IOWA HBE PMO PROJECT

EXCHANGE BUSINESS REQUIREMENTS: PROGRAM INTEGRITY (INTERNAL CONTROL BLUEPRINT)

VERSION 1.2
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1.0	March 30, 2012	Initial Submission
1.1	April 13, 2012	Addressed comments given by CSG team and added section 5.
1.2	June 28, 2012	Final Submission
1.2	November 16, 2012	Updated date

1. EXECUTIVE SUMMARY

This report is intended to provide the State of Iowa with an Internal Control Blueprint for a state-based health benefits exchange. As the state has not yet decided on exchange IT systems or business processes, many of our recommendations represent best practices in designing and developing an internal control system to prevent and detect fraud, waste, and abuse (FWA) in a state-based exchange.

To guide and inform the Internal Control Blueprint, we first looked to the Affordable Care Act (ACA) and other health care related laws on FWA. We then identified private market best practices in designing and developing a system of internal control by detailing the Committee of Sponsoring Organizations of the Treadway Commission, or COSO framework, for a structural tool which is especially helpful for a new organization such as the Exchange.

Finally, we utilized a Wakely proprietary tool called The Exchange Business Requirements – Internal Controls Grid which crosswalks key exchange financial business requirements to internal control objectives and identifies specific internal control objectives by business requirement. We then provide examples of specific activities to achieve the internal control objectives which are system and business process agnostic. When the exchange systems and financial management processes are finally implemented, the examples we have provided are highly relevant and can be easily customized to the specifications of the actual system or process.

2. INTRODUCTION

2.1 Purpose

Wakely Consulting Group (Wakely) has been hired by the State of Iowa, through a subcontract with CSG Government Solutions, to develop a Program Integrity or "Internal Control Blueprint" to be utilized by senior management and staff of its Health Benefit Exchange (HBE), should the state decide to move forward with a state-based exchange, as Iowa continues its planning of an HBE administrative infrastructure.

In developing an approach to the work, Wakely has identified the following steps:

1. Identify ACA Standards and industry best practices relative to a system of internal control designed to detect and prevent fraud, waste, and abuse (FWA),

2. Identify key exchange business requirements that should be an early focus for development of a system of internal control,

3. Interview no more than three (3) state agencies to understand and document policies and procedures designed to prevent and detect FWA that may be able to be leveraged by the HBE, and

4. Using results from steps 1, 2 and 3 above, develop a list of internal control objectives and specific activities to achieve such objectives, as well identification of existing Iowa state systems which may be able to be leveraged for exchange internal control best practices.

2.2 Background

In establishing guidelines for internal controls for the HBE, Wakely utilized a proprietary tool it has developed that crosswalks key exchange business requirements in the area of financial reporting and operations to common internal control objectives found in public or private organizations.

This tool, which is called *The Exchange Business Requirements – Internal Controls Grid,* has been subjectively organized by Wakely into 9 Summary Level Categories representing broad areas of responsibility for the exchange based on published federal guidance and Wakely experience. In addition, these 9 Summary Level Categories have been further refined into 34 Detail Level Categories. The categories are not representative of all the functional requirements of the HBE, but categories we believe are most relevant to the financial operations of the exchange and thus, an important area of focus in the HBE's system of internal control.

We have further refined the *Exchange Business Requirements – Internal Controls Grid* by cross walking the business requirements to 8 key internal control objectives. By organizing the exchange business requirements to specific control objectives, management of the Iowa HBE can customize the design of

its internal control activities to provide reasonable assurance that the stated control objectives are achieved or related progress has been met. The eight internal control objectives are as follows:

1) Existence and Occurrence (E/O) – Only valid or authorized transactions are processed (i.e. no invalid transactions) and the transactions occurred during the correct period or were processed timely.

2) Completeness (C) – All transactions are processed that should be (i.e. no omissions.)

3) Valuation or Allocation (V) – Transactions are calculated using an appropriate methodology or are computationally accurate.

4) Rights & Obligations (R/O) – Assets represent the rights of the entity, and liabilities its obligations, as of a given date.

5) Presentation & Disclosure (P/D) – Components of financial statements (or other reporting) are properly classified (by type or account) and described.

6) Reasonableness (R) – Transactions or results appear reasonable relative to other data or trends.

7) Fraud (F) – Transactions have not been executed as a result of fraudulent activities.

8) Entity-wide (E/W) – Transactions and activities are designed to ensure performance across the entity.

Anchoring the evaluation on a specific set of internal control objectives will provide criteria in which to develop tailored internal control activities for each of the HBE business requirements. As a new entity with no actual historical experience in which to base its processes, this methodology provides the necessary framework and guidance in which to begin to design and build a set of internal control activities for the key HBE business requirements. Once operational, management of the HBE can modify the control objectives to tailor its internal control system to the environmental and business conditions in which it is operating or most concerned with. The Internal Control Objective Tool which was utilized for the evaluation is at **Table 1** in the Appendix.

Additionally, we have cross-walked the 34 detail level categories to the applicable federal statutory reference, the CCIIO Funding Opportunity Announcement (FOA), or a Wakely identified business need. See **Table 2** in the Appendix.

As a final step in the development of the internal control blueprint, Wakely performed a high-level assessment of certain state programs so that we can understand and document the systems and processes currently in effect in Iowa which might be leveraged by the state for its HBE business requirements. This assessment of certain state agencies will allow Wakely to identify:

1) Current system processes that may be able to be leveraged by the HBE; and

2) HBE financial business requirements that are not handled by an existing state processes.

3. INTERNAL CONTROL BLUEPRINT

3.1 ACA Standards & Federal Law

As a new entity at the forefront of heath care implementation, the Health Benefit Exchange (HBE) will be highly visible and under intense public scrutiny. Due to its unique function in the market, the HBE needs to build credibility and trust with the public and its business partners. One of the quickest ways to lose credibility and trust is to fail to develop a strong system of internal control that results in errors and omissions and does not prevent and detect fraud, waste and abuse thus tarnishing the image of the Exchange.

The statutory case for a strong system of internal control is equally compelling. Section 1313 of the Affordable Care Act (ACA) specifies the need for the exchange to keep an accurate accounting of all activities, receipts, and expenditures and must submit a report to the Secretary of HHS annually regarding such accounting. The Secretary of HHS may also investigate the affairs of the exchange and subject it to annual audits. Section 1313 also provides for Government Accountability Office (GAO) oversight with a study to begin no later than 5 years after the exchange begins operations, conducted by the Comptroller General, regarding Exchange operations and administration.

As a result of this significant public, federal, and state oversight and attention, it is clear that the administrators of the exchange will need to ensure that its accounting and financial management system is well designed with an internal control framework that provides assurance that the accounting system and its underlying data are reliable.

