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Fraud, Waste, and Abuse Under the Affordable Care Act

Testimony of:

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Good afternoon, Chairman Jordan, Ranking Member Krishnamoorthi, and other distinguished Members of the Subcommittee. I am Vicki Robinson, Senior Counselor for Policy in the Office of Inspector General (OIG), U.S. Department of Health and Human Services (HHS or the Department). Thank you for the opportunity to appear before you today to discuss findings and recommendations from OIG's oversight of the Federal and State-based marketplaces established under the Patient Protection and Affordable Care Act (ACA).

Created by statute in 1976, OIG remains a nonpartisan body of evaluators, auditors, and investigators deployed across the Nation to help assess and protect the integrity of Federal health and human services programs enacted by Congress. We are committed to working with our stakeholders to protect taxpayer-funded programs and patients from fraud, waste, and abuse and to promote efficient and effective program operations. We focus on prevention, detection, and enforcement to fight fraud, waste, and abuse; promote quality, safety, and value; and foster sound financial stewardship of HHS programs. When we identify misconduct, we take appropriate enforcement action and make recommendations to address vulnerabilities and improve Department programs and operations.

OIG's Oversight of ACA Marketplaces

ACA established health insurance exchanges (commonly referred to as "marketplaces") to allow individuals and small businesses to shop for health insurance in all 50 States and the District of Columbia. States could choose to operate their own State marketplace or the Department would operate a Federal marketplace for residents of States without a State marketplace. ACA provided funding assistance, known as establishment grants, to States for planning and establishing their own marketplaces. In addition, ACA provided funding to assist eligible consumers. This assistance consists of subsidies in the form of tax credits and cost-sharing reductions. ACA also provided funding for health insurance issuers in the form of premium stabilization programs, such as the reinsurance and risk adjustment programs. The marketplaces presented complex regulatory, operational, and technological challenges for the Department and for States.

Beginning in 2012, OIG identified implementation, operation, and oversight of the health insurance marketplaces as among the most significant management challenges facing the Department. Our marketplace oversight work has focused on key program integrity questions, including:

- Are taxpayer funds being expended correctly for their intended purposes?
- Are the right people getting the right benefits?
- Is the Department managing and administering the marketplace programs effectively and efficiently?

Since 2013, we have issued 38 audits and evaluations regarding the Federal and State-based marketplaces and related programs.[1] In addition to this oversight work, OIG has established relationships with its law enforcement partners to investigate fraud and closely monitor activities and concerns. We work with the Department to help identify potential fraud and ensure that allegations of fraud are investigated appropriately.

Today, I will summarize findings and recommendations from our oversight work with respect to payment accuracy, eligibility determinations, and the Department's management of the Federal marketplace. My testimony will highlight challenges and lessons learned that can inform the Department and policymakers as they consider HHS programs going forward.

OIG's Findings and Recommendations

OIG's work identified several challenges that potentially hampered the operation of the marketplaces. These challenges generally fall into three categories: insufficient payment controls that could lead to wasteful spending, vulnerabilities in ensuring accurate eligibility determinations at the Federal and State-based marketplaces, and challenges for Departmental management. For example, we found weaknesses in the Centers for Medicare & Medicaid Services' (CMS) financial management systems as well as deficiencies in States' management of establishment grants. In addition, CMS's contract monitoring and administration needed improvement. Finally, OIG identified broader lessons through our review of CMS's development and administration of HealthCare.gov (the website consumers use to access the Federal marketplace), including the poor launch and subsequent improvement of the site. OIG has recommended various improvements to address these challenges and vulnerabilities.

[1] A complete list of OIG reports related to ACA is on OIG's website at http://oig.hhs.gov/reports-and-publications/aca/.

Insufficient Payment Controls That Could Lead to Wasteful Spending

Ensuring sound expenditure of taxpayer funds for financial assistance payments and other marketplace purposes posed a substantial management challenge. OIG identified deficiencies that put Federal funds at risk of being misused or wasted due to ineffective internal controls in the financial management systems at both the Federal and State-based marketplaces.

