NEW JERSEY STATE-BASED HEALTH INSURANCE EXCHANGE

(A Component Unit of the New Jersey Department of Banking and Insurance)

PERFORMANCE AUDIT

June 30, 2023

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May 31, 2024

Gloria Freeman
Deputy Director
New Jersey State-Based Health Insurance Exchange
New Jersey Department of Banking and Insurance
20 West State Street
Trenton, NJ 08625

Dear Ms. Freeman,

This report presents the results of our work performed to address the performance audit objectives relative to the New Jersey State-Based Health Insurance Exchange's (the "Exchange") compliance with the Centers for Medicare and Medicaid Services ("CMS") 45 CFR § 155 subparts C, D, E and K requirements. Our work was performed for the period July 1, 2022 to June 30, 2023.

We conducted this performance audit in accordance with *Generally Accepted Government Auditing Standards* ("GAGAS") and with 45 CFR. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and recommendations based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and recommendations based on our audit objectives.

This report is intended solely for the use of the Exchange and CMS and is not intended to be, and should not be, used by anyone other than these specified parties.

Mercadien, P.C.
Certified Public Accountants

May 31, 2024

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PERFORMANCE AUDIT
July 1, 2022 to June 30, 2023

BACKGROUND

The Patient Protection and Affordable Care Act ("PPACA") and the Health Care and Education Reconciliation Act of 2010 (together referred to as the "Affordable Care Act" or "ACA") were signed by President Obama in March 2010. Section 1311(b) of the ACA requires each state to establish health insurance exchanges. Since the inception of the PPACA, New Jersey has utilized the Federally Facilitated Exchange ("FFE"), or Marketplace, which provides a platform for consumers to shop for and enroll in coverage.

In June 2019, Governor Phil Murphy signed legislation (P.L. 2019 c. 141) to establish a state-based health insurance exchange ("SBE") for the State of New Jersey. The state-based exchange was established, and is operated by, the New Jersey Department of Banking and Insurance ("NJ DOBI" or "Department") and is a division within the department. The purpose of the Exchange is to provide a centralized location where individuals can anonymously shop for a health insurance plan, entering the platform by way of a landing page, creating an account, receiving an assessment or determination of eligibility for any applicable financial assistance, appropriate referral to the State Medicaid agency, and selection of a health insurance plan, as appropriate.

The Exchange's operations began on November 1, 2019, when the Exchange began conducting outreach and advertising as a state-based exchange on the federal platform. The Exchange's operating activity and initial startup was funded solely by the State of New Jersey Treasury appropriations. This included expenditures related to design, development and implementation, including outreach and advertising activities designed to attract new enrollees. The Exchange amounts appropriated by the state were to be reimbursed to the Treasury when the Exchange was able to begin collecting revenues from participating insurance carriers.

The Exchange is a division within NJ DOBI. Department personnel perform various Exchange operations including business administration, carrier and plan management and oversight, finance, legal, public policy and outreach, reporting and customer support. In addition to NJ DOBI personnel, the Exchange utilizes various third-party vendors to assist in these operations and the critical services of the Exchange. Some of the key vendors utilized are those that operate as Navigators. Navigators support the Exchange by facilitating the outreach and enrollment in health and dental coverages and the purchase and sale of Qualified Health Plans ("QHP") in the individual insurance market in the State of New Jersey. Navigators are individuals or entities that are trained and able to help consumers, including completing eligibility and enrollment forms, as they look for health coverage options through the Marketplace. Only those individuals or entities that meet the criteria of 45 CFR § 155.210 and apply for and are awarded funding through the New Jersey State Navigator Grant program are authorized to operate as Navigators in the State of New Jersey for each plan year.

