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COLORADO HEALTH INSURANCE BENEFITS EXCHANGE: CONNECT FOR HEALTH COLORADO



JUNE 2017

PERFORMANCE AUDIT

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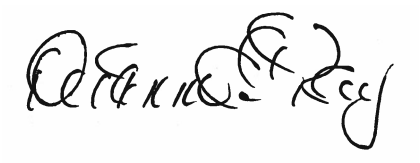
DIANNE E. RAY, CPA
STATE AUDITOR

June 28, 2017

Members of the Legislative Audit Committee:

This report contains the results of a performance audit of the State's health insurance benefits exchange, Connect for Health Colorado (Connect for Health). The audit was conducted pursuant to Section 10-22-105(4)(c), C.R.S., which authorizes the State Auditor to conduct performance audits of Connect for Health. The report presents our findings, conclusions, and recommendations, and Connect for Health's responses.



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CONTENTS

STATE · OF · COLORADO
UNION AND CONSTITUTION
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1876

REPORT HIGHLIGHTS

COLORADO HEALTH INSURANCE BENEFITS EXCHANGE: CONNECT FOR HEALTH COLORADO

PERFORMANCE AUDIT, JUNE 2017

KEY CONCERNS

Connect for Health Colorado (Connect for Health) has strengthened its financial management and internal controls related to procurement, contracting, and grants since 2014 and has taken steps to become financially self-sustaining without public funds. However, we found that financial policies and procedures are not consistently followed, and customer service related to appeals and complaints needs improvement.

KEY FINDINGS

- Connect for Health took steps to control costs, increase revenues, and monitor its financial position after our 2014 Limited Performance Audit. For example, over Fiscal Years 2015 to 2017, it cut $18.5 million in costs by renegotiating major contracts and reducing administrative expenses. While these steps help ensure the organization will be financially sustainable without federal and state funds, significant changes to the Affordable Care Act could reduce Connect for Health's fee revenue from the sale of health plans, limiting its ability to operate in the future.

- Management and staff did not comply with financial policies, procedures, and/or contract provisions for $50,700 (11 percent) of sampled payments and $3.99 million in contract costs we reviewed. For example, some vendor and grantee payments lacked complete documentation to support the payments, one contract was paid more than the contracted amount, and grantees performed work before contracts were executed.

- From Fiscal Year 2014 to Fiscal Year 2016, Connect for Health improved its customer service and website functionality. For example, call center wait times were reduced from 11 minutes in 2014 to less than 3 minutes in 2016, and website tools were added to help consumers evaluate the costs and benefits of health plans and calculate financial assistance.

- Connect for Health did not always resolve appeals in a timely manner or maintain data needed to track appeals and complaints. For example, in 2016, data was incomplete or inaccurate for 42 out of the 153 appeals, and one-third of appeals were not resolved within the 90-day federal timeline. In addition, Connect for Health's customer complaint filing process is confusing and challenging.

BACKGROUND

- Pursuant to the federal Affordable Care Act, Connect for Health was established in 2011 to operate Colorado's health exchange where individuals can purchase private health insurance. The organization is a non-profit overseen by a 12-member Board of Directors and administered by a Chief Executive Officer.

- Connect for Health transitioned from a start-up funded with federal grants in Fiscal Year 2012 to a self-sustaining organization that receives no government funding in Fiscal Year 2017.

- About 178,000 Coloradans enrolled in a 2017 private health plan through the exchange, with 108,600, or 61 percent, receiving federal financial assistance with their health insurance costs.

KEY RECOMMENDATIONS

- Improve controls over procurement, contracting, and grants management by updating written policies and procedures to reflect current processes, revising contracts to reflect vendor performance expectations and payment documentation requirements, training staff, and developing a corrective action plan to address all audit findings.
- Conduct reviews to ensure that staff comply with written policies and procedures.
- Report the timeliness of appeals to the Board and prioritize appeals handling to help meet timeliness standards.
- Implement a written complaint process and update the website to provide clear instructions on complaint filing.

Connect for Health agreed with these recommendations.

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CHAPTER 1

OVERVIEW

The Patient Protection and Affordable Care Act of 2010 (Affordable Care Act, or Act) requires that all Americans obtain health insurance or pay a penalty [26 USC 5000A], and it authorized federal funding to establish health insurance exchanges. According to the Centers for Medicare and Medicaid Services (CMS) within the federal Department of Health and Human Services (HHS), a health insurance exchange is a competitive, organized marketplace that helps consumers shop for and compare available health plans based on prices and benefits, and helps reduce the overall costs of health plans by spreading risk across a large pool of consumers.

HEALTH EXCHANGES

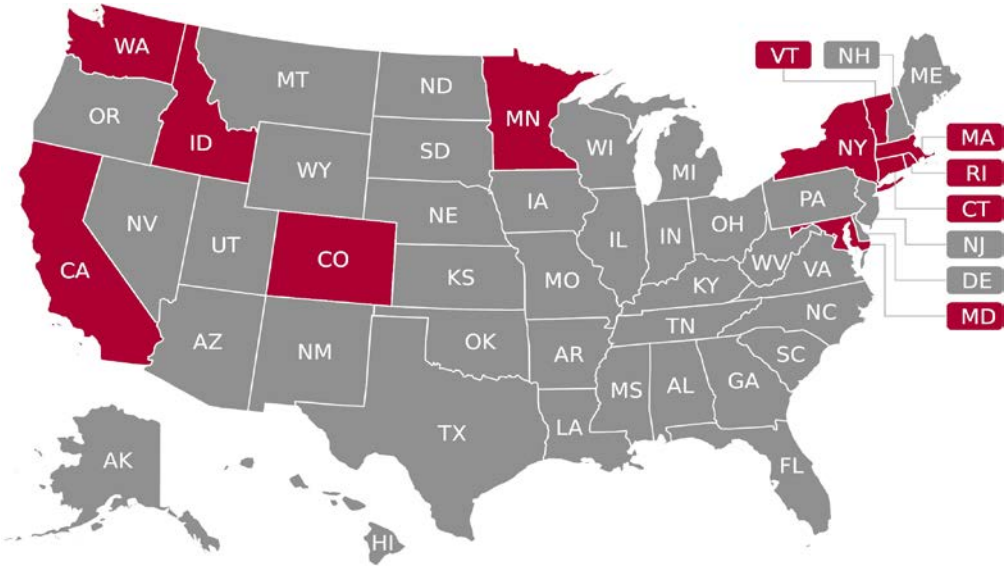
The Act [42 USC 18041] requires states to use one of two types of health exchanges:

- **FEDERALLY-FACILITATED EXCHANGE,** administered by HHS, if the state does not have its own exchange. As of May 2017, there were 39 states using the federal exchange. Residents of these states enroll in a health plan through the federal website, and in some states, the state helps administer certain aspects of the exchange, such as customer service.

- **STATE-BASED EXCHANGE** created by the state and operating as either a government agency or nonprofit organization outside of government. Each state exchange administers a state-based website to enroll its residents in health insurance plans and provides consumers assistance in enrolling in a plan. As of May 2017, there were 11 states, including Colorado, with a state-based health insurance exchange.

EXHIBIT 1.1 shows the 11 states with a state-based exchange (in red) and the remaining 39 states using the federal exchange (in gray).

EXHIBIT 1.1. HEALTH EXCHANGES IN THE UNITED STATES AS OF MAY 2017



SOURCE: Office of the State Auditor analysis of federal and state health exchange data.

The Act also gives states the option to offer a Small Business Health Options Program (SHOP) to help small businesses shop for and provide health care coverage for their employees. States that do not administer their own SHOP marketplace refer small businesses to the federal SHOP marketplace. As of May 2017, there were 15 states that operated their own SHOP marketplaces—the 11 state-based exchanges and Arkansas, Mississippi, New Mexico, and Utah.

COLORADO'S HEALTH EXCHANGE

The General Assembly created Colorado's health exchange in 2011 as a non-profit organization outside of state government. The exchange, named Connect for Health Colorado (Connect for Health), began operating in February 2012. The legislative declaration states that the exchange is intended to "increase access, affordability, and choice for individuals and small employers purchasing health insurance in Colorado" [Section 10-22-102, C.R.S.].

Connect for Health's primary responsibilities and services are required by federal regulations [45 CFR 155], and described below:

- **PROVIDES A MARKETPLACE FOR PURCHASING HEALTH INSURANCE PLANS.** Connect for Health operates the website where Colorado residents may purchase health plans that have been certified by the State's Division of Insurance. Since 2013, Connect for Health has offered consumers annual open enrollment periods from about November through the following January. About 178,000 individuals enrolled in a 2017 health plan through the exchange.

- **OFFERS CONSUMER ASSISTANCE.** Connect for Health offers consumers information on health plans, insurance affordability programs, and insurance eligibility requirements; and assists consumers with questions and complaints primarily through a toll-free customer service telephone line. Connect for Health contracts with a vendor to operate a customer assistance call center that handles inbound and outbound telephone calls, emails, and online chat assistance. In Calendar Year 2016, Connect for Health's call center assisted with approximately 385,000 questions and concerns.

- **VERIFIES ELIGIBILITY.** Individuals in Colorado are eligible for a federal tax credit or financial assistance with their health plan premiums if their income is between 133 and 400 percent of the federal poverty level, which in 2016 was the equivalent of an annual income between about $15,900 and $47,500. The State's shared eligibility website, PEAK, which is administered by the Department of Health Care Policy and Financing, determines consumers' eligibility for this federal financial assistance, but Connect for Health verifies this eligibility and consumers' eligibility for enrolling in health plans, including citizenship status and residency. About 108,600 consumers were eligible for financial assistance in 2017.

- **AWARDS GRANTS TO PROVIDE IN-PERSON CONSUMER ASSISTANCE ON BEHALF OF CONNECT FOR HEALTH.** For Fiscal Year 2017, Connect for Health awarded $2.6 million in grants to 25 non-profit community organizations and local governmental entities, such as county health departments. According to Connect for Health, its grantees, along with brokers and other trained assisters, provided in-person assistance to about 52,000 consumers during the recent health plan open enrollment period, November 2016 through January 2017.

In addition to the services listed above, since July 2015, Connect for Health has operated a Medical Assistance (MA) site that helps Colorado residents apply for State-authorized medical assistance, including Medicaid and Child Health Plan Plus, and processes the applications.

ADMINISTRATION

Connect for Health is administered by a Chief Executive Officer (CEO) who is responsible for its daily management. As of May 2017, Connect for Health had about 78 full-time staff and management who administer and oversee operations from an office in Denver, Colorado. Connect for Health also uses contractors to assist with MA site supervision, human resources, and information technology.

Connect for Health's Board of Directors (Board) provides oversight and governance [45 CFR 155.110(c)]. The Board comprises nine voting and

three nonvoting members. The Governor appoints five voting members and General Assembly leadership appoints the remaining four voting members [Section 10-22-105(1)(a), C.R.S.]. Statute [Section 10-22-105(1)(b), C.R.S.] requires the voting Board members to possess knowledge and skills in the areas of health insurance and benefits administration, health care finance and service provision, information technology, and small business development. The three nonvoting Board members are the Executive Director of the Department of Health Care Policy and Financing, the Commissioner of Insurance, and the Director of the Governor's Office of Economic Development and International Trade, or a designee [Section 10-22-105(1)(c), C.R.S.].

According to statute [Section 10-22-106, C.R.S.], the Board's key duties and responsibilities include appointing Connect for Health's CEO, approving financial and operational plans, reporting to the Governor and General Assembly, and providing the organization technical and advisory assistance. The Board also sets Connect for Health's fee annually based on factors such as projected health plan enrollment, operational expenses, and average premiums.

