

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**NOT ALL INTERNAL CONTROLS
IMPLEMENTED BY THE NEW YORK
MARKETPLACE WERE EFFECTIVE IN
ENSURING THAT INDIVIDUALS WERE
ENROLLED IN QUALIFIED HEALTH
PLANS ACCORDING TO FEDERAL
REQUIREMENTS**

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



**Daniel R. Levinson
Inspector General**

**September 2015
A-02-14-02020**

Office of Inspector General

<http://oig.hhs.gov>

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

Office of Audit Services

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

Office of Evaluation and Inspections

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

Office of Investigations

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

Office of Counsel to the Inspector General

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

Notices

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

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

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

Not all of the New York marketplace's internal controls were effective in ensuring that individuals were enrolled in qualified health plans according to Federal requirements.

WHY WE DID THIS REVIEW

The Patient Protection and Affordable Care Act (ACA) requires the establishment of a health insurance exchange (marketplace) in each State and the District of Columbia. A marketplace is designed to serve as a “one-stop shop” at which individuals get information about their health insurance options; are evaluated for eligibility for a qualified health plan (QHP) and, when applicable, eligibility for insurance affordability programs; and enroll in the QHP of their choice. As of October 1, 2013, New York was 1 of 15 States that had established State-based marketplaces (State marketplaces).

A previous Office of Inspector General review found that not all internal controls implemented by the federally facilitated marketplace (Federal marketplace) and the State marketplaces in California and Connecticut were effective in ensuring that individuals were enrolled in QHPs according to Federal requirements. This review of the New York State of Health (New York marketplace), which was established within the New York Department of Health (DOH), is part of an ongoing series of reviews of seven State marketplaces across the Nation. We selected the individual State marketplaces to cover States in different parts of the country. Our nationwide audit of State marketplace eligibility determinations is part of a larger body of ACA work, which also includes audits of how costs incurred to create State marketplaces were allocated to establishment grants.

Our objective was to determine whether the New York marketplace's internal controls were effective in ensuring that individuals were enrolled in QHPs according to Federal requirements.

BACKGROUND

Qualified Health Plans and Insurance Affordability Programs

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

To be eligible to enroll in a QHP, an individual must be a U.S. citizen, a U.S. national, or lawfully present in the United States; not be incarcerated; and meet applicable residency standards. To be eligible for insurance affordability programs, the individual must meet

additional requirements for annual household income. An individual is not eligible for these programs if he or she is eligible for minimum essential coverage that is not offered through a marketplace. Minimum essential coverage consists of employer-sponsored and non-employer-sponsored insurance (ESI). The latter includes Government programs (such as Medicare and Medicaid), grandfathered plans, and other plans.

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

An applicant may submit an application to enroll in a QHP during an open enrollment period. An applicant may also enroll in a QHP during a special enrollment period outside of the open enrollment period if the applicant experiences certain life changes, such as marriage or the birth of a child.

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

After reviewing the applicant's information, the marketplace determines whether the applicant is eligible for a QHP and, when applicable, eligible for insurance affordability programs. To verify the information submitted by the applicant, the marketplace uses multiple electronic data sources, including sources available through the Federal Data Services Hub (Data Hub). The data sources available through the Data Hub are the U.S. Department of Health and Human Services, the Social Security Administration (SSA), the U.S. Department of Homeland Security, and the Internal Revenue Service, among others.

State marketplaces can access additional sources of data to verify applicant information. For example, the New York marketplace can use data from New York's Small Business Health Options Program (SHOP) to verify whether applicants are eligible for ESI. (The SHOP marketplace enables small businesses to access health coverage for their employees.) If the marketplace determines that the applicant is eligible to enroll in a QHP, the applicant selects a QHP, and the marketplace transmits the enrollment information to the insurance company, i.e., the QHP issuer.

Generally, when a marketplace cannot verify information that the applicant submitted or the information is inconsistent with information available through the Data Hub or other sources, the marketplace must attempt to resolve the inconsistency. If the marketplace is unable to resolve an inconsistency through reasonable efforts, it must generally provide the applicant 90 days to submit satisfactory documentation or otherwise resolve the inconsistency. (This 90-day period is referred to as "the inconsistency period.") The marketplace may extend the inconsistency period

if the applicant demonstrates that a good-faith effort has been made to obtain required documentation. During the inconsistency period, the applicant may still enroll in a QHP and, when applicable, may choose to receive the APTC and cost-sharing reductions. After the inconsistency period, if the marketplace is unable to resolve the inconsistency, it determines the applicant's eligibility on the basis of available data sources and, in certain circumstances, the applicant's attestation.

HOW WE CONDUCTED THIS REVIEW

We reviewed the internal controls that were in place at the New York marketplace during the open enrollment period for insurance coverage effective in calendar year 2014 (October 1, 2013, through March 31, 2014). We performed an internal control review because it enabled us to evaluate the effectiveness and efficiency of the New York marketplace's operations and compliance with applicable Federal requirements.

We limited our review to those internal controls related to (1) verifying applicants' identities, (2) determining applicants' eligibility for enrollment in QHPs and eligibility for insurance affordability programs, and (3) maintaining and updating eligibility and enrollment data. To determine the effectiveness of the internal controls, we:

- reviewed a sample of 45 applicants randomly selected from applicants who were enrolled in QHPs during the open enrollment period (a total of 379,932 applicants), which included the review of supporting documentation to evaluate whether the marketplace determined the applicants' eligibility in accordance with Federal requirements, and
- performed other audit procedures, which included interviews with marketplace management, staff, and contractors; observation of staff performing tasks related to eligibility determinations; and reviews of supporting documentation and enrollment records.

Because our review was designed to provide only reasonable assurance that the internal controls we reviewed were effective, it would not necessarily have detected all internal control deficiencies.

WHAT WE FOUND

Not all of the New York marketplace's internal controls were effective in ensuring that individuals were enrolled in QHPs according to Federal requirements.

On the basis of our review of 45 sample applicants from the enrollment period for insurance coverage effective in calendar year 2014, we determined that certain internal controls were effective, such as the controls for verifying the applicant's Social Security number through SSA. However, the internal controls were not always effective for:

- verifying annual household income (3 sample applicants),

- resolving inconsistencies in eligibility data (5 sample applicants), and
- verifying eligibility for minimum essential coverage through ESI by obtaining information from the Office of Personnel Management (OPM) and SHOP (27 sample applicants) and ensuring that insurance affordability programs were authorized only for individuals who do not have ESI (1 sample applicant).

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

The deficiencies that we identified occurred because the New York marketplace did not (1) design its eligibility and enrollment system to always verify annual household income properly, (2) use existing system functionality to resolve inconsistencies in eligibility data, and (3) ensure that it follows requirements to verify applicants' eligibility for minimum essential coverage through ESI using OPM and SHOP data and ensure that applicants who are eligible for minimum essential coverage through ESI are not determined eligible for APTC and cost-sharing reductions.

WHAT WE RECOMMEND

We recommend that the New York marketplace:

- modify its eligibility and enrollment system to always verify annual household income properly,
- use existing system functionality to resolve inconsistencies in eligibility data, and
- ensure that it follows requirements to verify applicants' eligibility for minimum essential coverage through ESI using OPM and SHOP data and ensure that applicants who are eligible for minimum essential coverage through ESI are not determined eligible for APTC and cost-sharing reductions.

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

DEPARTMENT OF HEALTH COMMENTS AND OUR RESPONSE

In written comments on our draft report, DOH, on behalf of the New York marketplace, concurred with our recommendations. Specifically, DOH provided details about corrective actions that have been or soon will be implemented by the New York marketplace. DOH also indicated that the New York marketplace has redetermined the eligibility of applicants included in our report. DOH also provided technical comments on our draft report, which we addressed.