While the case for a highly functioning system of internal control for the HBE is clear, Exchange specific internal control and FWA federal guidance has not yet been released beyond the areas identified in the ACA. However, in developing an internal control blueprint, we can look to existing federal laws on health care fraud for initial guidance. Some of the more relevant laws that management and staff of the exchange should be concerned with and educated on include:

1. Federal False Claims Act (FCA) – 31 U.S.C. Title 1347.

   This is the primary federal law used to fight fraud in Medicaid and Medicare. Section 1313 of the ACA specifically references compliance of this statute for issuers of QHP's that are receiving payments, including premium tax credits and cost sharing reductions, through the exchange.

2. Whistleblower (Qui Tam) Protections – United States Code (USC) 3730 (h).

   This law protects employees who assist the federal government in investigation and prosecution of violations of the False Claims Act (FCA). A Qui Tam suit is brought by a citizen against a company, person, or entity that is in some way cheating the federal or state government. Although, the suit is brought by an individual, the government may actually join the case and

litigate alongside the individual. An individual who successfully pursues a Qui Tam action is entitled to a bounty that ranges from 15% to 30% of the government's recovery.

3. Physician Self-referral Prohibition Statute – 1877 of the Social Security Act (42 USC 1395), commonly known as the "Stark Law".

   Commonly known as the 'stark law' for Congressman Peter Stark, who initially sponsored the bill, prohibits physicians from referring Medicare patients to an entity with which the physician, or immediate family member of the physician, has a financial relationship. When originally enacted, the law only applied to clinical laboratory services, but congressional actions in 1993, 1994, and 1997 expanded the law to a range of additional health services and applied it to both Medicare and Medicaid.

4. Anti-Kickback Statute – Section 1128 of the Social Security Act (42 USC 1320a-7b (b)).

   This statute provides for criminal penalties for certain acts impacting Medicare and Medicaid reimbursable services. The statute prohibits health care professional entities and vendors from offering, paying, soliciting, or receiving incentives to induce the referral of business under a federal health program. The statute contains certain exceptions which allow conduct that would otherwise violate the statute, such as discounts and safe harbor regulations.

5. Anti-trust Laws

   This body of laws prohibits monopolistic conduct and agreement that restrain trade. Anti-trust laws are intended to encourage competition in the marketplace and ensure the protection of businesses and consumers. Anti-trust laws prohibit agreement in restraint of trade, monopolization and attempted monopolization, anticompetitive mergers and tie-in schemes, and in certain circumstances can protect against price discrimination in the sale of commodities. Regulation and enforcement of these laws on the federal level fall under the purview of the United States Department of Justice and the Federal Trade Commission.

6. Health Insurance Portability & Accountability Act of 1996 (HIPPA).

   This act establishes standards and requirement for the electronic transmission of certain health information. The HIPPA Rule provides federal protections for personal health information held by covered entities and provides patient rights with respect to that information. However, the rule also permits the disclosure of personal health information needed to provide patient care. Protection of private information may decrease fraudulent activities.

While it is not necessary for the HBE to be concerned with all of the health care related laws regarding FWA, the exchange should minimally be well versed in, and have measures in place to ensure compliance with the Federal False Claims Act, Whistleblower Protections, Anti-Kickback Statute, and HIPAA.

3.2 Industry Best Practices

As a hybrid public/private entity, the exchange should look both to public government and private industry for organizational and operational best practices. However, as an entity whose primary function is to sell health insurance and is competing with similar private sector entities for retail business, private industry models may offer more suitable solutions.

In developing the exchange financial infrastructure and system of internal controls, we recommend looking to the private sector for guidance. More specifically, the most commonly used framework in the United States is the Committee of Sponsoring Organizations of the Treadway Commission or COSO. COSO defines internal control as having 5 components:

1. Control Environment
2. Risk Assessment
3. Control Activities
4. Information & Communication Systems
5. Monitoring Process

Each of the COSO components are highly inter-related and work together to form an internal control approach that is entity-wide, and touches all aspects of an organizations infrastructure. While specific business cycles such as Accounts Payable/Purchasing can be separately assessed and analyzed, by utilizing a more holistic approach such as the model recommended by COSO, an organization will create a more lasting framework that will allow for adaptability and flexibility as the exchange moves from a start-up organization to a more mature business entity potentially requiring different internal control procedures. A brief description of each COSO component is as follows.

1. Control Environment

   This describes an entity's culture or "tone-at-the-top". The senior leaders of any organization significantly influence a company's business practices, and what the company holds important as core operating principles.

   Under the COSO framework, the control environment explains how management must establish the overall attitude, awareness and actions of the importance of internal control and detecting FWA. Going further, management must place emphasis on control in policies, procedures, methods, and organizational structure.

2. Risk Assessment

   This component involves the identification and analysis of relevant internal and external risk to the organization. This work begins by subdividing the exchange into "control cycles" such as Eligibility Determination, Accounts Receivable/Billing, Accounts Payable/Purchasing, and Payroll.

This type of assessment needs to be performed on a periodic basis, as current policies and procedures may be inadequate to meet evolving challenges which is especially true during exchange start-up relative to ongoing operations. The details of each control cycle will be customized to meet the unique structure and business of the exchange, as well as its business environment.

3. Control Activities

   The work of designing, implementing, and maintaining internal control related policies and procedures are the foci of this component. Key internal control concepts such as segregation of incompatible duties, budgeting and reporting process, and a disaster recovery plan are some of the control activities that will be employed by the exchange.

   To assist the exchange in this area, we have specified a number of examples of specific activities to that can be employed to meet the control objectives of each of the specified business requirements. While many of the control activities will be dependent on the type of IT system and process employed by the exchange, we believe many of the examples noted can be utilized regardless of the type of system or process employed.

4. Information & Communication Systems

   In order to be effective, an internal control system needs to have processes that support the identification, capture, and transfer of information in a form and time-frame that enables Management and other appropriate personnel to carry out their responsibilities. This includes clear lines of communication throughout the organization, with the BOD and Board subcommittees, and with outside parties.

