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REVIEWING THE ACCURACY OF MEDICAID AND

EXCHANGE ELIGIBILITY DETERMINATIONS

FRIDAY, OCTOBER 23, 2015

House of Representatives,

Subcommittee on Health,

Committee on Energy and Commerce,

Washington, D.C.

The subcommittee met, pursuant to call, at 9:00 a.m., in Room 2322, Rayburn House Office Building, Hon. Joseph R. Pitts [chairman of the subcommittee] presiding.

Present: Representatives Pitts, Guthrie, Shimkus, Murphy, Blackburn, Lance, Griffith, Bilirakis, Long, Bucshon, Brooks, Collins, Green, Engel, Capps, Butterfield, Sarbanes, Matsui, Lujan, Schrader, Kennedy, Cardenas, and Pallone (ex officio).

Staff Present: Clay Alspach, Counsel, Health; Rebecca Card, Staff Assistant; Graham Pittman, Legislative Clerk; Michelle

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Rosenberg, GAO Detailee, Health; Chris Sarley, Policy Coordinator, Environment and Economy; Heidi Stirrup, Health Policy Coordinator; Josh Trent, Professional Staff Member, Health; Christine Brennan, Minority Press Secretary; Jeff Carroll, Minority Staff Director; Tiffany Guarascio, Minority Deputy Staff Director and Chief Health Advisor; Una Lee, Chief Oversight Counsel; Rachel Pryor, Minority Health Policy Advisor; and Samantha Satchell, Minority Policy Analyst.

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Mr. Pitts. The hearing will come to order. The chair will recognize himself for an opening statement.

Today's hearing will review the accuracy of eligibility and financing determinations made by the Center of Medicare and Medicaid Services, CMS. Both CMS's eligibility determinations for Medicaid and subsidies in the Federal and State health insurance exchanges, and CMS's oversight of Federal matching funds in the Medicaid program.

As we know, the ACA created taxpayer-funded subsidies for healthcare coverage for certain individuals, and also required establishment of State-based or federally-facilitated exchanges. As of June of this year, more than 9 million individuals have had effectuated exchange coverage, including more than 8 million individuals who are receiving Federal subsidies. The ACA also expanded Medicaid to cover childless adults in what was the largest expansion of Medicaid since the program's creation in 1965.

Since October of 2013, more than 13 million individuals have been enrolled in Medicaid and CHIP, including at least 7.5 million newly eligible individuals enrolled in Medicaid. Whether or not CMS is making accurate determinations for the exchanges in Medicaid not only impacts millions of people, it implicates billions of dollars. The Congressional Budget Office has estimated that exchange subsidies and related spending, as well as the increased Medicaid and CHIP outlays under the law, cost Federal taxpayers $77 billion just in 2015 alone.

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The total cost for exchange and Medicaid-related spending next year, due to the law, jumps to $116 billion.

Today's hearing comes at a critical time. Today, we are just over a week away from the start of open enrollment for federally subsidized exchange coverage under the Affordable Care Act.

So it is important that we examine the administration's actions taken, or not taken, to impact the accuracy of Medicaid and exchange coverage eligibility determinations and the Federal matching rate for State Medicaid expenditures.

Previous reports in 2014 and earlier this year from the nonpartisan Department of Health and Human Services Office of Inspector General, the OIG, and the Government Accountability Office, the GAO, have raised very serious concerns about the systematic and ongoing vulnerabilities of eligibility verification systems in place governing the Healthcare.Gov and State-operated health exchanges. It is important that today we not only get an update on the exchange systems, but also examine Federal efforts undertaken to ensure the accuracy of Medicaid eligibility determinations, and the Federal matching rate for State Medicaid expenditures. We will also look at the Federal and State procedures to minimize duplicative coverage for Medicaid and exchange premium subsidies. Regardless of member differences over the ACA, I hope we can all agree that good government need not be a partisan issue, and that protecting taxpayer dollars is a constitutional

responsibility we all share.

Federal officials have a legal and ethical duty to be good stewards of Federal dollars and ensure programs operate within statutory requirements. If an individual is not eligible for a program, taxpayers should not be forced to subsidize that individual just because Federal controls are lax.

Our two witnesses today are from the GAO, and we appreciate their presence with us. They will share with us the data-driven assessment from the nonpartisan GAO regarding a range of challenges related to exchange eligibility controls and the Medicaid expansion.

I now recognize the ranking member of the subcommittee, Mr. Green.

Mr. Green. Thank you, Mr. Chairman.

Mr. Pitts. The mike is a little bit too loud.

Mr. Green. Well, thank you, Mr. Chairman. And I can't agree more than what you said about good government is not a partisan issue, but I have to admit, the hearing this morning is -- I am disappointed, because for one thing, our office didn't get the GAO report within the 48 hours we should have had to be able to properly prepare. And this is a hearing by ambush. It is just not the way this subcommittee ought to work. And I have a briefing, or I have a list of things of the GAO in their report. But, again, I don't know if that is a game that was being played, because when I asked for it 3 days ago, we didn't have

it. And then I was told that our staff got to see it, and it was taken back. That is not the way this Congress ought to legislate, particularly in the Energy and Commerce Committee. I have been on the committee since 1997, and I hope this is not the standard we are going to be using. And I would like to unanimously consent to place my statement in the record. But, again, I don't think any of our members have had the opportunity to look at the GAO. They couldn't release it to us because of the request from you all, from the Republican majority, and we would expect the courtesy of being able to get a report so we can actually prepare questions and a statement in response.

But I will start with saying --

Mr. Pitts. Will the gentleman yield just a moment?

The staff informs me that you received the embargoed reports on Monday, the same time we did, and testimony on Wednesday. We got it at the same time.

Mr. Green. When did they give us the report on GAO?

Mr. Pitts. On Monday.

Mr. Green. Well, from what I heard, last night when we were briefed, is that we got a copy of it, but then it was requested not to make copies of it and not to give it back. Again, I hope our staff doesn't play games like that with what we need to do.

Mr. Pitts. They were -- we will try to make sure you get them in plenty of time.

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Mr. Green. Let me talk about some of the concerns I have about the findings presented in the hearing in the GAO undercover testing is preliminary. They were put in testimony form and given to the minority less than 2 days prior to the hearing. These findings are not generalized, by GAO's own admission. The investigation was based on a small, statistically insignificant number of GAO created fictitious secret shoppers. These secret shoppers are not representative of the average consumer. GAO used the Federal Government's resources and knowledge in forging documents. GAO made -- knew all the fraud prevention safeguards that were placed in advance and had experience getting around these controls.

Mr. Chairman, I know of no Republican support for the Affordable Care Act. Frankly, you couldn't survive a primary if you did. But, again, we are legislators, and we shouldn't have a hearing where, if you want to go after the ACA, we will be glad to battle with you, because I can talk about the success it is. 17.6 million uninsured have obtained coverage through the lowest uninsured rate on record. In fact, that has been reported widely in the newspapers.

But, again, I was hoping we would get past this and we would actually be legislating. If there are problems with the Affordable Care Act, then let's fix them. Some of the things that were in the bill are in the law now, are what the Senate put in. And believe me, I would like to change some of those. But, again, to have a hearing

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in our Health Subcommittee without having adequate notice so we can even prepare for the GAO report. And, again, I will yield back my time, I would ask unanimous consent to be able to place a statement on the record later.

Mr. Pitts. The chair recognizes vice chair of the full committee, Mrs. Blackburn, 5 minutes for her opening statement.

Mrs. Blackburn. Thank you, Mr. Chairman.

And I want to welcome our witnesses. I am so pleased that you are here and that we have got a chance to talk about eligibility standards and the eligibility systems for Medicaid. And ObamaCare has changed a lot of this, and we know that that focus that ObamaCare has been on bolstering enrollment numbers. And it didn't matter what the cost was, it was get the numbers up. So they have really thrown the door open for fraud.

Now, I come from a State that has a track record of working through expansions and enrollment. I come from Tennessee, and we were the test case with TennCare. We were the test case for HillaryCare. You all are familiar with that story, and you know what happened in our State. It was rampant with abuse. We didn't need secret shoppers. We had people that were coming from Kentucky and Alabama and Georgia and North Carolina and Arkansas and Mississippi and jumping into the TennCare program. And we had a fraud unit. We had to go in. I was a State Senator, set up a fraud unit because the fraud was so rampant.

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The reason, it turned out, was there was no verification or reverification of the eligibility standards. So people said, Hey, this is great. It is a "come on in, get what you want." And some of the cases that are there of the fraud that was rooted out and found are astounding. People that would enroll a spouse with dementia in the program, and then they would be driven by ambulance from another State to Tennessee for their doctor's appointments, return home, then put in long-term care facilities and nursing facilities, and how did they get by with it? Because there was no reverification and no checking on these eligibility standards. We know that fraud is a problem. I find it amazing that HHS responded to the GAO findings.

And, Mr. Chairman, I just want to read this quote. "It is important to consider whether it is likely that uninsured Americans would replicate the next actions the GAO took; namely, knowingly and willingly providing false information in violation of Federal law, which could subject the individual to up to a $250,000 fine."

Does anyone realize how totally naive this statement from Meaghan Smith from HHS is? If you have someone who is terminally ill, and you can skirt the eligibility because you know there is no reverification, $250,000? You bet. They are going to give it a shot, and see if they don't get caught, and if they can get by because there is no verification.

Mr. Chairman, I appreciate the attention to this issue. I

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appreciate that the GAO has done a report. If you want to go back and look at government-managed healthcare programs, you see that much of the growth, much of the escalation and the cost per enrollee rate comes down to fraud. I yield back.

Mr. Pitts. The chair thanks the gentlelady, now recognize the ranking member of the full committee, Mr. Pallone, for 5 minutes of his opening statement.

Mr. Pallone. Mr. Chairman, I think we would both agree that this committee has a long history of working respectfully together even on the most difficult of topics, but unfortunately, that did not happen here today with this hearing. It seems to me that my colleagues want nothing more than a flashy, top-line message to justify their obsession with undermining the Affordable Care Act, the result of which is an attempt to take away healthcare coverage from millions of Americans. I say this partly because I received only one paper copy of each of the GAO reports under discussion from the majority approximately 72 hours before this hearing, despite the fact that my staff had asked for these reports for at least a week prior; and my staff had to push multiple times for a time briefly from the GAO on this preliminary so-called fake shopper undercover work, also the topic of today's hearing.

Meanwhile, the only documentation available regarding the fake shopper investigation was GAO's testimony, which was made available

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to our committee less than 48 hours ago, and this is not a positive reflection on this committee.

Let me also point out that while today's hearing may purport to be an honest examination of GAO's work, I question GAO's motives and methods. GAO is supposedly a nonpartisan body. Its mission is supposedly to help government work more effectively and efficiently, but it certainly is not meant to go undercover to create headlines and play I gotcha with Federal agencies.

What is GAO's goal here today? Basically trying to take coverage away for millions of fellow Americans? That is a pretty sad goal and certainly not something that they should be proud of. The fact that GAO refuses to provide CMS with the information on the fake identities it created so that the agency can learn from the GAO's work and fix potential vulnerabilities in the system runs counter to their mission. That is why I sent a letter this morning to GAO comptroller general, Gene Dodaro, outlining these and other growing concerns about GAO, and I hope he conducts an investigation of the policies of GAO in this case.

Mr. Chairman, I do not believe that today's hearing is about program integrity. It is just another example of Republicans' relentless and tone-deaf war on the Affordable Care Act. In addition to GAO's fake shopper investigation, we are here today about two additional reports. If it were not for Republicans' continual mission to undermine the ACA, these reports could have provided a good policy

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discussion. Both highlight important areas where the agency could -- should continue to focus on the ACA's streamline on no-wrong-door policy. That policy rightfully allows consumers to apply for coverage on either the marketplace, or with their State Medicaid agency to ensure appropriate healthcare coverage.

Importantly, the reports highlight the extent of the amount of work the Federal Government and States have done to improve these processes. In fact, CMS is already implementing all GAO's recommendations. But I cannot say the same for the preliminary fake shopper investigation. Let me be clear, Democrats are not opposed to program integrity. However, using fake identities and fake documents is not a fear or realistic test of the accuracy and effectiveness of the eligibility enrollment system in the new healthcare marketplace. In fact, no reality exists in which a person can financially gain from gaming the system. At best, someone would pay an insurance company a monthly premium, pay their deductible, all to get well from an illness or disease.

And this is not some charlatan's trick. What is it that the GAO is trying to accomplish here? I would like to know to what extent. My understanding, and I am going to ask this in my question, is that you are Federal employees. You get your health insurance through the Federal employee program. There are a lot of people that don't get health insurance that easily and have to go through the system with

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the exchange. And it is often difficult for them to do that. And I understand that it is difficult, and I understand that there are problems. But for you to spend your time and your effort, taxpayer money, in trying to make it more difficult or somehow highlight the difficulties, I just don't understand.

It is inconceivable to me that some of the most vulnerable individuals in this country would have the desire, time, money, and expertise to try over and over again to fraudulently gain coverage. In fact, I worry that some of our country's neediest individuals end up forgoing coverage because the system is so confusing to them. And I want to commend HHS for criticizing the way GAO went about this, frankly.

Mr. Chairman, all of GAO's fake shoppers that went through the healthcare Web site failed the identity check. They were all required under penalty of perjury to submit additional documents at which point GAO provided counterfeit information, such as fictitious Social Security cards and immigration documents. Further, GAO stopped short of filing tax returns for the fake shoppers. That makes it clear to me that we have important controls in place.