TABLE OF CONTENTS

INTRODUCTION 1

Why We Did This Review 1

Objective 2

Background 2

Patient Protection and Affordable Care Act 2

Health Insurance Marketplaces 2

Qualified Health Plans and Insurance Affordability Programs 3

Application and Enrollment Process for Qualified Health Plans and
Insurance Affordability Programs for All Marketplaces 6

CMS’s Oversight of Marketplaces 10

The New York State Marketplace 10

How We Conducted This Review 10

FINDINGS 11

The New York Marketplace Did Not Always Verify
Annual Household Income Properly 12

The New York Marketplace Did Not Always Resolve
Inconsistencies in Eligibility Data 13

The New York Marketplace Did Not Always Properly Determine
Eligibility for Insurance Affordability Programs 13

RECOMMENDATIONS 14

DEPARTMENT OF HEALTH COMMENTS AND
OFFICE OF INSPECTOR GENERAL RESPONSE 15

APPENDIXES

A: The New York Marketplace’s Process for Verifying Annual Household Income and
Eligibility for Minimum Essential Coverage Through Employer-Sponsored and
Non-Employer-Sponsored Insurance 16

B: Steps and Outcomes for Resolving Inconsistencies 19

C: The New York Marketplace’s Inconsistency Resolution Process 20

D: Overview of Internal Controls 21

E: Audit Scope and Methodology.....22

F: Department of Health Comments25

INTRODUCTION

WHY WE DID THIS REVIEW

The Patient Protection and Affordable Care Act (ACA)¹ requires the establishment of a health insurance exchange (marketplace) in each State and the District of Columbia. A marketplace is designed to serve as a “one-stop shop” at which individuals get information about their health insurance options; are evaluated for eligibility for a qualified health plan (QHP) and, when applicable, eligibility for insurance affordability programs; and enroll in the QHP of their choice.² As of October 1, 2013, New York was 1 of 15 States that had established State-based marketplaces (State marketplaces).

A previous Office of Inspector General (OIG) review found that not all internal controls implemented by the federally facilitated marketplace (Federal marketplace) and the State marketplaces in California and Connecticut were effective in ensuring that individuals were enrolled in QHPs according to Federal requirements (A-09-14-01000, issued June 30, 2014).³ This review of the New York State of Health (New York marketplace) is part of an ongoing series of reviews of seven State marketplaces across the Nation.⁴ We selected the individual State marketplaces to cover States in different parts of the country.

This report, in part, responds to a Congressional request for information on how the State marketplaces use Internal Revenue Service’s (IRS) household income data and self-reported, third-party, and other income data in eligibility determinations.

Our nationwide audit of State marketplace eligibility determinations is part of a larger body of ACA work, which also includes audits of how costs incurred to create State marketplaces were allocated to establishment grants. See “Affordable Care Act Reviews” on the OIG Web site for a list of related OIG reports on marketplace operations.⁵

¹ P.L. No. 111-148 (March 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010, P.L. No. 111-152 (March 30, 2010).

² An individual is considered to be enrolled in a QHP when he or she has been determined eligible and has paid the first monthly insurance premium. An individual may also obtain information from a marketplace about Medicaid and the Children’s Health Insurance Program (CHIP) (ACA § 1413 and 45 CFR § 155.405).

³ Our previous review covered the internal controls in place during the first 3 months of the open enrollment period for applicants enrolling in QHPs (October to December 2013).

⁴ The other six State marketplaces we reviewed were Colorado, the District of Columbia, Kentucky, Minnesota, Vermont, and Washington.

⁵ <http://oig.hhs.gov/reports-and-publications/aca/>.

OBJECTIVE

Our objective was to determine whether the New York marketplace's internal controls were effective in ensuring that individuals were enrolled in QHPs according to Federal requirements.

BACKGROUND

Patient Protection and Affordable Care Act

The ACA established marketplaces to allow individuals and small businesses to shop for health insurance in all 50 States and the District of Columbia.⁶ A goal of the ACA is to provide more Americans with access to affordable health care by, for example, providing financial assistance through insurance affordability programs for people who could not afford insurance without it.

Health Insurance Marketplaces

The three types of marketplaces operational as of October 1, 2013, were the Federal, State, and State-partnership marketplaces:

- **Federal marketplace:** The Department of Health and Human Services (HHS) operates the Federal marketplace in States that did not establish their own marketplaces. Individuals in these States enroll in QHPs through the Federal marketplace.
- **State marketplace:** A State may establish and operate its own marketplace. A State marketplace may use Federal services (e.g., the system that provides Federal data) to assist with certain functions, such as eligibility determinations for insurance affordability programs.
- **State-partnership marketplace:** A State may establish a State-partnership marketplace, in which HHS and a State share responsibilities for core functions. For example, HHS may perform certain functions, such as eligibility determinations, and the State may perform other functions, such as insurance plan management and consumer outreach. A key distinction between a State-partnership and State marketplace is that the former uses the Federal marketplace Web site (HealthCare.gov) to enroll individuals in QHPs, and the latter uses its own Web site for that purpose.

As of October 1, 2013, 36 States, including 7 State-partnership marketplaces, used the Federal marketplace, and 15 States, including the District of Columbia, had established State marketplaces. During our audit period, these were the types of marketplaces approved by the Centers for Medicare & Medicaid Services (CMS).

⁶ Each State can have an individual marketplace and a Small Business Health Options Program (SHOP) marketplace, which enables small businesses to access health coverage for their employees. This report does not cover applicants who enrolled in QHPs through New York's SHOP marketplace.

Qualified Health Plans and Insurance Affordability Programs

Qualified Health Plans

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

Insurance Affordability Programs: Premium Tax Credit and Cost-Sharing Reductions

The ACA provides for two types of insurance affordability programs to lower individuals’ insurance premiums or out-of-pocket costs for QHPs: the premium tax credit and cost-sharing reductions.⁸

- **Premium tax credit:** The premium tax credit reduces the cost of a QHP’s premium and is available at tax filing time or in advance. Generally, the premium tax credit is available on a sliding scale to an individual or a family with annual household income from 100 percent through 400 percent of the Federal poverty level. When paid in advance, the credit is referred to as the “advance premium tax credit” (APTC).⁹ The Federal Government pays the APTC amount monthly to the QHP issuer on behalf of the taxpayer to offset a portion of the cost of the premium of any metal-level plan. For example, if an individual who selects a QHP with a \$500 monthly insurance premium qualifies for a \$400 monthly APTC (and chooses to use it all), the individual pays only \$100 to the QHP issuer. The Federal Government pays the remaining \$400 to the QHP issuer. Starting in January 2015, taxpayers were required to include on their calendar year (CY) 2014 tax returns (and subsequent years’ tax returns) the amount of any APTC made on their behalf. The IRS reconciles the APTC payments with the maximum allowable amount of the credit.
- **Cost-sharing reductions:** Cost-sharing reductions help qualifying individuals with out-of-pocket costs, such as deductibles, coinsurance, and copayments.¹⁰ For example, an individual who visits a physician may be responsible for a \$30 copayment. If the individual qualifies for a cost-sharing reduction of \$20 for the copayment, the individual

⁷ An individual who is under 30 years old or qualifies for a hardship exemption may also choose a catastrophic plan, which requires the individual to pay all of his or her medical expenses until the deductible amount is met (ACA § 1302(e) and 45 CFR §§ 156.155 and 156.440).