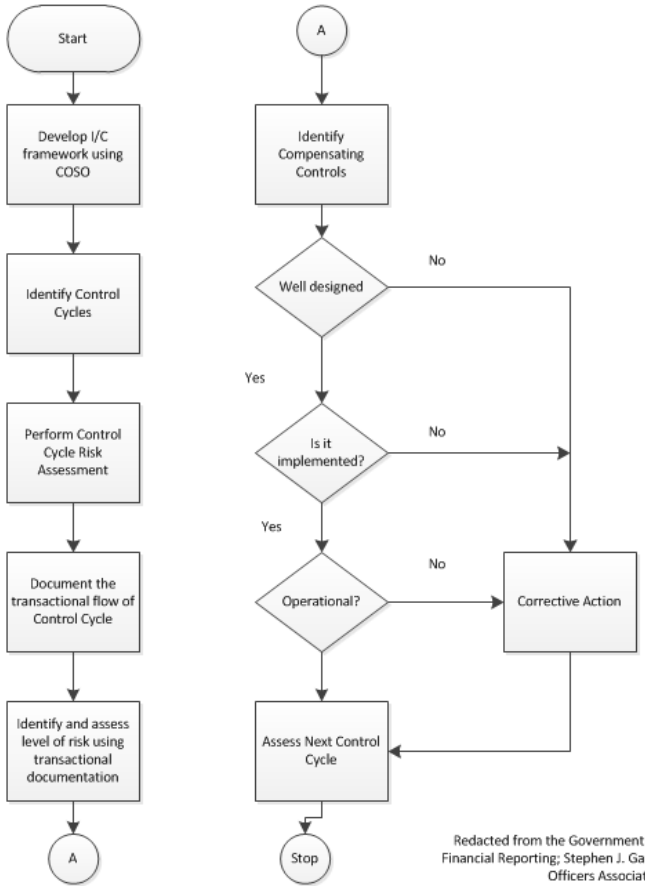
5. Monitoring Process

   This step provides the critical feedback loop for to maintain an effective system of internal control. To do so, management and staff must continuously monitor its financial management processes and system of internal control, which includes commissioning independent financial and operational audits.

   For this component, business process flows, reporting, and policies and procedures based on management or audit findings will be modified and refined, as the exchange embarks on its journey of continuous self-assessment and improvement.

For reference purposes, a flowchart of the internal control development process based on the COSO model is included below.

Internal Control Development Flowchart



Redacted from the Government Accounting, Auditing, and Financial Reporting; Stephen J. Gauthier, Government Finance Officers Association, 2005.

4. Exchange Business Requirements & Internal Control Procedures - Best Practices

4.1 QHP Certification Process

Certifying, offering, managing, and reporting on the performance of QHPs are core business functions of the HBE, and the ability to implement and perform these functions will involve several steps and will depend on much of the activities laid out in the following section.

4.1.1 Establish Certification Procedures

The HBE must establish a process to award certification to QHPs, consistent with the certification criteria outlined in § 155.1000(c). This process must be completed prior to open enrollment. In addition, the HBE must establish a process to recertify QHPs on an annual basis.

Further, the HBE must develop and maintain a process to monitor ongoing QHP compliance with certification criteria and establish a decertification process for plans found not in compliance. The decertification process must include a QHP appeal process and appropriate notification to the issuer, the state insurance bureau, HHS, and enrollees, who must be granted a special open enrollment period to change plans.

4.1.2 Premium Rates

The HBE will need to monitor premium rates offered by QHP issuers on regular basis. To support this, issuers must provide justification for requested rate increases to the HBE on annual basis. The HBE is responsible for reviewing this information prior to the effective date of the increase, and must incorporate both state guidance as well as information related to the rate of increase for products sold outside the HBE.

4.1.3 Benefits

While this does not come out directly from federal regulations, we believe establishing procedures for tracking benefits offered by QHP issuers is an important activity for efficient execution of the HBE's business operations.

4.1.4 Contract Management

To ensure that services provided by QHP issuers are continuous and flawless, it is imperative for HBE to have processes in place for managing contracts with QHP issuers. Contract management essentially covers certification, decertification and re-certification of carriers as QHPs.

4.1.5 Internal Control Procedures - Best Practices

Examples of Internal Control Objectives	Examples of Specific Activities in Support of Internal Control Objectives

QHP certification criteria document utilized for certifying QHP's are consistent with federal regulations and state law.	• Establish process in which documents prepared as part of the certification process are reviewed and authorized by senior management of exchange (examples include the ED, Legal Counsel, CFO, and COO). • Review QHP certification documents with exchange Board of Directors (BOD). • Ensure that the review of QHP certification documents with BOD is reflected in meeting minutes. • Document process of how QHP's were selected and/or reasons why an Issuer was not selected. • Review the application of selection criteria and the results with the BOD. • Document the review in meeting minutes.
Ensure Issuer compliance with QHP certification terms	• Review and document that each Issuer of QHPs continues to be in compliance with certification criteria. • Review and documentation should be approved by senior manager(s) of exchange.
Premium rate development and benefits provided by Issuers of QHP's are consistent with terms of QHP certification process	• Prior to open enrollment, verify that data submitted/interfaced with exchange systems are consistent with terms of the QHP certification process agreed to between exchange and Issuers of QHP's. • Verify information in support of data elements presented on exchange portal (such as premium rates) is consistent with information submitted by Issuers of QHP's to exchange. Data elements include; premium base rates, premium rate factors, benefits by actuarial value, provider network, etc. • Periodically sample premium rates offered inside and outside the exchange for same plan design to ensure rates are the same, or explain discrepancies.

Contract terms have been implemented timely and accurately	• Ensure contracts (or Memorandum of Understanding) or whatever legal form is in effect between Issuers of QHP's and the Exchange has been properly executed. • If Service Level Agreements (SLA's) are in effect, periodically calculate and review the metrics for compliance. • If any contract terms or SLA's are non-compliant, document and perform follow through as prescribed by Agreement. • Develop contract implementation plan and checklist to ensure all contract terms are being implemented, as well as timeliness of implementation (by both the Exchange and Issuers of QHP's).

4.2 Eligibility Determination

The HBE must assess eligibility for individuals seeking premium and cost-sharing subsidies, screen for Medicaid/CHIP, as well as eligibility for those not seeking subsidies to enroll in QHPs. The HBE must facilitate the eligibility determination process either directly or through contracting arrangements with other entities qualified to carry out this exchange function. The HBE must ensure a streamlined and coordinated eligibility determination process across Medicaid, CHIP, and HHS. The eligibility system must capture and verify required information to determine eligibility, support the ability to track changes in individual income, circumstances, and employment status, and interface with the required tax credit, enrollment, billing, and account management functions operated by or on behalf of the HBE.

4.2.1 Premium Tax Credits

The Secretary of HHS and Treasury will develop a system to calculate advance determinations of cost sharing reductions and tax credits based on individual eligibility criteria. Tax credit eligibility will be based upon household income in the most recent taxable year for which information is available. A tax filer is eligible for Advanced Payment of Premium Tax Credit (APTC) if he or she meets the requirements for eligibility for enrollment in a QHP through the Exchange and additional requirements as detailed in section 155.305(f) Eligibility standards of the HHS final rule CMS-9989-F. Once the HBE has determined individual eligibility for tax credits and/or cost-sharing subsidies, it must provide notification and information. The HBE must also promptly provide data when enrollees are terminated from coverage. The following entities must be notified related to Advanced Payments of Premium Tax Credits:

- QHPs – eligibility for and the amount of advance payments of premium tax credits and cost-sharing reductions.

