

Editorial

ObamaCare: Fraud, Incompetence, Confusion, and Higher Costs

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More than 9 months after the flawed and non-functional Healthcare.gov website made its debut, “ObamaCare” continues to flounder in a sea of incompetence. Preliminary findings of a Government Accountability Office (GAO) undercover investigation reveal that controls for determining enrollment and income eligibility for government subsidies are essentially non-existent. The GAO investigation found that 92 percent (11/12) of fictitious enrollees were approved and given subsidized coverage.¹ If one wanted to design a system that would be vulnerable to fraud, waste and abuse, this is it.

GAO Sting Operation Tests Enrollment Eligibility and Income Eligibility for Subsidies

The GAO investigation was requested by Rep. Charles Boustany, Jr., M.D., (R-La.), Chairman of the Subcommittee on Oversight, House Ways and Means Committee; Rep. Dave Camp (R-Mich.), Chairman of the House Ways and Means Committee; Sen. Tom Coburn, M.D., (R-Okla.), and Sen. Orrin Hatch (R-Utah).¹

In order to be eligible to enroll in “ObamaCare,” the applicant must be a “U.S. citizen or national, or otherwise lawfully present in the United States; reside in the marketplace service area; and not be incarcerated (unless jailed while awaiting disposition of the charges).”¹

Two types of government subsidies are available to qualified applicants: a premium tax credit and a cost-reduction subsidy (to help pay co-pays and deductibles). Those who earn between 100 percent and 400 percent of the federal poverty level (e.g. \$11,490 for a single person/\$39,630 for family of eight), qualify for the premium tax credit.

Premium tax credits are subject to reconciliation on the applicant’s federal tax return, and if actual income exceeds qualification limits, repayment would be required. Those earning between 100 percent and 250 percent of the federal poverty level also qualify for the cost-sharing reduction subsidy. The cost-sharing reduction subsidy is not subject to reconciliation on the applicant’s federal tax return.¹ Both premium tax credits and cost-reduction subsidies are paid directly to insurers.

In the first part of the GAO undercover investigation, controls for verifying identity, citizenship, immigration status, and incarceration status were tested. The GAO used 12 fictitious identities. The fake applicants included those who provided non-valid Social Security numbers and non-citizens who claimed to be lawfully present in the U.S. The results were shocking: “For 11 of these 12 applications, which were made by phone and online using fictitious identities, GAO obtained subsidized coverage.”¹

The results likely would have been 100 percent (12/12) of fake applicants obtaining coverage if one of the fake participants had not refused to provide a Social Security number (as part of the test), citing concerns about possible identity theft.

The second part of the GAO’s test, designed to see to what extent, if any, “in-person assisters would encourage applicants to misstate income in order to qualify for income-based subsidies,” could not even be done because of the non-functioning Healthcare.gov website and pervasive bureaucratic incompetence.¹ The “GAO was unable to obtain in-person assistance in five of the six initial undercover attempts...the in-person assister was not able to assist us because Healthcare.gov website was down and did not respond to follow-up phone calls.”¹ The bureaucratic morass and incompetence the GAO encountered included:

- One of the three Navigators required that we make an appointment in advance by phone. When we were unable to reach the Navigator by phone, we made an in-person visit. The Navigator declined to provide assistance, or to schedule an appointment, saying instead we would need to phone to schedule an appointment to return.
- One of the three non-Navigators initially said it provides assistance only after people already have an application in progress. The non-Navigator did offer to assist us with an application, but the Healthcare.gov website was down. He directed us to call later for assistance. After we did so, this non-Navigator did not respond to three follow-up phone calls.
- Another of the three non-Navigators, a health care services company, told us it only handles applications from those having a medical bill at its medical facility.
- The third non-Navigator did not provide assistance, telling us it handles only applications for Medicaid.
- For another test, which occurred late in the open-enrollment period, non-Navigator representatives declined to provide help, telling us they were uncomfortable doing so and planned to take a seminar on enrollment.¹

The Centers for Medicare and Medicaid Services (CMS), however, assures us that “Navigators and non-Navigators must complete comprehensive training, according to CMS.”¹ In fact, CMS has provided \$67 million in grants for Navigators and separate funds and grants for non-Navigators to ensure that they are competent to assist applicants.

In some cases, applicants attempted to upload enrollment

and income verification documents to the HealthCare.gov website, only to encounter system error messages. As a result, they had to resort to mailing copies of documents by U.S. mail.² Some applicants ended up sending multiple copies of the documents. The *Miami Herald* reported: “For consumers such as Martinez, the frustration of submitting multiple copies of information—only to have the government ask for it again and again—is almost worse than having to repay money [advance premium tax credits that government had paid on his behalf] he cannot afford.”³

The GAO reported that multiple applications for the same applicant are common: “In the course of follow-up dealings with the Marketplace, call-center representatives in at least four cases could not locate our existing applications and, as a result, began new applications, according to our conversations with representatives. According to CMS call-center and document-processing contractors, multiple electronic applications have been common.”¹

