D.C. HEALTH BENEFIT EXCHANGE AUTHORITY

FISCAL YEAR 2016 PROGRAMMATIC AUDIT REPORT

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

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May 3, 2017

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) Programmatic audit fiscal year 2016 (October 1, 2015 to September 30, 2016). Our work was performed during the period of January 25, 2017 through May 3, 2017 and our results are as of May 3, 2017.

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 the 45 CFR: Part 155 for the fiscal year ended September 30, 2016.

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 C, D, E, F 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. 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. However, our audit does not provide a legal determination of the D.C. Health Benefit Exchange Authority's compliance.

Opinion on Compliance with 45 CFR: Part 155

In our opinion, except for the instances of noncompliance, the Exchange complied in all material respects, with the types of compliance requirements referred to above for the fiscal year ended September 30, 2016.

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Other Matters

The Exchange's response to the noncompliance findings is identified in the accompanying corrective action plan. The Exchange's response was not subjected to the auditing procedures applied in the audit of compliance and accordingly we express no opinion on the response.

This programmatic audit did not constitute an audit of any portion of the Exchange's fiscal year 2016 financial statements in accordance with *Government Auditing Standards*. Additionally, we were not engaged to, and did not, audit or render an opinion on the Exchange's internal controls over financial reporting or over financial management systems.

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 individuals who are ineligible for Medicaid but have incomes between 100 and 400 percent of federal poverty guidelines.

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. PURPOSE OF AUDIT

The purpose of this programmatic audit was to determine the D.C. Health Benefit Exchange Authority's (the Exchange or HBX) 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 OF AUDIT

The scope of the programmatic audit covers the Exchange's compliance with the requirements under 45 CFR: Part 155 subparts C, D, E, F and K for the period October 1, 2015 through September 30, 2016.

We did not audit the requirements under (1) Subpart B - General Standards Related to the Establishment of an Exchange; (2) Subpart G - Exchange Functions in the Individual Market: Eligibility Determinations for Exemptions; (3) Subpart H - Exchange Functions Small Business Health Options Program (SHOP); (4) Subpart M - Oversight and Program Integrity Standards for State Exchanges; (5) Subpart N - State Flexibility and (6) Subpart O - Quality Reporting Standards for Exchanges.

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.

V. METHODOLOGY

The methodology was used to determine the Exchange's compliance with the programmatic audit requirements. Specific procedures included the following:

- Conducted meetings and interviews 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:
  - General Counsel and Chief Policy Advisor
  - Associate General Counsel and Policy Advisor
  - Assistant Director of Marketplace Innovation, Policy, and Operations for Plan Management and Enrollment
  - Assistant Director of Marketplace Innovation, Policy, and Operations for the Individual Market
  - Senior Curam Developer
  - Senior EnrollApp Developer
  - Chief Security Officer and Privacy Architect
  - DIMS/CATCH Project Manager
  - Technical Project Manager

- We reviewed the following key documents, regulations and requirements, and policies and procedures:
  - Bylaws for the District of Columbia Health Benefit Exchange Authority
  - Centers for Medicare and Medicaid Services Frequently Asked Questions about the Annual Independent External Audit of State-based marketplaces dated June 18, 2014
  - 45 CFR: Part 155
  - Minimum Acceptable Risk Standards for Exchanges (MARS-E)
  - Applicable sections of the Affordable Care Act of 2010
  - 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 Department of Human Services Economic Security Administration for Eligibility Determination Services
  - Memorandum of Agreement Between the Health Benefit Exchange Authority and the D.C. Office of Administrative Hearing for Eligibility Appeal Hearings
  - D.C. Conflicts of Interest Restrictions D.C. Official Code § 31-3171-10
  - D.C. Ethics Act – D.C. Official Code § 1-1162.03
  - Privacy and Securities Policies for Exchange Operations
  - D.C. Primary Care Association – Conflict of Interest Plan and Disclosures
  - Navigator Grant Agreement
  - Training Modules and Examinations
- Reviewed governance documents.
- Reviewed legislation relating to the Exchange.
- Reviewed oversight monitoring policies and procedures.
- Reviewed processes and procedures designed to prevent improper enrollment.
- Reviewed supporting documentation over subpart requirements.
- 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 over the appeals process.
- Reviewed standards designed to prevent and mitigate conflicts of interests, financial or otherwise.
- Reviewed policies and procedures over navigator program standards.
- Reviewed evidence for the existence of consumer assistance tools.
- Tested oversight and program integrity standards.
- Tested privacy and security standards.
- Tested training standards.
- Tested user access to enrollment applications and databases.
- Testing enrollment data backup procedures.

