage is difficult to determine.

- Between 1 million and 2 million people who would be covered by their employer's plan (or a plan offered to a family member) under current law would instead obtain coverage in the exchanges. Under the legislation, workers with an offer of employment-based coverage would generally be ineligible for exchange subsidies, but that "firewall" would be enforced imperfectly and an explicit exception to it would be made for workers whose offer was deemed unaffordable.

Effects of the Legislation on Discretionary Costs

CBO has not completed an estimate of the potential impact of the legislation on discretionary spending, which would be subject to future appropriation action. Discretionary costs would arise from the effects of the legislation on several federal agencies and on a number of new and existing programs subject to future appropriation. Those discretionary costs fall into three general categories.

The first category is implicit authorization of discretionary costs associated with implementing the new policies established under the legislation. Although no provisions in the legislation specifically authorize such spending, it would be necessary for agencies to carry out the responsibilities that would be required of them by the bill. For example:

- CBO expects that the cost to the Internal Revenue Service of implementing the eligibility determination, documentation, and verification processes for premium and cost sharing subsidies would probably be between $5 billion and $10 billion over 10 years.

- CBO expects that the costs to the Department of Health and Human Services (especially the Centers for Medicare and Medicaid Services) and the Office of Personnel Management of implementing the changes in Medicare, Medicaid, and the Children's Health Insurance Program, as well as certain reforms to the private insurance market, would probably be at least $5 billion to $10 billion over 10 years. (The administrative costs of establishing and operating the exchanges were included as direct spending in CBO's estimate for the legislation.)

The second category of discretionary costs is explicit authorizations for a variety of grant and other programs for which specified funding levels for possible future appropriations are set in the act for one or more years. (Such cases include provisions where a specified funding level is authorized for an initial year along with the authorization of such sums as may be necessary for continued funding in subsequent years.) CBO has identified at least $50 billion in such specified and estimated authorizations in H.R. 3590, as passed by the Senate.[6]

A third category of discretionary spending is explicit authorizations for a variety of grant and other programs for which no funding levels are specified in the legislation. CBO has not yet completed estimates of the amounts of such authorizations.

Effects of the Legislation Beyond the First 10 Years

Although CBO does not generally provide cost estimates beyond the 10-year budget projection period, certain Congressional rules require some information about the budgetary impact of legislation in subsequent

[6] For further details, see Congressional Budget Office, Potential Effects of the Patient Protection and Affordable Care Act on Discretionary Spending (March 15, 2010).

decades, and many Members have requested CBO's analysis of the long-term budgetary impact of broad changes in the nation's health care and health insurance systems. Therefore, CBO has developed a rough outlook for the decade following the 2010–2019 period by grouping the elements of the legislation into broad categories and (together with JCT) assessing the rate at which the budgetary impact of each of those broad categories is likely to increase over time.

Effects on the Deficit. Using this analytic approach, CBO estimated that enacting H.R. 3590, as passed by the Senate, would reduce federal budget deficits over the ensuing decade relative to those projected under current law—with a total effect during that decade in a broad range between one-quarter percent and one-half percent of gross domestic product (GDP).[7] The imprecision of that calculation reflects the even greater degree of uncertainty that attends to it, compared with CBO's 10-year budget estimates.

The reconciliation proposal would make a variety of changes to H.R. 3590 that would have significant effects on the legislation's overall budgetary impact—both in the 10-year projection period and in the ensuing decade. For example, the reconciliation proposal would increase the premium subsidies offered in the new insurance exchanges beginning in 2014, but would also change the annual indexing provisions beginning in 2019 so that those subsidies would grow more slowly thereafter. Over time, the spending on exchange subsidies would therefore fall back toward the level under H.R. 3590 by itself. As another example, the reconciliation proposal would reduce the impact in the 10-year projection period of an excise tax on health insurance plans with relatively high premiums, but would index the thresholds for the tax, beginning in 2020, to the rate of general inflation rather than to inflation plus 1 percentage point (as in H.R. 3590).

Reflecting the changes made by the reconciliation proposal, the combined effect of enacting H.R. 3590 and the reconciliation proposal would also be to reduce federal budget deficits over the ensuing decade relative to those projected under current law—with a total effect during that decade in a broad range around one-half percent of GDP. The incremental effect of enacting the reconciliation bill (over and above the effect of enacting H.R. 3590 by itself) would thus be to further reduce federal budget deficits

[7] For a more extensive explanation of that analysis, see Congressional Budget Office, letter to the Honorable Harry Reid regarding the longer-term effects of the manager's amendment to the Patient Protection and Affordable Care Act (December 20, 2009).

in that decade, with an effect in a broad range between zero and one-quarter percent of GDP.

CBO has not extrapolated estimates further into the future because the uncertainties surrounding them are magnified even more. However, in view of the projected net savings during the decade following the 10-year budget window, CBO anticipates that the reconciliation proposal would probably continue to reduce budget deficits relative to those under current law in subsequent decades, assuming that all of its provisions continued to be fully implemented.

Congressional rules governing the consideration of reconciliation bills also require an assessment of their budgetary impact separately by title, as shown in Table 7 for the 2010–2019 period. Relative to H.R. 3590, CBO's analysis of the longer-term effects of the reconciliation proposal, by title, is as follows:

- Most of the changes to H.R. 3590 having significant budgetary effects would be made by title I of the reconciliation proposal, so the conclusions about the longer-term impact for the proposal as a whole—that it would reduce deficits relative to those under H.R. 3590—also apply to that title.

- The changes regarding health care contained in title II would have a much smaller budgetary impact than those in title I and would, by themselves, increase budget deficits somewhat during the 2010–2019 period and in the ensuing decade. That title also contains the proposal's education provisions, which CBO estimates would reduce deficits during the next 10 years and in the following decade. In CBO's estimation, the savings generated by the education provisions would outweigh the costs related to health care arising from title II, so the title as a whole would reduce budget deficits in both the 10-year projection period and subsequent years.

CBO has not yet completed an assessment of the impact for the longer term of enacting the reconciliation proposal by itself—that is, an assessment of the reconciliation proposal's longer-term impact under current law.

Key Considerations. Those longer-term calculations reflect an assumption that the provisions of the reconciliation proposal and H.R. 3590 are enacted and remain unchanged throughout the next two decades, which is often not the case for major legislation. For example, the sustainable growth rate

mechanism governing Medicare's payments to physicians has frequently been modified (either through legislation or administrative action) to avoid reductions in those payments, and legislation to do so again is currently under consideration by the Congress.

The reconciliation proposal and H.R. 3590 would maintain and put into effect a number of policies that might be difficult to sustain over a long period of time. Under current law, payment rates for physicians' services in Medicare would be reduced by about 21 percent in 2010 and then decline further in subsequent years; the proposal makes no changes to those provisions. At the same time, the legislation includes a number of provisions that would constrain payment rates for other providers of Medicare services. In particular, increases in payment rates for many providers would be held below the rate of inflation (in expectation of ongoing productivity improvements in the delivery of health care). The projected longer-term savings for the legislation also reflect an assumption that the Independent Payment Advisory Board established by H.R. 3590 would be fairly effective in reducing costs beyond the reductions that would be achieved by other aspects of the legislation.[8]

Under the legislation, CBO expects that Medicare spending would increase significantly more slowly during the next two decades than it has increased during the past two decades (per beneficiary, after adjusting for inflation). It is unclear whether such a reduction in the growth rate of spending could be achieved, and if so, whether it would be accomplished through greater efficiencies in the delivery of health care or through reductions in access to care or the quality of care. The long-term budgetary impact could be quite different if key provisions of the legislation were ultimately changed or not fully implemented.[9] If those changes arose from future legislation, CBO would estimate their costs when that legislation was being considered by the Congress.

Other Effects of the Legislation

Many Members have expressed interest in the effects of proposals on various other measures of spending on health care. One such measure is the

[8] The Independent Payment Advisory Board would be required, under certain circumstances, to recommend changes to the Medicare program to limit the rate of growth in that program's spending. The Board's recommendations would go into effect automatically unless blocked by subsequent legislative action.

[9] For an example of the long-term budgetary effect of altering several key features of the legislation, see Congressional Budget Office, letter to the Honorable Paul Ryan responding to questions about the preliminary estimate of the reconciliation proposal (March 19, 2010).

"federal budgetary commitment to health care," a term that CBO uses to describe the sum of net federal outlays for health programs and tax preferences for health care.[10] CBO estimated that H.R. 3590, as passed by the Senate, would increase the federal budgetary commitment to health care over the 2010–2019 period; the net increase in that commitment would be about $210 billion over that 10-year period. The combined effect of enacting H.R. 3590 and the reconciliation proposal would be to increase that commitment by about $390 billion over 10 years. Thus, the incremental effect of the reconciliation proposal (if H.R. 3590 had been enacted) would be to increase the federal budgetary commitment to health care by about $180 billion over the 2010–2019 period.

In subsequent years, the effects of the provisions of the two bills combined that would tend to decrease the federal budgetary commitment to health care would grow faster than the effects of the provisions that would increase it. As a result, CBO expects that enacting both proposals would generate a reduction in the federal budgetary commitment to health care during the decade following the 10-year budget window—which is the same conclusion that CBO reached about H.R. 3590, as passed by the Senate.

Members have also requested information about the effect of the legislation on health insurance premiums. On November 30, 2009, CBO released an analysis prepared by CBO and JCT of the expected impact on average premiums for health insurance in different markets of PPACA as originally proposed.[11] Although CBO and JCT have not updated the estimates provided in that letter, the effects on premiums of the legislation as passed by the Senate and modified by the reconciliation proposal would probably be quite similar.

CBO and JCT previously determined that H.R. 3590, as passed by the Senate, would impose several intergovernmental and private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA). CBO and JCT estimated that the total costs of those mandates to state, local, and tribal governments and the private sector would greatly exceed the annual thresholds established in UMRA ($70 million and $141 million,

[10] For additional discussion of that term, see Congressional Budget Office, letter to the Honorable Max Baucus regarding different measures for analyzing current proposals to reform health care (October 30, 2009).

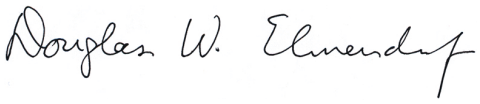
[11] See Congressional Budget Office, letter to the Honorable Evan Bayh providing an analysis of health insurance premiums under the Patient Protection and Affordable Care Act (November 30, 2009).

respectively, in 2010, adjusted annually for inflation) in each of the first five years that the mandates would be in effect.

If both the reconciliation proposal and H.R. 3590 were enacted, that combination would impose similar mandates on both intergovernmental and private-sector entities with costs exceeding the thresholds established in UMRA. The incremental effect of enacting the reconciliation proposal—assuming that H.R. 3590 had already been enacted—would be to increase the costs of the mandates on private-sector entities. That increase in costs would exceed the annual UMRA threshold as well.

I hope this analysis is helpful for the Congress's deliberations. If you have any questions, please contact me or CBO staff. Many people at CBO have contributed to this analysis, but the primary staff contacts are David Auerbach, Colin Baker, Reagan Baughman, James Baumgardner, Tom Bradley, Stephanie Cameron, Julia Christensen, Mindy Cohen, Anna Cook, Noelia Duchovny, Sean Dunbar, Philip Ellis, Peter Fontaine, April Grady, Stuart Hagen, Holly Harvey, Tamara Hayford, Jean Hearne, Janet Holtzblatt, Lori Housman, Justin Humphrey, Paul Jacobs, Deborah Kalcevic, Daniel Kao, Jamease Kowalczyk, Julie Lee, Kate Massey, Alexandra Minicozzi, Keisuke Nakagawa, Kirstin Nelson, Lyle Nelson, Andrea Noda, Sam Papenfuss, Lisa Ramirez-Branum, Lara Robillard, Robert Stewart, Robert Sunshine, Bruce Vavrichek, Ellen Werble, Chapin White, and Rebecca Yip.

Sincerely,



Douglas W. Elmendorf
Director

Enclosures

cc: Honorable John A. Boehner
Republican Leader

Honorable John M. Spratt Jr.
Chairman
Committee on the Budget

Honorable Paul Ryan
Ranking Member

Honorable Harry Reid
Senate Majority Leader

Honorable Mitch McConnell
Senate Republican Leader

Honorable Kent Conrad
Chairman
Senate Committee on the Budget

Honorable Judd Gregg
Ranking Member

TABLE 2. Estimate of Changes in Direct Spending and Revenue Effects of the Reconciliation Proposal Combined with H.R. 3590 as Passed by the Senate

	By Fiscal Year, in Billions of Dollars											
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
CHANGES IN DIRECT SPENDING (OUTLAYS)												
Education	*	*	4	-6	-3	-5	-4	-2	-2	-2	-5	-19
Health Insurance Exchanges												
Premium and Cost Sharing Subsidies	0	0	0	0	14	32	59	75	82	88	14	350
Start-up Costs	*	*	*	1	*	*	0	0	0	0	2	2
Other Related Spending	0	1	2	2	1	*	*	*	*	0	5	5
Subtotal	0	2	2	2	15	33	59	75	82	88	21	358
Reinsurance and Risk												
Adjustment Payments[a]	0	0	0	0	11	18	18	18	19	21	11	106
Effects of Coverage Provisions												
on Medicaid and CHIP	*	-1	-2	-4	29	56	81	87	91	97	22	434
Medicare and Other Medicaid and CHIP Provisions												
Reductions in Annual Updates to												
Medicare FFS Payment Rates	*	-1	-5	-9	-13	-19	-25	-33	-41	-51	-28	-196
Medicare Advantage Rates based on												
Fee-for-Service Rates	0	-2	-6	-9	-13	-17	-19	-21	-23	-25	-30	-136
Medicare and Medicaid DSH Payments	0	0	*	*	-1	-4	-5	-7	-9	-11	*	-36
Other	2	1	*	*	-16	-11	-10	-14	-18	-22	-12	-87
Subtotal	2	-2	-11	-17	-42	-50	-59	-75	-92	-108	-71	-455
Other Changes in Direct Spending												
Community Living Assistance												
Services and Supports	0	0	-5	-9	-10	-11	-11	-9	-8	-7	-24	-70
Other	2	6	8	5	5	4	2	-1	-1	*	26	30
Subtotal	2	6	2	-4	-5	-7	-10	-10	-8	-7	2	-40
Total Outlays	4	5	-5	-28	6	44	86	92	90	90	-20	382
On-Budget	4	5	-5	-28	5	44	85	92	89	89	-20	379
Off-Budget	0	*	*	*	*	*	1	1	1	1	*	4

