



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

*for*

*Presbyterian Health Plan (Presbyterian)*

*January 13, 2020*

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## I. EXECUTIVE SUMMARY

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### Background

Presbyterian Health Plan (Presbyterian) 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 New Mexico during the 2015 benefit year. Presbyterian submitted its final restated 2015 benefit year data in the July 2016 Enrollment and Payment Data Workbook (EPDW). The issuer received a total of \$9,786,080.12 in advance payments of the premium tax credit (APTC) from CMS for its 2015 benefit year individual market plans.

This report is an assessment of Presbyterian'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.<sup>1</sup>

### 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 audit<sup>2</sup> 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.

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

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<sup>1</sup> 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.

<sup>2</sup> 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.

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 four (4) findings and three (3) observations for Presbyterian. The net financial impact of the four (4) audit findings is a payment to CMS of \$9,240.34, consisting of APTC owed to CMS. The three (3) observations do not require corrections to payments. The findings and observations include the following:

### **Findings:**

1. Differences in premium and APTC amounts identified in the comparison of the issuer's data included in the EPDW to a UF/APTC Desk Audit File containing subscriber level data from Presbyterian's systems;
2. Inclusion of premium amounts that were less than the APTC amounts for ten (10) subscribers in the UF/APTC Desk Audit File;
3. Inclusion of enrollment and payment data for four (4) subscribers with a coverage period of five (5) days or fewer that was not effectuated in the UF/APTC Desk Audit File; and
4. Inclusion of enrollment and payment data in the UF/APTC Desk Audit File for two (2) of the fifteen (15) selected subscribers with coverage that was not effectuated in the issuer's systems.

### **Observations:**

1. Billing of negative premium amounts for two (2) subscribers reported in the UF/APTC Desk Audit File;
2. Incorrect reporting of premium amounts for four (4) of the forty-five (45) selected subscribers in the UF/APTC Desk Audit File due to a birthday premium rating issue; and
3. Receipt of late full binder payments for nine (9) subscribers, including one (1) 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 findings and observations listed above, including the condition, cause, effect, corrective actions, and the issuer's responses.

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## **II. BACKGROUND, OBJECTIVES, SCOPE, AND METHODOLOGY**

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### **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 § [156.50](#): Financial Support;
- 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 Presbyterian for an audit on issuer compliance with the aforementioned regulations. CMS evaluated Presbyterian’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 July 2016 by the issuer to CMS to support APTC payments.

CMS sent Presbyterian 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 Presbyterian on May 14, 2018 that identified data requirements required to conduct the audit. CMS’s audit contractor reviewed the audit data file submitted by Presbyterian 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 File<sup>3</sup> 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

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

systems to determine if the subscribers existed and their coverage was effectuated 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.

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### **III. RESULTS OF REVIEW**

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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**

One (1) finding and no observations resulted from the comparison of the final 2015 EPDW to Presbyterian's UF/APTC Desk Audit File. Please refer to Finding No. 1 included in section IV for details on the finding.

#### **Unreconciled Subscribers Review**

No findings or observations resulted from the review of Presbyterian'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**

No findings or observations resulted from the review of Presbyterian's UF/APTC Desk Audit File to verify that duplicate Exchange-assigned subscriber IDs were not reported on the file.

#### **Premium Less than APTC Validation**

One (1) finding and one (1) observation resulted from the review of Presbyterian'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. Please refer to Finding No. 2 included in section IV for details on the finding and Observation No. 1 included in section V for details on the observation.

#### **Coverage Days Validation**

One (1) finding and no observations resulted from the review of Presbyterian'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. Please refer to Finding No. 3 included in section IV for details on the finding.

#### **Forty-five (45) Subscribers Sample Review**

No findings and one (1) observation resulted from the review and comparison of the data from Presbyterian'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. Please refer to Observation No. 2 included in section V for details on the observation.

#### **Fifteen (15) Subscribers Sample Review**

One (1) finding and one (1) observation resulted from the review of the data and documentation from Presbyterian'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

Finding No. 4 included in section IV for details on the finding and Observation No. 3 included in section V for details on the observation.

