



Advance Payments of the Premium Tax Credit (APTC) Program Assessment Report

for

Time Insurance Company (Nevada) (Time NV)

December 11, 2019

Table of Contents

I. EXECUTIVE SUMMARY	3
II. BACKGROUND, OBJECTIVES, SCOPE, AND METHODOLOGY	5
III. RESULTS OF REVIEW	8
IV. FINDINGS	10
V. OBSERVATIONS.....	14
VI. MANAGEMENT RESPONSES	17
Appendix 1 – Issuer Management Response to Net Financial Adjustment	18
Appendix 2 – Applicable Regulations	19
Appendix 3 – Glossary of Terms and Acronyms	21

I. EXECUTIVE SUMMARY

Background

Time Insurance Company (Nevada) (Time NV) is a health insurance issuer that offered qualified health plans (QHPs) in the individual market State-based Exchange (SBE) on the Federal platform (SBE-FP) in Nevada during the 2015 benefit year. Time NV submitted its final restated 2015 benefit year data in the November 2016 Enrollment and Payment Data Workbook (EPDW). The issuer received a total of \$11,579,547.93 in advance payments of the premium tax credit (APTC) from CMS for its 2015 benefit year individual market plans. Time NV, a wholly-owned subsidiary of Assurant, Inc., discontinued writing individual and employer-sponsored small group major medical health insurance business and exited the individual and small group market effective January 1, 2016.

This report is an assessment of Time NV's compliance with the APTC program established in section 1401 of the Patient Protection and Affordable Care Act (Pub. L. 111–148) enacted on March 23, 2010 and further amended and revised by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152) enacted on March 30, 2010 (collectively referred to throughout as PPACA), and implementing regulations.¹

Audits to Determine Compliance with the Administration of APTC Program

Under title 45 of the Code of Federal Regulations (CFR), sections §§ [156.480](#) and [156.705](#), the Department of Health and Human Services (HHS) may audit² issuers that offer a QHP in the individual market through an Exchange to assess the degree of compliance with the APTC program requirements. HHS designates the Centers for Medicare & Medicaid Services (CMS) to conduct these audits and to achieve the following:

- Safeguard Federal funds;
- Instill confidence amongst regulated entities of data quality, soundness, and robustness;
- Evaluate health insurance issuer compliance with program rules and regulations; and
- Develop a successful and coordinated risk-based, multi-year audit program that maximizes resources.

This audit is part of CMS's program to validate the enrollment and payment data reported on the final 2015 EPDW, and to analyze controls and policies of selected issuers pursuant to the authority defined in the regulations.

¹ CMS did not charge issuers offering QHPs through SBE-FPs user fees during the 2015 benefit year, and so this audit does not involve review of compliance with user fee program requirements.

² To provide the flexibility needed when standing up a new oversight program and to ensure that issuers are able to provide CMS with their most accurate data, audit protocols allow for dialog between auditor and issuer to identify and correct errors in data submission that differ somewhat from some independence and reporting standards laid out under Generally Accepted Government Auditing Standards (GAGAS). These procedures were defined and executed consistent with the competence, integrity, and analytical discipline required for performance audits as defined by GAGAS.

The findings and observations are documented below. If CMS found an instance of issuer non-compliance with APTC program requirements that requires correction to payment, then CMS classified it as a *finding*. If CMS found a deviation from APTC program requirements that we are calling to the attention of management for purposes of improving compliance in future program years, but that does not require correction to payment, then CMS categorized it as an *observation*.

Results of Review

CMS identified one (1) finding and one (1) observation for Time NV. The net financial impact of the one (1) audit finding is a payment to CMS of \$0.61, consisting of APTC owed to CMS. The one (1) observation does not require corrections to payments. The finding and observation include the following:

Finding:

1. Inclusion of incorrectly prorated enrollment and payment data for two (2) subscribers in the UF/APTC Desk Audit File.

Observation:

1. Under-billed premiums for three (3) of the fifteen (15) selected subscribers reported in the UF/APTC Desk Audit File.

Please refer to sections IV and V for details on the finding and observation listed above, including the condition, cause, effect, corrective action, and the issuer's responses.

