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

for

Humana Health Plan, Inc. (Colorado)

March 22, 2022

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I. EXECUTIVE SUMMARY

Background

Humana Health Plan, Inc. (Humana) is a health insurance issuer that offered qualified health plans (QHPs) in the individual market State-Based Exchange (SBE) in Colorado during the 2014 benefit year. The state of Colorado submitted Humana's final restated 2014 benefit year data in the November 2016 Enrollment and Payment Data Workbook (EPDW). The issuer received a total of $10,571,724.06 in advance payments of the premium tax credit (APTC) from CMS and the SBE reported a total of $19,349,719.21 in premiums for the issuer's 2014 benefit year individual market plans.

This report is an assessment, conducted in coordination with the SBE, of Humana'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 2014 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 audit[1] 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 2014 EPDW submitted by the SBE, 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 three (3) findings and four (4) observations for Humana. The net APTC financial impact of the three (3) findings is an overstatement of $260,307.57 in APTC in the final EPDW submitted by the SBE and therefore a payment to CMS of $260,307.57, consisting of APTC owed to CMS. The net premium impact of the four (4) observations is an understatement of $33,295.13 in premiums in the final EPDW submitted by the SBE. The findings and observations include the following:

Findings:

1. Differences in APTC amounts identified in the comparison of the issuer's data included in the November 2016 EPDW submitted by the SBE to a Payment Desk Audit File containing subscriber level data from Humana's systems;
2. Inclusion of full month enrollment and APTC payment data for two (2) duplicate subscribers in the Payment Desk Audit File; and
3. Inclusion of premium amounts that were less than the APTC amounts and therefore incorrect APTC amounts for twenty-four (24) subscribers in the Payment Desk Audit File.

Observations:

1. Differences in premium amounts identified in the comparison of the issuer's data included in the November 2016 EPDW submitted by the SBE to a Payment Desk Audit File containing subscriber level data from Humana's systems;
2. Inclusion of full month enrollment and premium data for three (3) duplicate subscribers in the Payment Desk Audit File;
3. Inclusion of premium amounts that were less than the APTC amounts and therefore incorrect premium amounts for nine (9) subscribers in the Payment Desk Audit File; and
4. Provision of coverage and reporting of enrollment and payment data for twenty-eight (28) subscribers, including one (1) of the fifteen (15) selected subscribers, in the 1A Payment Desk Audit File with enrollments that were effectuated in error.

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 2014, 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 2014 benefit year, the interim payment process required SBE submitters, including the state of Colorado, to submit enrollment and payment data on behalf of its issuers 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 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 2014 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 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 SBE-generated EPDW data reported for premiums and the APTC program;
(2) Identify potential CMS APTC payment errors resulting from issuer or SBE 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 Humana for an audit to assess the issuer's compliance with 45 CFR §§ 155.1210, 156.460 and 156.480. CMS evaluated Humana's activities related to the 2014 benefit year (January 1, 2014 through December 31, 2014) individual market data reported in the final EPDW submitted in November 2016 by the SBE to CMS to support APTC payments and premium amounts.

CMS sent Humana an electronic letter on May 25, 2018 to notify them of the scope of this audit. CMS's audit contractor sent a follow-up letter to Humana on May 29, 2018 that identified data requirements required to conduct the audit. CMS's audit contractor reviewed the audit data file submitted by Humana, as well as the final 2014 EPDW submitted by the SBE 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 regulations.

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[2]:

- Validations of the Payment Desk Audit File data submitted to CMS:
    - EPDW Validations: Review and comparison of the SBE's final submitted 2014 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 that file were not less than the APTC amounts reported in that 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. During the discrepancy phase, Humana submitted an updated Payment Desk Audit Files to include a missing QHP and updated subscriber-level premium amounts. The procedures were re-performed using the updated Payment Desk Audit File.

Follow-up with the SBE was performed as necessary to confirm or resolve the audit findings and observations resulting from the procedures that entailed the use of the SBE's EPDW and PLR data. The SBE provided information surrounding preliminary issues and differences resulting from the Unreconciled Subscribers Review and Forty-five (45) Subscribers Sample Review but noted it did not have a snapshot of the underlying data supporting the final 2014 EPDW and therefore was unable to confirm or resolve the EPDW Validation differences identified.