Continued

TABLE 2. Estimate of Changes in Direct Spending and Revenue Effects of the Reconciliation Proposal Combined with H.R. 3590 as Passed by the Senate

	By Fiscal Year, in Billions of Dollars											
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
CHANGES IN REVENUES												
Coverage-Related Provisions												
Exchange Premium Credits	0	0	0	0	-5	-11	-18	-22	-24	-26	-5	-107
Reinsurance and Risk Adjustment Collections	0	0	0	0	12	16	18	18	19	22	12	106
Small Employer Tax Credit	-2	-4	-5	-6	-5	-3	-3	-3	-4	-4	-21	-37
Penalty Payments by Employers and Uninsured Individuals	0	0	0	0	3	9	12	13	13	14	3	65
Excise Tax on High-Premium Plans	0	0	0	0	0	0	0	0	12	20	0	32
Associated Effects of Coverage Provisions on Revenues	*	-1	-2	-5	1	6	14	18	10	7	-8	46
Other Provisions												
Fees on Certain Manufacturers and Insurers[b]	0	2	3	5	12	15	15	18	19	18	22	107
Additional Hospital insurance Tax	0	0	1	21	17	29	33	35	37	39	38	210
Other Revenue Provisions[c]	*	7	8	13	22	4	11	12	13	14	49	103
Total Revenues	-3	3	5	27	57	65	83	89	95	104	89	525
On-Budget	-3	4	5	27	55	62	78	82	87	95	88	492
Off-Budget	*	*	-1	1	2	3	5	7	8	9	1	33
NET IMPACT ON THE DEFICIT FROM CHANGES IN DIRECT SPENDING AND REVENUES[d]												
Net Change in the Deficit	6	1	-10	-56	-51	-20	3	4	-5	-15	-109	-143
On-Budget	6	1	-10	-55	-50	-18	8	10	2	-6	-108	-114
Off-Budget	*	*	1	-1	-1	-2	-5	-6	-7	-9	-1	-29

Sources: Congressional Budget Office and staff of the Joint Committee on Taxation (JCT).

Note: Does not include effects on spending subject to future appropriation. Components may not sum to totals because of rounding.
* = between $0.5 billion and -$0.5 billion.
CHIP = Children's Health Insurance Program; FFS = Fee-for-service; DSH = Disproportionate Share Hospital.

a. Risk-adjustment payments lag revenues shown later in the table by one quarter. Reinsurance payments total $20 billion over the 10-year period.
b. Amounts include fees on manufacturers and importers of branded drugs and certain medical devices as well as fees on health insurance providers.
c. Amounts include $89 billion in increased revenues, as estimated by JCT, for tax provisions other than those broken out separately in the table.
In addition, this line includes an increase in revenues of about $14 billion for other provisions shown in Table 5.
d. Positive numbers indicate increases in the deficit, and negative numbers indicate reductions in the deficit.

Table 3. Estimate of the Incremental Effects on Deficits of the Reconciliation Proposal, Relative to H.R. 3590 as Passed by the Senate

By Fiscal Year, in Billions of Dollars

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
CHANGES IN DIRECT SPENDING												
Change in Outlays	*	6	6	-1	*	-1	3	5	5	4	12	27
On Budget	*	6	6	-1	*	-1	3	6	5	4	12	28
Off Budget	0	*	*	*	*	*	*	*	*	*	*	-1
CHANGES IN REVENUES												
Change in Revenues	-2	2	2	2	13	3	10	8	7	7	17	52
On Budget	-2	3	2	5	13	6	14	13	11	12	21	76
Off Budget	0	*	*	-4	-1	-3	-4	-5	-4	-4	-5	-24
NET IMPACT ON DEFICITS FROM CHANGES IN DIRECT SPENDING AND REVENUES /a												
Net Change in Deficits	2	4	4	-3	-13	-4	-7	-3	-2	-3	-5	-25
On Budget	2	4	4	-6	-14	-7	-11	-7	-6	-7	-10	-48
Off Budget	0	*	*	4	1	3	4	4	4	4	5	23

Sources: Congressional Budget Office and staff of the Joint Committee on Taxation (JCT).

Notes: Positive numbers indicate increases in the deficit, and negative numbers indicate reductions in the deficit.
Components may not sum to totals because of rounding; * = between $0.5 billion and -$0.5 billion.

a. Positive numbers indicate increases in the deficit, and negative numbers indicate reductions in the deficit.

Table 4. Estimated Effects of the Insurance Coverage Provisions of the Reconciliation Proposal Combined with H.R. 3590 as Passed by the Senate

EFFECTS ON INSURANCE COVERAGE /a (Millions of nonelderly people, by calendar year)		2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Current Law Coverage /b	Medicaid & CHIP	40	39	39	38	35	34	35	35	35	35
	Employer	150	153	156	158	161	162	162	162	162	162
	Nongroup & Other /c	27	26	25	26	28	29	29	29	30	30
	Uninsured /d	50	51	51	51	51	51	52	53	53	54
	TOTAL	267	269	271	273	274	276	277	279	281	282
Change (+/-)	Medicaid & CHIP	*	-1	-2	-3	10	15	17	16	16	16
	Employer	*	3	3	3	4	1	-3	-3	-3	-3
	Nongroup & Other /c	*	*	*	*	-2	-3	-5	-5	-5	-5
	Exchanges	0	0	0	0	8	13	21	23	24	24
	Uninsured /d	*	*	-1	-1	-19	-25	-30	-31	-31	-32
Post-Policy Uninsured Population											
Number of Nonelderly People /d		50	50	50	50	31	26	21	21	22	23
Insured Share of the Nonelderly Population /a											
Including All Residents		81%	82%	82%	82%	89%	91%	92%	92%	92%	92%
Excluding Unauthorized Immigrants		83%	83%	83%	83%	91%	93%	95%	95%	95%	94%
Memo: Exchange Enrollees and Subsidies											
Number w/ Unaffordable Offer from Employer /e						*	1	1	1	1	1
Number of Unsubsidized Exchange Enrollees						1	2	4	5	5	5
Average Exchange Subsidy per Subsidized Enrollee							$5,200	$5,300	$5,500	$5,700	$6,000

Sources: Congressional Budget Office and the staff of the Joint Committee on Taxation.

Note: CHIP = Children's Health Insurance Program; * = between 0.5 million and -0.5 million people.

a. Figures for the nonelderly population include only residents of the 50 states and the District of Columbia.
b. Figures reflect average annual enrollment; individuals reporting multiple sources of coverage are assigned a primary source.
c. Other, which includes Medicare, accounts for about half of current-law coverage in this category; the effects of the proposal are almost entirely on nongroup coverage.
d. The count of uninsured people includes unauthorized immigrants as well as people who are eligible for, but not enrolled in, Medicaid.
e. Workers who would have to pay more than a specified share of their income (9.5 percent in 2014) for employment-based coverage could receive subsidies via an exchange.

Table 4. Estimated Effects of the Insurance Coverage Provisions of the Reconciliation Proposal Combined with H.R. 3590 as Passed by the Senate

EFFECTS ON THE FEDERAL DEFICIT / a,b (Billions of dollars, by fiscal year)	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2019
Medicaid & CHIP Outlays /c	0	-1	-2	-4	29	56	81	87	91	97	434
Exchange Subsidies & Related Spending /d	0	2	2	2	20	45	77	97	106	113	464
Small Employer Tax Credits /e	2	4	5	6	5	4	3	3	4	4	40
Gross Cost of Coverage Provisions	2	5	5	5	54	104	161	187	201	214	938
Penalty Payments by Uninsured Individuals	0	0	0	0	0	-2	-3	-4	-4	-4	-17
Penalty Payments by Employers /e	0	0	0	0	-3	-8	-10	-10	-10	-11	-52
Excise Tax on High-Premium Insurance Plans /e	0	0	0	0	0	0	0	0	-12	-20	-32
Other Effects on Tax Revenues and Outlays /f	1	3	4	5	-1	-7	-15	-20	-11	-7	-48
NET COST OF COVERAGE PROVISIONS	**3**	**7**	**9**	**10**	**49**	**87**	**132**	**154**	**164**	**172**	**788**

Sources: Congressional Budget Office and the staff of the Joint Committee on Taxation.

Note: CHIP = Children's Health Insurance Program.

a. Does not include federal administrative costs that would be subject to appropriation.
b. Components may not sum to totals because of rounding; positive numbers indicate increases in the deficit, and negative numbers indicate reductions in the deficit.
c. Under current law, states have the flexibility to make programmatic and other budgetary changes to Medicaid and CHIP. CBO estimates that state spending on Medicaid and CHIP in the 2010-2019 period would increase by about $20 billion as a result of the coverage provisions.
d. Includes $5 billion in spending for high-risk pools and the net budgetary effects of proposed collections and payments for reinsurance and risk adjustment.
e. The effects on the deficit of this provision include the associated effects of changes in taxable compensation on tax revenues.
f. The effects are almost entirely on tax revenues. CBO estimates that outlays for Social Security benefits would increase by about $2 billion over the 2010-2019 period, and that the coverage provisions would have negligible effects on outlays for other federal programs.

Table 5. Estimate of the Effects of Non-Coverage Health Provisions of the Reconciliation Proposal Combined with H.R. 3590 as Passed by the Senate

Estimated effects on direct spending and revenues in billions of dollars, by fiscal year

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019	Change from H.R. 3590[a]
Changes in Direct Spending Outlays													
TITLE I—QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS													
Subtitle A—Immediate Improvements in Health Care Coverage for All Americans													
1001 Amendments to the Public Health Service Act	Included in estimate for expanding health insurance coverage.												
1002 Helping Consumers Receive Quality Accountable Coverage	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Subtitle B—Immediate Assistance to Preserve and Expand Coverage													
1101 Temporary High Risk Health Insurance Pool	Included in estimate for expanding health insurance coverage.												
1102 Reinsurance for Early Retirees	1.3	2.5	1.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	5.0	5.0	**0.0**
1103 Assistance to Consumers in Identifying Affordable Coverage Options	Included in estimate for expanding health insurance coverage.												
1104 Administrative Simplification													
Effects on Medicaid spending	0.0	0.0	-0.1	-0.1	-0.2	-0.4	-0.9	-1.7	-1.9	-2.1	-0.4	-7.3	**-0.2**
Effects on exchange subsidies	0.0	0.0	0.0	0.0	-0.1	-0.3	-0.6	-1.0	-1.2	-1.2	-0.1	-4.3	**0.0**
Subtitle C—Effective Coverage for All Americans	Included in estimate for expanding health insurance coverage.												
Subtitle D—Available Coverage for All Americans	Included in estimate for expanding health insurance coverage.												
Subtitle E—Affordable Coverage for All Americans	Included in estimate for expanding health insurance coverage.												
Subtitle F—Shared Responsibility for Health Care	Included in estimate for expanding health insurance coverage.												
Subtitle G—Miscellaneous Provisions													
1556 Equity for Certain Eligible Survivors	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Sections 1551-1555 and 1557-1562	Included in estimate for expanding health insurance coverage.												
TITLE II—ROLE OF PUBLIC PROGRAMS													
Subtitle A—Improved Access to Medicaid													
Sections 2001-2004	Included in estimate for expanding health insurance coverage.												
2005 Payments to Territories	0.0	0.3	0.7	0.7	0.9	0.9	0.9	1.0	1.0	1.0	2.5	7.3	**2.0**
2006 Special Adjustment to FMAP Determination for Certain States Recovering from a Major Disaster	0.0	0.1	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.2	**0.0**
2007 Medicaid Improvement Fund Rescission	0.0	0.0	0.0	0.0	0.0	-0.2	-0.2	-0.2	-0.2	0.0	0.0	-0.6	**0.0**
Subtitle B—Enhanced Support for the Children's Health Insurance Program													
2101 Additional Federal Financial Participation for CHIP	Included in estimate for expanding health insurance coverage.												
2102 Technical Corrections	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.1	0.1	**0.0**
Subtitle C—Medicaid and CHIP Enrollment Simplification	Included in estimate for expanding health insurance coverage.												