⁸ We did not review other types of insurance affordability programs, such as Medicaid and CHIP. An individual or a family with income below 100 percent of the Federal poverty level may be eligible for Medicaid under the State’s Medicaid rules but would not qualify for the premium tax credit or cost-sharing reductions.

⁹ ACA § 1401 and 45 CFR § 155.20.

¹⁰ ACA § 1402 and 45 CFR § 155.20.

pays only \$10. In most cases, an individual must select a silver-level QHP to qualify for cost-sharing reductions. Generally, cost-sharing reductions are available to an individual or a family with annual household income from 100 percent through 250 percent of the Federal poverty level. The Federal Government makes monthly payments to QHP issuers to cover estimated costs of cost-sharing reductions provided to individuals. At the end of each year, HHS plans to reconcile the total amount of estimated payments of cost-sharing reductions made to QHP issuers with the actual costs of cost-sharing reductions incurred.¹¹

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

Federal Eligibility Requirements for Qualified Health Plans and Insurance Affordability Programs

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

- be a U.S. citizen, a U.S. national, or lawfully present in the United States;¹²
- not be incarcerated;¹³ and
- meet applicable residency standards.¹⁴

To be eligible for insurance affordability programs, an individual must meet additional requirements for annual household income.¹⁵

Additionally, an individual is not eligible for these programs if he or she is eligible for minimum essential coverage that is not offered through a marketplace.¹⁶

¹¹ CMS issued guidance to delay reconciliation of cost-sharing reductions provided in CY 2014 and will reconcile 2014 cost-sharing reductions for all issuers beginning in April 2016 (Timing of Reconciliations of Cost-Sharing Reductions for the 2014 Benefit Year (February 13, 2015)).

¹² An individual may be considered “lawfully present” if his or her immigration status meets any of the categories defined in 45 CFR § 152.2.

¹³ An individual must not be incarcerated, other than incarceration pending the disposition of charges (45 CFR § 155.305(a)(2)).

¹⁴ ACA §§ 1312(f) and 1411(b) and 45 CFR § 155.305(a)(3).

¹⁵ ACA §§ 1401 and 1402 and 45 CFR §§ 155.305(f) and (g).

¹⁶ 45 CFR § 155.20 and 26 U.S.C. § 5000A(f). Minimum essential coverage consists of employer-sponsored and non-employer-sponsored insurance (ESI). For the purpose of this report, we use the term “non-ESI” to include Government-sponsored programs (e.g., Medicare, Medicaid, TRICARE, and Peace Corps), grandfathered plans, and other plans.

To determine an individual’s eligibility for enrollment in a QHP and for insurance affordability programs, marketplaces verify information submitted by the applicant using available electronic data sources. Through this verification process, marketplaces can determine whether the applicant’s information matches information from available electronic data sources in accordance with certain Federal requirements

Marketplaces must verify the following, as appropriate, when determining eligibility for QHPs and insurance affordability programs:

- Social Security number,
- citizenship,
- status as a national,¹⁷
- lawful presence,
- incarceration status (e.g., whether an individual is serving a term in prison or jail),
- residency,
- whether an individual is an Indian,¹⁸
- family size,
- annual household income,
- eligibility for minimum essential coverage through ESI, and
- eligibility for minimum essential coverage through non-ESI.¹⁹

¹⁷ The term “national” may refer to a person who, though not a citizen of the United States, owes permanent allegiance to the United States. All U.S. citizens are U.S. nationals, but only a relatively small number of people acquire U.S. nationality without becoming U.S. citizens (8 U.S.C. § 1101(a)).

¹⁸ “Indian” is defined as an individual who meets the definition in section 4(d) of the Indian Self-Determination and Education Assistance Act (ISDEAA), P.L. No. 93-638. Under section 4(d), “Indian” is a person who is a member of an Indian tribe. The ISDEAA defines “Indian tribes” as “any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act, which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians” (25 U.S.C. § 450b(e)).

¹⁹ 45 CFR §§ 155.315 and 155.320.

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

An applicant²⁰ may submit an application to enroll in a QHP during an open enrollment period. An applicant may also enroll in a QHP during a special enrollment period outside of the open enrollment period if the applicant experiences certain life changes, such as marriage or the birth of a child.²¹ For insurance coverage effective in CY 2014, the New York marketplace's open enrollment period was October 1, 2013, through March 31, 2014.²²

To enroll in a QHP, an applicant must complete an application and meet eligibility requirements defined by the ACA. An applicant can enroll in a QHP through the Federal or a State marketplace, depending on the applicant's State of residence. Applicants can enroll through a Web site, by phone, by mail, in person, or directly with a QHP issuer's broker or agent.

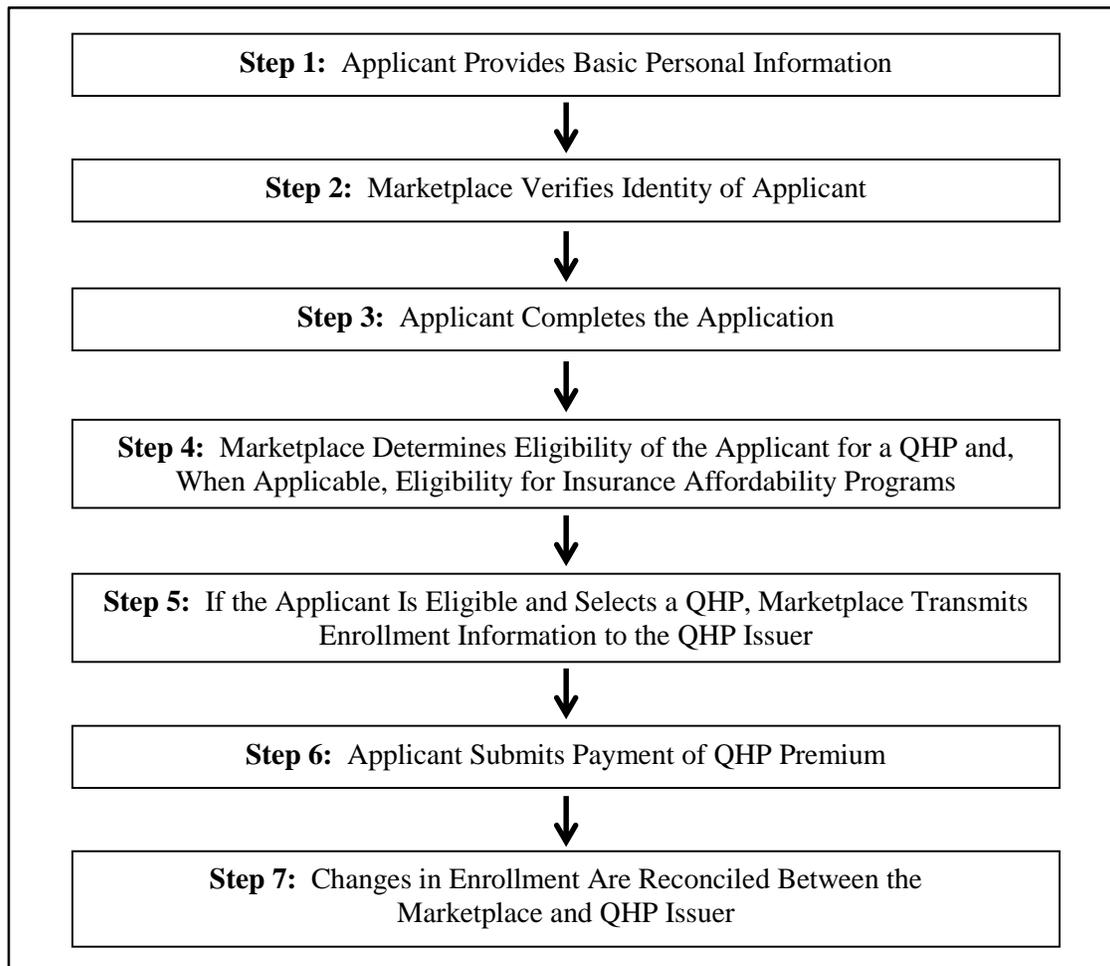
The figure on the following page shows a summary of the steps in the application and enrollment process, and the sections that follow describe in more detail the key steps in the process.

