



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

for

SelectHealth Inc. (Idaho)

March 10, 2022

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I. EXECUTIVE SUMMARY

Background

SelectHealth Inc. (SelectHealth) is a health insurance issuer that offered qualified health plans (QHPs) in the individual market State-Based Exchange (SBE) in Idaho during the 2015 benefit year. SelectHealth submitted its final restated 2015 benefit year data in the November 2016 Enrollment and Payment Data Workbook (EPDW). The issuer received a total of \$37,462,338.93 in advance payments of the premium tax credit (APTC) from CMS and reported a total of \$64,445,266.79 in premiums for its 2015 benefit year individual market plans.

This report is an assessment, conducted in coordination with the SBE, of SelectHealth's compliance with the APTC program established in sections 1401 and 1412 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. This report also details the results of the assessment of premiums for information purposes only as CMS did not charge user fees to issuers offering QHPs through SBEs during the 2015 benefit year.

Audits to Determine Compliance with the Administration of APTC Program

Under title 45 of the Code of Federal Regulations (CFR) sections §§ [155.1210](#) and [156.480](#), 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 program requirements. HHS designates the Centers for Medicare & Medicaid Services (CMS) to conduct these audits and to achieve the following objectives:

- 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 in the final 2015 EPDW submitted by the issuer, and to analyze controls and policies of selected issuers pursuant to the authority defined in 45 CFR §§ 155.1210 and 156.480.

The findings and observations are documented below. If CMS found an instance of issuer non-compliance with APTC program requirements that requires correction to the APTC reported in

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.

the final EPDW, then CMS classified it as a *finding*. If CMS found a deviation from CMS or Exchange 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 two (2) findings and five (5) observations for SelectHealth. The net APTC financial impact of the two (2) findings is an overstatement of \$7,447.20 in APTC in the final EPDW and therefore a payment to CMS of \$7,447.20, consisting of APTC owed to CMS. The net premium impact of the five (5) observations is an overstatement of \$1,208.52 in premiums in the final EPDW. The findings and observations include the following:

Findings:

1. Inclusion of full month enrollment and APTC payment data for one (1) duplicate subscriber in the Payment Desk Audit File; and
2. Inclusion of premium amounts that were less than the APTC amounts and therefore incorrect APTC amounts for four (4) subscribers in the Payment Desk Audit File.

Observations:

1. Provision of coverage and reporting of enrollment and payment data in the Payment Desk Audit File for fifty-four (54) subscribers with enrollments that should have been cancelled or terminated;
2. Inclusion of full month enrollment and premium data for one (1) duplicate subscriber in the Payment Desk Audit File;
3. Inclusion of premium amounts that were less than the APTC amounts and therefore incorrect premium amounts for six (6) subscribers in the Payment Desk Audit File;
4. Billing and inclusion of premium amounts that were less than the APTC amounts in the Payment Desk Audit File for three (3) subscribers as no updates from the SBE were received; and
5. Provision of coverage and inclusion of enrollment and payment data for two (2) subscribers with a coverage period of five (5) days or fewer in the Payment Desk Audit File that should have been cancelled.

Please refer to section IV 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

In 2015, CMS implemented a temporary process (“interim payment process”) to calculate and make monthly payments of APTC and advance cost-sharing reduction (CSR) amounts. CMS used this interim payment process to calculate payments for all SBE issuers for the 2014-2017 benefit years. CMS transitioned most SBE issuers to policy-based payments (PBP) in 2018 and transitioned the last SBE to PBP in 2020.

For the 2015 benefit year, the interim payment process required SBE issuer submitters, including issuers in Idaho, 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. SBE issuer submitters were required to calculate the QHP enrollment and payment amounts and to submit that information in the EPDW using their internal source data.

CMS calculated and made monthly payments based on the 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

CMS conducted a SBE payment close-out process for the 2015 benefit year in which CMS compared the EPDW data against the policy-level reporting (PLR) data submitted by the SBE. The PLR data was based on the monthly submissions that SBEs sent to the Internal Revenue Service (IRS) for reporting purposes and contained cumulative individual market enrollment APTC data. CMS requested that SBEs append an additional field for the QHP ID for each policy and separately submit these data to CMS for this purpose. CMS asked SBE or SBE issuers to explain any outlier discrepancies between EPDW and PLR data and to re-submit the EPDW, if necessary, or to verify that payment data was accurate despite discrepancies with PLR data.