Table 5. Estimate of the Effects of Non-Coverage Health Provisions of the Reconciliation Proposal Combined with H.R. 3590 as Passed by the Senate

Estimated effects on direct spending and revenues in billions of dollars, by fiscal year

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019	Change from H.R. 3590[a]
Subtitle D—Improvements to Medicaid Services													
2301 Coverage for Freestanding Birth Center Services	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
2302 Concurrent Care for Children	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.2	**0.0**
2303 State Eligibility Option for Family Planning Services	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
2304 Clarification of Definition of Medical Assistance	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Subtitle E—New Options for States to Provide Long-Term Services and Supports													
2401 Community First Choice Option	0.0	0.0	0.1	0.2	0.3	0.8	0.9	1.0	1.2	1.4	0.6	6.0	**-0.9**
2402 Removal of Barriers to Providing Home and Community-Based Services	0.0	0.1	0.1	0.1	0.2	0.3	0.4	0.4	0.4	0.4	0.5	2.4	**0.0**
2403 Money Follows the Person Rebalancing Demonstration	0.0	0.0	0.0	0.0	0.1	0.2	0.3	0.4	0.3	0.3	0.2	1.7	**0.0**
2404 Protection for Recipients of Home and Community-Based Services Against Spousal Impoverishment	0.0	0.0	0.0	0.0	0.2	0.3	0.3	0.3	0.3	0.2	0.2	1.5	**0.0**
2405 Funding to Expand State Aging and Disability Resource Centers	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	**0.0**
2406 Sense of the Senate Regarding Long-Term Care	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
10202 Incentives for States to Offer Home and Community-Based Services as a Long-Term Care Alternative to Nursing Homes	0.0	0.0	0.1	0.2	0.3	0.3	0.2	0.2	0.2	0.2	0.7	1.8	**0.2**
Subtitle F—Medicaid Prescription Drug Coverage	-0.4	-2.5	-3.2	-3.3	-3.7	-4.1	-4.7	-5.0	-5.4	-5.8	-13.1	-38.1	**-0.1**
Subtitle G—Medicaid Disproportionate Share Hospital (DSH) Payments	0.0	0.0	0.0	0.1	-0.5	-0.6	-0.6	-1.8	-5.0	-5.6	-0.4	-14.0	**4.1**
Subtitle H—Improved Coordination for Dual Eligible Beneficiaries													
2601 5-Year Period for Demonstration Projects	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
2602 Providing Federal Coverage and Payment Coordination for Dual Eligible Beneficiaries	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Subtitle I—Improving the Quality of Medicaid for Patients and Providers													
2701 Adult Health Quality Measures	0.0	0.0	0.0	0.1	0.1	0.0	0.0	0.0	0.0	0.0	0.2	0.3	**0.0**
2702 Payment Adjustment for Health Care-Acquired Conditions	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
2703 State Option to Provide Health Homes for Enrollees With Chronic Conditions	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.7	**0.0**
2704 Demonstration Project to Evaluate Integrated Care Around a Hospitalization	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
2705 Medicaid Global Payment System Demonstration Project	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
2706 Pediatric Accountable Care Organization Demonstration Project	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
2707 Medicaid Emergency Psychiatric Demonstration Project	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	**0.0**
Subtitle J—Improvements to the Medicaid and CHIP Payment and Access Commission (MACPAC)													
2801 MACPAC Assessment of Policies Affecting All Medicaid Beneficiaries	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**

Table 5. Estimate of the Effects of Non-Coverage Health Provisions of the Reconciliation Proposal Combined with H.R. 3590 as Passed by the Senate

Estimated effects on direct spending and revenues in billions of dollars, by fiscal year

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019	Change from H.R. 3590[a]
Subtitle K—Protections for American Indians and Alaska Natives													
2901 Special Rules Relating to Indians													
No Cost Sharing for Indians with Income at or Below 300 Percent of Poverty	Included in estimate for expanding health insurance coverage.												
Payer of Last Resort	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Facilitating Enrollment of Indians Through the Express Lane Option	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
2902 Elimination of Sunset for Reimbursement for All Medicare Part B Services													
Furnished by Certain Indian Hospitals and Clinics	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.2	**0.0**
Indian Health Improvement Act	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Subtitle L—Maternal and Child Health Services													
2951 Maternal, Infant, and Early Childhood Home Visiting Programs	0.0	0.1	0.3	0.4	0.4	0.2	0.1	0.0	0.0	0.0	1.2	1.5	**0.0**
2952 Support, Education, and Research for Postpartum Depression	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
2953 Personal Responsibility Education	0.0	0.0	0.1	0.1	0.1	0.1	0.0	0.0	0.0	0.0	0.3	0.4	**0.0**
2954 Restoration of Funding for Abstinence Education	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	**0.0**
2955 Inclusion of Information About The Importance of Having a Health-Care Power of Attorney in Transition Planning for Children Aging Out of Foster Care and Independent Living Programs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Support for Pregnant and Parenting Teens and Women	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.2	**0.0**
TITLE III—IMPROVING THE QUALITY AND EFFICIENCY OF HEALTH CARE													
Subtitle A—Transforming the Health Care Delivery System													
PART I—LINKING PAYMENT TO QUALITY OUTCOMES UNDER THE MEDICARE PROGRAM													
3001 Hospital Value-Based Purchasing Program	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
3002 Physician Quality Reporting System													
PPO Stabilization Fund	0.0	0.0	0.0	0.0	-0.1	0.0	0.0	0.0	0.0	0.0	-0.1	-0.2	**0.0**
Physicians' Services	0.0	0.0	0.2	0.2	0.2	0.3	-0.1	-0.2	-0.2	-0.2	0.6	0.3	**0.0**
3003 Improvements to the Physician Feedback Program	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
3004 Quality Reporting for Long-Term Care Hospitals, Inpatient Rehabilitation Hospitals, and Hospice Programs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-0.1	**0.0**
3005 Quality Reporting for PPS-Exempt Cancer Hospitals	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
3006 Plans for a Value-Based Purchasing Program for Skilled Nursing Facilities and Home Health Agencies	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
3007 Value-based Payment Modifier Under the Physician Fee Schedule	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
3008 Payment Adjustment for Conditions Acquired in Hospitals	0.0	0.0	0.0	0.0	0.0	-0.2	-0.3	-0.3	-0.3	-0.3	0.0	-1.4	**0.0**
PART II—NATIONAL STRATEGY TO IMPROVE HEALTH CARE QUALITY													
3011 National Strategy	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
3012 Interagency Working Group on Health Care Quality	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
3013 Quality Measure Development	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
3014 Quality Measurement	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	**0.0**
3015 Data Collection; Public Reporting	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Effect of Quality-Measure Development/Endorsement Provisions on Medicare Spending	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**

Table 5. Estimate of the Effects of Non-Coverage Health Provisions of the Reconciliation Proposal Combined with H.R. 3590 as Passed by the Senate

Estimated effects on direct spending and revenues in billions of dollars, by fiscal year

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019	Change from H.R. 3590[a]
PART III—ENCOURAGING DEVELOPMENT OF NEW PATIENT CARE MODELS													
3021 Establishment of Center for Medicare and Medicaid Innovation	0.0	0.1	0.2	0.2	0.2	0.2	0.0	-0.3	-0.7	-1.2	0.7	-1.3	**0.0**
3022 Medicare Shared Savings Program	0.0	0.0	0.0	-0.1	-0.3	-0.6	-0.7	-0.9	-1.0	-1.2	-0.5	-4.9	**0.0**
3023 National Pilot Program on Payment Bundling	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
3024 Independence at Home Demonstration Program	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
3025 Hospital Readmissions Reduction Program	0.0	0.0	0.0	-0.1	-0.3	-1.1	-1.3	-1.3	-1.4	-1.5	-0.5	-7.1	**0.0**
3026 Community-Based Care Transitions Program	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.0	0.0	0.0	0.3	0.5	**0.0**
3027 Extension of Gainsharing Demonstration	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Subtitle B—Improving Medicare for Patients and Providers													
PART I—ENSURING BENEFICIARY ACCESS TO PHYSICIAN CARE AND OTHER SERVICES													
3101 Increase in the Physician Payment Update	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
3102 Extension of the Work Geographic Index Floor and Revisions to the Practice Expense Geographic Adjustment Under the Medicare Physician Fee Schedule	0.9	1.0	0.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.2	2.2	**0.4**
3103 Extension of Exceptions Process for Medicare Therapy Caps	0.3	0.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.8	0.8	**0.0**
3104 Extension of Payment for Technical Component of Certain Physician Pathology Services	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	**0.0**
3105 Extension of Ambulance Add-Ons	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	**0.0**
3106 Extension of Certain Payment Rules for Long-Term Care Hospital Services and of Moratorium on the Establishment of Certain Hospitals and Facilities	0.0	0.1	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.2	**0.0**
3107 Extension of Physician Fee Schedule Mental Health Add-On	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
3108 Permitting Physician Assistants to Order Post-Hospital Extended Care Services	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
3109 Exemption of Certain Pharmacies From Accreditation Requirements	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
3110 Part B Special Enrollment Period for Disabled TRICARE Beneficiaries	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
3111 Payment for Bone Density Tests	0.1	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	**0.0**
3112 Revision to the Medicare Improvement Fund	0.0	0.0	0.0	0.0	-15.6	-5.2	0.0	0.0	0.0	0.0	-15.6	-20.7	**0.0**
3113 Treatment of Certain Complex Diagnostic Laboratory Tests	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	**0.0**
3114 Improved Access for Certified-Midwife Services	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**

Table 5. Estimate of the Effects of Non-Coverage Health Provisions of the Reconciliation Proposal Combined with H.R. 3590 as Passed by the Senate

Estimated effects on direct spending and revenues in billions of dollars, by fiscal year

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019	Change from H.R. 3590[a]
PART II—RURAL PROTECTIONS													
3121 Extension of Outpatient Hold Harmless Provision	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.2	**0.0**
3122 Reasonable Costs Payments for Certain Clinical Diagnostic Laboratory Tests Furnished to Hospital Patients in Certain Rural Areas	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
3123 Extension of the Rural Community Hospital Demonstration Program	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
3124 Extension of the Medicare-Dependent Hospital (MDH) Program	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
3125 Payment Adjustment for Low-Volume Hospitals	0.0	0.0	0.1	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.3	**0.0**
3126 Demonstration Project on Community Health Integration Models	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
3127 Study on Adequacy of Medicare Payments in Rural Areas	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
3128 Technical Correction Related to Critical Access Hospital Services	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
3129 Medicare Rural Hospital Flexibility Program	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
PART III—IMPROVING PAYMENT ACCURACY													
3131 Payment Adjustments for Home Health Care (includes effect of section 3401)	0.0	-0.4	-0.8	-1.1	-1.9	-3.3	-5.3	-7.5	-9.0	-10.3	-4.2	-39.7	**0.0**
3132 Hospice Reform	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-0.1	**0.0**
3133 Medicare Disproportionate Share Hospital (DSH) Payments	0.0	0.0	0.0	0.0	0.0	-3.6	-4.0	-5.0	-4.4	-5.1	0.0	-22.1	**3.0**
3134 Misvalued Codes Under the Physician Fee Schedule	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
3135 Equipment Utilization Factor for Advanced Imaging Services	0.0	-0.1	-0.2	-0.2	-0.3	-0.3	-0.3	-0.3	-0.3	-0.3	-0.9	-2.3	**-1.2**
3136 Revision of Payment for Power-Driven Wheelchairs	0.0	-0.4	-0.1	0.0	0.0	0.0	0.0	-0.1	-0.1	-0.1	-0.6	-0.8	**0.0**
3137 Hospital Wage Index Improvement	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.3	0.3	**0.0**
3138 Treatment of Certain Cancer Hospitals	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
3139 Payment for Biosimilar Biological Products	Included in estimate for title VII, subtitle A.												
3140 Medicare Hospice Concurrent Care Demonstration Program	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
3141 Application of Budget Neutrality on a National Basis in the Calculation of the Medicare Hospital Wage Index Floor	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
3142 HHS Study on Urban Medicare-Dependent Hospitals	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Subtitle C—Provisions Relating to Part C													
3201 Medicare Advantage Payments	0.0	-1.8	-6.0	-9.4	-13.1	-16.7	-19.2	-21.3	-23.2	-25.0	-30.3	-135.6	**-17.5**
3202 Benefit protection and simplification	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
3203 Repealed	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.7**
3204 Simplification of Annual Beneficiary Election Periods	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
3205 Extension for Specialized MA Plans for Special Needs Individuals	0.0	0.1	0.2	0.2	0.2	0.0	0.0	0.0	0.0	0.0	0.6	0.7	**-0.2**
3206 Extension of Reasonable Cost Contracts	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
3207 Technical Correction to MA Private Fee-for-Service Plans	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	**0.0**
3208 Making Senior Housing Facility Demonstration Permanent	Included in estimate for section 3205.												
3209 Authority to Deny Plan Bids	Included in estimate for section 3201.												
3210 Development of New Standards for Certain Medigap Plans	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-0.1	**0.0**

Table 5. Estimate of the Effects of Non-Coverage Health Provisions of the Reconciliation Proposal Combined with H.R. 3590 as Passed by the Senate

Estimated effects on direct spending and revenues in billions of dollars, by fiscal year

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019	Change from H.R. 3590[a]
Subtitle D—Medicare Part D Improvements for Prescription Drug Plans and MA–PD Plans													
3301 Medicare Coverage Gap Discount Program	0.2	2.4	1.6	2.1	2.9	3.8	5.2	6.4	7.6	10.4	9.2	42.6	**24.8**
3302 Determination of Medicare Part D Low-Income Benchmark Premium	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.3	0.7	**0.0**
3303 Voluntary de minimis Policy for Subsidy Eligible Individuals Under Prescription Drug Plans and MA–PD Plans	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.4	**0.0**
3304 Special Rule for Widows and Widowers Regarding Eligibility for Low-Income Assistance	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.2	**0.0**
3305 Improved Information for Subsidy Eligible Individuals Reassigned to Prescription Drug Plans and MA–PD Plans	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
3306 Funding Outreach and Assistance for Low-Income Programs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
3307 Improving Formulary Requirements for Prescription Drug Plans and MA–PD Plans With Respect to Certain Categories or Classes of Drugs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
3308 Reducing Part D Premium Subsidy for High-Income Beneficiaries	0.0	-0.3	-0.5	-0.7	-0.9	-1.1	-1.3	-1.6	-2.0	-2.4	-2.4	-10.7	**0.0**
3309 Elimination of Cost Sharing for Certain Dual Eligible Individuals.	0.0	0.0	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.3	1.1	**0.0**
3310 Reducing Wasteful Dispensing of Outpatient Prescription Drugs in Long-Term Care Facilities	0.0	0.0	-0.1	-0.3	-0.5	-0.8	-1.0	-1.0	-0.9	-1.1	-1.0	-5.7	**0.0**
3311 Medicare Prescription Drug Plan and MA–PD Plan Complaint System	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
3312 Uniform Exceptions and Appeals Process for Prescription Drug Plans and MA–PD Plans	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
3313 Office of the Inspector General Studies and Reports	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
3314 Including Costs Incurred by AIDS Drug Assistance Programs and Indian Health Service in Providing Prescription Drugs Toward the Annual Out-of-Pocket Threshold Under Part D	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.6	**0.0**
3315 Immediate Reduction in Coverage Gap in 2010	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
10328 Improvement in Part D Medication Therapy Management Programs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Subtitle E—Ensuring Medicare Sustainability													
3401 Revision of Certain Market Basket Updates and Incorporation of services Productivity Improvements into Market Basket Updates that do not Already Incorporate Such Improvements (effect of productivity adjustment for home health included in estimate for section 3131)	-0.1	-1.1	-3.8	-7.4	-11.3	-15.3	-19.5	-25.4	-32.3	-40.5	-23.7	-156.6	**-9.9**
3402 Temporary Adjustment to the Calculation of Part B Premiums	0.0	-1.3	-1.9	-1.9	-2.5	-2.6	-2.8	-3.2	-4.0	-4.9	-7.5	-25.0	**0.0**
3403 Independent Payment Advisory Board	0.0	0.0	0.0	0.0	0.0	-1.5	-2.6	-3.0	-3.7	-4.7	0.0	-15.5	**12.6**
Subtitle F—Health Care Quality Improvements	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
10323 Medicare Coverage for Individuals Exposed to Environmental Health Hazards	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.3	**0.0**
10324 Protections for Frontier States	0.0	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.3	0.8	2.0	**0.0**
10325 Revision to Skilled Nursing Facility Prospective Payment System	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
10326 Pilot Testing of Pay-for-Performance	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
10329 Methodology to Assess Health Plan Value	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
10330 Modernizing CMS Computer and Data Systems	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
10331 Public Reporting of Performance Information	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
10332 Availability of Medicare Data	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
10333 Community-based Collaborative Care Networks	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**