II. BACKGROUND, OBJECTIVES, SCOPE, AND METHODOLOGY

A. Background

Sections 1401 and 1412 of the PPACA established the APTC program to support the provision of affordable health care coverage to individuals.

CMS has the responsibility to confirm successful implementation of, and adherence to, the PPACA provisions and implementing regulations governing the APTC program. As such, CMS established this audit program.

Interim Payment Process

Since automated payment systems were not yet developed during the first years of FFE and SBE-FP implementation, CMS implemented an interim payment process to calculate and make monthly payments of APTC and advance Cost-sharing Reduction (CSR) amounts. The interim payment process required issuers to self-report enrollment and payment data on a monthly basis, including any adjustments to previous months' requests, via manual submission of an EPDW, and to attest to the accuracy of the data.

For the 2015 benefit year, CMS used this interim payment process to calculate and make monthly payments based on QHP data submitted in the EPDW. While using this interim process, CMS designed and implemented a robust set of internal controls within a larger program integrity framework to ensure payment accuracy. CMS required submitters to send the following QHP plan information at the variant level via the password-protected template:

1. State
2. Tax Identification Number (TIN)
3. Health Insurance Oversight System (HIOS) ID
4. QHP ID
5. Total premium amount for all enrollments
6. Total APTC amount
7. Total advance CSR amount
8. Total effectuated enrollment groups
9. Total effectuated enrollment groups with APTC
10. Total effectuated enrollment groups with advance CSR
11. Total effectuated members
12. Total effectuated members with APTC
13. Total effectuated members with advance CSR

B. Regulations Governing APTC Program

CMS established an audit protocol to assess health insurance issuers' compliance with the following regulations governing the APTC program:

- 45 CFR § [156.460](#): Reduction of enrollee’s share of premium to account for advance payments of the premium tax credit;
- 45 CFR § [156.480](#): Oversight of the administration of the cost-sharing reductions and advance payments of the premium tax credit programs;
- 45 CFR § [156.705](#): Maintenance of records for Federally-facilitated Exchanges.

Please refer to Appendix 2 for the specific requirements established under the authorities listed above.

C. Objectives

The objectives of this audit are to:

- (1) Evaluate the accuracy and integrity of issuer-generated EPDW data reported for the APTC program;
- (2) Identify potential CMS APTC payment errors resulting from issuer data reporting errors; and
- (3) Test accuracy and integrity of issuer processes for reducing an enrollee’s share of premium to account for APTCs.

D. Scope and Methodology

CMS selected Time NV for an audit on issuer compliance with the aforementioned regulations. CMS evaluated Time NV’s activities related to the 2015 benefit year (January 1, 2015 through December 31, 2015) individual market data reported on the final EPDW submitted in November 2016 by the issuer to CMS to support APTC payments.

CMS sent Time NV an electronic letter on May 11, 2018 to notify them of the scope of this audit. CMS’s audit contractor sent a follow-up letter to Time NV on May 14, 2018 that identified data requirements required to conduct the audit. CMS’s audit contractor reviewed the audit data file submitted by Time NV and used CMS’s audit procedures to assess compliance with APTC program rules and regulations.

CMS’s audit contractor applied CMS’s audit protocol to identify the findings and observations listed in sections IV and V of this report. CMS’s audit contractor performed the following procedures:

- Validations of the UF/APTC Desk Audit File³ data submitted to CMS:
 - EPDW Validations: Review and comparison of the issuer’s final submitted 2015 EPDW to the UF/APTC Desk Audit File from the issuer’s systems.
 - Unreconciled Subscribers Review: Review and comparison of the subscribers reported on the UF/APTC Desk Audit File to the subscribers included in CMS’s systems to determine if the subscribers existed and their coverage was effectuated

³ The UF/APTC Desk Audit File is CMS’s standard document for issuers to provide information in support of this audit.

in the issuer's system (i.e., the amount the subscriber is responsible to pay toward the first month's total premium amount has been paid in full by the subscriber).