Below are the results of this review following the discrepancy phase.

EPDW Validation

One (1) finding and one (1) observation resulted from the comparison of the final 2014 EPDW submitted by the SBE to Humana's Payment Desk Audit File. Please refer to Finding No. 1 and Observation No. 1 included in section IV for details on the finding and observation.

Unreconciled Subscribers Review

No findings or observations resulted from the review of Humana's Payment Desk Audit File to determine if the subscribers reported in the file existed in the SBE's PLR data and their coverage was effectuated in the issuer's systems.

Duplicate Exchange-assigned Subscriber IDs Check

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

Premium Less than APTC Validation

One (1) finding and one (1) observation resulted from the review of Humana'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. 3 and Observation No. 3 included in section IV for details on the finding and observation.

Coverage Days Validation

No findings or observations resulted from the review of Humana'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.

Forty-five (45) Subscribers Sample Review

No findings or observations resulted from the review and comparison of the data from Humana'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 and one (1) observation resulted from the review of the data and documentation from Humana's systems to verify effectuation and the appropriate application of premium and APTC amounts to policies for a selected sample of fifteen (15) subscribers. Please refer to Observation No. 4 included in section IV for details on the observation.

Policy and Procedure Review

No findings or observations resulted from the review of Humana'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 three (3) findings, which resulted in a change to the APTC amounts reported in Humana's EPDW submitted by the SBE for individual market plans for the 2014 benefit year.

An observation is a deviation from CMS 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 four (4) observations, consisting of three (3) observations that resulted in a change to the premium amounts reported in Humana's EPDW submitted by the SBE for individual market plans for the 2014 benefit year and one (1) observation that did not result in a change to the premium amounts reported in Humana's EPDW submitted by the SBE but that are noted for purposes of improving compliance in future year programs.

In light of the three (3) findings and four (4) observations, the adjusted 2014 benefit year EPDW APTC and premium amounts for individual market plans are shown in the following table.

Recalculated EPDW for the 2014 Benefit Year

	APTC	Premium (Observations)
EPDW as Filed by the SBE in November 2016	$10,571,724.06	$19,349,719.21
Finding No. 1 and Observation No. 1 - EPDW Validations Adjustment	$(235,793.84)	$33,018.03
Finding No. 2 and Observation No. 2 – Duplicate Exchange-assigned Subscriber IDs Check Adjustment	$(3,774.26)	$(5,893.02)
Finding No. 3 and Observation No. 3 – Premium Less Than APTC Validation Adjustment	$(20,739.47)	$6,170.12
Observation No. 4 – Fifteen (15) Subscribers Sample Review Adjustment	$0.00	$0.00

	APTC	Premium (Observations)
EPDW As Recalculated	$10,311,416.49	$19,383,014.34
Total Impact	**$(260,307.57)**	**$33,295.13***

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

The net financial impact of the three (3) findings is a payment of $260,307.57, consisting of APTC owed to CMS.

*Note: The premium impact of the four (4) observations is an understatement of $33,295.13 in premiums. The premium impact is noted for purposes of improving compliance in future program years.

For the three (3) findings and four (4) observations, CMS documented the criteria, cause, effect, corrective actions, and Humana's responses as seen in the charts below.

Finding No. 1 and Observation No. 1 – EPDW Validations	
Condition:	**APTC Differences (Finding) –** For one (1) or more months of 2014 benefit year enrollment in fifteen (15) QHPs, the net "Total APTC Amount by QHP ID for effectuated enrollments" included in Humana's EPDW submitted by the SBE was greater than the total APTC amount included in Humana's Payment Desk Audit File, resulting in an overpayment of $235,793.84 in APTC. For the one (1) or more months of 2014 benefit year enrollment in fifteen (15) QHPs, the total net enrollment in the EPDW was overstated by seven hundred and forty (740) APTC enrollment groups and one thousand and fifty-five (1,055) APTC members. **Premium Differences (Observation) –** For one (1) or more months of 2014 benefit year enrollment in fifteen (15) QHPs, the net "Total Premium Amount by QHP ID for effectuated enrollments" included in Humana's EPDW submitted by the SBE was less than the total premium amount included in Humana's Payment Desk Audit File, resulting in an understatement of $33,018.03 in premiums. For the one (1) or more months of 2014 benefit year enrollment in fifteen (15) QHPs, the total net enrollment in the EPDW was understated by four hundred and eighty-seven (487) enrollment groups and overstated by eight hundred and twenty-five (825) members.
Criteria:	Pursuant to CMS guidance and EPDW submission requirements: 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."