Republicans have said that Democrats care too much about insuring people and access coverage, and that is an accusation that I am proud to own. I do believe that priority should be first and foremost that people can access the coverage they need or are entitled to have, and

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I am proud to have been the chief architect of the law that helps that happen.

Thank you, Mr. Chairman.

Mr. Pitts. The chair thanks the gentleman.

Again, let me just briefly reiterate, the minority received the testimony on Wednesday, when we received it. I am told the GAO briefed the minority last Friday, and we provided the full report on Monday to your office, Mr. Pallone, which I understand you distributed to the member offices.

So we gave the minority more info and lead time than required under the rules. And this hearing is about accountability, which all of us want.

So, with that, sorry to have this start on a partisan note, but that concludes the members' opening statements. As usual, all members' written opening statements will be made part of the record, and we will proceed to our panel.

Our two witnesses today are from the GAO, and we appreciate their presence with us. They will share with us the data-driven assessment from the nonpartisan GAO regarding a range of challenges related to exchange eligibility controls and the Medicaid expansion.

And on our panel we have Ms. Carolyn Yocom, Director, Health Care, of the Government Accountability Office; and Mr. Seto Bagdoyan, Director, Audit Services, Forensic and Investigative Services, General

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Accountability Office.

Thank you for coming today. Your written testimony will be made a part of the record. You will each be given 5 minutes to summarize your written testimony.

And, Ms. Yocom, we will start with you. You are recognized for 5 minutes for your summary.

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STATEMENTS OF CAROLYN YOCOM, DIRECTOR, HEALTH CARE, GOVERNMENT ACCOUNTABILITY OFFICE; AND SETO BAGDOYAN, DIRECTOR, AUDIT SERVICES, FORENSIC AND INVESTIGATIVE SERVICE, GOVERNMENT ACCOUNTABILITY OFFICE

STATEMENT OF CAROLYN YOCOM

Ms. Yocom. Thank you. Chairman Pitts, Ranking Member Green, and members of the subcommittee, I am pleased to be here today to discuss issues related to CMS oversight of Medicaid eligibility determination, and coordination between Medicaid and the health insurance exchanges, which are also referred to as marketplaces.

The Patient Protection and Affordable Care Act has provided millions of Americans new options for obtaining health insurance by qualifying for Medicaid, or purchasing private insurance through a State-based or federally-facilitated exchange. Because income volatility occurs for many low-income individuals, they are likely to switch between Medicaid and subsidized exchange coverage. It has been estimated that 6.9 million individuals who receive either Medicaid or the exchanges will switch between coverage some time during the year.

Due to the likelihood of these transitions, the Act requires the creation of coordination between Medicaid and the exchanges. However, the complexity of designing such coordinated processes can raise

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challenges, and careful CMS oversight is crucial to ensure that Medicaid eligibility determinations are appropriate, and that the risk of coverage gaps and duplicate coverage is minimized. My statement draws from two reports and will focus on, first, CMS oversight of enrollment of beneficiaries and reporting of expenditures; and, secondly, the extent to which CMS and States have policies and procedures in place to reduce the potential for coverage gaps and duplicate coverage when individuals transition between Medicaid and the exchange.

Regarding Medicaid enrollment, CMS has taken some interim steps to review the accuracy of State eligibility determination and examine State's expenditures for different eligibility groups, but more efforts are required. In particular, CMS has excluded Federal eligibility determinations from their review. This creates a gap in efforts to ensure that only eligible individuals are enrolled in Medicaid, and that State expenditures are correctly matched by the Federal Government.

CMS also does not use information from these eligibility reviews to better target its oversight of Medicaid expenditures for the different eligibility groups. Consequently, CMS cannot identify erroneous expenditures due to incorrect eligibility determinations.

To improve its oversight, we recommended, and CMS generally agreed, that CMS should review Federal determinations of Medicaid

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eligibility for accuracy and use the information obtained from State and Federal eligibility reviews to inform its review of expenditures for different eligibility groups.

With regard to coordination between Medicaid and the exchanges, CMS has implemented several policies and procedures, and has additional controls planned to minimize the potential for coverage gaps and duplicate coverage. However, we found weaknesses in internal controls for these Federal exchanges. For example, CMS's controls do not provide reasonable assurance that electronic records for individuals transitioning from Medicaid to exchange coverage are transferred by States in near real time, thus putting individuals at greater risk for experiencing gaps in coverage. We also found weaknesses in CMS's controls for preventing, detecting, and resolving duplicate coverage.

To further minimize the risk of coverage gaps and duplicate coverage, we recommended, and CMS agreed, that CMS take three actions: First, to routinely monitor the timeliness of account transfers from States; secondly, to establish a schedule for regular checks of duplicate coverage; and then, thirdly, to develop a plan to monitor the effectiveness of these checks. CMS did report a number of planned steps to address the risks that we identified.

Chairman Pitts, Ranking Member Green, and members of the subcommittee, this concludes my statement, and I would be pleased to respond to any questions.

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[The prepared statement of Ms. Yocom follows:]

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Mr. Pitts. The chair thanks the gentlelady, and now recognizes Mr. Bagdoyan 5 minutes for his summary.

STATEMENT OF SETO BAGDOYAN

Mr. Bagdoyan. Thank you. Chairman Pitts, Ranking Member Green, and members of the subcommittee, I am pleased to be here today to discuss the preliminary results of GAO's undercover tests assessing the enrollment controls of the Federal marketplace and selected State marketplaces under the ACA for coverage year 2015.

We performed 18 undercover tests through phone or online applications. Our tests were designed specifically to identify indicators of potential weak -- control weaknesses, and inform our separate forensic audits of these controls, which cover the entire universe of enrollees. I would note that our results, while illustrative, cannot be generalized, as pointed out earlier, to the entire applicant population. We did discuss details of our observations extensively, both with CMS and the selective States, to seek their responses to the issues we identified.

CMS and State officials explained, for example, that in the applicable instances, the marketplaces and Medicaid agencies are only required to inspect application documentation for obvious alteration. If there are no signs of alteration, the documents won't be questioned

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for their authenticity.

In terms of context, health coverage offered through the marketplaces is a significant expenditure for the Federal Government, as Chairman Pitts pointed out.

Current levels of coverage involve several million enrollees, of whom about 85 percent are receiving subsidies. CBO pegs subsidy costs for fiscal year 2016 at about $60 billion, and a total of $880 billion for fiscal years 2016 to 2025.

I would note that while subsidies are paid to insurers and not directly to enrollees, they nevertheless represent the financial benefit to them. I would also note that a program of this scope and scale, millions of enrollees and hundreds of billions of dollars in expenditures, is inherently at risk for errors, including improper payments and fraudulent activity.

Accordingly, it is essential that there are effective enrollment controls in place to help narrow the window of opportunity for such risk, and safeguard the government's investment in the program.

With this as backdrop, I will now discuss our test principal results.

Overall, we first observed no year-on-year improvements in the Federal marketplace's controls from our coverage year 2014 tests. Second, we found similar control vulnerabilities in the State marketplaces. And third, following the system's own instructions,

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employed relatively simple workarounds such as making phone calls and making self-attestations to circumvent the controls we did encounter to obtain coverage.

More specifically, the Federal and selected State marketplaces approved subsidized coverage, either private plans or Medicaid, for 17 of our 18 fictitious applicants. The subsidies totaled about $41,000 on an annualized basis.

For 10 applicants, we tested application enrollment into subsidized qualified health plans, or QHPs, available through the Federal marketplace to include the States of North Dakota and New Jersey, and State marketplaces in Kentucky and California. These applicants were directed to submit supporting documents, such as proof of income or citizenship, and submitted fake documents in response. In each instance, the Federal or State marketplaces approved coverage. This included four applications where we used Social Security numbers that could not have been issued by the Social Security Administration.

For the remaining eight applicants, we tested Medicaid enrollment through the Federal marketplace as a portal for North Dakota and New Jersey, and State marketplaces in California and Kentucky.

For three of eight applications, we were approved for Medicaid. In each of these tests, we provided identity information that would not match SSA records. Each applicant was directed to submit supporting documents. Again, we submitted fake documents, and the

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applications were approved.

For four of eight applications, we were unable to obtain Medicaid approval; however, as a result of this failure, we subsequently applied for and were approved for subsidized qualified health plans. For the remaining application, we were unable to apply for Medicaid coverage in California, because the applicant declined to provide a Social Security number, citing privacy concerns.

In closing, our results highlight the need for CMS and the States to make program integrity a priority and implement effective controls to help reduce the risks for potential improper payments and fraud. Otherwise, there are significant potential for such risks to be embedded early in a major new benefits program such as the ACA. We plan to include a number of recommendations to CMS regarding controls in a forthcoming report, and we have already discussed these recommendations in detail, including with Acting Administrator Slavitt.

Mr. Chairman, this concludes my statement. I look forward to the subcommittee's questions.

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[The prepared statement of Mr. Bagdoyan follows:]

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Mr. Pitts. The chair thanks the gentleman. Thanks to both of you for your testimony.

We will begin the questioning. I will recognize myself 5 minutes for that purpose.

And this question is for both of you. I will start with you, Ms. Yocom. Today, we are just over a week away from the start of open enrollment for exchange coverage under the Affordable Care Act. Do you have any reason to believe that the vulnerabilities identified by GAO and reported in your testimony have been sufficiently addressed by CMS, or are these program gaps in vulnerabilities ongoing?

Ms. Yocom. There certainly are remaining concerns about the need for better oversight of the eligibility determination process, and also checking for -- to ensure that the appropriate matching rate is -- has been used. CMS has taken some actions over the course of the summer, but there is more to do.

Mr. Pitts. Mr. Bagdoyan.

Mr. Bagdoyan. Yes. Thank you, Mr. Chairman.

I would echo what Ms. Yocom said in terms of questions and concerns that remain. As I mentioned in my opening statement, we have not detected any change in the CMS control environment, which is the broad set of controls from the front, the middle, and the end. In fact, for the end control, which is essentially the tax reconciliation process, there have been several reports from the Treasury inspector

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general for tax administration, the HHS, OIG, as well as GAO itself, questioning the capability of CMS and the IRS to effectively implement that control. So my answer would be the vulnerabilities remain based on the evidence that we have.

Mr. Pitts. When did GAO first make CMS aware of the vulnerabilities identified? For example, in the undercover work specifically, hasn't CMS known about these problems since at least last summer?

Ms. Yocom, or Mr. Bagdoyan?

Mr. Bagdoyan. Yes, thank you. Yes, we had a hearing before the House Ways and Means Committee in July of 2014, and we discussed our initial look at the time for coverage year 2014 with CMS in detail. And so they were aware, at least, of the very specific issues that we raised, in terms of control vulnerabilities.

Mr. Pitts. Let's continue, Mr. Bagdoyan. During the first 2 years, GAO has successfully obtained federally-funded, or subsidized coverage, for 28 of 30 of the fictitious applicants, each of which should have been denied coverage because they did not have or provide sufficient evidence of eligibility according to your testimony. That is a 93 percent error rate. Does GAO find that acceptable? I mean, is there any other Federal Government program with even near as high an error rate?

Mr. Bagdoyan. Well, I would certainly caution the use of that

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93 percent. Certainly, the sample we used was not generalizable. It was designed to raise concerns and flags about specific controls. As you know, the issue of improper payments was discussed by the comptroller general recently. The trend is up after several years of some modest decline. So that is the environment we are looking at, this issue overall. We are not trying to specifically target any one individual for their health coverage. As I mentioned in my opening statement, we have parallel forensic audit work ongoing right now, and that is looking at each and every enrollee in the system, and we would be subjecting those enrollee databases to various types of analyses.

Mr. Pitts. Now, supporters of the Affordable Care Act like to claim -- or they are likely to claim that GAO's fictitious applications do not represent actual fraud, and question whether GAO has identified any real fraud. It is my understanding that GAO's undercover work was also supposed to be paired with a forensic audit of actual exchange enrollment data, but that CMS has stonewalled GAO in providing the data necessary to do that work. Can you please describe the delays GAO has experienced in obtaining the necessary data from CMS?

Mr. Bagdoyan. Sure. Yes. First, just to restate the fact that the work we did undercover was not designed to detect fraud, per se, in the general population. Although when we did perform the work, we obviously engaged in fraudulent activity, which is consistent with our investigative authority for these purposes. And, yes, we do have

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ongoing forensic audits for coverage year 2014. In discussions with staff, we are ready to request 2015 information for coverage year 2015 or other --

Mr. Pitts. And could you just briefly --

Mr. Bagdoyan. Yes, I will mention that our initial contact with CMS to obtain the 2014 data began in April of last year, and it was not resolved until -- until recently this year. So it took about a year of negotiation to obtain that data set.

Mr. Pitts. Okay. My time has expired. I recognize the ranking member, Mr. Green, 5 minutes for questions.

Mr. Green. Thank you, Mr. Chairman. I thank the witnesses for your testimony today.

Mr. Bagdoyan, I want to ask some of the results, your preliminary results of your work on the eligibility of enrollment, and hopefully, because I have a lot of questions, we can get yes or no.

First of all, how many fictitious identifies did GAO create and attempted to get the coverage from Medicaid or subsidized marketplace coverage?

Mr. Bagdoyan. For coverage year 2015, which is the work I am testifying on today, there were 18 separate applications.

Mr. Green. Okay. How many of these applications were made online?

Mr. Bagdoyan. I think about -- most of them actually, began

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online, and then switched to phone application as we encountered the identity proofing restriction.

Mr. Green. So all 18 started online?

Mr. Bagdoyan. Most of them did.

Mr. Green. Okay. How many of the applicants failed on ID spoofing? How many of these applications failed on ID spoofing?

Mr. Bagdoyan. I would say the vast majority of them failed the online ID proofing step.

