D.C. HEALTH BENEFIT EXCHANGE AUTHORITY

FISCAL YEAR 2022 PROGRAMMATIC AUDIT REPORT

BSC
BERT SMITH & CO.
CERTIFIED PUBLIC ACCOUNTANTS
& MANAGEMENT CONSULTANTS

TABLE OF CONTENTS

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CERTIFIED PUBLIC ACCOUNTANTS
& MANAGEMENT CONSULTANTS

1090 Vermont Avenue, NW
Suite 250
Washington, DC 20005

P.O. Box 2478
Kingshill, VI 00851

200 E Pratt Street
Suite 4100
Baltimore, MD 21202

TRANSMITTAL LETTER

May 30, 2023

Executive Director
D.C. Health Benefit Exchange Authority
Washington, D.C.

This report presents the results of our work conducted to address the programmatic audit objectives relative to the D.C. Health Benefit Exchange Authority (the Exchange) audit for fiscal year 2022 (October 1, 2021 to September 30, 2022). Our work was performed during the period of January 12, 2023 through May 30, 2023 and our results are as of May 30, 2023.

Report on Compliance with 45 CFR Part 155

We have audited the D.C. Health Benefit Exchange Authority's compliance with the types of compliance requirements described in 45 CFR Part 155 subparts D and E for the fiscal year ended September 30, 2022.

Management's Responsibility

Management is responsible for compliance with the requirements of laws, regulations, contracts, and grants applicable under and pursuant to 45 CFR Part 155.

Auditor's Responsibility

Our responsibility is to express an opinion on the Exchange's compliance with 45 CFR Part 155 subparts D and E. We conducted our audit of compliance in accordance with auditing standards generally accepted in the United States of America; and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States, and Centers for Medicare and Medicaid Services (CMS). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether noncompliance with the types of compliance requirements referred to above could have a direct and material effect on the program occurred. An audit includes examining, on a test basis, evidence about the Exchange's compliance with those requirements and performing such other procedures as we considered necessary in the circumstances.

We believe that our audit provides a reasonable basis for our opinion on compliance with 45 CFR Part 155 subparts D and E. However, our audit does not provide a legal determination of the Exchange's compliance with those requirements.

T:202.393.5600
TF: 1.855.479.0548
F: 202.393.5608

bertsmithco.com
bsmith@bertsmithco.com

Opinion on Compliance with 45 CFR Part 155

In our opinion, except for the instances of noncompliance, which are described in the accompanying schedule of findings and recommendations as items 2022-001 and 2022-002, the Exchange complied in all material respects, with the types of compliance requirements referred to above for the fiscal year ended September 30, 2022.

Other Matter

The Exchange's responses to the noncompliance findings are described in the accompanying schedule of findings and recommendations. We did not audit the Exchange's responses and, accordingly, we express no opinion on them.

Sincerely,

Bert Smith & Co.

Bert Smith & Co.

EXECUTIVE SUMMARY

I. BACKGROUND

In 2010, the federal Patient Protection and Affordable Care Act (ACA) was enacted to reform the health care system in the United States. A key requirement of the Affordable Care Act is that all Americans obtain public or private health insurance or pay a penalty (42 U.S.C. 18091 and 26 U.S.C. 5000A). To accomplish this requirement, the ACA authorizes federal funding to: (1) establish health insurance exchanges, (2) allow states to expand Medicaid eligibility, and (3) provide federal tax credits to lower-income individuals who are ineligible for minimum essential coverage (such as Medicaid or affordable employer-sponsored coverage).

As one of the key components of the ACA, each state is required to make available a health insurance exchange for individuals and small businesses to compare and select health insurance plans. These exchanges, also known as "marketplaces," were to be established and managed by individual states, by the federal government for a state, or through a federal-state partnership. Pursuant to Section 3 of the Health Benefit Exchange Authority Establishment Act of 2011, the District of Columbia established its own state-based health insurance marketplace to meet the needs of District residents and small businesses.

II. AUDIT OBJECTIVES

The objectives of this audit were to determine the Exchange's compliance with the rules, regulations and guidelines under 45 CFR Part 155 governing the programmatic requirements set forth by the Centers for Medicare & Medicaid Services (CMS).

III. SCOPE

The scope of the programmatic audit covers the Exchange's compliance with the requirements under 45 CFR Part 155 subparts, Subpart D – Exchange Functions in the Individual Market: Eligibility Determinations for Exchange Participation and Insurance Affordability Programs and Subpart E – Exchange Functions in the Individual Market: Enrollment in Qualified Health Plans for the period October 1, 2021 through September 30, 2022.