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 § 155.1210](#): Maintenance of Records;
- [45 CFR § 156.460](#): Reduction of enrollee's share of premium to account for advance payments of the premium tax credit; and
- [45 CFR § 156.480](#): Oversight of the administration of the cost-sharing reductions and advance payments of the premium tax credit programs.

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 premiums and the APTC program;
- (2) Identify potential CMS APTC payment errors resulting from issuer data reporting errors;
- (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 SelectHealth for an audit to assess the issuer's compliance with 45 CFR §§ 155.1210, 156.460 and 156.480. CMS evaluated SelectHealth's activities related to the 2015 benefit year (January 1, 2015 through December 31, 2015) individual market data reported in the final EPDW submitted in November 2016 by the issuer to CMS to support APTC payments and premium amounts.

CMS sent SelectHealth an electronic letter on February 15, 2019 to notify them of the scope of this audit. CMS's audit contractor sent a follow-up letter to SelectHealth on February 20, 2019 that identified data requirements required to conduct the audit. CMS's audit contractor reviewed the audit data file submitted by SelectHealth, as well as the final 2015 EPDW submitted by the issuer to CMS and the PLR data submitted by the SBE to CMS, and used CMS's audit procedures to assess compliance with APTC program rules and regulations².

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

- Validations of the Payment Desk Audit File² data submitted to CMS:
 - EPDW Validations: Review and comparison of the issuer's final submitted 2015 EPDW to the Payment Desk Audit File from the issuer's systems.
 - Unreconciled Subscribers Review: Review and comparison of the subscribers reported in the Payment Desk Audit File to the subscribers included in the SBE's PLR data 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 Payment 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 in the file twice in the same month with full month or incorrectly prorated payment data) were not reported in the file.
 - Premium Less than APTC Validation: Review of the Payment Desk Audit File to verify that the subscribers' premium amounts reported in the file were not less than the APTC amounts reported in the file.
 - Coverage Days Validation: Review of the Payment Desk Audit File to verify that enrollments of five (5) days or fewer reported in 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 the SBE's PLR data 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 Payment 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.

To build collaborative relationships and identify process improvements that support program integrity goals, CMS conducted a discrepancy phase following the review of the initial audit data submission to work with the issuer to resolve or reduce audit findings, thereby improving compliance. Additional follow-up with the SBE was performed as necessary to confirm or resolve the identified audit findings. Below are the results of this review following the discrepancy phase.

EPDW Validation

No findings or observations resulted from the comparison of the final 2015 EPDW submitted by the issuer to SelectHealth's Payment Desk Audit File.

Unreconciled Subscribers Review

No findings and one (1) observation resulted from the review of SelectHealth's Payment Desk Audit File to determine if the subscribers reported in the file existed and their coverage was effectuated in the issuer's systems. Please refer to Observation No. 1 included in section IV for details on the observation.

Duplicate Exchange-assigned Subscriber IDs Check

One (1) finding and one (1) observation resulted from the review of SelectHealth's Payment Desk Audit File to verify that duplicate Exchange-assigned subscriber IDs were not reported in the file. Please refer to Finding No. 1 and Observation No. 2 included in section IV for details on the finding and observation.

Premium Less than APTC Validation

One (1) finding and two (2) observations resulted from the review of SelectHealth's Payment Desk Audit File to verify that subscribers were not reported in the file with premium amounts that were less than the APTC amounts. Please refer to Finding No. 2 and Observation No. 3, and Observation No. 4 included in section IV for details on the finding and observations.

Coverage Days Validation

No findings and one (1) observation resulted from the review of SelectHealth's Payment Desk Audit File to verify that enrollments of five (5) days or fewer reported in the file were effectuated and had active coverage in the issuer's systems. Please refer to Observation No. 5 included in section IV for details on the observation.

