

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**NOT ALL OF THE DISTRICT OF  
COLUMBIA MARKETPLACE'S INTERNAL  
CONTROLS 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](mailto:Public.Affairs@oig.hhs.gov).*



Daniel R. Levinson  
Inspector General

February 2016  
A-03-14-03301

# *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 District of Columbia marketplace's internal controls were effective in ensuring that individuals were enrolled in qualified health plans according to Federal*

### 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 (the District). 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, the District and 14 States 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 District's Health Benefit Exchange (the District marketplace) 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 District 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 insurance (ESI) and non-employer-sponsored insurance (non-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 those available through the Federal Data Services Hub (Data Hub). Data sources available through the Data Hub are the U.S. Department of Health and Human Services, Social Security Administration (SSA), U.S. Department of Homeland Security, and Internal Revenue Service, among others. The marketplace can verify an applicant's eligibility for ESI through Federal employment by obtaining information from the U.S. Office of Personnel Management through the Data Hub.

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 give 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 District marketplace during the open enrollment period for insurance coverage effective in calendar year (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 District 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 (1) reviewed a sample of 45 applicants randomly selected from applicants who were determined eligible for QHPs during the open enrollment period (9,735 applicants), which included the review of supporting documentation to evaluate whether the marketplace determined the applicants' eligibility in accordance with Federal requirements, and (2) performed other audit procedures, which included interviews with marketplace management, staff, and contractors 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 District of Columbia marketplace's internal controls were effective in ensuring that individuals were enrolled in qualified health plans 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 applicants' citizenship status. However, the controls were not effective for:

- maintaining identity-proofing documentation,
- verifying annual household income,
- verifying an applicant's eligibility for minimum essential coverage (both ESI and non-ESI), and
- maintaining application and eligibility verification data.

The presence of an internal control deficiency does not necessarily mean that the District 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 District marketplace did not properly oversee the identity-proofing process and did not ensure that its eligibility system was always fully functional.

## **WHAT WE RECOMMEND**

We recommend that the District marketplace:

- maintain identity-proofing documentation for all applicants who apply for QHPs;
- verify annual household income in accordance with Federal requirements;
- maintain documentation demonstrating that it verified whether an applicant was eligible for minimum essential coverage; and
- ensure that its enrollment system maintains application, eligibility, and verification documentation, including all electronic eligibility verifications, from the Data Hub.

## **DISTRICT MARKETPLACE COMMENTS**

The District marketplace concurred with our findings. District marketplace officials did not specifically address our recommendations but detailed the steps they had taken, both before the start of our audit and as a result of our audit, to ensure that applicants were properly enrolled and that their enrollment would be properly documented.

**TABLE OF CONTENTS**

INTRODUCTION ..... 1

    Why We Did This Review ..... 1

    Objective ..... 1

    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 ..... 5

        CMS’s Oversight of Marketplaces ..... 10

        The District Marketplace ..... 10

    How We Conducted This Review ..... 10

FINDINGS ..... 11

    The District Marketplace Did Not Always Maintain Identity-Proofing Documentation .. 12

    The District Marketplace Did Not Always Verify Annual Household Income  
    According to Federal Requirements ..... 13

    The District Marketplace Did Not Maintain Documentation That It Verified Applicants’  
    Eligibility for Minimum Essential Coverage According to Federal Requirements ..... 14

    The District Marketplace Did Not Always Maintain Application and Eligibility  
    Verification Data ..... 15

        The District Marketplace Did Not Maintain Applicants’  
        Eligibility Verification Data ..... 16

        The District Marketplace Did Not Always Maintain Eligibility Verification  
        Data Regarding Applicants’ Incarceration Status ..... 16

RECOMMENDATIONS ..... 17

DISTRICT MARKETPLACE COMMENTS AND  
OFFICE OF INSPECTOR GENERAL RESPONSE ..... 17

    District Marketplace Comments ..... 17

    Office of Inspector General Response ..... 17

**APPENDIXES**

A: The District of Columbia Marketplace’s Process for Verifying Annual Household Income .....19

B: Steps and Outcomes for Resolving Inconsistencies.....21

C: The District of Columbia Marketplace’s Inconsistency Resolution Process .....22

D: Overview of Internal Controls .....23

E: Audit Scope and Methodology.....24

F: District Marketplace Comments .....27

## INTRODUCTION

### WHY WE DID THIS REVIEW

The Patient Protection and Affordable Care Act (ACA)<sup>1</sup> requires the establishment of a health insurance exchange (marketplace) in each State and the District of Columbia (the District). 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.<sup>2</sup> As of October 1, 2013, the District and 14 States 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).<sup>3</sup> This review of the District’s Health Benefit Exchange (the District marketplace) is part of an ongoing series of reviews of seven State marketplaces across the Nation.<sup>4</sup> 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 State marketplaces use the 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.<sup>5</sup>

### OBJECTIVE

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

---

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

<sup>2</sup> 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).

<sup>3</sup> 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).

<sup>4</sup> The other six State marketplaces we reviewed were Colorado, Kentucky, Minnesota, New York, Vermont, and Washington.

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

## 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. 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.<sup>6</sup> 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 cannot afford insurance without it.

### Health Insurance Marketplaces

The three types of marketplaces in operation 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, had established State marketplaces. During our audit period, these were the types of marketplaces approved by the Centers for Medicare & Medicaid Services (CMS).

---

<sup>6</sup> This report does not cover applicants who enrolled in QHPs through the District'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.<sup>7</sup> 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.<sup>8</sup>

- **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).<sup>9</sup> 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 (CSR) help qualifying individuals with out-of-pocket costs, such as deductibles, coinsurance, and copayments.<sup>10</sup> 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

---

<sup>7</sup> 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).

<sup>8</sup> 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.

<sup>9</sup> ACA § 1401 and 45 CFR § 155.20.

<sup>10</sup> ACA § 1402 and 45 CFR § 155.20.

individual 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.<sup>11</sup>

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;<sup>12</sup> not be incarcerated;<sup>13</sup> and meet applicable residency standards.<sup>14</sup>

To be eligible for insurance affordability programs, an individual must meet additional requirements for annual household income.<sup>15</sup> 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.<sup>16</sup>

To determine an individual's eligibility for enrollment in a QHP and for insurance affordability programs, the marketplaces verify the information submitted by the applicant using available electronic data sources. Through this verification process, the marketplaces can determine whether that applicant's information matches the 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:

---

<sup>11</sup> 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 Reconciliation of Cost-Sharing Reductions for the 2014 Benefit Year* (Feb. 13, 2015)).