BACKGROUND (CONTINUED)

For the 2020 plan year, the Exchange operated as a state-based health insurance exchange on the federal platform. This included utilization of the federal systems and platforms. For the 2021 plan year enrollment period and all subsequent periods, the Exchange converted from a state-based health insurance exchange on the federal platform to a fully autonomous state-based exchange. Fully autonomous state-based exchanges are entities through which qualified individuals can purchase health insurance coverage in which the state-based exchange performs the eligibility and enrollment functions utilizing its own enrollment infrastructure instead of the federal exchange infrastructure to perform eligibility and enrollment functions. The eligibility criteria that the SBE must be able to evaluate include residency in the State of New Jersey, citizenship and noncitizen status, enrollment in other insurance, and income. Eligibility is used to determine the ability to purchase coverage on the Marketplace and also to determine if the applicant is eligible to receive financial help to assist with the monthly cost of the insurance plan premiums.

Many individuals who enroll in QHPs through the Exchange may be eligible to receive a premium tax credit (PTC) to reduce their costs for health insurance premiums and receive reductions in required cost-sharing payments to reduce out-of-pocket expenses for health care services. Eligible individuals can receive the estimated amount of the PTC on an advance basis, known as advance payments of the premium tax credit (APTC).

AUDIT OBJECTIVES

The objective of our audit was to conduct a performance audit in accordance with 45 CFR and GAGAS to assess the Exchange's compliance with 45 CFR § 155 subparts C, D, E and K requirements for the period July 1, 2022 to June 30, 2023.

We are responsible for preparing a written report communicating the results of the audit, including relevant findings and recommendations for noncompliance noted, if any. These results should include deficiencies in internal controls that are significant within the context of the audit objectives, any identified instances of fraud or potential illegal acts, unless determined to be inconsequential within the context of the audit objectives, and significant abuse that was identified as a result of our audit procedures. In accordance with GAGAS, we are also required in certain circumstances to report fraud, illegal acts and violations of provisions of contracts or grant agreements, or abuse that we may detect as a result of this engagement, directly to parties outside of the Exchange.

AUDIT SCOPE

We were engaged to assess the Exchange's compliance with 45 CFR § 155 subparts C, D, E and K requirements for the period July 1, 2022 to June 30, 2023. Our procedures were limited to the following areas:

AUDIT SCOPE (CONTINUED)

Audit Areas			Procedures	Documentation
Subpart	**Section**	**Topic**		
C	155.200	Functions of an Exchange.	- Interview key staff and members of management regarding policies, procedures and controls for each applicable audit area.	- Policies and procedures documents on Exchange functions, including standard forms utilized by the Exchange for QHP applications, monitoring, reporting and payments.
C	155.205	Consumer assistance tools and programs of an Exchange.		
C	155.210	Navigator program standards.		
C	155.220	Ability of States to permit agents and brokers to assist qualified individuals, qualified employers, or qualified employees enrolling in QHPs.		
C	155.221	Standards for HHS-approved vendors to perform audits of agents and brokers participating in direct enrollment.	- Inspection of supporting documentation.	
C	155.225	Certified application counselors.	- Review of policies and procedures documents on Exchange functions.	
C	155.227	Authorized representatives.		
C	155.230	General standards for Exchange notices.		
C	155.240	Payment of premiums.		
C	155.260	Privacy and security of personally identifiable information.	- Inspection and Observation of security and system data transmissions and reporting.	
C	155.270	Use of standards and protocols for electronic transactions.		
C	155.280	Oversight and monitoring of privacy and security requirements.		
C	155.285	Bases and process for imposing civil penalties for provision of false or fraudulent information to an Exchange or improper use or disclosure of information.		
D	155.302	Opinions for conducting eligibility determinations.	- Interview key staff and members of management regarding policies, procedures and controls for each applicable audit area. - Select samples to evaluate the design and effectiveness of key process controls and to test compliance of each audit area through inspection and reperformance. - Review process and control supporting documentation for each applicable audit area.	- Policies and procedures documents (SSAP) on Exchange functions including standard forms utilized by the Exchange. - Eligibility, Data Match Issue and Appeal supporting documentation. - Walkthrough of GetCovered website and applicant platform to verify compliance reporting and control specifications are in place. - Reperformance of eligibility determination with test data in the GetCovered platform.
D	155.305	Eligibility Standards.		
D	155.310	Eligibility Process.		
D	155.315	Verification process related to eligibility for enrollment in a QHP through the Exchange.		
D	155.320	Verification process related to eligibility for insurance affordability programs.		
D	155.330	Eligibility redetermination during a benefit year.		
D	155.340	Administration of advance payments of premium tax credit and cost sharing reductions.		
D	155.345	Coordination with Medicaid, CHIP, the Basic Health Program, and the Pre-existing Condition Insurance Plan.		
D	155.355	Right to appeal.		