Table 5. Estimate of the Effects of Non-Coverage Health Provisions of the Reconciliation Proposal Combined with H.R. 3590 as Passed by the Senate

Estimated effects on direct spending and revenues in billions of dollars, by fiscal year

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019	Change from H.R. 3590[a]
TITLE IV—PREVENTION OF CHRONIC DISEASE AND IMPROVING PUBLIC HEALTH													
Subtitle A—Modernizing Disease Prevention and Public Health Systems													
4002 Prevention and Public Health Fund	0.1	0.6	0.8	1.0	1.3	1.6	1.8	1.9	2.0	2.0	3.7	12.9	**0.0**
Sections 4001, 4003, 4004	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Subtitle B—Increasing Access to Clinical Preventive Services													
4101 School-Based Health Centers	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.2	**0.0**
4102 Oral Healthcare Prevention Activities	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
4103 Medicare Coverage of Annual Wellness Visit Providing a Personalized Prevention Plan	0.0	0.3	0.3	0.4	0.4	0.4	0.4	0.4	0.5	0.5	1.4	3.6	**0.0**
4104 Removal of Barriers to Preventive Services in Medicare	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.3	0.8	**0.0**
4105 Evidence-Based Coverage of Preventive Services in Medicare	0.0	0.0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.3	-0.7	**0.0**
4106 Improving Access to Preventive Services for Eligible Adults in Medicaid	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	**0.0**
4107 Coverage of Comprehensive Tobacco Cessation Services for Pregnant Women in Medicaid	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-0.1	**0.0**
4108 Incentives for Prevention of Chronic Diseases in Medicaid	0.0	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	**0.0**
Subtitle C—Creating Healthier Communities													
4201 Community Transformation Grants	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
4202 Healthy Aging, Living Well; Evaluation of Community-Based Prevention and Wellness Programs for Medicare Beneficiaries	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	**0.0**
4203 Removing Barriers and Improving Access to Wellness for Individuals With Disabilities	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
4204 Immunizations	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
4205 Nutrition Labeling of Standard Menu Items at Chain Restaurants	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
4206 Demonstration Project Concerning Individualized Wellness Plan	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
4207 Reasonable Break Time for Nursing Mothers	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Subtitle D—Support for Prevention and Public Health Innovation													
4301 Research On Optimizing The Delivery of Public Health Services	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
4302 Understanding Health Disparities: Data Collection and Analysis													
Data Collection, Analysis, and Quality	0.0	0.1	0.1	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.2	**0.0**
Addressing Health Care Disparities	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
4303 CDC and Employer-Based Wellness Programs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
4304 Epidemiology-Laboratory Capacity Grants	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
4305 Advancing Research and Treatment for Pain-Care Management	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
4306 Funding for Childhood Obesity Demonstration Project	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
10407 Better Diabetes Care	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
10408 Grants for Workplace Wellness	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
10409 Cures Acceleration Network	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
10410 Centers of Excellence for Depression	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
10411 Programs Relating to Congenital Heart Disease	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
10412 Automated Defibrillation	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
10413 Young Women's Breast Health	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Subtitle E—Miscellaneous Provisions	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**

Table 5. Estimate of the Effects of Non-Coverage Health Provisions of the Reconciliation Proposal Combined with H.R. 3590 as Passed by the Senate

Estimated effects on direct spending and revenues in billions of dollars, by fiscal year

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019	Change from H.R. 3590[a]
TITLE V—HEALTH CARE WORKFORCE													
Subtitle A—Purpose and Definitions	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Subtitle B—Innovations in the Health Care Workforce	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Subtitle C—Increasing the Supply of the Health Care Workforce	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Subtitle D—Enhancing Health Care Workforce Education and Training													
Sections 5301-5314	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
5315 United States Public Health Sciences Track	Included in estimate for section 4002.												
5316 Family Nurse Practitioner Training Programs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Subtitle E—Supporting the Existing Health Care Workforce	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Subtitle F—Strengthening Primary Care and Other Workforce Improvements													
5501 Expanding Access to Primary Care Services and General Surgery Services	0.0	0.4	0.6	0.7	0.7	0.8	0.3	0.0	0.0	0.0	2.5	3.5	**0.0**
5502 Medicare Federally Qualified Health Center Improvements	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.0	0.4	**0.0**
5503- 5506 Medicare Graduate Medical Education Policies	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.3	1.1	**0.0**
5507 Demonstration Projects to Address Health Professions Workforce Needs and Extension of Family-To-Family Health Information Centers	0.0	0.1	0.1	0.1	0.1	0.1	0.0	0.0	0.0	0.0	0.4	0.4	**0.0**
5508 Increasing Teaching Capacity	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.2	**0.0**
5509 Graduate Nurse Education Demonstration Program	0.0	0.0	0.0	0.1	0.1	0.1	0.0	0.0	0.0	0.0	0.1	0.2	**0.0**
Subtitle G—Improving Access to Health Care Services	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
5707 Infrastructure to Expand Access to Care	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	**0.0**
5606 State Grants to Health Care Providers	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Medical Training in Underserved Communities	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Preventive Medicine and Public Health Training Program	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Scholarship and Loan program	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
5708 Community Health Centers and the National Health Service Corps Fund	0.0	0.7	2.2	1.8	2.3	3.3	1.8	0.2	0.0	0.0	7.0	12.3	**2.5**
5709 Demonstration Project to Provide Access to Affordable Care	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Subtitle H—General Provisions	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
TITLE VI—TRANSPARENCY AND PROGRAM INTEGRITY													
Subtitle A—Physician Ownership and Other Transparency													
6001 Limitation on Medicare Exception to the Prohibition on Certain Physician Referrals for Hospitals	0.0	0.0	0.0	0.0	0.0	0.0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.5	**0.1**
6002 Reporting of Physician Ownership or Investment Interests	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
6003 Disclosure Requirements for In-Office Ancillary Services Exception to the Prohibition on Physician Self-Referral for Certain Imaging Services	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
6004 Prescription Drug Sample Transparency	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
6005 Pharmacy Benefit Managers Transparency Requirements	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**

Table 5. Estimate of the Effects of Non-Coverage Health Provisions of the Reconciliation Proposal Combined with H.R. 3590 as Passed by the Senate

Estimated effects on direct spending and revenues in billions of dollars, by fiscal year

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019	Change from H.R. 3590[a]
Subtitle B—Nursing Home Transparency and Improvement	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Subtitle C—Nationwide Program for National and State Background Checks on Direct Patient Access Employees of Long-term Care Facilities and Providers	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	**0.0**
Subtitle D—Patient-Centered Outcomes Research													
6301 Patient-Centered Outcomes Research													
Medicare	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-0.1	-0.2	0.1	-0.3	**0.0**
Non-Medicare	0.0	0.0	0.1	0.1	0.2	0.3	0.4	0.4	0.4	0.5	0.4	2.5	**0.0**
6302 Federal Coordinating Council for Comparative Effectiveness Research	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Subtitle E—Medicare, Medicaid, and CHIP Program Integrity Provisions													
6401 Provider Screening and Other Enrollment Requirements Under Medicare, Medicaid, and CHIP	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-0.1	**0.0**
6402 Enhanced Medicare and Medicaid Program Integrity Provisions	0.0	-0.2	-0.3	-0.3	-0.3	-0.3	-0.4	-0.4	-0.4	-0.4	-1.1	-2.9	**0.3**
6403 Elimination of Duplication Between the Healthcare Integrity and Protection Data Bank and the National Practitioner Data Bank	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
6404 Maximum Period for Submission of Medicare Claims	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
6405 Physicians Who Order Items or Services Required to Be Medicare-Enrolled Physicians or Eligible Professionals	0.0	0.0	0.0	0.0	0.0	0.0	-0.1	-0.1	-0.1	-0.1	-0.2	-0.4	**0.0**
6406 Requirement for Physicians to Provide Documentation on Referrals to Programs At High Risk of Waste and Abuse	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
6407 Face to Face Encounter With Patient Required Before Physicians May Certify Eligibility for Home Health Services or Durable Medical Equipment Under Medicare	0.0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.3	-1.0	**0.0**
6408 Enhanced Penalties	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
6409 Medicare Self-Referral Disclosure Protocol	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
6410 Adjustments to the Competitive Acquisition Program in Medicare for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies	0.0	0.0	0.0	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.3	-1.4	**0.0**
6411 Expansion of the Recovery Audit Contractor (RAC) Program	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
10606 Health Care Fraud Enforcement	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Subtitle F—Additional Medicaid Program Integrity Provisions													
6501 Termination of Provider Participation Under Medicaid If Terminated Under Medicare or Other State Plan	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
6502 Medicaid Exclusion From Participation Relating to Certain Ownership, Control, and Management Affiliations	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
6503 Billing Agents, Clearinghouses, or Other Alternate Payees Required to Register Under Medicaid	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
6504 Requirement to Report Expanded Set of Data Elements Under MMIS to Detect Fraud and Abuse	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
6505 Prohibition on Payments to Institutions or Entities Located Outside of the United States	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
6506 Overpayments	0.1	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	**0.0**
6507 Mandatory State Use of National Correct Coding Initiative	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-0.1	-0.1	-0.3	**0.0**
6508 General Effective Date	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**

Table 5. Estimate of the Effects of Non-Coverage Health Provisions of the Reconciliation Proposal Combined with H.R. 3590 as Passed by the Senate

Estimated effects on direct spending and revenues in billions of dollars, by fiscal year

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019	Change from H.R. 3590[a]
Subtitle G—Additional Program Integrity Provisions													**0.0**
10607 State Demonstration Programs: Alternatives to Tort Litigation	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
10608 Liability Coverage in Free Clinics	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	**0.0**
10609 FDA Labeling Changes	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-0.1	**0.0**
Subtitle H—Elder Justice Act	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Subtitle I—Sense of the Senate Regarding Medical Malpractice	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
TITLE VII—IMPROVING ACCESS TO INNOVATIVE MEDICAL THERAPIES													
Subtitle A—Biologics Price Competition and Innovation	0.0	0.0	0.0	0.0	-0.1	-0.3	-0.7	-1.2	-1.9	-2.7	-0.1	-7.0	**0.1**
Subtitle B—More Affordable Medicines for Children and Underserved Communities													
7101 Expanded Participation in 340B Program	Included in estimate for section 2501.												
7102 Improvements to 340B Program Integrity	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
7103 GAO Study to Make Recommendations on Improving the 340B Program	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
TITLE VIII—COMMUNITY LIVING ASSISTANCE SERVICES AND SUPPORTS	0.0	0.0	-5.4	-8.8	-10.0	-11.3	-11.1	-9.1	-7.6	-7.0	-24.1	-70.2	**0.0**
TITLE IX—REVENUE PROVISIONS	Estimates provided by the Joint Committee on Taxation in a Separate Table (see JCX-17-10).												
PROVISIONS OF RECONCILIATION BILL THAT ARE NOT INCLUDED IN ESTIMATES FOR PROVISIONS OF H.R. 3590													
1005 Administrative Funding	0.0	0.4	0.5	0.1	0.0	0.0	0.0	0.0	0.0	0.0	1.0	1.0	**1.0**
1109 Payment for Qualifying Hospitals		0.1	0.3	0.0							0.4	0.4	**0.4**
1202 Improving Payments to Primary Care Practitioners	0.0	0.0	0.0	1.9	3.0	1.6	0.9	0.8	0.1	0.0	4.9	8.3	**8.3**
1206 Drug Rebates for New Formulations of Existing Drugs	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.6	**0.6**
1301, 1302, 1304 Program Integrity Provisions: Sections 1301, 1302,1304	0.0	0.0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.3	-0.9	**-0.9**
1305 Increased Funding to Fight Fraud, Waste, and Abuse	Included in estimate for section 6402.												**0.0**
1501 Community College and Career Training Grant Program	0.0	0.0	0.4	0.5	0.5	0.5	0.1	0.0	0.0	0.0	1.3	2.0	**2.0**
2303 Drugs Purchased by Covered Entities	0.1	0.2	0.2	0.2	0.2	0.3	0.3	0.3	0.4	0.4	0.8	2.5	**2.5**
INTERACTIONS													
Medicare Advantage Interactions	0.0	0.0	-0.6	-1.9	-7.9	-7.8	-8.9	-11.7	-14.1	-17.2	-10.4	-70.3	**-52.9**
Premium Interactions	0.0	-0.2	0.5	1.1	6.3	4.8	4.8	6.0	7.0	8.1	7.6	38.4	**6.8**
Medicare Part D Interactions with Medicare Advantage Provisions	0.0	0.0	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.3	0.4	1.5	**-1.5**
Medicare Part B Interactions with Medicare Part D Provisions	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.3	0.8	**0.0**
Medicaid Interactions with Medicare Part D Provisions	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.2	0.1	0.7	**0.0**
Medicare Interaction with 340b	0.0	0.0	0.0	0.0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.5	**0.0**
TRICARE Interaction	0.0	0.0	-0.1	-0.2	-0.3	-0.4	-0.6	-0.8	-1.0	-1.2	-0.5	-4.4	**-0.9**
FEHB Interaction (on-budget)	0.0	0.0	0.0	0.0	0.2	0.3	0.3	0.4	0.8	0.9	0.3	2.9	**0.1**
FEHB Interaction (off-budget)	0.0	0.0	0.0	0.0	0.2	0.2	0.2	0.1	0.3	0.3	0.3	1.3	**-0.2**
Total, Changes in On-Budget Direct Spending	**3.0**	**3.0**	**-10.7**	**-22.0**	**-47.5**	**-55.7**	**-66.6**	**-83.2**	**-99.1**	**-114.7**	**-74.1**	**-493.3**	**-13.7**
Total, Changes in Unified-Budget Direct Spending	**3.0**	**3.0**	**-10.6**	**-22.0**	**-47.3**	**-55.5**	**-66.4**	**-83.1**	**-98.9**	**-114.4**	**-73.8**	**-492.0**	**-13.9**