- HHS – (1) eligibility for and the amount of advance payments of premium tax credits and cost-sharing reductions; and (2) enrollees' names in cases where the HBE determines eligibility based in part on a lack of affordable coverage provided by an individual's employer. This data enables HHS to begin, end or change the APTC amount.
- Treasury - To reconcile the amount of advance payments received by an individual with the amount allowed based on his or her tax returns.
- Employers – In cases when an employee is determined eligible for tax credits and subsidies based in part on a finding that the employer does not provide minimum coverage that is affordable.

4.2.2 Cost Sharing Subsidy & Other Subsidized Program

The HBE will determine if an individual is eligible for cost sharing reductions if he or she meets the eligibility requirements to enroll in a QHP; must be eligible for the APTC; and is expected to have a household income not to exceed 250% of FPL for the benefit year the coverage is requested. The Exchange must interface with the federal data hub system to calculate the amount of advance tax credits and cost sharing reductions for individual enrollees.

The HBE must implement procedures developed by HHS to evaluate changes in enrollee circumstances, such as substantially reduced income, changes in family size or household circumstances, change in filing status, the filing of an application for unemployment benefits, or other significant changes affecting eligibility.

4.2.3 Navigator Program

A Navigator is a private or public entity or individual that is qualified, and licensed if appropriate, to engage in activities such as public education and assistance related to eligibility, health programs, selection and enrollment in a QHP. The HBE is required to choose Navigators from the following entities: consumer focused non-profit groups, professional associations, commercial fishing organizations, chambers of commerce, unions, licensed brokers, Indian tribes, tribal organizations, and state or local human service agencies.

When evaluating candidates, the HBE must assess whether the Navigator has demonstrated existing relationships (or the ability to establish relationships) with employers, employees, consumers, and the self-employed and whether any conflict of interests exist. The HBE must also have the resources available to ensure that all Navigators meet any licensing, certification, or other standards prescribed by the Exchange, the state, or HHS as applicable.

4.2.4 Internal Control Procedures - Best Practices

Examples of Internal Control Objectives	Examples of Specific Activities in Support of Internal Control Objectives
Individuals identified as qualifying for tax credit	• No less than quarterly, on a test-basis, sample audit eligibility determination

or cost sharing subsidies legitimately qualify	results to ensure procedures for determining eligibility, appeals, and exceptions are consistent with federal and state regulations, is accurate, and rules-logic consistently applied. • If contracting out eligibility determination, establish audit procedures and reporting criteria to ensure determination logic is applied consistently and correctly. • Eligibility Notices - implement quality control procedures to ensure the correct information/data is delivered to the applicant. • Establish audit process to confirm verification process for APTC and CSR is accurate (key attestation data points – family size, annual household income, changes in household income).
Individuals identified as not qualifying for tax credit or cost sharing subsidies legitimately do not qualify	• Same as above.
Individuals identified as qualifying for other state-subsidized programs (Medicaid and other) legitimately qualify	• Same as above.
Small employers identified as qualifying for tax credit subsidies legitimately qualify	• Same as above.
Small employers identified as not qualifying for tax credit subsidies legitimately do not qualify	• Same as above.
Selected Navigators meet the eligibility criteria as established by the ACA and applicable regulations (including any state-specific criteria)	• Establish process in which documents prepared as part of Navigator selection criteria are reviewed and authorized by senior management of exchange (examples include the ED, Legal Counsel, CFO, and COO). • Develop certification and training standards and periodically assess each Navigator against the standards.

Develop contract for rights and obligations between Navigators and Exchange	• Ensure contract has been approved by Exchange senior management prior to sharing with Navigators. • Verify contract has been properly executed by senior management of the Exchange and the Navigator entity. • Develop contract implementation plan and verify terms are implemented timely and accurately. Ensure document is reviewed and approved by senior level person of exchange. • Monitor any Navigator compensation program that is created.

4.3 Enrollment

Once an individual has selected a plan, the HBE must notify the issuer of the enrollee's selection and transmit information necessary for the carrier to enroll the applicant.

The HBE must send enrollment information to carriers on a timely basis and develop a process by which carriers can verify and acknowledge the receipt of this information. Enrollment information must be reconciled with QHP issuers no less than monthly. The HBE must maintain records of all enrollments in QHPs through the HBE and submit enrollment information to HHS on a monthly basis.

4.3.1 Enrollment

The HBE must integrate its core technology and back office solutions with multiple stakeholders to offer a user friendly health insurance comparison shopping experience. With the "no wrong door" approach, the exchange will provide screening and enrollment into the appropriate insurance programs, whether it is Medicaid, CHIP, subsidized or non-subsidized non-group or small business.

4.3.2 Termination

The HBE and/or issuers may terminate coverage in the following circumstances:

- Loss of eligibility
- Access to minimum essential coverage
- Lack of payment beyond three month grace period
- Coverage is rescinded
- The QHP is terminated or decertified
- The enrollee changes from one QHP to another during annual open enrollment or special enrollment period

4.3.3 Internal Control Procedures - Best Practices

Examples of Internal Control Objectives	Examples of Specific Activities in Support of Internal Control Objectives
Submit listing of enrolled members to Issuers of QHP's & ensure Issuer receipt of data	• Monthly, reconcile enrollment from the exchange enrollment system to the 834 Form submitted to Issuers of QHP's. • Research discrepancies and document follow up. • Submit the reconciled enrollment listing noted above to Issuers of QHP's. • Receive Issuer acknowledgement of data receipt and file.
Develop & submit monthly a listing of enrolled members to HHS	• The reconciled enrollment list between Exchange and Issuers of QHP's (as described above) should be the same listing sent to HHS (to ensure a consistent set of figures among key parties.) • Develop a process to ensure HHS is in receipt of data and data received is consistent with data submitted.
Verify amount of APTC & Cost-Sharing reduction funds flow between Treasury and Issuers of QHP's	• For enrolled members, from the exchange enrollment system, develop a data extract listing individuals receiving APTC and Cost-sharing reductions including the amount of the subsidy. • Submit this enrollment extract to Issuers of QHP's, HHS, and Treasury. • Use this extract as source of reconciliation of APTC and cost-sharing reduction funds flow between Issuers of QHP's and Treasury. • Document any discrepancies and follow-up with Treasury and Issuers for resolution of discrepancy.
Track status of members for change in circumstances such as; switch QHP, loss of eligibility, significant event change, non-payment	• Periodically verify accuracy of a change in a member enrollment record. For example, reconcile enrollment file for member terminated due to non-payment with general

status, etc.	ledger and premium billing records (to ensure accuracy and timeliness of termination).

4.4 Premium Billing

Draft regulations do not specify HBE responsibilities with respect to premium billing and collections. The HBE can bill members and collect payments on behalf of QHP issuers, or enrollees may choose to pay carriers directly. For enrollees who elect to make payments through the HBE, the HBE will need to develop the capacity to generate bills, process electronic funds transfer and/or credit card payments, and generate receipts. Uniform policies should be established across carriers for enrollment, billing cycles, collections, late payments, and termination for non-payment.

