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

for

Health Insurance Plan of Greater New York (New York)

October 29, 2020

Table of Contents

I. EXECUTIVE SUMMARY

Background

Health Insurance Plan of Greater New York (Health Insurance Plan) is a health insurance issuer that offered qualified health plans (QHPs) in the individual market State-Based Exchange (SBE) in New York during the 2014 benefit year. Health Insurance Plan submitted its final restated 2014 benefit year data in the November 2015 Enrollment and Payment Data Workbook (EPDW). The issuer received a total of $50,431,894.44 in advance payments of the premium tax credit (APTC) from CMS and reported a total of $120,584,069.69 in premiums for its 2014 benefit year individual market plans.

This report is an assessment, conducted in coordination with the SBE, of Health Insurance Plan'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 issuer, and to analyze controls and policies of selected issuers pursuant to the authority defined in 45 CFR §§ 155.1210 and 156.480.

[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 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 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 one (1) finding and six (6) observations for Health Insurance Plan. The net APTC financial impact of the one (1) audit finding is an overstatement of $61,899.82 in APTC in the final EPDW and therefore a payment to CMS of $61,899.82, consisting of APTC owed to CMS. The net premium impact of the six (6) observations is an understatement of $591,763.16 in premiums in the final EPDW. The finding and observations include the following:

Finding:

1. Inclusion of premium amounts that were less than the APTC amounts resulting in reporting incorrect APTC amounts for eighty-one (81) subscribers in the Payment Desk Audit File.

Observations:

1. Reporting of APTC amounts in catastrophic plans and differences in premium amounts identified in the comparison issuer's data included in the November 2015 EPDW submitted by Health Insurance Plan to a Payment Desk Audit File containing subscriber level data from Health Insurance Plan's systems;
2. Provision of coverage and reporting of enrollment and payment data in the Payment Desk Audit File for twenty-two (22) subscribers with enrollments that were effectuated in error;
3. Inclusion of premium amounts that were less than the APTC amounts as a result of reporting incorrect premium amounts for five (5) subscribers in the Payment Desk Audit File;
4. Inclusion of an incorrect coverage period and therefore understated premium amounts for one (1) of the forty-five (45) selected subscribers in the Payment Desk Audit File;
5. Billing of the incorrect APTC amount for two (2) of the fifteen (15) selected subscribers, which included one (1) of the forty-five (45) selected subscribers, in the Payment Desk Audit File as the amounts were not updated following a transaction received from the SBE; and
6. Provision of coverage and reporting of extra months of enrollment for which no premium payments were received for sixty (60) subscribers, including one (1) of the fifteen (15) selected subscribers, in the Payment Desk Audit File.

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 issuer submitters, including issuers in New York, 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 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 the data to CMS for this purpose. CMS asked SBEs 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 Health Insurance Plan for an audit to assess the issuer's compliance with 45 CFR §§ 155.1210, 156.460 and 156.480. CMS evaluated Health Insurance Plan'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 2015 by the issuer to CMS to support APTC payments and premium amounts.

CMS sent Health Insurance Plan 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 Health Insurance Plan on May 29, 2018 that identified data requirements required to conduct the audit. CMS's audit contractor reviewed the audit data file submitted by Health Insurance Plan, as well as the final 2014 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 regulations[2].

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 File[2] data submitted to CMS:
    - EPDW Validations: Review and comparison of the issuer'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 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. During the discrepancy phase, Health Insurance Plan submitted an updated Payment Desk Audit File to address data issues and the procedures were re-performed. Following the discrepancy phase with the issuer, 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 and one (1) observation resulted from the comparison of the final 2014 EPDW submitted by the issuer to Health Insurance Plan's Payment Desk Audit File. Please refer to Observation No. 1 included in section IV for details on the observation.

Unreconciled Subscribers Review

No findings and one (1) observation resulted from the review of Health Insurance Plan'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. 2 included in section IV for details on the observation.

Duplicate Exchange-assigned Subscriber IDs Check

No findings or observations resulted from the review of Health Insurance Plan's Payment Desk Audit File to verify that duplicate Exchange-assigned subscriber IDs were not reported in the file.

Premium Less than APTC Validation

One (1) finding and one (1) observation resulted from the review of Health Insurance Plan'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. 1 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 Health Insurance Plan'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 and two (2) observations resulted from the review and comparison of the data from Health Insurance Plan'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. One (1) of the two (2) observations also applies to the Fifteen (15) Subscribers Sample Review procedure as described in the "Fifteen (15) Subscribers Sample Review" section below. Please refer to Observation No. 4 and Observation No. 5 included in section IV for details on the observations.