STATE AND FEDERAL OVERSIGHT

Statute [Section 10-22-107, C.R.S.] created the Colorado Health Insurance Exchange Oversight Committee (Legislative Oversight Committee) to guide the implementation of an exchange in Colorado, make recommendations to the General Assembly, ensure the best interests of Coloradans are protected and furthered, and approve an executive director for Connect for Health [Sections 10-22-106(1)(a) and 10-22-107(6) and (7), C.R.S.]. The Legislative Oversight Committee comprises 10 legislators appointed by the General Assembly's legislative leadership; its primary responsibility is to review Connect for Health's operational and financial plans [Section 10-22-107(7), C.R.S.].

CMS promulgates rules and regulations for health insurance exchanges and provides states with ongoing guidance about health exchange operations. The Act also allows the Government Accountability Office (GAO) and the Office of the Inspector General (OIG) within HHS to audit and investigate the exchanges [42 U.S.C. 18033(a)(2) and (b)].

REVENUES AND EXPENDITURES

Connect for Health's fiscal year is the same as the state fiscal year, July 1 through June 30. During Fiscal Years 2012 through 2015, Connect for Health was primarily funded through federal grants provided for the startup of the exchange. These federal grants totaled about $184 million and ended in June 2016. Connect for Health's revenue sources besides federal grants and investment income have been fees, donations, and private grants, as follows:

- **MARKET ASSESSMENT FEE.** Statute [Section 10-22-109, C.R.S.] allowed Connect for Health to charge each insurance carrier a market assessment fee of up to $1.80 per life insured per month for each insurance plan sold in Colorado through December 2016 when the fee expired. In 2015, the fee was $1.25; in 2016, it was $1.80.

- **COVERCOLORADO FUNDS.** CoverColorado, the State's former insurance program for individuals with pre-existing medical conditions, was discontinued in 2013 because the Act began requiring universal health care coverage. Statute [Section 10-22-109(2)(b), C.R.S.] required unused CoverColorado funds totaling $27.3 million during Fiscal Years 2014 and 2015 to be transferred to Connect for Health for its operations.

- **ADMINISTRATIVE FEE.** Federal regulations [45 CFR 155.160] allow exchanges to "generate funding, such as through user fees on participating issuers…", but do not specify a maximum for this administrative fee. In 2016 and 2017, Connect for Health collected a 3.5 percent fee on the monthly premium for each health plan sold through the exchange, an increase from the 1.4 percent fee charged in 2015.

- **DONATIONS FROM INSURANCE CARRIERS.** Statute [Section 10-22-110, C.R.S.] allows insurance carriers to donate a combined total of $5 million to Connect for Health annually in exchange for a state tax credit. Prior to the creation of Connect for Health, CoverColorado collected these donations to help fund its operations.

- **COLORADO HEALTH FOUNDATION GRANTS.** Since 2013, Connect for Health has received annual Colorado Health Foundation grants to operate its in-person customer assistance grant program.

EXHIBIT 1.2 shows Connect for Health's revenues and expenditures for Fiscal Years 2013 through 2016, as reported in its audited financial statements, and its self-reported revenues and expenditures based on Connect for Health's general ledger for Fiscal Year 2017 through May 2017.

EXHIBIT 1.2. CONNECT FOR HEALTH COLORADO
REVENUES AND EXPENDITURES (IN MILLIONS)
FISCAL YEARS 2013 THROUGH 2017, AS OF MAY 31, 2017[1]

	2013	2014	2015	2016	2017[1]
REVENUES					
Administrative Fees	$ 0.0	$ 2.1	$ 6.9	$ 14.7	$ 23.1
Market Assessment Fees	0.0	0.0	7.4	17.2	10.1
Insurance Carrier Donations	0.0	5.0	5.0	5.0	5.0
Health Foundation Grants	<0.1	1.5	3.0	3.1	2.6
CoverColorado Transfers	0.0	15.0	14.0	0.0	0.0
Federal Grants	44.0	86.1	45.8	5.3	0.0
Other Revenue[2]	<0.1	0.1	0.1	0.1	<0.1
TOTAL REVENUES	$ 44.2	$ 109.8	$ 82.2	$ 45.4	$ 40.9
EXPENDITURES					
Customer Service	$ 1.7	$ 22.1	$ 20.8	$ 17.4	$ 12.3
Depreciation and Amortization	1.1	4.8	9.5	12.6	12.4
Technology Development	18.0	21.8	13.7	12.4	11.2
Salaries and Benefits	2.1	3.8	5.3	7.3	6.7
Professional Services[3]	1.3	3.1	4.8	3.7	0.7
Marketing and Outreach	2.1	8.8	4.7	1.1	2.5
Assistance Network Grants	0.0	7.8	7.8	2.8	2.4
Other Expenditures[4]	0.4	2.2	1.4	1.4	1.3
TOTAL EXPENDITURES	$ 26.7[5]	$ 74.4	$ 68.0	$ 58.7	$ 49.5
NET INCOME (LOSS)	$ 17.5	$ 35.4	$ 14.2	$ (13.3)[6]	$ (8.6)

SOURCE: Office of the State Auditor analysis of Connect for Health's audited financial statements for Fiscal Years 2013 through 2016, and its self-reported revenues and expenditures for Fiscal Year 2017.
[1] Actuals, year to date through May 31, 2017.
[2] Other Revenue includes interest income and unrestricted donations.
[3] Professional Services include costs for legal, accounting, and human resources consultants; payroll processing professionals; audit fees; and software support.
[4] Other Expenditures include costs for building occupancy of the Denver office and call center, equipment and supplies, insurance, telecommunications, travel, and training. It also includes bad debt, which is an estimation of uncollectible administrative fees and market assessment fees.
[5] All expenditures in Fiscal Year 2013 were for start-up costs related to implementing Connect for Health.
[6] Net Income includes depreciation. If depreciation is subtracted from Net Income, the net loss for Fiscal Year 2016 is about $755,000.

The Act [42 USC 18031(d)(5)] requires state exchanges, including Connect for Health, to be financially self-sustaining after depleting their federal implementation grants, and Colorado statute [Section 10-22-

108, C.R.S.] specifies that state general fund monies shall not be used to support Connect for Health. More information on Connect for Health's financial sustainability can be found in CHAPTER 2 of this report.

AUDIT PURPOSE, SCOPE, AND METHODOLOGY

We conducted this audit pursuant to Section 10-22-105(4)(c), C.R.S., which authorizes the State Auditor to conduct performance audits of Connect for Health. This audit was conducted in response to a legislative request, which expressed concerns about Connect for Health's financial sustainability. This audit was conducted from September 2016 through June 2017. We appreciate the assistance provided by Connect for Health during this audit.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

The objectives of this audit were to determine whether Connect for Health:

- Is financially self-sustainable.
- Meets legislative intent effectively by providing quality services and measuring and monitoring its performance.
- Implemented the recommendations from our October 2014 *Colorado Health Insurance Benefits Exchange: Connect for Health Colorado, Limited Performance Audit* (2014 audit).

To accomplish the audit objectives, we performed the following work related to Connect for Health:

- Evaluated its written policies and procedures and unwritten operational practices.
- Analyzed its general ledgers from Fiscal Years 2016 and 2017, which included evaluating the revenue sources and reasonableness of expenditures.
- Reviewed its contract tracking and data.
- Reviewed its financial projection models for Fiscal Years 2017 through 2019, and its measures taken to reduce its costs and become financially sustainable.
- Analyzed its internal audits related to financial management and internal controls, and external financial and performance audits from Calendar Years 2015 and 2016.
- Analyzed its performance metrics and data for Calendar Years 2014, 2015, and 2016.
- Evaluated its customer service surveys and results conducted during Fiscal Years 2014 and 2017.
- Reviewed its complaint and appeal processes and data for Calendar Year 2016.
- Reviewed the Board's strategic plans, meeting minutes, and annual reports.
- Interviewed Connect for Health Board members, management, and staff; interviewed CMS staff; and surveyed members of the Legislative Oversight Committee.
- Researched the operations and financial information for other state-based health exchanges.

We relied on sampling to support some of our audit work and selected the following samples:

- **VENDOR PAYMENTS.** We selected a non-statistical sample of 10 of the 424 vendor payments made by Connect for Health between July and September 2016, totaling $429,200. We also reviewed all contracts related to the vendor payments.

- **GRANTEE PAYMENTS.** We selected a non-statistical sample of five of the 23 grantee reimbursements made by Connect for Health during September 2016, totaling $46,700. We also reviewed all contracts related to the grantee payments.

The samples were selected to provide sufficient coverage to test controls of those areas that were significant to the objectives of the audit; the sample testing results are not intended to be projected to the entire population. We designed our samples to provide sufficient and appropriate evidence for the purpose of evaluating Connect for Health's internal controls related to procurement, payments, and contract management and to determine whether it implemented the prior audit recommendations.

We planned our audit work to assess the effectiveness of those internal controls that were significant to our audit objectives. Our conclusions on the effectiveness of those controls, as well as specific details about the audit work supporting our findings, conclusions, and recommendations, are described in CHAPTERS 2 and 3 of this report. APPENDIX A includes a summary of the implementation status of the four recommendations from our 2014 audit.

CHAPTER 2

SUSTAINABILITY OF OPERATIONS

When the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act, or Act) was implemented, 14 states opted to create a state-based health insurance exchange with federal implementation grants. The state exchanges began enrolling consumers in health plans in 2013. The Act required that, once the exchanges' federal startup grants were depleted, each had to be financially self-sustaining without further federal implementation grants [42 USC 18031, Section 1311(d)(5)(A)]. Some states, including Colorado, also required their exchanges to operate without state general funds [Section 10-22-108, C.R.S.]. Since 2013, three state exchanges (Hawaii, Nevada, and Oregon) closed because they became financially insolvent due to higher startup costs and/or lower health plan enrollment than the states had estimated before implementing their exchanges.

Our audit assessed, in part, whether Connect for Health Colorado (Connect for Health) is able to financially self-sustain its operations without federal implementation grants and state general funds. Overall, we found that Connect for Health will be sustainable through the current 2017 health plan year which ends in December 2017. Further, Connect for Health is on track to be sustainable beyond 2017 because it has made improvements to its financial management and internal controls since our October 2014 *Colorado Health Insurance Benefits Exchange: Connect for Health Colorado, Limited Performance Audit* (2014 audit).

During this audit, we identified a number of steps that Connect for Health has taken since mid-2015, when its current Chief Executive Officer (CEO) and Chief Financial Officer joined the organization, to control costs, increase revenues, and monitor its financial position to ensure its operations are sustainable, as described below. CHAPTER 3 discusses steps taken by Connect for Health to improve its services, enhance its marketing and outreach, and monitor its overall performance.

COST CONTROLS AND REVENUE INCREASES

In 2016, Connect for Health hired a firm to conduct a study to provide management with an analysis of options to improve sustainability by minimizing costs and eliminating duplication of services between Connect for Health and the State of Colorado. The study evaluated the costs of moving Connect for Health's information technology functions, such as electronic eligibility verifications and consumer notifications, to the Department of Health Care Policy and Financing, and found that the move would cost the State between $2.8 and $5.3 million by 2018. The study estimated that it would cost the State $23 million to transition to using the federally-facilitated exchange and website rather than Connect for Health's marketplace and systems. The study also found that Connect for Health's only option to be sustainable without costs to the State would be continuing to operate as an independent

organization with expense reductions. This option represents the current operating status of Connect for Health in Fiscal Year 2017.