**Policy and Procedure Review**

No findings or observations resulted from the review of Presbyterian'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 four (4) findings that resulted in a change to Presbyterian's reported EPDW for individual market plans for the 2015 benefit year. In light of the four (4) findings, 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 July 2016	\$23,525,392.22	\$9,786,080.12
Finding No. 1 - EPDW Validations Adjustment	\$(14,976.09)	\$(4,617.81)
Finding No. 2 - Premium Less than APTC Validation Adjustment	\$3,570.14	\$(1,613.05)
Finding No. 3 - Coverage Days Validation Adjustment	\$(35.80)	\$(15.48)
Finding No. 4 – Fifteen (15) Subscribers Sample Review Adjustment	\$(4,591.38)	\$(2,994.00)
EPDW As Recalculated	\$23,509,359.09	\$9,776,839.78
<b>Total Financial Impact</b>	<b>\$(16,033.13)*</b>	<b>\$(9,240.34)</b>

**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 four (4) audit findings is a payment to CMS of \$9,240.34, consisting of APTC owed to CMS.

For the four (4) audit findings, CMS documented the criteria, cause, effect, corrective actions, and Presbyterian’s responses as seen in the charts below.

<b>Finding No. 1 - EPDW Validations</b>	<b>Condition:</b>	<p><b>Premium Differences</b> – For one or more months of 2015 benefit year enrollment in twenty-seven (27) QHPs, the net "Total Premium Amount by QHP ID for effectuated enrollments" included in Presbyterian’s EPDW was greater than the total premium amount included in Presbyterian’s UF/APTC Desk Audit File, resulting in an overstatement of \$14,976.09 in premiums. For the one or more months of 2015 benefit year enrollment in twenty-seven (27) QHPs, the EPDW was understated by ninety (90) enrollment groups and one hundred and twenty-seven (127) members.</p> <p><b>APTC Differences</b> – For one or more months of 2015 benefit year enrollment in twenty-two (22) QHPs, the net "Total APTC Amount by QHP ID for effectuated enrollments" included in Presbyterian’s EPDW was greater than the total APTC amount included in Presbyterian’s UF/APTC Desk Audit File, resulting in an overpayment of \$4,617.81 in APTC. For the one or more months of 2015 benefit year enrollment in twenty-two (22) QHPs, the EPDW was understated by fifty (50) APTC enrollment groups and seventy-five (75) APTC members.</p>
	<b>Criteria:</b>	<p>Per CMS guidance and EPDW submission requirements:</p> <p>The “Total premium amount by QHP ID for effectuated enrollments” submitted on the EPDW is the "total premium amount for the health coverage for all effectuated enrollments within that plan”.</p> <p>The “Total APTC amount by QHP ID for effectuated enrollments” submitted on the EPDW is the "total APTC toward the total premium amount for effectuated enrollments within a 16-digit QHP ID."</p> <p>Additionally, the premium and APTC amounts reported in the EPDW and in the enrollment group</p>

		<p>enrollment records of the UF/APTC Desk Audit File must be prorated using the proration formulas set forth in the 2015 payment notice and outlined in 45 CFR § 155.240.</p>
	<p><b>Cause:</b></p>	<p>The issuer indicated "We cannot reconcile at the member level on this request. We pulled information per instruction in 2016 at the plan level, and 2018 at subscriber level. We have confirmed that we do not have access to the point in time member level data that was submitted in 2016 for the 2015 year. Additionally, the information pulled in 2016 was from billing tables, and the information pulled in 2018 was from Rate &amp; APTC tables.</p> <p>When we were participating in the Exchange, we used the 834 EDI transactions as a source of truth. We also received HICS (Health Insurance Casework System) cases daily that would provide updated information for members, such as the incorrect benefit plan was sent over, or the benefit dates were incorrect. We would then research these cases and determine if any action was needed. The monthly Pre-Audit files were provided from the FFM to us, and were used as an extra resource for research and verification purposes, but were not reconciled against Facets. Often the HICS cases were not reflected in the Pre-Audits, which leads to discrepancies in Audits. The HICS cases were assigned to us by the FFM, so we were updating membership based on information they were sending us. In addition, we cannot reconcile at the member level on this request. We have confirmed that we do not have access to the point in time member level data that was submitted in 2016 for the 2015 year."</p> <p>The issuer further indicated "We believe that numerous discrepancies were due to HICS cases and retro activity. We cannot reconcile at the member level on this request. We have confirmed that we do not have access to the point in time member level data that was submitted in 2016 for the 2015 year. Additionally, the information pulled in 2016 was from billing tables, and the information pulled in 2018 was from Rate &amp; APTC tables. "</p>