<sup>12</sup> An individual may be considered "lawfully present" if his or her immigration status meets any of the categories defined in 45 CFR § 152.2.

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

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

<sup>15</sup> ACA §§ 1401 and 1402 and 45 CFR §§ 155.305(f) and (g).

<sup>16</sup> 45 CFR § 155.20 and 26 U.S.C. § 5000A(f). Minimum essential coverage consists of employer-sponsored insurance (ESI) and non-employer-sponsored insurance (non-ESI).

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

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

An applicant<sup>20</sup> 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

---

<sup>17</sup> 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)).

<sup>18</sup> “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), an “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)).

<sup>19</sup> 45 CFR §§ 155.315 and 155.320. 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.

<sup>20</sup> 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.

enrollment period if the applicant experiences certain life changes, such as marriage or the birth of a child.<sup>21</sup> For insurance coverage effective in CY 2014, the District marketplace open enrollment period was October 1, 2013, through March 31, 2014.<sup>22</sup>

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.

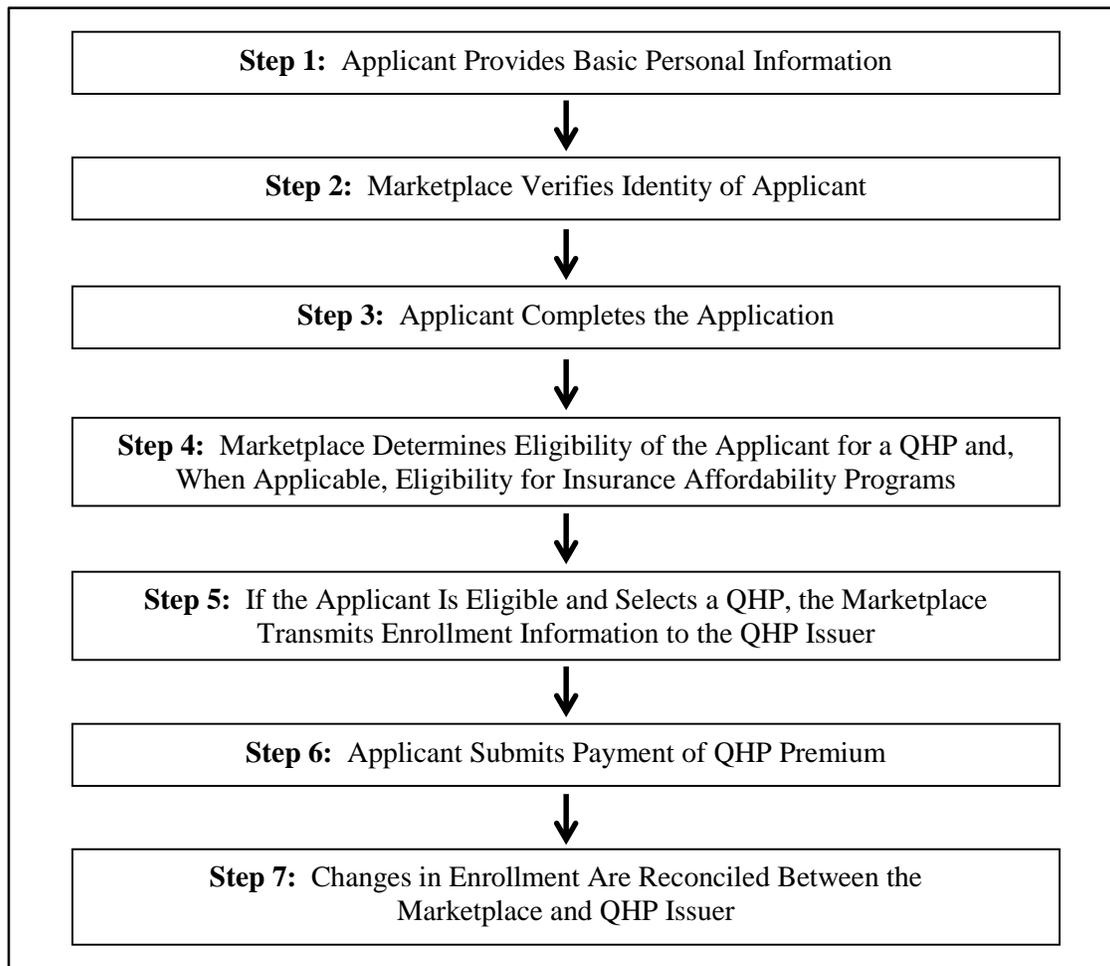
The figure on the following page summarizes the steps in the application and enrollment process, and the sections that follow describe the key steps in more detail.

---

<sup>21</sup> ACA § 1311(c)(6)(C) and 45 CFR § 155.420.

<sup>22</sup> The District marketplace created a special enrollment period to allow an applicant to finish the application and enrollment process by April 30, 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. These applicants had to enroll in a QHP by May 30, 2014.

**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.<sup>23</sup>

<sup>23</sup> 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 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.<sup>24</sup>

#### *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.<sup>25</sup> 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).<sup>26</sup> 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)).<sup>27</sup> Additionally, the marketplace can verify an applicant's eligibility for ESI through Federal employment by obtaining information from the U.S. Office of Personnel Management 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 the information is reasonably compatible.<sup>28</sup> 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 give the applicant 90 days to submit satisfactory documentation or otherwise

---

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

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

<sup>26</sup> State marketplaces can access additional sources of data to verify applicant information. For example, the District marketplace uses the District's Department of Motor Vehicles to verify residency.

<sup>27</sup> See Appendix A for information on the District marketplace process for verifying annual household income and eligibility for minimum essential coverage through ESI and non-ESI.

<sup>28</sup> 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.

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

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.<sup>31</sup> 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<sup>32</sup> attests that he or she understands that the APTC is subject to reconciliation.<sup>33</sup> 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.<sup>34</sup> 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 District 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’s<sup>35</sup> coverage occurs after the coverage becomes effective, the marketplace and the QHP issuer must reconcile the revised enrollment records (45 CFR § 155.400).