4.4.1 Invoicing

This activity does not directly come from federal regulations but arises as an important business need. The HBE needs to generate bills based on the plans selected by enrollee and mail the invoice to enrollees.

4.4.2 Collections

Once the premium bill is sent to enrollee, payment needs to be collected. This activity can either be performed by exchange or can be outsourced to any third party vendor.

4.4.3 Lockbox

Lockbox service can be utilized by the HBE to facilitate collections of premium payments from enrollees in efficient and effective manner.

4.4.4 Internal Control Procedures - Best Practices

Examples of Internal Control Objectives	Examples of Specific Activities in Support of Internal Control Objectives
Billing activity is valid, complete, accurately calculated, and quoted	• No less than quarterly, sample-test member accounts and perform the following: - Recalculate invoice amounts using member demographic data from the enrollment system - Verify the effective date of coverage is consistent with enrollment file - Account adjustments have been properly approved consistent with exchange policies.

	• Establish Quality Assurance procedures to ensure the monthly invoicing process contains the correct member account and premium information prior to mailing the invoices. • Establish Quality Assurance procedures to ensure if payment is posted by cutoff date of enrollment effective date.
Billing activity is properly reflected in the general ledger	• Monthly, reconcile premium billing transaction history to the general ledger.
Member accounts that are adjusted or terminated (for example, member non-payment) are timely and accurate	• The ability to process member write-offs and adjustments is properly restricted in the premium billing system. • Adjustment, write-off or account termination is reviewed to ensure posting is in correct period. • Write-offs and adjustments are approved by a senior manager prior to transaction posting and invoice generation.
Exchange administrative fees that are derived as a percent of premium billings is accurately calculated	• Periodically manually calculate amount of exchange administrative fees derived as a percent of premium. • Verify and trace manual calculation to premium billing system and general ledger.
Lockbox postings are reconciled to general ledger	• Daily, trace all cash lockbox postings to the general ledger. • Review should be reviewed and approved by a person senior to person performing the review.
All receipts are reconciled to a member account	• A cash receipt that cannot be posted to a member account is recorded in a suspense account. • Suspense account is cleared daily. • Cash receipt is researched and posted to appropriate member account or returned to payer.

Cash receipts are properly accounted for and reconciled	• All general ledger cash accounts are reconciled to associated bank statements on a monthly basis. Reconciling items are investigated and corrected in a timely manner.

4.5 Financial Administration

4.5.1 Vendor payments, Budgeting and acquisition of capital assets

The HBE must keep an accurate accounting for all activities, receipts, and expenditures and must submit an annual financial report to the Secretary of HHS. The HBE must publish the costs and fees associated with operating the organization, including the average cost of licensing, required regulatory fees and payments to operate the exchange, HBE administrative costs, and an accounting of money lost to fraud, waste, and abuse.

4.5.2 Internal Control Procedures - Best Practices

Examples of Internal Control Objectives	Examples of Specific Activities in Support of Internal Control Objectives
All purchases for goods and services are valid, complete, authorized and entered into AP/Purchasing system timely	• Purchase orders are processed only against valid vendors on a pre-approved master vendor list. • All purchases, including contracts are approved by senior level staff and consistent with exchange documented policies and procedures. • All disbursements, including wire transfers are properly approved and authorized. • New vendors added to the master vendor list are properly approved and effective date of contracts /disbursements should occur after date of approval of vendor to master list.
Cash disbursements are properly accounted for and reconciled	• All general ledger cash accounts are reconciled to associated bank statements on a monthly basis. Reconciling items are investigated and corrected in a timely manner.
Payroll related data are accurately calculated and recorded to the general ledger	• Ability to change payroll information such as salary, withholdings, employee

	additions/deletions, is appropriately restricted. • Any changes to an employee payroll record is reviewed and approved by a person senior to person making change. • Salary amount is reconciled to employee offer letter and subsequent job performance evaluations. • Bonus payments are approved by appropriate personnel of exchange and evidence of approval is validated prior to processing change. • Payroll register is reconciled to general ledger monthly. • Payroll register is reviewed and approved prior to submitting for payment.
Capital assets are valid, authorized, accurately valued and recorded in the general ledger in the appropriate period	• Physical observations of capital assets are performed periodically. • Differences between physical counts and general ledger balances are investigated and reconciled timely. • Capital asset disposals are appropriately authorized. • Evidence of authorization of disposal is maintained. • Capital asset sub-ledger is reconciled to the general ledger, including accumulated depreciation. • Depreciation methodology, by asset type, is documented and maintained.
Leases are authorized and properly recorded in accordance with US GAAP and exchange policy	• Lease classifications are properly reviewed to ensure consistency with US GAAP and appropriate financial statement disclosure.
Financial planning and monitoring is performed regularly	• Exchange management develops realistic business plans and budget targets for comparison with actual performance. • Significant variances to budget are explained. • Budget to actual performance shared with

	BOD periodically, but at least quarterly.

4.6 Operational Administration

4.6.1 Human Resources, Policies & Procedures, Appeals

Areas of focus for this business requirement include the administration of employee benefits and the development of HR Policies & Procedures. Appeals regarding eligibility determination and the issuance of certificates of exemption from the individual responsibility requirement will be a newly developed process, as well as contract management, security of data and equipment, and operational policies and procedures.

For many start up organizations, this area is generally not fully developed until an external event precipitates the need. As a highly transparent entity, the HBE should have much of this area, except for the appeals function, completed prior to the heavy ramp up of HBE staff in late 2012. For example, the employee handbook should include rules in areas such as office hours, attendance expectations, training and hiring, annual reviews and employee leave. The Exchange will also need to develop Purchasing and Contracting Policies, Corporate Planning, Regulatory Compliance, Federal Regulation Review, Disaster Response, as well as a formal process for regular updates and revisions.

The HBE must develop or make provision for the requisite administrative infrastructure such as human resources, developing organizational policies & procedures, contract management to carry out the regulatory requirements outlined in the ACA and regulations, as well as the policy and business goals of the HBE.