		<p>During the audit, CMS coordinated with the issuer to determine whether the differences were due to retroactivity (e.g., HICS cases and changes that occurred after July 2016). The issuer noted “Yes, that is the reason for the majority of the issues. Additional reasons that could have caused minor differences are as follows: Due to the fact that 2018 was calculated from the rate table, but 2016 was from the billing tables, our reports were affected in a couple of ways:</p> <ol style="list-style-type: none"> <li>1. Birthday issue was handled in a different manner</li> <li>2. One day span was billed differently – 2016 was billed, 2018 we did not include in calculation”.</li> </ol> <p>Based on this feedback that there were discrepancies due to HICS cases and retroactivity, CMS concluded that the premium and APTC amounts reported in the final, restated 2015 benefit year EPDW were overstated.</p> <p>The net understatements in enrollment groups and members identified in the condition represent aggregated differences, i.e., the aggregated understatements include QHP-level overstatements in some months and QHP-level understatements in other months. The differences may have resulted from incorrect reporting of the enrollment groups and members reported on the EPDW due to the lack of guidance, uncertainty around EPDW reporting requirements, and/or differences in the approaches for calculating and reporting enrollment groups and members on the EPDW versus the approaches for calculation and reporting enrollment groups and members for audit purposes.</p>
	<b>Effect:</b>	The premium and APTC differences resulted in a change to Presbyterian’s final, restated 2015 benefit year EPDW data.
	<b>Corrective Action Required:</b>	The net financial impact of this finding is a payment to CMS of \$4,617.81, consisting of APTC owed to CMS. Presbyterian should confirm the

		<p>financial impact and coordinate on resolution with CMS as indicated in section VI of this report.</p> <p>The premium financial impact for this finding is an overstatement of \$14,976.09 in premiums; however, this is for informational purposes only as CMS did not charge issuers offering QHPs through SBE-FPs user fees during benefit year 2015.</p>
	<b>Management Response:</b>	Management agrees with finding.

<b>Finding No. 2 - Premium Less than APTC Validation</b>	<b>Condition:</b>	<p>Presbyterian reported premium amounts that were less than the APTC amounts for ten (10) subscribers in the UF/APTC Desk Audit File. As a result, Presbyterian understated the 2015 benefit year premium amounts for six (6) of the ten (10) subscribers and overstated the 2015 benefit year APTC amounts for four (4) of the ten (10) subscribers in the UF/APTC Desk Audit File.</p>
	<b>Criteria:</b>	<p>Issuers cannot report a premium amount that is less than an APTC amount. Per CMS guidance, the APTC amount reported on the EPDW and UF/APTC Desk Audit File is the APTC amount toward the total premium amount for effectuated enrollments. Per CMS guidance, the premium amount reported on the EPDW is the premium amount by 16 digit QHP ID for the effectuated enrollment within a qualified health plan.</p>
	<b>Cause:</b>	<p>The issuer indicated the following explanations for each of the ten (10) subscribers:</p> <ul style="list-style-type: none"> <li>• "Dependent separated in Facets but APTC was always [issuer provided APTC amount of \$X for subscriber] in Facets. Dependent termination did not come from File, dependent and Subscriber were termed by the auto term functionality of our system of record. Enrollment worked manual report identifying term should not have been done due to payment being made. Enrollment corrected Subscriber but did not correct</li> </ul>