AUDIT SCOPE (CONTINUED)

		Audit Areas	Procedures	Documentation
E	155.400	Enrollment of qualified individuals into QHPs.	- Interview key staff and members of management regarding policies, procedures and controls for each applicable audit area. - Select samples to evaluate the design and effectiveness of key process controls and to test compliance of each audit area. - Review process and control documentation for each applicable audit area.	- Policies and procedures documents (SSAP) on Exchange functions including standard forms utilized by the Exchange. - QHP plan documents on SERFF system and GetCovered website. - Enrollment period calendar, including special enrollment periods and related exemptions.
E	155.405	Single streamlined application.		
E	155.410	Initial and annual open enrollment periods.		
E	155.420	Special enrollment periods.		
E	155.430	Termination of Exchange enrollment or coverage.		
K	155.1000	Certification standards for QHPs.	- Review process and control documentation for each applicable audit area. - Conduct walkthroughs of key process controls.	- Navigator applications, grant agreements and attachments, progress reports and budgets. - Certified Application Counselor Designated Org Applications.
K	155.1010	Certification process for QHPs.		
K	155.1020	QHP issuer rate and benefit information.		
K	155.1030	QHP certification standards related to advance payments of the premium tax credit and cost-sharing reductions.		
K	155.1040	Transparency in coverage.	- Select samples to evaluate the design and effectiveness of key process controls and to test compliance of each audit area.	- Carrier QHP application and related documentation as well as Exchange website review.
K	155.1045	Accreditation timeline.		
K	155.1050	Establishment of Exchange network adequacy standards.		
K	155.1055	Service area of a QHP.		
K	155.1065	Stand-alone dental plans.		
K	155.1075	Recertification of QHPs.		
K	155.1080	Decertification of QHPs.		
K	155.1090	Request for reconsideration.		

AUDIT METHODOLOGY

In order to effectively determine compliance with specified elements of 45 CFR § 155 subparts C, D, E and K, testing was performed in accordance with GAGAS. We gathered information from a variety of sources using various methodologies, including those listed below.

- **Performance Audit Standards**
  In the execution of the performance audit, we performed the engagement in accordance with GAGAS issued by the Comptroller General of the United States of America. 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. Accordingly, we performed testing of records and source documentation as well as other auditing procedures determined necessary in the circumstances. We believe that the evidence obtained provides a reasonable basis for our findings and recommendations based on our audit objectives.

- **Interviews with Key Staff**
  A formal project kickoff meeting was held with NJ DOBI management and staff who operate and perform key functions of the Exchange at the outset of the engagement. The project kickoff meeting was conducted to confirm the understanding of the audit scope and objectives. In addition to the kickoff meeting, interviews with key staff were conducted to understand the Exchange's programmatic operations and oversight related to 45 CFR § 155 subparts C, D, E and K. This understanding was critical to properly plan our audit procedures and determine the essential processes, controls and supporting documentation required to achieve the audit objectives.

- **Walkthroughs**
  To corroborate our understanding of the Exchange's operations and to substantiate the conclusions reached from initial inquiries performed, we "walked-through" specific operations and processes of the Department. The walkthrough procedures included additional corroborative inquiries of key staff and inspection of critical source documents, forms and systems of the Exchange.

