



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

for

CareSource Indiana, Inc.

February 1, 2023

I. EXECUTIVE SUMMARY

Sections 1401 and 1412 of the Affordable Care Act (ACA) established the advance payments of the premium tax credit (APTC) program to support the provision of affordable health care coverage to individuals. Additionally, section 1311 of the ACA allows the Federally-facilitated Exchanges (FFE) to charge participating issuers user fees to support FFE operations.

Under title 45 of the Code of Federal Regulations (CFR), sections 156.480 and 156.705, the Department of Health and Human Services (HHS) may audit issuers that offer a Qualified Health Plan (QHP) in the individual market through an Exchange to assess the degree of compliance with the APTC and FFE user fee program requirements. The Centers for Medicare & Medicaid Services (CMS) established an audit protocol to assess health insurance issuers' compliance with the following regulations governing APTC and FFE user fee programs and other related applicable Exchange operational standards:

- 45 CFR § 155.400: Enrollment of qualified individuals into QHPs;
- 45 CFR § 155.430: Termination of Exchange enrollment or coverage;
- 45 CFR § 156.50: Financial support;
- 45 CFR § 156.270: Termination of coverage or enrollment for qualified individuals;
- 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; and
- 45 CFR § 156.705: Maintenance of records for Federally-facilitated Exchanges.

This report is an assessment of CareSource Indiana, Inc. (CareSource (IN))'s compliance with the APTC and FFE user fee programs. CareSource (IN) is a health insurance issuer that offered QHPs in the individual market on the FFE in Indiana during the 2018 benefit year. The issuer received a total of \$203,958,652.45 in APTC from CMS and paid a total of \$14,218,197.09 in FFE user fees to CMS for the 2018 benefit year. The payment amounts were calculated using CMS's automated payment system, policy-based payments (PBP).

Based on the assessment of CareSource (IN)'s program participation, if CMS found any instances of issuer non-compliance with APTC and FFE user fee program requirements that requires correction to payment, then CMS classified it as a *finding* in section III. If CMS found a deviation from APTC and FFE user fee program requirements that does not require correction to payment, then CMS categorized it as an *observation* in section IV in order to call management's attention to the issue(s) for purposes of improving compliance in future program years.

As noted in the Payment Policy and Financial Management Group (PPFMG) External Audit Communication letter dated July 19, 2019, consistent with the expiration of the good faith policy at 45 CFR § 156.800(c), CMS may begin imposing civil money penalties (CMPs) for observations identified beginning with benefit year 2020 audits.

II. BACKGROUND AND AUDIT METHODOLOGY

A. PBP Background

Starting in 2016, CMS implemented an automated PBP system to support the collection of FFE user fees and to make monthly payments of APTC. The PBP system calculates the payment and charge amounts based on enrollment information at the policy level. CMS and issuers use the X12 standard 834 enrollment transaction in real time to exchange FFE enrollment data. To confirm the accuracy and consistency of the FFE enrollment data that CMS uses to make automated payments, CMS also conducts a monthly enrollment reconciliation process. CMS provides a Pre-Audit File to issuers containing a snapshot of the FFE database for the benefit year, and issuers respond by submitting an Inbound Reconciliation (RCNI) File to CMS that contains the benefit year's enrollment data as reflected in the issuer's systems. As a part of the reconciliation processes, CMS reconciles the RCNI file with the Pre-Audit File using a set of business rules that reflect CMS's enrollment policy to determine whether updates were required. This process implements a complex set of business rules to determine which issuer enrollment updates are accepted or rejected. The output of the comparison, the Outbound Reconciliation (RCNO) File, is sent to issuers to show which records CMS anticipates updating in the FFE database and which records CMS is directing the issuer to update in their systems. CMS conducted this enrollment reconciliation process for the 2018 benefit year from December 2017 through March 2019.

CMS provided a final opportunity for issuers to compare their 2018 FFE individual enrollment data with the current 2018 enrollment data in the FFE database, via an optional off-cycle enrollment reconciliation process. Unlike typical enrollment reconciliation runs, CMS did not update FFE enrollment data based on the off-cycle enrollment reconciliation. Instead, issuers were encouraged to submit disputes for any outstanding discrepancies resulting from the off-cycle enrollment reconciliation processes that required updates to FFE data.