		<p>dependent. Enrollment processor error.” (Five (5) subscribers)</p> <ul style="list-style-type: none"> <li>• “Dependent [issuer provided dependent name for subscriber] termed [issuer provided date of X/X/2015 for subscriber.]” (Three (3) subscribers)</li> <li>• "Consumer enrolled on 06/16/2015 in Individual Silver Plan D, (800) 356-2219. The consumer's application ID is X. The consumer's FFM assigned policy number is Y. Preferred call back time: Any spouse was taken off the plan because he was eligible for Medicare and the insurance company states they do not have this cancelation.” (One (1) subscriber)</li> <li>• "This issue is because of our data issue. Enrollment source was missing for the dependent and that is the reason we calculated premium for only one (Subscriber). The actual premium should be 838.55.” (One (1) subscriber)</li> </ul> <p>Based on the feedback that there were enrollment processing errors, changes and data issues, CMS concluded that incorrect 2015 benefit year premium and APTC amounts were reported in the UF/APTC Desk Audit File for the ten (10) subscribers. During the audit, the issuer provided the correct premium and APTC amounts for the ten (10) subscribers to inform the financial impact calculation.</p>
	<p><b>Effect:</b></p>	<p>The inclusion of the incorrect premium and APTC amounts for the ten (10) subscribers resulted in a change to Presbyterian’s final, restated 2015 benefit year EPDW data.</p>
	<p><b>Corrective Action Required:</b></p>	<p>The net financial impact of this finding is a payment to CMS of \$1,613.05, consisting of APTC owed to CMS. Presbyterian should confirm the financial impact and coordinate on resolution with CMS as indicated in section VI of this report.</p> <p>The premium financial impact for this finding is an understatement of \$3,570.14 in premiums; however, this is for informational purposes only as CMS did</p>

		not charge issuers offering QHPs through SBE-FPs user fees during benefit year 2015.
	<b>Management Response:</b>	Management agrees with finding.

<b>Finding No. 3 - Coverage Days Validation</b>	<b>Condition:</b>	Presbyterian overstated the 2015 benefit year premium and APTC amounts for four (4) subscribers in the UF/APTC Desk Audit File by incorrectly reporting enrollments that were not effectuated.
	<b>Criteria:</b>	Per CMS guidance, the issuer must create a single Inbound UF/APTC Desk Audit File consisting of detailed enrollment group effectuated enrollment records (one per enrollment group, per month) with the corresponding payment data.
	<b>Cause:</b>	The issuer indicated the following explanations for each of the four (4) subscribers: <ul style="list-style-type: none"> <li>• “Did not have an effectuated enrollment. Member was on passive enrollment file for 1/1/2015” (One (1) subscriber).</li> <li>• “Member did not have an effectuated enrollment” (Three (3) subscribers).</li> </ul>
	<b>Effect:</b>	The inclusion of the enrollment and payment data for the four (4) subscribers resulted in a change to Presbyterian’s final, restated 2015 benefit year EPDW data.
	<b>Corrective Action Required:</b>	The net financial impact of this finding is a payment to CMS of \$15.48, consisting of APTC owed to CMS. Presbyterian should confirm the financial impact and coordinate on resolution with CMS as indicated in section VI of this report.  The premium financial impact for this finding is an overstatement of \$35.80 in premiums; however, this is for informational purposes only as CMS did not charge issuers offering QHPs through SBE-FPs user fees during benefit year 2015.