Fifteen (15) Subscribers Sample Review

No findings and two (2) observations resulted from the review of the data and documentation from Health Insurance Plan'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. 5 and Observation No 6 included in section IV for details on the observations.

Policy and Procedure Review

No findings or observations resulted from the review of Health Insurance Plan'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 one (1) finding, which resulted in a change to the APTC amounts reported in Health Insurance Plan's EPDW for individual market plans for the 2014 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 six (6) observations, consisting of three (3) observations that resulted in a change to the premium amounts reported in Health Insurance Plan's EPDW for individual market plans for the 2014 benefit year and three (3) observations that did not result in a change to the premium amounts reported in Health Insurance Plan's EPDW for individual market plans for the 2014 benefit year.

In light of the one (1) finding and six (6) 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 in November 2015	$50,431,894.44	$120,584,069.69
Observation No. 1 - EPDW Validations Adjustment	$0.00	$584,632.23
Observation No. 2 – Unreconciled Subscribers Review Adjustment	$0.00	$0.00
Finding No. 1 and Observation No. 3 – Premium Less Than APTC Validation Adjustment	$(61,899.82)	$2,697.17
Observation No. 4 – Forty-five (45) Subscribers Sample Review Adjustment	$0.00	$4,433.76
Observation No. 5 – Forty-five (45) Subscribers Sample Review & Fifteen	$0.00	$0.00

	APTC	Premium (Observations)
(15) Subscribers Sample Review Adjustment		
Finding No. 6 – Fifteen (15) Subscribers Sample Review Adjustment	$0.00	$0.00
EPDW As Recalculated	$50,369,994.62	$121,175,832.85
Total Impact	**$(61,899.82)**	**$591,763.16***

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

The net financial impact of the one (1) audit finding is a payment of $61,899.82, consisting of APTC owed to CMS.

*Note: The premium impact of the six (6) audit observations is an understatement of $591,763.16 in premiums. The premium impact is noted for purposes of improving compliance in future program years.

For the one (1) audit finding and six (6) observations, CMS documented the criteria, cause, effect, corrective actions, and Health Insurance Plan's responses as seen in the charts below.

Observation No. 1 – EPDW Validations	
Condition:	**APTC Differences (Observation) –** For one (1) catastrophic QHP, Health Insurance Plan's Payment Desk Audit File included a total APTC amount of $5,830.30 while Health Insurance Plan's EPDW correctly included a "Total APTC Amount by QHP ID for effectuated enrollments" of $0.00. The APTC amount reported in Health Insurance Plan's Payment Desk Audit File was incorrect as enrollments in catastrophic plans are not eligible for APTC and therefore no correction to payment and the APTC amount reported in the final EPDW is required. **Premium Differences (Observation) –** For one (1) or more months of 2014 benefit year enrollment in four (4) QHPs, the net "Total Premium Amount by QHP ID for effectuated enrollments" included in Health Insurance Plan's EPDW was less than the total premium amount included in Health Insurance Plan's Payment Desk Audit File, resulting in an understatement of $584,632.23 in premiums. For the one (1) or more months of 2014 benefit year enrollment in four (4) QHPs, the total net enrollment in the EPDW was understated by two thousand,

Observation No. 1 – EPDW Validations	
	eight hundred and thirteen (2,813) enrollment groups and two thousand, eight hundred and sixty (2,860) 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." 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.” Additionally, pursuant to 45 CFR § 155.305, the Exchange may provide advance payments of the premium tax credit on behalf of a tax filer only if one or more applicants for whom the tax filer attests that he or she expects to claim a personal exemption deduction for the benefit year, including the tax filer and his or her spouse, is enrolled in a QHP that is not a catastrophic plan, through the Exchange.
Cause:	For the APTC differences noted in the catastrophic plan, the issuer indicated “The APTC amounts for this particular population were included in the desk file because the original transaction received from SBE included an APTC amount. Therefore, that is what was loaded on our system.” During the audit, CMS coordinated with the SBE and the SBE indicated “these enrollments exist in NYSOH's system. Five of the eight members in question had $0 APTC under some or all of the reported coverage months. APTC amounts should not be applied to Catastrophic plans in NYSOH. Members receiving APTC when enrolled in Catastrophic plans was a result of a defect found in our system in early 2014, which has since been fixed.” Issuers cannot receive APTC for catastrophic plan enrollments and therefore CMS noted an observation. For the premium differences, the issuer indicated “As the health exchange and associated processes were still fairly new, it was not completely clear what exact data was required for the submission of the original 2014 restated file. Due to lack of clarity, the entire catastrophic population (88582NY018000101) that were enrolled with us at the time were not included as part of the final submission which is the primary reason for the discrepancies.”
Effect:	The APTC differences did not result in a change to Health Insurance Plan’s final, restated 2014 benefit year EPDW data as issuers cannot receive APTC for catastrophic plan enrollments. The premium

