United States Government Accountability Office

Report to Congressional Requesters

March 2023

PAYMENT INTEGRITY

Additional Coordination Is Needed for Assessing Risks in the Improper Payment Estimation Process for Advance Premium Tax Credits

Accessible Version

GAO-23-105577

GAO Highlights

Highlights of GAO-23-105577, a report to congressional requesters

March 2023

PAYMENT INTEGRITY

Additional Coordination Is Needed for Assessing Risks in the Improper Payment Estimation Process for Advance Premium Tax Credits

Why GAO Did This Study

To help taxpayers cover the cost of health insurance premiums, PPACA provides advance premium tax credits for individuals who meet certain eligibility requirements. For fiscal year 2022, the Department of Health and Human Services (HHS) reported an estimated $256 million in improper payments for the federally facilitated marketplace.

GAO was asked to review advance premium tax credit payment integrity efforts. This report examines (1) key control activities selected states and CMS implemented to prevent providing advance premium tax credits to ineligible individuals through the state-based marketplaces and (2) the extent to which CMS developed a reliable methodology to estimate improper payments in the program.

GAO analyzed policies and procedures for determining eligibility in plan year 2022 from CMS, and selected states to include those with the highest average monthly payment amounts and those with new and more established marketplaces (California, Colorado, Nevada, New Jersey, and Pennsylvania). GAO also reviewed CMS's improper payment estimation methodology for the advance premium tax credit for fiscal year 2022.

What GAO Recommends

GAO is making two recommendations to CMS to coordinate with the states to assess residual risks when estimating improper payments, and to determine if additional guidance or actions are needed. HHS disagreed with GAO's recommendations. GAO continues to believe the recommendations are valid,

View GAO-23-105577. For more information, contact Hannah Padilla at (202) 512-5683 or padillah@gao.gov.

What GAO Found

Control activities for preventing improper advance premium tax credit eligibility determinations varied among the selected state-based marketplaces. Selected states verified most key eligibility criteria for enrollment in the program using the Centers for Medicare & Medicaid Services' (CMS) Federal Data Services Hub. The Patient Protection and Affordable Care Act (PPACA) and CMS's regulations grant marketplaces flexibilities in the eligibility verification process. GAO found that all five selected states exercised certain flexibilities in their eligibility-verification processes, as detailed in the table below. However, CMS did not coordinate with the states to conduct a risk assessment to evaluate the likelihood of improper eligibility determinations when exercising these flexibilities. As such, states were not aware of residual risks—risks that remain after existing control activities have mitigated inherent risks—or whether additional risk-mitigation strategies were needed. Until CMS coordinates with the states to identify any residual risks, neither CMS nor the states will know if additional guidance or other actions are needed to mitigate these potential residual risks.

State-Based Marketplaces' Key Control Activities for Verifying Eligibility Requirements for the Advance Premium Tax Credit beyond Self-Attestation

Key control activities beyond self-attestation	California	Colorado	Nevada	New Jersey	Pennsylvania
Verifying identity on mail applications	N	Y	Y	Y	Y
Verifying residency	N	N	N	N	N
Identifying duplicate coverage through nonfederal employer-sponsored insurance	N	N	N	N	N
Identifying duplicate coverage through Medicaid in other states	N	N	N	N	N

Legend: N = Did not perform additional verifications; Y = Performed additional verifications

Source: GAO analysis of the selected state's information. | GAO-23-105577

Although CMS has developed a reliable methodology to estimate improper advance premium tax credit payments, it was limited to the 33 states that use the federally facilitated marketplace and did not consider the 18 states that operate their own. CMS has a process to engage with the states on the best way to incorporate them into the improper payment measurement program and on the related requirements. However, CMS's process does not consider residual risks in the state-based marketplaces' processes for verifying and determining eligibility. Without additional coordination with these marketplaces that includes assessing and identifying any residual risks to which they may be vulnerable, CMS's process for estimating improper payments may not reflect significant program risks. As such, the resulting improper payment estimate may be incomplete and provide a less useful basis for developing effective corrective action plans.

Contents

Abbreviations

APTC	advance premium tax credit
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
FFM	federally facilitated marketplace
FTI	Federal Tax Information
Hub	Federal Data Services Hub
HHS	Department of Health and Human Services
IRS	Internal Revenue Service
OMB	Office of Management and Budget
PIIA	Payment Integrity Information Act of 2019
PPACA	Patient Protection and Affordable Care Act
QLE	qualifying life event
ROP	reasonable opportunity period
SBM	state-based marketplace

U.S. GOVERNMENT ACCOUNTABILITY OFFICE
441 G St. N.W.
Washington, DC 20548

March 9, 2023

The Honorable Mike Crapo
Ranking Member
Committee on Finance
United States Senate

The Honorable Jason Smith
Chair
Committee on Ways and Means
House of Representatives

In the United States, one option for purchasing health-insurance plans is through marketplaces. To help individuals and their dependents pay the premiums for these plans, the Patient Protection and Affordable Care Act (PPACA) provides a premium tax credit to individuals who meet certain income and other eligibility requirements.[1] Individuals may have the federal government pay this credit to their health insurance issuers in advance on their behalf, known as advance premium tax credits (APTC), which lowers their monthly premium payments.[2]

Under PPACA, states may elect to operate their own state-based marketplace (SBM), or to use the federally facilitated marketplace (FFM) that the Department of Health and Human Services (HHS) operates.[3] These marketplaces help individuals compare and choose among insurance plans that participating private health care coverage issuers, such as health insurance companies, offer. The Centers for Medicare & Medicaid Services (CMS) within HHS is responsible for overseeing the establishment of these SBMs and maintaining the FFM.

For fiscal year 2021, HHS reported outlays of APTCs, of approximately $57.7 billion, for the FFM and SBMs, representing a significant financial

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

[2]We use “issuer” when referring to an insurance entity that a state has certified and licensed to engage in the business of insurance in that state.

[3]For plan years beginning January 2022, 18 states were operating an SBM and 33 were using the FFM.

commitment for the federal government and risk for improper payments. Although HHS assessed its APTC program as susceptible to significant improper payments,[4] both the HHS Office of Inspector General and GAO have previously reported that CMS has not met specific requirements for assessing, estimating, and reporting on improper payments related to the program.[5]

We previously reviewed CMS's key control activities related to preventing and detecting improper APTC payments in the FFM.[6] Based on that review, we made several recommendations that addressed improving control activities related to eligibility determinations and calculations of APTCs. We focused that report and its related recommendations on the FFM, not SBMs.

You asked us to review issues related to APTC payment integrity efforts. This report examines (1) what key control activities, if any, selected states and CMS designed and implemented to prevent providing APTCs to ineligible individuals through the SBMs and (2) the extent to which CMS has developed a reliable methodology to estimate improper APTC payments, identify their root causes, and develop corrective actions.

To address our first objective, we selected five states (see below for selection methodology) for review. We examined PPACA and its implementing regulations, examined relevant federal internal control standards[7] and leading practices for managing fraud risks in federal

[4]Although APTC is one of many payment streams within CMS's overall administration of the health insurance marketplaces, HHS has assessed it as an independent program for purposes of improper payment estimation and reporting. As such, we refer to APTC as a program in this report.

[5]GAO, *Improper Payments: Improvements Needed in CMS and IRS Controls over Health Insurance Premium Tax Credit*, GAO-17-467 (Washington, D.C.: July 13, 2017); GAO, *Financial Audit: FY 2021 and FY 2020 Consolidated Financial Statements of the U.S. Government*, GAO-22-105122 (Washington, D.C.: Feb. 17, 2022); and Department of Health and Human Services, Office of Inspector General, *Department of Health and Human Services Met Many Requirements, but It Did Not Fully Comply With the Payment Integrity Information Act of 2019 and Applicable Improper Payment Guidance for Fiscal Year 2021*, A-17-22-52000 (Washington, D.C.: May 2022).

[6]GAO-17-467.

[7]GAO, *Standards for Internal Control in the Federal Government*, GAO-14-704G (Washington, D.C.: September 2014).

programs,[8] and identified key risks for which states and CMS may need control activities. We focused on key control activities related to selected states' SBMs for plan year 2022. We evaluated CMS's and selected states' policies, procedures, and other relevant documents, such as interagency agreements and standard operating procedures.

We analyzed the extent to which these documents aligned with relevant principles in *Standards for Internal Control in the Federal Government*[9] and leading practices in the Fraud Risk Framework.[10] Specifically, we assessed the extent to which these documents aligned with the principles related to assessing risks, designing control activities, and providing effective information and communication.[11] The relevant leading practices from the Fraud Risk Framework relate to identifying and assessing fraud risks and designing and implementing specific control activities to prevent and detect fraud.[12] We compared the key risks with the control activities we identified to evaluate whether CMS and the selected states' design of key controls sufficiently addressed each key risk area.

For our review, we selected a nongeneralizable sample of five states from the 15 that were operating an SBM in plan year 2021. To make our selection, we considered several factors, including average monthly APTC payments, marketplace longevity, and which insurance providers offered plans throughout each state. Based on those considerations, we selected California, Colorado, Nevada, New Jersey, and Pennsylvania, which collectively covered approximately 72 percent of approximately 2.9 million APTC consumers enrolled in SBMs for the 2021 annual open-enrollment period.

To address our second objective, we reviewed federal laws, including the Payment Integrity Information Act of 2019 (PIIA), and Office of

[8]GAO, *A Framework for Managing Fraud Risks in Federal Programs*, GAO-15-593SP (Washington, D.C.: July 2015). This benchmark is commonly known as the Fraud Risk Framework.

[9]GAO-14-704G.

[10]GAO-15-593SP.

[11]See app. I for a full list of principles, as outlined in *Standards for Internal Control in the Federal Government*, reviewed as part of this work.

[12]We selected the leading practices from the Fraud Risk Framework that are most relevant to this objective based on a review of selected states' and CMS's documents and discussions with selected state officials responsible for making APTC eligibility determinations.

Management and Budget (OMB) guidance to identify key criteria agencies must meet when addressing improper payments, including developing estimation methodologies, identifying root causes, and developing corrective action plans. We compared these requirements with CMS's Exchange Improper Payment Measurement Sampling and Estimation Methodology Plan to determine if CMS had developed a reliable estimation methodology and appropriately executed it. Appendix I provides additional details on our scope and methodology.

We conducted this performance audit from November 2021 to March 2023 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 conclusion 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.

