



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

for

BlueCross Blue Shield of New Mexico (BCBS of NM)

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	16
Appendix 1 – Issuer Management Response to Net Financial Adjustment	17
Appendix 2 – Applicable Regulations	18
Appendix 3 – Glossary of Terms and Acronyms	20

I. EXECUTIVE SUMMARY

Background

BlueCross Blue Shield of New Mexico (BCBS of NM) 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. BCBS of NM submitted its final restated 2015 benefit year data in the October 2017 Enrollment and Payment Data Workbook (EPDW). The issuer received a total of \$28,758,193.03 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 BCBS of NM'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.

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

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.

years, but that does not require correction to payment, then CMS categorized it as an *observation*.

Results of Review

CMS identified two (2) findings and two (2) observations for BCBS of NM. The net financial impact of the two (2) audit findings is a payment to CMS of \$12,440.99, consisting of APTC owed to CMS. The two (2) observations do not require corrections to payments. The findings and observations include the following:

Findings:

1. Differences in 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 BCBS of NM's systems; and
2. Inclusion of full month enrollment and payment data for two (2) duplicate subscribers in the UF/APTC Desk Audit File.

Observations:

1. Receipt of late binder payment for one (1) of the fifteen (15) selected subscribers reported in the UF/APTC Desk Audit File due to a mailed check; and
2. Application of premium payment threshold policy that is inconsistent with CMS guidance for 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.

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 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 BCBS of NM for an audit on issuer compliance with the aforementioned regulations. CMS evaluated BCBS of NM'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 October 2017 by the issuer to CMS to support APTC payments.

CMS sent BCBS of NM 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 BCBS of NM on May 14, 2018 that identified data requirements required to conduct the audit. CMS's audit contractor reviewed the audit data file submitted by BCBS of NM 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 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

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

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

One (1) finding and no observations resulted from the comparison of the final 2015 EPDW to BCBS of NM'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 BCBS of NM'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 BCBS of NM'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. 2 included in section IV for details on the finding.

Premium Less than APTC Validation

No findings or observations resulted from the review of BCBS of NM'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 BCBS of NM'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 BCBS of NM'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 two (2) observations resulted from the review of the data and documentation from BCBS of NM'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 and Observation No. 2 included in section V for details on the observations.

Policy and Procedure Review

No findings or observations resulted from the review of BCBS of NM'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 two (2) findings that resulted in a change to BCBS of NM's reported EPDW for individual market plans for the 2015 benefit year. In light of the two (2) 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 October 2017	\$65,799,493.42	\$28,758,193.03
Finding No. 1 - EPDW Validations Adjustment	\$(26,107.99)	\$(12,185.99)
Finding No. 2 - Duplicate Exchange-assigned Subscriber IDs Check Adjustment	\$(335.07)	\$(255.00)
EPDW As Recalculated	\$65,773,050.36	\$28,745,752.04
Total Financial Impact	\$26,443.06*	\$(12,440.99)

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 two (2) audit findings is a payment to CMS of \$12,440.99, consisting of APTC owed to CMS.

For the two (2) audit findings, CMS documented the criteria, cause, effect, corrective actions, and BCBS of NM's responses as seen in the charts below.

Finding No. 1 - EPDW Validations	Condition:	<p>Premium Differences – For one or more months of 2015 benefit year enrollment in thirty-seven (37) QHPs, the net "Total Premium Amount by QHP ID for effectuated enrollments" included in BCBS of NM's EPDW was greater than the total premium amount included in BCBS of NM's UF/APTC Desk Audit File, resulting in an overstatement of \$26,107.99 in premiums. For the one or more months of 2015 benefit year enrollment in thirty-seven (37) QHPs, the EPDW was overstated by forty-nine (49) enrollment groups and sixty-eight (68) members.</p> <p>APTC Differences – For one or more months of 2015 benefit year enrollment in thirty-five (35) QHPs, the net "Total APTC Amount by QHP ID for effectuated enrollments" included in BCBS of NM's EPDW was greater than the total APTC amount included in BCBS of NM's UF/APTC Desk Audit File, resulting in an overpayment of \$12,185.99 in APTC. For the one or more months of 2015 benefit year enrollment in thirty-five (35) QHPs, the EPDW was overstated by fifty-five (55) APTC enrollment groups and seventy-four (74) APTC members.</p>
	Criteria:	<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 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>

	Cause:	The issuer indicated the premium amounts reported on the final, restated 2015 benefit year EPDW were overstated by \$26,107.99 and the APTC amounts reported on the final, restated 2015 benefit EPDW were overstated by \$12,185.99 as a result of “retroactive changes in the coverage start or end dates in our membership system after the final submission in 2015.”
	Effect:	The premium and APTC differences resulted in a change to BCBS of NM’s final, restated 2015 benefit year EPDW data.
	Corrective Action Required:	The net financial impact of this finding is a payment to CMS of \$12,185.99, consisting of APTC owed to CMS. BCBS of NM 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 \$26,107.99 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.
	Management Response:	BCBSNM agrees with this finding.