---

<sup>29</sup> 45 CFR § 155.315(f).

<sup>30</sup> 45 CFR § 155.315(f)(3).

<sup>31</sup> 45 CFR § 155.315(f)(4).

<sup>32</sup> 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)).

<sup>33</sup> 45 CFR § 155.315(f)(4).

<sup>34</sup> 45 CFR §§ 155.315(f)(5), (f)(6), and (g).

<sup>35</sup> 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 the marketplaces.<sup>36</sup> 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.<sup>37</sup>

### **The District Marketplace**

The District established the District marketplace on December 20, 2011.<sup>38</sup> The District's Health Benefit Exchange Authority is responsible for operating the District marketplace.<sup>39</sup> For insurance coverage effective in CY 2014, the District marketplace had contracts with three insurance companies to offer QHPs to individuals.

The District marketplace uses a Web site (dhealthlink.com) to determine applicants' eligibility for enrollment in QHPs and, when applicable, eligibility for insurance affordability programs. The system also assesses eligibility for Medicaid and CHIP.

## **HOW WE CONDUCTED THIS REVIEW**

We reviewed the internal controls that were in place at the District 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 District marketplace 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 (9,735 applicants), which included the review of supporting documentation to evaluate whether the marketplace determined the applicants' eligibility in accordance with Federal requirements, and

---

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

<sup>37</sup> ACA § 1313 and 45 CFR §§ 155.110 and 155.1200.

<sup>38</sup> The District's Health Benefit Exchange Authority Establishment Act of 2011, DC Law 19-0094 (effective Mar. 3, 2012).

<sup>39</sup> The District's marketplace is commonly known as DC Health Link.

- 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'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 District marketplace 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 District marketplace's determinations of applicants' eligibility that resulted from changes in applicant information reported by applicants after March 31, 2014.

We performed fieldwork from July to December 2014 at the District marketplace's office in the District of Columbia.

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 District of Columbia marketplace's internal controls were effective in ensuring that individuals were enrolled in qualified health plans 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 applicants' citizenship status. However, the controls were not effective for:

- maintaining identity-proofing documentation,
- verifying annual household income,
- verifying an applicant's eligibility for minimum essential coverage (both ESI and non-ESI), and
- maintaining application and eligibility verification data.

The presence of an internal control deficiency does not necessarily mean that the District 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 marketplace did not properly oversee the identity-proofing process and did not ensure that its eligibility system was always fully functional.

### **THE DISTRICT MARKETPLACE DID NOT ALWAYS MAINTAIN IDENTITY-PROOFING DOCUMENTATION**

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

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

According to CMS's Identity-Proofing Guidance for State marketplaces, before a marketplace accepts an online or telephone application for enrollment in a QHP, it must conduct identity proofing<sup>40</sup> sufficient to provide assurance that only the appropriate individual has access to

---

<sup>40</sup> Identity proofing helps to ensure the privacy of personal information and to prevent an unauthorized individual from submitting an online or phone application.

restricted data. The guidance explains that identity proofing involves the (1) collection of core attributes, including the applicant's name, birth date, Social Security number (optional), address, phone number, and email address; (2) validation of core attributes with a trusted data source; and (3) for some applicants, collection and validation of responses to questions about the applicant's personal history, e.g., the names of current and past employers. CMS allows States to use Federal identity-proofing services.

The District marketplace did not maintain documentation demonstrating that it performed identity proofing for a number of applicants. Specifically, for 19 of 45 applicants in our sample, the marketplace did not maintain documentation demonstrating that it had performed identity proofing in accordance with CMS Identity-Proofing Guidance.<sup>41</sup> Lack of documentation does not necessarily indicate that identity proofing was not completed. According to marketplace officials, an applicant could not complete an online application unless he or she passed the identity-proofing process.<sup>42</sup>

This deficiency occurred because the District marketplace did not properly oversee the identity-proofing process. Marketplace officials said they did not know the marketplace contractor had turned off the system function that allowed maintenance of the identity-proofing documentation and other verification documentation sent to and received from the Data Hub.<sup>43</sup> Without maintaining identity-proofing documentation, the marketplace could not demonstrate that it performed identity proofing in compliance with Federal requirements.

## **THE DISTRICT MARKETPLACE DID NOT ALWAYS VERIFY ANNUAL HOUSEHOLD INCOME ACCORDING TO FEDERAL REQUIREMENTS**

If an applicant requests an eligibility determination for insurance affordability programs, the marketplace must generally verify annual household income, or modified adjusted gross income (MAGI), and the size of the household (45 CFR § 155.320). Marketplaces use data from the IRS to verify annual household income information provided on an application. If electronic data sources 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)).

As part of the verification process, the marketplace must compute annual household income based on tax return data regarding MAGI and family size from the IRS and data regarding Social Security benefits described in 26 CFR § 1.36B-1(e)(2)(iii) from SSA (45 CFR § 155.320(c)(3)(ii)). The marketplace computes a tax filer's household income as it is defined in

---

<sup>41</sup> The District marketplace performed identity proofing of application filers. If a sample applicant was not the application filer, we reviewed supporting documentation for identity proofing of the application filer.

<sup>42</sup> We observed that the system was designed to prevent an applicant who did not successfully pass the identity-proofing process from completing a marketplace application online.

<sup>43</sup> District officials stated that the marketplace maintained identity-proofing documentation for the other 26 applicants as part of its quality-testing procedures.

26 CFR § 1.36B-1(e). For Medicaid eligibility, it computes an applicant's household income in accordance with 42 CFR § 435.603(d).

A marketplace must require the applicant to attest regarding a tax filer's projected annual household income (45 CFR § 155.320(c)(3)(ii)(B)).

The District marketplace did not always verify annual household income according to Federal requirements. Specifically, for two of the six applicants who were determined eligible for an APTC, the marketplace did not demonstrate that it had verified annual household income or did not appropriately verify annual household income.

