Emerging Trend in ACA Enrollment

A costly new scheme has been the topic of conversation

Affordable Care Act (ACA) enrollment issues are not new, but it seems they are taking a twist, leaving some plans exasperated by the continuous hustle to stop the bleeding. All of us in the industry understand the struggle to qualify enrollments timely, especially when a huge federal agency is at the helm. For some plans, this is costing millions of dollars in fraud, waste, and abuse losses.

Healthcare fraud within the ACA enrollment and verification space has been a growing concern and has the potential to strain the already complex U.S. healthcare system. The ACA was introduced to expand access to healthcare for millions of Americans. Unfortunately, with the emergence of the ACA, some individuals have sought to exploit the enrollment and verification process for financial gain.

So, what is the scheme?

Under ACA enrollment guidelines, particularly the relaxed guidelines for the American Indian and Alaska Native (AI/AN) groups who can enroll at any time and with little to no out of pocket expenses, fraudulent enrollments are on the rise. While these guidelines are intended for good, we know opportunity and incentive are two of the three sides to the fraud triangle framework.

We are seeing perpetrators falsely enrolling in ACA coverage, submitting substantial claims during the initial three-month verification of enrollment period, managed by CMS. Often the addresses used to enroll are homes for sale, homeless shelters or the like, deeming the enrollees as not qualified for coverage in the state where they applied. Many enrollees are indicating false income levels, have never lived in the state they are enrolling in, and/or are not AI/AN.

In order to get these enrollees removed from coverage and support the denial of claims, payers need to submit and get approved rescission files from CMS. Completion of these files requires several hours of leg work by the investigation teams to research enrollee addresses and coverage requirements, making a minimum of several phone calls per person to prove outreach to enrollees, brokers and facilities.

How should we handle it?

Mitigating the possibility of healthcare fraud during the enrollment verification period may involve the implementation of a multifactor crosscheck system for improved verification, collaboration amongst law enforcement agencies with insurers and policy holders, and audits/reviews within the insurers organization immediately upon enrollment of all ACA enrollees. The list goes on, but the goal is to prevent the massive loss of money and resources that is occurring as a result of fraudulent enrollments as a result of the ACA.

Addressing this issue is crucial to ensure that ACA resources are directed towards those who legitimately need assistance and prevent the misuse of public funds. Insurers, members, brokers, providers, and law enforcement agencies share the burden of responsibility when it comes to this and all healthcare fraud. It is essential for government, regulatory agencies, and healthcare providers to work together to develop comprehensive strategies that strengthen the verification process, proactively detect fraudulent activities, and deter individuals from exploiting the system for personal gain. By doing so, we can protect the ACA's goal of expanding access to healthcare and ensuring its sustainability for those who truly depend on it.

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