True Enrollment Numbers Unknown; Subsidy Controls Ineffective

So-called controls depend largely on the applicants’ attestation that they did not provide false information: “Applicants for coverage are required to attest that they have not intentionally provided false or untrue information.”¹ The “ObamaCare” program also depends on insurers to tell how much the government should pay insurers for subsidized coverage. “As a result, under current operations, CMS must rely on health insurance issuers to self-report enrollment data reflecting individuals for whom CMS owes the issuers the income-based subsidies arising from obtaining coverage through the Marketplace.”¹ In effect, CMS has given insurers a blank check, allowing them to fill in the amount according to the number of individuals the insurer claims to have enrolled. CMS does not even have the capability of determining how many people have actually enrolled and paid their premiums. GAO reported:

Thus, a key factor in analyzing enrollment in Marketplace coverage—and federal expenditures and subsidies that follow—is the ability to identify which applicants approved for coverage have subsequently paid premiums and put policies in force. According to HHS [the Department of Health and Human Services], more than 8 million people selected a plan for coverage during the initial open-enrollment period that ended in April [2014]. CMS officials, however, told us they are thus far unable to identify individuals who have made premium payments. Issuers have reported this information to CMS, but the agency has not yet created a system to process the information, according to CMS officials.¹

Image Quality Standard for Resolving Inconsistencies

Information provided by applicants is supposed to be

checked against information from government sources including the Social Security Administration, Department of Homeland Security, and the IRS. In addition, information from credit reporting agencies may also be checked. Any inconsistencies between information supplied by an applicant and information obtained from other sources are supposed to be resolved within a 90-day period:

Where the marketplace identifies certain inconsistencies in an application that it cannot resolve through reasonable effort, the marketplace must undertake an “inconsistency process,” under which the applicant is typically given 90 days to present satisfactory evidence to resolve the identified inconsistencies. During this time, the marketplace must allow the applicant to enroll in a qualified health plan, and, if applicable, receive premium tax credit and cost-sharing reduction subsidies.¹

In 11 out of the 12 fake applications submitted by the GAO, fake applicants were asked to provide supplementary documentation. Three of the 12 fake applicants provided no documentation, yet were approved to receive subsidized coverage.

The number of inconsistencies that have been identified is very high: “Overall, among all applications for the federal Marketplace, about 4.3 million application inconsistencies have been identified, representing about 3.5 million people, according to the CMS contractor handling receipt and evaluation of submitted materials.”¹ As of mid-July 2014, only 650,000 inconsistencies had been cleared by the government’s contractor. “In some cases, according to the CMS contractor, documents cannot be matched to their respective applications, and become ‘orphans.’ As of mid-July 2014, the contractor said, there had been about 227,000 such documents.”¹

The HHS Office of Inspector General has also noted that the fraction of inconsistencies which the Marketplace was not able to resolve is quite high: “The HHS Office of Inspector General recently reported on applicant inconsistencies, noting that the Marketplace was unable to resolve a high fraction of inconsistencies because the CMS eligibility system was not fully operational.”¹

Incredibly, call centers do not have access to document-submission information, and, therefore, cannot answer questions about the status of document filings:

When we [GAO] called to inquire about the status of our document filings, representatives could not answer our questions. They told us they were not able to confirm receipt of requested documentation and were not able to provide information on whether requested documentation has been reviewed. The CMS contractors handling consumer calls and document verification each confirmed to us that the call-centers cannot access document-submission information. Hence, it is currently not possible for a call-center representative, fielding an inquiry such as ours, to obtain document status information in order to provide that information

to the consumer.¹

The process that government contractors use to authenticate and verify enrollment information is limited to an evaluation of image quality. As long as someone can make out an image, and the image does not appear to be obviously altered, the document is approved as authentic and verified. The image quality standard is also quite low:

[T]he review standard the contractor uses is that it accepts documents as authentic unless there are obvious alterations.... Specifically, in the contractor's standard operating procedures for its work for CMS, document review workers are directed under "general verification guidance" to "determine if the document image is legible and appears unaltered by visually inspecting it...." According to the contractor executives, when consumers send copies of documents, as directed, rather than originals, there inevitably is a loss of image quality such that the contractor could not closely examine whether a document is authentic.¹

CMS claims that proper authentication of documents would increase costs several-fold.

Certifying Authenticity and Detecting Fraud Not Part of Enrollment Process

When the GAO inquired about efforts to detect fraud in the enrollment process and the process of obtaining government subsidies, CMS essentially told the GAO that was not in its job description:

According to CMS officials, its document processing contractor is not required under its contract to authenticate documentation or to conduct forensic analysis.... [T]he review standard the contractor uses is that it accepts documents as authentic unless there are obvious alterations.... Further, the contractor is not equipped to attempt to identify fraud, the contractor executives told us, and the contractor does not have the means to judge whether documents submitted might be fraudulent. The standard of accepting authenticity unless there is obvious alteration originated from CMS, the executives said.... Even if such an effort was attempted, they said, it would be difficult to say if anti-fraud measures would be effective, because that is not the company's business.¹

The inescapable conclusion is that the designers of "ObamaCare" did not care about eligibility of enrollees or qualifications for government subsidies. The goal was simply to sign people up.