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

- From a record of 15 employees who were hired on or after October 1st 2015, we selected a sample of 6 employees to verify compliance with Subpart C - General Functions of an Exchange. Training rosters were reviewed to verify the appropriate Privacy and Security training was provided.

- From a record of 84,420 applications which were submitted on or after October 1st 2015, we selected a sample of 50 (25 denied and 25 approved) 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 23,869 applicants who had enrolled in a Qualified Health Plan on or after October 1st 2015, we selected a sample of 45 cases to test the compliance with 45 CFR 155 Subpart E – Enrollment in Qualified Health Plans. Enrollment records were tested to verify timely and accurate communication of applicant details and APTC determinations to insurance carriers.

- 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 D - Eligibility Determinations for Exchange Participation and Subpart E - Enrollment in Qualified Health Plans.

- A sample of 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 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.

VI. NATURE OF CONFIDENTIAL OR SENSITIVE INFORMATION OMMITTED

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 C – General Functions of an Exchange	1. Privacy and security of navigators.	The Exchange is in compliance with this requirement.
	2. Processes and procedures for addressing complaints.	The Exchange is in compliance with this requirement.
	3. Processes and procedures for providing assistance in culturally and linguistically appropriate manner.	The Exchange is in compliance with this requirement.
	4. Training standards.	The Exchange is in compliance with this requirement.
	5. Breaches of security or privacy by a navigator grantee.	The Exchange is in compliance with this requirement.
	6. Standards designed to prevent and mitigate any conflicts of interest, financial or otherwise.	The Exchange is in compliance with this requirement.
	7. Confirmation that assures funding for navigator grants does not come from Federal funds.	The Exchange is in compliance with this requirement.
	8. Privacy and security safeguards.	The Exchange is in compliance with this requirement.
	9. 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 not in compliance with this requirement. **Finding # 2016-001:** The Exchange did not adequately verify applicant income to re-assess APTC amounts as defined in 45 CFR: Part 155.305.
	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 # 2016-002:** The Exchange did not provide an eligibility determination for all submitted applications.
	3. Redeterminations, both during the benefit year and the annual open enrollment period.	The Exchange is in compliance with this requirement.
	4. Process for the administration of payments of advance premium tax credits (APTCs).	The Exchange is in compliance with this requirement.
	5. Processes and procedures for addressing appeals.	The Exchange is in compliance with this requirement.
	6. 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 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 in compliance with this requirement.
	4. Data and records maintenance related to enrollments.	The Exchange is in compliance with this requirement.
Subpart F – Appeals of Eligibility Determinations for Exchange Participation	1. The Exchange must allow an applicant or enrollee to request an appeal 90 days of the date of the notice of eligibility determination.	The Exchange is in compliance with this requirement.
	2. The Exchange must send timely acknowledgment to the appellant of the receipt of his or her valid appeal request.	The Exchange is in compliance with this requirement.
	3. The Exchange must promptly and without undue delay, send written notice to the applicant or enrollee informing the appellant of the appeal determination.	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 not in compliance with this requirement. **Finding # 2016-003:** The Exchange does not have documented Standard Operating Policies and Procedures for the decertification of QHPs.

II. FINDINGS AND RECOMMENDATIONS

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

2016-001: ***Inadequate Applicant Verification Procedures***

Condition: Eligibility applications submitted electronically through the DC Health Link website were not verified in two (2) of the 25 cases tested for income verification requirements. In these two instances, APTC was not properly terminated following a conditional eligibility determination based on income self-attestation. Income was not properly verified using the primary applicant's supporting income verification documentation and therefore is not in accordance with 45 CFR Part 155.