B. Audit Methodology

On February 16, 2021, CareSource (IN) was notified by CMS that they were selected for audit for the 2018 benefit year. Once selected, CMS required the submission of a new RCNI file that contained the 2018 benefit year individual market enrollment data as currently reflected in the issuer's systems. CMS also required the submission of policies and procedures, policy documentation for selected samples of policies, and a Premium Payment Data Extract containing premium payment data from the issuer's system for a selected sample of policies. Using the issuer provided data files and documentation, the following audit procedures were performed to assess compliance with APTC and FFE user fee program rules and regulations.

Validations of PBP Payments/Charges based on Data Reported in CMS's Systems through Enrollment Reconciliation

For purposes of the audit, the issuer submitted an updated RCNI file that reflected a current snapshot of individual market enrollment data for the 2018 benefit year. During the audit, CMS reconciled the issuer provided RCNI file with the Pre-Audit File representing the most recent FFE data as of the beginning of the audit to identify any data differences and used the output of the comparison (the audit RCNO file) as the basis for performing the checks in its audit procedures to validate PBP payments. CMS executed audit procedures to identify the policies that have a financial impact listed in section III of this report. CMS referred to its enrollment policy and PBP requirements to develop the audit protocols that determine

whether the discrepancies identified through these reviews and comparisons required adjustment to payment¹. Data differences identified between the issuer's enrollment records and the FFE data in the audit RCNO file were reviewed and communicated to the issuer for resolution or confirmation as part of the audit process. Any policies with the following remaining confirmed data differences that required adjustment to payment after the completion of this process are detailed in an Excel file provided to CareSource (IN) in conjunction with the draft report:

- 1) Coverage status: Policies that were effectuated in CMS's data but not the issuer's data or vice-versa (referred to as "CMS Unreconciled" or "Issuer Unreconciled", respectively);
- 2) Coverage dates: Policies where the dates of coverage did not align between CMS and the issuer (referred to as "CMS Extra Coverage" or "Issuer Extra Coverage"); and/or
- 3) Financial differences: Policies where premium and resulting FFE user fee and/or APTC amounts differed between CMS's data and the issuer's data (referred to as "Financial Differences with/without Coverage Differences").

Validations of the Correct Application of CMS Enrollment Policy

Using the policy documentation, data files, and policies and procedures provided by the issuer, CMS executed audit procedures to identify the observations listed in section IV of this report. The reviews include the Forty-Five (45) Subscriber Sample Policy-level Documentation Review, Premium Payment Data Extract Validation, and Policies and Procedures Review.

CMS conducted a discrepancy phase following execution of the audit procedures detailed above to work with the issuer to resolve or reduce data differences identified. CMS adjudicated the issuer follow-up and, after the analysis, issued this report.

¹ [Enrollment Reconciliation rules](https://regtap.cms.gov) are available on <https://regtap.cms.gov>.

III. SUMMARY OF FINDINGS WITH FINANCIAL IMPACT

A finding is the 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 data differences that resulted in a change to the total APTC payment made to CareSource (IN) and the total FFE user fees collected from CareSource (IN) for individual market plans during the 2018 benefit year. The APTC and FFE user fee financial impact is shown in the following table.

APTC Payment and FFE User Fee Collection Financial Impact

	Number of Policies Impacted	APTC Payment	FFE User Fee Payment	Total
Policies where CMS owes the Issuer APTC	145	\$494,547.15	\$(23,193.79)	\$471,353.36
Policies where the Issuer owes CMS APTC	251	\$(656,438.54)	\$33,617.02	\$(622,821.52)
User Fee Only Policies where CMS owes the Issuer FFE UF	304	N/A	\$62,887.74	\$62,887.74
User Fee Only Policies where the Issuer owes CMS FFE UF	62	N/A	\$(6,229.91)	\$(6,229.91)
Total Impact	762	\$(161,891.39)	\$67,081.06	\$(94,810.33)

Note: Positive values indicate funds owed to the issuer; negative values indicate amounts owed to CMS.