CMS Not Aware of Fraudulent Applications

The CMS figurative panel of three monkeys—see no fraud, hear no fraud, and speak of no fraud—boldly states that there is no evidence that applicants are defrauding the "ObamaCare" Marketplace. And besides, CMS says that it really does not have any processes to know whether fraud is being committed or not.

And, because CMS sees no evidence of fraud being committed, it sees no reason to change its eligibility-determination process. According to the GAO report:

Overall, the contractor executives told us, the contractor is not aware of any fraudulent applications and that, based on its practices, it also is not in a position to know whether fraud is being attempted. CMS officials similarly told us they did not know the extent of any attempts at application or enrollment fraud, but said that to date, there is no evidence of applicants defrauding the federal Marketplace.... Overall, CMS officials told us that they have internal controls for the eligibility-determination process, and that experience has not shown the need for any changes in that process.¹

Apparently, 92 percent of fake applicants obtaining subsidized coverage is not a persuasive statistic for CMS.

Financial Implications of Lack of Effective Controls

The GAO reported: "According to the Congressional Budget Office, the estimated net cost of coverage provisions to the federal government are \$36 billion for fiscal year 2014 and \$1.4 trillion for fiscal years 2015-2024, with subsidies and related spending accounting for a large portion of the total."¹ Estimates of the percentage of premiums paid by subsidies range from 76%⁴ to 85%.³ GAO also reported the cost of subsidies for the 11 fake applicants: "The total amount of these credits for the 11 approved applications is about \$2,500 monthly or about \$30,000 annually. We also obtained cost-sharing reduction subsidies, according to Marketplace representatives, in at least nine of the 11 cases."¹

Double Standard Applied to GAO Findings

Although government-run medical programs have often generalized and extrapolated the findings involving a small sample of disputed charges to a physician's entire practice, in order to prosecute physicians and recoup funds, the GAO says that its findings in this situation cannot be generalized to the entire enrollment or applicant populations: "Because the number of fictitious applications we made was limited, and the applications do not reflect a sample of actual applications, the results of our testing, while illustrative, cannot be generalized to the overall applicant or enrollment population."¹

Widespread Confusion among Enrollees

Just as the House of Representatives was told they had to pass "ObamaCare" so the public could find out what's in it, many enrollees are finding that you have to sign up for an "ObamaCare" plan to find out what is in it. Many of those who signed up for coverage were essentially insurance-illiterate, and were not familiar with such terms as premiums, co-pays, deductibles, and tiered networks. In one case, reported by *The New York Times*, the new enrollee stated: "None of that [complicated tiered networks of physicians and hospitals] was

explained when I signed up,' she said. 'This is the first I'm hearing it.'"⁵

Apparently many people had the idea that once they obtained their "ObamaCare" insurance card, medical care would essentially be free. The person cited in the *Times* article was shocked that she had to pay a \$60 co-pay to see her usual physician, who was in the most expensive tier in the insurer's physician network. Later, when she lost her job, she made too little to qualify for subsidies, and her financial situation did not yet qualify for Medicaid. She fell into the abyss of the "coverage gap," losing both her doctor and her insurance plan.

As a result of widespread confusion among enrollees, CMS has implemented a "From Coverage to Care" program to educate the newly insured about the basic essentials of insurance coverage.⁶

Automatic Renewals

Although it is now widely recognized that the promise of more affordable care under the ACA was a complete lie, newly insured enrollees in particular may be facing much higher costs next year.

Higher costs for the newly insured will occur as a result of an automatic renewal process and changes in benchmark plans.

As reported in *The Buffalo News*, "Overall, premiums on the exchanges in 2015 may be a bit higher for most people.... [A]verage premiums for Silver plans will climb an average of 8 percent."⁷

The government-provided subsidies are based on a Silver "benchmark" plan—the second-lowest priced Silver plan in the area. The benchmark plan can change from year to year, thus the subsidy an enrollee obtained for 2014 may not be the same dollar amount for 2015. If the subsidy amount is lower for 2015 and the cost of the automatically renewed plan is higher, the result will be much higher out-of-pocket costs for the enrollee.

The only way an enrollee can avoid these higher costs is to go through the onerous bureaucratic mess of applying for coverage again through the "ObamaCare" Marketplace. That in itself represents a high cost in terms of time and frustration.

Conclusions

Total lack of any effective controls in "ObamaCare" invites fraud and abuse. The fact that 92 percent of fake applicants were able to obtain government-subsidized coverage should be a concern for all. Likewise, the government's practice of handing insurance companies the equivalent of blank checks is abhorrent. The pervasive incompetence in the "ObamaCare" bureaucracy, demonstrated by the GAO's findings, is shocking and clearly beyond repair. The arrogance of CMS, which finds no evidence of any fraud and no need to change its procedures, is an affront to every taxpayer. The ACA's goal was to enroll and control. Detecting and eliminating fraud was never a consideration. Widespread confusion among enrollees and much higher costs were a predictable outcome.

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