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

²¹ ACA § 1311(c)(6)(C) and 45 CFR § 155.420.

²² The New York marketplace created a special enrollment period to allow an applicant to finish the application and enrollment process by April 15, 2014. The special enrollment period was open to applicants who started their applications by March 31, 2014, and could not complete them because of high consumer traffic on the marketplace's Web site.

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



Verification of Applicant's Identity (Figure: Steps 1 through 3)

An applicant begins the enrollment process in a QHP by providing basic personal information, such as name, birth date, and Social Security number. Before an applicant can submit an online or phone application, the marketplace must verify the applicant's identity through identity proofing. The purpose of identity proofing is to (1) prevent an unauthorized individual from creating a marketplace account for another individual and applying for health coverage without the individual's knowledge and (2) safeguard personally identifiable information created, collected, and used by the marketplace. For paper applications, the marketplace requires the applicant's signature before the marketplace processes the application.²³

²³ CMS's *Guidance Regarding Identity Proofing for the Marketplace, Medicaid, and CHIP, and the Disclosure of Certain Data Obtained through the Data Services Hub*, (Identity-Proofing Guidance), June 11, 2013.

When an applicant completes any type of application, the applicant attests that answers to all questions are true and that the applicant is subject to the penalty of perjury.²⁴

Verification of Applicant's Eligibility (Figure: Step 4)

After reviewing the applicant's information, the marketplace determines whether the applicant is eligible for a QHP and, when applicable, eligible for insurance affordability programs.²⁵ To verify information submitted by the applicant, the marketplace uses multiple electronic data sources, including sources available through the Federal Data Services Hub (Data Hub).²⁶ The Data Hub is a single conduit for marketplaces to send electronic data to and receive electronic data from multiple Federal agencies; it does not store data. Federal agencies connected to the Data Hub are HHS, the Social Security Administration (SSA), the U.S. Department of Homeland Security, and the IRS, among others (ACA § 1411(c)).²⁷ The marketplace can also verify an applicant's eligibility for ESI through Federal employment with the U.S. Office of Personnel Management (OPM) through the Data Hub.

Resolution of Inconsistencies in Applicant Information (Figure: Step 4)

Generally, when a marketplace cannot verify information that the applicant submitted or the information is inconsistent with information available through the Data Hub or other sources, the marketplace must attempt to resolve the inconsistencies. For these purposes, applicant information is considered to be consistent with information from other sources if it is reasonably compatible.²⁸ Information is considered reasonably compatible if any difference between the applicant information and that from other sources does not affect the eligibility of the applicant. Inconsistencies do not necessarily indicate that an applicant provided inaccurate information or is enrolled in a QHP or receiving financial assistance through insurance affordability programs inappropriately.

A marketplace must make a reasonable effort to identify and address the causes of an inconsistency by contacting the applicant to confirm the accuracy of the information on the application. If the marketplace is unable to resolve the inconsistency through reasonable efforts, it must generally provide the applicant 90 days to submit satisfactory documentation or

²⁴ Any person who fails to provide correct information may be subject to a civil monetary penalty (ACA § 1411(h)).

²⁵ An applicant can apply for enrollment in a QHP without applying for insurance affordability programs.

²⁶ State marketplaces can access additional sources of data to verify applicant information. For example, the New York marketplace uses State wage reporting and unemployment insurance benefits data to verify annual household income.

²⁷ See Appendix A for information on the New York marketplace's eligibility verification process for applicants' annual household income and eligibility for minimum essential coverage through employer-sponsored and non-ESI.

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

otherwise resolve the inconsistency. (This 90-day period is referred to as “the inconsistency period.”)²⁹ The marketplace may extend the inconsistency period if the applicant demonstrates that a good-faith effort has been made to obtain required documentation.³⁰

During the inconsistency period, the applicant may still enroll in a QHP and, when applicable, may choose to receive the APTC and cost-sharing reductions.³¹ An applicant may choose to enroll during the period only if the applicant is otherwise eligible to enroll in a QHP and may receive the APTC and cost-sharing reductions if (1) the applicant meets other eligibility requirements and (2) the tax filer³² attests that he or she understands that the APTC is subject to reconciliation.³³ After the inconsistency period, if the marketplace is unable to resolve the inconsistency, it determines the applicant’s eligibility on the basis of available data sources and, in certain circumstances, the applicant’s attestation.³⁴ For example, if the marketplace is unable to resolve an inconsistency related to citizenship, it should determine the applicant ineligible for a QHP and terminate the applicant’s enrollment from the QHP if the applicant is already enrolled.

For more information on how marketplaces may resolve inconsistencies, see Appendix B. For specific information on the New York marketplace’s inconsistency resolution process, see Appendix C.

Transmission of Applicant’s Enrollment Information to the Qualified Health Plan Issuer (Figure: Steps 5 through 7)

If an applicant is determined to be eligible and selects a QHP, a marketplace transmits enrollment information to the QHP issuer (45 CFR § 155.400). Generally, an applicant must pay the first month’s QHP premium for the insurance coverage to be effective. If a change to the enrollee’s³⁵ coverage occurs after the coverage becomes effective, the marketplace and the QHP issuer must reconcile the revised enrollment records (45 CFR § 155.400).

²⁹ 45 CFR § 155.315(f).

³⁰ 45 CFR § 155.315(f)(3).

³¹ 45 CFR § 155.315(f)(4).

³² Generally, a “tax filer” is an individual or a married couple who indicate that they are filing an income tax return for the benefit year (45 CFR § 155.300(a)).

³³ 45 CFR § 155.315(f)(4).

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

³⁵ For the purpose of this report, the term “enrollee” refers to an applicant who completed an application, was determined eligible, and selected a QHP and whose enrollment information was sent to a QHP issuer.

CMS's Oversight of Marketplaces

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

The New York State Marketplace

On April 12, 2012, Governor Andrew M. Cuomo issued Executive Order No. 42. The executive order established a marketplace within the New York Department of Health (DOH) and directed DOH to work with the Department of Financial Services and other State agencies to create the marketplace and carry out requirements of the ACA.

New York contracted the development and operation of the marketplace eligibility and enrollment system to Computer Sciences Corporation. As part of this system, the marketplace performed eligibility determinations for the APTC and cost-sharing reductions.

HOW WE CONDUCTED THIS REVIEW

We reviewed the internal controls that were in place at the New York marketplace during the open enrollment period for insurance coverage effective in CY 2014 (October 1, 2013, through March 31, 2014). We performed an internal control review because it enabled us to evaluate the effectiveness and efficiency of the New York marketplace's operations and compliance with applicable Federal requirements. Appendix D provides general information on internal controls.

We limited our review to those internal controls related to (1) verifying applicants' identities, (2) determining applicants' eligibility for enrollment in QHPs and eligibility for insurance affordability programs, and (3) maintaining and updating eligibility and enrollment data. To determine the effectiveness of the internal controls, we:

- reviewed a sample of 45 applicants randomly selected from applicants who were determined eligible for QHPs during the open enrollment period (a total of 379,932 applicants), which included the review of supporting documentation to evaluate whether the marketplace determined the applicants' eligibility in accordance with Federal requirements, and
- performed other audit procedures, which included interviews with marketplace management, staff, and contractors; observation of staff performing tasks related to eligibility determinations; and reviews of supporting documentation and enrollment records.