- **Internal Controls**
  We obtained an understanding of the design, operation and effectiveness of internal controls which were significant within the context of the compliance objectives. During our preliminary assessment of the five components of internal controls (control environment, risk assessment, control activities, information and communication, monitoring), we determined that each component was relevant to the audit objective of assessing the Exchange's compliance with the specified provisions of 45 CFR § 155, both in their daily activities and overall operations, as well as services performed. As it relates to 45 CFR § 155 subparts C, D, E and K requirements, the Exchange is responsible for establishing an adequate control environment, performing risk

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AUDIT METHODOLOGY (CONTINUED)

- **Internal Controls (Continued)**
  assessments and assessing fraud risk, developing control activities through formal policies and procedures, providing and communicating information internally and externally, and continuously monitoring their compliance with those requirements. We documented our understanding of the design of internal controls obtained through inspection of policies and procedures, and inquiries with NJ DOBI staff who manage and perform key functions of the Exchange. We then identified the key controls that have an impact on compliance. These key controls were then tested as well as the related procedures for testing of compliance with the applicable federal requirements. As a result of these procedures, we concluded on whether the Department has adequate controls in place that are designed and operating effectively to determine compliance with policies and procedures.

- **Requirements Tested**
  The elements tested during our audit correspond directly to the requirements established by 45 CFR § 155.1200 subparts C, D, E and K under the Affordable Care Act as outlined in our engagement letter dated January 30, 2024. A summary of the areas and compliance elements tested included:
  - **General Functions of the Exchange and Website**: Testing to determine if the Department implemented adequate procedures to establish and properly monitor consumer assistance tools, Navigator program standards, and certified application counselors. Specific elements of subpart C tested included 155.205, 155.210 and 155.225. Specific elements of subpart E tested included 155.400, 155.405, 155.410, 155.420 and 155.430.
  - **Functions of the GetCovered Applicant Platform**: Testing to determine if the Department implemented adequate procedures and systems to process and properly monitor consumer applications for insurance coverage, determine eligibility for coverage and other benefits, and proper approval of insurance plans and benefits given applicable requirements and standards. Specific elements of subpart D tested included 155.310, 155.315, 155.320, 155.330, 155.340 and 155.345.
  - **General Functions of Qualified Health Plans (QHP)**: Testing to determine if the Department implemented adequate procedures to establish and properly monitor QHP standards, QHP processes, QHP rate and benefit structures, and applicable certification and decertification procedures if applicable for plan year 2023 operations. The entirety of subpart K (155.1000 to 155.1090) was subject to testing, though certain elements were determined to not be applicable for testing for plan year 2023.

AUDIT METHODOLOGY (CONTINUED)

- **Sampling**
  Due to the nature of the compliance requirements tested and the availability of supporting source documentation, we determined that control and compliance sampling of the following was most efficient and effective:
  - Population of consumer applicants
    - Subsample of eligibility in the enrollments and redeterminations
    - Subsample of consumers receiving premium tax credit or cost reduction benefits
    - Subsample of consumers with data match issues or appeals
  - Population of navigator entities and related reports
  - Population of certified application counselors and related reports
  - Population of insurance carriers and their plan year 2023 QHPs and rates

- **Reporting**
  Upon completion of our audit procedures we reviewed any noncompliance identified, if any, with the Exchange staff and noted any reportable matters in the findings and recommendations section below.

PROCEDURES PERFORMED

We reviewed the requirements of 45 CFR § 155.1200 subparts C, D, E and K to identify audit objectives relevant to the Exchange's functions. We performed this engagement and developed audit procedures in accordance with GAGAS and Mercadien audit methodologies.

- **Interviews**
  As part of our procedures, we interviewed eleven individuals responsible for the various departments or programmatic functions of the Exchange. The individuals included:
  - *Deputy Director of Program Operations* – responsible for supervising the exchange staff and processes, enrollment, carriers, finance and budget.
  - *Deputy Director of Technology* – responsible for the exchange platform, system improvements and changes, data analysis and management, metric reporting, compliance and security oversight.
  - *Deputy Director of Consumer Operations* – responsible for consumer communications and call center management.
  - *Associate Counsel/Legal Specialist* – focused on appeals, audits, regulations compliance and policy development.
  - *Senior Eligibility Specialist* – Eligibility knowledge expert with a focus on system evaluations and policy development.
  - *Policy & Strategy Analyst* – focused on exchange audits, regulatory compliance and policy development.
  - *Health Plan Operations Lead* – focused on coordination of plan carriers.

