



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

for

Network Health Plan

October 25, 2022

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 Network Health Plan (Network Health)'s compliance with the APTC and FFE user fee programs. Network Health is a health insurance issuer that offered QHPs in the individual market on the FFE in Wisconsin during the 2018 benefit year. The issuer received a total of \$53,142,631.44 in APTC from CMS and paid a total of \$2,523,904.73 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 Network Health'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, Network Health 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. In the audit RCNO file, data differences identified between the issuer's enrollment records and the FFE data 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 Network Health 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). Additional information is 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 Network Health and the total FFE user fees collected from Network Health 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 | 4 | \$12,522.02 | \$(500.96) | \$12,021.06 |
| Policies where the Issuer owes CMS APTC | 27 | \$(37,128.09) | \$1,732.58 | \$(35,395.51) |
| User Fee Only Policies where CMS owes the Issuer FFE UF | 22 | N/A | \$1,576.64 | \$1,576.64 |
| User Fee Only Policies where the Issuer owes CMS FFE UF | 6 | N/A | \$(1,335.48) | \$(1,335.48) |
| Total Impact | 59 | \$(24,606.07) | \$1,472.78 | \$(23,133.29) |

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

The net financial impact is a payment from Network Health to CMS of \$23,133.29, which consists of \$24,606.07 in APTC to be returned to CMS and \$1,472.78 in FFE user fees to be returned to Network Health. The policies impacted and the associated financial impact are detailed in an Excel file provided to Network Health 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 observations 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 three (3) observations:

- Network Health continued to provide coverage despite not receiving the full outstanding premium balance within the three (3) month grace period for two (2) of the seventy-three (73) policies reviewed in the Premium Payment Data Extract Validation and for three (3) policies reviewed in the Forty-Five (45) Subscriber Sample Policy-level Documentation Review. The issuer indicated the following for the five (5) policies:
 - For four (4) policies with late payments, the issuer noted that the members paid late. The issuer further indicated, "Network Health reviews all terminations for non-payment to verify that the proper grace period notifications were sent to the member. In this case we could not confirm that this was done so we reached out to the member to address the problem and the member agreed to pay the balance."
 - For one (1) policy with coverage from 1/1/2018 through 3/3/2018, the issuer indicated, "The member was termed exactly 30 days after the last monthly payment. Because Feb is short month, 3 days of coverage in March was included to get to the 30 days. We no longer term on a '30' day basis but by calendar month." CMS noted that the inconsistent application of a 30-day basis for non-payment terminations may impact additional enrollments in the issuer's systems.

The issuer's failure to invoice timely prevented the issuer from complying with 45 CFR § 156.270(g), which states that 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.

- For two (2) policies reviewed in the Forty-Five (45) Subscriber Sample Policy-level Documentation Review who were in the grace period and did not pay all outstanding premiums prior to the end of the three (3) month grace period, Network Health incorrectly terminated the enrollment based on the later member-requested termination date received from CMS instead of the earlier date the enrollee's coverage should have been terminated for non-payment of premiums. For the two (2) policies with no payments received for the last two (2) months of enrollment, the issuer indicated, "Member entered grace period and followed grace period rules as required." The issuer further indicated, "CMS initiated a termination as of [termination date]" and the enrollments were terminated based on the CMS provided date. CMS noted the issuer's failure to continue to assess for non-payment of premiums during the grace period could impact additional enrollments in their systems. Pursuant to CMS guidance outlined in the CMS FFE 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.”

- Health Network’s internal policies for the 2018 benefit year were inconsistent with CMS requirements and guidance surrounding grace period reporting. The issuer’s internal policies indicate grace period non-payment termination are performed on a 30 day basis and members are termed exactly 30 days after the last monthly payment if the full outstanding balance is not received within a 90-day period. The issuer indicated that the internal policies have been updated to be consistent with CMS requirements and that “[w]e no longer term on a '30' day basis but by calendar month.” 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.

Appendix 1 – Issuer Management Response to Net Financial Adjustment

Issuer HIOS ID: 81413

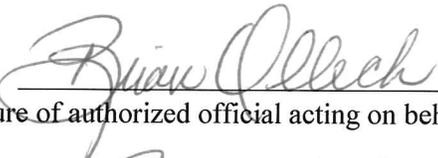
Issuer Name: Network Health Plan (Network Health)

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 \$23,133.29, consisting of \$24,606.07 in APTC to be returned to CMS and \$1,472.78 in FFE user fees to be returned to Network Health, and:

(INITIAL) BKO 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.

Signed: 
(Signature of authorized official acting on behalf of the Issuer)

Printed Name: Brian Ollech
(Print name of signature)

Position Title: Chief Financial Officer
(Title of authorized official acting on behalf of the Issuer)

Direct Telephone Number: 920-720-1886

Email Address: bolleche@networkhealth.com

Date: 11/9/2022