



Advance Payments of the Premium Tax Credit (APTC) & Federally-facilitated Exchange (FFE) User Fee (UF) Program Assessment Report

for

Health Options, Inc. (Health Options)

December 11, 2019

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I. EXECUTIVE SUMMARY

Background

Health Options, Inc. (Health Options) is a health insurance issuer that offered qualified health plans (QHPs) in the individual market Federally-facilitated Exchange (FFE) in Florida during the 2015 benefit year. Health Options submitted its final restated 2015 benefit year data in the July 2016 Enrollment and Payment Data Workbook (EPDW). The issuer received a total of \$270,312,617.86 in advance payments of the premium tax credit (APTC) from CMS and paid a total of \$14,369,532.28 in FFE user fees (UF) to CMS for its 2015 benefit year individual market plans.

This report is an assessment of Health Options' compliance with the APTC and FFE user fee programs established in sections 1311 and 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.

Audits to Determine Compliance with the Administration of APTC and FFE User Fee Programs

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 audit¹ issuers that offer a QHP in the individual market through an Exchange to assess the degree of compliance with the APTC and FFE user fee 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 and FFE user fee program requirements that requires correction to

¹ 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.

payment, then CMS classified it as a *finding*. If CMS found a deviation from APTC and FFE user fee 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 six (6) findings and no observations for Health Options. The net financial impact of the six (6) audit findings is a payment to CMS of \$303,866.88, consisting of \$17,690.36 in FFE user fees returned to Health Options and \$321,557.24 in APTC owed to CMS. The findings include the following:

1. Differences in premium/FFE user fee 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 Health Options' systems;
2. Inclusion of enrollment and payment data in the UF/APTC Desk Audit File for nine hundred and ninety-two (992) subscribers with coverage that was not effectuated in the issuer's systems;
3. Inclusion of full month enrollment and payment data for forty (40) duplicate subscribers in the UF/APTC Desk Audit File;
4. Inclusion of premium amounts that were less than the APTC amounts for fifty-one (51) subscribers in the UF/APTC Desk Audit File;
5. Inclusion of enrollment and payment data for sixty-six (66) subscribers with a coverage period of five (5) days or fewer that was not effectuated in the UF/APTC Desk Audit File; and
6. Inclusion of enrollment and payment data in the UF/APTC Desk Audit File for one (1) of the fifteen (15) selected subscribers with coverage that was not effectuated in the issuer's systems.

Please refer to section IV for details on the findings 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. Additionally, section 1311 of the PPACA allows the FFEs to charge participating issuers user fees to support FFE operations.

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

Interim Payment Process

Since automated payment systems were not yet developed during the first years of FFE implementation, CMS implemented an interim payment process to calculate and make monthly payments of APTC and advance Cost-sharing Reduction (CSR) amounts, and to collect FFE user fees. 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 FFE User Fee amount
9. Total effectuated enrollment groups
10. Total effectuated enrollment groups with APTC
11. Total effectuated enrollment groups with advance CSR
12. Total effectuated members
13. Total effectuated members with APTC
14. Total effectuated members with advance CSR

FFE issuers were required to calculate the QHP enrollment and payment amounts and submit that information on the EPDW template using their internal source data.

B. Regulations Governing APTC and FFE User Fee Programs

CMS established an audit protocol to assess health insurance issuers' compliance with the following regulations governing APTC and FFE user fee programs:

- 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 and FFE user fee programs;
- (2) Identify potential CMS APTC payment and FFE user fee collection 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 Health Options for an audit on issuer compliance with the aforementioned regulations. CMS evaluated Health Options' 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 and FFE user fee collections.

CMS sent Health Options 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 Health Options on May 14, 2018 that identified data requirements required to conduct the audit. CMS's audit contractor reviewed the audit data file submitted by Health Options and used CMS's audit procedures to assess compliance with APTC and FFE user fee 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 File² 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 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.

² The UF/APTC Desk Audit File is CMS's standard document for issuers to provide information in support of this audit.