Criteria: 45 CFR: Part 155.305(k)Incomplete application states that "If an application filer submits an application that does not include sufficient information for the Exchange to conduct an eligibility determination for enrollment in a QHP through the Exchange or for insurance affordability programs, if applicable, the Exchange must – (3).... not proceed with an applicant's eligibility determination or provide advance payments of the premium tax credit or cost-sharing reductions.

45 CFR: Part 155.305 (f)(1) In general. The Exchange must determine a tax filer eligible for advance payments of the premium tax credit if the Exchange determines that he or she is expected to have a household income, as defined in 26 CFR 1.36B-1(e), of greater than or equal to 100 percent but not more than 400 percent of the FPL for the benefit year for which coverage is requested;

Cause: Inadequate controls over the income verification requirement process.

Effect: HBX provided inaccurate eligibility determinations to applicants beyond the allowable period as defined in 45 CFR: Part 155.305.

Recommendation: Management should strengthen its procedures to ensure all electronic verifications are successfully completed or manually verified.

Management's Response: HBX concurs, with the following explanation.

HBX has signed a memorandum of agreement (MOA) with the DC Department of Human Services (DHS) to review and process verification documentation for applicants seeking financial assistance (IAP applications). HBX staff review and process verification documentation for all other applications. HBX is responsible for terminations as necessitated based on such review.

Customer 1 (Concur) – HBX concurs that the agency, and its verification contractor DHS, did not properly handle the verification of this household's income, causing this customer to receive more APTC than she was eligible. The customer enrolled in coverage and provided the documentation

necessary to resolve the outstanding verification. The type of income in this case is foreign income, which is included in MAGI but not included in AGI. This type of income is extremely rare and was handled incorrectly. HBX and DHS will retrain workers on how to handle foreign income so that this type of error does not occur in the future.

Customer 2 (Concur) - HBX concurs that the agency, and its call center contractor Maximus, did not properly handle the verification of this household's income, causing this customer to receive more APTC than she was eligible for. The customer enrolled in coverage and provided the documentation necessary to resolve the outstanding verification. The cause of the error is that, while the HBX case manager properly reviewed the documentation and indicated a need to terminate APTC, the call center representative assigned to the case closed it instead of sending it for termination. HBX is reviewing whether this case was an isolated error or the result of a flaw in case flow and will develop a corrective action plan. At a minimum, the corrective action plan will include retraining and may involve IT changes or process changes to serve as a check on terminations.

Point of Contact for Corrective Action Plan: Robert Shriver, Director of Marketplace Innovation, Policy, and Operations, Robert.Shriver@dc.gov, (202) 741-8820.

2016-002: ***Lack of QHP Determination for Submitted Applications (Repeat Finding)***

Condition: An eligibility determination for submitted Insurance Affordability Program (IAP) applications was not always provided to customers seeking a QHP or Medicaid. Due to various system processing errors on the D.C. Health Link website, we noted 509 (1%) of submitted IAP applications did not receive a timely eligibility determination. However, the system used by HBX to conduct eligibility determinations for non-IAP applications provided an eligibility determination.

The Exchange established a team to review and resolve "stuck" IAP applications on a weekly basis, however due to various system errors, not all applicants received an eligibility determination in a timely manner.

Criteria: 45 CFR: Part 155.310(c) states that the Exchange must "make an eligibility determination for an applicant seeking an eligibility determination at any point in time during the year."

45 CFR: Part 155.310(d) states that the Exchange must "determine an applicant's eligibility, in accordance with the standard specified in 45 CFR: Part 155.305."

Memorandum of Agreement (MOA) between the Health Benefit Exchange Authority and the Department of Health Care Finance (Medicaid) Section C.4 states that "The parties agree to ensure the implementation of a streamlined system for eligibility determinations that minimizes the burden

on individuals, provides prompt determination of eligibility and enrollment into Medicaid, other IAPs, and QHPs, and provides timely notifications of eligibility decisions to applicants and enrollees."

Cause: Processing errors on the D.C. Health Link website led to "stuck" IAP application cases and the lack of eligibility determinations.

Effect: IAP applicants may not receive timely eligibility determinations in order to enroll in a QHP.

Recommendation: Management must continue to investigate and resolve system issues in order to ensure compliance with 45 CFR: Part 155.310(c), 45 CFR: Part 155.310(d) and the MOA.