Table 5. Estimate of the Effects of Non-Coverage Health Provisions of the Reconciliation Proposal Combined with H.R. 3590 as Passed by the Senate

Estimated effects on direct spending and revenues in billions of dollars, by fiscal year

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019	Change from H.R. 3590[a]
Changes in Revenues													
Transitional Reinsurance - Collections for Early Retirees	0.0	0.0	0.0	0.0	1.5	1.5	0.8	0.0	0.0	0.0	1.5	3.8	**0.0**
Fraud, Waste, and Abuse (on-budget)	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.4	0.9	**0.0**
Effect of Administrative Simplification on Revenues[b]	0.0	-0.2	-0.2	0.0	0.5	0.9	1.3	1.9	2.0	2.0	0.1	8.2	**0.0**
Effect on Revenues of Changes in Health Insurance Premiums as a Result of Comparative Effectiveness Research, Changes in the Medicaid Drug Program, Biosimilar Biological Products, and FDA Labeling													
Income and Medicare payroll taxes (on-budget)	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.2	0.3	0.3	0.1	1.0	**0.0**
Social Security payroll taxes (off-budget)	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.2	0.0	0.5	**0.0**
Total, Changes in Unified-Budget Revenues[c]	**0.0**	**-0.1**	**-0.1**	**0.2**	**2.1**	**2.6**	**2.4**	**2.2**	**2.5**	**2.6**	**2.1**	**14.3**	**0.0**
Total, Changes in Unified-Budget Deficits[c]	**3.0**	**3.1**	**-10.6**	**-22.1**	**-49.4**	**-58.1**	**-68.7**	**-85.3**	**-101.4**	**-117.0**	**-75.9**	**-506.4**	**-13.9**
Memorandum													
Non-scoreable Effects													
Savings from HCFAC and Medicaid Integrity Spending	0.0	-0.1	-0.1	-0.2	-0.2	-0.2	-0.3	-0.3	-0.4	-0.4	-0.5	-2.1	
Recovery Audit Contractor (RAC) Program in Medicaid	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-0.2	

Notes: AIDS = Acquired Immune-Deficiency Syndrome; CDC = Center for Disease Control and Prevention; CHIP = Children's Health Insurance Program; CMS = Centers for Medicare & Medicaid Services; FMAP = federal medical assistance percentage; FDA = Food and Drug Administration; FEHB = Federal Employees Health Benefits program; GAO = Government Accountability Office; HCFAC = Health Care Fraud and Abuse Control; HHS = Department of Health and Human Services; MA = Medicare Advantage; MA-PD = Medicare Advantage prescription drug plan; MMIS = Medicaid Management Information System; PPO = preferred provider organization; PPS = prospective payment system; TRICARE is the health plan operated by the Department of Defense.

a. Incremental effects over the 2010-2019 period of health provisions of the reconciliation proposal relative to H.R. 3590 as passed by the Senate.
b. Includes both on and off-budget revenues.
c. The revenue effects of the provisions of title IX are estimated by the Joint Committee on Taxation, and are not included in this table.

Table 6. Estimate of the Incremental Effects of the Health and Revenue Provisions of the Reconciliation Proposal Relative to H.R. 3590 as Passed by the Senate

Estimated effects on direct spending and revenues in billions of dollars, by fiscal year

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
Changes in Deficits												
TITLE I—COVERAGE, MEDICARE, MEDICAID, AND REVENUES												
Subtitle A—Coverage (direct spending and revenues)												
Coverage Provisions (sections 1001-1004, 1201, and 1401)	0	0.2	0.3	5.9	14.2	17.4	21.6	30.2	35.0	35.6	20.6	160.4
1005 Implementation Funding	0	0.4	0.5	0.1	0	0	0	0	0	0	1.0	1.0
Subtitle B—Medicare (direct spending)												
1101 Closing the Medicare Prescription Drug "Donut Hole"	0.2	1.5	-0.3	0.7	1.3	2.0	3.0	4.1	5.0	7.2	3.5	24.8
1102 Medicare Advantage Payments	0	4.2	1.0	1.4	-1.8	-4.4	-5.2	-4.5	-4.2	-3.4	4.8	-17.0
1103 Savings from Limits on MA Plan Administrative Costs	Interacts with section 1102; budgetary effects are included in estimate for that section.											
1104 Disproportionate Share Hospital (DSH) Payments	0	0	0	0	*	0.2	0.5	0.7	0.7	0.9	*	3.0
1105 Market Basket Updates	0	0	0	0	-0.2	-0.2	-0.4	-1.6	-3.0	-4.5	-0.2	-9.8
1106 Physician Ownership-Referral	*	*	*	*	*	*	*	*	*	*	*	0.1
1107 Payment for Imaging Services	0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.5	-1.2
1108 Practice Expense Geographic Practice Cost Index Adjustment for 2010	0.3	0.2	0	0	0	0	0	0	0	0	0.4	0.4
1109 Payment for Qualifying Hospitals	0	0.1	0.3	*	0	0	0	0	0	0	0.4	0.4
Subtitle C—Medicaid (direct spending)												
1201 Federal Funding for States	Included in coverage estimate.											
1202 Payments to Primary Care Physicians	0	0	0	1.9	3.0	1.6	0.9	0.8	0.1	0	4.9	8.3
1203 Disproportionate Share Hospital Payments	0	0	*	*	-0.5	2.2	3.0	2.0	-1.1	-1.6	-0.4	4.1
1204 Funding for the Territories	0	0.2	0.5	0.6	0.2	0.1	0.1	0.1	0.1	0.1	1.5	2.0
1205 Delay in Community First Choice Option	0	-0.1	-0.1	-0.1	-0.3	-0.1	*	-0.1	*	-0.1	-0.6	-0.9
1206 Drug Rebates for New Formulations of Existing Drugs	*	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.6
Subtitle D—Reducing Fraud, Waste, and Abuse (direct spending)												
1301 Community Mental Health Centers	0	*	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.6
1302 Medicare Prepayment Medical Review Limitations	0	0	*	*	*	*	*	*	*	*	*	-0.1
1303 Funding to Fight Fraud, Waste, and Abuse	0	0.1	0.1	*	*	*	*	*	*	*	0.2	0.3
1304 90-Day Period of Enhanced Oversight for Initial Claims of DME Suppliers	0	*	*	*	*	*	*	*	*	*	-0.1	-0.2
Subtitle E—Revenues (direct spending and revenues)[a]	1.9	-2.6	-2.3	-7.7	-23.0	-15.3	-24.1	-26.6	-27.8	-28.7	-33.6	-155.9
Subtitle F—Community College and Career Training Grant Program (direct spending)	0	*	0.4	0.5	0.5	0.5	0.1	*	0	0	1.3	2.0

Table 6. Estimate of the Incremental Effects of the Health and Revenue Provisions of the Reconciliation Proposal Relative to H.R. 3590 as Passed by the Senate

Estimated effects on direct spending and revenues in billions of dollars, by fiscal year

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
INTERACTIONS (direct spending)												
Effect of Coverage Provisions on Medicare/Medicaid/CHIP Spending	*	-0.2	-0.1	*	*	-0.2	-0.2	-0.4	-0.1	-0.1	-0.4	-1.3
Medicare Advantage Interactions	0	0	-0.2	-0.9	-6.1	-5.9	-6.5	-8.9	-11.1	-13.3	-7.1	-52.9
Premium Interactions	0	-0.4	-0.1	-0.1	1.1	1.0	1.1	1.2	1.4	1.5	0.5	6.8
IPAB Interactions	0	0	0	0	0	*	1.5	2.6	3.9	4.6	0	12.6
TRICARE Interaction	0	*	*	*	-0.1	-0.1	-0.1	-0.2	-0.2	-0.3	-0.1	-0.9
FEHB Interaction (off-budget)	0	*	-0.1	-0.1	0.1	*	-0.1	-0.1	*	*	-0.1	-0.2
Subtotal, Title I Changes in Unified-Budget Deficits	**2.4**	**3.6**	**-0.2**	**2.2**	**-11.9**	**-1.3**	**-4.8**	**-0.8**	**-1.4**	**-2.3**	**-3.8**	**-14.4**
TITLE II—HEALTH, EDUCATION, LABOR, AND PENSIONS												
Subtitle A—Education (direct spending)	See Table 7.											
Subtitle B—Health (direct spending and revenues)												
2301 Insurance Reforms	0	0.3	0.4	0.3	0.7	0.6	0.5	0.4	0.4	0.3	1.6	3.8
2302 Drugs Purchased by Covered Entities	0.1	0.2	0.2	0.2	0.2	0.3	0.3	0.3	0.4	0.4	0.8	2.5
2303 Community Health Centers	0	0.2	0.3	0.4	0.5	0.6	0.3	*	0	0	1.5	2.5
Subtotal, Title II Subtitle B Changes in Unified-Budget Deficits	**0.1**	**0.6**	**0.9**	**0.9**	**1.4**	**1.6**	**1.1**	**0.8**	**0.7**	**0.7**	**3.9**	**8.7**
Total Changes in Unified-Budget Deficits for Title I and Subtitle B of Title II	**2.5**	**4.2**	**0.7**	**3.1**	**-10.4**	**0.3**	**-3.7**	**-0.1**	**-0.7**	**-1.6**	**0.1**	**-5.7**

Sources: Congressional Budget Office and staff of the Joint Committee on Taxation

Notes: * = between -$50 million and $50 million. Negative numbers indicate reductions in the deficit.
CHIP = Children's Health Insurance Program; DME = durable medical equipment; FEHB = Federal Employees Health Benefits program;
IPAB = Independent Payment Advisory Board; MA = Medicare Advantage; TRICARE is the health plan operated by the Department of Defense.

a. Estimated effects on the deficit of section 1401 (High-cost plan excise tax) are included in the estimate for coverage provisions in Title I, Subtitle A.

Table 7. Estimate of the Incremental Effects of the Reconciliation Proposal, Relative to H.R. 3590 as Passed by the Senate
Includes effects of education provisions as well as health care and revenue provisions

Billions of Dollars, by Fiscal Year

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
INCREASE OR DECREASE (-) IN THE DEFICIT FROM CHANGES IN DIRECT SPENDING OR REVENUES												
Title I - Coverage, Medicare, Medicaid, and Revenues[a]												
Subtotal, Title I	2.4	3.6	-0.2	2.2	-11.9	-1.3	-4.8	-0.8	-1.4	-2.3	-3.8	-14.4
On-Budget	2.4	3.5	-0.2	-1.2	-12.6	-3.6	-8.2	-5.1	-5.3	-6.3	-8.1	-36.6
Off-Budget[b]	0	0.1	0.1	3.4	0.7	2.3	3.4	4.3	3.9	4.0	4.3	22.2
Title II - Health, Education, Labor, and Pensions												
Subtitle A - Education	-0.3	-0.4	3.7	-5.6	-2.5	-4.5	-3.6	-2.4	-1.8	-1.7	-5.1	-19.2
Subtitle B - Health	0.1	0.6	0.9	0.9	1.4	1.6	1.1	0.8	0.7	0.7	3.9	8.7
Subtotal, Title II	-0.3	0.2	4.6	-4.6	-1.1	-3.0	-2.5	-1.7	-1.0	-1.0	-1.2	-10.5
On-Budget	-0.3	0.1	4.5	-4.7	-1.3	-3.2	-2.7	-1.8	-1.1	-1.1	-1.7	-11.7
Off-Budget[b]	0	0.1	0.1	0.1	0.2	0.2	0.2	0.1	0.1	0.1	0.5	1.2
Net Increase or Decrease (-) in the Deficit	2.2	3.8	4.4	-2.5	-12.9	-4.2	-7.3	-2.5	-2.4	-3.4	-5.0	-24.9
On-Budget	2.2	3.6	4.2	-5.9	-13.9	-6.8	-10.9	-6.9	-6.4	-7.4	-9.8	-48.3
Off-Budget[b]	0	0.2	0.2	3.5	0.9	2.6	3.6	4.4	4.0	4.1	4.8	23.4

Sources: Congressional Budget Office and the staff of the Joint Committee on Taxation.

Notes: Components may not sum to totals because of rounding.

a. Also includes funding for Community College and Career Training Grant Program.
b. Off-budget effects include changes in Social Security spending and revenues as well as spending by the U.S. Postal Service.

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

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

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

Daniel R. Levinson
Inspector General

June 2014
A-09-14-01000

Faulk v. USA
Exhibit
E

Office of Inspector General

https://oig.hhs.gov

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

Office of Audit Services

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

Office of Evaluation and Inspections

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

Office of Investigations

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

Office of Counsel to the Inspector General

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

Notices

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

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

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

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

WHY WE DID THIS REVIEW

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

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

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

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

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

OBJECTIVE

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

BACKGROUND

Health Insurance Marketplaces

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

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

Qualified Health Plans and Insurance Affordability Programs

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

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

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

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

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

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

HOW WE CONDUCTED THIS REVIEW

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

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

- tested controls by reviewing a sample of 45 applicants randomly selected at each marketplace from all applicants who were determined eligible to enroll in QHPs with coverage effective January 1, 2014,[1] and

- performed other audit procedures, which included interviews with marketplace management, staff, and contractors; observation of staff performing tasks related to eligibility determinations; and reviews of supporting documentation and enrollment records.

Our attribute sampling approach is commonly used to test the effectiveness of internal controls for compliance with laws, regulations, and policies. According to the Government Accountability Office and President's Council on Integrity and Efficiency's[2] *Financial Audit Manual* (July 2008), section 450, auditors may use a randomly selected sample of 45 items to perform a compliance review. If all sample items are determined to be in compliance with requirements, a conclusion that the controls are effective can be made. If one or more sample items are determined not to be in compliance with requirements, a conclusion that the controls are ineffective can be made. We tested the controls at each marketplace separately. Our sampling methodology was limited to forming an opinion about whether the internal controls at each marketplace were effective and was not designed to estimate the percentage of applicants for whom each marketplace did not perform the required eligibility verifications.