PROCEDURES PERFORMED (CONTINUED)

- **Interviews (Continued)**
  - *Enrollment Program Coordinator* – responsible for Navigator, CDO and broker oversight and coordination.
  - *Call Center Manager* – responsible for oversight of call center staff and operations and reporting to management of consumer or carrier issues.
  - *Project Management and Quality Assurance Officer* – supports the Deputy Director of Technology and all program deputy directors.
  - *EDI Specialist* – Maintains data security and supports the carrier coordination, issue resolution and reporting reconciliations.

  The results of the interviews were that the individuals inquired of provided a clear understanding of their and their staffs' job responsibilities, day-to-day functions, and policies and procedures that ensure compliance with applicable requirements and standards. Additionally, key documentation and systems that would illustrate or support the statements received during our inquiries were identified by staff and provided.

- **Walkthroughs and Observations**
  Subsequently, we completed walkthroughs of controls and understanding obtained during our initial inquiries. The walkthroughs involved additional follow-up interviews with the multiple individuals listed above to corroborate understanding previously received, inspection of the Exchange's various standard operating procedure manuals for eligibility, enrollment, change processes, data sharing and reporting, consumer guidance and Navigator support entities. Additional inspection of related supporting documentation that illustrated the controls and procedures detailed was also performed. Lastly, observation and inspection of the applicant and QHP systems utilized by staff for the plan, eligibility and rate determinations. From the interviews and walkthroughs procedures performed, it was determined that sufficient controls and procedures appear to be in place to maintain compliance with the applicable general functions of the Exchange and QHPs and limited risk of noncompliance existed for the period under audit.

- **Document Inspection**
  Upon completion of the walkthroughs, we sampled and performed an assessment of the applicable supporting documentation to evaluate the Exchange's compliance with the direct and material requirements of 45 CFR § 155 subparts C, D, E and K. The supporting documentation inspected included:
  - Consumer applications and related support for eligibility determinations and annual redeterminations for prior plan year enrollees,
  - Data match issues identified in the eligibility determination process forms,
  - Duplicate enrollment and other enrollment application system warnings,

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PROCEDURES PERFORMED (CONTINUED)

- **Document Inspection (Continued)**
  - Weekly, monthly and bi-annual metric reporting provided by the Exchange to federal agencies,
  - Standard Department forms and attestation documents used for the application and determination of Navigator and certified application counselor entities,
  - Completed Navigator and certified application counselor applications, budgets, contracts, certifications and attestations from the July 1, 2022 to June 30, 2023 year,
  - Navigator monthly reporting, and
  - Completed insurance carrier health and dental plan submissions and rate documents that were remitted to the Exchange for review against federal and state requirements for approval.

For eligibility and enrollment testing, we reviewed the supporting documentation for 20 initial enrollment applications, 20 annual enrollment redeterminations, 60 data match issues and ten appeals. We also evaluated the eligibility determination system controls and automations by inputting into the application system 120 hypothetical enrollees that had varying unique household sizes, income levels, citizenship and lawful presence status, New Jersey residency, age, employment status, current insurance coverage, and incarceration status. The system tested was an offline copy of the system used for open enrollment by the Exchange. Because of this, not all possible data match issues could be identified and evaluated, however, we were able to determine that the proper eligibility determinations, cost sharing, premium tax credit and plan alternatives, such as Medicaid and CHIP, were properly identified and in compliance with 45 CFR § 155.1200 subpart D requirements. We also noted the Exchange reported the various data points on their website and to federal regulators as required and alternative plan eligible applicants to the NJ Family Care program administrators for proper enrollment in an alternative plan such as Medicaid. Lastly, we noted through review of screen prints of the live system, the error message to applicants who have unique identifiers in their information or their household information matches an existing enrollee in the Exchange platform. Of the files sampled and testing performed, other than the matter noted findings and recommendations page, no control issues or noncompliance was noted.