The net financial impact is a payment from CareSource (IN) to CMS of \$94,810.33, which consists of \$161,891.39 in APTC to be returned to CMS and \$67,081.06 in FFE user fees to be returned to CareSource (IN). The policies impacted and the associated financial impact are detailed in an Excel file provided to CareSource (IN) in conjunction with the draft report.

The APTC payment and user fee payment adjustments will be processed in the monthly payment cycle and netted against any other payments or charges as indicated by CMS’s netting rules.²

² For more information on CMS’s payment and collections processes, please visit <https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-156/subpart-M/section-156.1215>.

IV. SUMMARY OF OBSERVATIONS

An observation is a deviation from APTC and FFE user fee program requirements that is called to the attention of management for purposes of improving compliance in future program years but that does not require correction to payment. While CMS is not adjusting APTC payment or imposing CMPs for the audit of the 2018 benefit year, we note issuer deviations from CMS's enrollment regulations or guidance where applicable. As noted in the PPFMG External Audit Communication letter dated July 19, 2019, consistent with the expiration of the good faith policy at 45 CFR § 156.800(c), CMS may begin imposing CMPs for observations identified beginning with benefit year 2020 audits. CMS's audit procedures identified the following four (4) observations:

- CareSource (IN) provided coverage despite not receiving the binder payment within the issuer's threshold of 98% within thirty (30) calendar days from the coverage effective date for two (2) of the seven hundred and twenty-nine (729) policies reviewed in the Premium Payment data Extract Validation, which included one (1) of the thirty-nine (39) policies reviewed in the Issuer Unreconciled Policy Review. For the two (2) policies, the issuer indicated, "This policy was originally cancelled for non-payment. A business decision was made to reinstate the policy." The issuer further indicated, "we had a reinstatement policy that was consistently applied. For example, for this member, the additional detail surrounding reinstatement is that in February of 2018, we sent a letter to all members letting them know we had revised our initial payment policy to extend the time we will receive and post a member's initial payment; due to this update, we reversed cancellations and reinstated policies to be consistent across the Marketplace, including for this member." CMS noted that the issuer's allowance for reinstatements following cancellations due to non-payment across all Marketplace enrollments is inconsistent with CMS requirements surrounding binder premium payment deadlines and could impact additional enrollments in the issuer's systems. Pursuant to 45 CFR § 155.400(e), for first month (or binder payment) premiums, premium payment deadlines must be no earlier than the coverage effective date, but no later than thirty (30) calendar days from the coverage effective date.
- For one (1) policy in the Forty-five (45) Subscriber Sample Policy-level Documentation Review, and for thirteen (13) of the seven hundred and twenty-nine (729) policies reviewed in the Premium Payment Data Extract Validation, who were in the grace period and did not pay all outstanding premiums, CareSource (IN) did not terminate based on the earlier of the termination date received from CMS and the date the enrollee's coverage is terminated for non-payment of premiums if the enrollee fails to pay all outstanding premiums. For the fourteen (14) policies, the issuer indicated, "The 834 term was received prior to the term for delinquency processing in CS system. Prior to 2020, CS utilized the 834 term date instead of the earlier, delinquency term date." The issuer further indicated, "This was the way CareSource systems were designed until our system enhancement beginning 1/1/2020." CMS noted that the issuer's incorrect application of terminations and failure to continue to assess payments for grace period reporting could impact additional enrollments in their systems. Pursuant to CMS guidance outlined in the CMS FFE and Federally-Facilitated Small Business Health Options Program (FF-SHOP) Enrollment Manual for the 2018 benefit year, "if an enrollee seeks to voluntarily terminate coverage while he or she is in a grace period due to non-payment of premiums, the effective date of termination is the earlier of: (1) the enrollee's voluntary termination date, or (2) the date the enrollee's coverage is terminated for non-payment of premiums (involuntary termination date) if the enrollee fails to pay all

outstanding premiums or an amount within the tolerance of any applicable premium payment threshold, before the end of the applicable grace period.”