IV. AUDITING STANDARDS

We conducted this programmatic audit in accordance with *Generally Accepted Government Auditing Standards*. Those standards require that we plan and perform the audit to obtain sufficient appropriate evidence to provide a reasonable basis for our findings and conclusions based upon our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

To determine the Exchange's compliance with the programmatic audit requirements we performed specific procedures as follows:

- Obtained data and conducted meetings with Exchange personnel, contractors and personnel from other District agencies to gain an insight and understanding of the policies, procedures and types of supporting documents required for our testing. Personnel interviewed included:

  - Deputy General Counsel and Policy Advisor, Health Benefit Exchange (HBX)
  - Associate General Counsel and Policy Advisor, (HBX)
  - Assistant Director of Plan Management – Marketplace, Innovation, Policy, and Operations (HBX)
  - Individual Market Member Services Manager (HBX)
  - Assistant Marketplace Operations Director – Exchange Data and Transactions (HBX)

- We reviewed the following key documents, regulations and requirements, and policies and procedures:

  - 45 CFR Part 155
  - D.C. Health Link Assister's Resource Guide
  - D.C. HBX Uniform Carrier Agreement
  - D.C. HBX Benefit Enrollment (834) Companion Guide
  - D.C. Transaction Error Handling Guide

- Reviewed governance documents.
- Reviewed legislation relating to the Exchange.
- Reviewed oversight monitoring policies and procedures.
- Reviewed processes and procedures designed to prevent improper enrollment.
- Tested the compliance and effectiveness of internal controls over the subpart requirements.
- Tested enrollment data backup procedures.

We analyzed the following information to assess HBX's compliance with the requirements of 45 CFR Part 155:

- From a record of 31,463 unique applications which were submitted in FY 2022, we selected a sample of 45 EnrollApp and 45 Curam applications to test the compliance with 45 CFR 155 Subpart D – Eligibility Determinations for Exchange Participation and Insurance Affordability Programs. Applications were tested to verify eligibility approval or denial determinations were accurately assessed.

- From a record of 18,767 applications which were submitted from October 1, 2021 to September 30, 2022, we reviewed seven (7) Curam instances of applicants who attested to being 'not lawfully present' and a sample of 12 EnrollApp applicants whose verification of immigration status was outstanding and enrolled in a QHP to verify compliance with 45 CFR 155 Subpart D – Eligibility Determinations for Exchange Participation and Subpart E – Enrollment in Qualified Health Plans.

- From a record of 18,767 applications which were submitted from October 1, 2021 to September 30, 2022, we reviewed 30 Curam instances of applicants whose verification of citizenship was outstanding and a sample of 12 EnrollApp applicants whose verification of citizenship was outstanding and enrolled in a QHP to verify compliance with 45 CFR 155 Subpart D – Eligibility Determinations for Exchange Participation and Subpart E – Enrollment in Qualified Health Plans.

- From a record of 18,767 applicants who had enrolled in a Qualified Health Plan on or after October 1, 2021, we selected a sample of 45 cases to test their compliance with 45 CFR 155 Subpart E – Enrollment in Qualified Health Plans. Enrollment records were reviewed to verify timely and accurate communication of applicant details and Advance Premium Tax Credit (APTC) determinations to insurance carriers.

- From a record of 18,767 applicants who had enrolled in a Qualified Health Plan on or after October 1, 2021, we reviewed all instances to verify the calculated Premium amount was not more than the allowed Advance Premium Tax Credit (APTC) amount to test their compliance with 45 CFR 155 Subpart D – Eligibility Determinations for Exchange Participation and Subpart E – Enrollment in Qualified Health Plans.

- From a record of 18,767 applicants who had enrolled in a Qualified Health Plan on or after October 1, 2021, we reviewed all instances where applicants were enrolled in the same QHP more than once to test their compliance with 45 CFR 155 Subpart E – Enrollment in Qualified Health Plans.

- A sample of four (4) monthly backup procedures which were conducted during the period of review was selected to ensure compliance with Subpart D – Eligibility Determinations for Exchange Participation and Insurance Affordability Programs and Subpart E – Enrollment in Qualified Health Plans. Backup logs and database backup configurations were reviewed to test data and records maintenance procedures related to eligibility and enrollment.