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

---

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

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

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

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

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

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

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

WHAT WE FOUND

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

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

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

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

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

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

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

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

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

Deficiencies Identified	Federal Marketplace	California Marketplace	Connecticut Marketplace
Verifying Identity of Applicants and Entering Application Information			
Identity proofing of applicants was not always performed			X
Information from paper applications was not always entered correctly into enrollment system		X	
Determining Eligibility of Applicants			
Social Security numbers were not always validated through the Social Security Administration	X		
Citizenship was not always verified through the Department of Homeland Security		X	
Lawful presence was not always verified through the Department of Homeland Security		X	
Eligibility for insurance affordability programs was not always determined properly			X
Inconsistencies in eligibility data were not always resolved	X[6]	X	
Maintaining and Updating Eligibility and Enrollment Data			
Eligibility data were not always properly maintained		X	X
System functionality to allow enrollees to update enrollment information had not been developed	X		
NOTES			
• The absence of an "X" for a deficiency indicates that, on the basis of our review, nothing came to our attention to indicate that the marketplace had this deficiency. • Although we identified deficiencies at each marketplace, the magnitude of the deficiencies varied. For example, the California marketplace did not verify citizenship through DHS for seven sample applicants but did not verify lawful presence through DHS for only one sample applicant.			

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

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

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

WHAT WE RECOMMEND

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

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

MARKETPLACES' COMMENTS AND OUR RESPONSES

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

- CMS concurred with all of our recommendations and provided information on actions that it had taken or planned to take to address our recommendations. However, it stated that it did not believe that the recommendations to perform identity proofing of all applicants and fully develop system functionality to allow enrollees to report life changes needed to be included in the report. After reviewing additional supporting documentation that CMS provided after issuance of our draft report, we removed our recommendation and the related finding on identify proofing of applicants.

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

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

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

TABLE OF CONTENTS

INTRODUCTION

WHY WE DID THIS REVIEW

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

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

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

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

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

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

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

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

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

OBJECTIVE

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

BACKGROUND

Patient Protection and Affordable Care Act

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

Health Insurance Marketplaces

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

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

- **Federal marketplace:** HHS operates the Federal marketplace in States that did not establish their own marketplaces. Individuals in these States enroll in QHPs through the Federal marketplace.

- **State marketplace:** A State may establish and operate its own marketplace. The State marketplace may use Federal services (e.g., the system that provides Federal data) to assist with certain functions, such as eligibility determinations for insurance affordability programs.

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

[5] ACA §§ 1311(b) and 1321(c).

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

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

Qualified Health Plans and Insurance Affordability Programs

Qualified Health Plans

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

Insurance Affordability Programs

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

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

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

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

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

[9] ACA § 1401 and 45 CFR § 155.20 (definition of "advance payment of the premium tax credit").

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

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

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

Federal Eligibility Requirements for Qualified Health Plans and Insurance Affordability Programs

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

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

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

[11] ACA § 1402 and 45 CFR § 155.20.

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

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

- not be incarcerated; and[14]
- meet applicable residency standards.[15]

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

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

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

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

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

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

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

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

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

11. whether the individual is eligible for minimum essential coverage through non-employer-sponsored insurance.[19]

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

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

To enroll in a QHP, an applicant[20] must complete an application and meet eligibility requirements defined by the ACA. An applicant can enroll in a QHP through the marketplace Web site (online), which is either HealthCare.gov (the Federal marketplace Web site) or the State marketplace Web site, depending on the applicant's State of residence; by phone; by mail; in person; or directly with a QHP issuer's broker or agent. For online and phone applications, the marketplace verifies the applicant's identity through an identity-proofing process. For paper applications, the marketplace requires the applicant's signature before the marketplace processes the application.[21] When an applicant completes any type of application, the applicant attests that answers to all questions are true and is subject to the penalty of perjury.[22]

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

[19] 45 CFR §§ 155.315 and 155.320.

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

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

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

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

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

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

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

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

During the inconsistency period, the applicant may choose to enroll in a QHP and, when applicable, may choose to receive the advance premium tax credit and cost-sharing reductions.[29] An applicant may choose to enroll during the period only if the applicant is otherwise eligible to enroll in a QHP and may receive the advance premium tax credit and cost-sharing reductions if (1) the applicant meets other eligibility requirements and (2) the tax filer[30] attests that the advance premium tax credit is subject to reconciliation.[31] After the inconsistency period, if the

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

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

[27] 45 CFR § 155.315(f)(3).

[28] ACA § 1411(e)(4).

[29] 45 CFR § 155.315(f)(4).

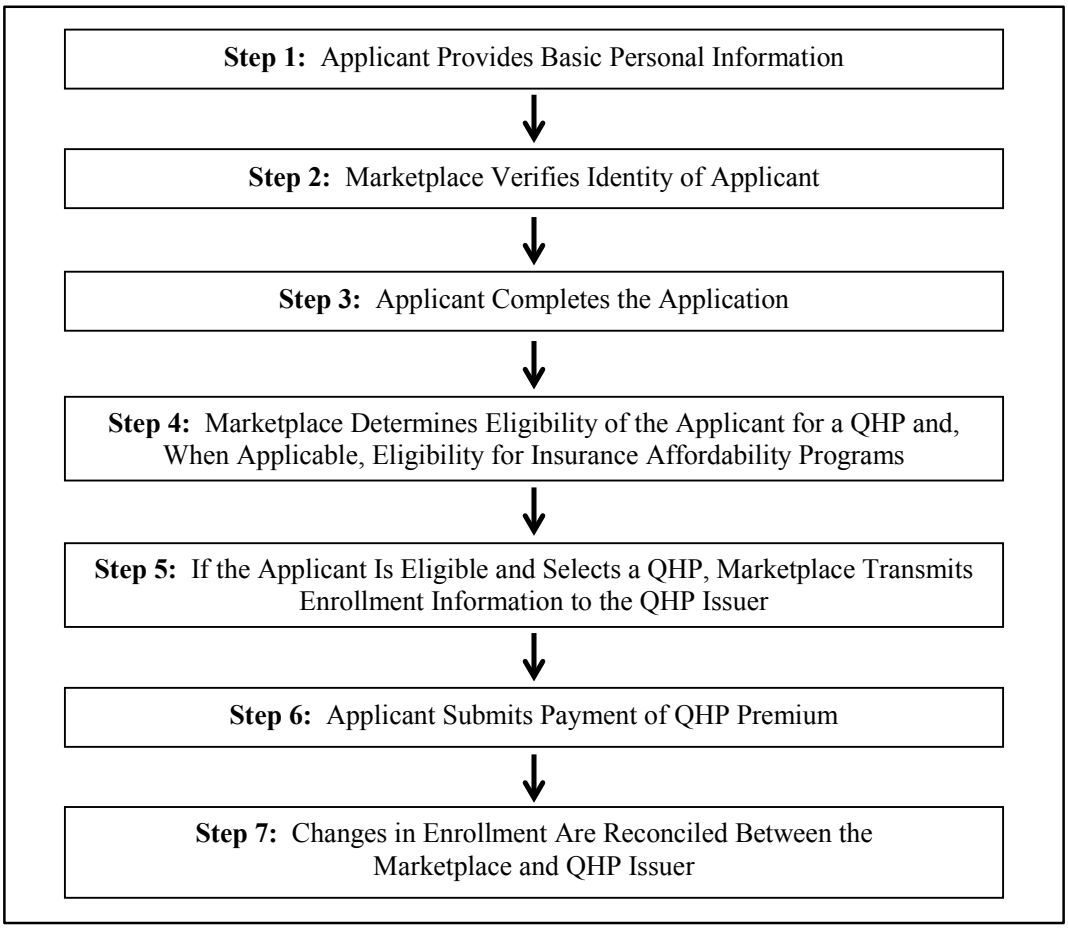
[30] Generally, a "tax filer" is an individual or a married couple who indicate that they are filing an income tax return for the benefit year (45 CFR § 155.300(a)).

[31] 45 CFR § 155.315(f)(4).

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

Generally, an applicant must pay the first month's QHP premium for the insurance coverage to be effective. If a change to the enrollee's[33] coverage occurs after the coverage becomes effective, the marketplace and the QHP issuer must reconcile the revised enrollment records (45 CFR § 155.400). Figure 1 provides a summary of the steps in the application and enrollment process, and Appendix C provides a detailed description of each step.

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



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

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

An applicant may submit an application to enroll in a QHP during an open enrollment period. An applicant may also enroll in a QHP during a special enrollment period outside of the open enrollment period if the applicant experiences certain life changes, such as marriage or birth of a child.[34] For calendar year (CY) 2014, the open enrollment period was October 1, 2013, through March 31, 2014.[35]

Administration of the Federal, California, and Connecticut Marketplaces

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

Federal Marketplace

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

California Marketplace

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

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

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

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

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

[37] See generally 45 CFR §§ 155.110 and 155.1200.

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

Connecticut Marketplace

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

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

HOW WE CONDUCTED THIS REVIEW

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

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

- tested controls by reviewing a sample of 45 applicants randomly selected at each marketplace from all applicants who were determined eligible to enroll in QHPs with coverage effective January 1, 2014,[40] and

- performed other audit procedures, which included interviews with marketplace management, staff, and contractors; observation of staff performing tasks related to eligibility determinations; and reviews of supporting documentation and enrollment records.

Our attribute sampling approach is commonly used to test the effectiveness of internal controls for compliance with laws, regulations, and policies. According to the Government Accountability Office and President's Council on Integrity and Efficiency's[41] *Financial Audit Manual* (July 2008), section 450, auditors may use a randomly selected sample of 45 items to perform a compliance review. If all sample items are determined to be in compliance with

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

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

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

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

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

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

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

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

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

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

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

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

FINDINGS

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

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

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

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

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

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

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

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

Deficiencies Identified	Federal Marketplace	California Marketplace	Connecticut Marketplace
Verifying Identity of Applicants and Entering Application Information			
Identity proofing of applicants was not always performed			X
Information from paper applications was not always entered correctly into enrollment system		X	
Determining Eligibility of Applicants			
Social Security numbers were not always validated through the Social Security Administration	X		
Citizenship was not always verified through the Department of Homeland Security		X	
Lawful presence was not always verified through the Department of Homeland Security		X	
Eligibility for insurance affordability programs was not always determined properly			X
Inconsistencies in eligibility data were not always resolved	X[44]	X	
Maintaining and Updating Eligibility and Enrollment Data			
Eligibility data were not always properly maintained		X	X
System functionality to allow enrollees to update enrollment information had not been developed	X		
NOTES			
• The absence of an "X" for a deficiency indicates that, on the basis of our review, nothing came to our attention to indicate that the marketplace had this deficiency. • Although we identified deficiencies at each marketplace, the magnitude of the deficiencies varied. For example, the California marketplace did not verify citizenship through DHS for seven sample applicants but did not verify lawful presence through DHS for only one sample applicant.			

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

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

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

DEFICIENCIES RELATED TO VERIFYING IDENTITY OF APPLICANTS AND ENTERING APPLICATION INFORMATION

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

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

Federal Requirements

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

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

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

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

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

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

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

Federal Requirements

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

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

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

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

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

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

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

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

DEFICIENCIES RELATED TO DETERMINING ELIGIBILITY OF APPLICANTS

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

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

Federal Requirements

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

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

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

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

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

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

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

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

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

Federal Requirements

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

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

For 7 of 10 sample applicants who attested that they were U.S. naturalized citizens[53] and provided documentation that could be verified through DHS,[54] the California marketplace did not verify citizenship through DHS when (1) the SSA system indicated that the applicant was not

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

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

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

a U.S. citizen or (2) SSA information was unavailable[55] to verify citizenship. The California marketplace placed six of the seven applicants in an inconsistency period when it should have verified citizenship through DHS according to the Federal requirements.[56]

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

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

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

Federal Requirements

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

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

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

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

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

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

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

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

Federal Requirements

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

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

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

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

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

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

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

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

Federal Requirements

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DEFICIENCIES RELATED TO MAINTAINING AND UPDATING ELIGIBILITY AND ENROLLMENT DATA

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

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

Federal Requirements

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

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

The California Marketplace Maintained Conflicting Application and Eligibility Data

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

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

- For another sample applicant, the data that the California marketplace provided to support the eligibility verification had multiple data fields, one of which showed that the

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

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

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

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

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

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

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

Federal Requirements

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

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

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

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

CONCLUSION

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

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

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

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

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

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

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

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

RECOMMENDATIONS

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

RECOMMENDATIONS TO CMS

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

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

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

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

RECOMMENDATIONS TO COVERED CALIFORNIA

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

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

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

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

RECOMMENDATIONS TO ACCESS HEALTH CT

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

- developing and implementing a procedure to ensure that it performs identity proofing of phone applicants,

- ensuring that it corrected the system programming errors related to applicants' eligibility for advance premium tax credits and cost-sharing reductions, and

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

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

MARKETPLACES' COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSES

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

- CMS concurred with all of our recommendations and provided information on actions that it had taken or planned to take to address our recommendations. However, it stated that it did not believe that the recommendations to perform identity proofing of all applicants and fully develop system functionality to allow enrollees to report life changes needed to be included in the report. After reviewing additional supporting documentation that CMS provided after issuance of our draft report, we removed our recommendation and the related finding on identify proofing of applicants.

- Covered California agreed with our recommendation that it ensure that documentation is maintained to support the resolution of inconsistencies and provided information on actions that it had taken or planned to take to address our remaining recommendations. Covered California did not concur with our findings that identity proofing of applicants was not always performed and citizenship was not always verified through DHS. In addition, it stated that it could not concur or disagree with our finding that lawful presence was not always verified through DHS. After reviewing supporting documentation that Covered California provided after issuance of our draft report, we

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

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

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

CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

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

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

COVERED CALIFORNIA COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

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

Covered California Comments

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

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

- Regarding our finding and related recommendation on identity proofing, Covered California stated that it planned to implement remote identity proofing before November 15, 2014.[68] It stated that, for the first open enrollment period, with CMS's approval, it had implemented an identity proofing process, which included accepting applicants' electronic signatures (for online applications) and verbal attestations to identity made under penalty of perjury (for phone applications). After issuance of our draft report, Covered California provided OIG with supporting documentation of CMS's approval. The documentation showed that CMS had approved Covered California's interim solution for the identity-proofing process, which allowed Covered California to accept applicants' electronic signatures and verbal attestations.