Mr. Green. According to your testimony, ID proofing, quote, "served as an enrollment control for those applying online"; is that correct?

Mr. Bagdoyan. That is correct.

Mr. Green. And let's see if I understand correctly. Each of these applicants were directed to phone the marketplace and reply by phone, correct?

Mr. Bagdoyan. We were directed to call the contractor, Experian, who is tasked with performing the identity proofing. When they also could not proof for identity, they directed us to call the marketplaces, and that is what we did, and we considered that a control workaround.

Mr. Green. Were these applicants informed over the phone that there were civil or criminal penalties for providing inaccurate, untruthful information to the exchange?

Mr. Bagdoyan. As I recall, the representatives did read them

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statements to that effect, yes.

Mr. Green. And are you aware that in addition to criminal penalties for perjury, there are significant civil penalties in the statute for negligent or knowingly reporting false information to the exchanges?

Mr. Bagdoyan. Yes, I am aware of that.

Mr. Green. And if I understand your testimony, each of the 18 applications, all of them resulted in inconsistency?

Mr. Bagdoyan. The ones that we were successful, which were 17 of 18, most of those were -- resulted in some sort of inconsistency which needed to be cleared, yes.

Mr. Green. And according to your testimony, if there is an inconsistency, the marketplace determines eligibility using the applicant's attestations and then requires applicants to provide additional documentation to resolve the inconsistency? Is that correct?

Mr. Bagdoyan. That is correct.

Mr. Green. And this is another control in the eligibility enrollment process?

Mr. Bagdoyan. Well, the submission of documentation, we consider that to be more of a middle control. I think the whole system essentially relies on self-attestation, which is a concern itself in an overall control environment.

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Mr. Green. And GAO submitted forged documentation for each of these applications for coverage?

Mr. Bagdoyan. That is correct.

Mr. Green. So, for instance, fake Social Security cards, fake driver's license, fake immigration documents, and so forth?

Mr. Bagdoyan. That is right.

Mr. Green. Okay. Are you aware that there are significant criminal and civil penalties under both State and Federal law for creating and using falsified documentation, such as driver's license and Federal immigration documents?

Mr. Bagdoyan. Yes, I am.

Mr. Green. Did GAO, at any time, contact the Office of Inspector General for Health and Human Services?

Mr. Bagdoyan. We coordinate our work upfront with them, but we don't discuss any of our investigative details.

Mr. Green. Okay. Has this report been submitted to the Office of Inspector General?

Mr. Bagdoyan. No, it has not.

Mr. Green. I want to thank you for your testimony. It makes clear that there are multiple layers of eligibility enrollment controls in the State and Federal marketplaces. While there is always room for improvement, I take issue with assertions of some of my colleagues that we have an ideological opposition to the ACA to seek to falsify, portray

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the eligibility enrollment system. I think there are some safeguards in it, but, again, we have a lot of different groups that can investigate that, including the inspector general for the Health and Human Services.

Mr. Chairman, I yield back my time.

Mr. Pitts. The chair thanks the gentleman, now recognize the vice chairman of the full committee, Mrs. Blackburn, 5 minutes for questions.

Mrs. Blackburn. Thank you, Mr. Chairman. And just as a point of clarification, as we are having this discussion, I think that it is important to note that having secret shopper programs are standard operating procedures for businesses that work in the consumer realm that are in customer service. Secret shopper programs are used by restaurants, by hotels, by retail establishments. They are used by our chambers of commerce many times.

So to say it is fake, or that it is something that is unseemly and stealth, I think it is important to note that this is how many organizations go in and do a spot check on how they are performing and how they are delivering a service.

As I said, coming from the State where we have had a little bit of a history with this through Medicaid expansion, I appreciate the attentiveness to the detail of trying to make certain there are fewer vulnerabilities within the system where people can come in, fake their

eligibility, enroll, and then get services that the taxpayers are paying for, services to which they are not entitled, and their utilization of those services means there is less for those who actually need and deserve and qualify for those services.

Mr. Bagdoyan, I want to start with you and go back to this vulnerability where you say that it was -- the documentation submitted does not appear to have any obvious alterations, it would not be questioned in its authenticity. That seems like a very low bar to me.

So did fabricating the documentation requested as part of the application process require specialized knowledge or any great technical skill?

Mr. Bagdoyan. Not really.

Mrs. Blackburn. So this is something that anybody could do from a simple home computer or a keyboard?

Mr. Bagdoyan. Yes. We used commercially available computers, software, and paper materials. You just have to have a basic knowledge of what these things look like, and those are readily available from the Internet.

Mrs. Blackburn. So in replicating the marketplace in order to do your research, you used as many different points of entry as options to enter the system?

Mr. Bagdoyan. Yeah. We had no foreknowledge of what the controls were that we would encounter. And that goes back to our 2014

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work. We went, behaving as a typical consumer would, encountering the program and the systems it has for the first time.

Mrs. Blackburn. And that is how any smart businessperson would do an evaluation of the vulnerabilities and the risks embedded in their system, and ascertain as to whether or not the proper controls are in place to prevent any type of fraud or leakage.

Let me ask you this: How would you respond to claims that the risk of fraud is low, because subsidies are provided directly to the insurer as opposed to the enrollees?

Mr. Bagdoyan. Right. Thank you for your question. In that regard, we view the subsidy issue as still being beneficial, financially, to an applicant. Essentially, it keeps more money in their pocket when they pay the premiums, or if they choose to take the subsidy in the form of a tax credit, that reduces their tax liability, or it could also result in a refund, which does involve getting a check from the government.

Mrs. Blackburn. Okay. Thank you.

Ms. Yocom, just one question before we move on. The 100 percent Federal funding for the newly eligible, the States obviously have a financial incentive to bulk up that enrollment. And what, if any, safeguards did CMS institute to ensure that taxpayers were not paying more than their share of the State's Medicaid program?

Ms. Yocom. The primary safeguard that CMS has been using has been

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the eligibility reviews that they have conducted. They have asked, first, for States to take samples of applications and review them, and then they have reviewed the results of those applications.

Mrs. Blackburn. So the States are following through on the verification?

Ms. Yocom. When errors or problems are identified, then the States need to file a corrective action plan with CMS, that says how they will correct those.

Mrs. Blackburn. Very good. Thank you.

I yield back.

Mr. Pitts. The chair thanks the gentlelady, now recognize the ranking member of the full committee, Mr. Pallone, 5 minutes of questions.

Mr. Pallone. Thank you, Mr. Chairman.

My questions are for Mr. Bagdoyan. I want you to understand, Mr. Bagdoyan, why I am so critical of this fake shopper investigation. I just feel that it is very important for people to get health insurance. And I know that the GAO is spending a lot of money doing this investigation, and it just seems to me that it is not a priority. I mean, my colleagues on the Republican side every year try to cut funding for the IRS. And, you know, you would think that the people that are cheating the income tax would be the ones you would be most concerned about defrauding the government, but they keep cutting the enforcement

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dollars for that. So it is always a question of priorities.

Who is it that asked you to do this fake shopper investigation?

Mr. Bagdoyan. Yes. As we reflect in my statement, Mr. Pallone, this request originated with the Senate Finance Committee, the House Committee on Ways and Means, and the House Committee on Energy and Commerce.

Mr. Pallone. The majority?

Mr. Bagdoyan. The majority.

Mr. Pallone. Okay. And why did you decide that this was a priority? In other words, I know a lot of times people ask -- you know, in Congress they ask Members -- committees ask GAO to do investigations, they don't do it. Why did you think this was a priority?

Mr. Bagdoyan. Well, actually, we do respond to each and every request.

Mr. Pallone. You respond, but you don't necessarily do it.

Mr. Bagdoyan. We prioritize them. And when the term of this engagement came, it was fully staffed, and the work began.

Mr. Pallone. So you just basically do every investigation that any congressional committee asks you to do?

Mr. Bagdoyan. For the most part, yes.

Mr. Pallone. Well, I haven't found that to be true.

Let me ask you this: You are a government employee, right?

Mr. Bagdoyan. That is correct.

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Mr. Pallone. And how do you get your health insurance?

Mr. Bagdoyan. Through the government, through the GAO.

Mr. Pallone. Well, not through the GAO, but through the Federal employee program, right?

Mr. Bagdoyan. Right.

Mr. Pallone. Why did you decide to investigate the exchange marketplaces and not the Federal employee program? Why didn't you set up fake shoppers for that?

Mr. Bagdoyan. Well, that was not my decision. It is a response to a request from Congress; we do our best to respond to that. And we operate for this work under the premise that this is the law on the books, and our work is to make sure that it gets done as intended.

Mr. Pallone. I understand that. But I also understand that in order to obtain coverage fraudulently, one would need to be extremely motivated, willing to break a number of different laws with serious civil and criminal penalties for no direct financial gain, and I think that is highly unlikely. And, you know, if an enrollee did manage to do all that, they would still have to pay their share of premiums before their coverage is effective, and you never even went so far as to ask for their income taxes, which is the final check.

So I just think that when you make decisions about what you are going to prioritize and investigate, you have got to think about what the consequences are. You are spending taxpayer dollars, and whether

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or not there is any legitimate reason to do this. Have you examined the incidents of fraudulent documentation being used in the marketplaces? In other words, how big a problem this is in reality? Is that something you have looked at as to what extent this is a real problem?

Mr. Bagdoyan. Sure. Thank you for that question. As I mentioned earlier in response to another question along those lines, we have parallel forensic audit work that is looking at all the enrollees from coverage year 2014, and we are in the process of requesting coverage year 2015 data, and we will subject those data sets to various sorts of analysis.

Mr. Pallone. But to this date, we have no information to tell us how big this problem is?

Mr. Bagdoyan. That is correct, yes.

Mr. Pallone. Okay. All right. I just think that it is important when -- it just disturbs me a great deal to think that what you are basically telling me is that anything Congress asks you to do, no matter how spurious it might be, no matter whether or not you think it is important or not, you are just going to do it because Congress asked you to do it. I mean, if that were the case, there would be no real-world applicability to what you do. And I just -- it is shocking to me to think that you had to -- every time someone went up and there was a check in the marketplace for someone who was trying to be

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fraudulent, you had to go and make another false identity each time. And then, finally, when you got to the point where they would have to submit their tax returns, you didn't even bother to do that, which probably would have been the ultimate check.

Why didn't you ask for the tax returns? Why didn't you go to that ultimate check?

Mr. Bagdoyan. This part of the work was designed to take our checks or control reviews to the middle part of the controls, which essentially ends with the document verification.

Mr. Pallone. So, in other words, is it possible you just thought that one would be too difficult for people to accomplish?

Mr. Bagdoyan. No, not at all.

Mr. Pallone. Well, why -- so it is just because you didn't have the time basically? You did the middle part but not the end result?

Mr. Bagdoyan. Each plan stands on its own merit, Mr. Pallone.

Mr. Pallone. It doesn't have any merit in my opinion, Mr. Bagdoyan. I just -- I am shocked. It seems to me that something has to be done about the way GAO proceeds, if they just do these things and we have no accountability as to whether it accomplishes anything or is useful in the real world. Thank you.

Mr. Bagdoyan. Thank you.

Mr. Pitts. The chair thanks the gentleman, now recognize the gentleman from Illinois, Mr. Shimkus, 5 minutes for questions.

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Mr. Shimkus. Thank you. Thank you, Mr. Chairman.

Thanks for being here. It is good to follow my friend, the ranking member, because the history is also instructive. The healthcare law was passed, especially the sidecar, with no debate through the committee, no oversight hearings, and really, no debate on the floor.

So that is why, you know, we on our side, continue to look and try to do our oversight. When we were still in the minority, we asked for numerous hearings on -- we asked for hearings on how the healthcare law would work; we asked for hearings on the rollout; we asked for hearings on the eligibility standards; we asked for hearings on fraud; we asked for hearings on Medicaid expansion. We never had any receptivity to any oversight hearings when we were in the minority. So now that we are doing oversight when we are on the majority, I am not sure why people should be surprised at that. So now I will go to my questions.

For Mr. Bagdoyan, it is my understanding that CMS asked GAO to provide identifying information about its fictitious applicants; is that correct?

Mr. Bagdoyan. That is correct.

Mr. Shimkus. Has GAO provided such information to other agencies in which similar undercover work has been performed?

Mr. Bagdoyan. Not to my knowledge.

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Mr. Shimkus. What would be the implications of providing the identities of the fictitious applicants on GAO's ability to conduct future undercover work, whether on the ACA or any Federal program?

Mr. Bagdoyan. Yeah, it would essentially compromise our sources, methods, and techniques. A lot of this information is directly connected to the agents who performed the work, so it would expose them to risk, such as identity theft, and overall, it could compromise our ability to conduct investigations for the current Congress, future Congresses. So those are significant implications.

GAO has been doing this for over 30 years, and it is a long-standing capability that we offer, and we pursue them according to the applicable investigative standards.

Mr. Shimkus. And your profession, I guess the frustration is -- we are actually on the same team, and we have got a law. We want it to be -- we want it to be applicable in a responsible manner. You have a role to help us do that. When I was in the Army and we had the IG coming down, we all -- you know, they are here to help us. They were a pain in the rear end, but they were just to help ensure that we had our procedures and our performance standards in line with the expectations of the command guidance in the Army. So no one likes to have people go through their dirty laundry, I get it. But that is -- that is -- that is your job, and we appreciate it.

Some of my colleagues on the other side of the aisle may question

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the utility of your findings because of the results of 18 fictitious applicants are not generalizable. In fact, you used that term earlier to another question. I understand that GAO's methodology was not intended to provide generalizable results; is that correct?