During Fiscal Years 2016 and 2017, the primary method that Connect for Health focused on to become sustainable was reducing its costs. By the end of Fiscal Year 2017, as of May 31, Connect for Health had reduced its costs relative to Fiscal Year 2015 by about $18.5 million or about 27 percent. Connect for Health reduced its expenses in the following ways:

- **RENEGOTIATED MAJOR CONTRACTS.** Since 2016, Connect for Health management has renegotiated vendor contracts to reduce costs and provide for more predictable expenditures. For example, three of the largest information technology contracts were renegotiated—reducing one by $1.3 million annually for 2 years, one by $1 million the first year and up to $8.75 million over 4 years, and one by $500,000 annually for 2 years—which saved the organization about $2.8 million the first year the renegotiated contracts were in place. Connect for Health also reduced its annual expenses by $3.4 million starting in Fiscal Year 2016 by realigning its customer service call center functions under one vendor and executing more favorable contract terms to control cost fluctuations.

- **CUT ADMINISTRATIVE EXPENSES.** Connect for Health reduced its use of contractor services by bringing key employee positions, such as General Counsel, Director of Marketing, and Technology and Business Intelligence, in-house, which reduced administrative expenses by about $400,000. As discussed later in CHAPTER 2, Connect for Health also improved its financial controls and processes to help ensure its expenditures are reasonable and appropriate. For example, Connect for Health reduced its assistance network expenses by $5 million, marketing and outreach expenses by $3.6 million, and technology expenses by $1.3 million.

As a secondary method of staying sustainable, Connect for Health evaluated ways to increase its revenue and made the following changes:

- **PURSUED FEDERAL REIMBURSEMENT.** Connect for Health determined that it could increase revenue without affecting the costs of health plans for consumers by requesting reimbursement from the federal government for the consumer assistance it provided related to Medicaid and Child Health Plan Plus. Connect for Health has provided Medicaid enrollment services through its customer service center and in-person assistance grant program, and in 2015, began operating a Medical Assistance (MA) site for enrolling customers in Medicaid and Child Health Plan Plus. Connect for Health estimated that it will receive about $6.8 million in reimbursements for Medicaid-related services for Fiscal Years 2017 and 2018, subject to approval by the Centers for Medicare and Medicaid Services (CMS).

- **TARGETED OUTREACH TO GROW ENROLLMENT.** As a means to grow health plan enrollment and thereby increase fee revenue, in November 2016, Connect for Health implemented a new marketing and outreach strategy to target communications to Colorado residents who were eligible for a tax credit or financial assistance but who had not enrolled in a health plan. Connect for Health's new strategy added about 6,900 new consumers who purchased health plans, resulting in about $1.3 million in revenue growth. CHAPTER 3 includes more information on trends in health plan enrollment in Colorado.

- **FEE CHANGE.** Although fee increases were considered a less desirable method for becoming sustainable compared to reducing expenses, Connect for Health's Board of Directors (Board) increased the administrative fee charged to insurance carriers for each health plan sold through the exchange. While a consumer's health plan costs are primarily determined by factors such as insurance carrier pricing of plans, the plan chosen by a consumer, and his or her individual tax credit, a fee increase could result in some carriers increasing health plan costs for consumers. Starting with Calendar Year 2016, the Board increased the administrative fee from 1.4 percent of monthly premiums for each plan sold to 3.5 percent of monthly premiums. This fee change increased revenue by about $7.8 million in 2016 and about $16.2 million in 2017, compared to revenue in 2015. In

addition, Connect for Health decreased the amount of time it was taking to bill insurance carriers for administrative fees in an attempt to receive revenue in a timely manner.

Other state-based exchanges charge administrative fees ranging from 1.65 percent to 4 percent of the premiums for each health plan sold through their exchanges. APPENDIX B compares Connect for Health's Fiscal Year 2016 fees, financial information, and enrollment to those of the other 10 state-based exchanges.

Connect for Health's financial audit for Fiscal Year 2016 determined there was no going concern with the financial viability of Connect for Health through June 30, 2017. The financial audit recognized decreases in most expense areas and improved fiscal management, stating that "the organization is on a path to financial sustainability."

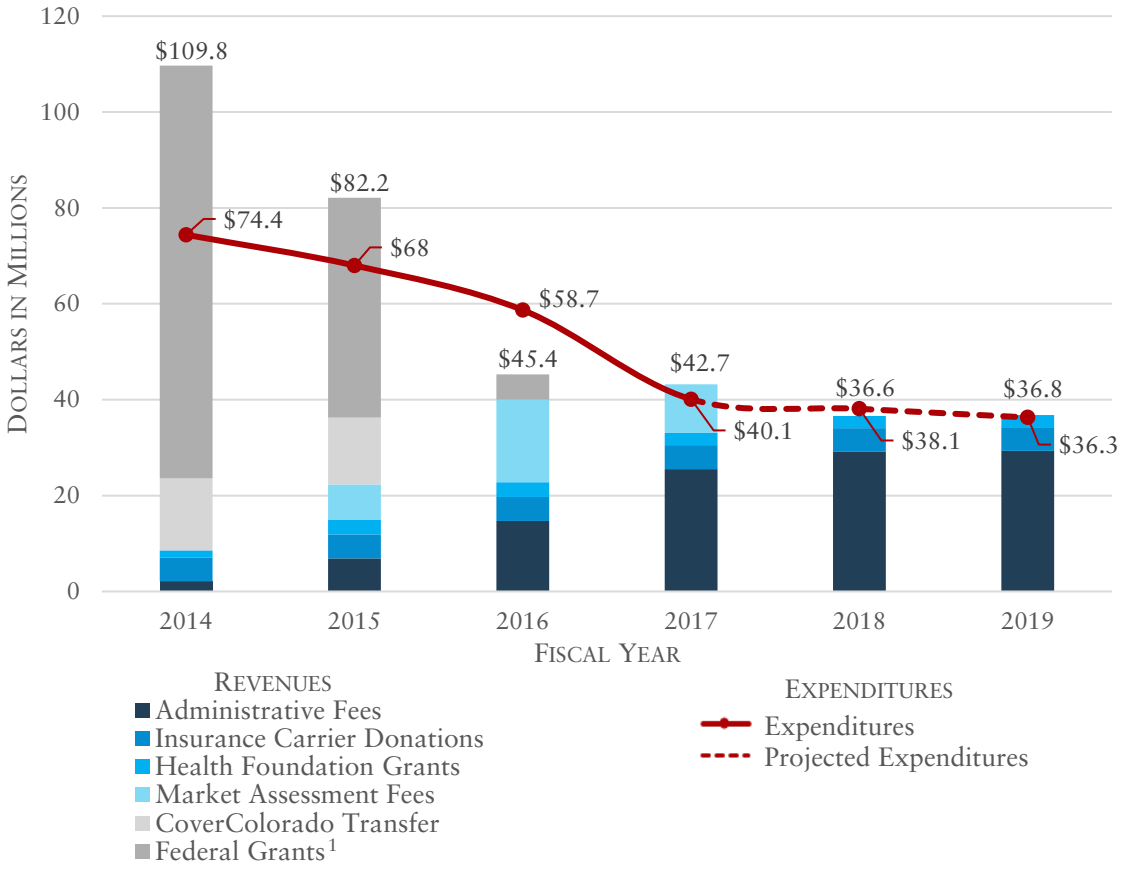
FINANCIAL MONITORING

In Fiscal Year 2016, Connect for Health implemented a financial model to forecast the organization's future financial condition based on different scenarios of expenses, enrollment, and revenue. Connect for Health revises its model quarterly using information on actual expenses, revenue, and enrollment in health plans in Colorado.

We reviewed the financial models from Calendar Year 2016 and the first quarter of Calendar Year 2017. Each model forecasted that the organization will maintain positive cash balances during the 3-year period 2017 through 2019. For example, the model from the first quarter of 2017 forecasts that Connect for Health will be sustainable with a cash balance of about $19 million by Fiscal Year 2019, if its expenses are reduced by 5 percent annually in Fiscal Years 2018 and 2019, enrollment in health plans remains constant in 2018 and 2019, and revenue from fees charged on the sale of health plans does not increase. The model's forecast does not include the anticipated revenue from Medicaid-related cost reimbursements which Connect for Health should begin receiving in Fiscal Year 2018.

EXHIBIT 2.1 shows Connect for Health's actual revenue and expenditures for Fiscal Years 2014 through 2016, and projections for Fiscal Years 2017 through 2019.

EXHIBIT 2.1. CONNECT FOR HEALTH COLORADO
REVENUES, EXPENDITURES, AND FINANCIAL PROJECTIONS (IN MILLIONS)
FISCAL YEARS 2014 THROUGH 2019



SOURCE: Office of the State Auditor analysis of Connect for Health's audited financial statements for Fiscal Years 2014 through 2016, and its projection model for Fiscal Years 2017 through 2019, as of March 31, 2017.
[1] In Fiscal Years 2014 and 2015, Connect for Health received federal grants totaling $86.1 million and $45.8 million, respectively, for start-up costs related to implementing the health exchange, which were the majority of Connect for Health's expenditures in those fiscal years.

Connect for Health's net financial position as of its Fiscal Year 2016 financial audit was about $56.3 million, and of this amount $30.9 million was invested in capital assets and $184,000 was restricted for the assistance network, leaving an unrestricted balance of $25.2 million.

Although Connect for Health is on track to be financially sustainable, the future of health exchanges in the United States is uncertain because

the U.S. Congress is working on legislation that would repeal and replace the Affordable Care Act and may remove the requirement that all Americans obtain health insurance [26 USC 5000A]. A repeal of the Act or significant changes to its provisions could reduce or eliminate Connect for Health's revenue from the sale of health plans and limit the organization's ability to operate.

Notwithstanding the improvements made by Connect for Health over the past 2 years and the potential federal legislative change, we found that there are additional steps that Connect for Health should take to help ensure its sustainability. Specifically, we found that Connect for Health has not fully implemented the financial controls recommended in our 2014 audit, and it should continue to improve its financial management and internal controls. We discuss this finding and recommendation in the remainder of CHAPTER 2.

IMPLEMENTATION OF PRIOR AUDIT RECOMMENDATIONS

Since Connect for Health began operating in 2013, it has used vendors to help implement and administer Colorado's health insurance exchange. For example, Connect for Health has contracted with vendors to develop and support its website and information systems, operate a customer service call center, and operate a medical assistance site to enroll consumers in Medicaid. Connect for Health also contracts with grantees to provide consumers with in-person assistance with enrolling in private health plans. These vendor and grant costs averaged approximately two-thirds of Connect for Health's annual expenditures in Fiscal Years 2016 and 2017, as shown in EXHIBIT 2.2.

EXHIBIT 2.2. CONNECT FOR HEALTH COLORADO EXPENDITURES FOR VENDORS AND GRANTS (IN MILLIONS) FISCAL YEARS 2016 AND 2017, AS OF MAY 31, 2017

	2016	Percentage of Total 2016 Expenditures	2017	Percentage of Total 2017 Expenditures
Expenditures for Vendors	$33.5	57%	$24.2	65%
Expenditures for Grants	$2.8	5%	$2.4	7%
All Other Expenditures	$22.4	38%	$10.5	28%
TOTAL EXPENDITURES	$58.7	100%	$37.1	100%

SOURCE: Office of the State Auditor analysis of Connect for Health's audited financial statements and general ledger data.

Connect for Health's executive management executes contracts, reviews and approves payments to vendors and grantees, and prepares and presents financial information on vendor and grant contract costs to Connect for Health's Board. The Board oversees financial management by approving the annual budget and contracts over $250,000, and reviewing financial statements.