4.6.2 Internal Control Procedures – Best Practices

Examples of Internal Control Objectives	Examples of Specific Activities in Support of Internal Control Objectives
Polices & Procedures are developed, adopted, and approved by exchange management and staff	• Exchange maintains formal job descriptions for all positions within the organization defining responsibilities, required experience, and educational minimums. • Succession plans are developed for all key senior managers and financial reporting and accounting personnel. • Performance evaluations are provided to staff no less than annually and a copy retained in employee file. • A Continuity of Operations Plan (COOP) is

	developed for the organization to ensure exchange is able to perform essential functions under a broad range of circumstances.
Exchange Periodically assesses its system of internal control to ensure they are working as designed	• An annual risk assessment is performed, including the risk of fraud, by senior management. • If gaps in the system of internal control are detected, a remediation plan is developed to correct.
Internal controls provide reasonable assurance that computer systems are appropriately tested and validated prior to being placed in production	• System interfaces are tested periodically to ensure data transmissions are complete. • Conversion of data is tested between its origin and its destination to ensure complete, accurate, and valid.
Controls provide reasonable assurance that IT components related to security, processing, and availability are protected and prevent any unauthorized changes	• Procedures are developed and implemented to ensure IT systems and technology is properly protected from viruses. • Periodic testing is performed to confirm software and network infrastructure is appropriately configured. • IT department has implemented procedures to ensure regular backup of data and programs. • Procedures exist and are followed to authenticate all users of the exchange system to support the validity of transactions, especially financial in nature.
Appeals responsibility is appropriately performed, consistent with Federal and state laws	• Appeal cases should include a secondary review of the case finding to ensure adequate oversight. • A review of all appeal findings should be shared with the BOD on a regular basis.

4.7 Reporting

4.7.1 Notification of eligibility, financial, and management reports

The HBE must keep accurate accounts and provide an annual financial report to HHS. In addition to receiving such reports, the Secretary of HHS will conduct annual audits and may also require additional financial reports and/or conduct investigations of Exchange financial activities at any time. The HBE must publish the costs and fees associated with operating the organization, including the average cost of licensing, required regulatory fees and payments to operate the Exchange, Exchange administrative costs, and an accounting of money lost to fraud, waste, and abuse.

In addition to the federal requirements, the exchange will also likely be subject to state-specific requirements to the legislature, Exchange BOD, stakeholders and other interested business partners and related parties.

4.7.2 Internal Control Procedures – Best Practices

Examples of Internal Control Objectives	Examples of Specific Activities in Support of Internal Control Objectives
Financial Statements and related disclosures are sufficiently prepared and adequately reviewed	• Financial statements and related disclosures are review regularly with BOD. • Senior managers of Exchange review financial statements monthly and any queries are appropriately addressed and incorporated in future drafts. • Evidence of senior manager review is maintained. • Financial statement disclosure checklist is utilized to ensure relevant financial information is properly disclosed. • Balance sheet fluctuation analysis is performed monthly for significant accounts. Analysis includes review of current period to prior period and to prior year end. Significant variances are researched and explained.
Non-financial information is assessed by the exchange for accuracy and validity	• Information disclosed by the exchange is verified for accuracy and completeness prior to disseminating. • Evidence of this review is documented and

	retained. • Required reconciliations and data submissions, such as enrollment to HHS, are reviewed by a person senior to the person preparing such reports prior to submission. Evidence of such review is retained.
Exchange regularly compares actual results to forecast	• Operating results are compared to budgets and prior periods. • Unusual fluctuations are investigated and explained. • Necessary adjustments are recorded and documented.

4.8 Consumer Assistance Tools

4.8.1 Call Center / Website / QHP Appeals

The HBE must provide a consumer assistance program, including a toll-free telephone number and accessible web portal. When available and appropriate, the HBE must also refer individuals to other appropriate consumer assistance programs in the State.

Federal statute and regulations determine much of the content of this business requirement. For example, the HBE website must include information for each available QHP, including premium and cost-sharing information, a summary of benefits and coverage, and the plan's rating tier (bronze, silver, gold, or catastrophic). The Exchange must also make accessible QHP provider directories received during the QHP certification process.

Further, the HBE must publish the results of enrollee satisfaction surveys conducted by the Secretary of HHS, plan quality ratings, plan medical loss ratio information, and measures of QHP coverage transparency.

In addition to QHP plan features (premium, cost-sharing, benefits summary, rating tier, etc.) the HBE must publish information about QHPs that would be helpful to consumers when comparing available health plans. Specifically, the ACA requires the Exchange to rate QHPs on the basis of quality and price.

Quality ratings will be determined based upon data collected from health issuers during the certification process (and thereafter).

4.8.2 Internal Control Procedures – Best Practices

Examples of Internal Control Objectives	**Examples of Specific Activities in Support of**

	Internal Control Objectives
Call center operations and website are readily accessible, fully functioning, and properly supported by secondary systems	• Periodic testing is performed to ensure confirm that software and network infrastructure is appropriately configured. • IT management has defined and implemented a problem management system such that data integrity and access control issues are recorded, analyzed, and resolved in a timely manner and reported to management. • IT security monitors and logs security activity and identified security violations are reported to senior management. • Calls are periodically monitored for quality control assessment and deficiencies documented and addressed with appropriate CSR representative. • Call center scripts and supporting information periodically reviewed and updated to ensure information reflects most current data screens.
Information on website is accurate and complete	• Information disclosed by the exchange is verified for accuracy and completeness prior to disseminating. • Evidence of this review is documented and retained.
Information presented to enrollees is accurate an consistent with Issuer of QHP data	• Periodically compare information disseminated to enrollee's to source data of information such as summary of plan benefits to Issuer information.

4.9 Regulatory Compliance

4.9.1 BOD and Exchange Governing Principles

The HBE must adopt and publish its governance principles, which must include standards for ethics, conflict of interest, accountability, transparency, and disclosure of financial interest. HHS may periodically review the accountability structure and governance principles of a State Exchange.

In addition, the HBE will be subject to Federal & State financial and operational audits.

4.9.2 Internal Control Procedures – Best Practices

Examples of Internal Control Objectives	Examples of Specific Activities in Support of Internal Control Objectives
BOD and Senior Management of Exchange establishes an overall attitude and awareness concerning the importance of compliance and internal controls	• Exchange maintains a code of conduct and policy related to conflicts of interest. • BOD is involved in evaluating the effectiveness of the "tone at the top" and management's adherence to the code of conduct • The HBE maintains a "Whistleblower" policy including a confidential hotline or other communication channel for employees to freely and anonymously report improprieties or deviations from Exchange policies. • The BOD maintains specific committees. Examples include: Audit & Finance, Policy, Compensation & Benefits, etc. • Exchange performs a review of independence for all BOD's which includes a search and disclosure of affiliations, relationships, financial interests to individuals and organizations doing business with the exchange.

5. High-Level Assessment of Existing State Programs

Due to a combination of state resource constraints and the timing of completion of this report, Wakely was able to interview one state agency called the Iowa Insurance Division (IID) and one subsidized health insurance program for children called healthy and well kids in Iowa or (hawk-i). Through these discussions, we determined that the IID did not have business functions that readily crosswalk to the business functions of an exchange in relation to developing a system of internal control. However, the hawk-i program, which is a state-subsidized health insurance program for children of low-income families, possessed a number of areas that could be leveraged when designing and implementing a system of internal control for the HBE. Our findings regarding the hawk-i program is summarized below.