- For one applicant, the marketplace did not maintain complete eligibility verification data. As a result, we could not determine whether the marketplace verified this applicant's income. The applicant completed an application but did not enroll. At a later time, this applicant completed a second application and did enroll. However, the marketplace had no record of the second application.<sup>44</sup> The marketplace's officials stated that this was a result of a system error that prevented the eligibility system from maintaining all applications submitted by an applicant.
- For a second applicant, the marketplace did not appropriately verify annual household income, which resulted in a miscalculation of the APTC. The applicant's application reported a biweekly income of \$2,560 from January through April 2014 and no additional income for the remainder of the CY. The marketplace calculated the applicant's annual household income as \$15,360. Marketplace officials stated that the marketplace should have determined the annual household income to be \$22,187.<sup>45</sup> They could not explain why the marketplace did not appropriately verify the annual household income or why the income amount was miscalculated.

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 DISTRICT MARKETPLACE DID NOT MAINTAIN DOCUMENTATION THAT IT VERIFIED APPLICANTS' ELIGIBILITY FOR MINIMUM ESSENTIAL COVERAGE ACCORDING TO FEDERAL REQUIREMENTS**

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) and (g)(1)(i)(B))). Federal regulations define "minimum essential

---

<sup>44</sup> As a result of this missing application, the District marketplace could not show that it had verified other eligibility standards, including incarceration status, residency, family size, and minimum essential coverage.

<sup>45</sup> Using its own formula, the District marketplace determined that the biweekly amount of \$2,560 should have been multiplied by 26 periods in a year (\$66,560), then the total multiplied by 1/3, the period worked (\$66,560 x .3333 = \$22,187).

coverage” as having the meaning given in 26 U.S.C. § 5000A(f) (45 CFR § 155.20). As described in 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)). Marketplaces must verify whether an applicant is eligible for minimum essential coverage other than through an employer-sponsored plan, Medicaid, or CHIP using information obtained by transmitting through the Data Hub identifying information specified for verification purposes (45 CFR § 155.320(b)(1)). The marketplace must also verify whether an applicant has already been determined eligible for coverage through Medicaid or CHIP in the State in which the exchange operates, using information obtained from the agencies administering such programs (45 CFR 155.320(b)(1)(ii)). In addition, 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)).

The marketplace did not maintain documentation that it had verified minimum essential coverage through ESI or non-ESI through the Data Hub. Six of the forty-five applicants were determined eligible for insurance affordability programs with no evidence that the District marketplace verified minimum essential coverage through the Data Hub.<sup>46</sup>

This deficiency occurred because the marketplace did not ensure that its eligibility system was fully functional to maintain documentation for verifying applicants’ eligibility for minimum essential coverage. According to marketplace officials, the marketplace checked electronic sources through the Data Hub and was able to conclude that no other insurance coverage was available to the applicants. However, the officials did not have documentation that the verification procedures had been performed because a contractor turned off the system function that would allow maintaining the data sent to and received from the Data Hub. The officials said that they have been turning the system function back on in phases.<sup>47</sup>

## **THE DISTRICT MARKETPLACE DID NOT ALWAYS MAINTAIN APPLICATION AND ELIGIBILITY VERIFICATION DATA**

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

---

<sup>46</sup> Five of the six applicants attested that they did not have minimum essential coverage available to them through a source other than the marketplace. The other applicant’s application was missing.

<sup>47</sup> As of May 2015, we verified that this system function was reactivated and showed responses from the Data Hub verifying the beneficiary’s ESI and non-ESI status.

The District marketplace did not maintain application and eligibility verification data for 29 applicants.<sup>48</sup> Because the marketplace did not maintain the data, we could not determine whether the marketplace performed certain eligibility verifications in accordance with Federal requirements.

### **The District Marketplace Did Not Maintain Applicants' Eligibility Verification Data**

For 19 of the 45 sample applicants, the District marketplace did not maintain applicants' eligibility verification data sent to and received from the Data Hub and other electronic sources.<sup>49</sup> As a result, we could not determine whether the marketplace performed the required verification in accordance with Federal requirements.

- For 7 of the 19 applicants, the marketplace did not maintain the documentation because it did not ensure that its eligibility system was always fully functional to maintain documentation for verifying applicants' eligibility data. According to marketplace officials, from October 12 through December 22, 2013, and without the marketplace's knowledge or consent, the contractor responsible for administration of the operations of the marketplace's eligibility system turned off the system function that allowed maintenance of the data sent to and received from Data Hub and other electronic sources. The District marketplace did not have controls in place to show that parts of the system were not functioning.
- For the remaining 12 applicants, marketplace officials indicated the eligibility verification data was incomplete or unreadable copies of the data were stored during the archiving process because of system errors.

### **The District Marketplace Did Not Always Maintain Eligibility Verification Data Regarding Applicants' Incarceration Status**

A marketplace must verify an applicant's attestation of incarceration status by relying on approved electronic data sources. If the data sources are unavailable, the marketplace can accept the applicant's attestation (45 C.F.R. § 155.315(e)).

For 13 of 45 sample applicants, the District marketplace did not maintain documentation of the applicant's attestation of incarceration status. Marketplace officials explained that all 45 applicants in our sample attested that they were not incarcerated.<sup>50</sup> Further, the officials stated that (1) the enrollment system's eligibility software program did not always properly transcribe the applicants' attestations at the time of the application and (2) the reliability and accuracy of

---

<sup>48</sup> Some applications lacked documentation in more than one area.

<sup>49</sup> Eligibility verification data was maintained for the remaining 26 sample applicants for testing purposes on a local server.

<sup>50</sup> We determined that the 45 sample applicants did not appear in the District's Department of Corrections' incarceration registry. This registry provides proof that the 45 sample beneficiaries were not incarcerated and thus eligible for coverage.

SSA's Prisoner Update Processing System (PUPS) data was evaluated and determined to be unreliable when determining an applicant's incarceration status. Therefore, although the SSA's PUPS data was an approved electronic data source, State marketplace officials decided to use the applicants' attestations that they were not incarcerated even if the attestation and PUPS information did not agree. Because the marketplace did not maintain documentation of the applicants' attestations, it could not demonstrate that it complied with Federal requirements for verifying applicants' incarceration status.