V. NATURE OF CONFIDENTIAL OR SENSITIVE INFORMATION OMITTED

We have deemed that the contents of this report are not considered confidential or sensitive and as such, the report is presented in its entirety.

AUDIT FINDINGS AND RECOMMENDATIONS

I. SUMMARY OF RESULTS AND FINDINGS

The results and findings are as follows:

45 CFR Part 155	Compliance/Internal Control	Results
Subpart D – Eligibility Determinations for Exchange Participation and Insurance Affordability Programs	1. Process and procedures for conducting eligibility determinations.	The Exchange is in compliance with this requirement.
	2. Verification of eligibility for enrollment in a Qualified Health Plan (QHP) and/or insurance affordability programs.	The Exchange is not in compliance with this requirement. **Finding # 2022-001:** Inadequate Eligibility Verification Procedures (Repeat Finding).
	3. Redeterminations, both during the benefit year and the annual open enrollment period.	The Exchange is not in compliance with this requirement. **Finding # 2022-001:** Inadequate Eligibility Verification Procedures (Repeat Finding).
	4. Process for the administration of payments of advance premium tax credits (APTCs).	The Exchange is in compliance with this requirement.
	5. Data and records maintenance related to eligibility.	The Exchange is in compliance with this requirement.
Subpart E – Enrollment in Qualified Health Plans	1. Management review/internal controls associated with the prevention of improper enrollment transactions, including processes to ensure that enrollees are receiving accurate advance premium tax credits (APTC's), cost sharing reductions (CSR's), and premiums (and for correction of any discrepancies).	The Exchange is in compliance with this requirement.
	2. Compliance with Centers for Medicaid and Medicare Services (CMS) - issued Standard Companion Guides (e.g., ASC X12 820 and 834).	The Exchange is in compliance with this requirement.
	3. Processes to reconcile enrollment information with qualified health plan (QHP) issuers and CMS no less than on a monthly basis.	The Exchange is not in compliance with this requirement. **Finding # 2022-002:** Duplicate QHP Enrollments (Repeat Finding).
	4. Data and records maintenance related to enrollments.	The Exchange is in compliance with this requirement.

II. FINDINGS AND RECOMMENDATIONS

Based upon the results of our testing, we have outlined the findings below:

2022-001: ***Inadequate Eligibility Verification Procedures (Repeat Finding)***

Condition: Inadequate outreach to applicants to obtain eligibility verification documentation was noted in the following instances:

- Verification of Citizenship or Lawful Presence – Two (2) enrollees attested to U.S. Citizenship or lawful presence and their status was not e-verified and HBX did not do further outreach to verify citizenship or lawful presence.
- Verification of Residency – In three (3) cases applicants attested to not being D.C. residents but were allowed to enroll during the 2021 and/or 2022 plan years without further outreach to verify the attestations.
- Verification of Household Income – In one (1) case, income attestations submitted through D.C. Health Link was not completed and outreach for documentation was not conducted. The applicant received APTC.
- Verification of Social Security Number – In two (2) cases, customers provided their social security numbers (SSN), the electronic verification was not successful and further outreach was not conducted to verify the attestations.

Criteria: 45 CFR §155.330(a): Eligibility redetermination during a benefit year – General requirement. The Exchange must redetermine the eligibility of an enrollee in a QHP through the Exchange during the benefit year if it receives and verifies new information reported by an enrollee.

45 CFR §155.330(c)(1): Verification of reported changes. The Exchange must verify any information reported by an enrollee in accordance with the processes specified in 45 CFR Part 155.315 and 155.320 prior to using such information in an eligibility redetermination.

45 CFR §155.315 (f)(1) for an applicant for whom the Exchange cannot verify information required to determine eligibility for enrollment in a QHP through the Exchange, (1) must make a reasonable effort to identify and address the causes of such inconsistency, including through typographical or other clerical errors, by contacting the application filer to confirm the accuracy of the information submitted by the application filer.

Cause: Applicants' prior "lawfully present" status or Washington, D.C. residency attestations would be accepted without verifying subsequent updated attestations to being "not lawfully present" or attestations to no longer residing in Washington, D.C.

Further review was not taken when electronic SSN or income eligibility verification were not successful.

Effect:

HBX provided inaccurate eligibility determinations to applicants as defined in 45 CFR §155.305(a)(1).