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 Health Options' UF/APTC Desk Audit File. Please refer to Finding No. 1 included in section IV for details on the finding.

Unreconciled Subscribers Review

One (1) finding and no observations resulted from the review of Health Options' 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. Please refer to Finding No. 2 included in section IV for details on the finding.

Duplicate Exchange-assigned Subscriber IDs Check

One (1) finding and no observations resulted from the review of Health Options' UF/APTC Desk Audit File to verify that duplicate Exchange-assigned subscriber IDs were not reported on the file. Please refer to Finding No. 3 included in section IV for details on the finding.

Premium Less than APTC Validation

One (1) finding and no observations resulted from the review of Health Options' 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. 4 included in section IV for details on the finding.

Coverage Days Validation

One (1) finding and no observations resulted from the review of Health Options' 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. 5 included in section IV for details on the finding.

Forty-five (45) Subscribers Sample Review

No findings or observations resulted from the review and comparison of the data from Health Options' 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

One (1) finding and no observations resulted from the review of the data and documentation from Health Options' 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. 6 included in section IV for details on the finding.

Policy and Procedure Review

No findings or observations resulted from the review of Health Options' APTC policies and procedures.

IV. FINDINGS

A finding is an identification of an instance of issuer non-compliance with APTC and FFE user fee program requirements that requires correction to payment. CMS's audit procedures identified six (6) findings that resulted in a change to Health Options' reported EPDW for individual market plans for the 2015 benefit year. In light of the six (6) findings, the adjusted 2015 benefit year EPDW APTC and FFE user fee amounts for individual market plans are shown in the following table.

Recalculated EPDW for the 2015 Benefit Year

	FFE User Fees	APTC
EPDW as Filed in July 2016	\$(14,369,532.28)	\$270,312,617.86
Finding No. 1 - EPDW Validations Adjustment	\$104.59	\$(10,044.03)
Finding No. 2 - Unreconciled Subscribers Review Adjustment	\$16,232.26	\$(281,236.81)
Finding No. 3 – Duplicate Exchange-assigned Subscriber IDs Check Adjustment	\$1,122.40	\$(18,307.64)
Finding No. 4 - Premium Less than APTC Validation Adjustment	\$(525.75)	\$(7,013.78)
Finding No. 5 - Coverage Days Validation Adjustment	\$734.58	\$(4,404.98)
Finding No. 6 – Fifteen (15) Subscribers	\$22.28	\$(550.00)

	FFE User Fees	APTC
Sample Review Adjustment		
EPDW As Recalculated	\$(14,351,841.92)	\$269,991,060.62
Total Financial Impact	\$17,690.36	\$(321,557.24)

Note: Positive values indicate funds owed to the issuer.

The net financial impact of the six (6) audit findings is a payment to CMS of \$303,866.88, consisting of \$17,690.36 in FFE user fees returned to Health Options and \$321,557.24 in APTC owed to CMS.

For the six (6) audit findings, CMS documented the criteria, cause, effect, corrective actions, and Health Options' responses as seen in the charts below.