## **RECOMMENDATIONS**

We recommend that the District marketplace:

- maintain identity-proofing documentation for all applicants who apply for QHPs;
- verify annual household income in accordance with Federal requirements;
- maintain documentation demonstrating that it verified whether an applicant was eligible for minimum essential coverage; and
- ensure that its enrollment system maintains application, eligibility, and verification documentation, including all electronic eligibility verifications from the Data Hub.

## **DISTRICT MARKETPLACE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE**

### **DISTRICT MARKETPLACE COMMENTS**

The District marketplace concurred with our findings. District marketplace officials did not specifically address our recommendations but detailed the steps they had taken, both before the start of our audit and as a result of our audit, to ensure that applicants were properly enrolled and that their enrollment would be properly documented.

District marketplace officials also asked that we make two changes to the report. The officials stated that our report "inaccurately asserts that HBX [the DC Health Benefits Exchange] initiated corrective actions only after the audit began." The District marketplace asked "that the draft report be corrected to reflect that HBX oversight of its marketplace resulted in quickly identifying the problem and quickly initiating corrective action in 2013." In addition, the District marketplace believed that footnote number 42 on page 13 contradicted our statement that the District marketplace "did not properly oversee the identity-proofing process."

The District marketplace's comments are included in their entirety as Appendix F.

### **OFFICE OF INSPECTOR GENERAL RESPONSE**

In our opinion, it is not necessary to make changes requested by the District marketplace. Our report did not contain the assertion that the District marketplace initiated corrective actions only

after the audit began. In addition, the footnote in question does not contradict our statement that the District marketplace “did not properly oversee the identity-proofing process.” The footnote reinforces the statement in the report that an applicant could not complete an online application unless the applicant passed the identity proofing. Although we were able to observe the controls in the District marketplace’s eligibility software application that would prevent applicants from continuing with the application process if they did not successfully complete identify proofing, the District was unable to provide evidence that identify proofing was performed for 19 of 45 applicants in our sample. Thus, our statement that the District marketplace did not properly oversee the identity-proofing process is accurate.

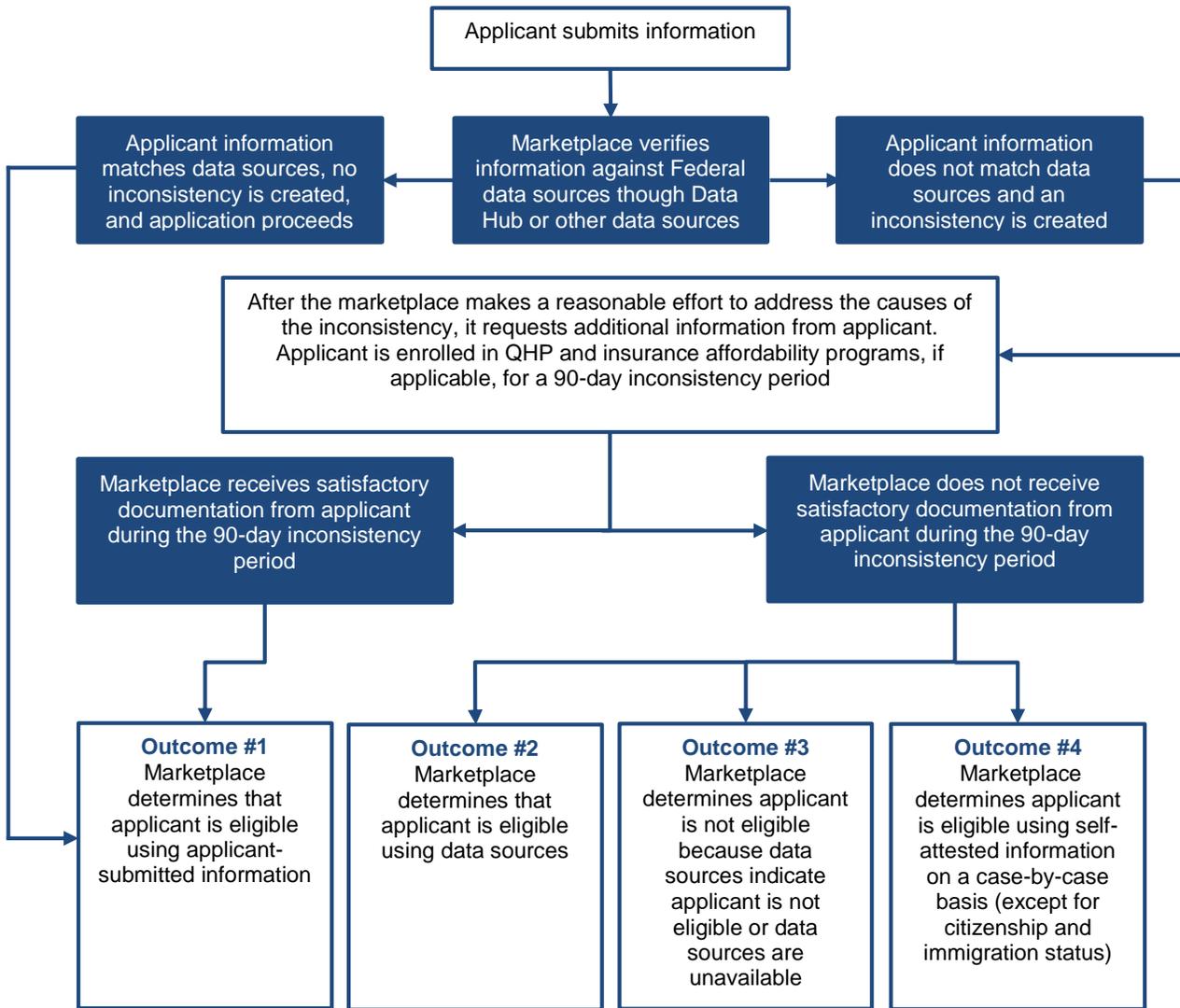
## **APPENDIX A: THE DISTRICT OF COLUMBIA MARKETPLACE'S PROCESS FOR VERIFYING ANNUAL HOUSEHOLD INCOME**

The following describes how the District marketplace uses data on annual household income to determine eligibility for insurance affordability programs (advance premium tax credit and cost-sharing reductions).