Forty-five (45) Subscribers Sample Review

No findings or observations resulted from the review and comparison of the data from SelectHealth's systems to the corresponding data included in the SBE's PLR data 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 or observations resulted from the review of the data and documentation from SelectHealth'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

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

IV. FINDINGS AND OBSERVATIONS

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, which resulted in a change to the APTC amounts reported in SelectHealth's EPDW for individual market plans for the 2015 benefit year.

An observation is a deviation from CMS or Exchange 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 five (5) observations, consisting of two (2) observations that resulted in a change to the premium amounts reported in SelectHealth's EPDW for individual market plans for the 2015 benefit year and three (3) observations that did not result in a change to the premium amounts reported in SelectHealth's EPDW but that are noted for purposes of improving compliance in future program years.

In light of the two (2) findings and five (5) observations, the adjusted 2015 benefit year EPDW APTC and premium amounts for individual market plans are shown in the following table.

Recalculated EPDW for the 2015 Benefit Year

	APTC	Premium (Observations)
EPDW as Filed in November 2016	\$37,462,338.93	\$64,445,266.79
Observation No. 1 – Unreconciled Subscribers Review Adjustment	\$0.00	\$0.00
Finding No. 1 and Observation No. 2 – Duplicate Exchange-assigned Subscriber IDs Check Adjustment	\$(5,065.20)	\$(5,065.20)
Finding No. 2 and Observation No. 3 – Premium Less Than APTC Validation Adjustment	\$(2,382.00)	\$3,856.68
Observation No. 4 – Premium Less Than APTC Validation Adjustment (No Updates Received)	\$0.00	\$0.00

	APTC	Premium (Observations)
Observation No. 5 – Coverage Days Validation Adjustment	\$0.00	\$0.00
EPDW As Recalculated	\$37,454,891.73	\$64,444,058.27
Total Impact	\$(7,447.20)	\$(1,208.52)*

Note: Positive APTC values indicate funds owed to the issuer.

The net financial impact of the two (2) findings is a payment of \$7,447.20, consisting of APTC owed to CMS.

*Note: The premium impact of the five (5) observations is an overstatement of \$1,208.52 in premiums. The premium impact is noted for purposes of improving compliance in future program years.

For the two (2) findings and five (5) observations, CMS documented the criteria, cause, effect, corrective actions, and SelectHealth's responses as seen in the charts below.

Observation No. 1 – Unreconciled Subscribers	
Condition:	SelectHealth provided coverage and reported enrollment and payment data for fifty-four (54) subscribers in the Payment Desk Audit File with enrollments that should have been cancelled or terminated as no payments were received.
Criteria:	Pursuant to Idaho SBE guidance, "Consistent with Idaho insurance code, consumers are required to make an initial premium payment to bind coverage (i.e. initial binder payment). The Idaho Department of Insurance (DOI) will provide carriers with guidance on initial binder payments. For payments during the plan year, each carrier sets their own tolerance levels for minimum acceptable partial payments before the carrier cancels coverage for non-payment. Consumers can cancel before the coverage effective date and up to 10 days after the coverage effective date, even if the carrier has received confirmation of enrollment (e.g. binder payment). This is also commonly referred to as the "10-day lookback." If a consumer has a delinquency on their account and enrolls with the same carrier within 12 months, the carrier can choose to not effectuate any new enrollments until the consumer's delinquency is satisfied. Carriers must provide consumers the opportunity to make delinquency payments and must provide adequate noticing prior to denying the new enrollment."