Of the 17 approved Navigator entities, we sampled and reviewed the applications, reports and other supporting documentation for seven entities, noting no issues or noncompliance with the documentation provided. Of the 19 certified application counselor designated organizations (“CDOs”), we sampled and reviewed the application and compliance documentation for six of the entities. For five of the six entities we noted the signed agreement between the CDO and the Exchange were not maintained. No other issues or noncompliance were noted, and the Exchange already implemented an amended procedure to store copies of these electronic agreements for future plan years.

PROCEDURES PERFORMED (CONTINUED)

Document Inspection (Continued)

We noted six unique insurance carriers that uploaded medical plan documentation to the System for Electronic Rate & Form Filing ("SERFF") system for managing plans and rates. One of those carriers also uploaded a dental plan. Six additional insurance carriers also uploaded dental plan documentation to the SERFF system for managing plans and rates. In examining each entity and the related supporting documentation, we noted that the required documentation and elements necessary for each plan offering for Federal and State standards were included and supported. Exchange staff reviewed the contents of each plan submitted and appeared to approve the plans in line with the applicable standards for the period July 1, 2022 to June 30, 2023.

FINDINGS AND RECOMMENDATIONS

Finding 2023-001

Criteria

45 CFR § 155.315 (c) (3) - Inconsistencies and inability to verify information. For an applicant who attests to citizenship, status as a national, or lawful presence, and for whom the Exchange cannot verify such attestation through the Social Security Administration or the Department of Homeland Security, the Exchange must follow the procedures specified in paragraph (f) of this section, except that the Exchange must provide the applicant with a period of 90 days from the date on which the notice described in paragraph (f)(2)(i) of this section is received for the applicant to provide satisfactory documentary evidence or resolve the inconsistency with the Social Security Administration or the Department of Homeland Security, as applicable. The date on which the notice is received means 5 days after the date on the notice, unless the applicant demonstrates that he or she did not receive the notice within the 5-day period.

45 CFR § 155.320 (d) (4) - Alternate procedures. For any benefit year for which it does not reasonably expect to obtain sufficient verification data as described in paragraphs (d)(2)(i) through (iii) of this section, the Exchange must follow the procedures specified in paragraph (d)(4)(i) of this section or, for benefit years 2016 and 2017, the Exchange may follow the procedures specified in paragraph (d)(4)(ii) of this section. For purposes of this paragraph (d)(4), the Exchange reasonably expects to obtain sufficient verification data for any benefit year when, for the benefit year, the Exchange is able to obtain data about enrollment in and eligibility for qualifying coverage in an eligible employer-sponsored plan from at least one electronic data source that is available to the Exchange and that has been approved by HHS, based on evidence showing that the data source is sufficiently current, accurate, and minimizes administrative burden, as described under paragraph (d)(2)(i) of this section.

Condition

During testing of 60 data match issues and the related processes and controls we noted:

- One applicant, who had a lawful presence data match issue, had their issue remediated by the Exchange staff through the incorrect application of another consumers lawful presence support to their household file. The actual applicant did not provide the necessary documentation to remediate the data matching issue.
- One applicant who had a Non-ESI MEC data match issue, had their issue remediated without providing the proper documentation. The call center accepted an insurance document that did not relate or resolve the data match issue. Subsequently, the consumer was contacted to resolve the incorrect support issue but the updated supporting documentation for the remediation was not maintained in the household file.

FINDINGS AND RECOMMENDATIONS (Continued)

Finding 2023-001 (Continued)

Cause

The policies and procedures over data match issues and documentation were not consistently followed.

Effect

No ineligible enrollments were noted. For the two files noted above, the first matter consumer did not continue an application or the enrollment process and the second consumer was properly determined to be eligible for the plan in which they were enrolled.

Recommendation

We recommend that the Exchange review its policies and procedures regarding data match issues and applicant file documentation. We also recommend additional staff training be provided for data match issue documentation. The Exchange has already implemented such policy and procedure review and added training for call center staff to address this issue.

Management's Response

Management is in agreement with the finding noted. The Exchange has already implemented policy and procedure review and added training for call center staff to address this issue.