D.C. HEALTH BENEFIT EXCHANGE AUTHORITY

FISCAL YEAR 2023 PROGRAMMATIC AUDIT REPORT

TABLE OF CONTENTS

Transmittal Letter....................1

Executive Summary....................3

Audit Findings and Recommendations....................7

Conclusion....................12

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, 2024

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 2023 (October 1, 2022 to September 30, 2023). Our work was performed during the period of January 30, 2024 through May 30, 2024 and our results are as of May 30, 2024.

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 B, C, D, E and K for the fiscal year ended September 30, 2023.

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 B, C, D, E and K. 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 that 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 B, C, D, E and K. 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

AN INDEPENDENT MEMBER OF BDO ALLIANCE USA

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 2023-001 and 2023-002, the Exchange complied in all material respects, with the types of compliance requirements referred to above for the fiscal year ended September 30, 2023.

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 Subpart B - General Standards Related to the Establishment of an Exchange, Subpart C - General Functions of an Exchange, Subpart D - Exchange Functions in the Individual Market: Eligibility Determinations for Exchange Participation and Insurance Affordability Programs, Subpart E - Exchange Functions in the Individual Market: Enrollment in Qualified Health Plans, and Subpart K - Exchange Functions: Certification of Qualified Health Plans for the period October 1, 2022 through September 30, 2023.

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)
  - Deputy Director - Partnerships and Marketplace Operations (HBX)
  - Chief Information Officer, HBX
  - Deputy Assistant Director for Plan Management, Electronic Data Interchange (EDI)
  - Deputy Assistant Director for Individual Marketplace and Member Services Manager (HBX)
  - Special Assistant for Administrative Matters (HBX)
  - Information Technology Assistant Director for Resource Allocation (HBX)
  - Information Technology Specialist, Application Support (Department of Human Services)

- 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
  - Memorandum of Agreement between the Health Benefit Exchange Authority and the Department of Health Care Finance
  - Memorandum of Agreement between the Health Benefit Exchange Authority and the D.C. Office of Administrative Hearing
  - Privacy and Securities Policies for Exchange Operations
  - Navigator Grant Agreement
  - Training Certificates
- 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.
- Reviewed policies and procedures for certification of qualified health plans.
- Reviewed policies and procedures for the complaints process.
- Reviewed standards designed to prevent and mitigate conflicts of interests, financial or otherwise.
- Reviewed policies and procedures for the navigator program.
- Reviewed evidence for the existence of consumer assistance tools.
- Tested privacy and security training standards.
- Tested user access to enrollment applications and databases.
- Tested enrollment data backup procedures.

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

- The complete record of Navigators and Certified Application Counselor organizations was reviewed to verify compliance with Subpart C - General Functions of an Exchange. Privacy and Security training attestations were reviewed to verify compliance.

- For a record of 13 employees who were hired or rehired during FY 2023, we verified compliance with Subpart C - General Functions of an Exchange. Training rosters were reviewed to verify the appropriate Privacy and Security training was completed.

- HBX's communication materials were reviewed to verify that HBX provides information in a manner that is culturally and linguistically appropriate to the needs of the population in compliance with Subpart C - General Functions of an Exchange.

- The complete record of all user accounts which were assigned access to the eligibility and enrollment applications and databases were reviewed to ensure compliance with Subpart C -General Functions of an Exchange, Subpart D - Eligibility Determinations for Exchange Participation and Insurance Affordability Programs and Subpart E - Enrollment in Qualified Health Plans.

- From a record of 79,320 unique applications which were submitted in FY 2023, 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 16,440 enrollees from October 1, 2022 to September 30, 2023, we reviewed 9 enrollees with Curam applications who attested to being 'not lawfully present' and a sample of 11 enrollees with EnrollApp applications whose verification of immigration status was outstanding 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 16,440 enrollees from October 1, 2022 to September 30, 2023, we reviewed a sample of 12 enrollees with EnrollApp applications whose verification of citizenship was outstanding 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 16,440 enrollees from October 1, 2022 to September 30, 2023, we reviewed a record of 27 Curam applicants whose Social Security Number (SSN) verification was outstanding 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 16,440 enrollees from October 1, 2022 to September 30, 2023, we reviewed a record of 8 EnrollApp applicants and 4 Curam applicants whose District of Columbia (DC) residency verification was outstanding 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 16,440 enrollees from October 1, 2022 to September 30, 2023, we reviewed a sample of 45 EnrollApp applicants and a sample of 45 Curam applicants with APTC whose

income verification was outstanding 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 16,440 enrollees who had enrolled in a Qualified Health Plan from October 1, 2022 to September 30, 2023, 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 16,440 enrollees who had enrolled in a Qualified Health Plan from October 1, 2022 to September 30, 2023, 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 16,440 enrollees who had enrolled in a Qualified Health Plan from October 1, 2022 to September 30, 2023, 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.

- From the monthly backup procedures which were conducted during the period of review, a sample of four (4) months 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 B – General Standards Related to the Establishment of an Exchange	1. State exchange approval provided by HHS	The Exchange is in compliance with this requirement.
Subpart C – General Functions of an Exchange	1. Privacy and security of navigators.	The Exchange is in compliance with this requirement.
	2. Training standards.	The Exchange is in compliance with this requirement.
	3. Processes and procedures for addressing complaints.	The Exchange is in compliance with this requirement.
	4. Processes and procedures for providing assistance in culturally and linguistically appropriate manner.	The Exchange is in compliance with this requirement.
	5. Standards designed to prevent and mitigate any conflicts of interest, financial or otherwise.	The Exchange is in compliance with this requirement.
	6. Privacy and security safeguards.	The Exchange is in compliance with this requirement.
	7. Call center information provided in plain language and in a manner that is accessible to individuals with disabilities and individuals with limited English proficiency.	The Exchange is in compliance with this requirement.
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 partially non-compliant with this requirement. **Finding # 2023-001:** Inadequate Eligibility Verification Procedures (Repeat Finding).
	3. Redeterminations, both during the benefit year and the annual open enrollment period.	The Exchange is partially non-compliant with this requirement. **Finding # 2023-001:** 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.