	<b>Management Response:</b>	Management agrees with finding.
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<b>Finding No. 4 - Fifteen (15) Subscribers Sample Review</b>	<b>Condition:</b>	Presbyterian overstated the 2015 benefit year premium and APTC amounts for two (2) of the fifteen (15) selected subscribers (subscriber 4 and subscriber 5) in the UF/APTC Desk Audit File by reporting enrollments with coverage that was not effectuated in the issuer's systems.
	<b>Criteria:</b>	Per CMS guidance, the issuer must create a single Inbound UF/APTC Desk Audit File consisting of detailed enrollment group effectuated enrollment records (one per enrollment group, per month) with the corresponding payment data. Issuers are to submit records for any effectuated enrollments and terminated enrollments (those enrollments that were effectuated and had some period of active coverage).
	<b>Cause:</b>	<p>The issuer indicated the following for the two (2) subscribers:</p> <ul style="list-style-type: none"> <li>• For subscriber 4, the issuer indicated "Member did not pay premium amount to effectuate."</li> <li>• For subscriber 5, the issuer indicated "Member did not pay full premium amount to effectuate."</li> </ul> <p>Upon further review of the policy level documentation for the two (2) subscribers, it was noted that no payments were received for any months of enrollment reported on the UF/APTC Desk Audit File. Therefore, CMS concluded that the issue was a finding as no payments were received at all and therefore the enrollments should not have been effectuated.</p> <p>During the audit, CMS coordinated with the issuer to determine whether the non-payment issue impacted other enrollments reported in the UF/APTC Desk Audit File. Presbyterian indicated "We queried and listed below the subscriber +</p>

		<p>enrollment month reported in Desk Audit file who do not have premium paid in full for the corresponding due date." The issuer provided a list of sixteen (16) additional subscribers identified as a result of the query and noted the following:</p> <ul style="list-style-type: none"> <li>• For eight (8) of the sixteen (16) subscribers identified, the issuer noted "Paid Within Tolerance, Not in Full" Based on this feedback that eight (8) subscribers had paid within the established premium payment threshold, CMS noted no issues.</li> <li>• For eight (8) of the sixteen (16) subscribers, the issuer indicated "Subscriber did not make timely binder payment but later made timely payments" (eight (8) subscribers). Based on this feedback that eight (8) subscribers had made a late binder payment but made timely payments thereafter, CMS noted an observation (refer to Observation No. 3 for additional details on the observations).</li> </ul> <p>The issuer further indicated "After reviewing the query that was ran we have determined that these [subscribers 4 and 5] were the only two members that had unique non-payment issues."</p>
	<p><b>Effect:</b></p>	<p>The inclusion of the enrollment and payment data for the two (2) subscribers resulted in a change to Presbyterian's final, restated 2015 benefit year EPDW data.</p>
	<p><b>Corrective Action Required:</b></p>	<p>The net financial impact of this finding is a payment to CMS of \$2,994.00, consisting of APTC owed to CMS. Presbyterian should confirm the financial impact and coordinate on resolution with CMS as indicated in section VI of this report.</p> <p>The premium financial impact for this finding is an overstatement of \$4,591.38 in premiums; however, this is for informational purposes only as CMS did not charge issuers offering QHPs through SBE-FPs user fees during benefit year 2015.</p>

	<b>Management Response:</b>	Management agrees with finding.
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## 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 three (3) observations.

<b>Observation No. 1 – Premium Less than APTC Validation</b>	<b>Condition:</b>	<p>Presbyterian reported premium amounts that were less than APTC amounts in the UF/APTC Desk Audit File for two (2) subscribers. As a result, Presbyterian understated the 2015 benefit year premium amounts for those subscribers.</p>
	<b>Criteria:</b>	<p>Issuers cannot report a premium amount that is less than an APTC amount. Per CMS guidance, the premium amount reported on the EPDW is the premium amount by 16 digit QHP ID for the effectuated enrollment within a qualified health plan.</p>
	<b>Cause:</b>	<p>The issuer indicated the following for the subscribers:</p> <ul style="list-style-type: none"> <li>For the subscriber with a premium amount of \$259.82 and APTC amount of \$284.00 for months 11 and 12, the issuer indicated "Everything matches - Continuing to Research. Billed (24.18) Subsidy \$284.00 for months 11 and 12. Billed (24.18) Subsidy \$284.00 for months 11 and 12." The issuer provided screenshots confirming the negative billed premium amounts of \$(24.18) for months 11 and 12. CMS concluded the issue was an observation as issuers cannot report premium amounts that were less than APTC amounts; however, the issuer operated in a SBE-FP and therefore the issue does not require corrections to payment as CMS did not charge issuers offering QHPs through SBE-FPs user fees during benefit year 2015</li> <li>For the subscriber with a premium amount of \$549.89 and APTC amount of \$622.00, the issuer indicated "Dependent X (REDACTED) termed 11/30/2015.</li> </ul>