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

³⁷ ACA § 1313 and 45 CFR §§ 155.110 and 155.1200.

Because our review was designed to provide only reasonable assurance that the internal controls we reviewed were effective, it would not necessarily have detected all internal control deficiencies.

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

Although the first open enrollment period for applicants to enroll in QHPs ended on March 31, 2014, an applicant could also have enrolled in a QHP during a special enrollment period if the applicant experienced certain life changes, such as marriage or the birth of a child. We did not review the New York marketplace's determinations of applicants' eligibility that resulted from changes in applicant information reported by applicants after March 31, 2014.

We performed fieldwork from June through December 2014 at the New York marketplace offices in New York, New York. We also performed fieldwork at selected marketplace contractor offices in Albany, New York.

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

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

FINDINGS

Not all of the New York marketplace's internal controls were effective in ensuring that individuals were enrolled in QHPs according to Federal requirements.

On the basis of our review of 45 sample applicants from the enrollment period for insurance coverage effective in CY 2014, we determined that certain internal controls were effective, such as the controls for verifying the applicant's Social Security number through SSA. However, the internal controls were not always effective for:

- verifying annual household income,

- resolving inconsistencies in eligibility data, and
- verifying eligibility for minimum essential coverage through ESI by obtaining information from OPM and SHOP and ensuring that insurance affordability programs were authorized only for individuals who do not have ESI.

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

The deficiencies that we identified occurred because the New York marketplace did not (1) design its eligibility and enrollment system to always verify annual household income properly, (2) use existing system functionality to resolve inconsistencies in eligibility data, and (3) ensure that it follows requirements to verify applicants' eligibility for minimum essential coverage through ESI using OPM and SHOP data and ensure that applicants who are eligible for minimum essential coverage through ESI are not determined eligible for APTC and cost-sharing reductions.

THE NEW YORK MARKETPLACE DID NOT ALWAYS VERIFY ANNUAL HOUSEHOLD INCOME PROPERLY

Marketplaces use data from IRS to verify annual household income information provided on an application and may also use current wage information that is available electronically. If electronic data are unavailable or an applicant's attestation of projected annual household income is more than 10 percent below the annual household income as computed using electronic data sources, the marketplace must follow the inconsistency resolution process (45 CFR § 155.320(c)(3)).

The New York marketplace did not always verify applicants' annual household income properly. Specifically, for 3 of 28 sample applicants who were determined eligible for insurance affordability programs, the marketplace improperly determined that the applicant's annual household income was verified when the attested income was more than 10 percent below the annual household income as computed from available electronic data sources.

The New York marketplace failed to identify income inconsistencies because it did not design its eligibility and enrollment system to properly verify annual household income in certain circumstances. According to marketplace officials, the system contained defects that allowed verification of attested income that was not reasonably compatible with data sources. Marketplace officials stated that as of September 2014 the system defect had been partially corrected, and the marketplace continues to work toward fully correcting the defect. Without verifying an applicant's annual household income properly, the marketplace cannot ensure that the applicant meets eligibility requirements for insurance affordability programs and that the amounts of the APTC and cost-sharing reductions are determined correctly.

THE NEW YORK MARKETPLACE DID NOT ALWAYS RESOLVE INCONSISTENCIES IN ELIGIBILITY DATA

Marketplaces must make a reasonable effort to identify and address the causes of inconsistencies in eligibility data. If a marketplace is unable to resolve an inconsistency, it must notify the applicant of the inconsistency and generally must give the applicant 90 days from the date on which the notice was sent to either present satisfactory documentary evidence or otherwise resolve the inconsistency (45 CFR § 155.315(f)). The marketplace may extend the inconsistency period when an applicant demonstrates a good-faith effort to obtain sufficient documentation to resolve the inconsistency (45 CFR § 155.315(f)(3)). During the inconsistency period, an applicant who is otherwise qualified is eligible to enroll in a QHP and, when applicable, eligible for insurance affordability programs (45 CFR § 155.315(f)(4)). After the inconsistency period, if the marketplace is unable to resolve the inconsistency, it determines the applicant's eligibility on the basis of available data sources and, in certain circumstances, the applicant's attestation (45 CFR §§ 155.315(f)(5), (f)(6), and (g)).

The New York marketplace did not always resolve inconsistencies in applicants' eligibility data. Specifically, for five of seven sample applicants who had inconsistencies in their eligibility data (as it related to citizenship, income, and incarceration status), the marketplace did not resolve the inconsistencies. For example, on December 13, 2013, the marketplace determined that an applicant was eligible for a QHP and the APTC and notified the applicant of an inconsistency related to annual household income. The marketplace requested that the applicant provide supporting documentation; however, the applicant did not provide any documentation to resolve the inconsistency by March 18, 2014, which was the end of the inconsistency period. After that date, the marketplace allowed the applicant to remain enrolled in the QHP and eligible to receive the APTC rather than follow its inconsistency resolution process by redetermining the applicant's eligibility using available data sources.

The marketplace did not use existing system functionality to resolve all inconsistencies in eligibility data. According to marketplace officials, the system functionality for determining eligibility using available data sources after the inconsistency period was not activated because of potential errors in notices sent to applicants.³⁸ Without resolving inconsistencies in an applicant's eligibility data, the marketplace cannot ensure that the applicant meets each of the eligibility requirements for enrollment in a QHP and, when applicable, for insurance affordability programs.

THE NEW YORK MARKETPLACE DID NOT ALWAYS PROPERLY DETERMINE ELIGIBILITY FOR INSURANCE AFFORDABILITY PROGRAMS

To be eligible for insurance affordability programs, an applicant must not be eligible for minimum essential coverage, with the exception of coverage in the individual market (45 CFR §§ 155.305(f)(1)(ii)(B), (g)(1)(i)(B))). Federal regulations define minimum essential coverage as having the meaning given in 26 U.S.C. § 5000A(f) (45 CFR § 155.20). As described in

³⁸ Marketplace officials stated that the functionality to resolve inconsistencies was activated on November 1, 2014.

26 U.S.C. § 5000A(f), specified government-sponsored programs, eligible employer-sponsored plans, grandfathered health plans, and certain other health benefits coverage are minimum essential coverage (26 CFR § 1.36B-2(c)).

The marketplace must verify whether an applicant reasonably expects to be enrolled in or is eligible for minimum essential coverage in an eligible employer-sponsored plan for the benefit year for which coverage is requested (45 CFR § 155.320(d)(1)). This includes verifying whether the applicant has coverage through Federal employment by transmitting identifying information through the Data Hub (45 CFR § 155.320(d)(2)(ii)) and obtaining available data from New York's SHOP (45 CFR § 155.320(d)(2)(iii)). Generally, the marketplace must verify ESI coverage through Federal employment by obtaining information from OPM.

During the audit period, the New York marketplace did not verify through electronic data sources whether an applicant was eligible for minimum essential coverage through ESI. For 27 of 28 sample applicants who were determined eligible for insurance affordability programs, the New York marketplace relied on applicants' attestations for ESI and did not obtain information from OPM to verify ESI coverage through Federal employment or check whether individuals were enrolled in New York's SHOP.

In addition, for 1 of the 28 sample applicants, the New York marketplace determined the applicant eligible for APTC even though the applicant attested to being eligible for minimum essential coverage through ESI.