Finding No. 1 - EPDW Validations	Condition:	<p>Premium and FFE User Fee Differences – For one or more months of 2015 benefit year enrollment in seventeen (17) QHPs, the net "Total Premium Amount by QHP ID for effectuated enrollments" included in Health Options' EPDW was greater than the total premium amount included in Health Options' UF/APTC Desk Audit File, resulting in an overstatement of \$2,988.16 in premiums and therefore an overpayment of \$104.59 in FFE user fees. For the one or more months of 2015 benefit year enrollment in seventeen (17) QHPs, the EPDW was overstated by two hundred and sixteen (216) enrollment groups and two hundred and forty-two (242) members.</p> <p>APTC Differences – For one or more months of 2015 benefit year enrollment in sixteen (16) QHPs, the net "Total APTC Amount by QHP ID for effectuated enrollments" included in Health Options' EPDW was greater than the total APTC amount included in Health Options' UF/APTC Desk Audit File, resulting in an overpayment of \$10,044.03 in APTC. For the one or more months of 2015 benefit year enrollment in sixteen (16) QHPs, the EPDW was overstated by one hundred and seven (107) APTC enrollment groups and one hundred and forty-three (143) APTC members.</p>
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	<p>Criteria:</p>	<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” and the Total User Fee Amount by QHP ID is "the total FFE user fee amount the issuer can expect to incur for participation in the Federally-facilitated Exchange."</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>
	<p>Cause:</p>	<p>The issuer indicated, “The original desk audit file was created using a detailed enrollment file that was provided from our enrollment management 3rd party vendor for the 2015 benefit year which created an initial EPDW submission based off of coverage records on our June 2016 submission. Several data points were added or duplicated in the desk audit file in error based on the detail provided from HPS. We have validated that the following data items were incorrectly added to our original desk audit file:</p> <ul style="list-style-type: none"> • The EPDW included 117 negative dollar amounts from potential reversal payments that did not appear in the Issuer Calc file. • The additional discrepancies represent a duplicated or an additional APTC value for a particular member and month that do not appear in the Issuer Calc file." <p>The issuer further clarified “The desk audit file was correct and reflects a current snapshot of what</p>

		<p>exists in our systems, and the EPDW validation differences were due to the fact that the EPDW submitted in July 2016 included negative dollar amounts and duplicated values that were correctly excluded from the desk audit file submitted for the audit.”</p> <p>Based on this feedback that there were data items that were incorrectly added to the EPDW in error and the desk audit file included the correct data, CMS concluded that the 2015 benefit year premium and APTC amounts reported in the final, restated 2015 benefit year EPDW were overstated.</p>
	Effect:	The premium/FFE user fee and APTC differences resulted in a change to Health Options’ final, restated 2015 benefit year EPDW data.
	Corrective Action Required:	The net financial impact of this finding is a payment to CMS of \$9,939.44, consisting of \$104.59 in FFE user fees returned to Health Options and \$10,044.03 in APTC owed to CMS. Health Options should confirm the financial impact and coordinate on resolution with CMS as indicated in section VI of this report.
	Management Response:	Management concurs.

Finding No. 2 - Unreconciled Subscribers Review	Condition:	Health Options overstated the 2015 benefit year premium amounts for nine hundred and ninety-two (992) subscribers, and overstated the 2015 benefit year APTC amounts for eight hundred and sixty-six (866) of those subscribers, in the UF/APTC Desk Audit File by reporting enrollment and payment data for subscribers with coverage that was not effectuated.
	Criteria:	Per CMS guidance and EPDW submission requirements, the EPDW should include data for effectuated enrollments where an effectuated enrollment is defined as “any enrollment in which the amount the enrollment group is responsible to

		pay toward the total premium amount has been paid in full by the enrollment group.”
	Cause:	The issuer indicated one of the following responses for the nine-hundred and ninety-two (992) subscribers: <ul style="list-style-type: none"> • “Enrollment files same day cancel” (Five-hundred and twenty (520) subscribers); • “Coverage provided for alternate ID” (Two (2) subscribers); or, • “No” in the ‘Effectuated in Issuer’s System’ field with no corresponding explanation (Four-hundred and seventy (470) subscribers).
	Effect:	The inclusion of the nine hundred and ninety-two (992) non-effectuated enrollments resulted in a change to Health Options’ final, restated 2015 benefit year EPDW data.
	Corrective Action Required:	The net financial impact of this finding is a payment to CMS of \$265,004.55, consisting of \$16,232.26 in FFE user fees returned to Health Options and \$281,236.81 in APTC owed to CMS. Health Options should confirm the financial impact and coordinate on resolution with CMS as indicated in section VI of this report.
	Management Response:	Management concurs.