		<p>Dependent Separated in Facets but APTC was always \$622 in Facets. I don't see a dependent term in enrollment File from CMS for 11/30/2015. HICS Case- E- &lt;&lt;REDACTED&gt;&gt; TERM SPOUSE 11/30/2015 - UPDATE SUBSCRIBER. UNABLE TO UPDATE APTC AS NO NEW FIGURE GIVEN. Billed (72.11) for month 12. Billed (72.11) for month 12." The issuer provided screenshots confirming the negative billed premium amount of \$(72.11) for month 12. CMS concluded the issue was an observation as issuers cannot report premium amounts that were less than APTC amounts; however, the issuer never received an updated premium amount as a result of a HICS case. Additionally, the issuer operated in a SBE-FP and therefore the issue does not require corrections to payment as CMS did not charge issuers offering QHPs through SBE-FPs user fees during benefit year 2015.</p>
	<b>Effect:</b>	The issuer reported premium amounts that were less than the APTC amounts and therefore did not comply with CMS guidance.
	<b>Management Response:</b>	Management agrees with observation.

<p><b>Observation No. 2 – Forty-five (45) Subscribers Sample Review</b></p>	<b>Condition:</b>	Presbyterian incorrectly reported the premium amounts for four (4) of the forty-five (45) selected subscribers in the UF/APTC Desk Audit File due to a birthday premium rating issue.
	<b>Criteria:</b>	Per CMS guidance, the premium amount reported on the EPDW and the UF/APTC Desk Audit File is the premium amount by 16 digit QHP ID for the effectuated enrollment within a qualified health plan.
	<b>Cause:</b>	The issuer indicated the following for the four (4) subscribers:

		<ul style="list-style-type: none"> <li>• "The difference is due to us not rating correctly. If we rated correctly we would have been charging what CMS states. Rating the wife as a 58 year old and husband as 59 year old."</li> <li>• "Member was rated as a 42 year old. Once the child was termed the member should have billed 243.86 Difference being (116.87)."</li> <li>• "The difference is due to us not rating correctly. If we rated correctly we would have been charging what CMS states. Both of these individuals are being billed a year too young."</li> <li>• "The difference is due to us not rating correctly. If we rated correctly we would have been charging what CMS states. This individual is being billed a year too young."</li> </ul> <p>During the audit, CMS coordinated with the issuer to determine whether the issue impacted other enrollments reported in the UF/APTC Desk Audit File. Presbyterian indicated "This is part of our Birthday issue that was reported to CMS. Reconciliation was done and refunds were sent to members that were charged incorrectly. The total premium financial impact due to the Premium rating birthday issue for 2015 was \$45,614.77. For 2015, if members were no longer with the plan, they received a refund. If members were with the plan, they were credited."</p> <p>CMS concluded the reporting of the incorrect premium amounts was an observation as the issuer operated in a SBE-FP and therefore the issue does not require corrections to payment as CMS did not charge issuers offering QHPs through SBE-FPs user fees during benefit year 2015.</p>
	<b>Effect:</b>	The issuer billed the incorrect premium amounts during the 2015 benefit year but corrected the bills through credits and refunds following reconciliation.
	<b>Management Response:</b>	Management agrees with observation.