- Regarding our finding on verification of citizenship through DHS, Covered California stated that CMS had approved its citizenship verification process of using SSA data to electronically verify applicants' citizenship. Covered California also stated that during the early months of open enrollment, the Data Hub was frequently offline, which had "impacted Covered California's ability to verify some cases as noted in the audit."

- Regarding our finding on verification of lawful presence through DHS, Covered California stated that it had consistently verified lawful presence with DHS. It also stated that verification of lawful presence for 1 of the 45 sample applicants "was not apparent in the data field of the record due to some form of technical error" and that it was conducting an analysis to determine whether this error resulted in any cases of lawful presence not being verified. Covered California stated that, until that analysis was complete, it could not concur or disagree with our finding.

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

Office of Inspector General Response

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

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

- After reviewing the supporting documentation that Covered California provided, we removed our finding and the related recommendation on identify proofing of applicants.

- We acknowledge that CMS approved Covered California's eligibility verification plan, which allowed use of SSA data to verify citizenship. However, this verification process did not meet the Federal requirements that marketplaces verify applicants' citizenship through DHS when (1) SSA cannot verify citizenship and (2) applicants provide documentation that can be used to verify citizenship through DHS.

- Covered California did not provide data that demonstrated that it had verified lawful presence through DHS. Therefore, we maintain that our finding and the related recommendation are valid.

ACCESS HEALTH CT COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

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

Access Health CT Comments

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

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

Office of Inspector General Response

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

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

OTHER ISSUES NOTED AT THE THREE MARKETPLACES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

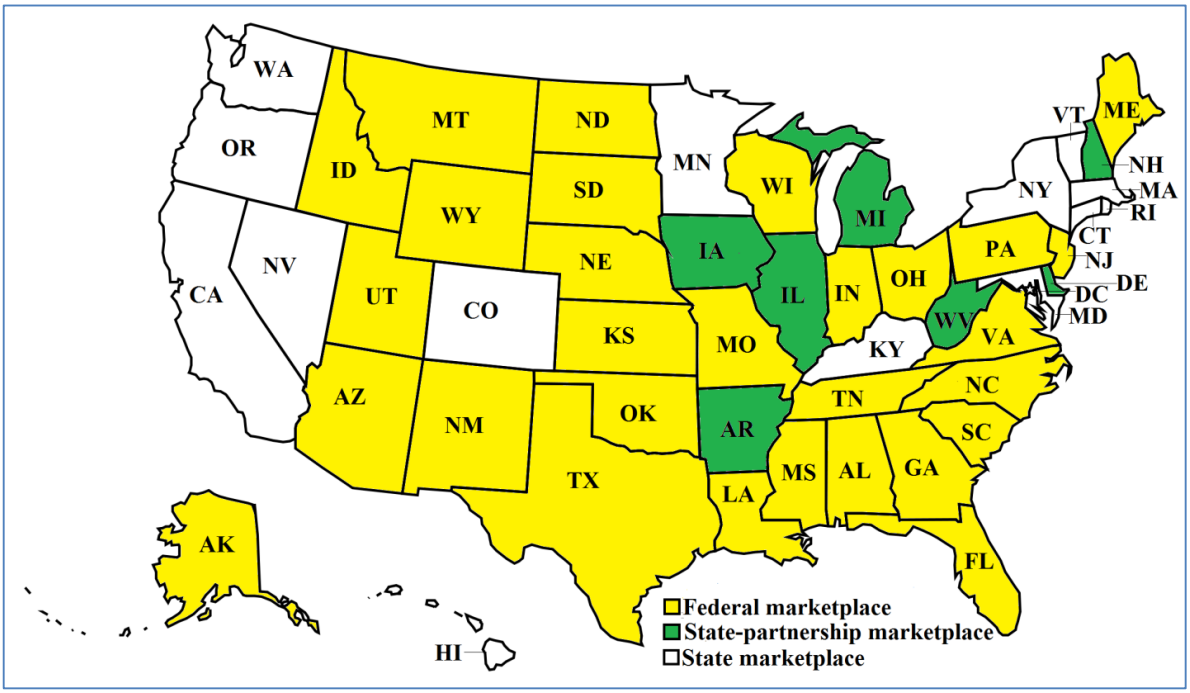


Table 2: Type of Marketplace in Each State as of October 1, 2013

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

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

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

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

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

ELIGIBILITY REQUIREMENTS FOR APPLICANTS

Eligibility Requirements for Enrollment in a Qualified Health Plan

45 CFR § 155.305(a)

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

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

Eligibility Requirements for Advance Premium Tax Credits

45 CFR § 155.305(f)

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

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

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

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

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

[73] 45 CFR § 155.310(d)(2)(ii).

Eligibility Requirements for Cost-Sharing Reductions

45 CFR § 155.305(g)

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

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

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

VERIFICATION REQUIREMENTS FOR MARKETPLACES

Enrollment in a Qualified Health Plan

ACA § 1411(b)

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

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

ACA § 1411(c)(1)

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

ACA § 1411(d)

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

Insurance Affordability Programs

ACA § 1411(c)(3)

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

Social Security Number

45 CFR § 155.315(b)

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

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

Citizenship, Status as a National, or Lawful Presence

ACA § 1411(c)(2)

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

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

45 CFR § 155.315(c)

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

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

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

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

Incarceration Status

ACA § 1312(f)(1)(B)

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

45 CFR § 155.315(e)

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

> (1) Relying on any electronic data sources that are available to the [marketplace] and which have been approved by HHS for this purpose, based on evidence showing that such data sources are sufficiently current, accurate, and offer less administrative complexity than paper verification; or
>
> (2) Except as provided in paragraph (e)(3) of this section, if an approved data source is unavailable, accepting his or her attestation without further verification.
>
> (3) To the extent that an applicant's attestation is not reasonably compatible with information from approved data sources described in paragraph (e)(1) of this section or other information provided by the applicant or in the records of the [marketplace], the [marketplace] must follow the procedures specified in § 155.315(f).

Residency

45 CFR § 155.315(d)

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

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

Indian Attestation

45 CFR § 155.350(c)

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

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

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

Family Size

ACA §§ 1411(c)(1) and (3)

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

45 CFR § 155.320(c)(3)(i)

> (A) The [marketplace] must require an applicant to attest to the individuals that comprise a tax filer's family for advance payments of the premium tax credit and cost-sharing reductions.
>
> (B) To the extent that the applicant attests that the information described in paragraph (c)(1)(i) of this section represents an accurate projection of a tax filer's family size for the benefit year for which coverage is requested, the [marketplace] must determine the tax filer's eligibility for advance payments of the premium tax credit and cost-sharing reductions based on the family size data in paragraph (c)(1)(i) of this section.
>
> (C) To the extent that the data described in paragraph (c)(1)(i) of this section is unavailable, or an applicant attests that a change in circumstances has occurred or is reasonably expected to occur, and so it does not represent an accurate projection of a tax filer's family size for the benefit year for which coverage is requested, the [marketplace] must verify the tax filer's family size for advance payments of the premium tax credit and cost-sharing reductions by accepting an applicant's attestation without further verification, except as specified in paragraph (c)(3)(i)(D) of this section.
>
> (D) If the [marketplace] finds that an applicant's attestation of a tax filer's family size is not reasonably compatible with other information provided by the application filer for the family or in the records of the [marketplace], with the exception of the data described in paragraph (c)(1)(i) of this section, the [marketplace] must utilize data obtained through other electronic data sources to verify the attestation. If such data sources are unavailable or information in such data sources is not reasonably compatible with the applicant's attestation, the [marketplace] must request additional documentation to support the attestation within the procedures specified in § 155.315(f).

Annual Household Income

45 CFR § 155.320(c)(1)(i)

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

45 CFR § 155.320(c)(3)(ii)

> (A) The [marketplace] must compute annual household income for the family described in paragraph (c)(3)(i)(A) of this section based on the data described in paragraph (c)(1)(i) of this section.
>
> (B) The [marketplace] must require the applicant to attest regarding a tax filer's projected annual household income.
>
> (C) To the extent that the applicant's attestation indicates that the information described in (c)(3)(ii)(A) of this section represents an accurate projection of the tax filer's household income for the benefit year for which coverage is requested, the [marketplace] must determine the tax filer's eligibility for advance payments of the premium tax credit and cost-sharing reductions based on the household income data in paragraph (c)(3)(ii)(A) of this section.
>
> (D) To the extent that the data described in paragraph (c)(1)(i) of this section is unavailable, or an applicant attests that a change in circumstances has occurred or is reasonably expected to occur, and so it does not represent an accurate projection of the tax filer's household income for the benefit year for which coverage is requested, the [marketplace] must require the applicant to attest to the tax filer's projected household income for the benefit year for which coverage is requested.

Minimum Essential Coverage Through Employer-Sponsored Insurance

ACA § 1411(b)(4)

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

45 CFR § 155.320(d)

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

The marketplace must:

(i) Obtain data about enrollment in and eligibility for an eligible employer-sponsored plan from any electronic data sources that are available to the [marketplace] and which have been approved by HHS, based on evidence showing that such data sources are sufficiently current, accurate, and minimize administrative burden.

(ii) Obtain any available data regarding enrollment in employer-sponsored coverage or eligibility for qualifying coverage in an eligible employer-sponsored plan based on federal employment by transmitting identifying information specified by HHS to HHS for HHS to provide the necessary verification using data obtained by HHS.

(iii) Obtain any available data from the SHOP that corresponds to the State in which the [marketplace] is operating.

Minimum Essential Coverage Through Non-Employer-Sponsored Insurance

45 CFR § 155.320(b)(1)

(i) The [marketplace] must verify whether an applicant is eligible for minimum essential coverage other than through an eligible employer-sponsored plan, Medicaid, CHIP, or the [Basic Health Program], using information obtained by transmitting identifying information specified by HHS to HHS for verification purposes.

(ii) The [marketplace] must verify whether an applicant has already been determined eligible for coverage through Medicaid, CHIP, or the [Basic Health Program], if a [Basic Health Program] is operating in the service area of the [marketplace], within the State or States in which the [marketplace] operates using information obtained from the agencies administering such programs.

Resolution of Inconsistencies in Eligibility Data

ACA § 1411(e)

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

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

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

45 CFR § 155.315(f)

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

- must make a reasonable effort to identify and address the causes of such inconsistency, including through typographical or other clerical errors, by contacting the applicant to confirm the accuracy of the information submitted;

- must provide notice to the applicant regarding the inconsistency and provide the applicant with a period of 90 days from the date when the notice is sent to the applicant to present satisfactory documentary evidence to the marketplace, if the marketplace is unable to resolve the inconsistency through reasonable efforts; and

- may extend the 90-day period for an applicant if the applicant demonstrates that a good-faith effort has been made to obtain the required documentation during the period.

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

- proceed with all other elements of eligibility determination using the applicant's attestation and provide eligibility for enrollment in a QHP to the extent that an applicant is otherwise qualified and

- ensure that advance payments of the premium tax credit and cost-sharing reductions are provided on behalf of an applicant within this period who is otherwise qualified for such payments and reductions, as described in § 155.305, if the tax filer attests to the marketplace that he or she understands that any advance payments of the premium tax credit paid on his or her behalf are subject to reconciliation.

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

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

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

Redetermination of Eligibility

45 CFR § 155.330(a)

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

45 CFR § 155.330(b)

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

- must not require an enrollee who did not request an eligibility determination for insurance affordability programs to report changes that affect eligibility for those programs;

- may establish a reasonable threshold for changes in income, such that an enrollee who experiences a change in income that is below the threshold is not required to report such a change; and

- must allow an enrollee to report changes via the channels available for the submission of an application, as described in § 155.405(c).

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

Step 1: Applicant Provides Basic Personal Information

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

Step 2: Marketplace Verifies Identity of Applicant

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

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

Step 3: Applicant Completes the Application

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

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

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

---

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

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

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

APPENDIX D: OVERVIEW OF INTERNAL CONTROLS

INTERNAL CONTROLS IN THE GOVERNMENT[75]

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

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

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

FIVE COMPONENTS OF INTERNAL CONTROL[76]

Internal control consists of five interrelated components:

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

---

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

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

APPENDIX E: AUDIT SCOPE AND METHODOLOGY

SCOPE

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

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

- tested controls by reviewing a sample of 45 applicants randomly selected at each marketplace from all applicants who were determined eligible to enroll in QHPs with coverage effective January 1, 2014, and

- performed other audit procedures, which included interviews with marketplace management, staff, and contractors; observation of staff performing tasks related to eligibility determinations; and reviews of supporting documentation and enrollment records.

Our attribute sampling approach is commonly used to test the effectiveness of internal controls for compliance with laws, regulations, and policies. According to the Government Accountability Office and President's Council on Integrity and Efficiency's[77] *Financial Audit Manual* (July 2008), section 450, auditors may use a randomly selected sample of 45 items to perform a compliance review. If all sample items are determined to be in compliance with requirements, a conclusion that the controls are effective can be made. If one or more sample items are determined not to be in compliance with requirements, a conclusion that the controls are ineffective can be made. We tested the controls at each marketplace separately. Our sampling methodology was limited to forming an opinion about whether the internal controls at each marketplace were effective and was not designed to estimate the percentage of applicants for whom each marketplace did not perform the required eligibility verifications.