- CareSource (IN) continued to provide coverage despite not receiving the full outstanding premium balance within the three (3) month grace period for thirteen (13) of the seven hundred and twenty-nine (729) policies reviewed in the Premium Payment Data Extract Validation. The issuer indicated the following for the thirteen (13) policies:
 - For seven (7) policies, the issuer indicated that there was a demographic change, a change in APTC, or a change in premiums that resulted in a rebill which “caused the grace period to start later than traditionally expected and the member was retro-termed to the last day of the first grace month.” CMS noted that the issuer’s systems did not correctly place the members in the grace period based on the month the member failed to make the premium payment. CMS notes any systematic invoicing issues may impact additional enrollments in the issuer’s systems.
 - For four (4) policies, the issuer indicated that the policy was originally terminated for payment delinquency; however, the policy was incorrectly reinstated and was eventually terminated for non-payment delinquency.
 - For one (1) policy, the issuer indicated, “member entered the grace period in October 2018. They were sent a final termination warning on 12/3/2018 with a due date of 1/2/2019. The member did not pay by the due date, but the termination did not process as expected. As a result, the member had additional time to pay.”
 - For one (1) policy with a payment receipt for months 9-12 on 12/21/2018, the issuer indicated, “CareSource records were updated on 8/13/2018 to reflect the loss in APTC beginning 9/1/2018. This change was billed on the October invoice (sent in September) with a due date of 9/25/2018. This caused the grace period to start later than traditionally expected (October). The member was sent a termination warning on 12/3/2018 with a final due date of 1/2/2019. The member paid before the grace period ended.”

Pursuant to 45 CFR § 156.270(g), if an enrollee receiving APTC exhausts the three (3) month grace period without paying all outstanding premiums, the QHP issuer must terminate the enrollee’s enrollment through the Exchange on the last day of the first month of the three (3) month grace period.

- CareSource (IN)’s internal procedures are inconsistent with CMS requirements and guidance surrounding placement of enrollees in three (3) month grace periods and termination of enrollments following the exhaustion of the three (3) month grace period. The issuer’s internal procedures and system configurations assess payments and apply grace period reporting requirements based on the timing of invoice cycles and due dates and not based on the timeliness of the payments for each month of enrollment, regardless of when the member was invoiced. The issuer indicated that the grace periods start based on the due dates of the invoices which can cause the grace periods to start later than traditionally expected if invoicing is delayed during a month or if invoices are reissued. CMS notes the issuer’s procedures and system configurations should be updated to be consistent with CMS requirements. Pursuant to CMS guidance outlined in the CMS FFE and FF-SHOP Enrollment Manual for the 2018 benefit year, “if an enrollee fails to make payment within the threshold tolerance, he or she will be placed in the applicable grace period.” Pursuant to 45 CFR § 156.270, if an enrollee receiving APTC exhausts the three (3) month grace period without paying all outstanding premiums, the QHP issuer must terminate the

enrollee's enrollment through the Exchange on the last day of the first month of the three (3) month grace period.

Appendix 1 – Issuer Management Response to Net Financial Adjustment

Issuer HIOS ID: 54192

Issuer Name: CareSource Indiana, Inc. (CareSource (IN))

The undersigned Chief Executive Officer (CEO), Chief Financial Officer (CFO) or other authorized official who can legally and financially bind this issuer has reviewed the information included in the audit report of the issuer's 2018 benefit year APTC and FFE user fee program, resulting in a payment to CMS of \$94,810.33, consisting of \$161,891.39 in APTC to be returned to CMS and \$67,081.06 in FFE user fees to be returned to CareSource (IN), and:

(INITIAL) LS Agrees with the audit net adjustment amount above, confirming the audit financial impact 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 audit. As you requested a review, CMS will consider this draft only a preliminary audit report. As the review option was 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.

DocuSigned by:
Signed: Lawrence Smart
(Signature of authorized official acting on behalf of the Issuer)

Printed Name: Lawrence Smart
(Print name of signature)

Position Title: CFO
(Title of authorized official acting on behalf of the Issuer)

Direct Telephone Number: Phone Number

Email Address: lawrence.smart@caresource.com

Date: 2/23/2023