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

In FY2016 there were 58,639 applications for eligibility through the DC Health Link website. Of those, 99.13% received a timely eligibility determination.

HBX was able to achieve this near-perfect outcome, improving from the finding in FY15, through the following methods.

IAP Applications

To process applications where applicants are seeking financial assistance (IAP applications), HBX shares a joint eligibility system with the DC Department of Health Care Finance (the Medicaid agency/DHCF). Both agencies use the CURAM/HCR platform for Medicaid, advance premium tax credit, and cost sharing reductions eligibility determinations.

DHCF uses another District agency, the DC Department of Human Services (DHS), for Medicaid eligibility determinations. HBX also uses DHS for verifications and eligibility processing of applications where applicants have applied for APTC or CSRs.

As indicated in our response to this issue in the FY15 programmatic audit report, HBX, in cooperation with DHS, implemented a series of technical fixes in advance of the FY15 programmatic audit to alleviate numerous IT causes for stuck cases, those cases where an eligibility determination is not provided. Additionally, DHS' technical teams run weekly reports to check for stuck cases and resolve issues to produce eligibility determinations promptly after the application. Cases that require review from DHS staff are reviewed by DHCF and DHS on a weekly basis. Starting at the beginning of FY17, the reports shifted from MS Excel spreadsheets to the use of a QuickBase application. In addition, OCTO continues to investigate and resolve the root causes of stuck cases to further reduce their occurrence.

Approximately 90% of customers that file an IAP application through DC Health Link are determined eligible for Medicaid coverage rather than private insurance exchange coverage. Therefore, DHS takes the primary role in resolving stuck cases in CURAM/HCR.

The few remaining stuck IAP cases identified in this audit, not resolved by the weekly review process are the result of a number of technical issues with CURAM/HCR including but not limited to:

- CURAM/HCR does not have proper safeguards to prevent caseworkers from creating a new application for customers with open applications. CURAM/HCR will not conduct an eligibility determination for duplicate applications until the original case has been closed.

- CURAM/HCR since 2016 has allowed users to both provide residential addresses and indicate not having a fixed address in DC. The conflicting information prevents an eligibility determination.

- CURAM/HCR overwrites non-MAGI eligibility determinations in the Medicaid system of record. To prevent this from happening, DHCF requested that eligibility determinations not be made in CURAM/HCR for two non-MAGI populations: those with Supplemental Security Income and those formerly in foster care.

Although these issues have been highlighted for technical fixes, such fixes have been prioritized behind other necessary technical changes and fixes to CURAM/HCR. Additionally, new versions by the vendor have not included fixes to these and other technical changes needed for APTC and CSR determinations.

Non-IAP Applications

In October 2015, HBX launched the EnrollApp platform for Non-IAP applications. This platform is within the exclusive management and technical control of HBX. The eligibility rules engine was built with the lessons learned from our experience processing Non-IAP applications through CURAM/HCR in plan years 2014 and 2015. Thus, known stuck case technical issues have not been repeated. Additionally, because all applications that go through EnrollApp are for an exchange product, HBX does not have competing priorities with Medicaid to resolve issues that arise. Further, while CURAM/HCR uses commercial off-the-shelf software from an outside software vendor, EnrollApp is built locally by HBX's own system architects and coders using open source coding that is nimble and can be repaired relatively faster in response to HBX's needs. Thus, HBX is not relying on version upgrades by the vendor.

Conclusion

As recommended in this finding, HBX intends to continue to investigate and resolve system issues in order to tackle the limited number of remaining exchange-related cases that do not receive an eligibility determination through CURAM/HCR. As noted, only 1% of all cases that go through CURAM in FY16 had these issues and, of those, we expect the vast majority would have resulted in a Medicaid determination and could only have been fixed by DHS and/or DHCF, not HBX.

Additionally, HBX is also in the process of expanding the EnrollApp platform to handle IAP applications for marketplace customers. Once marketplace customers are served by this new platform, we anticipate the same level of technical accuracy and service for marketplace IAP customers that we are currently able to provide to non-IAP customers.

Point of Contact: Robert Shriver, Director of Marketplace Innovation, Policy, and Operations, Robert.Shriver@dc.gov, (202) 741-8820.

