DC Health Benefit Exchange Authority

January 27, 2023

Submitted via www.regulations.gov

Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-9899-P,
P.O. Box 8016,
Baltimore, MD 21244-8016.

Re: Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters (NBPP) for 2024 – CMS-9899-P

The District of Columbia Health Benefit Exchange Authority (HBX) appreciates your consideration of our comments.

By way of background, HBX is a private-public partnership established by the District of Columbia (District) to develop and operate the District's on-line health insurance marketplace, DC Health Link (DCHealthLink.com). We cover approximately 100,000 people -- District residents and people who work for District small businesses. DC Health Link fosters competition and transparency in the private health insurance market, enabling individuals and small businesses to compare health insurance prices and benefits and to purchase affordable, quality health insurance. Since we opened for business, we have cut the uninsured rate by half and now more than 96% of District residents have health coverage.

HBX supports CMS's policies that provide flexibility for state-based marketplaces (SBMs), allowing states to design programs that best serve the needs of their consumers and allow for state innovation. HBX also applauds and strongly supports CMS for its strong commitment to equity and nondiscrimination. CMS and states need to reexamine all regulatory impediments to enrollment in affordable quality coverage. As such, HBX strongly supports CMS's proposals that would remove barriers to enrollment, such as expanding the availability of special enrollment periods, modifying the income verification requirements to eliminate unnecessary customer documentation requests, limiting the circumstances where customers would be categorically barred from tax credits based on a failure to reconcile, and creating a notification standard prior to plan termination for non-payment of premiums. HBX also supports efforts to increase consumer enrollment by allowing door-to-door Assister/Navigator enrollment and supports strong federal oversight of web-based enrollers as proposed in the NBPP. These proposals are essential to ensuring that consumers can access high quality coverage that meets their needs.

There is one proposed area that we oppose in its entirety -- the Improper Payment Pre-Testing and Assessment (IPPTA) Program proposal because it is duplicative creating an unnecessary resource burden on SBMs.

Improper Payment Pre-Testing and Assessment (IPPTA) Program (§ 155.1500 *et. seq.*)

HBX opposes the proposal to create the IPPTA Program, a precursor to the State Exchange Improper Payment Measurement (SEIPM) program that was proposed but ultimately not adopted by CMS in the 2023 Payment Notice. These proposals duplicate existing audits and create significant new financial, system, and resource burdens on SBMs such as HBX. Because existing federal and local audit and reconciliation requirements already satisfy the oversight requirements of the Payment Integrity Information Act of 2019 (PIIA), the proposed new audit is duplicative and unnecessary. To the degree the existing audits and reports do not meet CMS' needs, guidance for such audits and reports should be updated rather than duplicating these with a new audit.

Existing Oversight Measures Meet PIIA Goals

CMS indicates that it must implement the IPPTA program, leading to the SEIPM program, to comply with the PIIA. However, CMS does not provide evidence as to why its existing oversight activities can't be used to conduct the improper payment risk assessment, improper payment estimates, and corrective action plan reporting required by the PIIA. In fact, the 2023 proposed Payment Notice acknowledged that CMS already monitors eligibility and enrollment errors and payment discrepancies through activities that include:[1]

- An annual report showing compliance with federal requirements, which includes completion of a programmatic audit by an independent auditor at the exchange's expense;
- Monthly payment dispute reconciliation;
- An annual report on instances in which the State Exchange did not reduce an enrollee's premium by the amount of the APTC in accordance with §155.340(g)(1); and
- Quarterly submission of performance monitoring data.

Given this extensive and frequent oversight framework, adding the IPPTA or SEIPM program to current oversight activities is redundant and unnecessarily burdensome. Adding this new burdensome audit is reminiscent of the early days when SBMs opened. Back then we had federal and local audits, many of which continue: HHS Office of Inspector General audits, HHS Office of Inspector General Cost Allocation audits, CMS SMART audit (annual), CMS Privacy Impact Assessment (triennial), IRS Federal Tax Information audit (periodic), IRS Safeguard Security Report (periodic), Inspector General for Tax Administration (periodic), GAO audits (periodic), GAO Special Enrollment Period audit, GAO IT audit, Comprehensive Annual Financial Report audit (local annual), Single-Audit (for federal grants), Single-Audit for ARP funding, Insurance Regulatory Trust Fund Bureau audits (local annual), DC OIG Risk Assessment of the use of the District's ARPA Funds, and other federal and local one-time, periodic, and annual audits. Requiring new duplicative, burdensome, and resource intensive

[1] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023, 87 Fed. Reg. 584, 654 (proposed Jan. 5, 2022).

audits depletes and diverts limited resources from enrollment and support for customers.

In particular, the following oversight and reconciliation activities already target eligibility and enrollment errors or improper payments:

> Annual Programmatic Audits – 45 C.F.R. §155.1200(c) requires that an exchange hire an independent auditor to conduct an annual programmatic audit. Unlike the 2023 Payment Notice proposal, this proposed rule lacks a modification to §155.1200 that would exempt exchanges from the annual programmatic audit for those years where they participate in the IPPTA. At a minimum, this exemption must be added back §155.1200(c) so that exchanges are not required to participate in both the IPPTA and the programmatic audit for the same calendar year.
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> CMS does not provide a reasonable rationale indicating that the IPPTA or SEIPM is a necessary replacement. CMS's rationale in the 2023 proposed Payment Notice for why it would not simply update its auditing guidelines for independent auditors is falsely premised. First, CMS acknowledges in the that this audit, along with the corrective action plans that CMS monitors closely, "allows HHS to oversee compliance with eligibility and enrollment standards to ensure that State Exchanges are conducting accurate eligibility determinations and enrollment transactions."[2] The independent auditors conduct these audits pursuant to CMS guidelines while allowing for necessary adjustments to ensure they are collecting the right data. Contrary to CMS's assertion that using different "third-party reviewers" to make improper payment estimates would undermine the utility of the results,[3] meaningful review must allow auditors to adjust for each marketplace's unique eligibility and enrollment system architecture and market conditions. Such adjustments are crucial to ensuring the audit results are accurate. For example, in 2022, only 17% of HBX's individual market enrollees received APTC. Recognizing this, our independent auditor created separate samples that test enrollment eligibility generally as compared to APTC eligibility specifically. Second, CMS has said that engaging "third-party reviewers" to estimate improper payments would place an additional burden on CMS and the SBMs because "the third party would need to obtain personally identifiable information from both state and federal data systems."[4] However, for the current programmatic audits, the independent auditors already receive extensive PII, information returned from federal data services that were used to verify eligibility, and data on the amount of APTC associated with all enrollments. Additionally, the independent auditors already make findings as to eligibility and enrollment errors. They could easily formulate improper APTC payment estimates.
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> Monthly Payment Dispute Reconciliation – On a monthly basis, CMS sends data files to exchanges to reconcile discrepancies between the APTC amounts issuers are claiming and the amounts reported to CMS by SBMs. Although HBX's experience indicates there are infrequent and easily explained discrepancies, these monthly engagements between CMS and HBX allows HBX to promptly make necessary corrections by updating the

[2] 87 Fed. Reg. at 654.
[3] 87 Fed. Reg. at 718.
[4] 87 Fed. Reg. at 718.

reporting in the next month's SBMI file and to address any systematic issues that may be creating the discrepancies. This is one of many ways CMS now has to assess improper payment risk and to estimate amounts of improper payments.

APTC Reconciliation - The ACA requires reconciliation of APTC on an individual's tax filing[5]. APTC determinations are based on whether the applicated is "expected to have a household income that will qualify" them for premium tax credits.[6] As such, the applicant must provide an estimation of income before the year is complete or before the year has even started in the case of applications and renewals in November and December for January 1 coverage. An individual is then required to reconcile the APTC on tax filings after the enrollment year ends. Any amount of over payment or underpayment is determined through review or adjudication by the IRS. Errors in calculation or documentation are overcome by the reconciliation of actual income earned and premium tax credit due. Instead of establishing an error rate which isn't appropriate or comparable to other healthcare programs given the reconciliation requirement, CMS and IRS should continue to use the oversight and audit requirements in place to identify and remedy improper payments.

HBX Supports Commitment to Minimizing Burden on SBMs

While HBX opposes the IPPTA program for the reasons stated above, and we ask CMS to reject the proposal in its entirety, if CMS proceeds with imposing this duplicative requirement, HBX encourages CMS to minimize the administrative burden on SBMs. CMS should also retain the proposed rule's language requiring strong coordination and consultation with SBMs as such consultation is crucial to collecting accurate information. CMS should adopt the proposal to:

- Allow SBMs to provide the application data associated with the sampled applicants, including electronic data responses, and CMS would use its own resources to map the data to the data elements they desire.[7] As noted by CMS, this would require a close level of interaction between CMS and the exchanges to ensure CMS is interpreting the data properly.

- Allow SBMs to provide information on 10 tax households, as proposed.[8] Data samples must be the minimum necessary to validate an SBM's eligibility processes. A sample of ten is sufficient and would help mitigate additional operational and resource burdens on an SBM. Importantly, CMS must allow for SBM documentation, such as the "entity relationship diagram" and "data dictionary", to be in various formats which would differ from other SBMs and the FFM. CMS should not expect SBMs to create new documentation to satisfy the IPPTA as this would be resource intensive and would divert limited resources from the exchange's central mission of helping people get covered and stay covered.

[5] 26 U.S.C. §36B(f); 26 C.F.R. §1.36B-4.
[6] 45 C.F.R. §155.305(f)(1)(i).
[7] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2024, 87 Fed. Reg. 78206, 78271 (proposed Dec. 21, 2022).
[8] 87 Fed. Reg. at 78271.

Finally, CMS should postpone any action or decision until after the current pilot program is complete, evaluated, and lessons identified. The FFM and SBM-FPs are measuring and reporting their improper payments as of 2022, and some SBMs are engaged in a voluntary evaluation process. HHS provided three options to State Exchanges—program analysis, program design, and piloting. Currently, of the 18 State Exchanges, 10 have participated in various levels of engagement. If CMS chooses to move forward with the IPPTA or duplicative audit requirements, it should only be after the current pilot states have fully completed their pilot and best practices can be used in the extension of these requirements to other states.

For the above-stated reasons, HBX opposes the proposed IPPTA program, a precursor to the SEIPM program. We ask CMS to reject this proposal in its entirety as duplicative, unworkable, unnecessary, and overly burdensome and instead devise mechanisms wherein it uses data already known to CMS, combined with existing audits, to meet its oversight obligations.

Conclusion

Thank you for considering our comments on issues that will directly impact District residents and the continued operations of our marketplace. We appreciate CMS's continued support for state flexibility consumer protections and working to ensure a more equitable future. We look forward to working with you on these issues.

Sincerely,

Mila Kofman
Executive Director
DC Health Benefit Exchange Authority