



DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201



May 8, 2017

The Honorable Gus Bilirakis
Subcommittee on Health
Committee on Energy and Commerce
House of Representatives
Washington, DC 20515

Dear Representative Bilirakis:

On September 14, 2016, I represented the Department of Health and Human Services, Office of Inspector General (HHS OIG), at a hearing before the House Committee on Energy and Commerce's Subcommittee on Oversight and Investigations and Subcommittee on Health, entitled "The Affordable Care Act on Shaky Ground: Outlook and Oversight." During the hearing, you requested that the HHS OIG provide information regarding the Centers for Medicare & Medicaid Services' (CMS) automated system for processing financial assistance payments (e.g., advance premium tax credits (APTCs) and cost-sharing reductions (CSRs)). This memorandum formally transmits the attached briefing document in response to your request.

This briefing document presents our initial review of the design and implementation of CMS's automated system from May 1, 2016, through October 31, 2016. To conduct this review, we met with CMS officials and reviewed applicable Federal requirements and CMS source documentation. We did not perform transaction testing of the automated system. Therefore, we did not determine whether the internal controls for ensuring accurate financial assistance payments under the automated system were effective. We conducted this audit in accordance with generally accepted government auditing standards.

We provided a draft of the briefing document to CMS for technical comments and incorporated those comments, as appropriate. In addition, we will be providing CMS with a copy of the final product, and we will be posting it on our website (<https://oig.hhs.gov>).

If you have any questions or comments about this briefing, please do not hesitate to call me, or your staff may contact Christopher Seagle, Director of External Affairs, through email at Christopher.Seagle@oig.hhs.gov.

Sincerely,

/Gloria L. Jarmon/
Deputy Inspector General
for Audit Services

Enclosure

cc:

The Honorable Michael Burgess
Chairman, Subcommittee on Health

The Honorable Gene Green
Ranking Member, Subcommittee on Health



Initial Review of CMS's Automated System for Processing Financial Assistance Payments

May 8, 2017





Overview

- Introduction
- Objective and Scope
- Methodology
- Background
- Regulatory and Policy Requirements
- Automated System for Processing Financial Assistance Payments
- Key Steps in the Automated Process
- Interim vs. Automated Process
- Observations
- OIG Related Reports
- Glossary of Terms





Overview

- This briefing will:
 - provide factual information about CMS's automated process for processing financial assistance payments,
 - provide information on CMS's authority over financial assistance payments, and
 - show how the automated system compares to the interim process used prior to implementation of the automated process.





Introduction

- The ACA established health insurance marketplaces to allow individuals and small businesses to shop for health insurance.
- A marketplace allows insurance companies (issuers) to offer individuals private health insurance plans, known as qualified health plans (QHPs), and enrolls individuals in those plans.





Introduction

- CMS operates the Federal marketplace and is responsible for reviewing, approving, and generating financial assistance payments (e.g., advance premium tax credits (APTCs) and cost-sharing reductions (CSRs)) made to QHPs for the Federal and State marketplaces.





Objective

To describe the design and implementation of CMS's automated system for processing financial assistance payments made to QHP issuers.





Scope

- We performed an initial review of the design and implementation of CMS's automated system for processing financial assistance payments for QHP issuers for the period May 1, 2016, through October 31, 2016.
- We did not perform transaction testing of the automated system. Therefore, we did not determine if the internal controls for ensuring accurate financial assistance payments under the automated system were effective.





Methodology

- Met with CMS officials to gain an understanding of the design and implementation of CMS's automated system for processing financial assistance payments made to QHP issuers.
- Reviewed applicable Federal requirements and CMS source documentation (e.g. Marketplace Cycle Memorandum, List of Marketplace Internal Controls, and Policy-level Payment Reports).





Methodology

- We conducted this performance 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 on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.



Background: Health Insurance Marketplaces

- Designed to serve as a one-stop shop at which individuals:
 - obtain information on health insurance options;
 - are evaluated for eligibility for a QHP;
 - when applicable, are evaluated for eligibility for premium tax credits (PTCs) and CSRs;
 - enroll in the QHP of their choice.





Background: Premium Tax Credits

- APTCs are advance payments of PTCs.
- PTCs reduce the cost of plan premiums and are available at tax filing time or in advance.
- Marketplaces determine eligibility for PTC primarily based on enrollees' income and family size.
- Federal regulations require the Department of the Treasury's Internal Revenue Service (IRS) to reconcile APTC payments made to QHP issuers on behalf of confirmed enrollees to individual taxpayer returns using data provided by the marketplaces.





Background: Cost-Sharing Reductions

- CSRs help qualifying individuals with out-of-pocket costs, such as deductibles, coinsurance, and copayments.
- The Federal Government makes an advance CSR monthly payment to QHP issuers to cover the enrollees' estimated CSR costs.
- CMS reconciles with the QHP issuers the total amount of advance CSR payments made to the issuers and the actual CSR costs incurred at the end of each calendar year.
- Federal regulations do not authorize CMS to identify and recover advance CSR payments made to QHP issuers on behalf of enrollees whose income for the benefit year, based on their reported personal income, exceeded the maximum allowable amount for them to be eligible to receive these payments.