- Duplicate Exchange-assigned Subscriber IDs Check: Review of the UF/APTC Desk Audit File containing subscriber level data from the issuer's systems to verify that duplicate Exchange-assigned subscriber IDs (i.e., Exchange-assigned subscriber IDs that were reported on the file twice in the same month with full month or incorrectly prorated payment data) were not reported on the file.
- Premium Less than APTC Validation: Review of the UF/APTC Desk Audit File to verify that the subscribers' premium amounts reported on the file were not less than the APTC amounts reported on the file.
- Coverage Days Validation: Review of the UF/APTC Desk Audit File to verify that enrollments of five (5) days or fewer reported on the file were effectuated and had active coverage in the issuer's systems.
- Validations on samples of issuer's systems data:
 - Forty-five (45) Subscribers Sample Review: Review and comparison of the coverage periods, premium and APTC amounts from the issuer's systems to the corresponding data included in CMS's systems for a selected sample of forty-five (45) subscribers.
 - Fifteen (15) Subscribers Sample Review: Analysis and review of data and documentation from the issuer's systems to verify effectuation and the appropriate application of premium and APTC amounts to policies for a selected sample of fifteen (15) subscribers.
- Policy and Procedure Review: Review of issuer APTC policies and procedures for completeness and clarity.

III. RESULTS OF REVIEW

CMS assessed issuer compliance with regulations using the following procedures: EPDW Validations, Unreconciled Subscribers Review, Duplicate Exchange-assigned Subscriber IDs Check, Premium Less than APTC Validation, Coverage Days Validation, Forty-five (45) Subscribers Sample Review, Fifteen (15) Subscribers Sample Review, and Policy and Procedure Review. Below are the results of this review.

EPDW Validations

No findings or observations resulted from the comparison of the final 2015 EPDW to Time NV's UF/APTC Desk Audit File.

Unreconciled Subscribers Review

No findings or observations resulted from the review of Time NV's UF/APTC Desk Audit File to determine if the subscribers reported on the file existed and their coverage was effectuated in the issuer's systems.

Duplicate Exchange-assigned Subscriber IDs Check

One (1) finding and no observations resulted from the review of Time NV's UF/APTC Desk Audit File to verify that duplicate Exchange-assigned subscriber IDs were not reported on the file. Please refer to Finding No. 1 included in section IV for details on the finding.

Premium Less than APTC Validation

No findings or observations resulted from the review of Time NV's UF/APTC Desk Audit File to verify that subscribers were not reported on the file with premium amounts that were less than the APTC amounts.

Coverage Days Validation

No findings or observations resulted from the review of Time NV's UF/APTC Desk Audit File to verify that enrollments of five (5) days or fewer reported on the file were effectuated and had active coverage in the issuer's systems.

Forty-five (45) Subscribers Sample Review

No findings or observations resulted from the review and comparison of the data from Time NV's systems to the corresponding data included in CMS's systems to determine accuracy of the reported enrollment months and the application of premium and APTC for a selected sample of forty-five (45) subscribers.

Fifteen (15) Subscribers Sample Review

No findings and one (1) observation resulted from the review of the data and documentation from Time NV's systems to verify effectuation and the appropriate application of premium and APTC amounts to policies for a selected sample of fifteen (15) subscribers. Please refer to Observation No. 1 included in section V for details on the observation.

Policy and Procedure Review

No findings or observations resulted from the review of Time NV's APTC policies and procedures.

IV. FINDINGS

A finding is an identification of an instance of issuer non-compliance with APTC program requirements that requires correction to payment. CMS's audit procedures identified one (1) finding that resulted in a change to Time NV's reported EPDW for individual market plans for the 2015 benefit year. In light of the one (1) finding, the adjusted 2015 benefit year EPDW APTC amounts for individual market plans are shown in the following table.

Recalculated EPDW for the 2015 Benefit Year

	Premium*	APTC
EPDW as filed in November 2016	\$22,370,079.36	\$11,579,547.93
Finding No. 1 - Duplicate Exchange-assigned Subscriber IDs Check Adjustment	\$0.00	\$(0.61)
EPDW As Recalculated	\$22,370,079.36	\$11,579,547.32
Total Financial Impact	\$0.00*	\$(0.61)

Note: Positive values indicate funds owed to the issuer.

* Note: The premium financial impact is for informational purposes only. CMS did not charge issuers offering QHPs through SBE-FPs user fees during the 2015 benefit year.