Observation No. 1 – Unreconciled Subscribers	
Cause:	<p>The issuer indicated that the enrollments for the fifty-four (54) subscribers were effectuated and provided dates of effectuation. However, the SBE indicated the enrollments were cancelled in their systems and indicated the following general explanations for the fifty-four (54) subscribers:</p> <ul style="list-style-type: none"> • "2015 policy is cancelled." • "SBE reflects policy as effectuated but cancelled." • "Do not reflect this policy in system." • "Confirmed but cancelled." • "SBE cancelled after benefit start date." • "SBE shows policy as effectuated but cancelled prior to confirmation transaction sent by carrier." • "SBE reflects that enrollment exists but never effectuated. Consumer cancelled policy prior to coverage start date." • "SBE reflects that enrollment was effectuated but later cancelled." <p>During the audit, CMS followed up with the issuer to request proof of payment for the enrollments. The issuer did not have proof of payments for the enrollments but indicated "we did cover for the time listed in the benefit start and end date" for the fifty-four (54) subscribers.</p>
Effect:	The issuer did not follow SBE enrollment guidance and requirements as the issuer provided coverage for fifty-four (54) subscribers with enrollments that should have been cancelled or terminated.
Corrective Action Required:	CMS notes this observation for purposes of improving compliance in future program years.
Management Response:	Agree.

Finding No.1 and Observation No. 2 – Duplicate Exchange-assigned Subscriber IDs Check	
Condition:	SelectHealth overstated the 2015 benefit year premium and APTC amounts for one (1) subscriber in the Payment Desk Audit File by reporting enrollment and full month payment data for the subscriber more than once in the same month.
Criteria:	Issuers cannot request full month payment from CMS for the same subscriber twice within a month.

Finding No.1 and Observation No. 2 – Duplicate Exchange-assigned Subscriber IDs Check	
Cause:	The issuer indicated “SelectHealth was sent two policies for 2015 and effectuated both. As a result, this member had overlapping coverage for 2015.” The issuer further indicated that claims “were processed under subscriber ID [issuer provided subscriber ID]. The overlapping policy had no claims paid under that subscriber ID of [issuer provided subscriber ID].”
Effect:	The inclusion of the one (1) duplicate subscriber resulted in a change to SelectHealth’s final, restated 2015 benefit year EPDW data.
Corrective Action Required:	<p>The net financial impact of this finding is a payment of \$5,065.20, consisting of APTC owed to CMS. SelectHealth should confirm the financial impact and coordinate on resolution with CMS.</p> <p>The premium impact of this observation is an overstatement of \$5,065.20 in premiums. CMS notes this observation for purposes of improving compliance in future program years.</p>
Management Response:	Agree.

Finding No. 2 and Observation No. 3 – Premium Less than APTC Validation	
Condition:	SelectHealth reported 2015 benefit year premium amounts that were less than the APTC amounts for ten (10) subscribers in the Payment Desk Audit File, resulting from SelectHealth understating the 2015 benefit year premium amounts for six (6) subscribers and overstating the 2015 benefit year APTC amounts for four (4) subscribers in the Payment Desk Audit File.
Criteria:	Issuers cannot report an APTC amount that exceeds the premium amount for a policy.
Cause:	<p>The issuer provided the correct premium and APTC amounts for the subscribers and indicated the following for the ten (10) subscribers:</p> <ul style="list-style-type: none"> • “There was an error when calculating the premium in the restated [file]. Policy holder was invoiced correctly.” (Three (3) subscribers) • “The dependent was termed [issuer provided termination date], but the APTC amount was not updated to reflect the change. This erroneously created a premium credit each month. We are

Finding No. 2 and Observation No. 3 – Premium Less than APTC Validation	
	<p>not able to find this file with the change noted by the SBE. Will correct due to SBE response.” (Three (3) subscribers)</p> <ul style="list-style-type: none"> • “There was an error while processing the file and the dependent was added effective 9/1/15 instead of 6/1/15. Due to this it is causing the credit for June - August. The correct premium is listed of what should have been calculated.” (One (1) subscriber) • “There is a dependent enrolled in 2015 per the 834 enrollment file; however, SelectHealth didn’t have the dependent enrolled. The APTC amount applied was for the two enrollees.” (One (1) subscriber) • “We are not able to find the file with this update. Will update our system to reflect per SBE response.” (One (1) subscriber). • “A file was received but was not updated in our system. Correcting to SBE response.” (One (1) subscriber) •
Effect:	The inclusion of the incorrect APTC and/or premium amounts for the ten (10) subscribers resulted in a change to SelectHealth’s final, restated 2015 benefit year EPDW data.
Corrective Action Required:	<p>The net financial impact of this finding is a payment of \$2,382.00, consisting of APTC owed to CMS. SelectHealth should confirm the financial impact and coordinate on resolution with CMS.</p> <p>The premium impact of this observation is an understatement of \$3,856.68 in premiums. CMS notes this observation for purposes of improving compliance in future program years.</p>
Management Response:	Agree.