Mr. Bagdoyan. Yes, that is correct, Mr. Shimkus.

Mr. Shimkus. And what was GAO's methodology designed to show? And given the results, what has GAO concluded?

Mr. Bagdoyan. Yes. The methodology, as with 2014 and with 2015, was designed specifically to flag potential control vulnerabilities. And in each case, we detected those vulnerabilities, and as I mentioned earlier, we have a separate report that will be coming out within the near future that will be directed to all the requesters with recommendations, specifically to CMS, and we have discussed those already at a general level with CMS, including the acting administrator.

Mr. Shimkus. Great. Thank you.

And for Ms. Yocom, do you find it concerning that at a time when States are implementing significant changes to the Medicaid eligibility determination process, and the Federal Government, for the first time, is determining Medicaid eligibility in some States, CMS decided to suspend its measurement of the eligibility component of its payment error rate measurement program?

Ms. Yocom. We are concerned about that. The eligibility

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determination rate is going -- is not going to be based on the Affordable Care Act and the eligibility actions there. And at this point, I believe the latest is it will not be until 2019 before the error rate is actually applied. CMS is doing eligibility reviews, and it is important to do this. We do want them to be a little more transparent about what they are finding and how they are fixing it.

Mr. Shimkus. Thank you, Mr. Chairman. I yield back my time. Thank you for coming.

Mr. Pitts. The chair thanks the gentleman, now recognize the gentlelady from California, Mrs. Capps, for 5 minutes of questions.

Mrs. Capps. Thank you, Mr. Chairman. I am going to yield a few seconds to my ranking member.

Mr. Green. Mr. Chairman and my colleague and good friend from Illinois, you were on the committee when we had exhaustive hearings in drafting the Affordable Care Act. In fact, I remember some very all-nighters, it seemed like. So our committee did do its due diligence in 2009 and 2010, as I recall, because I was on the committee in 2003, when we expanded the prescription drug plan.

Mr. Shimkus. Will the gentleman yield?

Mr. Green. It is not my time.

Mrs. Capps. It is my time. Certainly.

Mr. Shimkus. I would ask the public to check the record. I will stand by my statement.

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Mrs. Capps. Thank you again, Mr. Chairman. As some of my colleagues have pointed out, the forensic work that GAO is providing testimony on today is interesting, unfortunately, not particularly applicable to the real word. It's highly unlikely that people would use fraudulent identities to enroll in a qualified health plan. The number of hurdles they would have no overcome in order to get coverage, not to mention the number of State and Federal laws they would have to break simply are not realistic for someone who is just trying to apply for health coverage, health coverage that they are going to pay for with their own premium dollars, by the way, with any subsidies going not to them, but to their insurance company.

In sharp contrast to GAO, the work of the HHS Office of Inspector General has been doing to review real-life cases have been far more constructive than finding areas where both the Federal and the State-based marketplaces can improve their eligibility and their enrollment processes. For example, the Office of Inspector General just released a report on Kentucky State-based marketplace, and reviewed a sample of 45 actual case files and reviewed staff and contractors and reviewed documents.

Mr. Bagdoyan, are you aware of this report? Yes or no?

Mr. Bagdoyan. Yes, I am.

Mrs. Capps. Thank you. The OIG report found that the States' controls were generally sufficient but did not -- but did find some

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issues that occurred primarily due to system errors, such as failing to send a notice of inconsistency, flagging that something is not right. The State has corrected these errors by addressing the problem with the system and also made sure that the people and the cases with errors were actually eligible, which, in fact, they were, despite the system errors.

Similarly, a review of the federally-run marketplace in August found some issues in how it resolves inconsistency. As in Kentucky, CMS confirmed that people in the cases with problems are actually eligible, and is making changes to improve the process of resolving inconsistency. The OIG provides specific information on the errors they find so they can be corrected, or otherwise remedied.

Mr. Bagdoyan, do you plan to make the identifying information for the fictitious applications available to CMS and to the State-based marketplace in order that these entities address the root causes of the errors, yes or no?

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[9:59 a.m.]

Mr. Bagdoyan. As with our past position, we will not be providing that information.

Mrs. Capps. Why not?

Mr. Bagdoyan. Because it involves investigative techniques, sources, and methods, undercover identities that are directly linked to our agents who would then be exposed to risk.

Mrs. Capps. Well, I find this important. And I must say I think this further supports what I have been saying about the real-world applicability of GAO's forensic work in this case, by looking at actual cases rather than wholly artificial ones, the OIG is identifying where there are actual real-life problems, and the eligibility enrollment system that needs to be corrected. And their investigation gives States like California where I live, and the Federal Government, the opportunity to actually improve the way the systems work, and this benefits consumers and taxpayers.

In contrast, GAO's work looks at theoretical problems involving fictitious applicants who do not actually operate as people, operate in the real world, and then refuses to provide information sufficient for these agencies to make genuine system improvements.

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One last question, Mr. Bagdoyan. You said that the documents forged and produced were deemed with readily available materials, how much money did you need to spend on these materials for computers, printers or other internals?

Mr. Bagdoyan. Very little to none. They are readily available to us as part of our investigative capability.

Mrs. Capps. What time -- how much time did you spend on this project?

Mr. Bagdoyan. The works been ongoing since 2014.

Mrs. Capps. This isn't an area suitable expectation for -- well, I appreciate that information. And again, it is just unfortunate. Thank you very much. I yield back the balance of my time.

Mr. Pitts. The chair thanks the gentlelady. I now recognize the vice chair of the subcommittee, Mr. Guthrie, for 5 minutes for questions.

Mr. Guthrie. Thank you very much, we have talked about Kentucky a lot. Kentucky has been talked about a lot in Affordable Care Act, and the one thing that I have always said were on the Affordable Care Act are people working for a State government made a Web site that worked, that actually operated when a lot of places weren't able to do that.

The problem is that in this study that you moved forward, and I understand what Ms. Capps is referring to, but those are people who

qualified, and there were just mistakes made on those applications. My understanding is in your fictitious people signing up that weren't qualified for subsidies, and the way you set up the scenario that Kentucky had five out of five get coverage, even though they should not have gotten coverage, so 100 percent.

I know that is not -- five cases, but if somebody told me it was two out of five and that is 40 percent, or if it is one out of five and that is 20 percent. But five out of five is 100 percent, so who knows? You can sort of start making some extrapolations as a statistics person even with those few numbers. There is also 17 out of 18, I understand.

And so in your statement, your written statement, Mr. Bagdoyan, you said, and I quote, that CMS told GAO officials "the eligibility and enrollment system is generally performing as designed."

Mr. Bagdoyan. That is correct.

Mr. Guthrie. Working as designed is what they said. What do you make of the statement, given that 93 percent, or 17 out of 18 of your fictitious applicants enrolled in subsidized coverage?

Mr. Bagdoyan. Well, I would answer that question in the context of what CMS told us in respect of balancing access to coverage with program integrity. So if you look at it that it was designed -- it is working as intended, that means that access is enabled. I would say that the overall balance would tilt to access over program integrity

at this point in time.

Mr. Guthrie. So they are willing to accept that fictitious people can register because it is easier for everybody to register?

Mr. Bagdoyan. That would be for CMS to respond to.

Mr. Guthrie. So in your opening statement, also, you indicated that GAO found no improvements in the federally-facilitated marketplace control environment between plan year 2014 and plan year 2015. When did GAO first share information with CMS about the weaknesses found in the marketplace, eligibility determination controls. And are there changes that CMS could have made between the 2-year plans to address these concerns?

Mr. Bagdoyan. Sure. We first broached the subject at the conclusion of our first round, if you will, of our undercover work, which would have occurred in early summer of 2014, right before the July hearing, before the House Ways and Means Committee.

Mr. Guthrie. Okay.

Mr. Bagdoyan. And in terms of having information from us, we discussed in detail how each scenario unfolded, both in 2014 and 2015. We explained how we worked around the identity proofing control that we encountered, and provided related information that they could have used to notice that the ID proofing workaround was a problem, and also the fact that the documents that we submitted were not really subjected to any kind of scrutiny other than did they really look altered to the

naked eye.

Mr. Guthrie. Okay.

Mr. Bagdoyan. And I would point out, in terms of providing information to others, that we had discussions with Kentucky officials in person.

Mr. Guthrie. It is my understanding they are very receptive to try to change --

Mr. Bagdoyan. They were receptive. Again, we provided information. We went to Kentucky to discuss those in person. And in response to the statement, those officials let us know that they are already taking action in two areas: One is training of their representatives, and the second one is to improve their system so the ID proofing step or control is not so easily over worked around.

Mr. Guthrie. Thank you for pointing that out. I should have pointed that out as well that our State employees were trying to make these improvements.

Mr. Bagdoyan. That is correct. They have been receptive to our discussions and already taking action. And they promised to provide us with additional details when we finalize this work, this 2015 round of undercover work in a final report.

Mr. Guthrie. I appreciate hearing that.

And then for Ms. Yocom, I have one quick question. Ten States have delegated authority to Medicaid eligibility determinations to the

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Federal Government. What, if anything, has CMS done to access the accuracy of Medicaid eligibility decisions made by the Federal exchanges in determining eligibility error rate?

Ms. Yocom. When we began our work, the short answer is they had not done anything. Our process is pretty interactive with CMS. They have reported to us that they have begun looking at the FFE, at the Federally Facilitated Exchange, eligibility determinations beginning in August. We do not know the results of those reviews.

Mr. Guthrie. Okay. So they just began this August and we are waiting to hear?

Ms. Yocom. Yes.

Mr. Guthrie. Okay. It would be interesting to hear when that time comes. Well, thank you. I just ran out of time. I yield back.

Mr. Pitts. The chair thanks the gentleman and now recognizes the gentleman from North Carolina, Judge Butterfield for 5 minutes for questions.

Mr. Butterfield. Thank you, Mr. Chairman, and good morning to both of you. I thank you very much for your testimony. And in the interest of time, I think most of my questions will be directed to the GAO representative, Ms. Yocom, but thank you as well, sir, for your participation.

Mr. Bagdoyan. You are welcome.

Mr. Butterfield. Mr. Chairman, I think it is important for us

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to remember why we have these systems in place in the first place. Democrats on this committee, as you would recall, who drafted the Affordable Care Act, envisioned a no-wrong-door policy in which individuals could apply either at the State Medicaid office, or they could apply through the exchanges and would get an eligibility determination for whichever program they are eligible for.

Ms. Yocom, let's start with this: I would like to ask you some questions about how the ACA implements this no-wrong-door policy and what this really entails?

Ms. Yocom. Sure. The purpose of the no-wrong-door is that an individual can approach a marketplace, they can approach the State Medicaid agency, they can go on to the Web site and from any of those areas, determine which type of insurance, if any, they are eligible for, and then how much of, and whether they would get a subsidy for the coverage in the event of exchange coverage.

Mr. Butterfield. That is what I recall. Is it correct, Ms. Yocom, that people can only enroll in a qualified health plan during open enrollment, unless there has been a change in circumstances, such as losing other coverage?

Ms. Yocom. That is correct.

Mr. Guthrie. And coverage on a QHP doesn't start until after the enrollment, and after payment of the first premium. Is that correct?

Ms. Yocom. That is correct.

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Mr. Butterfield. I am informed that the general rule is that enrollment before the 15th of the month starts coverage in the following month, and enrollment after the 15th results in coverage starting in the month following the month of enrollment. Is that correct?

Ms. Yocom. I believe so, yes.

Mr. Butterfield. Yes, that is my recollection as well. If individuals had to wait to have their attestations verified through review of paper documents, it could result in significant delays in coverage, or they could miss the open enrollment period altogether. Would you agree with that statement?

Ms. Yocom. Yes, there are delays we have identified as potential scenarios, yeah.

Mr. Butterfield. All right. Moving right along. Under the ACA eligibility to enroll in coverage through a QHP, and to qualify for premium tax credits and cost-sharing reductions is determined on a real-time basis, based on the information individuals attest to on their application, and I might say, under penalty of perjury. Verification occurs in real time using electronic data to the fullest extent possible.

Ms. Yocom, the eligibility determination process, using the electronic data through the Federal data hub, is an important feature of the marketplace that operates to prevent individuals from obtaining fraudulent coverage, coverage that they are not eligible for, and even

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duplicate coverage. Is that close to being correct?

Ms. Yocom. Yes. Yeah, the one thing I would add is that with the Medicaid eligibility determination, the connection between exchange coverage and Medicaid is where the difficulty is and the potential duplication is likely to occur.

Mr. Butterfield. Do you know of any other system in Federal Government that operate like this in real time and using data sources across the Federal Government?

Ms. Yocom. I don't, but I am not an expert.

Mr. Butterfield. When eligibility factors can't be verified immediately using electronic data sources, people must apply paper documents within a set time period to verify their eligibility. Am I correct on that?

Ms. Yocom. That is correct.

Mr. Butterfield. Do you agree or disagree that this is another backstop in the process to ensure that individuals are only getting the coverage they are entitled to?

Ms. Yocom. Yes, getting the documentation as a backup is important, yes.

Mr. Butterfield. Then would you agree that on the back end, the Federal Government reconciles the premium tax credits to ensure that beneficiaries only get what they are entitled to on the back end?

Ms. Yocom. That is the hope. We have done some work GAO has that

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does look at issues with the IRS and the ability to reconcile right now, so --

Mr. Butterfield. All right. We said in the beginning, years ago when we passed the Affordable Care Act, and we continue to say today, it is not perfect, but we are going to continue until it reaches perfection.

I thank both of you for your testimony. I yield back.