The net financial impact of the one (1) audit finding is a payment to CMS of \$0.61, consisting of APTC owed to CMS.

For the one (1) audit finding, CMS documented the criteria, cause, effect, corrective action, and Time NV's response as seen in the chart below.

Finding No. 1 - Duplicate Exchange-assigned Subscriber IDs Check	Condition:	Time NV overstated the 2015 benefit year APTC amounts for one (1) subscriber and understated the 2015 benefit year APTC amounts for one (1) subscriber in the UF/APTC Desk Audit File by reporting enrollment and incorrectly prorated payment data for the subscribers.
---	-------------------	--

	Criteria:	<p>Issuers cannot request full month payment from CMS for the same subscriber twice within a month. Additionally, per the HHS Notice of Benefit and Payment Parameters for 2015 and 45 CFR § 155.240, in a Federally-facilitated Exchange, the premium for coverage lasting less than one month must equal the product of (i) The premium for one month of coverage divided by the number of days in the month; and (ii) The number of days for which coverage is being provided in the month.</p>
	Cause:	<p>The issuer indicated the following explanations for the two (2) subscribers:</p> <ul style="list-style-type: none"> For one (1) subscriber with two (2) records where the issuer correctly prorated the first record but incorrectly prorated the second record, the issuer indicated “Baby was added to policy X effective 3/7/15; the new premium was \$462.17; however, the policy was replaced on 3/11/15 by policy Y. Prorated premium based on the 6 days without the baby and 4 days with the baby: $\begin{aligned} & \\$282.67 / 31 \times 6 = \\$54.71; \\ & \\$462.17 / 31 \times 4 = \\$59.63; \\ & \\$54.71 + \\$59.63 = \\$114.34 \end{aligned}$ APTC for X was \$126.00 for 4 days in March: $\\$126.00 / 31 \times 4 = \\24.39 APTC was \$346.00 for 25 days in March: $\\$346.00 / 31 \times 25 = \\279.03 Total APTC for March was \$303.42; however, policy was only effective for 10 days: $\\$303.42 / 31 \times 10 = \\97.88 Premium on policy Y was \$462.17 per month; however, policy was only effective for 21 days in March. $\\$462.17 / 31 \times 21 = \\313.08 APTC was \$346 per month. $\\$346.00 / 31 \times 21 = \\234.39. The original response in column L contain an error for the APTC calculation. It should have shown 6 days instead of 4 days: $\\$126.00 / 31 \times 6 = \\24.39 APTC was \$126.00 from 3/1/2015-3/7/2015, 6 days.

		<p>APTC was \$346.00 from 3/7/2015-3/11/2015, 4 days. Using individual APTC amounts, the calculation would be: $\\$126.00/31 \times 6 = \\24.39 and $\\$346.00/31 \times 4 = \\44.66 for a total of \$69.05. We were notified with the 1/14/2016 Marketplace report that policy X was replaced by policy Y. At the time of the replacement, our system showed the total APTC for the entire month of March, which was \$303.42 (see calculation in column L). That total was used for the proration calculation ($\\$303.42/31 \times 10 = \\97.88) for the 10 days the policy was effective in March (after the replacement) and APTC was reported as \$97.88.”</p> <ul style="list-style-type: none"> For one (1) subscriber with two (2) records where the issuer correctly prorated the first record but incorrectly prorated the second record, the issuer indicated "Policy X was replaced by policy Y effective 3/10/2015; Premium on X was \$879.46 per month; however, policy was effective only 9 days in March. $\\$879.46 / 31 \times 9 = \\255.33 APTC was \$510.00 for 9 days in March; $\\$510.00 / 31 \times 9 = \\148.06 APTC was \$373.00 for 22 days in March: $\\$373.00 / 31 \times 22 = \\264.71 Total APTC for March was \$412.77; $\\$412.77 / 31 \times 9 = \\119.84 Premium on Y was \$1049.46 per month; however, policy was effective only 22 days in March. $\\$1049.46 / 31 \times 22 = \\744.78 APTC was \$373.00 per month; $\\$373 / 31 \times 22 = \\264.71 Using the individual APTC amounts, the calculation would be: $\\$510.00/31 \times 9 = \\148.06. We were notified with the 1/14/2016 Marketplace report that policy X was replaced by policy Y. At the time of the replacement, our system showed the total APTC for the entire month of March, which was \$412.77 (see calculation in column L).
--	--	--