Regulatory and Policy Requirements

- The marketplaces are required to determine an applicant's eligibility for a QHP and financial assistance payments, along with the associated amounts.
- The marketplaces must transmit eligibility and enrollment information to CMS “promptly and without undue delay.”
- Marketplaces must submit confirmed enrollment data to CMS monthly.
 - Data contains information on when to begin, modify, or end enrollee financial assistance payments for both APTCs and advance CSRs.
- IRS is required to reconcile APTC payments made to QHP issuers on behalf of confirmed enrollees to individual taxpayer returns using data provided by the marketplaces.





Automated System For Processing Financial Assistance Payments

- Prior to January 2016, CMS strictly used an interim process for calculating and authorizing financial assistance payments. Past OIG work found internal control deficiencies with this process (see slide 22 for a list of OIG related reports).
- In January 2016, CMS began transitioning QHP issuers operating through the Federal marketplace to its automated system for reviewing, approving, and generating financial assistance payments.





Automated System For Processing Financial Assistance Payments

- The automated system processes payments on a policy-level basis.
- CMS fully transitioned QHP issuers operating through the Federal marketplace to the automated system in May 2016.
- CMS plans to fully transition QHP issuers operating through State marketplaces to the automated system in 2018.





Automated System For Processing Financial Assistance Payments

- The automated system will allow the marketplaces, CMS, and issuers to share health insurance information, such as:
 - individuals included in a policy,
 - the QHP selected and the associated premium amount,
 - eligible financial assistance payment amount.





Key Steps in the Automated Process

- Applicants submit personal, demographic, and personal income information to the marketplaces.
- Marketplaces determine eligibility for QHP and financial assistance payments, along with associated amount.
- Marketplaces electronically submit approved enrollee information to issuers through what is known as “834 transactions.”
- State marketplaces are required to share electronic files detailing enrollee information and financial assistance payment amounts with CMS and update these data monthly.





Key Steps in the Automated Process

- Issuers contact enrollees to collect the portion of their first month's premium payment (premium amount less APTC).
- Issuers send “confirmation 834 transaction” to marketplaces indicating enrollees are confirmed and eligible for health coverage and financial assistance.
- CMS maintains all confirmed enrollment and associated financial assistance payment data through their enrollment system.
- CMS transmits appropriate financial assistance payment amounts and provides a payment report to issuers detailing payment on a policy-level basis.





Interim vs. Automated Process

CMS's Interim Process	CMS's Automated Process
<p>Step 1: Enrollees select a QHP and are determined eligible for financial assistance and their associated amounts by their respective marketplace.</p>	<p>Step 1: Same as the interim process.</p>
<p>Step 2: Marketplaces send enrollment and financial assistance payment data to selected QHP issuer via an “834 transaction.”</p>	<p>Step 2: Same as the interim process.</p>
<p>Step 3: QHP issuers send aggregate enrollment and financial assistance payment data to CMS covering all policies in all of the QHP issuers’ plans, due to undeveloped computerized systems.</p>	<p>Step 3: QHP issuers confirm individual enrollees/policies paid their portion of the first month’s premium (premium amount less APTC) and QHP issuers electronically send a “confirmation 834 transaction” to CMS.</p>





Interim vs. Automated Process

CMS's Interim Process	CMS's Automated Process
<p>Step 4: QHP issuers also submit an attestation agreement stating that all aggregate payment information included in the template is accurate. Attestations are provided because CMS is unable to independently verify financial assistance payment data on a policy-level basis.</p>	<p>Step 4: CMS independently verifies the accuracy of the payment data using enrollment and financial assistance payment data on a policy-level basis through its confirmed enrollment system.</p>
<p>Step 5: CMS relies on attested aggregate enrollment and payment data submitted by QHP issuers to calculate and authorize financial assistance payment amounts to QHP issuers.</p>	<p>Step 5: CMS calculates and authorizes financial assistance payment amounts to QHP issuers based on policy-level data maintained in its confirmed enrollment system. CMS provides a payment report to QHP issuers that comprises all of the covered policies and their associated financial assistance payment amounts.</p>





Observations

- As of May 2016, CMS had fully implemented the automated system for the Federal marketplace:
 - CMS obtains financial assistance payment data on a policy-level basis, rather than on an aggregate basis.
 - CMS can independently verify financial assistance payment data and no longer relies on issuers' attestations.
- CMS plans to fully transition issuers operating through State marketplaces to the automated system in 2018.





OIG Related Reports

- CMS Could Not Effectively Ensure That Advance Premium Tax Credit Payments Made Under the Affordable Care Act Were Only for Enrollees Who Paid Their Premiums (A-02-14-02025, issued December 31, 2015)
- CMS's Internal Controls Did Not Effectively Ensure the Accuracy of Aggregate Financial Assistance Payments Made to Qualified Health Plan Issuers Under the Affordable Care Act (A-02-14-02006, issued June 16, 2015)





Glossary of Terms

- **834 transactions:** Electronic files used to share health insurance information between QHP issuers, marketplaces, and CMS. These files contain the calculation for any applicable financial assistance amounts that would be sent from the marketplace to the selected QHP issuer.
 - **Confirmation 834 transaction:** Created after the QHP issuer reviews the application data and ensures that enrollees paid their first month's premium (premium amount less APTC) in order to receive any financial assistance payments.





Glossary of Terms

- **Attestation agreement:** The act of signing a document verifying that all information provided is accurate and in compliance with Federal policies and regulations.
- **Confirmed enrollees:** Individuals enrolled in a QHP who have paid their first month's premium and have had their enrollment information approved by the QHP issuer.