For example, OIG identified the following deficiencies in CMS's financial management systems related to advance premium tax credits (APTC) and cost-sharing reductions made available under ACA:

- CMS lacked controls to ensure that financial assistance payments were correctly calculated. Specifically, CMS had limited ability to ensure that payments were made accurately to health insurance issuers because CMS obtained payment data from issuers on an aggregate basis, rather than by enrollee. As a result, CMS could not verify the accuracy of the nearly $2.8 billion it authorized for financial assistance payments for the first four months of 2014. We recommended that CMS implement computerized systems for the Federal and State-based marketplaces to maintain individual enrollee and payment information.

- CMS lacked controls to ensure effectively that APTC payments were made only for enrollees who paid their monthly premiums. CMS relied on health insurance issuers to verify that enrollees paid their monthly premiums to the issuers. CMS did not obtain APTC payment information from the issuers on an enrollee-by-enrollee basis and thus could not verify whether individual enrollees had paid premiums. We recommended that CMS establish policies and procedures to ensure that APTC payments are made only on behalf of enrollees who have paid their premiums.

OIG identified establishment grants awarded to State-based marketplaces as a risk for potential misspent funds because of the complex requirements related to implementation and the potential overlap with other programs. OIG has issued seven reports that review establishment grants. The following deficiencies were identified in these reports:

- Four of the State-based marketplaces misallocated costs between establishment grant funding designated for marketplaces and funding for other programs that shared marketplace systems, such as Medicaid. We found that this misallocation occurred because these States used outdated or flawed information when better data were available. Generally, States allocated more costs to the establishment grant than they should have under Federal grant rules. For example, one State misallocated $28.4 million in costs to the establishment grant. A portion of those costs may be claimed through the

State's Medicaid program, which would require the State to pay for a percentage of those costs using State funds. We recommended that States refund misallocated costs, update or amend cost allocation methodologies to make use of better data, and develop written policies to ensure that costs are allocated appropriately.

- In our most recent report, the State-based marketplace charged the establishment grant for $4.5 million in unallowable costs, including prepaid operational expenses. OIG found that costs were unallowable because the marketplace used establishment grant funds to pay for operational support and maintenance services provided after December 31, 2014. Establishment grant funds were not available for such purposes after this date. In addition, the marketplace had other deficiencies, resulting in an additional $5.2 million not being expended in accordance with Federal requirements. We recommended that the marketplace refund $9.7 million and develop, finalize, and implement policies and procedures to ensure that it expends Federal grant funds in accordance with applicable requirements.

OIG also identified a risk related to insufficient CMS guidance regarding the particular types of operational costs that State-based marketplaces could charge against an establishment grant. We were concerned that, absent better guidance, States might incorrectly charge the establishment grant funds for prohibited costs, such as rent, software maintenance, telecommunications, and utilities. To help prevent potential waste of establishment grant funds, we issued an alert to CMS. As a result, CMS published updated guidance to clarify which costs States could not charge against the grants.

Vulnerabilities in Ensuring Accurate Eligibility Determinations

Accurate eligibility determinations ensure that only qualifying consumers can enroll in qualified health plans and receive financial assistance. OIG found vulnerabilities in CMS's eligibility verification and enrollment processes, as well as CMS's resolution of data inconsistencies. In three separate reviews of the Federal marketplace, OIG identified deficiencies related to the Federal marketplace's internal controls, including the following:

- Social Security numbers were not always validated with the Social Security Administration.
- Citizenship was not always verified in accordance with Federal requirements.
- Household income was not always verified properly.
- Inconsistencies between applicants' self-attested information and data received through the Federal data hub or from other data sources related to certain eligibility requirements, most commonly citizenship and income, were not resolved properly.

These deficiencies may have limited the Federal marketplace's ability to prevent inaccurate or fraudulent information from being used to determine eligibility of applicants.

OIG also reviewed internal controls on eligibility determinations at seven State-based marketplaces. We determined that certain internal controls were effective at the State-based marketplaces. However, we found that most of the State-based marketplaces had some ineffective internal controls for ensuring that individuals were enrolled in a qualified health plan in accordance with Federal requirements. Common deficiencies we identified included:

- Six State-based marketplaces did not always use existing data sources to verify whether applicants were eligible for health insurance through an employer or through other sources, such as Medicare or the Federal Employees Health Benefits Program.
- Four State-based marketplaces did not always properly verify annual household income.
- Seven State-based marketplaces did not always resolve inconsistencies or notify applicants of inconsistencies.
- Four State-based marketplaces did not always properly maintain data or accurate records.