Observation No. 1 – EPDW Validations	
	differences resulted in a change to Health Insurance Plan's final, restated 2014 benefit year EPDW data.
Corrective Action Required:	There is no APTC financial impact for this finding as issuers cannot receive APTC for catastrophic plan enrollments. The premium impact of this observation is an understatement of $584,632.23 in premiums. CMS notes this observation for purposes of improving compliance in future program years.
Management Response:	A report is generated monthly to ensure that the existing catastrophic population (88582NY018000101) do not have an APTC attached to their accounts. Any discrepancies are quickly identified and reported back to the state-based exchange for corrections.

Observation No. 2 – Unreconciled Subscribers Review	
Condition:	Health Insurance Plan did not receive the binder payments but effectuated the enrollments in error and provided coverage for twenty-two (22) subscribers reported in the Payment Desk Audit File.
Criteria:	Pursuant to New York SBE guidance, "Enrollment is not effectuated until CONTRACTOR receives initial payment of premium, if applicable, from the prospective enrollee and sends a confirmation 834 transaction to the STATE (the "Coverage Effective Date"). Unless required otherwise by federal law, CONTRACTOR shall provide a grace period of no less than ten (10) days to Enrollees for their initial premium payment to effectuate coverage. Initial payments received by the 10th of the month in which the initial coverage is in effect shall be considered timely. Contractor will be financially responsible for any claims incurred by Enrollee during the ten (10) day grace period provided that the Enrollee pays the initial premium prior to or during such ten (10) day grace period." 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." Pursuant to 45 CFR § 155.400, Exchanges may, and the Federally-facilitated Exchange will, require payment of the first month's premium to effectuate an enrollment.

Observation No. 2 – Unreconciled Subscribers Review	
Cause:	The issuer indicated a "Yes" for "Effectuated in Issuer's Systems?" for twenty-two (22) subscribers in the Payment Desk Audit File but indicated "No initial payment received" for the subscribers. The issuer further indicated that the twenty-two (22) enrollments "were manually effectuated in error. Coverage was provided from the effective date up until the previous end date assigned by NYSOH." The Payment Desk Audit File included a total premium amount of $36,823.20 and total APTC amount of $22,835.34 for the twenty-two (22) subscribers.
Effect:	The issuer did not follow SBE and CMS enrollment guidance and requirements as the issuer effectuated enrollment when the first month's binder payment was not received.
Corrective Action Required:	CMS notes this observation for purposes of improving compliance in future program years.
Management Response:	A report is generated weekly to ensure that the paid status of initial invoices for all new active enrollments have been fully satisfied. Any discrepancies identified will be promptly reviewed and rectified. Additionally, a new core functionality was implemented to detect and recognize any active accounts with an open invoice that is outside their grace period. Once identified, the system will automatically terminate or cancel coverage based on the existing delinquency rules in accordance with the corresponding line of business.

Finding No. 1 and Observation No. 3 - Premium Less than APTC Validation	
Condition:	Health Insurance Plan reported 2014 benefit year premium amounts that were less than the APTC amounts for eighty-five (85) subscribers in the Payment Desk Audit File, resulting from Health Insurance Plan overstating the 2014 benefit year APTC amounts for eight-one (81) subscribers, and overstating the 2014 benefit year premium amounts for one (1) of those subscribers, in the Payment Desk Audit File. Additionally, Health Insurance Plan understated the 2014 benefit year premium 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. Pursuant to CMS guidance, the premium amount reported in the EPDW and Payment Desk Audit File is the total