HBX permitted applicants to receive APTC payments who may not be eligible. HBX permitted non-D.C. residents to enroll through the D.C. Health Benefit Exchange.

Recommendation:

Management should strengthen its procedures for lawful presence attestations during the eligibility determination and redetermination processes to ensure all verifications are successfully completed.

HBX should strengthen outreach procedures to address outstanding verifications in a timelier manner.

Management's Response:

The Exchange concurs with the finding with the following explanation:

HBX appreciates the work of the auditors, which shows the issue of insufficient outreach on verifications is extremely remote.

Background and Public Health Emergency Considerations

HBX has established a process for reviewing outstanding verifications that exceed the 90-day inconsistency period with a holistic viewpoint supported by federal regulation. These regulations permit both extensions of the inconsistency period and waivers of the verification requirement in appropriate circumstances. Furthermore, HBX's approach to resolving cases with outstanding eligibility verifications in FY22 must also be understood in the context of local and federal efforts to increase and maintain coverage during the COVID-19 Public Health Emergency. The pandemic represented a broad-based "special circumstance."

HBX acted quickly to respond to COVID-19. Like other state-based marketplaces and the federal marketplace, established and implemented changes to expand and maintain enrollment in healthcare coverage, refocusing limited existing staff and budget resources to these efforts. HBX established a special enrollment period allowing District residents and employees of District businesses to enroll in coverage outside of open enrollment, changed the online IT system to make it as easy to enroll as during open enrollment, made it easier for employers to sign up for group coverage, and eliminated barriers to care where all DC Health link plans covered diagnosis, testing, treatment, and vaccination for COVID-19 at no cost to enrollees. Recognizing the uneven recovery due to COVID-19, the federal marketplace continues to make a special enrollment period available to consumers who are impacted by COVID-19. Modeling after the federal marketplace, HBX also continues to make this special enrollment period available to ensure District residents and employees of District businesses have access to coverage outside of open enrollment period. Consistent with the federal marketplace, this SEP is available until 60 days following the end of the federal Public Health Emergency based on COVID-19 (60 days from May 11, 2023).

HBX has dedicated its limited resources to maintaining and expanding coverage during the Public Health Emergency while continuing to monitor outstanding verifications and communicate with effected consumers to gather documentation. HBX's experience has been that consumers have been harder to reach and focused on a multitude of competing priorities and that aggressive termination inappropriately assumes that effected consumers are actually ineligible.

Citizenship/Lawful Presence Finding

The two (2) cases alleged by the auditors as not receiving appropriate outreach to clear citizenship/lawful presence verification are out of the 21,160 QHP enrollees during FY22, thus representing less than 0.01% of all QHP enrollees during the fiscal year. To find these cases, the auditors did not sample the entire population of enrollees. Instead, the auditors identified instances where enrolled individuals identified themselves as being not lawfully present or where U.S. Citizenship or lawful presence was not immediately e-verified - a total of 392 instances - and asked HBX to review 59 of these instances. Out of this review, the auditors identified two (2) cases where HBX did not have documentation supporting outreach to verify citizenship or lawful presence. One of these cases involved a short enrollment of 5 months.

Residency Finding

The three (3) cases alleged by the auditors as not receiving appropriate outreach to clear residency verification are out of the 21,160 QHP enrollees during FY22, thus representing 0.01% of all QHP enrollees during the fiscal year. To find these cases, the auditors did not sample the entire population of enrollees. Instead, the auditors identified a total of 486 instances where enrolled individuals identified themselves, at some point, as not having a DC address or otherwise meeting the residency requirement under federal regulations. The auditors asked HBX to review 30 of these instances. The audit revealed that 27 of these instances did not call for verification or involuntary enrollment termination. In three (3) cases the auditors found HBX did not have documentation supporting outreach to verify residency after an enrollee changed their address from a DC address to a non-DC address. In one of these cases, the enrollee changed their address back to a DC address approximately eight months after the previous change to a non-DC address.

Income Finding

The economic impacts of COVID-19 made projecting 2021 and 2022 incomes nearly impossible for many. Lay-offs, furloughs, and shutdowns with uneven reopening and recovery of businesses made it impossible to predict income. The auditors identified one (1) enrollee where HBX did not have documentation supporting outreach to verify income. The customer was enrolled for 7 months during FY22 and terminated coverage at the end of 2022.