The marketplace did not ensure that it followed requirements to verify applicants' eligibility for minimum essential coverage through ESI using OPM and SHOP data. According to marketplace officials, this occurred because they did not have the resources or capacity to include every eligibility check in time for open enrollment. Marketplace officials stated that although they do not check whether applicants have an ESI record using the OPM data, that review remains on their agenda. In addition, as of mid-April 2014, the marketplace has been verifying whether applicants had an ESI record in SHOP. Without verifying whether applicants have coverage through Federal employment or are enrolled in its SHOP, the New York marketplace did not ensure that every applicant met each of the eligibility requirements for the APTC and cost-sharing reductions.

RECOMMENDATIONS

We recommend that the New York marketplace:

- modify its eligibility and enrollment system to always verify annual household income properly,
- use existing system functionality to resolve inconsistencies in eligibility data, and
- ensure that it follows requirements to verify applicants' eligibility for minimum essential coverage through ESI using OPM and SHOP data and ensure that applicants who are eligible for minimum essential coverage through ESI are not determined eligible for APTC and cost-sharing reductions.

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

**DEPARTMENT OF HEALTH COMMENTS AND
OFFICE OF INSPECTOR GENERAL RESPONSE**

In written comments on our draft report, DOH, on behalf of the New York marketplace, concurred with our recommendations. Specifically, DOH provided details about corrective actions that have been or soon will be implemented by the New York marketplace. In addition, DOH indicated that the New York marketplace has redetermined the eligibility of applicants included in our report. DOH also provided technical comments on our draft report, which we addressed. DOH's comments appear in their entirety as Appendix G.

APPENDIX A: THE NEW YORK MARKETPLACE'S PROCESS FOR VERIFYING ANNUAL HOUSEHOLD INCOME AND ELIGIBILITY FOR MINIMUM ESSENTIAL COVERAGE THROUGH EMPLOYER-SPONSORED AND NON-EMPLOYER-SPONSORED INSURANCE

The following describes how the New York marketplace used data on annual household income and eligibility for minimum essential coverage through employer-sponsored and non-ESI to determine eligibility for the APTC and cost-sharing reductions.

ANNUAL HOUSEHOLD INCOME

1. An applicant applies for financial assistance.
2. The applicant enters projected annual household income on an application (attested income).
3. If the applicant indicates that his or her projected annual income is close to that listed on the applicant's last tax return, the marketplace compares the attested income with data available from IRS and SSA.
 - If the attested income is lower than the income reflected in IRS and SSA data but is within 10 percent of the amount from those sources, the attested income is considered verified.
 - If the attested income is higher than the income reflected in IRS and SSA data, the attested income is considered verified.
 - If the attested income is lower than the income reflected in IRS and SSA data by more than 10 percent, the applicant is asked to submit his or her modified adjusted gross income, which is then verified against other data sources maintained by State agencies (e.g., State wage reporting data and unemployment insurance benefits).
 - If the attested income is above the Medicaid threshold and above other data source amounts, income is verified. If the other data source amounts are above the attested income by less than 10 percent, income is verified.
 - If the attested income is above the Medicaid threshold but more than 10 percent below the data source, the applicant is given an opportunity to provide a reasonable explanation of the discrepancy. If the reasonable explanation is acceptable (e.g., work hours reduced), income is verified on the basis of the

explanation. If the explanation is not acceptable, the marketplace starts an inconsistency period.³⁹

4. During the inconsistency period, the applicant is granted eligibility for the APTC and cost-sharing reductions on the basis of the attested income.
5. If the applicant submits acceptable supporting documentation (e.g., copies of Form W-2) reflecting that household income is within 10 percent of the attested income, the marketplace determines that the attested income is verified.
6. If the applicant does not submit the requested documentation within the specified timeframe, the marketplace determines the applicant's eligibility for the APTC and cost-sharing reductions on the basis of data available from IRS and SSA. If the data are unavailable from these sources, the marketplace discontinues any APTC and cost-sharing reductions.

ELIGIBILITY FOR MINIMUM ESSENTIAL COVERAGE THROUGH EMPLOYER-SPONSORED INSURANCE

1. An applicant applies for financial assistance.
2. The applicant attests that he or she is eligible (or will be eligible during the coverage year) for health insurance through a job, even if it is from a job held by another person, such as a spouse. The applicant states "Yes" or "No" on the application.
3. The marketplace relies on applicants' attestations for ESI and does not check for ESI based on Federal employment by transmitting identifying information to HHS for necessary verification.

ELIGIBILITY FOR MINIMUM ESSENTIAL COVERAGE THROUGH NON-EMPLOYER-SPONSORED INSURANCE

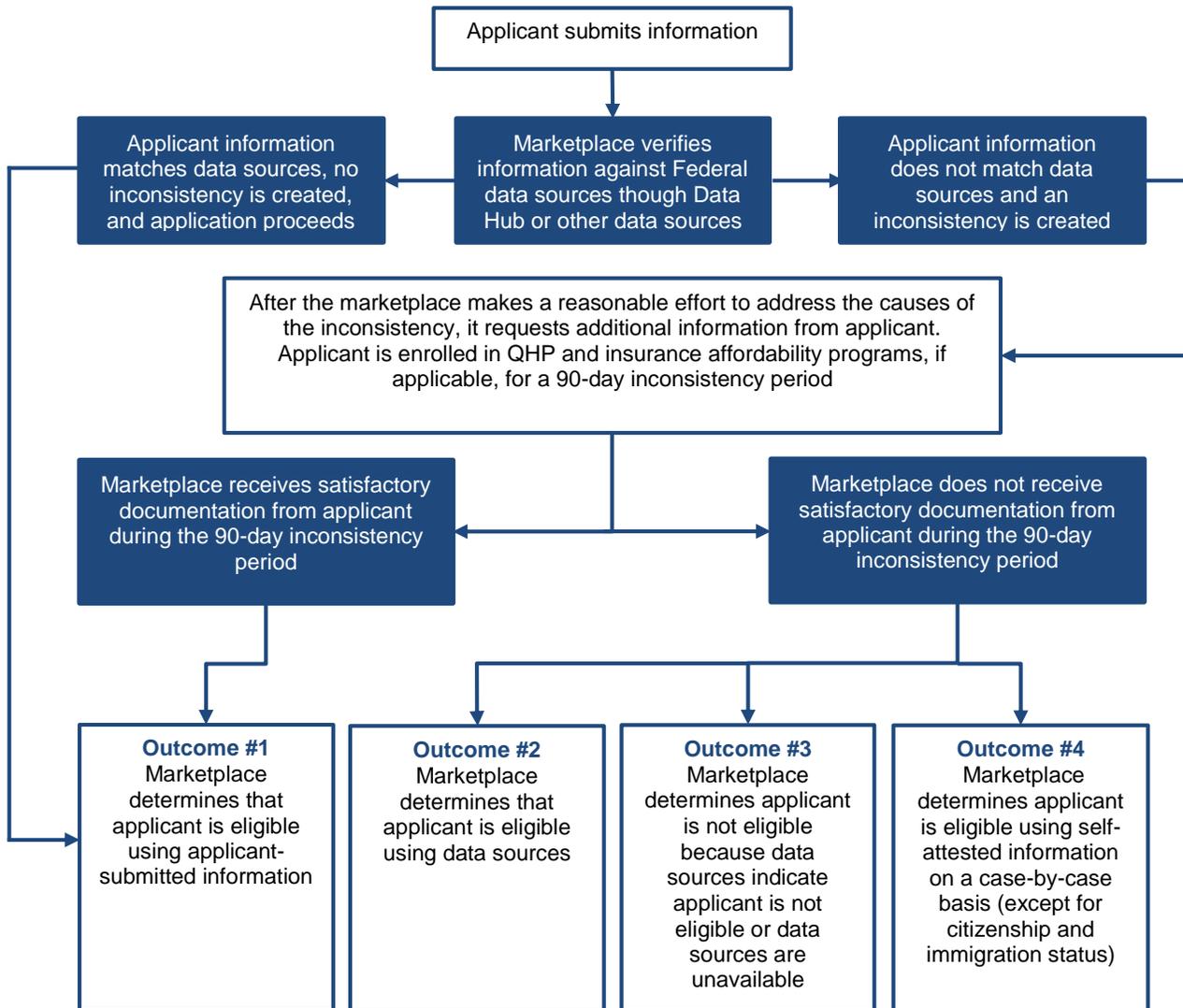
1. An applicant applies for financial assistance.
2. The marketplace uses available data sources to verify whether an applicant is eligible for non-ESI. The marketplace presents data from the Data Hub⁴⁰, and from State sources (for Medicaid and CHIP), to an applicant to confirm whether the applicant is eligible for non-ESI.