Background

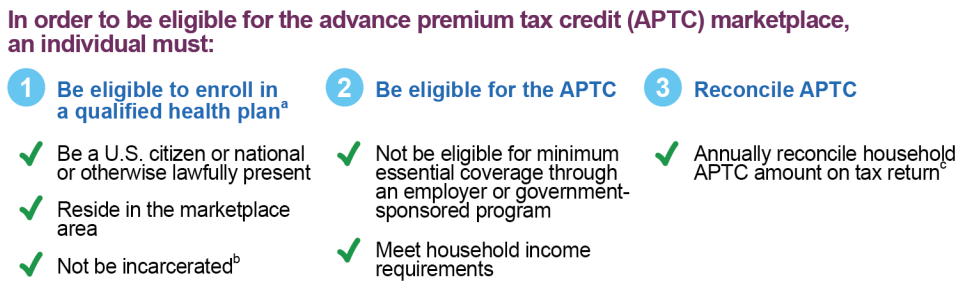
Under PPACA, qualified individuals may use health care marketplaces to enroll in qualified health plans and apply for financial assistance to offset the costs of their coverage, including APTCs. Marketplaces determine the amount of APTC for which individuals are eligible based on projected family size and estimated household income for the year of coverage. Those who choose to have some or all of the premium tax credit paid to issuers on their behalf must reconcile the amount of the APTC with the actual premium tax credit for which they are eligible on their income tax returns for the year of coverage. Individuals whose premium tax credit is more than their APTC for the year of coverage may claim this amount on their tax return as a refundable tax credit that reduces their income tax liability and results in a refund to the extent it is more than their tax liability.

APTC Eligibility and Qualifications

To be eligible for APTCs, individuals must meet certain criteria, as shown in figure 1. Additionally, according to CMS guidance, before submitting an

online or phone application, an applicant must complete identity proofing.[13]

Figure 1: Eligibility Requirements for the Advance Premium Tax Credit



Source: GAO analysis of eligibility requirements for the APTC. | GAO-23-105577

[a]In order to apply and qualify for the APTC, an individual must first be enrolled in a qualified health plan offered through the individual's respective marketplace. The eligibility requirements shown above only reflect those that pertain to an individual applying during the open enrollment period, as there may be additional requirements during special enrollment periods.

[b]An incarcerated individual who is awaiting disposition of charges is eligible for a qualified health plan.

[c]Tax return reconciliation is completed for the household of the individual receiving advance payments toward insurance premiums. In response to the COVID-19 pandemic, CMS released guidance in July 2021 that granted flexibilities to the marketplaces' processes for individuals who failed to file tax returns and reconcile a previous year's APTC, as CMS's regulations generally require. This guidance allows marketplaces to opt out of actions taken to terminate an individual's APTC due to filing status.

Responsibilities for Administering APTCs in SBMs

CMS, the Internal Revenue Service (IRS), and the marketplaces themselves each have responsibilities in administering APTCs in SBMs. As previously discussed, CMS is responsible for overseeing the establishment of SBMs. States that elect to operate an SBM must apply to CMS for approval. CMS will grant conditional approval contingent on a state demonstrating its ability to perform all required SBM activities—including to confirm that APTC recipients are meeting a variety of

[13]For online applications, marketplaces (including the FFM and SBMs) employ a process known as remote identity proofing to verify an individual's identity. The verification performed uses personal and financial history on file with a contracted credit-reporting agency. The marketplaces' online application process generates questions for individuals initiating an online application, based on information on file with the contractor, that only each individual is believed to likely know.

eligibility requirements—and ongoing compliance with future guidance and regulations.

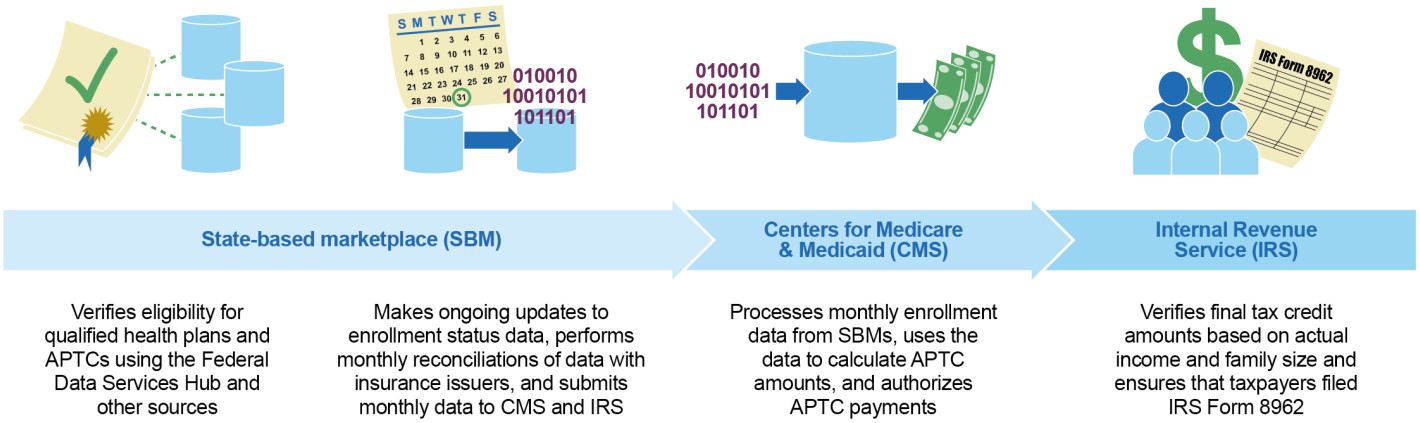
In order to qualify for the APTC, individuals must enroll in a qualified health plan a marketplace offers.[14] The law requires marketplaces to verify certain application information to determine applicant eligibility for enrollment and, if applicable, the APTC. A key factor in administering the credit effectively and efficiently is enrollment-control activities, which reasonably assure that only qualified individuals receive the premium tax credit and any advance payments toward their insurance premiums. As such, PPACA requires that certain applicant-submitted information undergoes verification through either an electronic verification system or another CMS-approved method.

SBMs generate a data-matching issue when there is an inconsistency between applicant-submitted information and information reported from trusted data sources. In order to resolve the data-matching issue, an SBM grants an applicant temporary eligibility based on the applicant's self-attestation, and asks the applicant to provide additional information or documentation to support it within a reasonable opportunity period (ROP). Under certain circumstances, when an applicant is unable to provide supporting documentation necessary to resolve the data-matching issue within the ROP provided, an SBM may redetermine or terminate the APTC and health plan coverage.

IRS is responsible for ensuring that individuals for whom the APTCs are paid comply with their tax-filing requirements, including reconciling their APTCs with their allowed premium tax credit on their tax returns for the year of coverage. (See fig. 2 for a summary of roles and responsibilities.)

[14]According to CMS, individuals can apply for APTC as part of the qualified health plan enrollment process.

Figure 2: Roles and Responsibilities for Operating the Advance Premium Tax Credit (APTC) in State-Based Marketplaces



Source: GAO analysis of CMS and IRS information. | GAO-23-105577

Text of Figure 2: Roles and Responsibilities for Operating the Advance Premium Tax Credit (APTC) in State-Based Marketplaces

1) State based marketplace (SBM)
   a) Verifies eligibility for qualified health plans and APTCs using the Federal Data Services Hub and other sources
   b) Makes ongoing updates to enrollment status data, performs monthly reconciliations of data with insurance issuers, and submits monthly data to CMS and IRS
2) centers for Medicare & Medicaid (CMS)
   a) Processes monthly enrollment data from SBMs, uses the data to calculate APTC amounts, and authorizes APTC payments
3) Internal Revenue Service (IRS)
   a) Verifies final tax credit amounts based on actual income and family size and ensures that taxpayers filed IRS Form 8962

Source: GAO analysis of CMS and IRS information. | GAO-23-105577

Key Requirements and Guidance on Agency Payment Integrity Efforts

PIIA defines an improper payment as any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements. This includes any payment to an ineligible recipient, any payment for an ineligible good or service, any duplicate payment, any payment for a good or service not received (except for such payments where authorized by law), and any payment that does not account for credit for applicable discounts.[15] Further, PIIA requires agencies to treat any payments for which they find insufficient or no documentation as improper in the risk assessment and estimation process.

Among other things, PIIA also requires federal executive agencies to (1) estimate the annual amount of improper payments for those programs and activities identified as susceptible to significant improper payments, (2) implement actions to reduce improper payments and set reduction targets with respect to the risk susceptible programs and activities, and (3) report on the results of addressing the requirements.[16]

PIIA and OMB guidance together provide the specific requirements for assessing, estimating, and reporting on improper payments. PIIA requires each executive agency to produce a statistically valid estimate, or an estimate whose methodology OMB has approved, of improper payments made under any program identified as susceptible to significant improper payments. In addition, agencies must describe the causes of improper payments they identify, actions they have planned or taken to correct those causes, and the planned or actual completion date of their actions.

Internal Control Standards and Fraud Risk Management

An effective internal control system improves accountability and transparency, provides feedback on how effectively an entity is operating,

[15]31 U.S.C. § 3351(4).

[16]PIIA defines significant improper payments as the sum of a program's improper payments and payments whose propriety cannot be determined due to lacking or insufficient documentation that may have exceeded either $10,000,000 and 1.5 percent of program outlays; or $100,000,000.

and helps reduce risks affecting the achievement of the entity's objectives. *Standards for Internal Control in the Federal Government* provides managers with criteria for designing, implementing, and operating an effective internal control system.[17] Components and principles define these standards and explain why they are integral to an entity's internal control system. Management's ongoing monitoring of the internal control system is essential in helping internal control remain aligned with changing objectives, environments, laws, resources, and risks.

The Fraud Risk Framework provides a comprehensive set of leading practices for agency managers to develop or enhance existing efforts to combat fraud in a strategic, risk-based manner.[18] The Fraud Risk Framework helps federal program managers, along with their stakeholders, meet their responsibilities for assessing and managing fraud risks, as federal internal control standards require. In its Circular A-123 guidelines, OMB has directed agencies to adhere to the Fraud Risk Framework's leading practices as part of their efforts to effectively design, implement, and operate an internal control system that addresses fraud risks.[19] The Fraud Reduction and Data Analytics Act of 2015, and its successor provisions in PIIA, require OMB and agencies to incorporate the Fraud Risk Framework's leading practices into their guidelines and controls, respectively.[20]

[17]GAO-14-704G.

[18]GAO-15-593SP.

[19]Office of Management and Budget, *Management's Responsibility for Enterprise Risk Management and Internal Control*, OMB Circular A-123 (Washington, D.C.: July 15, 2016).

[20]The Fraud Reduction and Data Analytics Act of 2015 (FRDAA), enacted in June 2016, required OMB to establish guidelines for federal agencies to create controls to identify and assess fraud risks and to design and implement antifraud control activities. Pub. L. No. 114-186, 130 Stat. 546 (2016). The act further required OMB to incorporate the leading practices from the Fraud Risk Framework into the guidelines. Although Congress repealed FRDAA in March 2020, PIIA requires these guidelines to remain in effect, subject to modification by OMB as necessary and in consultation with GAO. See 31 U.S.C. § 3357.