We recommended that both the Federal and State-based marketplaces improve their internal controls and redetermine eligibility for the applicants in our sample whose eligibility verifications did not meet Federal requirements.

Challenges That Impede Effective Department Management

Effective Department management and administration are critical to meeting program objectives and providing sound stewardship of Federal resources. OIG conducted several reviews focused on CMS's management of marketplace programs. For example, we examined CMS' acquisition planning and procurement of contracts to implement the Federal marketplace. CMS awarded 60 contracts across 33 companies to support the development and operation of the Federal marketplace. We identified vulnerabilities and offered recommendations related to contract monitoring and administration of payments for contracts related to the marketplaces. For example, we found:

- CMS did not always manage and oversee contractor performance in accordance with Federal requirements and contract terms. For example, CMS was unable to identify contractor delays and performance issues in all instances and was unable to identify when a contractor incurred $ 28 million in unauthorized costs that increased the cost of the contract. OIG recommended that CMS direct its acquisition personnel to refrain from authorizing additional work on contracts, absent proper approval and funding. In response, CMS updated its internal guidance to delineate clearly that only the contracting

officer could make changes to the terms and conditions of a contract or direct a contractor to perform work or make deliveries not specifically required under the contract.

- CMS did not accurately identify all obligations and expenditures for six contracts we reviewed related to the Federal marketplace. CMS recorded $24.3 million of obligations and $22.9 million of expenditures, but it did not identify them as being related to the Federal marketplace. Consequently, CMS was unable to account accurately for and report to interested stakeholders the amount spent on the development, implementation, and operation of the Federal marketplace. We recommended that CMS include all relevant contract costs when it identifies total obligations and expenditures related to the design, development, and operation of the Federal marketplace.

- CMS missed the opportunity to plan for a lead systems integrator to coordinate the efforts of multiple contractors for the Federal marketplace. CMS did not identify a systems integrator until after the October 2013 launch of the Federal marketplace. The many companies that were awarded Federal marketplace contracts had individual tasks to support the implementation of the Federal marketplace. Yet there was no single point of contact with responsibility for integrating contractors' efforts and communicating the common project goals to all companies.

OIG also examined CMS's overall management and administration of HealthCare.gov. In 2016, OIG published a case study detailing the implementation of the website and identifying organizational factors that contributed to the website's poor launch and subsequent improvement. This work highlights lessons that can inform not just the management and administration of the marketplaces, but also other complex Department programs and operations now and in the future. These lessons learned will become increasingly important as Government programs become more dependent on the effective intersection of policy, technology, and management.

In the case study, OIG found that HHS and CMS made many avoidable missteps in developing HealthCare.gov that contributed to the poor website launch. For example:

- Lack of clear project leadership led to fragmentation and poor coordination, causing delays in making policy decisions and confusion about goals and objectives.
- Mismanagement of information technology contracts resulted in inefficient use of resources, problematic technological decisions, and limited oversight of contractor performance.
- Poor communication, particularly between policy and technical staff, hampered efforts to identify and correct problems, leading to a compressed timeframe for completing the

website build and a failure to recognize the magnitude of problems as the project deteriorated.

Following the poor launch, CMS changed its management approach to improve operations, including:

- hiring a systems integrator to coordinate the work of multiple contractors, simplify processes, and increase accountability;
- integrating the policy and technical teams of employed and contracted staff into a single, "badgeless" team that fosters innovation, problem solving, and communication; and
- practicing what CMS officials called "ruthless prioritization" of tasks to target the most urgent needs and align goals with available resources.

These strategies led to broader organizational changes focused on leadership, a deeper integration of policy and technology, and more active communication among partners, such as other Federal agencies, States, contractors, and insurers.

Conclusion

OIG is committed to fighting fraud, waste, and abuse in HHS programs and promoting their economy, efficiency, and effectiveness. OIG's marketplace oversight work highlights challenges and lessons learned with respect to payment systems, eligibility determinations, and management and administration of complex programs. Ensuring program integrity requires vigilance and sustained focus on preventing problems from occurring in the first place, detecting problems promptly when they occur, and rapidly remediating detected problems through investigations, enforcement, and corrective actions. Program integrity is central to OIG's mission and should be a priority for current and future HHS programs.

Thank you, again, for inviting me to speak with the Committee today to discuss our oversight of ACA marketplaces.