45 CFR Part 155	Compliance/Internal Control	Results
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 partially non-compliant with this requirement. **Finding # 2023-002:** Duplicate QHP Enrollments (Repeat Finding).
	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 in compliance with this requirement.
	4. Data and records maintenance related to enrollments.	The Exchange is in compliance with this requirement.
Subpart K – Certification of Qualified Health Plans	1. Policies and procedures for certification of qualified health plans.	The Exchange is in compliance with this requirement.
	2. The Exchange established contracts with carriers that offer Qualified Health Plans (QHPs) through the DC Health Link.	The Exchange is in compliance with this requirement
	3. Policies and procedures for the recertification of Qualified Health Plans (QHPs).	The Exchange is in compliance with this requirement.
	4. Policies and procedures for the decertification of QHPs.	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:

2023-001: ***Inadequate Eligibility Verification Procedures (Repeat Finding)***

Condition: Inadequate eligibility verification procedures were noted for the:

- Verification of citizenship or lawful presence – One (1) enrollee maintained coverage during FY23 after changing their attestation to an ineligible immigration status. A further two (2) enrollees attested to U.S. Citizenship or lawful presence, but their status was not verified.
- Verification of household income – In seven (7) cases where applicants received APTC allowances, verification of income attestations was not completed within one hundred and fifty (150) days and the Exchange did not take timely action to terminate APTC.

Criteria: 45 CFR §155.320(c)(1)(i)(A): For all individuals whose income is counted in calculating a tax filer's household income, as defined in 26 CFR 1.36B-1(e), or an applicant's household income, calculated in accordance with 42 CFR 435.603(d), and for whom the Exchange has a Social Security number, the Exchange must request tax return data regarding MAGI and family size from the Secretary of the Treasury and data regarding Social security benefits described in 26 CFR 1.36B-1(e)(2)(iii) from the Commissioner of Social Security by transmitting identifying information specified by HHS to HHS.

45 CFR §155.315(f)(5) If, after the period described in paragraph (f)(2)(ii), the Exchange remains unable to verify the attestation, the Exchange must determine the applicant's eligibility based on the information available from the data sources specified in this subpart, unless such applicant qualifies for the exception provided under paragraph (g) of this section, and notify the applicant of such determination in accordance with the notice requirements specified in §155.310(g), including notice that the Exchange is unable to verify the attestation.

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 attestations would be accepted without verifying subsequent updated attestations to being "not lawfully present."

Timely review was not taken when income eligibility verification procedures were not successful.

Effect: HBX permitted applicants to enroll or remain enrolled, and in some instances receive APTC payments, who may not be eligible.

Recommendation: Management should strengthen its procedures for lawful presence attestations during the eligibility determination and redetermination processes to ensure all verifications are successfully completed 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 enrollees maintaining coverage and/or APTC during FY23 without verification of their eligibility within the inconsistency period is an extremely remote concern. The auditors found this issue affected 10 cases. The delays noted in this finding are largely connected to a reasonable approach to verifications and adverse eligibility actions during and following the end of the Public Health Emergency.

HBX will continue to review its procedures for ensuring caseworker compliance with verification and adverse eligibility action procedures.

<u>Point of Contact</u>: Eliza Bangit, Senior Advisor and Director of Health Coverage and Innovation, Eliza.Bangit@dc.gov, (202) 297-4697.

2023-002:

Condition: ***<u>Duplicate QHP Enrollments (Repeat Finding)</u>***

HBX transmitted duplicate QHP enrollments for three (3) customers to carriers and failed to initiate cancellation for those duplicate enrollments. Enrollment transmission occurred in:

- one (1) instance where the individual enrolled in a different plan for the same period and DCHBX communicated a duplicate enrollment to the Carrier without cancelling the prior plan.
- one (1) instance where the individual selected the same plan twice and DCHBX communicated a duplicate plan to the Carrier without cancelling the prior plan.
- one (1) instance where the individual was reinstated in a plan, and HBX communicated both a reinstatement and a new enrollment in the same plan to the Carrier.

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.

45 CFR §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 three (3) cases identified as being improperly handled are out of the 16,440 unique QHP enrollees that enrolled during FY23, thus representing less than 0.02% 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 FY23 enrollment report.

Consistent with our corrective action plan articulated in our response to the FY22 finding, in FY23 HBX conducted more frequent checks of the enrollment records and cancelled duplicate enrollments. While this finding demonstrates that 3 cases that should have been cancelled were missed, the finding nonetheless shows HBX has successfully reduced duplicate enrollments by 87% from the FY22 finding and only a handful were missed.

HBX's investigation of this matter reveals that it is caused by duplicate records rather than duplicate enrollments. In the three (3) 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 three (3) 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 3 customers did not have duplicate enrollments in the carrier systems.

HBX will continue to monitor enrollment records to remove the duplicate records which inaccurately indicate duplicate enrollment.

Point of Contact: Jennifer Beeson, Director of Partnerships and Marketplace Operations, Jennifer.Beeson@dc.gov, (202) 480-5436.

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: *Bert Smith & Co.*

COMPLETION DATE OF AUDIT FINDINGS REPORT: **May 30, 2024**