Mr. Pitts. The chair thanks the gentleman. I now recognize the gentleman from Florida, Mr. Bilirakis, for 5 minutes for questions.

Mr. Bilirakis. Thank you, Mr. Chairman, I appreciate it very much. And I thank the panel for their testimony.

Mr. Bagdoyan, under Federal law, an individual who has access to affordable minimal essential coverage through their employer is not eligible for the subsidy on the exchange. Based on GAO's work, what are the Federal and State exchanges doing to assess whether an applicant has access to employer-sponsored insurance before providing them a taxpayer-funded subsidy?

Mr. Bagdoyan. Thank you for your question Mr. Bilirakis. For the scenarios we conducted, I believe there were four of those instances, we did not detect any activity between the exchanges and the employer.

Mr. Bilirakis. Thank you. Another question for you, sir. Are you aware of any actions that the Federal and State marketplaces have

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taken in response to your findings?

Mr. Bagdoyan. The Federal marketplace has not, to our knowledge. As I mentioned, we detected no changes in the control environment between 2014 and 2015. At least two of States we spoke with, as I mentioned to Mr. Guthrie, Kentucky is one of them. They gave specific information as to the actions they are currently taking, as well as the California State exchange. We had an extensive discussion with them, and they provided us with an overview of what they are doing, and plan to do, and they promised us additional details to include in our final report on this --

Mr. Bilirakis. Those States have been able to make changes in response to your findings in just a few months, but CMS has not made changes, even though they had more than a year. Is that correct?

Mr. Bagdoyan. That would be one way to characterize it, yes.

Mr. Bilirakis. Thank you. Ms. Yocom, you indicated that States raised concerns about the quality of Medicare -- Medicaid eligibility assessments and determinations made by Federal exchanges. What actions did CMS take to review those assessments and determinations?

Ms. Yocom. They have -- the short answer is at the beginning of our work, they had not done any. They did, in response to our recommendations, say that they were going to begin conducting reviews of the facilitated exchangeability to determine Medicaid eligibility, and they have conducted reviews in two States so far.

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Mr. Bilirakis. What types of errors were identified and what were the causes of those errors?

Ms. Yocom. Most of the errors were related to income verification. There were training issues where the individuals who were doing the reviews were not doing them correctly, so there was a need to train staff; and then the last issue does have to do with transferring the applications and the application information between the exchanges and the Medicaid programs.

Mr. Bilirakis. And no corrective action has been taken. Is that correct?

Ms. Yocom. At this point, CMS has taken some actions, but none that we would consider sufficient to address the concerns.

Mr. Bilirakis. Okay, thank you very much. I yield back, Mr. Chairman.

Mr. Pitts. The chair thanks the gentleman, and I now recognize the gentleman from Oregon, Dr. Schrader, for 5 minutes for questions.

Mr. Schrader. Thank you very much, Mr. Chairman. I appreciate you all being here. I want to get a little perspective, I guess, with the degree of fraud that we are worried about. Ms. Yocom, do you have any expertise, or any background, in what fraud has been historically in Medicaid or Medicare?

Ms. Yocom. There really isn't a good estimate of fraud. There is estimates of improper payments and the Medicaid --

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Mr. Schrader. What would those be?

Ms. Yocom. About 7 percent, if I remember correctly.

Mr. Schrader. Okay. In both programs?

Ms. Yocom. For Medicaid, yeah, I do not know the number for Medicare.

Mr. Schrader. Medicare, it is somewhere about the same, between 5 and 10 percent in the literature. And in private insurance, which is what we are talking about with regard to the QHPs, at the marketplace; your own report refers to marketplaces. What is the fraud generally in those?

Ms. Yocom. That is not known.

Mr. Schrader. Well, there is actually estimates that we have been able to get in the 1 to 1.5 percent range.

Ms. Yocom. Would that be fraud or improper payments?

Mr. Schrader. Improper payments. So I am trying to get at whether or not -- to keep this whole thing in perspective, would appear to me, based on the information that is out there, that improper payments and fraud is less in the marketplaces, where private and price has some incentive obviously to monitor what is going on. As has been alluded to here today with the advent of the Affordable Care Act, there has been an emphasis on access.

Mr. Bagdoyan, are you surprised at all that CMS would, perhaps, lean a little more towards access versus program integrity as they roll

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the program out?

Mr. Bagdoyan. Well, obviously, Dr. Schrader, that is a policy call that CMS has made, and that is a defensible position from their perspective. The balance, as I said, clearly tilts towards providing access, but we also like to emphasize that program integrity, it is very important.

Mr. Schrader. Certainly that would be your job and I appreciate you doing your job. I don't think it is astonishing to any of us that access is extremely important to make sure these people who haven't had health care in the greatest country on Earth, and the most industrialized Nation, should at least be able to get a little bit of health care. And there is, obviously, personal responsibility because they do have programs.

Contrary to some of what we have heard today, there are ways and procedures by which Medicaid does check or recheck authentication. Isn't that correct, Ms. Yocom?

Ms. Yocom. Yes, that is correct.

Mr. Schrader. Yeah. That is quarterly or whatever, as I understand?

Ms. Yocom. Yeah, they are doing quarterly reviews right now.

Mr. Schrader. So there is a way, even though someone could, a determined criminal, as we have established, your shoppers are very determined, can defraud the system. I think that is commonplace in

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anything in America, unfortunately, but there is this way to catch them on the back end. And with the QHPs, there is the annual check with the IRS documents; is that correct, also, as a way to check on the eligibility?

Ms. Yocom. That is correct.

Mr. Schrader. So we have got a system that is not perfect, but obviously there are some initial checks that the ranking member alluded to that, and Mr. Bagdoyan, you responded, so there are some initial checks. There is the review down the line. So it is not quite as profligate a system as some would paint it. Can it be better? I think the answer is absolutely yes.

Is there a current program -- I am trying to get at the nuts and bolts. The biggest issue I see coming forward is the nether land between Medicaid program and QHP program, as people move up or down the food chain with regard to their wages. Is there currently in place an opportunity for program integrity to check into that, besides just the year end checks?

Ms. Yocom. There is. The conducting reviews of eligibility determinations that are made, not just in the States, but also in the Federal marketplaces, is a good place. The other really key issue is, at this point, CMS is doing eligibility reviews, but then they are also doing expenditure reviews and they need to connect those two together so that when they do identify errors, they can make sure that the

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matching rate is correct.

Mr. Schrader. If I were to interpret your comments and maybe Mr. Bagdoyan's too, it is the two programs talking to one another?

Ms. Yocom. Correct.

Mr. Schrader. Medicaid and the QHP programs, for lack of better terminology, that we could work on.

The last comment I guess I would make is, as I understand, while the States have been responsive to some of the concerns that GAO has come up with. CMS, at least within this last year, did not find time or have the interest to perhaps do that. You will be monitoring this going into 2016 I assume, and we will get a report. From your understanding, CMS is more responsive now perhaps, than it was a year ago in terms of some of the concerns you have?

Ms. Yocom. They have been with our recommendations, yes. And we have had good conversations with them about, specifically, that they could adjust their processes.

Mr. Schrader. Well, I look forward to a healthier report next time, and appreciate all the access that has been +recognizes the gentleman from New Jersey, Mr. Lance, for 5 minutes for questioning.

Mr. Lance. Thank you, Mr. Chairman, and good morning to the panel. As I understand it, CBO estimates that exchange subsidies and related spending this year is roughly $77 billion, and next year the exchange in Medicaid-related spending may increase to $116 billion.

Given those very large amounts of money, even a small sample involves a significant amount of money. Would that be accurate, Ms. Yocom?

Ms. Yocom. Yes.

Mr. Lance. And so I think that it is relevant in our discussion here today that we are investigating, through your fine offices, significant amounts of taxpayer funds.

As you mentioned in your testimony, many low-income individuals are likely to switch between exchange coverage and Medicaid eligibility due to income volatility. Could you explain to us when and how is an enrollee notified that he or she is eligible for a different type of coverage? And can you walk the subcommittee through the process for an enrollee transitioning from one type of coverage to another?

Ms. Yocom. Sure. At this point, the primary way that a change in coverage comes is the enrollee reporting a change in circumstance. So an individual who is on the exchange perhaps loses their job and no longer has coverage, and then goes to apply for Medicaid. We have three scenarios in our report that look at the potential for gaps and for duplication. The gaps have to do with the timing of the transition between living from the exchange to Medicaid. The duplications have to do with the individuals failing to report a change in coverage, or their being enrolled in both places at once.

Mr. Lance. Is this a complicated system for the person likely involved in these programs to navigate?

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Ms. Yocom. I would say there is a lot of complication, yes.

Mr. Lance. Thank you. Mr. Chairman, I yield back the balance of my time.

Mr. Pitts. The chair thanks the gentleman. I now recognize the gentlelady from California, Ms. Matsui, for 5 minutes for questions.

Ms. Matsui. Thank you, Mr. Chairman. I want to thank the witnesses for coming here today.

Mr. Bagdoyan, I would like to ask you a question regarding the use of self attestation, I think I am pronouncing it right, in the marketplace application process. When applying for coverage, a consumer may self attest, for example that their income is a certain amount under the penalty of perjury. In layman's terms, lying on your self attestation is against the law and subject to criminal penalties.

In your testimony, you describe in detail the processes that were used to maneuver vague identities through the marketplace system. In order to work through the system, the agency had to provide an attestation as to the accuracy and truthfulness of the application. Is that correct?

Mr. Bagdoyan. Yes.

Ms. Matsui. Now, last July, when you testified in front of the Senate Finance Committee on a similar secret shopper study, you had an interesting exchange with Senator Portman. In that exchange, you stated "We were able to get through via self attestation," and further

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went on to say, quote, "We would view that as a control gap." For the record, would you acknowledge you made that statement?

Mr. Bagdoyan. Sounds about right.

Ms. Matsui. Just for the record, I would like to read the attestation that the secret shopper signed. "I am signing this application under penalty of perjury, which means I provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under Federal law if I intentionally provide false or untrue information."

This is attestation that the GAO encountered. Is that correct?

Mr. Bagdoyan. I believe so, yes.

Ms. Matsui. Mr. Bagdoyan, I am sure you filed income taxes in the past. Do you recall signing your name after reading the following phrase: "Under penalties of perjury, I declare that I have examined this return and accompanying schedules and statements. And to the best of my knowledge and belief, they are true, correct and complete"?

While I understand limitations of a self attestation system, it has been proven over time that self attestation tied to audits and penalties is the best viable option. In fact, on its Web site, the IRS has the original 1040 form on display. Interestingly, it was introduced in 1913, and yet over an entire century later, the self attestations are essentially unchanged.

While the system isn't perfect, no system ever is, it has been

proven over time to be the best viable option, and I have yet to hear widespread news reports denouncing the use of self attestation in the tax system. While I welcome the GAO's suggestion on this topic, I respectfully decline to ask any additional questions, since the GAO has not yet finished its review process, nor have they issued formal recommendations yet. And with that, I yield back the balance of my time.

Mr. Pitts. The chair thanks the gentlelady. I now recognize the gentleman from Missouri, Mr. Long, for 5 minutes for questions.

Mr. Long. Thank you, Mr. Chairman, and I will stick with my friend's line of questioning on self attestation. I will start with you, Mr. Bagdoyan. Based on your written statement, it appears that in several instances, the exchanges accept applicants' self attestation as sufficient evidence. Can you describe the instances where the only evidence provided was applicant self attestation?

Mr. Bagdoyan. Well, I think all the information we provided on the applications, on the phone, for example, and then confirmed with submitting documents to that effect, to verify that the information we provided was, indeed, accurate, would be, in the broadest sense, a process of self attestation.

We provide -- the marketplace reviews the documents, checks what we said on our application against what they have in hand in terms of a document. If they don't see an alteration, they accept the self

attestation as the truth.

Mr. Long. Okay. Do you think that relying on this self attestation is sufficient?

Mr. Bagdoyan. It is probably not sufficient on its own. If the document is accepted at face value without any further check, that would be a material weakness.

Mr. Long. And how often do you think that is done?

Mr. Bagdoyan. I am sorry?

Mr. Long. How often do you think that is done, where it is accepted without any further checking?

Mr. Bagdoyan. Yes, sure, that is a fair question. In the two rounds of undercover that we performed, we are not aware of any kind of cross-check between any of the parties, either the exchanges or the State-level agencies.

Mr. Long. Okay, 100 percent comes to mind.

Ms. Yocom, let me ask you: In your report, you noted that in July, the CMS was to conduct a data match to identify consumers who may be dually enrolled in Medicaid and marketplace coverage. Do you know what the results of this data match were? And how frequently CMS plans to conduct such matching?

Ms. Yocom. We do not know the results of that data match. My current understanding is that CMS is conducting quarterly reviews, but they are invest -- they are still in the process of determining how

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frequently they will do them.

Mr. Long. Why do you not know the results?

Ms. Yocom. They just have not been provided. At that point, we were -- we had a time period that was earlier than that, so.

Mr. Long. What do you mean earlier than that? This is back in July.

Ms. Yocom. Sorry, our coverage period that we were investigating was not -- did not include July. CMS offered that as additional information, but told us they were still analyzing the results.

Mr. Long. Okay.

Ms. Yocom. I don't know if that is helping.

Mr. Long. Given the financial implications of duplicate coverage for both the beneficiary and the American taxpayers, what is CMS doing to prevent such duplication from occurring?

Ms. Yocom. We think there is more to be done, they are taking some actions, they are starting to do these reviews, but there needs to be more review of the determinations and more cross-checking across the exchanges and the Medicaid program.

Mr. Long. Okay. But apparently, it will take more than 90 days to get the results from what you said here today.