Selected States' Control Activities Related to Preventing Ineligible APTC Vary Due to Flexibility in CMS's Regulations

Selected States Used the Federal Data Services Hub and Medicaid State Agencies to Verify Most Eligibility Criteria

In order to verify certain key eligibility criteria, all five selected states we reviewed used their respective Medicaid state agencies and the Federal Data Services Hub (Hub), which CMS developed. CMS made the Hub available to all marketplaces, both the FFM and SBMs, so that they may perform required eligibility verifications in an automated manner.[21] Marketplaces send applicant data to the Hub, which verifies individuals' data against information in existing secure and trusted federal and state databases. To prevent unauthorized individuals from creating marketplace accounts using identities other than their own, the Hub also uses a remote identity-proofing service. As shown in figure 3, most key eligibility information is available through trusted data sources partnered with the Hub.

[21]42 U.S.C. § 18081; 45 C.F.R. §§ 155.315, 155.320.

Figure 3: Key Advance Premium Tax Credit (APTC) Eligibility Information Available in the Federal Data Services Hub (Hub)

Eligibility category	Citizenship or lawful presence	Incarceration status	Minimum essential coverage through government-sponsored programs[a]	Minimum essential coverage through a federal employer-sponsored plan	Household income and family size	Compliance with tax filing requirements[b]
What federal agency provided information through the Hub?	Social Security Administration, Department of Homeland Security	Social Security Administration	Defense Health Agency (TRICARE), Veterans Health Administration, Peace Corps, Centers for Medicare & Medicaid Services (Medicare)	Office of Personnel Management	Internal Revenue Service	Internal Revenue Service

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) information. | GAO-23-105577

Data table for Figure 3: Key Advance Premium Tax Credit (APTC) Eligibility Information Available in the Federal Data Services Hub (Hub)

Eligibility category	Citizenship or lawful presence	Incarceration status	Minimum essential coverage through government-sponsored programs /a/	Minimum essential coverage through a federal employer-sponsored plan	Household income and family size	Compliance with tax filing requirements /b/
What federal agency provided information through the Hub?	Social Security Administration, Department of Homeland Security	Social Security Administration	Defense Health Agency (TRICARE), Veterans Health Administration, Peace Corps, Centers for Medicare & Medicaid Services (Medicare)	Office of Personnel Management	Internal Revenue Service	Internal Revenue Service

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) information. | GAO-23-105577

[a]Although the Hub provides information on certain government-sponsored programs, marketplaces must coordinate with their respective Medicaid state agencies to verify whether individuals have been determined eligible for Medicaid or Children's Health Insurance Program coverage within the state where the marketplace operates.

[b]In response to the COVID-19 pandemic, CMS released guidance in July 2021 that granted flexibilities to the marketplaces' processes for individuals who failed to file tax returns and reconcile a previous year's APTC, as CMS's regulations generally require. This guidance allows marketplaces to opt out of actions taken to terminate an individual's APTC due to filing status.

Selected states generally used Hub services to verify an applicant's identity for online and phone applications, citizenship or lawful presence, and incarceration status; to check for duplicate government-sponsored coverage through TRICARE, the Veterans Health Administration, the Peace Corps, Medicare,[22] or federal employers; and to verify that individuals meet income requirements and are in compliance with applicable tax-filing requirements.[23] All five selected states coordinated directly with their respective Medicaid state agencies to determine if an individual was receiving or was eligible for coverage through Medicaid or Children's Health Insurance Program (CHIP).[24]

Flexibilities in Eligibility Verification Requirements Led to Differing Verification Processes among Selected States

In an effort to minimize administrative costs and burdens on marketplaces and applicants, PPACA and CMS's regulations grant marketplaces flexibilities in the verification process for certain eligibility criteria, such as allowing SBMs to accept self-attestation or opt to perform additional levels of verification, based on the state's discretion. According to CMS officials, this is in part due to whether reliable data sources are available that would allow a marketplace to conduct additional levels of verification. Additionally, SBMs may propose alternative methods to CMS for meeting the eligibility verification requirements.[25] CMS has the authority to determine whether alternative methods that SBMs propose are allowable

[22]TRICARE is the Defense Health Agency's regionally structured health care program for eligible military members and their dependents. The Veterans Health Administration operates the Department of Veterans Affairs health care system. The Peace Corps provides health benefits to individuals who perform work overseas on behalf of the federal government. Medicare is the federally financed health insurance program for people aged 65 or older, certain individuals with disabilities, and individuals with end-stage renal disease.

[23]Colorado did not use the Hub's service to check for duplicate federal employer-sponsored coverage. However, it is coordinating with CMS to determine an appropriate verification process for this criterion. Although New Jersey received incarceration data via the Hub, New Jersey did not generate an inconsistency if the information did not match an applicant's attestation.

[24]Medicaid is a joint federal-state program that finances health care coverage for low-income and medically needy individuals. CHIP finances health care coverage for children whose household incomes are too high for Medicaid eligibility but may be too low for their families to afford private coverage.

[25]45 C.F.R. § 155.315 and 45 C.F.R. § 155.320.

based on criteria described in CMS's regulations.[26] We found that all five selected states exercised certain flexibilities in their eligibility-verification processes. However, none of the selected states conducted risk assessments to evaluate the likelihood of improper APTC eligibility determinations by exercising these flexibilities. As such, states were not aware of any residual risks or whether additional risk-mitigation strategies were needed.[27]

According to federal internal control standards, management should identify, analyze, and respond to risks related to achieving the defined objectives. As part of these efforts, management conducts a risk assessment to identify risks throughout the entity to provide a basis for designing risk responses. According to the Fraud Risk Framework, it is a leading practice to plan regular fraud risk assessments and examine the suitability of existing controls and prioritize residual risks. CMS does not coordinate with the states to perform such risk assessments to identify any residual risks and determine the potential effect these flexibilities may have on preventing APTCs to ineligible individuals.

According to CMS officials, states have the legal authority to use these flexibilities, as detailed below. Given the differences among SBMs, CMS believes that states must determine how to best operate within federal requirements. CMS officials said that CMS requires SBMs to conduct a defined set of oversight activities, and tracks and monitors how SBMs establish program integrity standards that comply with marketplace-related policy and operational requirements set forth in statute, regulations, and guidance. According to CMS agency officials, CMS monitors SBM compliance with program integrity standards, including any flexibilities provided, through regularly scheduled calls with SBM leadership and staff. Additionally, CMS developed annual audit and reporting requirements, which direct that SBMs attest to their compliance with federal requirements, and provide supporting documentation for certain eligibility and enrollment policies and procedures, including those related to eligibility verifications.

[26]45 C.F.R. § 155.315(h).

[27]Inherent risk is the risk to an entity prior to considering management's response to the risk. Residual risk is the risk that remains after management's response to inherent risk.

Table 1 illustrates the key eligibility criteria we identified for which CMS provides flexibilities within the verification process, and whether selected states designed additional control activities for verifying such criteria.

Table 1: State-Based Marketplaces' Key Control Activities for Verifying Eligibility Requirements for the Advance Premium Tax Credit beyond Self-Attestation

Key control activities related to eligibility requirements for the advance premium tax credit eligibility beyond self-attestation	California	Colorado	Nevada	New Jersey	Pennsylvania
Verifying eligibility criteria using the Federal Data Services Hub (i.e., citizenship or lawful presence, incarceration status, household income and family size, and compliance with tax filing requirements)	Y	Y	Y	Y	Y
Verifying identity on mail applications	N	Y	Y	Y	Y
Verifying residency	N	N	N	N	N
Identifying duplicate coverage through nonfederal employer-sponsored insurance	N	N	N	N	N
Identifying duplicate coverage through Medicaid or Children's Health Insurance Program (CHIP) in other states	N	N	N	N	N
Verifying qualifying life events	N	Y	Y	N	Y
Reverifying eligibility for required criteria periodically and annually	Y	N	N	Y	Y
Reverifying all key eligibility criteria periodically and annually for criteria that regulations do not specifically require	N	N	N	N	N

Legend: N = Did not perform additional levels of verification; Y = Performed additional levels of verification

Source: GAO analysis of the selected states' information. | GAO-23-105577

As detailed below, CMS regulations and guidance allow flexibilities related to the eligibility-verification process.

Verifying Identity on Mail Applications

According to the Fraud Risk Framework, it is a leading practice to conduct data matching to verify key information, including self-reported data and information necessary to determine eligibility. However, CMS guidance allows marketplaces to accept an applicant's signature as proof of identity on mail applications.

In our review, we found that selected states had different control activities for verifying identities on mail applications. One selected state—California—accepted a signature as proof of identity on mail applications.

The remaining four states opted to implement additional controls.[28] Specifically, three states—Colorado, Pennsylvania, and Nevada—entered mailed applications into their respective online application systems and coordinated with the applicants to complete the identity proofing. New Jersey required applicants to provide supporting documentation (e.g., a copy of a driver's license) along with their mail applications. If an applicant did not provide such documentation, New Jersey coordinated with the applicant to complete the identity-proofing process.

Until CMS coordinates with the states to identify any residual risks related to validating the identities of individuals who apply by mail, SBMs may not be aware of potential vulnerabilities associated with inadvertently enrolling ineligible individuals in qualified health plans.

Verifying Residency

Individuals must reside in the marketplace service area to be eligible to enroll in a qualified marketplace health plan.[29] CMS regulations allow marketplaces to accept an applicant's attestation as verification of residency unless the information the applicant provides is not reasonably compatible with other information that individual has provided or with records of the marketplace or databases available to the SBM.[30] All five selected states accepted applicant attestations. Until CMS coordinates with the states to identify any residual risks related to verifying the residencies of individuals, SBMs may not be aware of potential vulnerabilities associated with enrolling ineligible individuals in qualified health plans.[31]

[28]Selected states generally indicated that the number of mail applications received each year is low.

[29]45 C.F.R. § 155.305(a)(3).

[30]45 C.F.R. § 155.315(d).

[31]GAO previously recommended that CMS assess and document the feasibility and availability of obtaining sufficiently reliable data to verify individuals' residencies. To address this recommendation, CMS completed a feasibility study and stated that the verification of individuals' residences is not feasible. See GAO-17-467.

Identifying Duplicate Coverage through Nonfederal Employer-Sponsored Insurance

Individuals eligible to receive affordable minimum essential coverage through either federal or nonfederal employers are not eligible for APTCs.[32] According to CMS regulations, marketplaces must verify whether an applicant is eligible for qualifying coverage or reasonably expects to be enrolled in an eligible nonfederal employer-sponsored plan during the plan year by using approved data sources that are available to the marketplace. If there is no data source available, marketplaces must accept the applicant's attestation, unless it is not reasonably compatible with information that the marketplace obtained or the applicant provided.[33] None of the selected states performed independent verification of applicant eligibility for duplicate coverage;[34] rather, all the selected states accepted attestations as verification that individuals were not receiving duplicate coverage through a nonfederal employer.[35] Until CMS coordinates with the states to identify any residual risks related to identifying individuals who have minimum essential coverage from nonfederal employers, SBMs may not be aware of potential vulnerabilities associated with enrolling ineligible individuals in qualified health plans.