Finding No. 1 and Observation No. 1 – EPDW Validations	
	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.”
Cause:	The issuer indicated “We have reviewed the information we have in house, which, as noted in our response, includes the latest restatement file we were sent from Colorado dated November 2015. We still do not have the restatement file from November 2016 that has previously been referenced. Our numbers in the 1A Payment Desk Audit File match what is in our system and the November 2015 restatement file.” The SBE indicated “We have no control, nor right to control over the issuers’ respective systems or processes. We do not have a snapshot of the underlying data from that point in time, therefore it is not possible for us to determine why there is a difference between the monthly premium amounts in C4HCO 1A workbook and various issuers’ systems below the established 1% benchmark for variance.” Therefore, the SBE did not provide agreement or additional support for the differences noted between the premium and APTC amounts reported on the issuer’s Payment Desk Audit File and the premium and APTC amounts reported on the EPDW submitted in November 2016.
Effect:	The APTC and premium differences resulted in a change to Humana’s final, restated 2014 benefit year EPDW data submitted by the SBE. Pursuant to CMS audit procedures for SBEs that submitted workbooks to CMS, in the event that the issuer’s Payment Desk Audit file and audit response do not fully substantiate APTC payments made, CMS will adjustment payment by recouping the unsubstantiated APTC amount difference.
Corrective Action Required:	The net financial impact of this finding is a payment of $235.793.84, consisting of APTC owed to CMS. Humana should confirm the financial impact by filling out Appendix 1. The premium impact of this observation is an understatement of $33,018.03 in premiums. CMS notes this observation for purposes of improving compliance in future program years.
Management Response:	Humana has confirmed the financial impact by filling out Appendix 1 and has taken the observation under advisement.

Finding No. 2 and Observation No. 2 - Duplicate Exchange-assigned Subscriber IDs Check	
Condition:	Humana overstated the 2014 benefit year premium amounts for three (3) subscribers, and overstated the benefit year APTC amounts for two (2) of those subscribers, in the Payment 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.
Cause:	The issuer indicated the following for the three (3) subscribers: • "Duplicate line of coverage was added in error. Enrollment for Subscriber was nulled and rekeyed for months September through December. The changes to the enrollment did not carry over correctly to the data warehouse from which was used to pull the desk audit universe." (Two (2) subscribers) • "Duplicate line of coverage was added in error. Enrollment for Subscriber was nulled and rekeyed for the month of December. The changes to the enrollment did not carry over correctly to the data warehouse from which was used to pull the desk audit universe." (One (1) subscriber)
Effect:	The inclusion of the three (3) duplicate subscribers resulted in a change to Humana's final, restated 2014 benefit year EPDW data submitted by the SBE.
Corrective Action Required:	The net financial impact of this finding is a payment of $3,774.26, consisting of APTC owed to CMS. Humana should confirm the financial impact by filling out Appendix 1. The premium impact of this observation is an overstatement of $5,893.02 in premiums. CMS notes this observation for purposes of improving compliance in future program years.
Management Response:	Humana has confirmed the financial impact by filling out Appendix 1 and has taken the observation under advisement.