Our 2014 audit identified significant problems related to Connect for Health's payments to vendors and grantees, contract management, and overall financial controls. The 2014 audit recommended, in part, that Connect for Health establish and implement:

- Controls over the purchase of goods and services requiring documentation to support all payments made and goods and services received;

- Grant management policies and procedures ensuring payments to grantees are based on supporting documentation;

- Contract management controls including accurate tracking of contracts and payments to contractors, procedures to execute contracts before paying contractors and ensure contract compliance, and Board approval of contracts and payments over certain dollar amounts;

- Ongoing monitoring to ensure organizational compliance with laws, regulations, and internal policies; and

- Training for staff on policies and procedures, and processes to maintain adequate staffing to help ensure compliance.

WHAT WAS THE PURPOSE OF THE AUDIT WORK AND WHAT WORK WAS PERFORMED?

The purpose of the audit work was to determine whether Connect for Health implemented the recommendations from our 2014 audit, and whether the problems identified during that audit have been addressed or if those problems still exist. As part of our audit work, we assessed the policies and procedures that Connect for Health developed in response to our 2014 audit, and reviewed its general ledgers, financial statements, external audits, and internal audits for Fiscal Years 2015 through 2017, as of September 2016.

We reviewed non-statistical samples of payments that Connect for Health made to vendors and grantees between July and September 2016, the most recent payment data available at the time of the test work, to determine if the payments and related contracts complied with the policies and procedures developed to address our audit recommendations. Specifically, we selected a non-statistical sample of 10 of the 424 vendor payments, totaling $429,238 of about $5 million paid to vendors during the period, and reviewed the invoices, contracts, and all supporting documentation on file related to each sampled payment. We also reviewed Connect for Health's list of vendor contracts and four vendor contracts outside of our sample. In addition, we sampled the five largest payments to five grantees, out of the 23 payments made to 21 grantees; the sample totaled $46,704 of the $119,770 paid to grantees during the period. For each sampled grant payment we reviewed the grant contract, grant budget, grantee reimbursement request, and all supporting documentation on file for the payments. We selected the samples to ensure sufficient audit coverage of the different types of expenses incurred and various internal policy requirements.

In response to our 2014 audit recommendations, Connect for Health reported that it would begin using a corporate credit card for small-dollar, recurring office expenses. We reviewed Connect for Health's general ledger entries for the 91 credit card purchases totaling $15,580 made between July and September 2016, to determine whether the purchases complied with its small purchases and credit card use policies. We verified the accuracy of Connect for Health's contract tracking for Fiscal Year 2016, and assessed the sufficiency of contract templates and contract management procedures. Lastly, we analyzed Board minutes and other Connect for Health documentation, and interviewed management, staff, and Board members, to determine steps taken to implement policies and procedures, train staff on the internal policies and procedures, and ensure staffing is sufficient to ensure internal controls over procurement, financial management, and contracting work as intended.

WHAT PROBLEMS DID THE AUDIT WORK IDENTIFY AND HOW WERE THE RESULTS MEASURED?

We found that, in response to our 2014 recommendations, Connect for Health strengthened its financial controls and established policies related to procurement, contract management, and grants management, which are an improvement over the policies that were in place at the time of our prior audit. For example, since our 2014 audit, Connect for Health established policies stating that all transactions should have complete and accurate supporting documentation before payments are made, contract payments should comply with contract terms, contracts and expenses over $250,000 should be approved by the Board, grantees should be reimbursed for their expenses based on Connect for Health's review of grantee supporting documentation, and grantees should not be paid in advance of incurring expenses. Connect for Health also implemented a process to help prevent overpayments on contracts by recording the assigned contract number in the general ledger when recording each respective contract payment. APPENDIX A provides more

information on the actions Connect for Health has taken to implement the 2014 audit recommendations.

Although Connect for Health has made progress in implementing policies and procedures, our 2017 audit continued to find a lack of documentation to support payments and services provided by vendors, and Connect for Health management and staff did not consistently follow established procurement and contracting policies and procedures or contract terms. Specifically, we identified one or more problems with two of 10 sampled vendor payments (20 percent), two of five sampled grantee payments (40 percent), and eight of the 19 contracts reviewed (42 percent). We also identified discrepancies with how Connect for Health followed its policies for about one-half of the 91 credit card purchases reviewed. Overall, we found that $50,696, or 11 percent of the sampled payments we tested, and an additional $3,996,314 in contract costs we tested, did not comply with Connect for Health policies, procedures, and/or contract provisions, as described in the following sections.

Lack of Support for Vendor Payments and Services

- Two of the 10 sampled payments to vendors, totaling $33,914, lacked complete documentation to support the payments, as required by Connect for Health policies and the vendors' contracts. Connect for Health paid the vendors without obtaining descriptions of the work the vendors performed or documentation of the deliverables required by the contracts. One contract required the vendor to provide Connect for Health documentation of the services delivered, but the vendor's invoice lacked detail specifying the services billed and documentation was not provided to support the invoice. The other vendor was required by its contract to report specific deliverables on Medicaid enrollments, but Connect for Health paid these vendors' invoices without obtaining the required information; the vendor's invoice listed only the hours its staff worked without a description of the work performed or services

provided. Connect for Health's policies state that "invoices must clearly identify the products (deliverables) and service period for which the invoice is requesting payment," and "all invoices from vendors must include…date of services [and] detailed information about the items that the invoice is for."

Contracts Not Executed, Approved, or Paid as Required

- One vendor outside our sample was paid more than its contract amount. The vendor's contract totaled $150,000 for sales and business development consulting, but Connect for Health paid this vendor $181,000, or 21 percent more than contracted. According to Connect for Health, this vendor provided additional services that were not included in the contract scope of work, but Connect for Health did not document the scope change or amend the contract.

- All five sampled grantee contracts, totaling $890,314 combined, were signed after the effective date of July 1, 2016, noted on the contracts, and the five grantees performed work before the contracts were signed. Three of the five contracts were signed in August 2016, and two contracts were signed on July 12, 2016.

  Additionally, one of the 10 sampled vendor contracts totaling $25,000 was approved by the CEO and signed after the contract effective date, and the vendor began work 8 weeks before the contract was executed.

- One contract for web-based database services totaling $2.9 million was signed in September 2016 by Connect for Health's General Counsel, who was not authorized to execute contracts for Connect for Health. Connect for Health policy at the time stated that only the CEO was authorized to approve and sign contracts over $250,000, and the policy did not allow the CEO to delegate this authority. In November 2016, Connect for Health revised its policy to allow the CEO to approve other staff to sign contracts.

Unsupported Payments to Grantees

- Two of the five sampled grantees were paid $3,047 for expenses for staff who were not the authorized staff in the approved grant budget. This included payments for salary and mileage for unapproved employees. Connect for Health policy requires that each grantee's budget include only authorized grantee staff and that Connect for Health staff verify the employees are authorized in the grant budget before reimbursing the grantee's costs.

- Two of the five sampled grantees were paid $16,442 without information needed to support the amounts in their reimbursement requests, as required by Connect for Health policy. Specifically, Connect for Health paid one grantee $9,380 for staff salaries without documentation, including timesheets, to support the salary costs. Connect for Health policy requires grantees to include staff timesheets with reimbursement requests. Connect for Health paid the other grantee $7,062 for salary costs, but the supporting documentation did not include hourly pay rates needed to verify salary calculations. After we brought this problem to Connect for Health's attention, it obtained documentation from the grantees to support these payments.

Inconsistent Policies and Procedures for Credit Card Purchases

- We identified discrepancies with how Connect for Health applied its policy on small purchases and its policy on reimbursing employees for business expenses. Connect for Health's policy for small purchases requires that management and staff use the credit card for all purchases below $5,000 that are "low-risk recurring office and business expenditures not requiring a formal contract" such as office supplies and equipment. Connect for Health's employee handbook states it will reimburse all employees for reasonable business expenses, including travel, and reimbursing employees for travel is

Connect for Health's standard practice. However, the majority of credit card transactions during the period we reviewed were for executive management's business travel. Specifically, 53 out of the 91 credit card transactions, totaling about $8,100, had been used for executive business travel that was sporadic and did not appear to be recurring.

Based on the problems described above, Connect for Health has not fully implemented the recommendations from our 2014 audit. APPENDIX A provides a summary of the findings and recommendations made in the 2014 audit, more information on the actions taken to implement the recommendations, and our conclusion on the implementation status of each recommendation and whether Connect for Health's actions addressed the problems identified in the 2014 audit.

WHY DID THESE PROBLEMS OCCUR?

Overall, Connect for Health does not consistently enforce its written policies, procedures, or contract terms or ensure that they reflect current practices. Connect for Health management stated that its staff closely monitor the two vendors that we identified lacking support for the payments, and that staff's knowledge was adequate for approving the payments without the detailed invoices and supporting documentation required by policies and contracts. For example, management stated that when one vendor in our sample did not comply with the terms of its contract by providing information on the work that it performed, Connect for Health staff who approved the vendor's invoices began closely supervising the vendor's staff to ensure that the vendor was providing the services required under the contract. Connect for Health did not revise the vendor's contract or the contract amount to reflect changes in performance expectations or maintain documentation that the problems with the vendor's performance required closer Connect for Health supervision.

Management also stated that it does not consistently update policies or contracts to align with current practices. For example, management stated that it began using the credit card for executive management's

travel to streamline the review and approval process; however, Connect for Health has not revised it policies to address the discrepancies between policies and practices. Connect for Health management began using the credit card for business travel in March 2016, but had not revised the small purchases policy to allow the credit card to be used for business travel as of the conclusion of our audit in June 2017.

Lastly, Connect for Health lacks sufficient corrective action processes to address audit findings. After our 2014 performance audit, Connect for Health's procurement and contract management processes were audited by the U.S. Health and Human Services' Office of the Inspector General (audit covering February 2012 through June 2014), Connect for Health's external financial auditors (audit covering July 2014 through June 2015), and internal auditor (audit covering November 2015 through May 2016). These audits found problems similar to those we identified in 2014, such as a lack of documentation for payments and Board approval for contracts and staff not consistently following its policies and procedures. The problems that we have identified in this 2017 audit indicate that Connect for Health needs to take more steps to improve its financial controls and ensure that it sufficiently implements audit recommendations.

Another factor contributing to partial implementation of the audit recommendations appears to be a lack of formal training of staff on policies and procedures. For example, Connect for Health management communicates information on new policies and procedures primarily through email without confirmation that staff who are responsible for following and enforcing the policies have read them or understand how they should be applied. Connect for Health management reported that it conducts some in-person training but could improve the structure and consistency of the training.

WHY DO THESE PROBLEMS MATTER?

Connect for Health's future is uncertain due to possible changes to the Affordable Care Act, which could significantly affect the organization's operations, sources of revenues, and financial sustainability. When

Connect for Health cannot demonstrate that it follows key financial and contract management controls, there is continued risk of improper or unnecessary payments that can increase the organization's costs and limit its ability to pay future expenses. Given that Connect for Health's future revenue growth may be limited or decline, it is important that it have financial controls that are working as intended to ensure that all of its expenses are reasonable and necessary.

Higher costs can also impact consumers because Connect for Health charges insurance carriers administrative fees that are based on Connect for Health's operating costs. Typically, insurers reflect administrative fees in their insurance premiums, so the costs of unallowable or unnecessary expenses incurred by Connect for Health could be passed on to Coloradans through their premiums.

RECOMMENDATION 1

Connect for Health Colorado should improve its controls over procurement, spending, contracting, and grants management by:

A Implementing a process to update written policies and procedures so that they consistently and accurately reflect the processes that management and staff are expected to follow.

B Implementing a process to revise contracts to ensure that they accurately reflect current vendor and grantee performance expectations and documentation requirements for payment requests.