Identifying Duplicate Coverage through Medicaid or CHIP in Other States

Individuals eligible to receive minimum essential coverage through a government-sponsored program, such as Medicaid or CHIP, are not

[32]See 26 U.S.C. § 36B(c)(2)(B).

[33]See 45 C.F.R. § 155.320(d).

[34]Previously, marketplaces were required to select a statistically random sample of applicants when no electronic data sources are available to verify employer-sponsored insurance. In anticipation of finalizing an evaluation of its employer-verification study, CMS did not take enforcement action against marketplaces that did not comply with the random sampling requirements for plan years 2020 through 2022. As a result of its evaluation, CMS updated the regulations to remove the random-sampling requirements for plan years beginning in 2023. It permitted each marketplace to design a verification process for enrollment in or eligibility for an employer-sponsored insurance plan based on the marketplace's assessment of risk for improper APTC payments.

[35]During our previous audit, CMS officials informed us that they have explored other possible data sources to identify individuals receiving minimum essential coverage through nonfederal employers, but they have been unable to identify comprehensive electronic data sources that are sufficiently current and accurate to verify this criterion. See GAO-17-467.

eligible for APTCs.[36] CMS regulations require the state marketplaces to verify whether individuals have been determined eligible for coverage through Medicaid and CHIP within the state by using information obtained from the agencies administering such programs.[37] All five selected states assessed for enrollment or eligibility for Medicaid or CHIP within their respective states, as required, and did not assess eligibility in other states.[38] Until CMS coordinates with the states to identify any residual risks regarding detection of duplicate coverage by Medicaid and CHIP in states other than those in which individuals applied for coverage and attested to residing, SBMs may not be aware of potential vulnerabilities associated with providing APTCs to ineligible individuals.

Verifying Qualifying Life Events

Generally, individuals may only enroll in qualified health plans during the open enrollment period. However, CMS regulations require the marketplaces to provide special enrollment periods for individuals who experience a triggering qualifying life event (QLE), such as the loss of minimum essential coverage.[39] This provides an opportunity for individuals who experience certain major life changes to enroll in a qualified health plan through the marketplaces outside of the annual open enrollment period.[40] CMS regulations grant marketplaces the option to verify an individual is eligible for a special enrollment period prior to processing an application, but marketplaces are not required to do so if

[36]45 C.F.R. § 155.305(f)(1)(ii)(B).

[37]45 C.F.R. § 155.320(b)(1)(ii).

[38]We previously recommended that CMS assess the feasibility for the FFM to identify duplicate coverage for individuals receiving Medicaid and CHIP in FFM states outside of the states where applicants attest to residing. See GAO-17-467. CMS subsequently evaluated the feasibility of implementing its periodic data-matching process to identify these individuals and determined such expansion was not feasible.

[39]45 C.F.R. § 155.420(d).

[40]Examples of major life changes include the loss of minimum essential coverage, permanent move of residence, birth of a child, and marriage.

the verification process is determined to cause undue burden on the individual.[41]

All five selected states allowed applicants to enroll during special enrollment periods. However, the states each had differing QLEs that required supporting documentation. For example, although Nevada generally verified all QLEs, Colorado and Pennsylvania had selected specific QLEs that required verification.[42] Additionally, California and New Jersey did not have a process to verify QLEs; however, New Jersey required applicants to sign an attestation form as support for certain QLEs. Until CMS coordinates with the states to identify any residual risks related to verifying events that trigger eligibility for enrollment during special enrollment periods, SBMs may not be aware of potential vulnerabilities associated with providing health care coverage to individuals who are not eligible to enroll outside of the annual open enrollment period.

Monitoring Continued Eligibility

CMS regulations require marketplaces to monitor continued eligibility periodically and annually. Specifically, marketplaces are required to periodically identify changes in death status, Medicare, and Medicaid or CHIP eligibility or enrollment. Marketplaces are required to perform these periodic examinations of data sources at least twice during the plan year. Additionally, each state that has implemented a fully integrated eligibility system with its respective state Medicaid program is deemed in compliance with the Medicaid requirement.[43] Selected states generally used a periodic data matching Hub service and their respective Medicaid state agencies for such periodic examinations and did not verify additional

[41]See 45 C.F.R. § 155.420(g); 87 Fed. Reg. 27208 (May 6, 2022). Changes to these regulations were made with the 2023 Notice of Benefit and Payment Parameters final rule, whereby all marketplaces using the FFM were required to verify eligibility for special enrollment periods based on loss of minimum essential coverage but otherwise retain the flexibility to determine whether to perform preenrollment verification for other QLEs. SBMs may opt to follow but are not subject to this requirement.

[42]According to Colorado officials, the marketplace uses a shared responsibility model for its special enrollment period verifications. Under that model, either the Colorado Division of Insurance, Colorado marketplace, or its issuers may verify certain QLEs and determine whether to grant an applicant conditional eligibility if they determined additional verification was necessary.

[43]45 C.F.R. § 155.330(d).

eligibility criteria, such as incarceration status or employer-sponsored insurance coverage, during such reviews.[44]

CMS regulations generally require marketplaces to redetermine the eligibility of a qualified individual annually by requesting an individual's updated tax return information and verifying any changes the individual reports with respect to eligibility.[45] Selected states generally used an annual redetermination Hub service that performs verifications of Medicare coverage, death status, changes in income, and compliance with tax filing requirements.[46] Four selected states did not verify any additional eligibility criteria, such as lawful presence or employer-sponsored insurance coverage. However, one of the selected states—California—implemented additional measures to verify incarceration status through the Hub during its annual review process. Until CMS coordinates with the states to identify any residual risks related to monitoring continued eligibility of key criteria, such as lawful presence or employer-sponsored insurance, SBMs may not be aware of potential vulnerabilities associated with continuing to provide health care coverage to individuals who are no longer eligible.

As discussed earlier, PPACA and CMS regulations offer flexibilities in the verification process, such as accepting applicant attestations, in order to minimize administrative costs and burdens for marketplaces and applicants. As such, CMS allows marketplaces to determine whether to exercise these flexibilities. However, as discussed above, such flexibilities may result in residual risks related to eligibility determinations, and CMS has not coordinated with the states to identify any potential vulnerabilities associated with using these flexibilities.

Federal internal control standards state that management should consider the potential for fraud when identifying, analyzing, and responding to risks and design and implement control activities to respond to risks. As part of these standards, management analyzes the identified fraud risks by estimating their significance, both individually and in the aggregate, to

[44]Due to the public health emergency, neither Colorado nor Nevada used the Hub service to perform periodic data examinations for plan year 2022. According to Nevada officials, Nevada has implemented the service for plan year 2023.

[45]45 C.F.R. § 155.335.

[46]Colorado did not use the Hub's annual redetermination service to redetermine the eligibility of a qualified individual. Colorado officials informed us they are coordinating with CMS to find a solution to verify information through the Hub for annual reenrollments.

assess their effect on achieving the defined objectives. Until CMS coordinates with the states to identify any residual risks regarding improper APTC eligibility determinations by exercising these flexibilities, neither CMS nor the states will know if additional guidance or other actions, such as data matching or additional verification processes, are needed to mitigate these potential residual risks.

Selected States Did Not Reduce or Terminate APTC Benefits When They Could Not Verify Eligibility during the COVID-19 Pandemic

SBMs generally must provide an applicant with a reasonable opportunity period (ROP) of 90 days to provide supporting documentation to resolve inconsistencies. However, SBMs have legal authority to extend the ROP in cases where applicants have demonstrated a good faith effort to obtain the required documentation. In addition, CMS regulations permit marketplaces to provide exceptions, excluding for inconsistencies related to citizenship or lawful presence status, to individuals who cannot reasonably obtain the required documentation, and accept, on a case-by-case basis, an individual's attestation.[47] Throughout the COVID-19 pandemic, SBMs were able to use this legal authority to extend their ROP for various eligibility criteria. Four of the five selected states—California, Colorado, Nevada, and New Jersey—exercised this authority at some point during the COVID-19 pandemic.

Two selected states—California and Colorado—continued to provide ROP extensions into plan year 2022 for certain key eligibility criteria. Specifically, beginning in March 2020, Colorado temporarily discontinued terminations of the APTC in cases where applicants failed to provide verification documentation. This discontinuation was for all eligibility criteria and will last until 90 days after the end of the public health emergency.[48]

Beginning in June 2020, California also provided various extensions to its SBM's ROP for all eligibility criteria. According to California officials, in April 2022, California reinstated the ROP for all eligibility criteria, with the exception of individuals in households with Medicaid or CHIP members

[47]45 C.F.R. § 155.315(f)(3); 45 C.F.R. § 155.315(g).

[48]In January 2023, it was announced that the COVID-19 public health emergency will end on May 11, 2023.

(mixed households). In such cases, California officials said that the state will continue to provide ROP extensions for all eligibility criteria, excluding deceased and incarceration status, through the end of the public health emergency and the subsequent unwinding of the Medicaid continuous enrollment requirement.

CMS Has Not Developed a Comprehensive Methodology for Estimating Improper APTC Payments, Identifying Root Causes, and Developing Corrective Actions

CMS's APTC Improper Payment Estimation Methodology Excluded the SBMs

CMS contracted with a statistician to develop an improper payment sampling and estimation methodology plan for its APTC program. For fiscal year 2022, CMS reported an estimated $256 million in FFM improper payments for the APTC program, with an improper payment rate of 0.62 percent. Our review of the statistical approach in the improper payment sampling and estimation methodology plan concluded that the methodology was reliable to estimate improper APTC payments in the FFM.

Our review, however, found that the methodology was not comprehensive, due to limitations in its sample design and review processes. Specifically, our review of the standard operating procedures for the methodology found that CMS considered most, but not all, of the key eligibility criteria, as the methodology did not include a review of electronic verifications for income[49] nor periodic data matching for death

[49]The household income and family size review consists of ensuring each application has (1) an annual household income verification date occurring on or before the application submission date, (2) the amount the individual attested to, and (3) whether income verification data were found in IRS records. The process does not include a review of the actual income amount that IRS provided to ensure that the electronic verification was concluded correctly, as this information is considered Federal Tax Information (FTI). According to CMS officials, CMS does not have authority to review FTI for purposes of the APTC estimated improper payment measurement program because of statutory constraints of section 6103 of the Internal Revenue Code.

status and Medicare enrollment.[50] In addition, CMS's methodology was limited to APTC payments related to the FFM, and excluded consideration of APTC payments related to the SBMs.