1. An applicant applies for the APTC and cost-sharing reductions.
2. To verify annual household income, the District marketplace compares the applicant's information to the IRS's data to determine whether the applicant is above the applicable Medicaid income threshold for that individual.
3. If the IRS data indicates that the applicant is above the Medicaid threshold, the applicant is asked to attest to (self-report) their current income. If the applicant attests to an amount greater than the IRS data, or if the amount is less than the IRS data by no more than 10 percent, they are considered "reasonably compatible," and the attestation is accepted and used to determine eligibility. If the IRS data indicates that the applicant is at or below the Medicaid threshold, or if no IRS data are available, the District marketplace contacts other Federal and local data sources including:
  - the Social Security Administration,
  - the Work Number (Equifax Workforce Solutions' verification system),
  - the State Wage Information Collection Agency,
  - the District's Department of Employment Services Unemployment Compensation Program,
  - the State Administration Supplementary Payment Program,
  - the Temporary Assistance for Needy Families program,
  - the Supplemental Nutrition Assistance Program, and
  - the State General Assistance Program.
4. After all other data sources are accessed, these sources are compared to the applicant's self-reported income. If the sum of the data accessed is greater than the self-reported income by no more than 10 percent, they are considered "reasonably compatible," and the self-reported amount is taken as the applicant's income and used to determine eligibility for Medicaid or insurance affordability programs through the District marketplace.

5. If the applicant's self-reported income is not accepted because it is not reasonably compatible or income sources do not exist, the applicant is required to provide paper documentation to confirm the attestation. Accepted paper documentation sources include:
  - a pay stub from a current job showing current income,
  - a statement of income completed and signed by a current employer,
  - register of business activity (for self-employed individuals), and
  - other official documentation that indicates the name and present income of the applicant.
6. If electronic data sources are not available because of scheduled system maintenance or for other reasons, paper documentation is used to substantiate the applicant's self-reported/attested income.

**APPENDIX B: STEPS AND OUTCOMES FOR RESOLVING INCONSISTENCIES**



## **APPENDIX C: THE DISTRICT OF COLUMBIA MARKETPLACE'S INCONSISTENCY RESOLUTION PROCESS**

Inconsistencies are generated when an applicant's attested information cannot be verified through electronic data sources. The marketplace accepts an applicant's attestation without further verification for information related to incarceration status, residency for individuals under age 19, family size, and applicants who claim homeless status.

For information that must be verified, the District marketplace allows 95 days for resolution: a 90-day inconsistency period and a 5-day allowance for processing, when the letter is sent to the applicant after eligibility is determined. If information is not received within the 95-day window, reminders are sent to the applicants in intervals of 10, 25, 50, and 65 days. Additionally, an applicant who demonstrates a "good faith effort" may be granted an additional 30 days to resolve the conflict. The District marketplace defines a "good faith effort" as the applicant requesting additional time online, through the call center, in person at a service center, or by mail. All correspondence for inconsistency reminders and "good faith effort" requests will be added to the District marketplace's application account.

To resolve the inconsistency, an applicant can mail the requested supporting documentation, deliver the documentation in person at a service center to be scanned into the system, or upload the documents to his or her personal District marketplace application account. Documents submitted online are linked to the applicant's account. The contractor scans and uploads to the Document Image Management System documentation that the applicant submits on paper. The documentation verification process is as follows:

- the service center system creates a work task,
- District marketplace management reviews the work task and assigns a social service representative to the task,
- the social service representative verifies and processes the submitted documents,
- the social service representative contacts the applicant for additional information if the submitted documentation does not meet clearance requirements,
- the enrollment system clears the documents and determines eligibility, and
- District marketplace management monitors completion of the task.

## APPENDIX D: OVERVIEW OF INTERNAL CONTROLS

### INTERNAL CONTROLS IN THE GOVERNMENT<sup>51</sup>

Internal controls are an integral component of an organization's management providing 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 the 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 their assigned functions, to achieve control objectives and address related risks.

### FIVE COMPONENTS OF INTERNAL CONTROL<sup>52</sup>

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 that 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.

---

<sup>51</sup> 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.

<sup>52</sup> 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 District 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 District marketplace 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 determined eligible for QHPs during the open enrollment period (9,735 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's<sup>53</sup> *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

---

<sup>53</sup> 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).

whether District marketplace 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 District marketplace determinations of applicants' eligibility that resulted from changes in applicant information reported by applicants after March 31, 2014.

We performed fieldwork from July to December 2014 at the District marketplace's office in the District of Columbia.

## **METHODOLOGY**

To accomplish our objective, we:

- reviewed applicable Federal and State laws, regulations, and guidance;
- reviewed the Secretary of HHS's report on the eligibility verifications for the APTC and cost-sharing reductions (submitted to Congress on December 31, 2013);
- assessed internal controls by:
  - interviewing officials from the District marketplace and their contractors and reviewing documentation provided by them to understand how the 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 District marketplace for 9,735 applicants who were determined eligible for QHPs during the open enrollment period (October 1, 2013 through March 31, 2014);
- 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 District marketplace internal controls for eligibility determinations by:
  - using the OIG, Office of Audit Services, statistical software to randomly select 45 applicants who were determined eligible to enroll in QHPs during the open enrollment period (October 1, 2013, through March 31, 2014) 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
  - reviewed the District marketplace’s methodology for calculating the APTC for sample applicants who were eligible for insurance affordability programs; and
- discussed the results of our review with District 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: DISTRICT MARKETPLACE COMMENTS



November 6, 2015

Stephen Virbitsky  
Regional Inspector General for Audit Services  
Office of Audit Services, Region III  
150 S. Independence Mall West, Suite 316  
Philadelphia, PA 19106

*RE: Audit Report A-03-14-03301*

Dear Mr. Virbitsky:

Thank you for the opportunity to provide you with feedback. The Department of Health and Human Services Office of Inspector General (HHS-OIG) focused on the first open enrollment period: October 1, 2013 to March 31, 2014. The audit included no findings in the following areas:

- Establishing standard operating procedures (SOPs) and processes for making accurate eligibility determinations in compliance with Federal regulations (including resolution of inconsistencies).
- Establishing management review/internal controls associated with the prevention of improper eligibility determinations.
- Establishing management review/internal controls associated with the identification of incorrect eligibility determinations.
- Establishing management review/internal controls associated with compliance with the requirements regarding confidentiality, disclosure, maintenance, and use of information.
- Maintaining current and fully executed agreements with other entities specifying their respective responsibilities in connection with eligibility determinations, including (if appropriate) those related to exemptions.