Finding No. 2 - Duplicate Exchange-assigned Subscriber IDs Check	Condition:	BCBS of NM overstated the 2015 benefit year premium amounts for two (2) subscribers, and overstated the 2015 benefit year APTC amounts for one (1) of those subscribers in the UF/APTC Desk Audit File by reporting enrollment and full month payment data for the subscribers more than once in the same month.
	Criteria:	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 or SBE-FP, 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.
	Cause:	<p>The issuer indicated the following for the two (2) duplicate subscribers:</p> <ul style="list-style-type: none"> • “Duplicate record is for QHP ID 75605NM039000102. Member only had coverage under QHP ID 75605NM039000103 for 3/1/2015 - 3/31/2015.” • “Issuer membership data had a discrepancy in the data causing the desk audit file to reflect a duplicate overlapping record for 3/1/2015 – 4/30/2015.”
	Effect:	The inclusion of the two (2) duplicate subscribers resulted in a change to BCBS of NM’s final, restated 2015 benefit year EPDW data.
	Corrective Action Required:	<p>The net financial impact of this finding is a payment to CMS of \$255.00, consisting of APTC owed to CMS. BCBS of NM 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 \$335.07 in premiums; however, this is for informational purposes only as CMS did not charge issuers offering QHPs through SBE-FPs user fees during the 2015 benefit year.</p>
	Management Response:	BCBSNM agrees with this finding.

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 two (2) observations.

Observation No. 1 – Fifteen (15) Subscribers Sample Review (Late Payment)	Condition:	BCBS of NM did not receive the binder payment within thirty (30) calendar days from the coverage effective date for one (1) of the fifteen (15) selected subscribers reported in the UF/APTC Desk Audit File.
	Criteria:	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.
	Cause:	The issuer indicated "Member mailed check 1/27/15 but was out-of-country, resulting in money not being received & credited to account until 2/12/2015."
	Effect:	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.
	Management Response:	BCBSNM agrees with this finding.

Observation No. 2 – Fifteen (15) Subscribers Sample Review (Premium Payment Threshold)	Condition:	BCBS of NM did not receive premium payments for the last four (4) months of enrollment for one (1) of the fifteen (15) selected subscribers reported in the UF/APTC Desk Audit File; and therefore, the owed amount accumulated and increased beyond the ninety-five percent (95%) premium payment threshold.
	Criteria:	Per CMS enrollment guidance and 45 CFR § 155.400(g) promulgated by the 2017 Payment

		Notice, issuers can consider enrollees to have paid all amounts due if the enrollees pay an amount sufficient to maintain a percentage of total premium paid out of the total premium owed equal to or greater than a level prescribed by the issuer.
	Cause:	CMS noted the issuer did not receive payments for the last four (4) months of enrollment and therefore the total owed amount each month accumulated and therefore increased beyond the payment threshold amount. However, the issuer indicated that "Member payment exceeded the 95% payment threshold for termination of non-payment." Per the issuer provided internal Delinquency Automation Policy, it was noted that "If a subscriber receives 95% or greater subsidy each month, they will never terminate or be considered for termination."
	Effect:	The issuer did not establish and apply a premium payment threshold policy that is consistent with CMS enrollment guidance.
	Management Response:	BCBSNM agrees with this finding.

VI. MANAGEMENT RESPONSES

Please provide management's response to the two (2) findings and two (2) 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 two (2) findings and two (2) 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 either of the two (2) findings and corrective actions or either of the two (2) 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 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
APTC	Advance Payments of the Premium Tax Credit
CEO	Chief Executive Officer
CFO	Chief Financial Officer
CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
CSR	Cost-sharing Reduction
EPDW	Enrollment and Payment Data Workbook
FFE	Federally-facilitated Exchange
GAGAS	Generally Accepted Government Auditing Standards
HHS	Department of Health and Human Services
HIOS	Health Insurance Oversight System
PPACA	Patient Protection and Affordable Care Act
QHP	Qualified Health Plan
SBE	State-based Exchange
SBE-FP	State-based Exchange on the Federal Platform
TIN	Tax Identification Number