According to CMS's standard operating procedures, developing an improper payment measurement program to account for the policies and operations of each SBM is a time-consuming and resource-intensive process, such that incorporating the SBMs into the improper payment measurement would have substantially delayed the implementation of the measurement program. In the interest of accelerating the timing of the improper payment measurement, and therefore of public reporting of improper payments and corrective action implementation, CMS resolved to develop and pilot test the measurement for the APTC program that SBMs administered under a separate continuing effort.

Further, agency officials informed us that they plan to commence a pilot program to estimate improper payments for SBMs. CMS intends to establish an improper payment pretesting and assessment program in the future to prepare the SBMs for the planned measurement of improper payments. CMS also intends to establish the improper payment measurement program subsequent to completing the pretesting and assessment program. CMS provided us a draft of its State Exchange Improper Payment Measurement Preparation Engagement Plan. The draft includes planned communication with the states regarding their requirements and the best way to incorporate the SBMs into the improper payment measurement program. However, the draft did not include a process to identify and consider residual risks that may result from SBMs' eligibility determinations.[51]

OMB guidance states management must perform an assessment to identify and evaluate the potential payment integrity risks the agency faces and that identification of payment integrity risks should be a

[50]For the fiscal year 2022 reporting, CMS had not developed a process to test the periodic data-matching results for death status and Medicare enrollment due to resource constraints and cost-benefit considerations. However, CMS has since developed this process and is executing review modules to test these areas for subsequent reporting years.

[51]As explained earlier, exercising flexibilities in the eligibility-verification process may result in residual risks related to eligibility determinations.

continuous process.[52] Further, OMB encourages agencies to ensure that significant payment integrity risks are part of the estimation methodology so that estimates can be used to assist in identifying root causes. Additionally, federal internal control standards state that management should identify, analyze, and respond to risks related to achieving the defined objectives. As part of these standards, management identifies risks throughout the entity to provide a basis for analyzing risks.

According to CMS officials, they have not completed developing an improper payment estimate that includes consideration of payments related to the SBMs because developing an effective and efficient improper payment measurement program requires multiple time-intensive steps, which CMS has not yet completed. These steps include procuring a contractor; developing measurement policies, procedures, and tools (including identifying payment integrity risks within SBMs); and conducting extensive pilot testing to ensure an accurate improper payment estimate.

Estimation of improper payments for SBMs is key to understanding the extent of any problems within the marketplaces and to developing effective corrective actions to address them. As previously mentioned, CMS is making efforts to engage with the states regarding improper payment measurement requirements and the best approach to incorporate the states into the measurement program. However, without additional coordination with the SBMs to assess and identify any residual risks to which SBMs may be vulnerable related to eligibility determinations within their respective marketplaces, CMS's process for estimating improper APTC payments may not reflect significant risks in the program. As such, the resulting improper payment estimate may be incomplete and provide a less useful basis for developing effective corrective action plans.

CMS Does Not Have Documented Policies and Procedures to Identify the Root Causes of Improper

[52]Office of Management and Budget, *Transmittal of Appendix C to OMB Circular A-123, Requirements for Payment Integrity Improvement*, OMB Memorandum M-21-19 (Washington, D.C.: Mar. 5, 2021). In this report, references to OMB guidance refer to this OMB memorandum and the guidance contained therein.

APTC Payments and Develop Corrective Actions to Address Them

For programs that are reporting improper payment estimates, PIIA requires agencies to determine the root causes of improper payments and develop corrective action plans to reduce them.[53] According to OMB guidance, as part of this process agencies should ensure they have identified a true root cause of an improper payment in order to formulate effective corrective actions. CMS officials informed us that they do not have documented policies and procedures for identifying root causes of improper APTC payments and developing corrective actions to address them; however, they stated that the process will be consistent with other programs for which there is an improper payment estimate.

Specifically, although not documented in policies and procedures, CMS officials explained that the agency will determine root causes as part of a detailed review of the findings from their annual improper payment estimation process, and that the root causes will be based on the professional judgment of reviewers and the specific facts and circumstances of each finding. Therefore, as discussed above, when CMS begins estimating improper payments related to the SBMs, if it does not identify potential residual risks related to eligibility determinations within the SBMs, there may be an increased risk that CMS may not develop effective corrective action plans, such as additional guidance or other actions, to mitigate such risks.

We previously recommended that HHS document in policies and procedures its improper payment corrective action plan process.[54] As part of these procedures, HHS should include its process for measuring the effectiveness of corrective actions. The process also should clearly demonstrate the effect HHS's corrective actions have on reducing improper payments. HHS disagreed with the recommendation, which remains open as of February 2023. Until HHS implements this recommendation and documents its processes in policies and procedures, there are risks that CMS will not develop corrective action plans that correspond to the root causes of improper payments, or that

[53]See 31 U.S.C. § 3352(d).

[54]GAO, *Payment Integrity: Selected Agencies Should Improve Efforts to Evaluate Effectiveness of Corrective Actions to Reduce Improper Payments*, GAO-20-336 (Washington, D.C.: Apr. 1, 2020).

CMS will not implement processes to effectively monitor progress and measure plans' effectiveness.

Conclusions

Federal law and regulations require SBMs, in coordination with CMS and other federal sources, to determine eligibility to enroll in a qualified health plan and receive APTCs. For some eligibility criteria, SBMs have the flexibility to accept an applicant's self-attestation in certain circumstances or to opt to conduct further verification. CMS and SBMs have not conducted a risk assessment to determine if these flexibilities make SBMs more susceptible to enrolling ineligible individuals in qualified health plans and making APTC payments on their behalf. With such considerable flexibilities, it is important that CMS, in coordination with SBMs, evaluate the risks in making improper eligibility determinations and establish strategies to mitigate those risks.

Estimating and reporting improper payments and developing corrective actions to reduce such payments is critical to agency accountability—particularly for new programs that make large expenditures in a given year. While CMS has made considerable progress in developing an estimating methodology for payments in the FFM program, CMS has not developed an improper payment estimation plan to address SBMs or their associated risks. Until HHS finalizes and implements its improper payment estimation measurement program for the SBMs, HHS will likely understate its overall improper payment estimate for the APTC program.

Recommendations for Executive Action

We are making the following two recommendations to CMS:

The Administrator for CMS should, in coordination with the states, assess and identify residual risks to which the SBMs may be vulnerable related to eligibility determinations and take these risks into account when developing and implementing the improper APTC payment estimation methodology for the SBMs. (Recommendation 1)

The Administrator for CMS should, in coordination with the states, assess and identify residual risks to which the SBMs may be vulnerable related to eligibility determinations and identify any additional guidance or other

actions, as needed, to mitigate any residual risks within the SBMs. (Recommendation 2)

Agency Comments and Our Evaluation

We provided a draft of this report to HHS, IRS, and selected states for review and comment. We received written comments from HHS, which are reproduced in appendix II and summarized below. We received technical comments from IRS, California, Colorado, Nevada, and New Jersey, which we incorporated as appropriate. Pennsylvania officials informed us that they had no comments on the report.

In its written comments, HHS stated that it does not concur with our two recommendations. HHS stated that in 2019 HHS developed an initiative to provide SBMs with an opportunity to voluntarily engage with HHS to prepare for future measurement of improper APTC payments. In our report, we acknowledge CMS's planned communication with the states regarding their improper payment estimation requirements and the best approach to incorporate the states into the improper payment measurement program. However, CMS's plan did not include a process to identify and consider residual risks that may result from SBMs' eligibility determinations.

HHS did not concur with our first recommendation to coordinate with the states to assess and identify residual eligibility determination risks to which the SBMs may be vulnerable and take those risks into account when developing and implementing the improper APTC payment estimation methodology for the SBMs. In response to this recommendation, HHS stated that PIIA and OMB guidance in Appendix C to Circular A-123 do not reference any requirements related to the assessment of residual risk. In addition, HHS stated the recommendation to assess and identify residual risks would be redundant with CMS's existing approach to developing the improper payment measurement methodology.

However, as discussed in our report, OMB guidance states management must perform an assessment to identify and evaluate the potential payment integrity risks the agency faces and that the identification of payment integrity risks should be a continuous process. Further, OMB encourages agencies to ensure that significant payment integrity risks are part of the estimation methodology so that estimates can be used to assist in identifying root causes. Without first identifying residual risks,

there is an increased likelihood that CMS's estimation methodology may not address key risks of improper payments, such as those related to eligibility determinations. This could possibly result in incomplete improper payment estimates that provide a less useful basis for developing effective corrective action plans. Therefore, we continue to believe that our recommendation is valid.

HHS also did not concur with our second recommendation to identify any additional guidance or other actions, as needed, to mitigate any residual risks within the SBMs. Specifically, HHS stated that PPACA provides states with flexibility in the design and operation of their marketplaces, within federal rules, to best meet the unique needs of their residents and insurance markets. HHS further stated that CMS regulations specify a set of eligibility verification requirements that all marketplaces, including SBMs, must follow and allow flexibility for how certain eligibility verification requirements should be met. In addition, HHS provided examples of the flexibilities allowed for certain eligibility verification requirements, specifically residency and duplicate coverage through Medicaid in other states.

HHS stated that in response to a prior GAO audit recommendation, the agency assessed and documented its options for verifying residency and concluded that accepting an applicant's attestation was the most practical option.[55] Also, HHS stated that identification or verification of dual Medicaid coverage across state lines is not a regulatory requirement for SBMs. HHS noted that a comprehensive, national electronic data source is currently not available for marketplaces to use in verifying dual Medicaid coverage in all other states outside of the service area of each marketplace.

We acknowledge in the report that PPACA and CMS regulations provide flexibilities related to certain eligibility verification requirements, in part due to whether reliable data sources are available that would allow a marketplace to verify eligibility criteria. Although HHS previously assessed and documented its options for verifying residency in response to a GAO recommendation related to the FFM, this does not account for potential data that may be available at the individual state level for the SBMs. If the residencies of individuals are not verified, there is a risk of enrolling ineligible individuals in qualified health plans and improperly providing APTC payments to issuers on their behalf. Further, without a

[55]See GAO-17-467.

process to identify duplicate coverage by Medicaid and CHIP in states other than those in which individuals applied for coverage and attested to residency, there is a risk that enrollees may apply for and receive duplicate coverage, specifically, Medicaid managed care in one state and APTC coverage in another state.

With such considerable flexibilities, it is important that CMS, in coordination with SBMs, evaluates the risks in making improper eligibility determinations and identifies any additional guidance or actions, if needed, to mitigate those risks. Therefore, we continue to believe that our recommendation to CMS is valid to help ensure that CMS addresses improper payment risks related to eligibility determinations.