C Developing and implementing a corrective action plan to address all audit findings.

D Conducting ongoing follow up reviews to ensure current policies are enforced and all external and internal audit recommendations have been implemented.

E Implementing methods to ensure that the Board, management, and staff are trained on new policies, procedures, and contract terms.

RESPONSE

CONNECT FOR HEALTH COLORADO

A AGREE. IMPLEMENTATION DATE: JULY 2017.

In order to operate more efficiently and effectively, Connect for Health Colorado practices continuous improvement in regards to both internal and external facing operations. Due to the dynamic environment the organization operates in, and the pressures to operate more efficiently, the documentation of the impact of operational changes on the internal policies and procedures have not always kept up. Instead of the current practice of an annual review of policies and procedures, the organization will adopt a quarterly "documented" review and updating process to assure policies and procedures reflect current practices. As part of the improvements being made to our internal control matrix in response to audit recommendation 1D, documentation of the quarterly review of our policies and procedures will be incorporated into our Intact Community Dashboard (ICD), an internal contract and budget management tool. The use of the ICD will also provide a means of identifying any changes necessary to our training program described more fully in our response to audit recommendation 1E.

B AGREE. IMPLEMENTATION DATE: SEPTEMBER 2017.

Due to the dynamic environment in which Connect for Health Colorado operates in, it is inevitable that contracts will need to be adjusted to changing circumstances. The organization will improve upon its processes for amending contracts when the original terms are no longer feasible or beneficial to the organization. The existing contract management procedures will be updated to provide direction to staff on the process to follow for making contract changes and their corresponding responsibilities in the process. In order to operationalize this review process, the organization will implement a contract management checklist that identifies the responsibilities, including documentation requirements for payment

requests, of staff in managing contracts. As part of the processes established in the response to recommendation 1E, the contract management training portion of the training program will incorporate instructions on this new contract review/checklist process. In addition, as part of this training, managers will be trained on processes for amending contracts when the terms of a contract need to be adjusted and instructed on their responsibilities for notifying management and finance of such changes. Staff with contract management responsibilities will be required to sign the contract management checklist at least annually subsequent to the initial checklist signoff implementation.

C AGREE. IMPLEMENTATION DATE: AUGUST 2017.

An action plan addressing the needed improvements in our policies, procedures, and processes and the implementation dates to address the audit findings will be completed by the beginning of August and will include the expected completion dates for each audit finding. The action plan will be incorporated into the internal control tracking system further discussed in our response to audit recommendation 1D.

D AGREE. IMPLEMENTATION DATE: AUGUST 2017.

Connect for Health Colorado will refine its audit/internal control tracking processes to incorporate dashboard indicators in its tracking matrix, which show the status of the implementation of all audit recommendations. The dashboard will be provided to the Board's Finance and Operations Committee on a quarterly basis and any issues discussed at the Committee's public meetings. Internal audit will sign off on the completion of each open matrix item before the dashboard status will be updated to show completion. Internal audit will use the matrix in the development of its audit plan to ensure existing policies are being enforced and new policies and procedures have been successfully implemented. The internal audit plan will be updated quarterly and shared with the Finance and Operations Committee along with the dashboard.

E AGREE. IMPLEMENTATION DATE: SEPTEMBER 2017.

Connect for Health Colorado will incorporate the use of its existing electronic training and tracking tools to provide and document training to those staff that are impacted by financial policies and procedures. This training will be performed at least annually after the initial formal training program is established. The Board will be provided an annual update and review of the financial policies and also a review of their relevant responsibilities in carrying out the financial policies and procedures. Included in the training program will be a module related to contract management that identifies the roles staff and management have in the oversight of contract terms. A review will be conducted of the contract management system of staff assignments to contracts and each responsible staff member will be provided a specific review of the contracts they are responsible for. Staff members will be provided regular updates of the list of contracts and access to the contracts where they have management/oversight responsibilities.

CHAPTER 3

CUSTOMER SERVICE

According to a 2016 survey of U.S. health care consumers conducted by Deloitte Center for Health Solutions, a nonpartisan research division of Deloitte LLC, consumers' decisions to enroll in a health plan are generally driven by the costs of available health plans and availability of financial assistance, while the success of a state-based health exchange largely depends on their approach to consumer engagement and consumers' ability to navigate the marketplace. Navigating the exchange marketplace involves understanding health plan options, their costs, financial assistance programs, and how to enroll in a plan, all of which can be challenging for consumers. To address the challenges, the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act, or Act) requires state-based health exchanges, including Connect for Health Colorado (Connect for Health), to provide services to assist consumers [45 CFR 155.205].

We reviewed Connect for Health's available performance data and performance metrics to gauge its customer service and the quality of its services. Overall, we found that Connect for Health's data and metrics indicate that it is meeting its legislative purpose to increase health insurance access, affordability, and choice for Coloradans [Section 10-22-102, C.R.S.]. As discussed in the following sections, Connect for Health provides services to assist consumers, has effective mechanisms to measure and monitor its performance, and utilizes the results of its performance monitoring to improve its services.

CONSUMER ASSISTANCE

In 2014, the Colorado Health Foundation commissioned the RAND Corporation to study the barriers to consumers enrolling in a health plan or Medicaid in Colorado. The study identified four barriers related to Connect for Health's customer service: (1) consumers had little understanding about the tax credits offered through the marketplace; (2) some consumers were unaware of how to find help with enrollment; (3) consumers reported challenges with the Connect for Health's call center, including busy signals or not having phone messages returned; and (4) Connect for Health's website was not user-friendly. The study recommended expanding and strengthening outreach to consumers, and improving technical support and the navigability of Connect for Health's website. To address the recommendations, Connect for Health increased its enrollment assistance network, provided consumers more ways to access information on health insurance and financial assistance through customer service and its website, and increased its website functionality. The assistance provided by Connect for Health and its website are described below.

STATE-WIDE ASSISTANCE. Connect for Health provides a variety of customer service and health plan enrollment assistance to help meet the needs of all consumers, as shown in EXHIBIT 3.1.

EXHIBIT 3.1. CONNECT FOR HEALTH COLORADO CUSTOMER SERVICE ASSISTANCE CALENDAR YEAR 2016 AND JANUARY 2017

ASSISTANCE CHANNEL	SERVICES PROVIDED
TELEPHONE, ONLINE, AND MAIL	
▪ 273 call center representatives (full time and seasonal)	▪ Assisted with 489,800 toll free calls, 56,800 online chats, and 9,278 emails ▪ Mailed over 968,000 notices and outreach letters to consumers
COMMUNITY-BASED IN-PERSON	
▪ 25 walk-in assistance sites ▪ 18 enrollment centers ▪ 961 certified insurance brokers ▪ 290 certified application counselors ▪ 110 health coverage guides	▪ Held 121 enrollment events ▪ Assisted 14,340 consumers at enrollment centers ▪ Insurance brokers had appointments with 21,710 consumers
MEDICAL ASSISTANCE (MA) SITE	
▪ Office with 13 staff	▪ Processed applications for Medicaid and Child Health Plan Plus, and determined 7,933 consumers eligible

SOURCE: Office of the State Auditor analysis of Connect for Health's 2016 Annual Report and enrollment reports for Calendar Year 2016 and January 2017.

Since Connect for Health began enrolling consumers in health plans in 2013, its customer service network has helped to reduce the uninsured rate in Colorado from 17 percent in 2013 to 6.7 percent in 2016.

MARKETPLACE WEBSITE. In 2017, the Council for Affordable Health Coverage, a nonpartisan group representing patients, providers, insurers, and employers, studied each health exchange website in the United States. The study reported that Connect for Health is the only state-based exchange with a website that offers consumers three key decision support tools to evaluate health plans—a calculator of out-of-pocket costs based on the consumer's expected health care usage; a financial assistance calculator; and directories allowing consumers to shop for plans that include their preferred doctors, facilities, and medications. During the open enrollment period, November 2016 to January 2017, Connect for Health's website allowed consumers to shop all 132 health plans certified by the State's Division of Insurance, about 178,000 consumers were enrolled in health plans through the website, and it received 23 million webpage views.

PERFORMANCE MEASUREMENT, MONITORING, AND IMPROVEMENT

Connect for Health uses various methods to measure and monitor its performance and effectiveness, including strategic plans, performance metrics, customer satisfaction surveys, and monthly reports to the Board of Directors (Board), as described below.

STRATEGIC PLANNING. Connect for Health uses a strategic plan to guide organizational decisions to meet its legislative purpose. The most recent strategic plan approved by the Board was in June 2015. Connect for Health began developing a new strategic plan in 2016, but it had not yet been approved by the Board as of May 2017. The 2015 strategic plan includes three main goals: (1) optimize the customer experience; (2) stabilize the right-size staffing, systems, and processes; and (3) become financially sustainable.

During Fiscal Year 2016, Connect for Health met its goal of optimizing the customer experience by improving call center response times by 75 percent, reducing overall wait times by 50 percent, and providing customers with the ability to make changes to their account online without contacting the call center. Connect for Health met its goal to stabilize staffing, systems, and processes by fully staffing its accounting division, adjusting its staffing at the call center to address higher workload during open enrollment, and revising its financial policies and procedures. Connect for Health also began administering the MA site in 2016, instead of using a contractor; this change provided Connect for Health management a greater understanding of the MA site's operations, and helped it identify ways to improve services such as by increasing staff during peak times. CHAPTER 2 provides information on the steps taken to meet the goal to become sustainable.

PERFORMANCE METRICS. Connect for Health uses over 50 metrics to measure and monitor its performance on a monthly basis. The metrics have changed some over the years as management has changed and as the Board has requested specific information. The metrics are generally

broken into categories related to health plan enrollment, assistance channels, call center activity, appeals, website performance, and consumer account activity. Connect for Health reviews the outcomes on each metric monthly and uses them to make business decisions, such as determining staffing levels needed at the call center or call center hours during open enrollment. Connect for Health also reports its performance metrics through a monthly dashboard that is available on Connect for Health's website and reported to the Board at its meetings.

We found that the performance metrics used by Connect for Health for Calendar Years 2014 through 2016 provided a reasonable and appropriate basis for measuring the organization's performance. Further, we reviewed the reliability of the data that Connect for Health used to measure and report its key performance metrics on enrollment, tax credits, website functionality, and customer service calls in December 2016, and found that the supporting data were accurate, complete, and reported correctly to the public and Board in the monthly dashboard. Specifically, we found that the data used to support the following metrics were reliable:

- **EFFECTUATED ENROLLMENTS** are the number of consumers who enrolled in a health plan and paid their first month's insurance premiums to the insurance carrier.

- **EFFECTUATED ENROLLMENTS WITH TAX CREDITS OR COST SHARING REDUCTIONS** are the number of consumers who enrolled in a health plan, paid their first month's premiums, and received tax credits or similar financial assistance. Tax credits lower the monthly premium when a customer enrolls in a health plan through Connect for Health. Cost share reductions are discounts that lower deductibles and copayments.

- **EFFECTUATED ENROLLMENTS WITHOUT TAX CREDITS OR COST SHARING REDUCTIONS** are the number of effectuated enrollments for consumers who did not receive tax credits or cost sharing reductions.

- **WEBSITE AVAILABILITY** is the percentage of time during each day that the website is fully functional and available for customers to purchase health plans. Connect for Health's current goal is 100 percent availability.

- **CALL RESPONSIVENESS** is the percentage of calls that Connect for Health's call center answers within 5 minutes. Connect for Health's current goal is 80 percent of calls answered within 5 minutes.

EXHIBIT 3.2 compares these key performance metrics and outcomes for 2014, 2015, and 2016, which show improvement over time.