With that, Mr. Chairman, I yield back.

Mr. Bagdoyan. If I may, Mr. Chairman, I would like to pick up on --

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Mr. Pitts. You may respond.

Mr. Bagdoyan. -- what Mr. Long asked earlier. One instance of an agency actually checking with another entity as to the validity of some of the information that was provided, there was a State agency approach the Social Security Administration to double-check about the validity of a Social Security number. The SSA advised the State agency that that could not be a valid Social Security number, and the agency, nevertheless, proceeded to approve our application. So I just wanted to make sure that you had a full picture on that one.

Mr. Pitts. All right, the gentleman yields back. The chair now recognizes the gentleman from Maryland, Mr. Sarbanes, 5 minutes for questions.

Mr. Sarbanes. Thank you, Mr. Chairman. I thank the panel. It is pretty clear that the process of eligibility verification going between the various systems is probably one of the most complex that any agency or group of agencies would have to manage, so I am impressed that it can be done, for the most part, as effectively as it is being done. And I understand that CMS is taking steps to respond to some of the recommendations and findings of the GAO's report to refine the policies and procedures.

I wanted to ask you, Mr. Bagdoyan, you said that, I think there was 18 -- were there 18 applications submitted as part of the secret shopper?

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Mr. Bagdoyan. Yes, we call them applications or scenarios, they are used interchangeably.

Mr. Sarbanes. And initially, through the first submission process, which was largely online, I guess, you said there might have been a couple that were conducted by phone --

Mr. Bagdoyan. That is correct.

Mr. Sarbanes. -- initially. The online ones, the system of checks and balances did pick up some issues, and rejected them at that point, right?

Mr. Bagdoyan. That is correct, yeah. The online application process involves an identity proofing step, if you will. And we failed that initial step, we were directed to call the contractor, which is Experian, whose job it is to --

Mr. Sarbanes. That is pretty good that you failed at the beginning.

Mr. Bagdoyan. At the beginning, the story gets a little more complicated as you move through.

Mr. Sarbanes. So we give a plus sign to the system for failing you at the front end.

Mr. Bagdoyan. And we failed through the contractor, who then directed us --

Mr. Sarbanes. So you failed twice. So the system caught you out twice.

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Mr. Bagdoyan. Initially, yes.

Mr. Sarbanes. Initially. So that is pretty good, because you then came back with, I guess, paper submissions.

Mr. Bagdoyan. In one instance, yes, and then by phone on most of the other ones, and that is where the workaround and the control weakness occurs is that we used the system's own instructions to overcome its initial control.

Mr. Sarbanes. Right. But you are getting in there pretty well versed in kind of where to poke at the system to find these potential weaknesses, right? I mean, you have got more, I would presume, given your forensic experience, you are going to have more knowledge than even a fairly sophisticated person out there whose intent on committing fraud is to -- where some of the weaknesses are, so you can kind of poke at them. And I commend you for the heroic efforts which your people apparently undertook to explore all of those various weaknesses.

Mr. Bagdoyan. If I may respond to that. When we started the work in 2014 for coverage year 2014, we had no idea what we would encounter. We were designed to act as typical consumers who got online; did whatever was instructed to do; went through the various steps, and when we reached the identity proofing step, we were caught, or flagged, if you will, referred to the contractor.

Mr. Sarbanes. Let me interrupt. There is one way in which you can't actually behave like the typical consumer, unless you are going

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to tell me that your folks are subject to the perjury penalties that apply to somebody who checks that submission box after reading the fact -- and I presume you have some kind of immunity?

Mr. Bagdoyan. Yeah, it is part of our investigative authority.

Mr. Sarbanes. So they are just blowing right through that check in terms of the deterrent effect that it might have, right? Because they are reading this thing and saying, you are subject to penalty of perjury, and they are saying well, obviously, the investigator is doing the secret shopping, that is not going to affect us at all.

So actually, one of the most important things that operates on the typical applicant to give them pause, particularly if they are going through one, two, and three stages of submitting false documents is actually not operating in this instance. So to draw conclusions about the ability of this system of checks and balances actually deter that kind of fraud, I think, from this exercise, is a little bit questionable. And with that, I would yield back.

Mr. Pitts. The chair thanks the gentleman, and now recognizes the gentleman from Indiana, Dr. Bucshon, for 5 minutes for questions.

Mr. Bucshon. Thank you, Mr. Chairman. Thank you for being here, and I think, I just want to point out, it is unfortunate that some today in the hearing have gone after the messenger rather than listening to a message they may or may not want to hear, including occasionally discussing your own personal lives, which I find unfortunate; because,

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clearly, you are not here to keep people from getting benefits, but to make sure that people that are are actually eligible for those, and I appreciate that work.

Mr. Bagdoyan, according to CMS, when an applicant's information can not immediately be verified, the system is to notify the agency of inconsistency so they can be addressed later after eligibility is granted. Presumably, all of your fictitious applications should have resulted in generation of inconsistency notifications. Did the marketplaces follow up with your applicants to rectify these inconsistencies?

Mr. Bagdoyan. We received extensive communication that our documents were submitted, and that they appeared to be correct, and that the inconsistency was resolved. There were some instances where the back and forth was more extensive than others. But in general, our coverage was sustained over time, yes.

Mr. Bucshon. So also on your statement, you indicate, and some of this has been kind of answered, but four of eight applicants who applied for Medicaid coverage were not ruled in Medicaid, but were able to obtain subsidized exchange coverage. And while this can be seen as a positive sign that Medicaid eligibility determinations are working, it could mean that at least some of the applicants were unable to get Medicaid coverage, not because they were deemed ineligible, but because coordination problems between the Federal exchange and

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Medicaid. Is that correct?

Mr. Bagdoyan. Yeah, that would be the top line story there, the coordination involves exchange of information, exchange of data files, and that sort of thing that without knowing what was going on on the other side, we can only surmise that the failure to exchange information, at least at an adequate level, prevented us from getting a determination. And since we were pursuing the coverage, we decided to represent ourselves as having failed to obtain Medicaid and subsequently qualified for a QHP.

Mr. Bucshon. Ms. Yocom, do you have anything to add to that that you haven't already talked about?

Ms. Yocom. No.

Mr. Bucshon. Okay. I don't have any more questions, but I would just like to say that whatever the level of fraud is, the people that I represent want to make sure we are not wasting their hard-earned taxpayer dollars. So I think that some of the implication that this may be a minor problem that shouldn't be looked into because the dollar amounts or the level of fraud may be low, but when I talk to the people that I represent, I am sure they don't want their taxpayer dollars going for any fraud in the system, and I recognize there are challenges, and there are some things that we don't -- you don't have the staff or the time to investigate. But I think your work is very important. I think any level of waste of the taxpayer dollars is important, and I

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appreciate your work. I yield back.

Mr. Bagdoyan. Thank you.

Mr. Pitts. The chair thanks the gentleman. I now recognize Mr. Lujan 5 minutes for questions.

Mr. Lujan. Thank you very much, Mr. Chairman. I want to pick up a little bit where my colleague from Maryland left off, just as I understand this. But before I do so, Mr. Bagdoyan, when were your findings presented to the committee?

Mr. Bagdoyan. I am sorry?

Mr. Lujan. When did GAO send your findings to the committee, to the majority, to the minority?

Mr. Bagdoyan. The statement was provided, I believe, mid-morning on Wednesday.

Mr. Lujan. Your testimony was provided?

Mr. Bagdoyan. Testimony, yes. And we briefed staff the week before.

Mr. Lujan. You briefed staff the week before?

Mr. Bagdoyan. That is correct, at their request.

Mr. Lujan. Were there any other documents before your testimony was submitted to the committee on Wednesday, were there any other documents submitted to the committee before you met a week ago?

Mr. Bagdoyan. No. This was an extensive oral briefing, and I assume notes were taken.

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Mr. Lujan. And so when you worked with your staff, Mr. Bagdoyan, to prepare for interviews with other individuals, would you say that more time or less time is better for you to be able to review documents before we get a chance to question?

Mr. Bagdoyan. In general, I would say more time.

Mr. Lujan. Would it surprise you that the committee didn't receive information -- the minority didn't receive information until 2 days prior to the hearing?

Mr. Bagdoyan. That is a good question, Mr. Lujan, but I followed the committee's rules as presented to me.

Mr. Lujan. I appreciate you doing that, but maybe we can all make sure we get the information to spread around so we can better prepare. I appreciate that, sir.

Mr. Bagdoyan, so the way that I understand it, GAO used the Federal Government -- so you used your knowledge about documents with fraud prevention safeguards that were put in place, to be able to look into this process with Medicaid coverage and into the marketplace, correct?

Mr. Bagdoyan. Yeah, we had some knowledge, but again, we didn't know about the specific controls that were involved that we would likely encounter.

Mr. Lujan. And so through your investigation, GAO falsified identities to get coverage?

Mr. Bagdoyan. That is correct.

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Mr. Lujan. Did GAO, with each false identity, did you enroll into multiple marketplaces at once?

Mr. Bagdoyan. There was one instance where we obtained coverage in additional --

Mr. Lujan. Not obtain, did you apply?

Mr. Bagdoyan. Apply and obtained, yes.

Mr. Lujan. And did GAO pay multiple premiums for coverage as this was going through the process?

Mr. Bagdoyan. Yes, that is part of the investigation.

Mr. Lujan. Do you think that an everyday person would pay multiple premiums to try to get coverage?

Mr. Bagdoyan. I can't speculate on that, sorry.

Mr. Lujan. I think it would be challenging for an individual maybe to pay multiple premiums in multiple areas.

Mr. Bagdoyan. That is an excellent question if I may clarify. That particular scenario was designed to see whether the issue of identity theft would come in. So that is a specific scenario.

Mr. Lujan. Let's talk about identity theft. So under penalty of perjury, these documents were submitted?

Mr. Bagdoyan. That is the up-front penalty, yes.

Mr. Lujan. But GAO is exempted from that, as we found out from --

Mr. Bagdoyan. Investigative authority, that is correct.

Mr. Lujan. So an everyday person, in this case, would, I guess

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assumption would be made, that if they paid multiple premiums for coverage, that they would still waive the penalty of perjury, and be subject to between $25- and $250,000 in fines. Is that correct?

Mr. Bagdoyan. That is the case, yes.

Mr. Lujan. Does GAO assist in any investigations to go after perpetrators of fraud with any of our agencies?

Mr. Bagdoyan. Yeah, it is an excellent question. We do, as a matter of course, whether it is an investigation or an audit. We do make referrals to the appropriate Office of Inspector General, or as appropriate to the Department of Justice, or both.

Mr. Lujan. During this investigation, did you identify any fraud?

Mr. Bagdoyan. Not on real individuals, no.

Mr. Lujan. Not on real individuals?

Mr. Bagdoyan. That was not designed as such in the beginning.

Mr. Lujan. I appreciate that answer.

Mr. Bagdoyan. Sure.

Mr. Lujan. It was, in fact -- the 14 secret shoppers that went through the online parameters were stopped, it worked.

Mr. Bagdoyan. The initial ID proofing, as I told Mr. Sarbanes, yes. But eventually, we found a workaround without have foreknowledge.

Mr. Lujan. And did the workaround include ignoring the filing

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under penalty of perjury?

Mr. Bagdoyan. Yes.

Mr. Lujan. No one that submitted these false documents will go to jail?

Mr. Bagdoyan. Right.

Mr. Lujan. Because there is an exemption?

Mr. Bagdoyan. That is right.

Mr. Lujan. If a normal person, outside of being exempted under GAO, would submit these documents and they got caught, what would happen to them?

Mr. Bagdoyan. They would probably be subject to the terms of whatever -- whether it is the fine or --

Mr. Lujan. 25- to $250,000 in fines and jail time, potentially. Mr Chairman, I appreciate this hearing, but I hope that we get all of the facts put on the table. But that we also get the recommendations that GAO has made to CMS, and to others presented to us, that way we can work on those together. And I am hopeful, Mr. Chairman, that as we do this, there is agreement with all of our colleagues to make sure we improve this process, as opposed to trying to find a way to try to kick everyone off the rolls, including the 423,000 individuals who were caught, whether it was for mistakes or whatever may be done through this process, that were removed from getting coverage in the marketplace.

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I thank you very much, Mr. Chairman. I yield back my time.

Mr. Pitts. The chair thanks the gentleman. I now recognize the gentleman from Virginia, Mr. Griffith, for 5 minutes of questions.

Mr. Griffith. Thank you very much. I find this discussion interesting. I would say, Mr. Bagdoyan -- I hope I said that correctly.

Mr. Bagdoyan. Yes.

Mr. Griffith. I would say I kind of wish you had brought up earlier, I do appreciate Mr. Sarbanes and others for bringing up that you all have immunity, but the first couple of times it came up, you know, was this done knowing there that was penalty of perjury? It sounded like you all were engaged in criminal conduct, so I am glad that we got that clarified, and obviously, in order to do an investigation, you would need such immunity from prosecution for doing that.

Now my background, which you probably don't know is, is that for 28 years, I practiced small town practice of law, the great predominance of that over the years was in the criminal defense field. Having represented a number of criminal defendants, I can assure you, and you are probably aware as well, that there are numerous people who ignore the perjury clause on all kinds of Federal documents, including IRS documents. Wouldn't you agree that those people who are larcenous in nature are likely not to pay much attention to the perspective penalties?

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Mr. Bagdoyan. Yeah, I would say if they have intent, they would probably just ignore that.

Mr. Griffith. They would probably disregard that. So when folks say, yes, but they had to sign off on the statement that you didn't have to worry about, or your secret shopper, so to speak, didn't have to worry about, that does not, in my experience, bode as a great impediment to going forward if you have a larcenous intent.

