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ONE HUNDRED THIRTEENTH CONGRESS

Congress of the United States

House of Representatives

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July 31, 2014

Ms. Joyce M. Greenleaf
Regional Inspector General
Office of Evaluations and Inspections
Office of Inspector General
U.S. Department of Health and Human Services
330 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Ms. Greenleaf:

Thank you for appearing before the Subcommittee on Health on Wednesday, July 16, 2014, to testify at the hearing entitled "Failure to Verify: Concerns Regarding PPACA's Eligibility System."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

Also attached are Member requests made during the hearing. The format of your responses to these requests should follow the same format as your responses to the additional questions for the record.

To facilitate the printing of the hearing record, please respond to these questions and requests with a transmittal letter by the close of business on Thursday, August 14, 2014. Your responses should be mailed to Sydne Harwick, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to **Sydne.Harwick@mail.house.gov**.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Frank Pallone, Jr., Ranking Member, Subcommittee on Health

Attachments

Attachment 1—Additional Questions for the Record

The Honorable Joseph R. Pitts

1. I have heard reports from multiple groups representing employers that they have not been notified a single time by CMS, as required by the law, that an employee has received an advanceable premium tax credit. CMS should be verifying up front whether the employee has access to affordable coverage. This information is important since certain coverage offered by an employer would make individuals ineligible for tax credits. I am deeply disturbed at this account since many workers may be inaccurately receiving thousands of dollars in inaccurate tax credits and subsidies. Is OIG aware of a process in place to accurately and timely verify whether an applicant has an offer of affordable employer-sponsored coverage?

2. Has CMS informed OIG of any work plan with specific mile markers to work through the estimated 2.2 million applicants who have inconsistencies in their eligibility? In OIG's opinion, to protect the integrity of the program and safeguard taxpayer dollars, is it important for CMS to remove ineligible individuals before they are automatically re-enrolled in the second enrollment period?

3. What is OIG's estimate of the total possible estimate of subsidies inappropriately provided to individuals not eligible?

4. Is HHS OIG aware of whether or not CMS has procured a contract to build the backend system that has not yet been built? If so, please detail the scope of the contract and the contractor.

5. Given the ineligibilities OIG has identified in the FFM's enrollment process, does OIG have confidence that the individuals who the FFM determined are eligible for Medicaid are indeed eligible for Medicaid?

6. How are states and/or the FFM determining whether or not childless adults enrolled in Medicaid are eligible for the full match (newly-eligible) or regular match (newly-enrolled/woodwork)?

7. Based on the work of OIG in documenting the problems with enrollment this past fall, in OIG's opinion, is CMS at this point adequately prepared to build, test and operate the backend system for the second open enrollment period?

The Honorable Michael C. Burgess

1. In the run up to the passage of the law, the President repeatedly assured the American people that illegal immigrants would not receive coverage under the ACA. Yet, your report states that nearly half of the 2.9 million inconsistencies were related to immigration status, meaning that there is a high likelihood that illegal immigrants are receiving tax payer funds for the purchase of health insurance. The law requires that inconsistencies in citizenship status be resolved within 90 days of notifying the applicant that their status cannot be verified. There is no exception.

   Have the Administration and that State-based exchanges complied with this aspect of the law? In what ways are they in violation?

2. In December, I sent a letter to HHS inquiring about a number of back-end issues, particularly the so-called IRS APTC reconciliation process. HHS never responded to my inquiries. It seems that the reconciliation process is more of a theory and less of a process. Can you provide any details about this reconciliation process with the IRS? Has the system to implement this process been developed?

3. The report says that during your investigation, IRS did not grant you access to Federal taxpayer information that IRS provides to marketplaces. Do you have a timeline for when you will be able to access this information?

Attachment 2—Member Requests for the Record

During the hearing, Members asked you to provide additional information for the record and you indicated that you would provide that information. For your convenience, descriptions of the requested information are provided below.

The Honorable Gus Bilirakis

1. Is HHS actually terminating coverage or withdrawing subsidies if an applicant has failed to provide documentation to address an inconsistency regarding citizenship or legal status within the 90-day period?

The Honorable Gene Green

1. Will you please give me some examples of other programs that GAO has investigated that have inconsistencies?