Observation No. 4 – Premium Less than APTC Validation	
Condition:	SelectHealth reported and billed 2015 benefit year premium amounts that were less than the APTC amounts for three (3) subscribers in the Payment Desk Audit File as no updates were received from the SBE.
Criteria:	Issuers cannot report an APTC amount that exceeds the premium amount for a policy.

Observation No. 4 – Premium Less than APTC Validation	
Cause:	<p>The issuer and SBE indicated the following for the three (3) subscribers:</p> <ul style="list-style-type: none"> • The issuer indicated “Per email from YHI (see attachment) Dependent was to be terminated 10/31/15. No update to the APTC was sent correcting for November - that is what is causing the credit for that one month.” The SBE indicated “Policyholder removed their dependent the day after policy was terminated by the system to 12/31/2015. This prevented an updated 834 from going out with the change.” • The issuer indicated “834 enrollment was received on 3/15/15 updating APTC to \$319.00; however, we received an e-mail on 03/25/15 from YHI asking us to term [issuer-provided dependent name for the subscriber]. A new 834 enrollment file to update tax credit back to 01/01/2015 was never received.” The SBE indicated “The APTC did update to \$319.00 beginning 03/01/2015. There was no update to retroactively correct APTC back to 01/01/2015.” • The issuer indicated “An 834 enrollment file was received on 04/18/2016 which updated the APTC amount from \$759.00 to \$848.52. This APTC amount change was captured in the restate file. The APTC update in 2016 was followed by e-mail correspondence with YHI on 03/30/2016 which led to SelectHealth approving that the policy be retroactively effectuated back to 01/01/2015 with a \$0.00 premium due from the consumer.” The SBE indicated “APTC was updated from \$759.00 to \$848.52 on 02/17/2015” and confirmed the values matched what the issuer reported in the Payment Desk Audit File.
Effect:	The issuer did not follow CMS enrollment guidance and policy as the issuer reported and billed APTC amounts that exceeded the premium amounts.
Corrective Action Required:	CMS notes this observation for purposes of improving compliance in future program years.
Management Response:	Agree.

Observation No. 5 – Coverage Days Validation	
Condition:	SelectHealth provided coverage and reported 2015 benefit year premium and APTC amounts for two (2) subscribers in the Payment Desk Audit File with enrollments of five (5) days or fewer that should have been cancelled.
Criteria:	<p>Pursuant to Idaho SBE guidance, “Consistent with Idaho insurance code, consumers are required to make an initial premium payment to bind coverage (i.e. initial binder payment). The Idaho Department of Insurance (DOI) will provide carriers with guidance on initial binder payments. For payments during the plan year, each carrier sets their own tolerance levels for minimum acceptable partial payments before the carrier cancels coverage for non-payment. Consumers can cancel before the coverage effective date and up to 10 days after the coverage effective date, even if the carrier has received confirmation of enrollment (e.g. binder payment). This is also commonly referred to as the "10-day lookback." If a consumer has a delinquency on their account and enrolls with the same carrier within 12 months, the carrier can choose to not effectuate any new enrollments until the consumer's delinquency is satisfied. Carriers must provide consumers the opportunity to make delinquency payments and must provide adequate noticing prior to denying the new enrollment.”</p> <p>Additionally, pursuant to 45 CFR § 156.270, QHP issuers must abide by the termination of coverage or enrollment effective dates described in § 155.430(d) of subchapter B.</p>
Cause:	<p>The issuer indicated the following for the two (2) subscribers:</p> <ul style="list-style-type: none"> • The issuer noted that initially a 1/5/15 term was received on 1/8/15, but a 1/1/15 termination was then later received on 2/23/16. The issuer indicated “We have the member active for five days because the cancellation was received too late.” • “The carrier received the 1/1/2015 cancel in March of 2016. We choose not to harm the member by retro terming the policy. We have the member active for six days because the cancellation was received too late.”
Effect:	The issuer did not follow SBE enrollment guidance and requirements as the issuer did not cancel the subscribers’ enrollments based on a retroactive transaction received from the SBE.
Corrective Action Required:	CMS notes this observation for purposes of improving compliance in future program years.