Finding No. 1 and Observation No. 3 - Premium Less than APTC Validation	
	monthly premium amount for the effectuated enrollment within a qualified health plan and the APTC amount reported in the EPDW and Payment Desk Audit File is the APTC amount toward the total premium amount for effectuated enrollments.
Cause:	The issuer indicated the following explanations for the eighty (81) subscribers with overstated APTC amounts, including the one (1) subscriber with overstated premium amounts: ▪ "According to [issuer provided transaction EXXXXXXXXXX], the dependent was removed from the policy as of [issuer provided date of X/X/2014]. Therefore, the account switched from couple to individual coverage beginning [issuer provided date of X/X/2014]. The 834 transaction adjusted the APTC amount to $XX.XX, but to take effect beginning [issuer provided date of X/X/2014]. Therefore, the policy retained the previous APTC amount of [issuer provided APTC amount of $XX.XX] for the month of [issuer provided Month] which is the reason for the discrepancy." (Thirty-seven (37) subscribers) ▪ "The original APTC that was assigned from [issuer provided date of X/X/2014] through [issuer provided date of X/X/2014] was [issuer provided APTC amount of $XX.XX]. However, an 834 transaction was received to add a dependent to the policy beginning [issuer provided date of X/X/2014] on [issuer provided date of X/X/2014]. The transaction provided a new APTC amount of [issuer provided APTC amount of $XX.XX], but did not update the date of when it would go into effect. Therefore, the APTC was retroactively adjusted to [issuer provided APTC amount of $XX.XX] all the way back to [issuer provided date of X/X/2014]." (Thirty (30) subscribers) ▪ "According to [issuer provided transaction EXXXXXXXXXX], the spouse was removed from the policy as of [issuer provided date of X/X/2014]. Therefore, the account switched from family to couple coverage beginning [issuer provided date of X/X/2014]. The 834 transaction adjusted the APTC amount to [issuer provided APTC amount of $XX.XX], but to take effect beginning [issuer provided date of X/X/2014]. Therefore, the policy retained the previous APTC amount of [issuer provided APTC amount of $XX.XX]." (Three (3) subscribers) ▪ "According to [issuer provided transaction EXXXXXXXXXX], the APTC amount was supposed to change to [issuer provided APTC amount of $XX.XX] beginning [issuer provided date of X/X/2014], but it was never processed." (Two (2) subscribers)

Finding No. 1 and Observation No. 3 - Premium Less than APTC Validation	
	▪ "According to [issuer provided transaction EXXXXXXXXXX], there was no APTC amount assigned from 1/1/2014 to 4/30/2014. Therefore, the listed amount of $244.00 is inaccurate. Additionally, the QHP ID is incorrectly listed. The correct IDs are 88582NY018000101 from 1/1/2014 to 4/30/2014 and 88582NY016000104 from 5/1/2014 to 12/31/2014.there was no APTC amount assigned from X/X/2014 to 4/30/2014. Therefore, the listed amount of $XX.XX is inaccurate. Additionally, the QHP ID is incorrectly listed." (One (1) subscriber) ▪ "According to [issuer provided transaction EXXXXXXXXXX], the correct APTC that should be assigned from 5/1/2014 to 5/31/2014 is $183.00. However, it was incorrectly updated to $656.00 on 11/29/2014 which is the reason for the discrepancy. Additionally, the QHP ID is incorrectly listed. The correct IDs should be 88582NY016000104 from 5/1/2014 to 5/31/2014 then 88582NY016000106 from 6/1/2014 to 12/31/2014." (One (1) subscriber) ▪ "According to [issuer provided transaction EXXXXXXXXXX], the enrollment for the dependent was cancelled. Therefore, the account switched from couple to individual coverage as of 5/1/2014. The APTC amount was adjusted to $246.00 on the 834 transaction, but gave the date that it would be in effect as 6/1/2014. Therefore, the policy retained the original APTC amount of $631.00 from 5/1/2014 to 5/31/2014. The QHP ID was also supposed to change to 88582NY016000101 beginning 11/1/2014, but it was never processed." (One (1) subscriber) ▪ "An 834 transaction [issuer provided transaction of EXXXXXXXXXX] was received on [issuer provided date of X/X/2014] to remove the dependent from the policy as of [issuer provided date of X/X/2014]. The transaction adjusted the rates from couple to individual coverage, but provided a date of 1/1/2015 of when it would go into effect. Therefore, the policy retained the previous APTC amount of [issuer provided APTC amount of $XX.XX], but under the individual rate of [issuer provided rate of $XX.XX] for the month of December." (Two (2) subscribers) ▪ "An 834 transaction [issuer provided transaction of EXXXXXXXXXX] was received on 6/20/2014 to push the coverage start date of the dependent from 1/1/2014 to 6/1/2014. Therefore, the policy switched to individual coverage from 1/1/2014 to 5/31/2014. The original APTC amount of $450.00 was retained since no transaction was received to re-adjust it thus resulting in the discrepancy. Additionally, the QHP ID is