³⁹ The New York marketplace failed to identify income inconsistencies for three sample applicants in our review because it did not design its eligibility and enrollment system to properly verify annual household income in certain circumstances.

⁴⁰ The Data Hub checks data from Medicare, the Peace Corps, TRICARE, and the Veterans Health Administration as part of the non-employer-sponsored insurance verification. The ACA defines insurance coverage provided under the Peace Corps for volunteers and TRICARE for military sponsors and their families as non-employer-sponsored insurance in accordance with 26 U.S.C. § 5000A(f).

3. If the applicant agrees with the data from available data sources, the marketplace accepts the attestation and determines that the applicant is ineligible for APTC and cost-sharing reductions.
4. If the applicant disagrees with the data from available data sources, the marketplace asks the applicant for documentation supporting his or her attestation. During this time, the marketplace may determine the applicant ineligible or temporarily eligible for APTC and cost-sharing reductions or for enrollment in a QHP. The documentation from the applicant should substantiate that the applicant is not eligible for non-ESI or that coverage has ended.
5. If the applicant submits acceptable documentation showing that he or she is not eligible for non-ESI, the marketplace determines the applicant to be eligible for APTC and cost-sharing reductions.
6. If the applicant does not submit the requested documentation within the specified timeframe, the marketplace determines the applicant to be ineligible for APTC and cost-sharing reductions on the basis of data obtained from the Data Hub or State sources.

APPENDIX B: STEPS AND OUTCOMES FOR RESOLVING INCONSISTENCIES



APPENDIX C: THE NEW YORK MARKETPLACE'S INCONSISTENCY RESOLUTION PROCESS

Inconsistencies are generated when an applicant's attested information cannot be verified through electronic data sources. For attested information related to residency and family size, the marketplace accepts the applicant's attestation without further verification unless contradicted by information in possession of the marketplace. The following describes the steps in the New York marketplace's inconsistency resolution process:

1. If the applicant's attested information cannot be verified through electronic data sources, the marketplace sends a letter to the applicant requesting an explanation or supporting documentation to resolve the inconsistency. The applicant is given 90 days from the date of the initial eligibility determination shown in the letter to provide the requested documentation. During the inconsistency period, the applicant may still enroll in a QHP and, when applicable, may choose to receive the APTC and cost-sharing reductions. An applicant may choose to enroll during the period only if the applicant is otherwise eligible to enroll in a QHP and may receive the APTC and cost-sharing reductions if (1) the applicant meets other eligibility requirements and (2) the tax filer attests that he or she understands that the APTC is subject to reconciliation. An applicant can provide the explanation or documentation by mail or upload the documentation through the marketplace Web site.
2. If the applicant does not provide any explanation or supporting documentation by the end of the 90-day inconsistency period, the marketplace determines the applicant's eligibility on the basis of data available from electronic data sources and the inconsistency is resolved. If no data are available from electronic sources, the applicant's enrollment may be terminated or the applicant may be determined ineligible for the APTC and cost-sharing reductions, as appropriate.
3. If the applicant provides documentation to support the attested information, the inconsistency is resolved.
4. If the applicant provides supporting documentation that is not sufficient to support the attested information, the inconsistency is considered unresolved. The marketplace sends a letter to the applicant indicating that the documentation was insufficient and requesting that the applicant provide sufficient supporting documentation by the end of the original 90-day inconsistency period.⁴¹ If the applicant provides sufficient supporting documentation by the due date, the inconsistency is resolved. If the supporting documentation does not resolve the inconsistency or the applicant does not provide any documentation, the marketplace determines the applicant's eligibility on the basis of data from electronic sources.

⁴¹ According to New York officials, the New York marketplace may extend the inconsistency period by 15 days when an applicant demonstrates a good-faith effort to obtain sufficient documentation to resolve the inconsistency.

APPENDIX D: OVERVIEW OF INTERNAL CONTROLS

INTERNAL CONTROLS IN THE GOVERNMENT⁴²

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

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

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

FIVE COMPONENTS OF INTERNAL CONTROL⁴³

Internal control consists of five interrelated components:

- **Control Environment:** The standards and processes that provide the foundation for carrying out internal control across the organization. The control environment includes factors such as the organizational structure, assignment of authority and responsibilities, and ethical values.
- **Risk Assessment:** The process for identifying and evaluating risks to achieve objectives.
- **Control Activities:** The actions established through policies and procedures to help ensure that management's directives to reduce risks are carried out. These activities include authorizations and approvals, verifications, and reconciliations.
- **Information and Communication:** Use of relevant and quality information to support the functioning of other internal control components. Through communication, management conveys, shares, and obtains necessary information.
- **Monitoring:** Ongoing or separate evaluations, or both, to ascertain whether the components are present and functioning.

⁴² Government Accountability Office's *Standards for Internal Control in the Federal Government: 1999* (known as the Green Book) and *Government Auditing Standards: 2011 Revision*. The Green Book was revised in September 2014, which was after our audit period.

⁴³ Committee of Sponsoring Organizations of the Treadway Commission: *Internal Control – Integrated Framework*, Executive Summary (May 2013).

APPENDIX E: AUDIT SCOPE AND METHODOLOGY

SCOPE

We reviewed the internal controls that were in place at the New York marketplace during the open enrollment period for insurance coverage effective in CY 2014 (October 1, 2013, through March 31, 2014). Internal controls are intended to provide reasonable assurance that an organization's objectives are being achieved, including effectiveness and efficiency of operations and compliance with applicable laws and regulations. We performed an internal control review because it enabled us to evaluate the effectiveness and efficiency of the New York marketplace's operations and compliance with applicable Federal requirements.

We limited our review to those internal controls related to (1) verifying applicants' identities, (2) determining applicants' eligibility for enrollment in QHPs and eligibility for insurance affordability programs, and (3) maintaining and updating eligibility and enrollment data. In our review, we focused on control activities, which is one of the five components of internal controls as described in Appendix D.

To determine the effectiveness of the internal controls, we:

- reviewed a sample of 45 applicants randomly selected from applicants who were enrolled in QHPs during the open enrollment period (a total of 379,932 applicants) which included the review of supporting documentation to evaluate whether the marketplace determined the applicants' eligibility in accordance with Federal requirements, and
- performed other audit procedures, which included interviews with marketplace management, staff, and contractors; observation of staff performing tasks related to eligibility determinations; and reviews of supporting documentation and enrollment records.