Point of Contact: Trey Long, Deputy Administrator, Division of Program Operations, Economic Security Administration, Department of Human Services. Trey.Long@dc.gov, (202) 698-3904.

2016-003: ***Lack of QHP Decertification Policy (Repeat Finding)***

Condition: QHP decertification refers to the termination, by the Exchange, of the certification status and offering of a QHP to qualified applicants. 45 CFR: Part 155.1080(c) allows for the Exchange to "at any time decertify a health plan if the Exchange determines that the QHP issuer is no longer in compliance with the general certification criteria as outlined in 45 CFR Part155.1000(c)."

The Exchange does not have documented Standard Operating Policies and Procedures for the decertification of QHPs. The DCHBX Carrier Reference Manual, dated July 2015, states that "the standards for decertification will be developed through the Plan Management Standing Advisory Committee," however documented procedures were not yet developed.

Criteria: 45 CFR: Part 155.1080(b) states that the Exchange must "establish a process for the decertification of QHPs, which at a minimum meets the requirements of this section."

Cause: The Exchange has not established policies and procedures to ensure the decertification of QHPs.

Effect: Undocumented decertification procedures may lead to ambiguity when addressing non-compliance of HBX Carrier requirements.

Recommendation: The Exchange must document the QHP decertification policy and procedures for inclusion to the HBX Carrier Manual.

Management's Response: HBX partially concurs with the finding. HBX's current decertification process leverages the existing mechanism for suspending a carrier's authority to operate in the District. However, HBX has not documented the existing procedure in the HBX Carrier Manual. HBX will document this in the HBX Carrier Manual by the end of FY17.

In our agency's written response to the finding on this issue in the FY15 Programmatic Audit Report, HBX indicated "[I]n 2016, HBX will focus one of its Plan Management Advisory Committee meetings on the topic of QHP decertification procedures." Consistent with this plan, on 11/15/16, the Plan Management Advisory Committee met to discuss this topic and in attendance were representatives from all four carriers that offer coverage through HBX and the DC Department of Insurance, Securities, and Banking (DISB). Prior to the meeting, HBX researched the decertification processes of every state based marketplace (SBM) and the federally-facilitated marketplace (FFM) looking at certification requirements, statutes and regulations, board meeting minutes, and carrier reference guides. Not every SBM had information publically available. HBX reached out to some states for more information.

The Plan Management Advisory Committee included information from Rob Shriver, Director of the Marketplace Innovation, Policy, and Operations and a presentation from Alexis Chappell, a program analyst with the HBX Office of General Counsel. The presentation focused on the decertification process in the FFM and some SBM's variations on the FFM process found in states such as Minnesota, Connecticut, Kentucky, New York, Washington, and Nevada. HBX sought feedback from carriers regarding such decertification processes but reiterated that at this time we continue to rely on the DISB decertification/appeals process.

Our current decertification process leverages the existing mechanism for suspending a carrier's authority to operate in the District. DC law provides for one marketplace for individual coverage in the District of Columbia – all individual/family policies in DC must be purchased through the individual marketplace on DC Health Link. Therefore, certification or decertification to offer individual coverage through DC Health Link is concurrent with the process for being certified to offer coverage under DC law. As such, DISB participates in the certification process of plans, checking that they meet the requirements under both DC law to offer in the District and the certification requirements under 45 CFR §155.1000. Similarly, if an issue were to arise that could lead to the removal of a health plan from the marketplace, specifically that a plan no longer met certification requirements, DISB could make that determination and administer the decertification process. It would be DISB that would revoke the carrier's authority to operate. This authority to be removed from the DC market pre-existed the ACA and can be found at D.C. Code §31-4305 (revocation and appeal language for life

insurance) and §31-5111 (applying §31-4305 to health insurance). To the degree an appeal is permitted by federal regulation under 45 CFR §155.1080(d), it is the appeal to the DISB Commissioner permitted by §31-4305(b).

Point of Contact for Corrective Action Plan:
Robert Shriver, Director of Marketplace Innovation, Policy, and Operations, Robert.Shriver@dc.gov, (202) 741-8820.

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 3, 2017