Finding No. 3 - Duplicate Exchange-assigned Subscriber IDs Check	Condition:	Health Options overstated the 2015 benefit year premium amounts for forty (40) subscribers, and overstated the 2015 benefit year APTC amounts for twenty-six (26) 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, 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:	The issuer indicated “We agree these are duplicates, in 2015 we utilized a 3rd party enrollment and billing vendor and would need additional time to coordinate with them as to why these were recorded twice.” During the audit, CMS coordinated with the issuer to determine which records were the true enrollment records and which records were the duplicates for the forty (40) subscribers.
	Effect:	The inclusion of the forty (40) duplicate subscribers resulted in a change to Health Options’ final, restated 2015 benefit year EPDW data.
	Corrective Action Required:	The net financial impact of this finding is a payment to CMS of \$17,185.24, consisting of \$1,122.40 in FFE user fees returned to Health Options and \$18,307.64 in APTC owed to CMS. Health Options should confirm the financial impact and coordinate on resolution with CMS as indicated in section VI of this report.
	Management Response:	Management concurs.

Finding No. 4 - Premium Less than APTC Validation	Condition:	Health Options reported premium amounts that were less than the APTC amounts for fifty-one (51) subscribers in the UF/APTC Desk Audit File. As a result, Health Options understated the 2015 benefit year premium amounts for forty-two (42) of the fifty-one (51) subscribers, and overstated the 2015 benefit year APTC amounts for ten (10) of those subscribers, in the UF/APTC Desk Audit File. Additionally, Health Options overstated the 2015 benefit year APTC amounts for nine (9) of the fifty-one (51) subscribers, and overstated the 2015
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		benefit year premium amounts for three (3) of those subscribers, in the UF/APTC Desk Audit File.
	Criteria:	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.
	Cause:	<p>The issuer indicated, "Our financial records indicate a retroactive adjustment occurred for this line item in the preceding months which caused a difference in premium. Based off of the financial records available to us at the present, the related premium amounts appear accurate. In 2015 we utilized a 3rd party enrollment and billing vendor and would need additional time, if needed, to determine the specific reasons these adjustments occurred."</p> <p>During the audit, CMS coordinated with the issuer to determine the correct premium and APTC amounts for the fifty-one (51) subscribers. For each of the fifty-one (51) subscribers, the issuer indicated the "Correct Premium is [issuer provided premium amount], Correct APTC Amount is [issuer provided APTC amount]".</p>
	Effect:	The inclusion of the incorrect premium and APTC amounts for the fifty-one (51) subscribers resulted in a change to Health Options' final, restated 2015 benefit year EPDW data.
	Corrective Action Required:	The net financial impact of this finding is a payment to CMS of \$7,539.53, consisting of \$525.75 in FFE user fees owed to CMS and \$7,013.78 in APTC owed to CMS. Health Options should confirm the financial impact and coordinate on resolution with CMS as indicated in section VI of this report.
	Management Response:	Management concurs.

Finding No. 5 - Coverage Days Validation	Condition:	Health Options overstated the 2015 benefit year premium amounts for sixty-six (66) subscribers, and overstated the 2015 benefit year APTC amounts for thirty (30) of those subscribers, in the UF/APTC Desk Audit File by incorrectly reporting enrollments that were not effectuated.
	Criteria:	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.
	Cause:	<p>The issuer indicated one of the following general responses for the sixty-six (66) subscribers:</p> <ul style="list-style-type: none"> • “Member had no coverage for this month under [issuer provided policy X]” (One (1) subscriber). • “Member only had coverage from [issuer provided coverage period X/X/15-X/X/5]” (Five (5) subscribers). • “Member had same day cancel” (Three (3) subscribers). • “Month of [issuer provided month] the APTC was billed then taken back.” (Three (3) subscribers). • “Member [issuer provided policy X] effective from [issuer provided coverage period X/X/15 - X/X/15]” (Fifty (50) subscribers). • “HICS case EX Marketplace termination member coverage terminated as of 5/31/15” (One (1) subscriber). • “Yes remove records”/”Yes both should be removed” (Two (2) subscribers). • “Member [issuer provided policy X] termed” (One (1) subscriber).
	Effect:	The inclusion of the enrollment and payment data for the sixty-six (66) subscribers resulted in a change to Health Options’ final, restated 2015 benefit year EPDW data.