<b>Observation No. 3 – Fifteen (15) Subscribers Sample Review</b>	<b>Condition:</b>	Presbyterian did not receive the full binder payment or the binder payment within the issuer's tolerance percentage within thirty (30) calendar days from the coverage effective date for nine (9) subscribers, including one (1) of the fifteen (15) selected subscribers (subscriber 11), reported in the UF/APTC Desk Audit File.
	<b>Criteria:</b>	Per CMS enrollment guidance and 45 CFR § 155.400(e) promulgated by the 2016 Payment Notice, for first month (or binder payment) premiums, premium payment deadlines must be no earlier than the coverage effective date, but no later than 30 calendar days from the coverage effective date.
	<b>Cause:</b>	<p>For the one (1) subscriber that was included in the Fifteen (15) Subscribers Sample Review with a late full binder payment (subscriber 11), the issuer indicated "Member did not pay full premium amount to effectuate. Premium payment on 2/9/2015 paid remaining amount needed to effectuate."</p> <p>The issuer further indicated "We queried and listed below the subscriber + enrollment month reported in Desk Audit file who do not have premium paid in full for the corresponding due date." The issuer provided a list of eight (8) subscribers identified as a result of the query and noted that the "Subscriber did not make timely binder payment but later made timely payments".</p>
	<b>Effect:</b>	The issuer did not follow CMS enrollment guidance as the issuer effectuated enrollment when the first month's premium payment was received later than 30 calendar days from the coverage effective date.
	<b>Management Response:</b>	Management agrees with observation.

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## **VI. MANAGEMENT RESPONSES**

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Please provide management's response to the four (4) findings and three (3) observations 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 four (4) findings and three (3) observations, complete the "Management Response" field of the findings and observations 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 any of the four (4) findings and corrective actions or any of the three (3) observations, complete the "Management Response" field of the findings and observations 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 findings and observations 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.

**Appendix 1 – Issuer Management Response to Net Financial Adjustment**

Issuer HIOS ID: 57173

Issuer Name: Presbyterian Health Plan (Presbyterian)

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 \$9,240.34, 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.

**Or**

(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: AMOR BRANNIN  
(Print name of signature)

Title: CFO, Presbyterian Health Plan  
(Title of authorized person acting on behalf of the Issuer)

Telephone Number: 1-505-923-5201  
(Direct Telephone Number)

Date: 1/30/2020

## Appendix 2 – Applicable Regulations

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

Regulation	Guidance
<p><b>45 CFR § 156.460 - Reduction of enrollee's share of premium to account for advance payments of the premium tax credit</b></p>	<p><b>(a) Reduction of enrollee's share of premium to account for advance payments of the premium tax credit.</b> 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—</p> <ul style="list-style-type: none"> <li>(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;</li> <li>(2) Notify the Exchange of the reduction in the portion of the premium charged to the individual in accordance with § 156.265(g); and</li> <li>(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.</li> </ul>
<p><b>45 CFR § 156.480 - Oversight of the administration of the cost-sharing reductions and advance payments of the premium tax credit programs.</b></p>	<p><b>(a) Maintenance of records.</b> 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>(b) Annual reporting requirements.</b> 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><b>(c) Audits.</b> 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>

Regulation	Guidance
<p><b>45 CFR § 156.705 – Maintenance of records for Federally-facilitated Exchanges</b></p>	<p><b>(a) <i>General standard.</i></b> 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><b>(1)</b> 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><b>(2)</b> 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>(b) <i>Records.</i></b> 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><b>(c) <i>Record retention timeframe.</i></b> Issuers offering QHPs in a Federally-facilitated Exchange must maintain all records referenced in paragraph (a) of this section for 10 years.</p> <p><b>(d) <i>Record availability.</i></b> 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

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<b>Terms &amp; Acronyms</b>	<b>Definition</b>
<b>APTC</b>	Advance Payments of the Premium Tax Credit
<b>CEO</b>	Chief Executive Officer
<b>CFO</b>	Chief Financial Officer
<b>CFR</b>	Code of Federal Regulations
<b>CMS</b>	Centers for Medicare & Medicaid Services
<b>CSR</b>	Cost-sharing Reduction
<b>EPDW</b>	Enrollment and Payment Data Workbook
<b>FFE</b>	Federally-facilitated Exchange
<b>GAGAS</b>	Generally Accepted Government Auditing Standards
<b>HHS</b>	Department of Health and Human Services
<b>HIOS</b>	Health Insurance Oversight System
<b>PPACA</b>	Patient Protection and Affordable Care Act
<b>QHP</b>	Qualified Health Plan
<b>SBE</b>	State-based Exchange
<b>SBE-FP</b>	State-based Exchange on the Federal Platform
<b>TIN</b>	Tax Identification Number

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