DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

JUL - 9 2015

The Honorable Charles E. Grassley
Chairman
Committee on the Judiciary
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

Thank you for your letter regarding the Centers for Medicare & Medicaid Services (CMS) process for verifying the accuracy of aggregate financial assistance payments made to Qualified Health Plan (QHP) issuers under the Affordable Care Act (ACA) and the Department of Health and Human Services (HHS) Office of the Inspector General (OIG) June 2015 report.[1] CMS operates all of its programs with a strong focus on program integrity and process controls.

As you know, the ACA was enacted in part to help Americans obtain high quality, affordable health care coverage, and the advance payment of the premium tax credit (APTC) and the cost-sharing reduction (CSR) payments are a key part of achieving that goal. Millions of Americans now rely on the health and financial security that comes from affordable coverage through the Marketplaces. On March 31, 2015, about 10.2 million consumers had "effectuated" coverage, which means those individuals paid for Marketplace coverage and had an active policy on that date.[2] Nearly 8.7 million (85 percent) consumers nationwide received an average premium tax credit of $272 per month to make their premiums more affordable throughout the year.

CMS takes seriously our responsibility to conduct oversight of the programs established by the ACA and to verify the accuracy of financial assistance payments. CMS has established multiple levels of review and reconciliation that are intended to confirm the accuracy of QHP issuer payments for APTCs and CSRs.

1. CMS instituted a system that conducts multiple levels of review and validation of the issuer and state-submitted data, including comparing the effectuated enrollment counts submitted by the issuers to the enrollment counts generated from the Federally-facilitated Marketplace (FFM) and "parallel processing" where two independent teams calculate the aggregate issuer payment.

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[1] 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. This report reviewed QHP issuer payments from January 1, 2014 through April 30, 2014. https://oig.hhs.gov/oas/reports/region2/21402006.pdf

[2] March 31, 2015 Effectuated Enrollment Snapshot: http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-06-02.html

2. CMS requires QHP issuers to certify the accuracy and completeness of their data submissions each month, as a prerequisite for payment. Deliberate misstatement of data in the face of this certification constitutes fraud.
3. Implementing a similar process as used in Medicare Part D, CMS requires QHP issuers and State-based Marketplaces to restate prior-month enrollment data in each subsequent payment cycle. This restatement process allows for correction of issuer payments for terminations, the three-month grace period for non-payment of premiums for consumers receiving APTC, and other enrollment changes, including births, deaths, and new eligibility determinations that result in new policies or revisions to existing policies.
4. Taxpayers must reconcile APTC with actual premium tax credit payments when they file their annual tax returns. As part of this reconciliation process, taxpayers must repay any excess APTC they received, subject to statutory limits.
5. For CSR, CMS intends to reconcile 2014 benefit year CSRs for all QHP issuers.[3] This reconciliation will allow issuers to implement the most accurate and preferred methodology for reconciling advance payments of CSR. CMS continues to provide technical assistance to issuers for CSR reconciliation.
6. CMS is testing an enhanced process with issuers and State-based Marketplaces that will further strengthen CMS' capacity to check the issuer and state-submitted aggregate plan data against policy-level data. This process will allow State-based Marketplaces to submit enrollee data.
7. CMS will have another opportunity to adjust issuer payments in 2016 through a risk adjustment program and data validation process, which will increase the oversight provisions available to CMS for issuer payments.

As with any CMS program, CMS is continuously working to strengthen Marketplace program integrity processes. On November 10, 2014, CMS completed the A-123 review of its internal controls, as required by the Office of Management and Budget. This review determined that the key controls surrounding the issuer payment process to be operating effectively. An independently certified public accounting firm conducted its review of the payment process and reported no significant issues. Both reviews were completed with no significant deficiencies or material weaknesses identified for the payment process.

The HHS OIG is a vital part of CMS's work to strengthen its program integrity processes. With respect to the specific report you reference in your letter, the HHS OIG did not find that the QHP issuers submitted fraudulent payment information to CMS. The HHS OIG identified approximately $314,000 as a reported underpayment of CSR to issuers, which represents approximately 0.1 percent of the HHS OIG's sample of total payments. CMS has already implemented the OIG June 2015 recommendation and changed the policies that resulted in the CSR underpayments identified by the OIG. Additionally, the Marketplace now calculates the monthly advance payment amount for a specific policy as the product of the total monthly premium for the specific policy and a CSR plan variation multiplier. Because this process no longer involves reliance on index rates, the review of outlier index rates is not a part of the CSR advance rate validation.

[3] https://www.regtap.info/uploads/library/APTC_CSR_Recon_timing_guidance_5CR_021315.pdf

I appreciate your interest in this important issue. As demonstrated by the system approach outlined above, CMS is continuously working to strengthen Marketplace program integrity. Because the HHS OIG's reports are a vital part of those efforts, CMS has already addressed – or is in the process of addressing – all of the recommendations made by the HHS OIG in its June 2015 report.

Please do not hesitate to contact me with any further thoughts or concerns. I will also provide this response to Chairman Hatch.

Sincerely,

Andrew M. Slavitt
Acting Administrator