	Corrective Action Required:	The net financial impact of this finding is a payment to CMS of \$3,670.40, consisting of \$734.58 in FFE user fees returned to Health Options and \$4,404.98 in APTC owed to CMS. Health Options should confirm the financial impact and coordinate on resolution with CMS as indicated in section VI of this report.
	Management Response:	Management concurs.

Finding No. 6 – Fifteen (15) Subscribers Sample Review	Condition:	Health Options overstated the 2015 benefit year premium and APTC amounts for one (1) of the fifteen (15) selected subscribers in the UF/APTC Desk Audit File by reporting an enrollment with coverage that was not effectuated in the issuer’s systems.
	Criteria:	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.
	Cause:	<p>The issuer indicated, “Only received APTC no payment from member received,” and “Member was never effectuated.”</p> <p>During the audit, we coordinated with the issuer to determine whether there were other subscribers reported in the UF/APTC Desk Audit File with coverage that was not effectuated, other than the subscribers identified as a result of the Unreconciled Subscribers Review, Coverage Days Validation and Fifteen (15) Subscribers Sample Review. The issuer indicated "to our knowledge, we are not aware of any enrollments for which we didn’t receive reported enrollment, other than the cases stated within the Unreconciled Subscribers tab."</p>
	Effect:	The inclusion of the enrollment and payment data for the subscriber resulted in a change to Health

		Options' final, restated 2015 benefit year EPDW data.
	Corrective Action Required:	The net financial impact of this finding is a payment to CMS of \$527.72, consisting of \$22.28 in FFE user fees returned to Health Options and \$550.00 in APTC owed to CMS. Health Options should confirm the financial impact and coordinate on resolution with CMS as indicated in section VI of this report.
	Management Response:	Management concurs.

V. OBSERVATIONS

An observation is a deviation from APTC and FFE user fee 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 no observations.

VI. MANAGEMENT RESPONSES

Please provide management's response to the six (6) findings 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 six (6) findings, complete the "Management Response" field of the findings 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 six (6) findings and corrective actions, complete the "Management Response" field of the findings 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 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: 30252

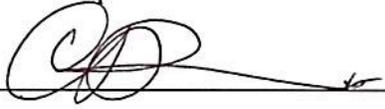
Issuer Name: Health Options, Inc. (Health Options)

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 and FFE UF program participation, resulting in a payment to CMS of \$303,866.88, consisting of \$17,690.36 in FFE user fees returned to Health Options and \$321,557.24 in APTC owed to CMS, and:

(INITIAL) CD 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: 

Printed Name: Chuck Divita

Title: EVP Commercial Markets – GuideWell Mutual Holding Corporation,
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Appendix 2 – Applicable Regulations

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

Regulation	Guidance
<p>45 CFR § 156.50 – Financial Support</p>	<p>(a) Definitions. The following definitions apply for the purposes of this section: <i>Participating issuer</i> means any issuer offering a plan that participates in the specific function that is funded by user fees. This term may include: health insurance issuers, QHP issuers, issuers of multi-State plans (as defined in § 155.1000(a) of this subchapter), issuers of stand-alone dental plans (as described in § 155.1065 of this subtitle), or other issuers identified by an Exchange.</p> <p>(b) Requirement for State-based Exchange user fees. A participating issuer must remit user fee payments, or any other payments, charges, or fees, if assessed by a State-based Exchange under § 155.160 of this subchapter.</p> <p>(c) Requirement for Federally-facilitated Exchange user fee. To support the functions of Federally-facilitated Exchanges, a participating issuer offering a plan through a Federally-facilitated Exchange must remit a user fee to HHS each month, in the timeframe and manner established by HHS, equal to the product of the monthly user fee rate specified in the annual HHS notice of benefit and payment parameters for the applicable benefit year and the monthly premium charged by the issuer for each policy under the plan where enrollment is through a Federally-facilitated Exchange.</p>
<p>45 CFR § 156.460 - Reduction of enrollee's share of premium to account for advance payments of the premium tax credit</p>	<p>(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—</p> <ol style="list-style-type: none"> (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
TIN	Tax Identification Number