Because our review was designed to provide only reasonable assurance that the internal controls we reviewed were effective, it would not necessarily have detected all internal control deficiencies.

Our attribute sampling approach is commonly used to test the effectiveness of internal controls for compliance with laws, regulations, and policies. According to the Government Accountability Office and the President's Council on Integrity and Efficiency's⁴⁴ *Financial Audit Manual* (July 2008), section 450, auditors may use a randomly selected sample of 45 items when testing internal controls. If all sample items are determined to be in compliance with requirements, a conclusion that the controls are effective can be made. If one or more sample items are determined not to be in compliance with requirements, a conclusion that the controls are ineffective can be made. Because our objective was limited to forming an opinion about whether the New York marketplace's internal controls were effective, our sampling methodology

⁴⁴ The President's Council on Integrity and Efficiency is now called the Council of the Inspectors General on Integrity and Efficiency (Inspector General Act § 11).

was not designed to estimate the percentage of applicants for whom the marketplace did not perform the required eligibility verifications.

Although the first open enrollment period for applicants to enroll in QHPs ended on March 31, 2014, an applicant could also have enrolled in a QHP during a special enrollment period if the applicant experienced certain life changes, such as marriage or the birth of a child. We did not review the New York marketplace's determinations of applicants' eligibility that resulted from changes in applicant information reported by applicants after March 31, 2014.

We performed fieldwork from June through December 2014 at the New York marketplace offices in New York, New York. We also performed fieldwork at selected marketplace contractor offices in Albany, NY.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State laws, regulations, and guidance;
- reviewed the Secretary of HHS's report on eligibility verifications for the APTCs and cost-sharing reductions (submitted to Congress on December 31, 2013);
- assessed internal controls by:
 - interviewing officials from the New York marketplace and their contractors and reviewing documentation provided by them to understand how the New York marketplace (1) verifies applicants' identities, (2) verifies information submitted on enrollment applications and makes eligibility determinations, and (3) maintains and updates eligibility and enrollment data;
 - observing marketplace staff performing tasks related to eligibility determinations; and
 - reviewing documents and records related to the marketplace's eligibility determinations, such as eligibility verification data;
- obtained enrollment records from the New York marketplace for 379,932 applicants who were determined eligible for QHPs during the open enrollment period;
- analyzed the enrollment records to obtain an understanding of information that was sent to QHP issuers;
- performed tests, such as matching records to the marketplace's enrollment system, to determine whether the enrollment data were reliable;

- performed testing of the New York marketplace’s internal controls for eligibility determinations by:
 - using the OIG, Office of Audit Services, statistical software to randomly select 45 applicants who were determined eligible for QHPs during the open enrollment period, and;
 - obtaining and reviewing eligibility data for each sample applicant to determine whether the marketplace performed the required eligibility verification and determination according to Federal requirements; and
- discussed the results of our review with New York marketplace officials.

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

APPENDIX F: DEPARTMENT OF HEALTH COMMENTS



**Department
of Health**

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

June 15, 2015

Mr. James P. Edert
Regional Inspector General for Audit Services
Department of Health and Human Services - Region II
Jacob Javitz Federal Building
26 Federal Plaza
New York, New York 10278

Ref. No: A-02-14-02020

Dear Mr. Edert:

Enclosed are the New York State Department of Health's comments on the United States Department of Health and Human Services, Office of Inspector General's Draft Audit Report A-02-14-02020 entitled, "Not All Internal Controls Implemented by the New York Marketplace Were Effective in Ensuring That Individuals Were Enrolled in Qualified Health Plans According to Federal Requirements."

Thank you for the opportunity to comment.

Sincerely,

Sally Dreslin

Sally Dreslin, M.S., R.N.
Executive Deputy Commissioner

Enclosure

cc: Donna Frescatore
Michael Nazarko
Lisa Sbrana
Danielle Holahan
Judith Arnold
Diane Farrell
Lori Conway

Empire State Plaza, Corning Tower, Albany, NY 12237 | health.ny.gov

**New York State Department of Health
Comments on the
Department of Health and Human Services
Office of Inspector General
Draft Audit Report A-02-14-02020 entitled
“Not All Internal Controls Implemented by the New York Marketplace
Were Effective in Ensuring That Individuals Were Enrolled in Qualified
Health Plans According to Federal Requirements”**

The following are the New York State Department of Health’s (Department) comments in response to the Department of Health and Human Services, Office of Inspector General (OIG) Draft Audit Report A-02-14-02020 entitled, “Not All Internal Controls Implemented by the New York Marketplace Were Effective in Ensuring That Individuals Were Enrolled in Qualified Health Plans According to Federal Requirements.”

General Comments:

While the Department concurs with the report’s three general recommendations – verify annual household income properly, use existing system functionality to resolve inconsistencies in eligibility data, and verify applicants’ eligibility for minimum essential coverage – we would like to clarify that system functions or modifications to address each of the identified issues were already implemented or developed prior to the audit. Further, as stated in the draft report, the cases cited by the audit do not necessarily mean that an applicant was improperly enrolled in a Qualified Health Plan or that the Marketplace improperly determined eligibility for insurance affordability programs.

The Department would also like to clarify several sections of the draft report:

- Page 17: The applicant applies for *‘financial assistance’*, not ‘advance premium tax credit (APTC) and cost sharing reductions’. The Marketplace operates an integrated eligibility system for all financial assistance programs, as well as for those seeking to purchase coverage without a subsidy.
- Page 17: The sentence that begins “If the other data source amounts are above the Medicaid level but more than...” needs to be replaced with “If attested income is above the Medicaid level but more than...”
- Page 21: For attested information related to residency and family size, the Marketplace accepts the applicant’s attestation without further verification unless contradicted by information in possession of the Marketplace.

In addition to the recommendations included below, the draft report also recommended that the marketplace redetermine, if necessary, the eligibility of applicants included in the report. Of the nine identified individuals, seven were correctly redetermined by the system and two are no longer seeking coverage. Two of the seven correctly redetermined by the system are pending implementation of the income clock, which is expected around July 2015.

Recommendation #1:

The New York marketplace should modify its eligibility and enrollment system to always verify annual household income properly.

Response #1

We agree that the eligibility and enrollment system should always verify annual household income properly. The system correctly generates a notice of inconsistency when a household attests to income at the APTC level that is more than a specified percentage below the income reported by trusted data sources without a reasonable explanation. In August 2014, additional system functionality was deployed to further ensure that temporary eligibility (with a documentation requirement) was established in such cases.

Recommendation #2:

The New York marketplace should use existing system functionality to resolve inconsistencies in eligibility data.

Response #2

We agree that existing system functionality should be used to resolve inconsistencies in eligibility data. Functionality including utilization of data from trusted federal and state data sources as outlined in the report, along with clocks, notice triggers and consumer notices, have already been or will soon be deployed to help resolve inconsistencies.

Recommendation #3:

The New York marketplace should ensure that it follows requirements to verify applicants' eligibility for minimum essential coverage through ESI using OPM and SHOP data and ensure that applicants who are eligible for minimum essential coverage through ESI are not determined eligible for APTC and cost-sharing reductions.

Response #3

We agree that the applicant's eligibility for minimum essential coverage (MEC) through Employer Sponsored Insurance (ESI) should be verified. Starting in April 2014, the system checks the Small Business Health Options Program's (SHOP) enrollment to verify that the applicant is not a covered employee of a small business that has enrolled through the state marketplace. The Marketplace plans to build and deploy a service to check for potential coverage with the Federal Office of Personnel Management in the event that a Federal employee who resides in NY applies for coverage through the state marketplace.