SSN Finding

The two (2) cases alleged by the auditors as not receiving appropriate outreach to verify SSN out of the 21,160 QHP enrollees during FY22, thus representing less than 0.01% of all QHP enrollees during the fiscal year. To find these cases, the auditors did not sample the entire population of enrollees. Instead, the auditors identified a total of 35 instances where SSN was not immediately e-verified and asked HBX to review all of them. HBX is aware that the federal data services hub (FDSH) may be down at the point of an application and thus unable to send an immediate verification. Therefore, we have a practice of re-pining the hub, which led to 28 of the 35 cases being subsequently e-verified. Ultimately, the auditors identified two (2) cases where HBX did not have documentation supporting outreach to verify SSN. Regardless, SSN is not an eligibility factor, and an unverified SSN does not trigger enrollment termination.

Conclusion:

Therefore, to address this remote issue, HBX will review its procedures for ensuring caseworker outreach to enrollees that need verification of eligibility criteria.

Point of Contact: Jennifer Beeson, Director of Marketplace Innovation, Policy, and Operations, Jennifer.Beeson@dc.gov, (202) 741-0656.

2022-002: ***Duplicate QHP Enrollments (Repeat Finding)***

Condition: HBX transmitted duplicate QHP enrollments for twenty-three (23) customers to carriers and failed to initiate cancellation for those duplicate enrollments. Enrollment transmission occurred in:

- six (6) instances where individuals enrolled in different plans for the same time period.
- six (6) instances where individuals selected the same plan twice and HBX sent a duplicate plan without cancelling the prior plan.
- ten (10) instances where individuals were added to coverage or changed APTC and HBX sent a new plan without cancelling the prior plan.
- one (1) instance where individual had two accounts, based on different SSNs, and picked the same plan twice, and HBX did not cancel one of the enrollments.

Criteria: 45 CFR §155.430(b)(2)(v) – The Exchange must terminate a prior QHP enrollment when it is replaced with a new QHP enrollment.

45CFR§155.430(c)(2) - The Exchange must send termination information to the QHP issuer and HHS, promptly and without undue delay in accordance with §155.400(b).

Cause: HBX failed to identify a duplicate enrollment, for customers with duplicate enrollments for the same carrier and QHP.

Effect: HBX maintained duplicate enrollments to the issuer for the same coverage period.

Recommendation: HBX should strengthen controls around the review of enrollment records to prevent duplicate enrollments from occurring or persisting.

Management's Response: The Exchange concurs with the finding with the following explanation:

HBX appreciates the work of the auditors, which shows this is an extremely remote issue. The twenty-three (23) cases identified as being improperly handled are out of the 21,160 unique QHP enrollees that enrolled during FY22, thus representing 0.1% of all unique QHP enrollees during the fiscal year. To find these cases, the auditors did not use a sampling method, but instead checked for duplicate enrollments in the entire FY21 enrollment report.

HBX's investigation of this matter reveals that it is caused by duplicate records rather than duplicate enrollments. In the 23 cases identified by the auditors as having duplicate enrollments in HBX's records, none involved an actual duplicate enrollment by the carrier. HBX has EDI transaction

protocols in place wherein carriers automatically override a prior enrollment with the new enrollment. In no instance, including in these 23 cases, would a customer be enrolled in multiple QHPs, or the same QHP, covering the same time period. Adherence to these protocols was confirmed by HBX during this audit; HBX checked the weekly enrollment reports and monthly reconciliation files provided by carriers to confirm the 23 customers did not have duplicate enrollments in the carrier systems.

While duplicate enrollment remains an extremely remote issue, HBX was unable during FY22 to implement the planned corrective action (from the FY20 and FY21 findings) of more frequent checks of the enrollment records to cancel duplicate enrollments. These efforts were postponed while HBX focused on efforts associated with the COVID-19 pandemic and particularly implementation of enhanced APTC/CSR under the American Rescue Plan and the Inflation Reduction Act. Efforts to eliminate duplicate enrollment records will remain part of HBX's ongoing review of reconciliation protocols with carriers.

Point of Contact: Jennifer Beeson, Director of Marketplace Innovation, Policy, and Operations, Jennifer.Beeson@dc.gov, (202) 741-0656.

CONCLUSION

We confirm that we have reviewed relevant documentation and determined that the D.C. Health Benefit Exchange Authority is in compliance with CMS requirements and GAGAS.

SIGNATURE OF AUDIT FIRM: Leist Smith & Co.

COMPLETION DATE OF AUDIT FINDINGS REPORT: May 30, 2023