We are sending copies of this report to the appropriate congressional committees, the Department of Health and Human Services, the Internal Revenue Service, and other interested parties. In addition, this report is available at no charge on the GAO website at https://www.gao.gov.

If you or your staffs have any questions about this report, please contact me at (202) 512-5683 or padillah@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix III.

M. Hannah Padilla
Director, Financial Management and Assurance

Appendix I: Objectives, Scope, and Methodology

This report examines (1) what key control activities, if any, selected states and the Centers for Medicare & Medicaid Services (CMS) have designed and implemented to prevent providing the advance premium tax credit (APTC) to ineligible individuals through the state-based marketplaces (SBM) and (2) the extent to which CMS has developed a reliable methodology to estimate improper APTC payments, identify the root causes of improper payments, and develop corrective actions to address such root causes.

For our first objective, we selected a nongeneralizable sample of approximately one-third (or five states) from the population of 15 SBMs operating for plan year 2021. To select the states for our review, we considered the following factors: monthly APTC payment data available from each state, marketplace longevity to review both established and new SBMs, and which major insurance providers were offered throughout each state. Specifically, in order to maximize our coverage, we primarily considered the amount of average monthly APTC payments by state because if deficiencies are identified within a state's processes, the overall effect may be greater for states with higher monthly payments than for those with lower monthly payments.[1] Two states—California and Pennsylvania—reported average monthly APTC payment amounts greater than $100 million; therefore, we included them in our review.

Next, we considered the timing of when states transitioned from the federal marketplace to begin operating their own SBM in order to include both newly transitioned and more established marketplaces. This allowed us to consider the potential for increased payment integrity risks as newly transitioned marketplaces establish appropriate control activities. We noted that three states—Nevada, New Jersey, and Pennsylvania—had recently transitioned to an SBM; therefore, we included Nevada and New Jersey in our review to cover all the newly transitioned marketplaces.

[1]We were unable to calculate the average monthly APTC payment amounts for Idaho and Nevada, as those states reported they were unable to report the average monthly APTC payment amount on the individual level.

Lastly, we considered the major health insurance issuers that were offered in the marketplaces. Issuers may have different processes and reporting mechanisms to exchange information with the SBMs. Therefore, in order to maximize our audit coverage, we ensured that the SBMs in the states we selected provided coverage from the major health insurance issuers offered in the SBMs for 2021. Specifically, we found that Cigna was the only major provider offered in the marketplaces in 2021 not included in our selection thus far. From the remaining states, we noted that Colorado was the state with the largest average monthly APTC payments that offered Cigna; therefore, we included Colorado in our review.

The SBMs from the five selected states—California, Colorado, Nevada, New Jersey, and Pennsylvania—covered approximately 72 percent of APTC consumers enrolled in SBMs for the 2021 open enrollment period. Our findings are limited to the five selected states included in our review and cannot be generalized to all states operating SBMs.

To assess what key control activities the selected states and CMS designed and implemented to prevent providing the APTC to ineligible individuals, we reviewed the Patient Protection and Affordable Care Act and its implementing regulations.[2] Based on this review, we identified key criteria that SBMs must consider when making APTC eligibility determinations. We also reviewed relevant internal control standards[3] and leading practices for measuring fraud risks in federal programs to determine the relevant control activities needed to help prevent improper APTC eligibility determinations.[4]

As part of this work, we determined that internal controls were significant to our objectives. Specifically, we determined that the control activities component of internal control, along with the underlying principles that management should design control activities to achieve its objectives and respond to risks, were significant to our first objective. Additionally, we determined that the risk assessment component of internal control and

[2]Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010).

[3]GAO, *Standards for Internal Control in the Federal Government*, GAO-14-704G (Washington, D.C.: September 2014).

[4]GAO, *A Framework for Managing Fraud Risks in Federal Programs*, GAO-15-593SP (Washington, D.C.: July 2015).

the principles that management should (1) identify, analyze, and respond to risks related to achieving the defined objectives and (2) consider the potential for fraud when identifying, analyzing, and responding to risks were significant to our objective. Also significant to our objective were the information and communication component and the principles that management should (1) use quality information to achieve the entity's objectives and (2) externally communicate the necessary quality information to achieve the entity's objectives.

We determined the leading practices from the Fraud Risk Framework relevant to our objective were related to (1) identifying and assessing fraud risks and (2) designing and implementing specific control activities to prevent and detect fraud. These leading practices include

1. planning to conduct fraud risk assessments at regular intervals and when there are changes to the program or operating environment, as assessing fraud risks is an iterative process;
2. examining the suitability of existing fraud controls and prioritizing residual fraud risks; and
3. conducting data matching to verify key information, including self-reported data and information necessary to determine eligibility.

We interviewed officials from the five selected states' SBMs and CMS regarding their roles in administering the APTC program and making eligibility determinations. We obtained selected states and CMS's written policies and procedures, cycle memos, and other supporting documentation, such as interagency agreements and computer-matching agreements, in place for plan year 2022. We analyzed the documentation provided from CMS and the selected SBMs to determine whether the control activities aligned with relevant federal internal control standards and leading practices in the Fraud Risk Framework and sufficiently addressed the key eligibility determination risk areas we identified. We also interviewed key agency officials from the Internal Revenue Service to gain an understanding of their roles in the APTC payment-reconciliation process.

To address our second objective, we reviewed agency payment integrity requirements in the Payment Integrity Information Act of 2019 (PIIA);[5] the related guidance in the Appendix C to Office of Management and Budget

[5]Pub L. No. 116–117, 134 Sat. 113 (Mar. 2, 2020).

(OMB) Circular A-123, Requirements for Payment Integrity Improvement;[6] and relevant internal control standards. We reviewed these documents to identify key criteria agencies must meet when developing improper payment estimation methodologies, identifying root causes of improper payments, and developing corrective action plans to reduce improper payments. Based on this review, we determined that the risk assessment component of internal control, along with the principle that management should identity, analyze, and respond to risks related to achieving the defined objectives, were significant to this objective. Additionally, we determined that the control activities component of internal control, along with the principles that management should (1) design control activities to achieve objectives and respond to risks and (2) implement control activities through policies, were significant to our objective.

We interviewed relevant CMS officials regarding their roles in estimating improper APTC payments, identifying root causes of improper payments, and developing corrective action plans to address root causes. We also obtained CMS's sampling and estimation methodology plan for fiscal year 2022 reporting and relevant policies and procedures. We then analyzed the provided documents against relevant PIIA requirements, OMB guidance, and relevant federal internal control standards. From our analysis, we assessed whether (1) CMS's estimation methodology was reasonably sufficient to produce a reliable estimate of improper APTC payments and (2) CMS designed and implemented a process to identify root causes of improper APTC payments and develop corrective actions that correspond to the identified root causes in accordance with applicable laws and guidance.

We conducted this performance audit from November 2021 to March 2023 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 conclusion 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.

[6]Office of Management and Budget, *Appendix C to Circular No. A-123, Requirements for Payment Integrity Improvement*, OMB Memorandum M-21-19 (Washington, D.C.: Mar. 5, 2021). In this report, references to OMB guidance refer to this OMB memorandum and the guidance contained therein.

Appendix II: Comments from the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

January 24, 2023

Hannah Padilla
Director, Financial Management and Assurance
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Ms. Padilla:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "***PAYMENT INTEGRITY: Better Coordination Is Needed for Assessing Risks in the Improper Payment Estimation Process for Advance Premium Tax Credit Payments***" **(GAO-23-105577).**

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

Sincerely,

Melanie Anne Egorin

Melanie Anne Egorin, PhD
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH & HUMAN SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED — Payment Integrity: Better Coordination Is Needed for Assessing Risks in the Improper Payment Estimation Process for Advance Premium Tax Credit Payments (GAO-23-105577)

The Department of Health and Human Services (HHS) appreciates the opportunity to review and comment on this draft report. HHS is committed to expanding access to quality, affordable health coverage and care by increasing access to health care services, simplifying choice and improving the plan selection process, reducing consumer barriers, strengthening markets, and bolstering program integrity.

In 2010, the Patient Protection and Affordable Care Act (ACA) established Health Insurance Exchanges through which consumers could submit applications and enroll in health coverage. Under the law, states have the authority to establish their own exchange, a State-based Exchange (SBE), or use the Federally-facilitated Exchange (FFE). HHS works with all states to address the specific needs of their consumers while also meeting the requirements and responsibilities set by statute. Eligible consumers enrolling in a qualified health plan (QHP) through the FFE or an SBE may receive financial assistance in the form of Advance Payments of the Premium Tax Credit (APTC). HHS is committed to protecting taxpayer funds while reducing the burden on consumers, employers, and other individuals and entities involved in the FFE and SBEs and other insurance affordability programs.

APTC Program Integrity

To better protect consumers and taxpayer dollars, HHS has implemented a number of initiatives to enhance oversight and operations, with a focus on program integrity. HHS has applied program integrity best practices to the Exchanges based on efforts to prevent and detect fraud, waste, and abuse in its other programs. In addition, HHS has experienced program integrity staff that work to prevent and address instances of potential fraud. As recommended by the GAO,[1] HHS completed an Exchange Fraud Risk Assessment, leveraging the GAO's fraud risk framework.[2] HHS has used this framework to identify and prioritize key areas for potential risk and mitigation activities in the FFE. In addition, HHS collaborates with and supports the SBE's on a bi-monthly basis regarding program integrity topics, including the sharing of fraud, waste, and abuse trends, patterns, and other information.

HHS has also made progress toward reporting APTC improper payment estimates by conducting a risk assessment for the APTC program, as required by the Payment Integrity Information Act of 2019 (PIIA) and Office of Management and Budget (OMB) guidance. As GAO previously reported,[3] HHS appropriately assessed all risk factors required by OMB, appropriately tailored the risk factors to the APTC program, and reached a conclusion supported by its analysis. Given the complexities of this program, HHS piloted different measurement methodologies for estimating improper payments associated with APTC to ensure accuracy and efficiency in reporting an improper payment rate. In November 2022, HHS announced the first improper payment rate for APTC payments made using the FFE platform, which was less than one percent

[1] GAO, Patient Protection and Affordable Care Act: CMS Should Act to Strengthen Enrollment Controls and Manage Fraud Risk, GAO-16-29. February 23, 2016. Accessed at: https://www.gao.gov/products/gao-16-29.
[2] GAO, A Framework for Managing Fraud Risks in Federal Programs, GAO-15-593SP. July 28, 2015. Accessed at: https://www.gao.gov/products/gao-15-593sp.
[3] GAO, Improper Payments: Improvements Needed in CMS and IRS Controls over Health Insurance Premium Tax Credit, GAO-17-467. July 13, 2017. Accessed at: https://www.gao.gov/products/gao-17-467.