		<p>That total was used for the proration calculation ($\\$412.77/31 \times 9 = \\119.84) for the 9 days the policy was effective in March (after the replacement) and APTC was reported as \$119.84.”</p> <p>Based on the feedback and issuer provided calculations and dates, CMS concluded that the incorrect 2015 benefit year APTC amounts were reported in the UF/APTC Desk Audit File for the two (2) subscribers.</p>
	Effect:	The inclusion of the incorrectly prorated APTC amounts for the two (2) subscribers resulted in a change to Time NV’s final, restated 2015 benefit year EPDW data.
	Corrective Action Required:	The net financial impact of this finding is a payment to CMS of \$0.61, consisting of APTC owed to CMS. Time NV should confirm the financial impact and coordinate on resolution with CMS as indicated in section VI of this report.
	Management Response:	Agree.

V. OBSERVATIONS

An observation is a deviation from APTC program requirements that we are calling to the attention of management for purposes of improving compliance in future program years but that does not require correction to payment. CMS's audit procedures identified one (1) observation.

Observation No. 1 – Fifteen (15) Subscribers Sample Review (Under-billed Premiums)	Condition:	Time NV under-billed premiums for three (3) of the fifteen (15) selected subscribers reported in the UF/APTC Desk Audit File as it did not balance bill the subscriber for the under-billed amounts following the changes that occurred.
	Criteria:	Under applicable rating rules and Exchange requirements, QHP issuers are required to establish rates, and make those rates applicable for the entire benefit year. Issuers generally may not waive premium amounts owed.
	Cause:	<p>The issuer indicated the following explanations for the three (3) subscribers:</p> <ul style="list-style-type: none"> "During the period of June-October 2015, our system reflected an APTC amount of \$894.65; therefore, the bills we originally sent for June-November 1, 2015 showed no premium was due. We notified the member of the APTC change on 11/2/15. We did not balance bill the member for the undercharged premium from June-October. Our understanding is that the \$0.01 voucher payment was used to override the amount due from June-October. The bill for 11/1/15 shows prior amount due and paid of \$0.05, representing \$0.01 for the 5 months from June to October." The issuer further noted "The APTC was changed to \$631.00 effective 6/1/2015." As a result of the feedback, CMS concluded that there was an under-billed premium of \$1,318.25. "The policy was set to terminate as of 5/1/2015; however, the member contacted the MP, and the policy was reinstated. During the period of June-October 2015, our system reflected an APTC amount of

		<p>\$205.00; therefore, we continued to bill the member \$443.76. We notified the member of the APTC change on 11/19/15. We did not balance bill the member for the undercharged premium from June-October." The issuer further noted "The APTC was changed to \$0.00 effective 6/1/2015." As a result of the feedback, CMS concluded that there was an under-billed premium of \$1,230.00.</p> <ul style="list-style-type: none"> • "During the period of May- August, our system reflected an APTC amount of \$458.00; therefore we continued to bill the member \$295.59. We notified the member of the APTC change on 11/2/15. We did not balance bill the member for the undercharged premium from May-August." The issuer further noted "The APTC was changed to \$0.00 effective 5/1/2015." As a result of the feedback, CMS concluded that there was an under-billed premium of \$1,832.00.
	Effect:	Under-billing of premiums may impact other enrollments reported on Time NV's final, restated benefit year 2015 EPDW or enrollments reported in the prior benefit year EPDW. Additionally, the uncollected premiums may not have been characterized as realized/earned premium for other purposes, such as MLR, RA data submission, and RC reporting.
	Management Response:	Agree.

Please provide management's response to the one (1) finding and one (1) observation identified in the draft audit report and complete the attached Appendix 1 - Issuer Management Response to Net Financial Adjustment (Appendix 1), within thirty (30) calendar days from the draft audit report date. Management's response should indicate agreement or disagreement.