EXHIBIT 3.2. CONNECT FOR HEALTH COLORADO
KEY PERFORMANCE METRICS AND OUTCOMES
2014 THROUGH 2016

REPORTED METRIC	2014	2015	2016
Effectuated enrollments	123,138	152,286	177,802
Effectuated enrollments with tax credits or cost share reductions[1]	69,578	80,388	104,160
Effectuated enrollments without tax credits or cost share reductions[1]	N/A[2]	67,834	70,896
Website availability	99.9%	99.9%	100%
Call responsiveness[3]	56%[4]	43%[4]	76%[4]

SOURCE: Office of the State Auditor analysis of Connect for Health's annual reports and dashboard reports in December 2014, December 2015, and December 2016.
[1] Adding the rows showing effectuated enrollments with and without tax credits does not sum to the total effectuated enrollments row because an enrollment could begin in one category and later change to another, and therefore would be counted in both categories.
[2] Connect for Health did not track this metric in 2014.
[3] In 2014, Connect for Health measured calls answered within 20 seconds; in 2015 and 2016 Connect for Health measured calls answered within 5 minutes.
[4] In 2014, the average wait time for a call was 11 minutes 30 seconds compared to an average wait of 10 minutes 17 seconds in 2015 and wait of less than 3 minutes in 2016.

We also reviewed the metrics and supporting data related to appeals, which is discussed later in this chapter, in RECOMMENDATION 2.

Connect for Health has helped increase affordability for consumers by providing information on health plan costs and helping consumers obtain federal tax credits and other financial assistance with their premiums. EXHIBIT 3.3 shows changes in the affordability of health plans between 2014 and 2016.

EXHIBIT 3.3. CONNECT FOR HEALTH COLORADO AFFORDABILITY OUTCOMES CALENDAR YEARS 2014 THROUGH 2016

	2014	2015	2016
Number of consumers receiving tax credits or cost share reductions[1]	69,578	80,388	104,160
Total tax credits to Coloradans	$191 million	$180 million	$318 million
Average tax credit or financial assistance per month[2]	$229	$187	$254
Average premium chosen by those receiving tax credits, after credits	$138	$156	$107
Average premium chosen by those not receiving tax credits	$287	$284	$209

SOURCE: Office of the State Auditor analysis of Connect for Health's annual reports.
[1] Some consumers receive tax credits or cost share reductions during part of the year, such as when they are seasonal workers, become ineligible for Medicaid and enroll in a private health plan, or end their health plan coverage during the year.
[2] Auditor-calculated by dividing the total tax credits to Coloradans by the number of consumers receiving tax credits or cost share reductions, then dividing by 12 months.

To obtain additional insight into Connect for Health's overall performance in meeting its legislative purpose, we surveyed the Colorado Health Insurance Exchange Oversight Committee (Legislative Oversight Committee). Overall, the Committee members did not have concerns with the quality of Connect for Health's services or its ability to meet legislative intent. Most members acknowledged that external factors limit the extent to which Connect for Health can increase health plan choice and affordability. For example, Connect for Health does not have the authority to control insurers entering and leaving the market, the number and types of health plans certified by the State, the tax credit amounts provided by the federal government, or the premiums charged by insurers. Nonetheless, Committee members reported that Connect for Health has made it easier for consumers to shop for and compare health plans and has increased consumers' access to health plan choices and understanding of financial assistance programs and the costs of plans.

We found that from 2015 to 2017, Connect for Health utilized the results of its performance monitoring to improve its services and the effectiveness of its spending. For example, Connect for Health reviewed

its effectuated enrollment metrics from 2015, as well as data on the number of Coloradans who began the health plan enrollment process and were eligible for tax credits or cost reductions in 2015, but who did not enroll in a health plan. Using these data, Connect for Health refocused and enhanced its marketing and outreach efforts, targeting calls, emails, and letters to inform 84,761 consumers that they were eligible for tax credits that would reduce their health insurance costs. After implementing this targeted outreach, Connect for Health enrolled 6,859 new consumers who were eligible for tax credits during the recent open enrollment period, November 2016 through January 2017.

CUSTOMER SATISFACTION SURVEYS. Connect for Health conducts customer satisfaction surveys of consumers who have used the exchange. An outside firm developed the survey questionnaires. We reviewed each question used in the survey and found that they appeared to be written in a manner that would provide unbiased feedback on the performance of Connect for Health's website, call center, outreach, and other customer service. Connect for Health uses the survey results to address problems and improve its performance. For example, Connect for Health's 2014 customer satisfaction survey found 84 percent of consumers surveyed had used the website to enroll in their health plan, but only 47 percent found the website easy to use. To address these problems, Connect for Health made annual improvements to its website such as by making it easier to navigate and adding the decision support tools discussed previously. In its 2017 survey, less than one-third of consumers reported having difficultly navigating the website.

Although we found that Connect for Health has taken many steps to ensure that it provides quality services and meets its legislative purpose, we found that the organization could improve aspects of its appeals and complaint processes. We discuss this finding and our recommendation for improvement in the remainder of CHAPTER 3.

CUSTOMER APPEALS AND COMPLAINTS

Connect for Health's customer service includes managing appeals and complaints. Federal regulations [45 CFR 155.505(b)] give customers the right to appeal a decision that Connect for Health makes regarding eligibility to enroll in a health plan, such as when enrollment in a health plan is denied due to the customer qualifying for Medicaid, a tax credit is denied, or the credit amount changes. Customers can submit an appeal online through their Connect for Health account, by telephone to Connect for Health's call center vendor, fax, mail, or in-person. Connect for Health's Office of Conflict Resolution and Appeals investigates and works to resolve appeals, and tracks them using a database that includes information such as the consumer who submitted the appeal, the date and time the appeal case was opened and closed, the reason for the appeal, the outcome, and case notes. If Connect for Health cannot resolve an appeal, it transfers the appeal to Colorado's Office of Administrative Courts for a formal hearing. As shown in EXHIBIT 3.4, Connect for Health received 153 appeals from January to early December 2016, the period the audit reviewed.

EXHIBIT 3.4. CONNECT FOR HEALTH COLORADO APPEALS AND THEIR STATUS JANUARY TO DECEMBER 2016

STATUS OF APPEAL	NUMBER OF APPEALS
Closed	71
Open	34
Dismissed	27
Pending Withdrawal	19
Sent to Office of Administrative Courts	2
TOTAL	153

SOURCE: Office of the State Auditor analysis of Connect for Health's appeals data from January 4 to December 5, 2016.

The Affordable Care Act [42 USC 18031, Section 2793(b)(1)] requires Connect for Health to receive and respond to complaints regarding health insurance coverage with respect to federal health insurance requirements. Connect for Health has defined an official complaint as

a concern that a customer submits in writing to Connect for Health by mailing a completed complaint form (located on Connect for Health's website) or a complaint letter. If customers have a concern, question, or need help, such as with their online Connect for Health account, they can contact the call center by phone, fax, or email. Connect for Health tracks general information about the complaints it receives in a log and forwards the complaint to its call center vendor, who investigates and resolves all complaints and concerns. The call center opens a "ticket" each time it receives a complaint, concern, or request for help. During Calendar Year 2016, it processed about 385,200 tickets, of which 22 were mailed-in complaints; the tickets were resolved within an average of 4 days.

Connect for Health reports information on appeals and the mailed-in complaints to the Centers for Medicare and Medicaid Services (CMS) upon request. In addition, Connect for Health's Board receives monthly reports summarizing the appeals and their outcomes as well as information on the most common topics of all tickets. These Board reports are publicly available on Connect for Health's website.

WHAT WAS THE PURPOSE OF THE AUDIT WORK AND WHAT WORK WAS PERFORMED?

The purpose of the audit work was to evaluate Connect for Health's procedures for resolving appeals and complaints, and assess how it uses data on appeals and complaints to improve its customer service, inform the Board and public, and track its performance to help ensure it is meeting its strategic goals and legislative purpose.

We reviewed Connect for Health's data for the 153 appeals it received from January 4 to December 5, 2016, and reviewed its complaint log for the 22 complaints it received from January 11 to December 8, 2016 to assess the reliability and completeness of the data and understand the nature of the appeals and complaints and how they were resolved. To understand appeals handling processes, we interviewed Connect for Health management and reviewed its written appeals policies and

procedures. To understand processes for handling complaints and concerns, we interviewed Connect for Health and call center management and reviewed the call center vendor's written complaints and concerns procedures. We also reviewed reports on appeals and tickets that were provided to the Board and posted on Connect for Health's website and contacted CMS to gain an understanding of the Act's requirements for complaint tracking and reporting.

HOW WERE THE RESULTS OF THE AUDIT WORK MEASURED?

- **APPEALS TRACKING AND DATA SHOULD BE COMPLETE AND ACCURATE.** Connect for Health's policies and procedures require appeals data to be complete and accurate. The procedures require that every appeal in the database include descriptive information such as the appeal issue, open and closed dates, status, and disposition. The Act [42 USC 18031, Section 2793(c)(2)] also requires health exchanges to "quantify problems and inquiries encountered by consumers" meaning that Connect for Health should have methods to quantify the types of appeals received.

- **APPEAL DECISIONS SHOULD BE ISSUED WITHIN 90 DAYS, AS ADMINISTRATIVELY FEASIBLE.** Federal regulations [45 CFR 155.545(b)(1)] require Connect for Health to "issue written notice of the appeal decision to the appellant within 90 days of the date an appeal…is received, as administratively feasible." Connect for Health's appeals procedure states that it "will strive to resolve the appeal...within 90 calendar days," and after 90 days, provide the appellant notice of the status of their appeal. After the 90 days, if Connect for Health cannot resolve the appeal or contact the appellant within 15 days, Connect for Health's procedure states that it will submit the case to the Office of Administrative Courts to be docketed for a hearing.

- **APPEALS SHOULD BE PRIORITIZED BY CONNECT FOR HEALTH STAFF.** Connect for Health's appeals procedures state that its appeals staff

are responsible for "intake, noticing, processing, management, and resolution of appeals." According to a Connect for Health supervisor who oversees appeal handling processes, management of appeals includes staff prioritizing their own caseloads.

- **Consumers should be assisted with filing complaints.** The Act [42 USC 18031, Section 2793(c)(1)] requires Connect for Health to "assist consumers with filing complaints."

- **Complaints should be tracked and quantified.** The Act [42 USC 18031, Section 2793(c)(2)] requires Connect for Health to "collect, track, and quantify problems and inquiries encountered by consumers."

WHAT PROBLEMS DID THE AUDIT IDENTIFY?

First, we found that Connect for Health did not always resolve appeals in a timely manner or maintain complete appeals data needed to track and quantify the types of appeals. Specifically, we found:

- **For 42 out of the 153 appeals (27 percent), Connect for Health had incomplete or inaccurate data.** Specifically:

  - For 38 appeals, the disposition field was blank. We could only determine the disposition of these 38 appeals by reading the detailed case notes in the database.

  - Two appeals were missing the date they were closed. We were unable to determine the timeliness of these appeals because Connect for Health did not record the date the case was closed in its database or document the date elsewhere.

  - Two appeals had closed dates but a status of "open" or "pending withdrawal," which indicates that Connect for Health was still working with the consumer on the appeal case. We could not determine why the data for these two appeals was inconsistent.