Observation No. 5 – Coverage Days Validation	
Management Response:	Agree.

V. MANAGEMENT RESPONSES

Please provide management's response to the two (2) findings and five (5) 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 five (5) 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 on the CCIIO webpage. CMS will process the final payment adjustment amount in the next available monthly payment cycle.

Disagreement

If management disagrees with either of the two (2) findings and corrective actions or any of the five (5) 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.

Please return the updated Appendix 1 within fifteen (15) calendar days. Upon receipt of the signed Appendix 1, CMS will finalize and publish the report on the CCIIO webpage. CMS will process the final payment adjustment amount in the next available monthly payment cycle.

Appendix 1 – Issuer Management Response to Net Financial Adjustment

Issuer HIOS ID: 26002

Issuer Name: SelectHealth Inc. (SelectHealth)

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 of \$7,447.20 to CMS and:

(INITIAL) TT 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: Todd Trettin
(Signature of authorized person acting on behalf of the issuer)

Printed Name: Todd Trettin
(Print name of signature)

Title: Chief Financial Officer (CFO)

(Title of authorized person acting on behalf of the Issuer)

Telephone Number: 801-442-7760

(Direct Telephone Number)

Date: 4/7/2022

Appendix 2 – Applicable Regulations

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

Regulation	Rules
45 CFR § 155.1210 – Maintenance of Records	<p>(a) General. The State Exchange must maintain and must ensure its contractors, subcontractors, and agents maintain for 10 years, documents and records (whether paper, electronic, or other media) and other evidence of accounting procedures and practices, which are sufficient to do the following:</p> <ul style="list-style-type: none">(1) Accommodate periodic auditing of the State Exchange's financial records; and(2) Enable HHS or its designee(s) to inspect facilities, or otherwise evaluate the State- Exchange's compliance with Federal standards. <p>(b) Records. The State Exchange and its contractors, subcontractors, and agents must ensure that the records specified in paragraph (a) of this section include, at a minimum, the following:</p> <ul style="list-style-type: none">(1) Information concerning management and operation of the State Exchange's financial and other record keeping systems;(2) Financial statements, including cash flow statements, and accounts receivable and matters pertaining to the costs of operations;(3) Any financial reports filed with other Federal programs or State authorities;(4) Data and records relating to the State Exchange's eligibility verifications and determinations, enrollment transactions, appeals, and plan variation certifications; and(5) Qualified health plan contracting (including benefit review) data and consumer outreach and Navigator grant oversight information. <p>(c) Availability. A State Exchange must make all records and must ensure its contractors, subcontractors, and agents must make all records in paragraph (a) of this section available to HHS, the OIG, the Comptroller General, or their designees, upon request.</p>

Regulation	Rules
<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> <p>(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;</p> <p>(2) Notify the Exchange of the reduction in the portion of the premium charged to the individual in accordance with § 156.265(g); and</p> <p>(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.</p>
<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>

Regulation	Rules
<p>45 CFR § 156.705 – Maintenance of records for Federally-facilitated Exchanges</p>	<p>(a) <i>General standard.</i> 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) <i>Records.</i> 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) <i>Record retention timeframe.</i> 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) <i>Record availability.</i> 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
DHHS	Department of Health and Human Services
EPDW	Enrollment and Payment Data Workbook
GAGAS	Generally Accepted Government Auditing Standards
HIOS	Health Insurance Oversight System
IRS	Internal Revenue Service
PPACA	Patient Protection and Affordable Care Act
PLR	Policy-level Reporting
QHP	Qualified Health Plan
SBE	State-based Exchange
TIN	Tax Identification Number