Agreement

If management agrees with the one (1) finding and one (1) observation, complete the "Management Response" field of the finding and observation in the draft audit report, and initial "Agree" and sign the attached Appendix 1. Return the draft audit report including Appendix 1 within thirty (30) calendar days from the draft audit report date. Upon receipt of the signed Appendix 1, CMS will finalize and publish the report. CMS will process the final adjustment amount in the next available monthly payment cycle.

Disagreement

If management disagrees with the one (1) finding and corrective action or the one (1) observation, complete the "Management Response" field of the finding and observation in the draft audit report, and initial "Disagree" and sign the attached Appendix 1. Return the draft audit report including Appendix 1 and any supporting documentation that substantiates management's response within thirty (30) calendar days from the draft audit report date. This will be the final opportunity to provide information or supporting documentation to correct any inaccuracies in the report before it is finalized.

CMS will review the written explanations in the "Management Response" field of the finding and observation and any supporting documentation to determine if the report can be amended in a mutually acceptable manner. If you and CMS are unable to come to a mutually acceptable result, your response to this report will be included in the final published audit report.

CMS will provide an updated audit report, including the stated final adjustment amount along with an updated Appendix 1, following receipt and review of management's response. Please return the updated audit report with management responses and signed Appendix 1 within fifteen (15) calendar days. Upon receipt of the signed Appendix 1, CMS will finalize and publish the report and process the final adjustment amount in the next available monthly payment cycle.

VI. MANAGEMENT RESPONSES

Please provide management's response to the one (1) finding and one (1) observation identified in the draft audit report and complete the attached Appendix 1 - Issuer Management Response to Net Financial Adjustment (Appendix 1), within thirty (30) calendar days from the draft audit report date. Management's response should indicate agreement or disagreement.

Agreement

If management agrees with the one (1) finding and one (1) observation, complete the "Management Response" field of the finding and observation in the draft audit report, and initial "Agree" and sign the attached Appendix 1. Return the draft audit report including Appendix 1 within thirty (30) calendar days from the draft audit report date. Upon receipt of the signed Appendix 1, CMS will finalize and publish the report. CMS will process the final adjustment amount in the next available monthly payment cycle.

Disagreement

If management disagrees with the one (1) finding and corrective action or the one (1) observation, complete the "Management Response" field of the finding and observation in the draft audit report, and initial "Disagree" and sign the attached Appendix 1. Return the draft audit report including Appendix 1 and any supporting documentation that substantiates management's response within thirty (30) calendar days from the draft audit report date. This will be the final opportunity to provide information or supporting documentation to correct any inaccuracies in the report before it is finalized.

CMS will review the written explanations in the "Management Response" field of the finding and observation and any supporting documentation to determine if the report can be amended in a mutually acceptable manner. If you and CMS are unable to come to a mutually acceptable result, your response to this report will be included in the final published audit report.

CMS will provide an updated audit report, including the stated final adjustment amount along with and an updated Appendix 1, following receipt and review of management's response. Please return the updated audit report with management responses and signed Appendix 1 within fifteen (15) calendar days. Upon receipt of the signed Appendix 1, CMS will finalize and publish the report and process the final adjustment amount in the next available monthly payment cycle.

Appendix 1 – Issuer Management Response to Net Financial Adjustment

Issuer HIOS ID: 29211

Issuer Name: Time Insurance Company (Nevada) (Time NV)

The undersigned Chief Executive Officer (CEO), Chief Financial Officer (CFO) or other individual who can legally and financially bind this issuer has reviewed the information included in the audit report of the issuer's 2015 benefit year APTC program participation, resulting in a payment to CMS of \$0.61, consisting of APTC owed to CMS, and:

(INITIAL)_____Agrees with the audit net adjustment amount above, confirming the audit finding(s) and observation(s), if applicable, and as such this report will be considered final and published.

(INITIAL) _____Disagrees and requests a review of additional information that may impact the audit net adjustment amount resulting from the 2015 benefit year audit. If review is requested, CMS will consider this draft only a preliminary audit report. If the review option is selected, you must provide a written explanation with any additional documentation when you return this response within thirty (30) calendar days of the date of this draft audit report. CMS will review the written explanation and any supporting documentation to determine if the report can be amended in a mutually acceptable manner. If you and CMS are unable to come to a mutually acceptable result, your response to this report will be included in the final published audit report.