Likewise, they have not previously been involved in the criminal justice system while the maximum penalty is jail time and up to, I think, $250,000 fine, it may sound fairly stiff, a first-time offender is not likely to get anywhere near the maximum, and is unlikely, in a crime of this nature, to receive jail time. Would you not agree?

Mr. Bagdoyan. I don't really have an opinion on whether that would happen or not.

Mr. Griffith. I did find it interesting that they wanted to point out that there were places that there was a stop, but it was a temporary stop, and you were very good to point out that, yes, but on other tries, or workarounds, there were ways do it. I noted with some interest in the document, which, by the way, does not appear to be all that long. I have heard folks complaining about how they didn't get it in time. I have read it while I have been sitting here this morning. But I noted that in one spot, in particular interest, that you all gave Social Security numbers that were impossible Social Security numbers.

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Mr. Bagdoyan. That is correct.

Mr. Griffith. They didn't match up with anything that would possibly be used.

Mr. Bagdoyan. They had not been issued ever by the Social Security Administration.

Mr. Griffith. And for the 10 undercover applications that used these numbers that would not possibly have been involved, only one picked up as a trigger and, that was in the State of Kentucky. And yet, even though -- I went through the material -- even though Kentucky picked it up, they did give them coverage anyway.

Mr. Bagdoyan. That is correct.

Mr. Griffith. And so help us figure out this impossible Social Security number, but we will give you coverage in the meantime. Is that accurate?

Mr. Bagdoyan. That is correct. And they did contact SSA, and SSA said that is not a good number and whoever the representative or the specialist was overrode that advisory and provided coverage.

Mr. Griffith. And provided coverage anyway. And also, when the fictitious applicants, I think there were four of those who said that their employer did not provide the minimum essential coverage, there was no check back to see with their employer if they, in fact, did qualify for an employer who did not provide the minimal essential coverage. Is that also accurate?

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Mr. Bagdoyan. That is correct. We set up a fictitious company for that purpose with contact information and we got no hits.

Mr. Griffith. That is the kind of thing that this hearing is about and is troubling to a lot of us. Whether you like the program or don't like the program is not the issue. The issue is, if we are going to go have a program at the Federal Government level, let's at least have some tests out there and some checks back over time to make sure that people are still eligible.

I appreciate the work that you all do. I appreciate you being here this morning. And with that, Mr. Chairman, I yield back.

Mr. Bagdoyan. Thank you.

Mr. Pitts. The chair thanks the gentleman. I now recognize the gentleman form Massachusetts, Mr. Kennedy, for 5 minutes of questions.

Mr. Kennedy. Thank you, Mr. Chairman. I want to thank the witness for their work and the work they do. I think I can say, I echo the comments of all my colleagues when I say that program integrity is absolutely critically important. We want to make sure that in a program such as this, that beneficiaries that are in need of these benefits and services are getting the services that they need, particularly when it comes to something like access to health care.

I want to build off an exchange of a couple of my colleagues, but first, Mr. Bagdoyan, I just want to make sure that I have your testimony clear in my head. We have talked through a number of front-end

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procedures, identity proofing and document requests already to reiterate online applications for the secret shoppers were caught and flagged. But let's not go out the back end side, if you can.

So for the fake applications that were created and received initial QHP coverage, a tax return was not filed, right?

Mr. Bagdoyan. That is correct.

Mr. Kennedy. So there is an additional check about making sure that those who do get coverage end up getting those records squared with tax attorneys, and that last check not done, right?

Mr. Bagdoyan. That is correct.

Mr. Kennedy. So did you know that any discrepancy will have to be repaid in full if there is a discrepancy paid by the beneficiary back to the Federal Government?

Mr. Bagdoyan. Yes, we had that awareness.

Mr. Kennedy. And were you aware that State Medicaid programs are required to also go through extensive eligibility redetermination process annually as well?

Mr. Bagdoyan. In general terms, yes.

Mr. Kennedy. So the process actually works sometimes too well, and we unintentionally disenroll eligible beneficiaries. I can also tell you that from my own State in Massachusetts, that it definitely works to check as an additional protocol, an additional control.

I want to touch base a little bit on the documents that you talked

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about earlier with response to some of the questions my colleagues asked. You said that your team was able to produce those documents with supplies and equipment that is readily dealt with. Is that right?

Mr. Bagdoyan. That is correct.

Mr. Kennedy. And you mentioned that you had a team of folks that were able to, with no prior knowledge, to somehow find their workaround through the system, right?

Mr. Bagdoyan. That is correct.

Mr. Kennedy. How many folks are on your team, sir?

Mr. Bagdoyan. My mission team has about 55 staff.

Mr. Kennedy. And how -- average education level?

Mr. Bagdoyan. Most would have masters or above.

Mr. Kennedy. How much time did you spend working on that workaround?

Mr. Bagdoyan. On the workaround itself? That occurred in real time, so we just followed the instructions of the system in real time.

Mr. Kennedy. But you have a team of 55 people, the majority of whom with master's degrees, with the resources of a fully -- at least, I should say, somewhat partially resourced Federal office to actually achieve this workaround, which is not necessarily the, one would say, potentially reflection of the average resources education level, or teammates of your average U.S. constituent.

Mr. Bagdoyan. Not all 55 worked on it at the same time, I wish

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they had.

Mr. Kennedy. Me, too.

Mr. Bagdoyan. But it was a much, much, much smaller team of less than half a dozen basically.

Mr. Kennedy. Still a half dozen folks with master's degrees and those resources, fair?

Mr. Bagdoyan. Fair.

Mr. Kennedy. Okay. So now, and most of them have a background as being professional investigators as well, yeah?

Mr. Bagdoyan. The people who actually do the work, they are -- yes, they are investigators.

Mr. Kennedy. So we are talking about a half dozen folks that are professional investigators with the resources of the Federal Government trying to do this?

Mr. Bagdoyan. That is the representation.

Mr. Kennedy. Okay. Now, we talked about it a little bit before with my colleague, the fact all of this is done underneath the penalties of perjury, and you went through the fact that those include potential civil fines and potential criminal liability as well, correct?

Mr. Bagdoyan. That is correct.

Mr. Kennedy. So what, I guess, I am trying to understand, sir, is we are talking about the fact that there are -- and you conceded in the first page of the summary sheet the fact that this was done for

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a number of individuals cannot actually be accurately generalized, the result of the findings cannot be actually generalized to a larger population.

Mr. Bagdoyan. That is correct.

Mr. Kennedy. But the concern would be, obviously, that there are a large number of individuals that can be using false documentation in order to get coverage?

Mr. Bagdoyan. That is the control we missed, yes.

Mr. Kennedy. Just so I am able to understand, the concern is that there would be tens of thousands, or hundreds of thousands of individuals in this country that are willing to risk the penalties of perjury, $25,000 to $250,000 fine, plus potential criminal liability in order to get access to affordable health care coverage?

Mr. Bagdoyan. That is the risk.

Mr. Kennedy. That is the risk.

Mr. Bagdoyan. That is correct.

Mr. Kennedy. And are you aware, that in about another half hour, this body is going to vote to repeal the Affordable Care Act for the 61st time.

Mr. Bagdoyan. I didn't know that.

Mr. Kennedy. So we are having a hearing which is critically important to examining program integrity, and we are trying to focus on the program integrity while we recognize the fact that there are

tens of thousands, potentially hundreds of thousands of folks, which is the concern of this report, that are willing to risk these liabilities in order to get access to affordable health care, the very program the majority is trying to repeal for the 61st time in an hour.

I yield back.

Mr. Pitts. The chair thanks the gentleman. I now recognize the gentleman from New York, Mr. Collins, 5 minutes for questions.

Mr. Collins. Thank you, Mr. Chairman. And I am sitting in this last chair means I am one of the newest members of the committee. And I have to admit, when I came here, I always asked my staff, tell me the tone of the hearing and generally a hearing like this they would say, this is an informational hearing, meaning bipartisan. So I have to tell you, I have sat here and listened to the comments and questions, and I am somewhat befuddled that here we are having a hearing on what I think of as being waste, fraud and abuse. I always thought those kinds of hearings and trying to identify problems didn't have a partisan take to it.

So, I just would start by saying I am extraordinarily disappointed in the other side of the aisle here in trying to take away from your hard work, just identifying potential problems to save the taxpayers money in what we call waste, fraud and abuse. So personally, I thank you for what you have done, and certainly know you are doing your best every day to then take these recommendations back to CMS to save

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taxpayers money, or as you said, Mr. Bagdoyan, identify weaknesses. That is really what this was about what you called your control vulnerabilities, the controls didn't work.

Just a couple of commonsense interesting questions here. Since these were fictitious -- Social Security numbers ultimately got through, did these individuals ultimately sign up with these totally bogus Social Security numbers, and effectively obtain coverage? Is that the primary identifier of a policy, the Social Security number?

Mr. Bagdoyan. It is not a condition of eligibility but it is identity proofing, yes.

Mr. Collins. So I will say, as a Member of Congress, and as an American, I am befuddled that in the era of big data, that ultimately somebody gets a policy with an identifier that couldn't exist and that there is no cross-checking again. The big data world that we live in, I am somewhat astounded that that vulnerability exists. That should be an immediate disqualifier.

So I am very not happy to hear you tell us that, but I would think that should be something that could be easily on the recommendations side of cross-check into the Social Security data files would eliminate that piece of it.

Now the other thing, if someone is on Medicaid, they don't pay anything, correct? And if this was an expansion, the States don't pay anything, so this is 100 percent on the Federal Government's back.

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If the individual ends up on Medicaid under, certainly, the expansion portion, and so I am worried about the individual who works for a small business, who provides coverage, that individual, under, certainly, the expansion of the poverty level, would qualify under Medicaid, legitimately qualify. They have their own Social Security number, they are who they are, they live where they live. Income records indicate they meet all the criteria. But if they sign up on their employer plan, they have to pay some percentage of that coverage, whether it is individual or family coverage, but if they can come in under Medicaid, then they don't pay anything.

So my worry would be back to somebody saying that they work at XYZ company, but XYZ doesn't provide healthcare coverage. So they are not being honest in that regard. And therefore, I am concerned what you are telling us, I think there was no cross-checking back on that piece. So somebody who, low-income, wants coverage but has an employer providing it, is cheating or being deceptive in saying, no, my employer doesn't offer it, therefore they get it. Is that some of the scenario?

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RPTR GENEUS

EDTR ROSEN

[11:00 p.m.]

Mr. Bagdoyan. Yeah, the scenario, itself, was the applicant claiming that whatever the employer did provide did not meet the minimum standard, so they were seeking better coverage. And as I mentioned to another member earlier, we did set up a fictitious company for that very purpose with contact information. And as I mentioned, we did not get a single hit for verification purposes.

Mr. Collins. So, just, you know, getting back and me initially thinking this was going to be a bipartisan informational hearing, I think a couple of things is, the Social Security check should be a no-brainer, but secondarily, a very big issue of potential -- and we use the word "fraud," but this is a low-income individual trying to get coverage at no cost, but happens to work for a company that does provide a policy that meets the standards, but that person has to pay something into that; that that is a very much a real-life scenario that could have happened that should be addressed in some way through that verification of somebody suggest that their company doesn't meet the minimum standard. Somebody should check on that. That is, I am assuming, what a recommendation might be.

Mr. Bagdoyan. That is the intent of the check, yes.

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Mr. Collins. Yes. Well, thank you all for the work that you do on behalf of the taxpayers.

Mr. Bagdoyan. Thank you.

Mr. Collins. With that, Mr. Chairman, I yield back.

Mr. Pitts. The chair thanks the gentleman, now recognize the gentleman, Mr. Cardenas, 5 minutes for questions.

Mr. Cardenas. Thank you very much, Mr. Chairman. The question to Mr. Bagdoyan. Are you familiar with the term "presumptive eligibility"?

Mr. Bagdoyan. In general, yes.

Mr. Cardenas. What we are talking about today, is this a program that has presumptive eligibility, or is it something that people have to properly and appropriately identify that they can or should be eligible before they actually receive their benefits?

Mr. Bagdoyan. Yeah, it has to be confirmed that they have eligibility that met all the requirements of the application process, they have submitted documents to clear any inconsistencies that were created as part of that.

Mr. Cardenas. So it appears that what we are discussing today isn't so much whether or not the Affordable Care Act law, in and of itself, encourages individuals who are not eligible to apply, receive services, and then after the fact, perhaps, be found out that they were not qualified.

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Mr. Bagdoyan. I presume the law would not encourage that to happen.

Mr. Cardenas. Correct. Because it is not a presumptive eligibility. Presumptive eligibility is not part of this law, correct?

Mr. Bagdoyan. That is my understanding. And as I mentioned earlier, CMS told us that they had to balance -- the agency had to balance access with program integrity. We see, based on our work, that access has a tilt in its favor at this time.

Mr. Cardenas. Okay. So would you say that it is being utilized as a presumptive eligibility program or not?

Mr. Bagdoyan. That type of analysis was not within the scope of our work. Our scope included testing controls --

Mr. Cardenas. Sure.

Mr. Bagdoyan. -- as part of the overall environment.

Mr. Cardenas. So let me ask this question: So are there some effective controls in the process that -- due to your research and your analysis and your efforts?

Mr. Bagdoyan. Right. As I -- as I responded to questions from members and as some members pointed out, the first step of the application process involved something called identity proofing.

Mr. Cardenas. Correct.

Mr. Bagdoyan. And that flag, we failed to clear online, and then

we failed to clear it with the contractor as the next step. But, again, following the system's own instructions, we were able to work around that control by engaging in a phone application.