5.1 Healthy and Well Kids in Iowa (hawk-i)

Based on a review of documentation and discussions with hawk-i personnel, we believe a number of the existing functionalities managed and administered by the hawk-i program can be leveraged for certain business and financial operations that the HBE will need to perform. The hawk-i program is managed by a modest number of staff who are full-time employees of the Iowa's Department of Health and Human Services. Oversight of the program is provided by a Board of Directors. A significant number of back-office functions of the program are administered by a third-party administrator (TPA) that is hired by the State. The overarching structure of this program with a BODs, highly outsourced businesss operations, providing subsidized health insurance through private health insurance carriers, and significant public outreach is not that dissimilar to how an HBE will be structured. Therefore, the set-up of this program offers an excellent proxy for a how system of internal control for ther HBE might be developed.

To provide a high level overview of how good of a fit exists between hawk-i and the HBE business requirements, we utilized the Wakely proprietary tool to cross walk the exchange business requirements to the program features of the hawk-i program. Please see **Table 3** in the appendix for the results of this high level analysis.

More specifically, The following hawk-i program features were reviewed and evaluated in performing our high level system fit analysis:

- **Data Matching –** Electronic data matching with external agencies such as the SSA, IRS, etc., to verify the authenticity of the data submitted by prospective enrollees. One of the major business requirements of the HBE is to screen applicants for authenticity of the data submitted. Strong internal controls need to be in place to avoid fraud and abuse. As hawk-i currently employs data match processes in which it verifies the data submitted by its applicants with the Social Security Administration (SSA), we believe this is an area to evaluate the controls that are operating in the hawk-i data match process. These controls

can be strengthened to reflect the additional complexity and risk associated with the inclusion of the new data match requirements of the HBE.

- **Premium Billing and Collections –** The current process of mailing invoices to enrollees and collecting payments appear to have strong performance integrity standards. In addition, the TPA currently hired by the State is a leading service provider in fulfilling premium billing and collections needs for government agencies, so has expertise in necessary integrity measures for public programs. The standard processes in use have evolved over time to reflect the needs of the hawk-i program. The Exchange HBE staff should evaluate these processes and perform a gap analysis between the industry best practices recommended in this report and current controls & processes in operation by the TPA on behalf of hawk-i.
- **Quality Improvement Strategies –** To ensure the delivery of high quality services provided by Issuers of QHP's, the HBE must evaluate quality improvement strategies and oversee implementation of enrollee satisfaction surveys, assessment and ratings of health care quality and outcomes, information disclosures, and data reporting pursuant to sections 1311(c)(1), 1311(c)(3), and 1311(c)(4) of the ACA. The hawk-i program has set clear and distinct performance standards for the TPA to ensure the quality of service provided to hawk-i enrollees. In addition, hawk-i also has a clinical advisory committee who meets on a quarterly basis to discuss the quality of health care provided through the program. This committee along with the existing performance benchmarks designed for the TPA can be a good reference benchmark for the HBE in designing the business process of the HBE regarding the collection of data, analyzing data, and developing new practices to improve the satisfaction level of enrollees.
- **Customer Service Center –** Regulations published by the Department of Health and Human Services outlines the standards for a number of consumer assistance tools and activities that exchanges must provide. One of the consumer assistance tools requires the HBE to provide for the operation of a call center to respond to requests for assistance by consumers that is accessible via a toll-free telephone number. Based on our discussions, the TPA is currently serving the customer service and call center needs of the hawk-i program. Understanding the process flows, and date integrity standards in use for this system will be an important reference point in establishing the internal control framework for the needs of the HBE regarding consumer assistance call center.
- **Payment Processing –** A design option for states is to have the HBE manage the process of collecting premium payments from enrollees and paying QHP issuers. Considering the sensitive nature of these financial transactions, there is a need for strong internal controls to be in place to prevent fraud in payment and collections processes. As the hawk-i program uses a capitation payment model to pay participating health plans and invoices members for monthly premium payments, this is another area in which the HBE could look to the TPA relative to processes and protocols regarding vendor payments and working with carriers.
- **Vendor Relationship Development –** Activities associated with vendor management and relationship development, such as developing RFP's, vendor selection, negotiating and

executing contracts, and contract management will be an important core competency of the HBE. While discussing the hawk-i program, it was clear that program administrators have a mature vendor selection process for contracts in excess of $25,000. The HBE should consider reviewing the policies and procedures in this area when developing the Purchasing/Payable internal control framework for the exchange.

The functions noted above offer the most promising areas of the hawk-i program that may be able to be leveraged by the HBE. A more detailed gap analysis of all the business processes and internal controls in operation for the hawk-i program relative to the business requirements of the HBE noted by Wakely in this report should be performed.

Since most of the business and financial operations of the hawk-i program are outsourced to a TPA, in addition to the specific internal controls procedures in effect for the functional areas noted above, we would recommend consideration of the following criteria in any future detailed assessment or gap analysis:

- **Scalability:** hawk-i is serving the needs of 40,000 enrollees. The Exchange is expected to be between 203,000 to 266,000 enrollees. Therefore, a critical evaluation regarding the scalability of the processes and services provided by the TPA will be necessary.
- **Reliability:** In its first few years of operations, the HBE will be under tight scrutiny by the public and federal agencies. It will be imperative that the HBE ensure the reliability of the services provided.
- **Ability to meet compliance requirements:** As a new entity at the forefront of heath care reform implementation, the HBE will be highly visible. One of the quickest ways to lose credibility and trust is to fail to comply with federal laws and regulations. The HBE will need to ensure that controls are adequate for the high degree of transparency and reporting that will be required.

6. CONCLUSION

The state's health benefit exchange will be a highly transparent organization, interfacing with a number of business partners, stakeholders, and residents of Iowa. Additionally, as a new business entity, it will need to perform at a high level right from the start of operations. Therefore, a strong system of internal control to ensure the integrity of its systems, completeness of its data, and accuracy of its reports will be critical to its ultimate success.

While the HBE will be required to develop a number of processes and implement functions not performed by existing state agencies or programs, we have minimally identified the hawk-i program as a area to further analyze and assess in order to leverage existing best practices for the design of the HBE system of internal control.