Signed: _____
(Signature of authorized person acting on behalf of the issuer.)

Printed Name: GORDON ROWELL
(Print name of signature)

Title: CHIEF OPERATING OFFICER
(Title of authorized person acting on behalf of the Issuer)

Telephone Number: 787-919-0762
(Direct Telephone Number)

Date: 01/10/2020

Appendix 2 – Applicable Regulations

The following table identifies the specific regulatory requirements around which CMS has organized its audits.

Regulation	Guidance
45 CFR § 156.460 - Reduction of enrollee's share of premium to account for advance payments of the premium tax credit	(a) Reduction of enrollee's share of premium to account for advance payments of the premium tax credit. A QHP issuer that receives notice from the Exchange that an individual enrolled in the issuer's QHP is eligible for an advance payment of the premium tax credit must— (1) Reduce the portion of the premium charged to or for the individual for the applicable month(s) by the amount of the advance payment of the premium tax credit; (2) Notify the Exchange of the reduction in the portion of the premium charged to the individual in accordance with § 156.265(g); and (3) Include with each billing statement, as applicable, to or for the individual the amount of the advance payment of the premium tax credit for the applicable month(s), and the remaining premium owed.

Regulation	Guidance
<p>45 CFR § 156.480 - Oversight of the administration of the cost-sharing reductions and advance payments of the premium tax credit programs.</p>	<p>(a) Maintenance of records. An issuer that offers a QHP in the individual market through a State Exchange must adhere to, and ensure that any relevant delegated entities and downstream entities adhere to, the standards set forth in § 156.705 concerning maintenance of documents and records, whether paper, electronic, or in other media, by issuers offering QHPs in a Federally-facilitated Exchange, in connection with cost-sharing reductions and advance payments of the premium tax credit.</p> <p>(b) Annual reporting requirements. For each benefit year, an issuer that offers a QHP in the individual market through an Exchange must report to HHS, in the manner and timeframe required by HHS, summary statistics specified by HHS with respect to administration of cost-sharing reduction and advance payments of the premium tax credit programs, including any failure to adhere to the standards set forth under § 156.410(a) through (d), § 156.425(a) through (b), and § 156.460(a) through (c) of this Part.</p> <p>(c) Audits. HHS or its designee may audit an issuer that offers a QHP in the individual market through an Exchange to assess compliance with the requirements of this subpart.</p>
<p>45 CFR § 156.705 – Maintenance of records for Federally-facilitated Exchanges</p>	<p>(a) General standard. Issuers offering QHPs in a Federally-facilitated Exchange must maintain all documents and records (whether paper, electronic, or other media) and other evidence of accounting procedures and practices, necessary for HHS to do the following:</p> <p>(1) Periodically audit financial records related to QHP issuers' participation in a Federally-facilitated Exchange, and evaluate the ability of QHP issuers to bear the risk of potential financial losses; and</p> <p>(2) Conduct compliance reviews or otherwise monitor QHP issuers' compliance with all Exchange standards applicable to issuers offering QHPs in a federally-facilitated Exchange as listed in this part.</p> <p>(b) Records. The records described in paragraph (a) of this section include the sources listed in § 155.1210(b)(2), (3), and (5) of this subchapter.</p> <p>(c) Record retention timeframe. Issuers offering QHPs in a Federally-facilitated Exchange must maintain all records referenced in paragraph (a) of this section for 10 years.</p> <p>(d) Record availability. Issuers offering QHPs in a Federally-facilitated Exchange must make all records in paragraph (a) of this section available to HHS, the OIG, the Comptroller General, or their designees, upon request.</p>

Appendix 3 – Glossary of Terms and Acronyms

Terms & Acronyms	Definition
CEO	Chief Executive Officer
CFR	Code of Federal Regulations
CSR	Cost-sharing Reduction
FFE	Federally-facilitated Exchange
HHS	Department of Health and Human Services
PPACA	Patient Protection and Affordable Care Act
SBE	State-based Exchange
TIN	Tax Identification Number