As a result of the incomplete data, there were four appeals that did not have enough information in the database to measure the timeliness of Connect for Health's resolution of appeals. For the 149 appeals that did have enough information to measure timeliness, we found:

- **OVER ONE-THIRD OF APPEALS WERE NOT RESOLVED WITHIN 90 DAYS.** For the 149 appeals, we identified 56 appeals (38 percent) that had not been resolved by Connect for Health within 90 days, as shown in EXHIBIT 3.5. Of the 149 appeals, 96 were closed because they had been resolved or dismissed and two were sent to the Office of Administrative Courts. The appeal cases that were closed had been resolved or dismissed by Connect for Health within an average of 28 days, but resolution timeliness ranged from same-day resolution to 184 days.

EXHIBIT 3.5. CONNECT FOR HEALTH COLORADO TIMELINESS OF APPEALS HANDLING JANUARY TO DECEMBER 2016

NUMBER OF DAYS APPEAL CASE WAS OPEN	NUMBER OF APPEALS	PERCENTAGE OF ALL APPEALS
0-30 days	70	46%
31-90 days	21	14%
91-180 days	21	14%
181 days or more[1]	35	23%
Cannot determine timeliness[2]	4	2%
Cases submitted to Office of Administrative Courts	2	1%
TOTAL	153	100%

SOURCE: Office of the State Auditor analysis of Connect for Health's appeals data from January 4 to December 5, 2016.
[1] Includes 34 appeals that were still being processed as of December 5, 2016, but which had been open 181 days or more, and therefore, exceeded the 90-day required timeframe.
[2] Connect for Health's data on 153 appeals included four cases that did not have closed dates needed to determine timeliness.

In addition, we found that Connect for Health does not adequately assist customers in filing complaints and has not maintained complete data needed to track complaints or quantify the types of complaints received, as required by the Act. We found:

- **CONNECT FOR HEALTH DOES NOT ASSIST CUSTOMERS IN FILING COMPLAINTS.** Connect for Health makes the complaint filing process challenging and confusing for customers. First, the complaint filing

process and complaint form are difficult to find on Connect for Health's website—to find any information about the complaint process on the website, customers must use the site's search function to search for "complaints," which leads to a page where they are instructed to call the call center or Connect for Health appeals staff. We had to review each page on Connect for Health's website to locate the complaint form; however, the website and complaint form do not state that a complaint must be mailed, and do not include an address where complaints should be mailed. The website also does not indicate that Connect for Health considers complaints to be only those concerns that are submitted by mail.

- **Connect for Health does not log the outcomes of complaints, dates complaint cases are closed or resolved, or categories of complaints.** We were not able to determine how Connect for Health resolved complaints or the timeliness of complaint resolution based on the data tracked for the 22 complaints. Connect for Health's call center documents the case history of each complaint, which may include complaint outcomes and dates; however, the only way to obtain aggregate data is to review each case history, which would be inefficient compared to tracking the information in the log.

  Since Connect for Health does not categorize complaints, we reviewed the description of each complaint in the complaint log to determine and categorize the general nature of each complaint. We determined that 12 complaints related to customer service or website issues, five related to tax forms, two related to an insurance agent or broker, one related to billing or payments, one related to the insurance carrier, and one related to a notice of Medicaid termination.

WHY DID THESE PROBLEMS OCCUR?

We identified the following reasons for the problems related to appeals tracking and timeliness:

- Staff who process appeals do not consistently follow Connect for Health policies and procedures. Some data recording errors had occurred because staff had not followed the procedures by completing all fields in the appeals database, and there is no supervisory review of the data to ensure that it is accurate or complete. In addition, staff do not always submit cases to the Office of Administrative Courts when the staff are not able to contact the appellant.

- There is no mechanism to hold the staff accountable to the 90-day timeliness standard, such as a requirement to report the aging of appeals to the Board or senior management. Currently, no information on appeals timeliness is reported to the Board.

- Staff do not prioritize appeals to meet timeliness standards. Connect for Health staff who handle appeals are expected to prioritize and manage their caseloads because the appeals database cannot notify staff of the age of appeals. Currently, staff prioritize work on expedited appeals, which are those for which the appellant has an immediate need for insurance due to a life-threatening condition. Prioritizing work based on the age or complexity of the appeals, in addition to whether the appeal is expedited, could help improve the overall timeliness of appeal resolution.

- Staffing during the period we reviewed did not appear sufficient to process appeals on a timely basis. Two of the four appeals staff positions were vacant for at least 3 months during the review period.

We identified two reasons for the problems related to complaints filing and tracking. First, Connect for Health's complaint filing process is difficult for customers because it has not added easy-to-follow links to its website for filing a complaint or added clear or accurate complaint

filing instructions to the site. Second, Connect for Health has not maintained a complete log of complaints because it does not have policies or procedures for complaint and concern intake and monitoring. There is no policy or procedure for what information should be maintained in the complaint log, or requiring that it be complete and accurate. For example, the complaint form contains a field to categorize complaints, but Connect for Health does not require tracking of this information or the date a complaint is closed in its complaint log.

WHY DO THESE PROBLEMS MATTER?

When Connect for Health does not follow its written appeals policies and procedures to track complete and accurate data on appeals, it is difficult for it to use the data to improve its appeals handling process. For example, when Connect for Health appeals data contains blank date or disposition fields, it cannot evaluate the timeliness of appeals resolution, or determine the disposition status of appeals in aggregate. Similarly, when Connect for Health complaint log is incomplete, it cannot evaluate the timeliness of complaint resolution, or identify common complaint issues and use the information to improve customer service. For example, when Connect for Health does not use the category information on its complaint form, it is difficult to analyze complaint trends.

When Connect for Health does not prioritize appeals to meet timeliness standards, it is difficult for the organization to monitor and improve the timeliness of appeals, and untimely resolution of problems could delay customers' enrollment in health plans. Without requirements to report appeals timeliness information to the Board, the Board does not have a complete understanding of the quality and efficiency of Connect for Health's services.

When Connect for Health does not have methods to adequately help customers file complaints as required by the Act, or provides unclear and inaccurate instructions, customers may not file complaints or may call the call center to discuss their complaint, in which case the issue

would not be considered a complaint. Of the 385,200 concern and inquiry tickets received during Calendar Year 2016, only 22 were mailed-in as official complaints. Further, there is a risk that Connect for Health is significantly underreporting complaints to CMS, the Board, and the public.

RECOMMENDATION 2

Connect for Health Colorado should improve its processes for tracking and analyzing appeals and complaints, and resolving them in a timely manner by:

A Ensuring staff follow the procedures for entering appeals information into its database and submitting cases to the Office of Administrative Courts, as appropriate, by implementing supervisory review of data.

B Establishing and implementing processes for reporting timeliness of appeals to the Board.

C Establishing and implementing methods to prioritize appeals to meet timeliness standards, and filling open appeals staff positions.

D Implementing a written policy and procedure for complaint processing.

E Updating its website to make complaint filing information easier to find and provide accurate instructions on how customers may file complaints.

RESPONSE

CONNECT FOR HEALTH COLORADO

A AGREE. IMPLEMENTATION DATE: AUGUST 2017.

Connect for Health Colorado will revise its process document to address the recommendation and conduct periodic training along with monthly meetings to ensure that staff are aligned with proper procedures. An Appeals and Compliance Attorney will also conduct a periodic review of a random sample of cases to verify compliance.

B AGREE. IMPLEMENTATION DATE: OCTOBER 2017.

Connect for Health Colorado will work with the Board in developing a process for reporting appeals information, including timeliness, and implement the agreed upon process.

C AGREE. IMPLEMENTATION DATE: SEPTEMBER 2017.

Connect for Health Colorado's Office of Conflict Resolution and Appeals currently prioritizes expedited appeals based on medical need. Other appeals are worked as received. Connect for Health Colorado will conduct a review of the prioritization process and make any changes in existing methods in order to meet timeliness standards. As part of this analysis, the appropriate level of staffing resources will be determined and incorporated into the organization's budgeting process.

D AGREE. IMPLEMENTATION DATE: SEPTEMBER 2017.

Connect for Health Colorado agrees with the recommendation to implement a written policy and procedure/operational guidelines for complaint processing, as we do not currently have a specific written complaint procedure or state that complaint processing is incorporated into existing escalation procedures within the service center [call center]. We will develop and implement the appropriate policy and procedure/operational guidelines and ensure it includes

definitions; provisions for logging, tracking and monitoring complaints from submission to resolution via our customer relationship management system (Atlas); anticipated process and timelines for resolution; and reporting to the Board of Directors on a regular basis. These activities will be completed and implemented no later than September 1, 2017.

E AGREE. IMPLEMENTATION DATE: SEPTEMBER 2017.

Connect for Health Colorado agrees with the recommendation to update its website to make complaint filing easier to find and provide accurate instructions on how customers may file a complaint. While we do not believe there was an intent to bury the form at the onset of the exchange, we will certainly evaluate the current structure and content, and create messaging that is easier to locate and visible. We will develop content that includes definitions and a description of what a consumer can expect following the submission of a complaint, such as the anticipated process and timelines for resolution. These activities will be completed and implemented no later than September 1, 2017.

APPENDIX A

STATE · OF · COLORADO
UNION AND CONSTITUTION
NIL SINE NUMINE
1876

The following table summarizes the recommendations made in the October 2014 *Colorado Health Insurance Benefits Exchange: Connect for Health Colorado, Limited Performance Audit* (2014 audit); the actions that Connect for Health Colorado (Connect for Health) has taken to implement the recommendations; and the Office of the State Auditor's (OSA's) conclusion on the implementation status of each recommendation based on the 2017 audit.

IMPLEMENTATION STATUS OF THE OSA'S 2014 AUDIT RECOMMENDATIONS AS OF JUNE 2017

RECOMMENDATION 1 – PAYMENTS TO VENDORS

The 2014 audit found that Connect for Health lacked effective processes and internal controls over the purchase of goods and services from vendors. For example, the audit found:

- Services and goods were paid for that were unallowable, unreasonable, or unnecessary.
- Vendors were paid without support for the payment amounts or documentation of the services provided.
- Supervisors did not consistently review expenses before staff paid vendors.

RECOMMENDATION 1A: Establish and implement written policies and procedures that require documentation of all goods and services to support the payment amounts, specify the documentation required prior to payment, and require all payments to be allowable, compliant, reasonable, and accurate.

ACTIONS TAKEN	OSA CONCLUSION
Connect for Health developed policies and procedures that address all areas of the recommendation, such as requiring detailed documentation to support all vendor payments and requiring payments to be allowable, compliant, reasonable, and accurate.	Partially Implemented. The 2017 audit identified noncompliance with policies and procedures, and problems with documentation to support payments to vendors. See RECOMMENDATION 1.

RECOMMENDATION 1B: Establish and implement written processes and guidance to ensure that staff and supervisors understand federal compliance requirements and consistently review transactions for compliance, reasonableness, and accuracy before they are paid.

ACTIONS TAKEN	OSA CONCLUSION
Connect for Health revised its financial policies and procedures to explain federal compliance requirements and to require review and documentation of the reasonableness and accuracy of all transactions before they are paid.	Partially Implemented. The 2017 audit identified noncompliance with policies and procedures and problems with staff's documentation review before payments are made. See RECOMMENDATION 1.