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

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

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

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

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

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

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

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

METHODOLOGY

To accomplish our objective, we:

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

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

- reviewed the Secretary of HHS's report on the eligibility verifications for advance premium tax credits and cost-sharing reductions (submitted to Congress on December 31, 2013);

- assessed internal controls by:

    - interviewing officials from CMS, Covered California, and Access Health CT and their contractors and reviewing documentation provided by them to understand how the marketplaces (1) verify the identity of applicants, (2) verify information submitted on enrollment applications and make eligibility determinations, and (3) maintain and update eligibility and enrollment data;

    - observing marketplace staff performing tasks related to eligibility determinations at the three marketplaces; and

    - reviewing documents and records at the three marketplaces;

- obtained enrollment records from the Federal, California, and Connecticut marketplaces for applicants for enrollment in a QHP with coverage effective January 1, 2014, representing:

    - 1,112,411 applicants (Federal marketplace),

    - 453,401 applicants (California marketplace), and

    - 34,095 applicants (Connecticut marketplace);

- analyzed the enrollment records to obtain an understanding of information that was sent to QHP issuers;

- performed tests, such as matching records to the marketplaces' eligibility or enrollment systems, to determine whether the enrollment data were reliable;

- performed testing of internal controls used by the Federal, California, and Connecticut marketplaces for eligibility determinations by:

    - randomly selecting 45 applicants who enrolled in a QHP effective January 1, 2014, at each marketplace using the OIG, Office of Audit Services, statistical software and

    - obtaining and reviewing eligibility data for each sample applicant to determine whether the marketplace performed the required eligibility verification and determination according to Federal requirements; and

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

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

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

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

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

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

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

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

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

APPENDIX G: CMS COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

Date: May 27, 2014

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

From: Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services

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

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

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

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

1

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

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

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

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

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

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

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

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

2

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

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

OIG Recommendation

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

CMS Response

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

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

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

3

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

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

OIG Recommendation

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

CMS Response

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

OIG Recommendation

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

CMS Response

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

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

4

OIG Recommendation

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

CMS Response

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

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

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

OIG Noted Issues Outside the Scope of the Review

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

CMS Response

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

OIG Noted Issues Outside the Scope of the Review

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

5

CMS Response

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

6

APPENDIX H: COVERED CALIFORNIA COMMENTS

COVERED CALIFORNIA

May 29, 2014

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

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

Dear Ms. Ahlstrand:

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

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

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

Sincerely,

Peter V. Lee
Executive Director

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

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

May 28, 2014

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

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

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

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

Office of Inspector General Findings:

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

Covered California does not concur with this finding.

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

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

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

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

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

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

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

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

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

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

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

Covered California does not concur with this finding.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

OIG RECOMMENDATIONS for COVERED CALIFORNIA

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

APPENDIX I: ACCESS HEALTH CT COMMENTS

access health CT

Connecticut's Health Insurance Marketplace

June 2, 2014

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

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

Dear Ms. Ahlstrand:

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

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

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

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

Sincerely,

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

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

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

Condition:

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

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

Criteria:

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

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

Effect:

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

OIG Recommendation:

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

AHCT Response:

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

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

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

Condition:

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

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

Criteria:

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

Effect:

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

OIG Recommendation:

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

AHCT Response:

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

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

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

Condition:

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

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

Criteria:

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

Effect:

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

OIG Recommendation:

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

AHCT Response:

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

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

Condition:

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

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

Criteria:

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

Effect:

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

OIG Recommendation:

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

AHCT Response:

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

OIG Recommendation:

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

to Federal requirements.

AHCT Response:

AHCT concurs with the OIG recommendation and completed necessary redeterminations.

Other issues outside the OIG audit scope:

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

Condition:

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

Criteria:

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

AHCT Response:

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

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

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

Condition:

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

Criteria:

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

AHCT Response:

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

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

Condition:

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

Criteria:

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

Effect:

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

AHCT Response:

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

Other Issue 4: APTC Amount Exceeds Total Plan Premium

Condition:

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

Criteria:

26 CFR § 1.36B-3 - Computing the premium assistance credit amount
(d) Premium assistance amount. The premium assistance amount for a coverage month is the lesser of—
(1) The premiums for the month for one or more qualified health plans in which a taxpayer or a member of the taxpayer's family enrolls; or
(2) The excess of the adjusted monthly premium for the applicable benchmark plan over 1/12 of the product of a taxpayer's household income and the applicable percentage for the taxable year.

Effect:

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

AHCT Response:

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

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

CMS Newsroom

Fact Sheets Oct 26, 2018

Federal Health Insurance Exchange 2019 Open Enrollment

Affordable Care Act Eligibility & enrollment

Share

FEDERAL HEALTH INSURANCE EXCHANGE 2019 OPEN ENROLLMENT

The Federal Health Insurance Exchange (also known as the Marketplace) Open Enrollment Period runs from November 1, 2018 to December 15, 2018, for coverage starting on January 1, 2019. Similar to last year, the Centers for Medicare & Medicaid Services (CMS) is taking a strategic and cost-effective approach to inform individuals about Open Enrollment, deliver a smooth enrollment experience, and use consumer feedback to drive ongoing improvements across the Exchange platform. Consumers can visit HealthCare.gov and CuidadodeSalud.gov to preview 2019 plans and prices before Open Enrollment begins.

Key Updates and Enhancements to Healthcare.gov for the 2019 Open Enrollment

Faulk v. USA
Exhibit
F

Streamlined Application Visual Refresh

CMS remains committed to improving the customer experience, this year the streamlined application on HealthCare.gov was refreshed based on feedback and testing. The refreshed application that will be available for some consumers will provide better content, improved help information integrated throughout the application, and enhanced mobile optimization. CMS will continue to make enhancements to the application based on feedback and testing.

Find Local Help Enhancements

The Find Local Help tool on HealthCare.gov has been redesigned this year based on feedback from consumers, agents and brokers. This year, consumers will be able to filter agents and brokers by their minimum years of participation on the Federal Exchanges. Additionally, for the first time, individuals will be able to search for a specific agent or broker by entering their first or last name. Find local help is a tool that allows consumers to search by city and state or ZIP code to see a list of local people and organizations who can help them enroll in coverage.

Improved plan information

CMS also added improved content on Health Savings Account (HSA) eligible high deductible health plans (HDHPs) to make it easier for consumers to search for and identify HSA-eligible HDHPs. In addition, HealthCare.gov now includes information on if a particular plan covers abortion services outside of exceptions for rape, incest, or if the pregnancy is determined to endanger the woman's life.

Consumer Tools and Support

Window Shopping

On October 26, 2018, CMS launched updates to window shopping (the "See plans & prices" page on HealthCare.gov) which allow consumers to preview 2019 plans and prices before Open Enrollment begins. As in previous years, window shopping lets consumers browse plans without logging in, creating an account, or filling out the official application. Starting November 1, consumers can log in to HealthCare.gov and CuidadodeSalud.gov or call 1-800-318-2596 to fill out an application and enroll in a 2019 Exchange health plan.

Consumer Call Center

The Call Center is often the front line of assistance for consumers as they apply for coverage and compare plan options. Last year, CMS' Call Center staffing peaked at 10,000 people during Open Enrollment. CMS plans to have the same amount of staff this year. During last year's Open Enrollment, consumer satisfaction rate was at an all-time high – averaging 90 percent – throughout the entire Open Enrollment Period. In order to help prepare the Call Center

representatives to handle high consumer demand, CMS will continue providing extensive training to Call Center staff prior to Open Enrollment and weekly refreshers throughout the Open Enrollment Period.

In addition to the Call Center, in-person assistance will continue to be available to help consumers with enrollment. This includes local agents and brokers, Certified Application Counselors, and federally-funded Navigators.

Help on Demand

CMS will continue to offer the "Help On Demand" services for agents and brokers. This service allows consumers to choose to have an agent or broker in their area contact them directly for assistance while they're available. For registered agents and brokers, this allows them to set times when they're available and then reach out to consumers who expressed interest in needing help applying and enrolling.

For more information, visit: https://www.cms.gov/cciio/programs-and-initiatives/health-insurance-marketplaces/a-b-resources.html

Financial Assistance

Premium tax credits will be available in 2019 for individuals who qualify. Consumers can continue to use Exchange coverage and take advantage of its benefits, including premium tax credits. Plans available from insurance companies will continue to reflect reduced copayments, coinsurance, and deductibles for eligible consumers.

Quality Rating System (QRS) Star Ratings Pilot

CMS is conducting a third year of the QRS pilot program to test consumer reaction to the public display of health plan quality rating information during the 2019 Open Enrollment Period. The QRS Pilot Program displays quality ratings (or "star ratings") for some health plans on HealthCare.gov. Each rated health plan has an overall quality rating of one to five stars, which accounts for member experience, medical care, and health plan administration.

CMS extended the QRS Star Ratings pilot this year to three additional states. In addition to Virginia and Wisconsin, the third pilot year will be conducted in

Michigan, Montana and New Hampshire. The pilot testing helps CMS analyze the impact of QRS star ratings on consumer behavior, with the ultimate goal of providing consumers with the information they need to compare plans based on quality and pick a plan that best meets their needs.

For more information, visit: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2018-QRS-QHP-Survey.pdf

Small Business Health Options Program (SHOP)

Similar to last year, for enrollment in SHOP Exchanges using the Federal platform, employers will be able to enroll directly with an issuer, or with a SHOP-registered agent or broker. HealthCare.gov provides information to help assist employers looking to enroll and SHOP-registered agents and brokers assisting consumers with SHOP coverage.

Re-enrollment Process

Similar to previous years, consumers who are currently enrolled in a plan will receive notices from the Marketplace prior to November 1 about the upcoming the Open Enrollment Period. These notices provide consumers with the dates for this year's Open Enrollment and the importance of returning during this time to update their application and actively re-enroll in a plan for 2019, as well as customized messaging for their situation, such as if they're at risk of losing tax credits. Consumers also receive notices from their current issuer with important information about premiums, coverage and benefit changes, and plan availability for 2019.

Consumers who are currently enrolled are encouraged to come back and update their information, shop, and pick a plan that best suits their health care needs before the December 15 deadline. Similar to Medicare's Open Enrollment Period, consumers who miss the deadline to enroll in a plan of their choice will not be able to make any plan changes until the next coverage year unless they qualify for certain Special Enrollment Periods.

The majority of consumers whose plan isn't available in 2019 will be automatically re-enrolled into a plan from a different issuer to avoid a gap in coverage – these consumers will need to pay their premium for January in order for this coverage

to begin. Consumers whose issuer isn't offering their plan in 2019 are eligible for a Special Enrollment Period due to losing coverage and have the opportunity to choose a different plan.

- **Automatic Re-enrollment:** As in previous years, CMS will automatically re-enroll consumers that don't actively re-enroll by December 15 into their same or similar plan, and if that is not available, another plan with a different insurance company. The Marketplace will send a notice to those consumers that were automatically re-enrolled.

- **Plans No Longer Available:** Consumers whose 2018 issuer does not have a plan available to them for 2019 will receive a discontinuation notice from their current issuer by the start of Open Enrollment. Those consumers may also receive a letter from the Marketplace notifying them that they have been matched with an alternate plan from a different issuer to help avoid a gap in coverage. These consumers generally will need to pay their premium for January in order for their 2019 coverage to begin. Consumers are not under any obligation to stay with their new plan and are encouraged to take action and choose a plan by December 15.

To see examples of consumer notices, visit:
https://marketplace.cms.gov/applications-and-forms/notices.html

Marketing and Outreach

Similar to last year, CMS plans to spend $10 million on marketing and outreach for the upcoming Open Enrollment Period. Last year's Open Enrollment Period was the agency's most cost effective and successful experience for HealthCare.gov consumers to date. CMS will continue to use similar marketing tactics from last year and focus funding and attention on the most strategic and efficient ways to reach consumers. This year's outreach and education campaign will target people who are uninsured as well as those planning to reenroll in health plans, with a special focus on young and healthy consumers. CMS committed resources to proven high impact, low cost digital outreach efforts including short YouTube videos, social media, and mobile and search advertising.

CMS will also continue to use direct response methods including email, text messaging and autodial messages. Targeted email has proven to be the most cost efficient and effective way to reach consumers. As part of this effort, CMS will send most consumers emails throughout each week, with increasing frequency as the deadline approaches. CMS will also reinforce educational messaging through ongoing text messages and provide reminder calls encouraging consumers to take action before the December 15 deadline.

HealthCare.gov Operations

HealthCare.gov Scheduled Maintenance Windows

Every year, CMS establishes scheduled maintenance windows that provide periods of time when CMS and its partners can make updates or resolve issues. Maintenance will only occur within these windows when deemed necessary to provide consumers with a better shopping experience. Consumer access to HealthCare.gov may be limited or restricted when this maintenance is required. Regular scheduled maintenance will continue to be planned for the lowest-traffic time periods on HealthCare.gov, including Sunday mornings.

The purpose in scheduling these times is to minimize any consumer disruption. Like other IT systems, these scheduled maintenance windows are how CMS updates and improve our system to run optimally and are the normal course of business.

For more information on the scheduled and actual maintenance times, visit: https://marketplace.cms.gov/technical-assistance-resources/healthcaregov-maintenance-windows.pdf

HealthCare.gov Waiting Rooms

Similar to previous years, CMS may deploy a “waiting room” for some consumers who are logging in or creating an account on HealthCare.gov if website traffic becomes high enough to impact the consumer experience. The waiting room is one tool CMS utilizes to optimize a consumers’ experience because it allows CMS to control the volume of users on healthcare.gov resulting in better performance of the website. If they are in a waiting room, consumers will see a message

asking them to stay on the page. The waiting room will refresh when a consumer can continue to apply and enroll with a smooth experience.

Additional Resources

Weekly Enrollment Snapshots

Similar to previous years, CMS plans to release weekly enrollment snapshots throughout the Open Enrollment Period.

2019 Health Insurance Exchange Premium Landscape Issue Brief

The view the U.S. Department of Health and Human Services 2019 Health Insurance Exchange Premium Landscape Issue Brief, visit: https://aspe.hhs.gov/pdf-report/health-plan-choice-and-premiums-2019-federal-health-insurance-exchange

2019 Plan Landscape Data

For more information on 2019 individual and family health plans available in the Federal Health Insurance Exchange, visit: https://www.healthcare.gov/health-and-dental-plan-datasets-for-researchers-and-issuers/

2019 Health Insurance Exchange Public Use Files

To see the 2019 Health Insurance Exchange Public Use Files, visit: https://www.cms.gov/CCIIO/Resources/Data-Resources/marketplace-puf.html

2019 Rate Review Public Use File

To see the 2019 Rate Review Public Use File, visit: https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2019-URR-PUF.zip

2019 Issuer Participation County Map

To see the 2019 Issuer Participation County Map, visit: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/Final-2019-County-Coverage-Map.pdf

###

Get CMS news at cms.gov/newsroom, sign up for CMS news via email and follow CMS on Twitter CMS Administrator @SeemaCMS, @CMSgov, and @CMSgovPress.

Previous Newsroom Article

Next Newsroom Article

CMS.gov

A federal government website managed and paid for by the U.S. Centers for Medicare & Medicaid Services.

7500 Security Boulevard, Baltimore, MD 21244