Finding No. 3 and Observation No. 3 - Premium Less than APTC Validation	
Condition:	Humana reported 2014 benefit year premium amounts that were less than the APTC amounts for twenty-nine (29) subscribers in the

Finding No. 3 and Observation No. 3 - Premium Less than APTC Validation	
	Payment Desk Audit File resulting from Humana overstating the 2014 benefit year APTC amounts for twenty-four (24) subscribers, and understating the 2014 benefit year premium amounts four (4) of those subscribers, in the Payment Desk Audit File. Additionally, Humana understated the 2014 benefit year premium amounts for five (5) subscribers in the Payment Desk Audit File.
Criteria:	Issuers cannot report an APTC amount that exceeds the premium amount for a policy.
Cause:	The issuer indicated the following general explanations that applied to twenty-two (22) of the subscribers: • "Correct APTC amount for [issuer provided month(s)] is $[issuer provided APTC amount]" (Twelve (12) subscribers) • "Correct total premium for [issuer provided month(s) is $[issuer provided premium amount] and APTC in the amount of $[issuer provided APTC amount]." (Ten (10) subscribers) The issuer indicated the following detailed explanations for seven (7) of the subscribers: • "Change was made retro effective back to 1/1/2014. Months January - June should be Total premium $869.02, APTC $657.62, and Subscriber's responsibility $211.40." (One (1) subscriber) • "Discrepancy is due to associate keying error. Per CO file 2/12/14, Total premium should be $436.87, APTC in the amount of $386.74, and Subscriber's in the amount of $50.13. Subscriber paid individual amount of $50.13 for month March through September. APTC of $386.74 was applied to Subscriber's account for the month of March through September." (One (1) subscriber) • "Due to associate error, billing was adjusted to indicate total premium was $544.37. Correction was made in August 2014 back to total premium in the amount of $966.91, APTC amount $916.00." (One (1) subscriber) • "From June to September 2014, the Total premium amount was $263.30, and APTC amount was $263.30. Adjustment was made to the Subscriber's account to correct APTC amount." (One (1) subscriber) • "Exchange Assigned Subscriber ID was change to [issuer provided subscriber ID]. Effective 5/1/2014, the total premium was $1070.92, and APTC amount was $1028.46." (One (1) subscriber)

Finding No. 3 and Observation No. 3 - Premium Less than APTC Validation	
	• "Per CO file received on 3/6/14, effective 2/1/14, APTC was changed to $683.80 and total premium in the amount of $875.68." (One (1) subscriber) • "Per CO file received on 12/23/13, the APTC amount was $791.61. APTC amount was adjusted in Billing system to Total premium amount in August 2014 to $549.87." The SBE noted the correct total premium amount was $549.87 and the correct APTC amount was $366.56." (One (1) subscriber)
Effect:	The inclusion of the incorrect APTC and premium amounts for the twenty-nine (29) subscribers resulted in a change to Humana's final, restated 2014 benefit year EPDW data submitted by the SBE.
Corrective Action Required:	The net financial impact of this finding is a payment of $20,739.47, consisting of APTC owed to CMS. Humana should confirm the financial impact by filling out Appendix 1. The premium impact of this observation is an understatement of $6,170.12 in premiums. CMS notes this observation for purposes of improving compliance in future program years.
Management Response:	Humana has confirmed the financial impact by filling out Appendix 1 and has taken the observation under advisement.

Observation No. 4 - Fifteen (15) Subscribers Sample Review	
Condition:	Humana provided coverage and reported enrollment and payment data for twenty-eight (28) subscribers, including one (1) of the fifteen (15) selected subscribers, in the Payment Desk Audit File with enrollments that were effectuated in error as no binder payment was received.
Criteria:	Pursuant to Colorado SBE guidance, "The following timing policies and procedures should be applied to initial enrollments in the Individual Exchange. • For a QHP selection received via 834 by the Exchange from the qualified individual between the 1-15th days of any month, coverage must be ensured the first day of the following month. Example: Enrollment submitted on January 15th = Effective February 1st. • For a QHP selection received via 834 by the Exchange between the 16th and last day of the month, coverage must be ensured the first day of the second following month.