In its audit, the HHS-OIG made four findings. HBX concurs with the four findings and provides the following observations for your consideration. Three of the four findings were based on one problem – source data from federal or local data calls were not maintained properly. Importantly, however, in all audited cases, the applicants were in fact eligible for the benefits. With respect to the root problem, the HHS-OIG report inaccurately asserts that HBX initiated corrective actions only after the audit began. In fact, HBX's aggressive oversight of its marketplace resulted in timely identification of the cause shortly after opening for business in 2013, long before the HHS-OIG audit began. By July 2014, when the audit commenced, HBX had either corrected most issues or was in the process. We ask that the draft report be corrected to reflect that HBX oversight of its marketplace resulted in quickly identifying the problem and quickly initiating corrective action in 2013.



1225 Eye Street NW, 4th Floor, Washington, DC 20005

In addition, we request that the report more accurately portray the District's efforts around identity proofing. The report states "the District marketplace did not properly oversee the identity proofing process." This is contradicted by a footnote in the report and fact that "the system was designed to prevent an applicant who did not successfully pass the identity-proofing process from completing a marketplace application online." The on-line marketplace was in fact designed to prevent completion of an application if a person could not pass the initial screening for identity proofing. The assertion of not properly overseeing the identity proofing process is not supported as an applicant is blocked and is not allowed to complete an application without proper identity proofing. Therefore, we request that the statement that the District did not properly oversee the identity proofing process be corrected.

HBX appreciates the professionalism and thoroughness with which your staff conducted this audit.

Sincerely,

/Mila Kofman, J.D./  
Executive Director  
Health Benefit Exchange Authority

**D.C. Health Benefit Exchange Authority Responses to  
Draft Audit Report A-03-14-03301**

**Comments Regarding Data Retention**

Three of the HHS-OIG's four findings relate to source data from federal or local data calls not being maintained in accordance with federal law. HBX concurs with these findings and offers the following comments.

**Maintenance of Source Data by Infosys Public Systems (IPS)**

IPS was the integration vendor contracted by the District of Columbia to build and initially manage system operations of the eligibility system. This contract was awarded by the District of Columbia's Office of Contracting and Procurement on behalf of the Department of Human Services. The Request for Proposal and review process occurred prior to HBX having any staff.

Without HBX authorization or knowledge, on October 12, 2013, IPS turned off XML logging of the source data – the request and responses from the federal data services hub. Due to timely and effective oversight of IPS by HBX, this issue was identified quickly, and action was taken to address it. Due to HBX's efforts, the logging of the source data was turned back on quickly on December 22, 2013. The assertion that HBX failed to properly oversee the vendor is not correct. The following is a detailed summary of HBX actions:

Prior to launch of the eligibility system, testing indicated XML data was being stored properly. The expectation of HBX going into launch on October 1, 2013 was that IPS staff would cooperate with HBX in the operations, maintenance, and internal control for the DC Health Link system. This expectation was not met, and subsequent to launch on October 1, 2013, IPS would not permit HBX access into the internal operations or coding environments sufficient to monitor performance. While IPS continued to engage with HBX business managers on policy, individuals working on DC Health Link were locked out of the security environment and unable to make technical changes to DC Health Link.

Recognizing that IPS was preventing HBX from performing appropriate oversight of the contract, in October 2013 HBX began hiring a replacement team to replace the operational roles being performed by IPS. One HBX IT consultant shifted from a coordination role with IPS to being the lead of the Operations and Maintenance team. A new IT consultant was hired to start on October 27, 2013 with the specific skill set necessary to assess whether IPS was performing necessary functions and with the capability to perform the functions directly if IPS was not performing the required functions.

On December 5, 2013, HBX had a ready team and removed IPS from operational control of the technical environment of DC Health Link. IPS staff was retained, in a separate office, to complete system documentation. After gaining access to the technical

environment, HBX assessed the environment and instituted a technical change management process.

The assessment completed in mid-December revealed that IPS had turned off XML logging on October 12, 2013, without approval from HBX. The necessary corrections, including reinstating logging, were processed through an Enterprise Change Request (ECR) ordered on December 19, 2013. The system refresh necessary to implement the ECR took until December 22, 2013 to complete.

Nine of the 45 cases OIG requested fell within the timeframe between October 12 and December 22, 2013, when logging was not fully functional and are therefore unrecoverable.

HBX identified the problem well in advance of the OIG audit and took action. This issue did not affect the integrity of the eligibility decisions. The XML files are one record of the information received from verification sources. However, this information is also stored in the DC Health Link eligibility system contemporaneously with receipt and used to make eligibility decisions. This secondary storage of this information in the eligibility system shows that DC Health Link received information from the data services hub and appropriately applied it. Additionally, for those individuals where the electronic verification sources did not confirm the eligibility factor, paper documentation was required and used. The XML record is not the source and basis for eligibility.

#### False Positives in Archiving with D.C. Office of Chief Technology Officer

Across the District of Columbia, the DC Office of Chief Technology Officer (OCTO) provides enterprise backup services to District agencies. Thousands of files are backed up at the District enterprise level daily by OCTO. HBX has an agreement with OCTO to backup DC Health Link data. Due to the size of the XML files, the data is held locally on HBX servers for 30 days, and then sent to archive enterprise servers maintained by OCTO.

Quality control includes the check for a satisfactory outcome for local agency tapes moving to enterprise backup storage. This is an indication that both the jobs creating the local tapes and the jobs creating the enterprise tapes completed their file transfer runs normally without any error. HBX applied the same historical protocol in establishing its archiving procedures with OCTO.

As a result of this HHS-OIG audit, an issue with the archiving procedure was discovered. Although HBX was sending complete files for archiving, incomplete and unreadable copies of those files were being stored on the OCTO servers as back-ups. The corruption in the process was not visible. In fact, both at the HBX and OCTO ends, the outcomes message was “successful” backup and error free. As a result of this problem, HBX was unable to produce readable XML files for 12 of the cases requested.