(0.62 percent) for Benefit Year 2020.[4] This rate is in line with the rate GAO reported in an audit of select eligibility requirements for Benefit Year 2015.[5] HHS identified the primary cause of improper payments was manual errors associated with determining consumer eligibility for APTC payments, representing 94.30 percent of overpayments, and 100 percent of underpayments.

As HHS stated in its announcement of the rate, the FFE improper payment estimate does not reflect payments made by SBEs. In 2019, HHS developed an initiative to provide SBEs with an opportunity to voluntarily engage with HHS to prepare for future measurement of improper payments of APTC. HHS provided three options to SBEs – program analysis, program design, and piloting – designed to accommodate the SBEs' schedules and availability to participate in the initiative. Currently, of the 18 SBEs, 10 have participated in various levels of engagement. HHS continues to develop the improper payment measurement program for SBEs and will continue to provide updates on the development status of the SBE improper payment measurement through its annual Agency Financial Report.

Oversight of State-based Exchanges

HHS requires SBEs to conduct a defined set of oversight activities, and tracks and monitors how SBEs establish program integrity standards that comply with Exchange-related policy and operational requirements set forth in statute, regulations, and guidance. The ACA provides states with flexibility in the design and operation of their Exchanges, within Federal rules, to best meet the unique needs of their residents and insurance markets. HHS monitors SBE compliance with program integrity standards, including any flexibilities provided, through regularly scheduled calls with SBE leadership and staff, as well as through HHS's State-based Marketplace Annual Reporting Tool (SMART) process, which requires states to attest to their compliance with federal requirements and provide supporting documentation for certain eligibility and enrollment policies and procedures, including those related to eligibility verifications.

Additionally, through the SMART process, SBEs must submit annual independent external programmatic audits conducted by an independent auditing entity, as required by 45 CFR 155.1200. As part of the audit requirement, the independent external auditor must review for compliance under 45 CFR 155 Subparts D (Eligibility) and E (Enrollment). SBEs must inform HHS of any audit findings and submit corrective action plans to address open findings. HHS reviews the audit results and monitors open audit findings until they are resolved through the SMART reporting process. In cases where an SBE does not take adequate steps to conduct corrective actions, HHS may take a stronger oversight role, which can include verbal and written communications from HHS staff and leadership, and increased monitoring through regular calls and/or site visits to receive daily/weekly updates on an SBE's progress.

Finally, all SBEs are required to submit documented plans demonstrating that they have a comprehensive oversight and monitoring program to ensure program integrity, which includes policies and procedures to identify incidents of fraud, waste, and abuse, as required under Section 1313(a)(5) of the ACA. HHS reviews the status of these plans annually and provides technical assistance as needed.

GAO's recommendations and HHS's responses are below.

[4] Department of Health and Human Services, Agency Financial Report, Fiscal Year 2022. Accessed at https://www.hhs.gov/sites/default/files/fy-2022-hhs-agency-financial-report.pdf.
[5] GAO, Federal Health-Insurance Marketplace: Analysis of Plan Year 2015 Application, Enrollment, and Eligibility-Verification Process. GAO-18-169. December 21, 2017. Accessed at: https://www.gao.gov/products/gao-18-169.

GAO Recommendation 1
The Administrator of CMS should, in coordination with the states, assess and identify residual risks to which the SBMs may be vulnerable related to eligibility determinations and take these risks into account when developing and implementing the improper APTC payment estimation methodology for the SBMs.

HHS Response
CMS non-concurs with GAO's recommendation. PIIA and OMB guidance in Appendix C do not reference any requirements relating to the assessment of residual risk. Additionally, the recommendation to assess and identify residual risks would be redundant with CMS's existing approach to developing the improper payment measurement methodology.

OMB guidance in Appendix C specifies the requirements for the Improper Payment Risk Assessment, the purpose of which is to determine if a program administered by the agency is susceptible to significant improper payments, and therefore is subject to the measurement and reporting requirements of PIIA. CMS completed this risk assessment in 2016, which GAO reported on in July 2017.[6] OMB guidance also requires that "the identification of payment integrity risks should be a continuous process to ensure new or changing risks are not overlooked." In the FFE program, CMS satisfies this requirement by reviewing and updating the improper payment measurement methodology on an annual basis. CMS will follow this approach to continuous improvement when developing and implementing the SBE improper payment measurement program methodology.

CMS approaches the design of the APTC improper payment measurement methodology comprehensively, such that substantially all[7] legally applicable requirements[8] related to payment and eligibility determinations are within the scope of the measurement.

In November 2022, HHS published the first improper payment rate for the FFE program, which was less than one percent (0.62 percent) for Benefit Year 2020.[9] This rate is in line with the rate GAO reported in an audit of select eligibility requirements for Benefit Year 2015.[10] HHS continues to develop the improper payment measurement program for SBEs and will continue to provide updates on the development status of the SBE improper payment measurement through its annual Agency Financial Report.

GAO Recommendation 2
The Administrator of CMS should, in coordination with the states, assess and identify residual risks to which the SBMs may be vulnerable related to eligibility determinations and identify any additional guidance or other actions, as needed, to mitigate any residual risks within the SBMs.

[6] GAO, Improper Payments: Improvement Needed in CMS and IRS Controls over Health Insurance Premium Tax Credit. GAO-17-467. July 2017. Accessed at: https://www.gao.gov/assets/gao-17-467.pdf
[7] For example, the APTC improper payment measurement methodology is unable to assess certain requirements related to income verification due to statutory constraints set forth in Section 6103 of the Internal Revenue Code, which limit the disclosure of taxpayer information.
[8] The improper payment measurement methodology is a statistical study to determine the extent and nature of improper payments. Improper payments are defined as a payment made "in an incorrect amount under statutory, contractual, administrative, or other legally applicable requirements."
[9] Department of Health and Human Services, Agency Financial Report, Fiscal Year 2022. Accessed at https://www.hhs.gov/sites/default/files/fy-2022-hhs-agency-financial-report.pdf.
[10] GAO, Federal Health-Insurance Marketplace: Analysis of Plan Year 2015 Application, Enrollment, and Eligibility-Verification Process. GAO-18-169. December 21, 2017. Accessed at: https://www.gao.gov/products/gao-18-169.

HHS Response

CMS non-concurs with GAO's recommendation.

The ACA provides states with flexibility in the design and operation of their Exchanges, within Federal rules, to best meet the unique needs of their residents and insurance markets. Accordingly, CMS regulations specify a set of eligibility verification requirements in 45 CFR 155 Subpart D that all Exchanges, including SBEs, must follow. These regulations, developed and finalized through a public comment process, allow flexibility for certain eligibility verification requirements as to how Exchanges should meet the verification requirement. For example, through regulations finalized in July 2013 (78 FR 42316), CMS requires Exchanges to accept an applicant's attestation of state residency as the primary means of verifying residency status, while allowing Exchanges the flexibility to individually identify and propose for CMS approval an electronic data source for verifying residency status. In response to a GAO audit recommendation in July 2017,[11] CMS assessed and documented its options for verifying residency and again concluded that accepting an applicant's attestation was the most practical option, as codified at 45 CFR 155.315(d); GAO subsequently closed its recommendation. As such, CMS would consider the potential risk associated with accepting applicant attestation for verifying residency as a risk that has been fully evaluated and is already inherently accounted for in our oversight and program integrity activities.

As another example, the identification or verification of dual Medicaid coverage across state lines is not a regulatory requirement for SBEs. CMS cited that a comprehensive, national electronic data source is currently not available for Exchanges to use in verifying dual Medicaid coverage in all other states outside of the service area of each Exchange. As such, conducting a separate assessment of risk and mitigation between CMS and each SBE related to verifying dual Medicaid coverage in all other states outside of the service area of an SBE would not be feasible, or in alignment with current CMS policy.

CMS requires SBEs to conduct a defined set of oversight activities and tracks and monitors how SBEs establish program integrity standards that comply with Exchange-related policy and operational requirements set forth in statute, regulations, and guidance. For example, SBEs are required to have a comprehensive, documented oversight and monitoring program to ensure program integrity, which includes policies and procedures to identify incidents of fraud, waste, and abuse, as required under section 1313(a)(5) of the ACA.

CMS notes that in developing and implementing the improper APTC payment measurement methodology for SBEs, CMS will follow OMB guidance in Appendix C to Circular No. A-123. CMS will develop an improper payment rate for the SBEs and subsequently develop and implement effective mitigation strategies and corrective actions, as relevant.

[11] GAO, Improper Payments: Improvements Needed in CMS and IRS Controls over Health Insurance Premium Tax Credit, GAO-17-467. July 13, 2017. Accessed at: https://www.gao.gov/products/gao-17-467.

Text of Appendix II: Comments from the Department of Health and Human Services

January 24, 2023

Hannah Padilla

Director, Financial Management and Assurance

U.S. Government Accountability Office 441 G Street NW

Washington, DC 20548 Dear Ms. Padilla:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "PAYMENT INTEGRITY: Better Coordination Is Needed for Assessing Risks in the Improper Payment Estimation Process for Advance Premium Tax Credit Payments" (GAO-23-105577).

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

Sincerely,

Melanie Anne Egorin, PhD Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH & HUMAN SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED — Payment Integrity: Better Coordination Is Needed for Assessing Risks in the Improper Payment Estimation Process for Advance Premium Tax Credit Payments (GAO-23-105577)

The Department of Health and Human Services (HHS) appreciates the opportunity to review and comment on this draft report. HHS is committed to expanding access to quality, affordable health coverage and care by increasing access to health care services, simplifying choice and improving the plan selection process, reducing consumer barriers, strengthening markets, and bolstering program integrity.

In 2010, the Patient Protection and Affordable Care Act (ACA) established Health Insurance Exchanges through which consumers could submit applications and enroll in health coverage. Under the law, states have the authority to establish their own exchange, a State-based Exchange (SBE), or use the Federally-facilitated Exchange (FFE). HHS works with all states to address the specific needs of their consumers while also meeting the requirements and responsibilities set by statute. Eligible consumers enrolling in a qualified health plan (QHP) through the FFE or an SBE may receive financial assistance in the form of Advance Payments of the Premium Tax Credit (APTC). HHS is committed to protecting taxpayer funds while reducing the burden on consumers, employers, and other individuals and entities involved in the FFE and SBEs and other insurance affordability programs.

APTC Program Integrity

To better protect consumers and taxpayer dollars, HHS has implemented a number of initiatives to enhance oversight and operations, with a focus on program integrity. HHS has applied program integrity best practices to the Exchanges based on efforts to prevent and detect fraud, waste, and abuse in its other programs. In addition, HHS has experienced program integrity staff that work to prevent and address instances of potential fraud. As recommended by the GAO,[1] HHS completed an Exchange Fraud Risk Assessment, leveraging the GAO's fraud risk framework.[2] HHS has used this framework to identify and prioritize key areas for potential risk and mitigation activities in the FFE. In addition, HHS collaborates with and supports the SBE's on a bi-monthly basis regarding program integrity topics, including the sharing of fraud, waste, and abuse trends, patterns, and other information.