7. APPENDIX

7.1 Table 1

Exchange Business Requirements - Financial Operations	Internal Control Objective							
	E/W	E/O	C	V	R/O	P/D	F	R
QHP Certification Process								
- Establish Certification Procedures		X	X					
- Premium Rates				X	X	X		
- Benefits					X	X		
- Contract Mgmt	X	X						
Eligibility Determination								
- Premium Tax Credits		X	X	X			X	
- Cost Sharing Subsidy		X	X	X			X	
- Other Subsidized Program		X	X				X	
- Navigator Program		X	X					
Enrollment								
- Advanced Premium Tax Credit & Cost Sharing Reduction		X	X	X				X
- Change in application		X	X	X				
- Termination		X	X	X				
Premium Billing								
- Invoicing		X	X	X	X		X	
- Collections (ACH; Credit Card, Cash; etc.)			X	X	X			
- Lockbox			X	X	X			
Financial Administration								
- Payroll		X	X	X	X		X	
- Pay Issuers of QHPs				X	X		X	

- Pay Brokers				X	X		X	
- Pay Navigators				X	X		X	
- Purchase Goods/Services				X	X		X	
- Capital Asset Tracking				X	X			
- Budgeting	X					X		X
Operational Administration								
- Human Resources								
- Develop P&P's - Logical and physical access policy - Security Policy - HR Policy	X					X		
- Appeals (Eligibility & Certificates of Exemption from Individual Resp.)					X		X	
- Contract Mgmt		X	X		X			
- Privacy and Security of Enrollee information	X		X			X		
Reporting								
- Notification of Employer/Employee Eligibility		X	X		X			
- Financial Statements			X	X		X		
- Management Reports								
- Enrollee Satisfaction			X			X		
- Assessment and ratings of health care quality			X			X		
- Reporting of enrollment records annually		X	X			X		
- Submit and reconcile enrollment information with HHS on monthly basis		X	X					
Consumer Assistance Tools								
- Call Center	X		X		X			
- Internet Website	X		X		X			
- Coverage Information								
- Compare Health Plans and Pricing								

- Premiums and cost-sharing information								
- Publish financial information								
- Contact information								
- Outreach and education activities	X				X			
- Appeals process for decertified health plans			X		X	X	X	
Compliance								
- Publication of governance principles and disclosures of financial interest of the governing members	X		X			X		

Legend:
E/W - Entity Wide
E/O - Existence & Occurrence
C - Completeness
V - Valuation or Allocation
R/O - Rights & Obligations
P/D - Presentation & Disclosure
F - Fraud
R - Reasonableness

7.2 Table 2

Exchange Business Requirements - Financial Operations	Requirement Reference:		
	NPRM Regulation	Bus. Ops per FOA	Wakely Identified Business Need
QHP Certification Process		**Y**	
- Establish Certification Procedures	Reg § 155.1010 Paragraph a		
- Premium Rates			✓
- Benefits			✓
- Contract Mgmt			✓
Eligibility Determination		**Y**	
- Premium Tax Credits	Reg § 155.200 Paragraph c	**Y**	
- Cost Sharing Subsidy	Reg § 155.200 Paragraph c		✓
- Other Subsidized Program	Reg § 155.200 Paragraph c		
- Navigator Program	Reg § 155.210 Paragraph b	**Y**	
Enrollment		**Y**	
- Advanced Premium Tax Credit & Cost Sharing Reduction	Reg § 155.200 Paragraph c	**Y**	
- Change in application			✓
- Termination	Reg § 155.430		
Premium Billing			
- Invoicing			✓
- Collections (ACH; Credit Card, Cash; etc.)	Reg § 155.240 Paragraph d		
- Lockbox			✓
Financial Administration			
- Payroll			✓
- Pay Issuers of QHPs			✓
- Pay Brokers			✓

- Pay Navigators			✓
- Purchase Goods/Services			✓
- Capital Asset Tracking			✓
- Budgeting			✓
Operational Administration			
- Human Resources			✓
- Develop P&P's - Logical and physical access policy - Security Policy - HR Policy			✓
- Appeals (Eligibility & Certificates of Exemption from Individual Resp.)	Reg § 155.200 Paragraph b	**Y**	
- Contract Mgmt			✓
- Privacy and Security of Enrollee information	Reg § 155.260		
Reporting			
- Notification of Employer/Employee Eligibility	Reg § 155.715 Paragraph e & f	**Y**	
- Financial Statements	Reg § 155.200 Paragraph e		
- Management Reports			
- Enrollee Satisfaction	Reg § 155.200 Paragraph f		
- Assessment and ratings of health care quality	Reg § 155.200 Paragraph f	**Y**	
- Reporting of enrollment records annually	Reg § 155.200 Paragraph f	**Y**	
- Submit and reconcile enrollment information with HHS on monthly basis	Reg § 155.400 Paragraph c & d		
Consumer Assistance Tools			
- Call Center	Reg § 155.205 Paragraph a	**Y**	
- Internet Website	Reg § 155.205 Paragraph b	**Y**	
- Coverage Information	Reg § 155.205 Paragraph b		
- Compare Health Plans and Pricing	Reg § 155.205 Paragraph b		

- Premiums and cost-sharing information	Reg § 155.205 Paragraph c		
- Publish financial information	Reg § 155.205 Paragraph b		
- Contact information	Reg § 155.205 Paragraph b		
- Outreach and education activities	Reg § 155.205 Paragraph e	**Y**	
- Appeals process for decertified health plans	Reg § 155.1080 Paragraph d		
Compliance			
- Publication of governance principles and disclosures of financial interest of the governing members	Reg § 155.110 Paragraph d		

7.3 Table 3

Exchange Business Requirements - Financial Operations	Business Requirements that hawk-i might fulfill
QHP Certification Process	
- Establish Certification Procedures	
- Premium Rates	
- Benefits	
- Contract Mgmt	
Eligibility Determination	
- Premium Tax Credits	✓
- Cost Sharing Subsidy	
- Other Subsidized Program	
- Navigator Program	
Enrollment	
- Advanced Premium Tax Credit & Cost Sharing Reduction	
- Change in application	✓
- Termination	✓
Premium Billing	
- Invoicing	✓
- Collections (ACH; Credit Card, Cash; etc.)	✓
- Lockbox	✓
Financial Administration	
- Payroll	✓
- Pay Issuers of QHPs	✓
- Pay Brokers	✓
- Pay Navigators	
- Purchase Goods/Services	✓

- Capital Asset Tracking	
- Budgeting	
Operational Administration	
- Human Resources	
- Develop P&P's - Logical and physical access policy - Security Policy - HR Policy	
- Appeals (Eligibility & Certificates of Exemption from Individual Resp.)	
- Contract Mgmt	
- Privacy and Security of Enrollee information	
Reporting	
- Notification of Employer/Employee Eligibility	
- Financial Statements	✓
- Management Reports	✓
- Enrollee Satisfaction	
- Assessment and ratings of health care quality	
- Reporting of enrollment records annually	
- Submit and reconcile enrollment information with HHS on monthly basis	
Consumer Assistance Tools	
- Call Center	✓
- Internet Website	✓
- Coverage Information	
- Compare Health Plans and Pricing	
- Premiums and cost-sharing information	
- Publish financial information	
- Contact information	

- Outreach and education activities	
- Appeals process for decertified health plans	
Compliance	
- Publication of governance principles and disclosures of financial interest of the governing members	