Observation No. 4 - Fifteen (15) Subscribers Sample Review	
	Example: Enrollment received on January 16th = Effective March 1st. • In order for the effective date on the 834 to remain and go into effect, the payment for the Individual must have been successfully processed (if electronic payment) or postmarked (if by check) by the 25th of the month before coverage begins. The carrier must give the consumer at least through the 25th of the month before coverage to pay for the premium. If the carrier wishes to provide the consumer with additional time to pay, that is acceptable so long as the effective date and premium amount are the same as what was sent in the initial 834. Example A: Payment Made on Time for Initial Effective Date o 834 sent 2/16 with effective date of 4/1 o Payment Processed OR Check Postmarked: 3/25 o Coverage begins: 4/1 • If payment is not postmarked or completed on the 25thor the more lenient date specified by the carrier, the carrier should: o Send a notice to the consumer that coverage has not begun, and that payment is due. o Send an 834 cancellation to C4HCO. o C4HCO will notify the member that their coverage has not begun and that they must repeat the enrollment process. • Since carriers will cancel the enrollments without corresponding payments, it is unlikely that there should be "orphaned" enrollments that were not effectuated. As an added precaution, C4HCO will run regular reports on initial enrollments that have been sent and not effectuated by the carrier. C4HCO will work with each carrier to investigate orphaned enrollments and seek a resolution. This may include reach out to the consumer and also a system update to remove or remedy the pending 834 files." Additionally, pursuant to CMS guidance and EPDW submission requirements, the EPDW should include data for effectuated enrollments where an effectuated enrollment is described 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 for the one (1) subscriber that "The first month's premium payment was not received. Screen shot of PBS in the Case Sample explained no payments received."

Observation No. 4 - Fifteen (15) Subscribers Sample Review	
	During the audit, CMS coordinated with the issuer to determine whether there were other enrollments reported in the Payment Desk Audit File for which the binder payment was not received. The issuer provided an analysis that detailed twenty-seven (27) additional subscribers with enrollments for which a binder payment was not received. The issuer's Payment Desk Audit File included a total premium amount of $83,450.10 and total APTC amount of $59,943.55 for the twenty-eight (28) subscribers for which no binder payment was received. The issuer further indicated "The 28 subscribers that did not make their initial payment who were not effectuated did have coverage due to their enrollment not being cancelled/nulled correctly within our enrollment system. Instead of cancelling/nulling the enrollment as per process for not receiving the initial premium, the Subscribers was not termed until they went through the grace period process."
Effect:	The issuer did not follow SBE enrollment guidance and requirements as the issuer provided coverage for twenty-eight (28) subscribers with enrollments that were effectuated in error.
Corrective Action Required:	CMS notes this observation for purposes of improving compliance in future program years.
Management Response:	Humana has taken the observation under advisement.

V. MANAGEMENT RESPONSES

Please provide management's response to the three (3) findings and four (4) 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 three (3) findings and four (4) 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 any of the three (3) findings and corrective actions or any of the four (4) 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: 74320

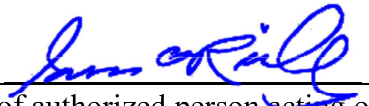
Issuer Name: Humana Health Plan, Inc. (Humana)

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 2014 benefit year APTC program participation, resulting in a payment of $260,307.57 to CMS and:

(INITIAL) SJO 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 2014 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: 
(Signature of authorized person acting on behalf of the issuer)

Printed Name: Sean J. O'Reilly
(Print name of signature)

Title: SVP, Chief Compliance Officer
(Title of authorized person acting on behalf of the Issuer)

Telephone Number: 502-580-8791
(Direct Telephone Number)

Date: 6/2/2022

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	**(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: (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. **(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: (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. **(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.

Regulation	Rules
45 CFR § 156.460 - Reduction of enrollee's share of premium to account for advance payments of the premium tax credit	**(a) Reduction of enrollee's share of premium to account for advance payments of the premium tax credit.** A QHP issuer that receives notice from the Exchange that an individual enrolled in the issuer's QHP is eligible for an advance payment of the premium tax credit must— (1) Reduce the portion of the premium charged to or for the individual for the applicable month(s) by the amount of the advance payment of the premium tax credit; (2) Notify the Exchange of the reduction in the portion of the premium charged to the individual in accordance with§ 156.265(g); and (3) Include with each billing statement, as applicable, to or for the individual the amount of the advance payment of the premium tax credit for the applicable month(s), and the remaining premium owed.
45 CFR § 156.480 - Oversight of the administration of the cost-sharing reductions and advance payments of the premium tax credit programs.	**(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. **(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. **(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.

Regulation	Rules
45 CFR § 156.705 – Maintenance of records for Federally-facilitated Exchanges	**(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: **(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 **(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. **(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. **(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. **(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.

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