HHS has also made progress toward reporting APTC improper payment estimates by conducting a risk assessment for the APTC program, as required by the Payment Integrity Information Act of 2019 (PIIA) and Office of Management and Budget (OMB) guidance. As GAO previously reported,[3] HHS appropriately assessed all risk factors required by OMB, appropriately tailored the risk factors to the APTC program, and reached a conclusion supported by its analysis. Given the complexities of this program, HHS piloted different measurement methodologies for estimating improper

[1] GAO, Patient Protection and Affordable Care Act: CMS Should Act to Strengthen Enrollment Controls and Manage Fraud Risk, GAO-16-29. February 23, 2016. Accessed at: https://www.gao.gov/products/gao-16-29.

[2] GAO, A Framework for Managing Fraud Risks in Federal Programs, GAO-15-593SP. July 28, 2015. Accessed at: https://www.gao.gov/products/gao-15-593sp.

[3] GAO, Improper Payments: Improvements Needed in CMS and IRS Controls over Health Insurance Premium Tax Credit, GAO-17-467. July 13, 2017. Accessed at: https://www.gao.gov/products/gao-17-467.

payments associated with APTC to ensure accuracy and efficiency in reporting an improper payment rate. In November 2022, HHS announced the first improper payment rate for APTC payments made using the FFE platform, which was less than one percent (0.62 percent) for Benefit Year 2020.[4] This rate is in line with the rate GAO reported in an audit of select eligibility requirements for Benefit Year 2015.[5]HHS identified the primary cause of improper payments was manual errors associated with determining consumer eligibility for APTC payments, representing 94.30 percent of overpayments, and 100 percent of underpayments.

As HHS stated in its announcement of the rate, the FFE improper payment estimate does not reflect payments made by SBEs. In 2019, HHS developed an initiative to provide SBEs with an opportunity to voluntarily engage with HHS to prepare for future measurement of improper payments of APTC. HHS provided three options to SBEs – program analysis, program design, and piloting – designed to accommodate the SBEs' schedules and availability to participate in the initiative. Currently, of the 18 SBEs, 10 have participated in various levels of engagement. HHS continues to develop the improper payment measurement program for SBEs and will continue to provide updates on the development status of the SBE improper payment measurement through its annual Agency Financial Report.

Oversight of State-based Exchanges

HHS requires SBEs to conduct a defined set of oversight activities, and tracks and monitors how SBEs establish program integrity standards that comply with Exchange-related policy and operational requirements set forth in statute, regulations, and guidance. The ACA provides states with flexibility in the design and operation of their Exchanges, within Federal rules, to best meet the unique needs of their residents and insurance markets. HHS monitors SBE compliance with program integrity standards, including any flexibilities provided, through regularly scheduled calls with SBE leadership and staff, as well as through HHS's State-based Marketplace Annual Reporting Tool (SMART) process, which requires states to attest to their compliance with federal requirements and provide supporting documentation for certain eligibility and enrollment policies and procedures, including those related to eligibility verifications.

Additionally, through the SMART process, SBEs must submit annual independent external programmatic audits conducted by an independent auditing entity, as

[4] Department of Health and Human Services, Agency Financial Report, Fiscal Year 2022. Accessed at https://www.hhs.gov/sites/default/files/fy-2022-hhs-agency-financial-report.pdf.

[5] GAO, Federal Health-Insurance Marketplace: Analysis of Plan Year 2015 Application, Enrollment, and Eligibility- Verification Process. GAO-18-169. December 21, 2017. Accessed at: https://www.gao.gov/products/gao-18-169.

required by 45 CFR 155.1200. As part of the audit requirement, the independent external auditor must review for compliance under 45 CFR 155 Subparts D (Eligibility) and E (Enrollment). SBEs must inform HHS of any audit findings and submit corrective action plans to address open findings. HHS reviews the audit results and monitors open audit findings until they are resolved through the SMART reporting process. In cases where an SBE does not take adequate steps to conduct corrective actions, HHS may take a stronger oversight role, which can include verbal and written communications from HHS staff and leadership, and increased monitoring through regular calls and/or site visits to receive daily/weekly updates on an SBE's progress.

Finally, all SBEs are required to submit documented plans demonstrating that they have a comprehensive oversight and monitoring program to ensure program integrity, which includes policies and procedures to identify incidents of fraud, waste, and abuse, as required under Section 1313(a)(5) of the ACA. HHS reviews the status of these plans annually and provides technical assistance as needed.

GAO's recommendations and HHS's responses are below.

GAO Recommendation 1

The Administrator of CMS should, in coordination with the states, assess and identify residual risks to which the SBMs may be vulnerable related to eligibility determinations and take these risks into account when developing and implementing the improper APTC payment estimation methodology for the SBMs.

HHS Response

CMS non-concurs with GAO's recommendation. PIIA and OMB guidance in Appendix C do not reference any requirements relating to the assessment of residual risk. Additionally, the recommendation to assess and identify residual risks would be redundant with CMS's existing approach to developing the improper payment measurement methodology.

OMB guidance in Appendix C specifies the requirements for the Improper Payment Risk Assessment, the purpose of which is to determine if a program administered by the agency is susceptible to significant improper payments, and therefore is subject to the measurement and reporting requirements of PIIA. CMS completed this risk assessment in 2016, which GAO reported on in July 2017.[6] OMB guidance also requires that "the identification of payment integrity risks should be a continuous

[6] GAO, Improper Payments: Improvement Needed in CMS and IRS Controls over Health Insurance Premium Tax Credit. GAO-17-467. July 2017. Accessed at: https://www.gao.gov/assets/gao-17-467.pdf

process to ensure new or changing risks are not overlooked." In the FFE program, CMS satisfies this requirement by reviewing and updating the improper payment measurement methodology on an annual basis. CMS will follow this approach to continuous improvement when developing and implementing the SBE improper payment measurement program methodology.

CMS approaches the design of the APTC improper payment measurement methodology comprehensively, such that substantially all[7] legally applicable requirements[8] related to payment and eligibility determinations are within the scope of the measurement.

In November 2022, HHS published the first improper payment rate for the FFE program, which was less than one percent (0.62 percent) for Benefit Year 2020.[9] This rate is in line with the rate GAO reported in an audit of select eligibility requirements for Benefit Year 2015.[10] HHS continues to develop the improper payment measurement program for SBEs and will continue to provide updates on the development status of the SBE improper payment measurement through its annual Agency Financial Report.

GAO Recommendation 2

The Administrator of CMS should, in coordination with the states, assess and identify residual risks to which the SBMs may be vulnerable related to eligibility determinations and identify any additional guidance or other actions, as needed, to mitigate any residual risks within the SBMs.

HHS Response

CMS non-concurs with GAO's recommendation.

[7] For example, the APTC improper payment measurement methodology is unable to assess certain requirements related to income verification due to statutory constraints set forth in Section 6103 of the Internal Revenue Code, which limit the disclosure of taxpayer information.

[8] The improper payment measurement methodology is a statistical study to determine the extent and nature of improper payments. Improper payments are defined as a payment made "in an incorrect amount under statutory, contractual, administrative, or other legally applicable requirements."

[9] Department of Health and Human Services, Agency Financial Report, Fiscal Year 2022. Accessed at https://www.hhs.gov/sites/default/files/fy-2022-hhs-agency-financial-report.pdf.

[10] GAO, Federal Health-Insurance Marketplace: Analysis of Plan Year 2015 Application, Enrollment, and Eligibility-Verification Process. GAO-18-169. December 21, 2017. Accessed at: https://www.gao.gov/products/gao- 18-169.

The ACA provides states with flexibility in the design and operation of their Exchanges, within Federal rules, to best meet the unique needs of their residents and insurance markets.

Accordingly, CMS regulations specify a set of eligibility verification requirements in 45 CFR 155 Subpart D that all Exchanges, including SBEs, must follow. These regulations, developed and finalized through a public comment process, allow flexibility for certain eligibility verification requirements as to how Exchanges should meet the verification requirement. For example, through regulations finalized in July 2013 (78 FR 42316), CMS requires Exchanges to accept an applicant's attestation of state residency as the primary means of verifying residency status, while allowing Exchanges the flexibility to individually identify and propose for CMS approval an electronic data source for verifying residency status. In response to a GAO audit recommendation in July 2017,[11] CMS assessed and documented its options for verifying residency and again concluded that accepting an applicant's attestation was the most practical option, as codified at 45 CFR 155.315(d); GAO subsequently closed its recommendation. As such, CMS would consider the potential risk associated with accepting applicant attestation for verifying residency as a risk that has been fully evaluated and is already inherently accounted for in our oversight and program integrity activities.

As another example, the identification or verification of dual Medicaid coverage across state lines is not a regulatory requirement for SBEs. CMS cited that a comprehensive, national electronic data source is currently not available for Exchanges to use in verifying dual Medicaid coverage in all other states outside of the service area of each Exchange. As such, conducting a separate assessment of risk and mitigation between CMS and each SBE related to verifying dual Medicaid coverage in all other states outside of the service area of an SBE would not be feasible, or in alignment with current CMS policy.

CMS requires SBEs to conduct a defined set of oversight activities and tracks and monitors how SBEs establish program integrity standards that comply with Exchange-related policy and operational requirements set forth in statute, regulations, and guidance. For example, SBEs are required to have a comprehensive, documented oversight and monitoring program to ensure program integrity, which includes policies and procedures to identify incidents of fraud, waste, and abuse, as required under section 1313(a)(5) of the ACA.

[11] GAO, Improper Payments: Improvements Needed in CMS and IRS Controls over Health Insurance Premium Tax Credit, GAO-17-467. July 13, 2017. Accessed at: https://www.gao.gov/products/gao-17-467.

CMS notes that in developing and implementing the improper APTC payment measurement methodology for SBEs, CMS will follow OMB guidance in Appendix C to Circular No. A-123. CMS will develop an improper payment rate for the SBEs and subsequently develop and implement effective mitigation strategies and corrective actions, as relevant.

Appendix III: GAO Contact and Staff Acknowledgments

GAO Contact

M. Hannah Padilla, (202) 512-5683 or padillah@gao.gov

Staff Acknowledgments

In addition to the contact named above, Matthew Valenta (Assistant Director), Stephanie Adams (Auditor in Charge), Carl Barden, Anthony Clark, Jason Kelly, Mike LaForge, Diana Lee, Christina Skinner, Angela Wills, and Emily Wilson Schwark made key contributions to this engagement.

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