RECOMMENDATION 1C: Ensure there is an adequate number of supervisors and staff to verify the basis for billed amounts and ensure goods and services are received before paying vendors.	
ACTIONS TAKEN	OSA CONCLUSION
Connect for Health's accounting department was fully staffed (including supervisors), as of September 2016 and during our 2017 audit, and staffing is now adequate to verify the basis for billed amounts and confirm goods and services were received before paying vendors.	Implemented. These actions address the problems identified in the 2014 audit.
RECOMMENDATION 1D: Establish and implement a risk-based process for expediting low-risk purchases during times of high workload.	
ACTIONS TAKEN	OSA CONCLUSION
Connect for Health developed a policy for small expenditures (less than $5,000) that are low-risk, recurring, and do not require a formal contract, and uses a credit card for small purchases.	Partially Implemented. The 2017 audit identified problems related to the small purchases policy. See RECOMMENDATION 1.
RECOMMENDATION 1E: Implement ongoing monitoring to ensure financial policies, procedures, and training are implemented and operating as intended.	
ACTIONS TAKEN	OSA CONCLUSION
Connect for Health developed an internal audit department that has a risk-based audit plan for ongoing monitoring and has conducted internal audits. Internal audits have found a lack of documentation for payments and inconsistent compliance with internal policies and procedures.	Partially Implemented. The 2017 audit identified noncompliance with policies and procedures, and the need for additional training, indicating that processes are not sufficient to address the problems identified through monitoring and audits. See RECOMMENDATION 1.
RECOMMENDATION 1F: Train management, supervisors, and staff, and Board members, as appropriate, on the policies and procedures developed to address PARTS A through E.	
ACTIONS TAKEN	OSA CONCLUSION
Accounting and administrative staff were trained on the new financially-related policies and procedures. Emails were sent to staff regarding policy and procedural changes and updates. All Board members received training.	Partially Implemented. The 2017 audit identified the need for additional staff training to ensure policy compliance. See RECOMMENDATION 1.

RECOMMENDATION 1G: Recover payments for the unallowable costs and errors identified by the audit, including payments to contracted vendors who were paid using the cost plus a percentage method, and revise such contracts to prohibit this payment method.	
ACTIONS TAKEN	OSA CONCLUSION
Connect for Health decided not to recover payments from vendors, but reimbursed the federal government so that federal funds were not used for the unallowable costs and errors identified by the audit, and updated policies to require timely resolution of errors and overpayments. Connect for Health revised its contracts and policies to prohibit cost plus a percentage payments.	Implemented. These actions address the problems identified in the 2014 audit.

RECOMMENDATION 2 – CONTRACT ADMINISTRATION

The 2014 audit found that Connect for Health lacked effective controls over payments to contractors and contract administration. Specifically, the audit found:

- Vendors were paid before contracts were executed and out of compliance with contracts.
- Board approval was not obtained for some high-dollar contracts.
- Some contracts were incomplete or insufficient to ensure public funds were used effectively.

RECOMMENDATION 2A: Establish a comprehensive written procurement policy or procedure that specifies the Board's contract approval responsibilities and a minimum threshold for executing contracts, and implement consistent procedures for Board-approval of contracts and payments that exceed the threshold.	
ACTIONS TAKEN	OSA CONCLUSION
Connect for Health developed and implemented a policy that requires Board approval of federally-funded procurements over $150,000 and non-federal procurements over $250,000.	Implemented. These actions address the problems identified in the 2014 audit.

RECOMMENDATION 2B: Establish and implement procedures to accurately track contracts and monitor payments to vendors to ensure that payments do not begin before the contract is fully executed; ensure payments do not exceed contract amounts without appropriate approval, an executed addendum, and documentation of services provided.	
ACTIONS TAKEN	OSA CONCLUSION
Connect for Health developed policies requiring payments monitoring, contract tracking, and procedures to ensure invoices are accurate with complete and accurate supporting documentation.	Partially Implemented. The 2017 audit identified problems related to vendor payments and contracts. See RECOMMENDATION 1.

RECOMMENDATION 2C: Consistently utilize contract templates to ensure contracts include all federally-required provisions, authorized signatures, statements of work, and payment terms; and develop and implement written procedures to review all contracts for completeness before they are executed.	
ACTIONS TAKEN	OSA CONCLUSION
Connect for Health developed policies requiring standard contract templates that have reasonable terms and conditions, federally-required terms when applicable, statements of work, and payment terms. Policies specify who is authorized to execute contracts and require reviews to ensure contracts are complete.	Partially Implemented. The 2017 audit identified problems related to authorized signatures. See RECOMMENDATION 1.

RECOMMENDATION 2D: Establish and implement written procedures to ensure the Board receives information on contracts exceeding the Board approval threshold and approvals are documented.	
ACTIONS TAKEN	OSA CONCLUSION
Connect for Health developed and implemented a policy that requires documented Board approval of federally-funded procurements over $150,000 and non-federal procurements over $250,000.	Implemented. These actions address the problems identified in the 2014 audit.

RECOMMENDATION 2E: Train management, staff, and Board members, as appropriate, on the policies and procedures developed to address parts A through D.	
ACTIONS TAKEN	OSA CONCLUSION
All Board members received training. Accounting and administrative staff were trained on the new financially-related procedures. Emails are sent to staff regarding policy changes and updates.	Partially Implemented. The 2017 audit identified the need for additional staff training to ensure policy compliance. See RECOMMENDATION 1.

RECOMMENDATION 3 – PAYMENTS TO GRANTEES

The 2014 audit found that Connect for Health did not ensure reimbursements and payments to grantees were reasonable, necessary, accurate, and allowable in accordance with federal laws and regulations, internal policies and procedures, and grant contracts. Specifically, the audit found:

- Grantees were paid federal funds for unallowable services.
- Grantees were reimbursed without support for the services provided or payment amounts.
- Grantees were paid inaccurately, untimely, and without supervisory review.

RECOMMENDATION 3A: Establish and implement comprehensive policies and procedures to administer the grant program, pay grantees in compliance with federal requirements and contract terms, require documentation supporting grantees' actual costs, and ensure timely payment processing.	
ACTIONS TAKEN	OSA CONCLUSION
Connect for Health developed comprehensive policies and procedures to administer the grant program, that require reimbursements to be supported by	Partially Implemented.

documentation of actual costs and contract terms, and require timely payment processing.	The 2017 audit identified noncompliance with grant policies and procedures. See RECOMMENDATION 1.
RECOMMENDATION 3B: Establish and implement processes to oversee the grant program, which include ensuring adequate staffing to review and process grantee payment requests, conducting supervisory review before grantees are paid, and accurately recording all transactions.	
ACTIONS TAKEN	OSA CONCLUSION
Connect for Health developed and implemented procedures to administer the grant program, ensure adequate staffing, review payment requests, conduct supervisory review, and record transactions accurately.	Implemented. These actions address the problems identified in the 2014 audit.
RECOMMENDATION 3C: Evaluate the practice of making advance payments to grantees before services are provided. If this practice continues, develop a written policy and/or procedure requiring grantees to submit documentation demonstrating an immediate need before making advance payments.	
ACTIONS TAKEN	OSA CONCLUSION
Connect for Health has not paid any grantees in advance since 2014 but updated procedures to clarify that if a grantee requests an advance, it must submit documentation to demonstrate that it has an immediate need before receiving payment.	Implemented. These actions address the problems identified in the 2014 audit.
RECOMMENDATION 3D: Investigate each overpayment resulting from noncompliance, instance of noncompliance, and error identified by the audit and recover funds from grantees, as appropriate.	
ACTIONS TAKEN	OSA CONCLUSION
Connect for Health investigated the overpayments and reduced reimbursements to grantees that had been previously paid in error.	Implemented. These actions address the problems identified in the 2014 audit.
RECOMMENDATION 4 - FISCAL MANAGEMENT	
The 2014 audit found that Connect for Health needed to improve its fiscal management. Specifically, Connect for Health did not have sufficient processes and internal controls to ensure federal funds were spent in compliance with laws and regulations, or ensure funds were used prudently or efficiently.	
RECOMMENDATION 4A: Establish and implement written financial policies, procedures, and internal controls that ensure proper accounting, recording of financial transactions and checks, and compliance with applicable laws, regulations, and internal requirements.	
ACTIONS TAKEN	OSA CONCLUSION
Connect for Health established and implemented written financial procedures and internal controls to ensure proper accounting and recording of transactions.	Implemented. These actions address the problems identified in the 2014 audit.

RECOMMENDATION 4B: Ensure an appropriate number of staff and supervisors are assigned to accounting functions and have appropriate system access and segregation of duties.	
ACTIONS TAKEN	OSA CONCLUSION
Connect for Health's accounting department was fully staffed (including supervisors), as of September 2016 and during the course of our 2017 audit. Accounting staff were provided appropriate system access and staffing was sufficient to ensure segregation of duties.	Implemented. These actions address the problems identified in the 2014 audit.
RECOMMENDATION 4C: Establish and implement periodic risk-based quality control reviews to ensure organizational compliance with laws, regulations, and internal policies and procedures.	
ACTIONS TAKEN	OSA CONCLUSION
Connect for Health's financial policies state that quality control reviews will be periodically conducted, and the results will be reported to the Board. Connect for Health created an internal audit department to conduct compliance and quality control reviews.	Partially Implemented. The 2017 audit identified noncompliance with policies and procedures. See RECOMMENDATION 1.
RECOMMENDATION 4D: Train Board members, management, and appropriate staff on the new policies and procedures developed to address parts A through C.	
ACTIONS TAKEN	OSA CONCLUSION
All Board members received training. Accounting and administrative staff were trained on the new financially-related procedures. Emails are sent to staff regarding policy changes and updates.	Partially Implemented. The 2017 audit identified the need for training. See RECOMMENDATION 1.

APPENDIX B

STATE · OF · COLORADO
UNION AND CONSTITUTION
NIL SINE NUMINE
1876

COMPARISON OF STATE-BASED HEALTH EXCHANGES FISCAL YEAR 2016					
State Exchange	Administrative Fee For Each Health Plan Sold[1]	Revenue (in Millions)	Expenditures (in Millions)	Health Plan Enrollment	Percentage of Population Enrolled
Colorado	3.5%	$45.4	$58.7	150,769	2.7%
California	$13.95[2]	$267.0	$269.3	1,575,340	4.0%
Connecticut	1.65%	$40.0	$49.8	116,019	3.2%
Idaho	1.99%[2]	$20.5	$22.6	101,073	6.0%
Maryland	2.0%	NA[3,4]	$101.4	162,177	2.7%
Massachusetts	3.0%	$526.8[5]	$574.0[5]	213,883	3.1%
Minnesota	3.5%	$57.0	$54.5	83,507	1.5%
New York	NA[6]	$69.6[4]	$61.2	271,964	1.4%
Rhode Island	3.5%	$22.5[4]	$22.5	34,670	3.3%
Vermont	NA[6]	NA[3,4]	NA[7]	29,440	4.7%
Washington	2.0%	$129.9[4]	$147.3	200,691	2.8%

SOURCE: Office of the State Auditor analysis of state-based health exchanges' Fiscal Year 2016 audited financial statements and annual reports, and interviews of exchange management in some states.

[1] In Fiscal Year 2016, Colorado charged this administrative fee for each health plan sold through the health exchange as well as a market assessment fee for each plan sold in the state; the market assessment fee was discontinued December 31, 2016. Connecticut and Maryland charged the administrative fee for each plan sold in the state while the other state-based health exchanges charged an administrative fee for each plan sold through the exchange. The administrative fee charged for the 39 states that use the federally-facilitated marketplace is 3.5 percent.

[2] California changed its fee to 4 percent for 2017. Idaho changed its fee to 2.29 percent starting in 2018.

[3] Maryland and Vermont do not track revenue for their health exchanges.

[4] These health exchanges receive funding from their state.

[5] Revenue for Massachusetts includes the premiums charged to consumers and state-funded premium and cost sharing subsidies. Expenditures include the premiums charged to consumers and state-funded premium and cost sharing subsidies, which are paid to carriers.

[6] New York and Vermont do not charge an administrative fee.

[7] Vermont does not track expenditures for its health exchange.

STATE · OF · COLORADO
UNION AND CONSTITUTION
NIL SINE NUMINE
1876