#### Corrective Action Plan

*IPS* – In addition to removing their staff from direct control of the eligibility and enrollment system, HBX no longer uses IPS. In areas not overlapping with Medicaid determinations, HBX is no longer using “certified off-the-shelf” (COTS) products, which have expensive licensing and maintenance fees. Instead, HBX developed its own application using open source code. This allows complete and direct control over upgrades and maintenance. In the area overlapping with Medicaid determinations – APTC determinations - HBX works with and relies on the Department of Health Care Finance and the Department of Human Services.

*OCTO* – Upon discovery of the corruption in the established process, HBX working with the IT team immediately formulated a remediation plan, which consists of the following:

- HBX and OCTO will communicate timeframes and schedules for executing local eligibility system and data transaction backups and for executing OCTO enterprise backups so that these services never overlap, minimizing the opportunity for errors.
- Every local eligibility system backup and its partner OCTO enterprise backup will be subject to file size and checksum comparisons between the two backups.
- Prior to purging the previous month's local DC Health Link backup tapes, a restore will be done of that month's partner OCTO enterprise backup tapes. This will also be done to the eligibility system's Oracle database server.
- Periodically, HBX will select a random set of Enterprise Service Bus (ESB) transactions from the ESB activity logs, and analyze them to make sure they've been successfully extracted.
- The successful ESB log extract results will be stored on the configuration management tracker so that the tracker's database can be queried at will to provide documentary proof that ESB transactions have been accurately stored on OCTO's enterprise database.
- Only once a positive back-up verification procedure has been completed will the previous month's local ESB files then be purged.

This corrective action plan was formulated in February 2015, after identification of issues by the OIG. Implementation of the plan began immediately. As of August 20, 2015, HBX and OCTO restarted the enterprise backup process after complete and successful testing by OCTO, in coordination with HBX IT staff.

***Finding #1: The District Marketplace Did Not Always Maintain Identify-Proofing Documentation - CONCUR***

The HBX agrees that, despite repeated recovery efforts, XML records for 19 out of the 45 cases sampled by HHS-OIG could not be recovered from archived data storage. The reasons and corrective action plans are stated above in the Data Retention explanation.

However, HBX strongly rejects HHS-OIG's statement that the "District marketplace did not properly oversee the identity proofing process" or that the "marketplace could not demonstrate that it performed identity proofing." To the contrary, HHS-OIG itself states in footnote 42 that "the system was designed to prevent an applicant who did not successfully pass the identity-proofing process from completing a marketplace application online."

All of these individuals applied online and therefore, the mere fact that they successfully enrolled is evidence that they passed identity proofing. Therefore, the failure here is not a failure to conduct the verification, but a problem with retaining the documentation of such verification as required.

***Finding #2: The District Marketplace Did Not Always Verify Annual Household Income According to Federal Requirements - CONCUR***

The HBX agrees that for 2 of the 45 cases reviewed by HHS-OIG, HBX staff were unable to substantiate verification of income.

As to the first application, the HBX concurs that there was an error in 2013 that discarded subsequent applications in cases of multiple applications, along with associated data, even though customers were permitted to enroll. This defect was identified in 2013, well before HHS-OIG began their audit, and remedied March 4, 2014. Customers can no longer submit more than one application of the same type unless they contact DC Health Link Customer Service, which will administratively close the prior application. This administrative step ensures that all associated data for the applications will be retained and viewable in the eligibility system.

As to the second referenced application, it is notable that the applicant was eligible for the full amount of APTC the applicant received based on the paystubs submitted by the customer and retained by HBX. The applicant would have received an additional \$3/month through the reconciliation at the time of tax filing had his income remained the same. However, the display of the income in the customer's on-line eligibility file was incorrect. The error leading to this incorrect display could not be duplicated in a manner sufficient to explain it because the application was from March 2014 and there had been multiple upgrades to the IT eligibility system between the time of application and the time the auditors reviewed in early 2015.

***Finding #3: The District Marketplace Did Not Maintain Documentation that it Verified Applicants' Eligibility for Minimum Essential Coverage According to Federal Requirements - CONCUR***

The HBX agrees that, despite repeated recovery efforts, the source data/XML records for 6 out of the 45 cases sampled by HHS-OIG could not be recovered from our archived data storage. The reasons and corrective action plans are stated above in the Data Retention Comments.

***Finding #4: The District Marketplace Did Not Always Maintain Application and Eligibility Verification Data - CONCUR***

The HBX agrees that, despite repeated recovery efforts, HBX could not recover the source data, the XML records from our archived data storage for some audited samples. The reasons and corrective action plans are stated above in the Data Retention Comments.

HBX strongly rejects HHS-OIG's statement that the "District marketplace did not have controls in place to identify that parts of the system were not functioning" when discussing IPS turning off the logging of the source data/XMLs. Exactly to the contrary, due to timely and effective oversight of the IPS by HBX, this issue was identified quickly, and action was taken to address it. Taking immediate action after HBX was locked out on October 1, 2013 from oversight, HBX built a team of experts to replace IPS functions. HBX turned on logging of the source data December 23, 2013.

As to incarceration data specifically, HBX concurs with the finding that the eligibility record-keeping system used by the District, which is a certified off-the-shelf (COTS) product developed by IBM/Curam, did not store a record when a customer attested to not being incarcerated. However, the converse was stored. The COTS product properly stored an eligibility record when a customer attested to being incarcerated and the rules engine appropriately distinguished between customers that were incarcerated pending disposition of criminal charges versus customers who were incarcerated post-conviction, the former being eligible for exchange enrollment and the latter not.

This design did not have an impact on eligibility outcomes, because customers who self-attested that they were incarcerated post-conviction were properly prohibited from enrollment.

HBX now uses open source code applications and no longer uses CURAM for full pay applicants. In areas overlapping with Medicaid determinations, DCHBX works with the Department of Health Care Finance and the Department of Human Services.

Recognizing the recording issue with these attestations, HBX took corrective action. HBX records this information in the open source code it developed for full pay applications (not APTC or Medicaid applications). Additionally, HBX plans to engage with IBM/Curam system developers to ensure a record of customer responses to the question of "Are you incarcerated?" is retained, even when the answer is "No" in applications that are also Medicaid applications.