Mr. Cardenas. Okay. So, by and large, based on what you have been able to uncover, is it a failed system or a flawed system of identifying who is or is not eligible?

Mr. Bagdoyan. In terms of failed and flawed, there are weaknesses is the best way to describe it.

Mr. Cardenas. Okay. So that is more in the genre of flawed rather than failed, wouldn't you say, based on what you have been able to glean --

Mr. Bagdoyan. Based on what we have done so far, right. And the forensic aspect of our work would give us a better idea of whether it is a failed or flawed or perfectly working system.

Mr. Cardenas. And who is in charge of doing that forensic analysis of your work?

Mr. Bagdoyan. That is done under my direction as well.

Mr. Cardenas. Okay. And when will you have that done?

Mr. Bagdoyan. We are working on it. We received the data set from CMS for coverage year 2014. We are in the process of assessing whether the data are even reliable for us to make our analyses. If they are not, we won't be able to proceed. If they are, we will go ahead and do that, and we expect results, assuming we can proceed some

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time next year.

Mr. Cardenas. Do you feel comfortable that the amount of resources that were made available to you and the budgetary decisions, et cetera, on this effort that you embarked on, was it robust enough for you to feel confident that you could go out there and do enough work so that you could eventually get to the forensic analysis and have a strong conclusion as to how good or bad this process is?

Mr. Bagdoyan. Yes. I think we have a solid plan in place. It is well-staffed, and the resources are adequate for that purpose.

Mr. Cardenas. Okay. So you felt comfortable that the amount of resources that were made available to your department, you were able to bifurcate those resources into the effort that you put together was good enough, big enough, funded well enough?

Mr. Bagdoyan. Yes, I would say on balance, that is correct.

Mr. Cardenas. Okay. Well, I hope that it bears out that it was good enough for you to come to a comfortable conclusion, because just by my thinking, 50 States, some participating, some not, the number of fake applicants, et cetera, by my view, is a bit small, but hopefully, like you said, there was enough -- big enough effort for you to come to some strong conclusions.

I have one last question. Of the fake names, how many of them were more Russian in nature or German in nature, or Spanish in nature, what have you, the fake names that you put together to try to get through

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this process?

Mr. Bagdoyan. It is a mix of names. We didn't pick any particular ethnic or other group to create the identities.

Mr. Cardenas. So no ethic group, name-wise, was over --

Mr. Bagdoyan. I don't recall.

Mr. Cardenas. -- sampled in this? Okay.

Well, I would love to see those names eventually. Thank you very much.

Mr. Bagdoyan. Thank you.

Mr. Cardenas. I yield back.

Mr. Pitts. The chair thanks the gentleman. I now recognize the gentleman from Pennsylvania, Dr. Murphy, 5 minutes for questions.

Mr. Murphy. Thank you. And thank you for the -- what you have done here.

First, let me ask this: Mr. Bagdoyan, when someone is testing out how a system works, do the companies, in general, run potential names through and see what works? Whatever the company is, whether it is Amazon, seeing if one can order a book, or it is Walmart, isn't that how generally people do that? They will put some name in and test it out?

Mr. Bagdoyan. In the private sector, from my personal experience, that is an extensive part of what a company does, yes.

Mr. Murphy. And we know that the rollout -- the initial rollout

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to the Affordable Care Act, as well as State exchanges, were filled with serious problems. And we had heard previously, through many people in our committees who were involved with the State and the Federal rollout, that they had even consulted with advisers, who said that there was going to be serious problems with security systems, and I assume that under those circumstances, they ran names through and see if the information was secured. So I am assuming this is standard practice. So let me ask a couple of questions here.

Ms. Yocom, in your report, you had talked about people with coverage gaps or they had also some duplication. Do we have any idea what the average or the number is in terms of number of people who have a coverage gap? Do we have any idea what the number is?

Ms. Yocom. We do not, no.

Mr. Murphy. Okay. So out of the millions of people enrolled, we just simply don't know. How many may have a plan, they lose it, and they go on to Medicaid, or they are on Medicaid, so we don't know --

Ms. Yocom. No.

Mr. Murphy. But there is also people who may have duplication, overlap, which cost the taxpayer, cost the government. Do you have a number, idea of how many that is?

Ms. Yocom. We do not have a national number. We did talk with issuers and also with States who had done some analyses, and right now, those numbers don't appear to be large, but --

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Mr. Murphy. When you say "don't appear to be large," are we talking thousands, hundreds of thousands, millions?

Ms. Yocom. Like, one insurer identified about 18 individuals who were covered in both.

Mr. Murphy. Okay. Fair enough.

Ms. Yocom. And that is a single issuer in a single State.

Mr. Murphy. I am concerned about those from the standpoint of the taxpayers, and further, most concerned about those who lose coverage and don't have health care. But we don't know what that number is, though?

Ms. Yocom. Right. We don't have a good number of that, no.

Mr. Murphy. All right. But if someone has duplicate coverage, are they counted twice when we are counting how many Americans now have coverage under the Affordable Care Act?

Ms. Yocom. Conceivably, they could be counted twice. So it would be -- they would -- they could be counted under the exchange, and then also as a Medicaid enrollee, so I would say yes, that is possible.

Mr. Murphy. So as we are looking at this and we are looking at huge cost overruns, do you have any idea how many people are fraudulently signing up for?

Ms. Yocom. No, we do not.

Mr. Murphy. Mr. Bagdoyan, can you extrapolate from your data how

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many people are gaming --

Mr. Bagdoyan. Absolutely not. As I mentioned earlier, this is not generalizable. It is not designed to extrapolate any rate of fraud.

Mr. Murphy. It was just a preliminary study?

Mr. Bagdoyan. And it is preliminary. As I said, we are looking at the entire enrollee database of 2014. If that database proves to be reliable enough for us to conduct analyses, we might have a better idea later on.

Mr. Murphy. So related to some questions you were answering before, I just want to be sure of this: Is this common practice among other areas of the government to test the system to see if it is vulnerable to fraud?

Mr. Bagdoyan. Well, GAO does that as a matter of course, and as part of its broader charge to --

Mr. Murphy. So is it generally-accepted valuable practice to --

Mr. Bagdoyan. It is, yes.

Mr. Murphy. -- to test to see if fraud --

Mr. Bagdoyan. Control environments, you may be familiar with the green book; it is a thick document that lays out the internal controls for the Federal Government agencies. They are required to follow those, and part of GAO's work either through audit and/or investigation --

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Mr. Murphy. But if you don't do this, how do you figure out if there is fraud in the system? Do you simply ask people if they have defrauded the system? So they ask a show of hands how many people are gaming the system, and which is, obviously, not going to do anything?

Mr. Bagdoyan. Yeah, you would have to do the work. Asking questions is not sufficient.

Mr. Murphy. So this is just the way to do it. And as a taxpayer, and as a Member of Congress protecting the taxpayers, that seems make sense to me, you have to test the system and find it out.

I go back here, and we have had, for example, Secretary Sebelius before us a couple of years ago. When the Affordable Care Act first came out, we talked about 35 or 45 million Americans without any health insurance coverage. And now what we are talking about, I hear different estimates, 9, 10, 11 million, whatever it is, of people who now have coverage. And so we had asked her, of that, how many were Medicaid-eligible for, but didn't apply but now have it? How many were not Medicaid-eligible for but now have it because the number went up? How many were eligible for private insurance but chose not to take it? How many did have insurance but their coverage got the pink slip because of the new standards for health care, so now they have to sign up for something new? And how many of these groups were generally folks that did not have insurance before and now could have it? And she said, there is no way of telling. We just wouldn't have those numbers.

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So I am puzzled by it, because out of this number of 9, 10, 11 million, I still don't know how many people the Affordable Care Act is helping. It truly wanted to help people who didn't have coverage and now have coverage. But of that, too, what you are telling me is, and of that, we don't know how many people may be gaming the system, and, in some cases, some people could even potentially say, an employer could even say, you know, we don't have coverage here, but here is how to get coverage but nobody has to pay, or here is how you can qualify for Medicaid, when you don't really have it. Am I correct that people could potentially do that?

Mr. Bagdoyan. I assume so, if there was intent, they could attempt it.

Mr. Murphy. Okay. And we won't judge their intent. But it seems to me, and I know that there is an old psychological principle that people tend to ascribe motives in others that they live in their own heart. I mean, I would hope that both sides of the aisle here would try to say, how do we fix this system, how do we deal with the defrauding the system so we don't have that. I hope that is a result of this hearing. I yield back, Mr. Chairman.

Mr. Pitts. The chair thanks the gentleman. I now recognize the gentleman from New York, Mr. Engle, 5 minutes of questions.

Mr. Engel. Thank you very much, Mr. Chairman. You know, obviously, nobody wants fraud. We need to root it out. But we don't

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want to use it as a reason to kill the program. I think the program is very important and is working well for the American people.

So, Ms. Yocom, I would like to ask you a bunch of questions, so I would like to request you keep your answers short, because I have a whole bunch of questions for you.

Ms. Yocom. I will do my best.

Mr. Engel. I want to talk to you about the issues of coverage gaps and duplicate coverage. Can you walk through the reasons why coverage gaps might occur for individuals transitioning between Medicaid and marketplace coverage?

Ms. Yocom. Yeah. It is -- gaps are more likely to occur, somebody going from the marketplace to Medicaid. And it basically is a difference of timing and the dates, and when the coverage becomes effective.

Mr. Engel. Thank you. The Affordable Care Act made a number of changes to streamline eligibility requirements and enrollment processes between Medicaid and marketplace coverage, but still, there is some inherent difficulty in coordinating coverage across multiple programs. So can you walk us through -- again, please keep it as brief as you can -- your recommendations to CMS to reduce the likelihood of coverage gaps and the impact of such gaps on beneficiaries?

Ms. Yocom. Yeah. Our recommendations are really around testing, testing the eligibility processes and identifying if there

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are common mistakes that keep happening, and then providing fixes to those.

Mr. Engel. And is it the case that CMS has agreed with your recommendations?

Ms. Yocom. They have.

Mr. Engel. Thank you. I would like to ask you about the possibility of duplicate coverage through Medicaid and the marketplaces. Why might this occur?

Ms. Yocom. It could occur for a couple of reasons. The most basic is that an individual may fail to resign their coverage; they have a change in circumstance, and they forget to notify the marketplace.

Mr. Engel. While I understand that there is always room for improvement, CMS has significant safeguards to minimize the impact of duplicate coverage; is that not correct?

Ms. Yocom. There are safeguards in place. We would -- we would suggest that more are needed.

Mr. Engel. For instance, APTC that is paid out for enrollees who are terminated for nonpayment of premiums are recouped from insurers. Am right about that?

Ms. Yocom. Yes.

Mr. Engel. And CMS requires insurers to update their prior month enrollment each month, and recoups APTC provided to -- for issuers for

terminating individuals; is that not correct?

Ms. Yocom. That is correct.

Mr. Engel. Additionally, can you talk about the periodic data matching that CMS has announced to help ensure that consumers enrolled in Medicaid are not also enrolled in the marketplace plan?

Ms. Yocom. Right. They are just beginning to conduct these, and, once again, are sharing if there are consistent patterns, sharing what needs to be done to fix it.

Mr. Engel. So CMS conducts periodic and regularly scheduled data matches to identify duplicate coverage and will send notices to individuals with duplicate coverage to immediately end their marketplace coverage, if they are enrolled in Medicaid. Future schedule for PDM will be determined based on a number of factors, including the level of effort required by State and Medicaid agencies; is that correct?

Ms. Yocom. Yes. Our concern is that they aren't -- they haven't yet settled on how periodic to be, and they haven't settled on how extensive those requests are. And we think that is going to be important for them to figure out and apply.

Mr. Engel. So what I have just said, is that a reasonable approach by the agency?

Ms. Yocom. It is. I think more surety on the periodicity of the reviews would be important.

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Mr. Engel. Okay. It is also the case that some duplicate coverage is allowable. Is that not right?

Ms. Yocom. That is correct. There are scenarios where it is allowed under the statute.

Mr. Engel. For instance, when a case is transferred to the Medicaid agency for a decision on eligibility, the individual doesn't have to end his or her subsidized coverage in a QHP until the month after he or she is determined eligible; is that correct?

Ms. Yocom. Right. And that is where these checks come in. That is why those checks are important, because it can be cut off earlier than -- and not extended, the duplicate coverage.

Mr. Engel. Thank you. Would you agree that the best practice at that point is for the marketplace to end eligibility for APTC once an individual has been determined eligible for Medicaid as some States do?

Ms. Yocom. We -- yes, in general. And CMS has said that they are working on a way to make that happen more automatically. Right now it is not automatic.

Mr. Engel. So CMS is definitely considering that; am I right?

Ms. Yocom. They are considering that.

Mr. Engel. Right. Right. Well, thank you very much.

Mr. Chairman, I yield back the balance of my time.

Mr. Pitts. The chair thanks the gentleman.

This is an unedited transcript. The statements within may be inaccurate, incomplete, or misattributed to the speaker.

That concludes the questions of the members present. As usual, we may have follow-up questions. Members who were unable to attend may provide us with questions in writing. We will submit those to you. We ask that you please respond promptly if we do.

And I remind the members that they have 10 business days to submit questions for the record. They should submit their questions by the close of business on Friday, November 12th.

Thank you for your testimony. Thank you for your work on behalf of the taxpayers. Thank you for your efforts to provide integrity to our programs to make sure that those who are eligible to receive assistance receive that assistance. And a very good hearing, very important hearing. And without objection, the subcommittee is adjourned.

[Whereupon, at 11:16 p.m., the subcommittee was adjourned.]