Finding No. 1 and Observation No. 3 - Premium Less than APTC Validation	
	incorrectly listed. The correct ID is 88582NY016000105." (One (1) subscriber) ▪ "According to [issuer provided transaction EXXXXXXXXXX], the 2 dependents were removed from the policy as of 5/31/2014. Therefore, the account switched from family to couple coverage beginning 6/1/2014. The 834 transaction adjusted the APTC amount to $101.00, but it was never processed. Therefore, the policy retained the previous APTC amount of $787.00 for the month of June which is the reason for the discrepancy." (One (1) subscriber) ▪ "According to [issuer provided transaction EXXXXXXXXXX], the assigned APTC should be $0.00 from 1/1/2014 to 12/31/2014. A subsequent 834 transaction [issuer provided transaction EXXXXXXXXXX] adjusted the APTC to $642.00 beginning 4/1/2015, but it was incorrectly loaded back to 2/1/2014 on QCARE. Additionally, the QHP ID is incorrectly listed. The correct ID is 88582NY014000101." (One (1) subscriber) • "The member completed 2 separate enrollments under 2 different plans on the marketplace. As a result, the state created 2 different account numbers on their system for each enrollment. [Policy ID X] was enrolled under 88582NY015000101 from 4/1/2014 to 12/31/2014, but [Policy ID Y] was enrolled under 88582NY016000105 from 1/1/2014 to 10/31/2014. A subsequent 834 transaction (ET000051559691) was received on 12/6/2014 to cancel the enrollment under [Policy ID Y] back to the original effective date. However, the transaction did not process correctly on QCARE leaving the member with coverage under 88582NY016000105 from 1/1/2014 to 3/31/2014 and terminating the 4/1/2014 enrollment under 88582NY015000101 for 10/31/2014. The member should not have any active coverage from 1/1/2014 to 3/31/2014." (One (1) subscriber) During the audit, the issuer provided the correct amounts for the eighty-one (81) subscribers. The issuer indicated the following for the four (4) subscribers with incorrect premium amounts: ▪ "According to [issuer provided transaction EXXXXXXXXXX], the enrollment was supposed to be for couple coverage. However, the spouse failed to load correctly on QCARE. Only the primary subscriber had coverage which is the reason for the discrepancy." (Two (2) subscribers) • "The dependent was initially enrolled for 12/1/2014. However, an 834 transaction [issuer provided transaction of

Finding No. 1 and Observation No. 3 - Premium Less than APTC Validation	
	EXXXXXXXXXX] was received to backdate the coverage to 11/1/2014, but it was never processed. Therefore, the member was incorrectly billed the individual rate for the month of November which is the reason for the discrepancy. Additionally, the QHP ID is incorrectly listed for the month of November as it should be 88582NY016000101." (One (1) subscriber) • "An 834 transaction [issuer provided transaction of EXXXXXXXXXX] was received on 7/1/2014 to retroactively backdate the coverage start date of the dependent from 5/1/2014 going back to 1/1/2014. The APTC amount of $478.00 was also adjusted to begin 1/1/2014 instead of 5/1/2014. The APTC adjustment was processed, but the coverage backdate for the dependent was not which is the reason for the discrepancy." (One (1) subscriber) During the audit, the issuer provided the correct premium amounts for the four (4) subscribers. For the eighty-five (85) subscribers, the issuer indicated "The incorrect amounts were initially billed then subsequently corrected during a re-bill."
Effect:	The inclusion of the incorrect APTC and premium amounts for the eighty-five (85) subscribers resulted in a change to Health Insurance Plan's final, restated 2014 benefit year EPDW data.
Corrective Action Required:	The net financial impact of this finding is a payment of $61,899.82, consisting of APTC owed to CMS. Health Insurance Plan should confirm the financial impact and coordinate on resolution with CMS. The premium impact of this observation is an understatement of $2,697.17 in premiums. CMS notes this observation for purposes of improving compliance in future program years.
Management Response:	A multi-tier enrollment reconciliation is performed both daily and weekly to ensure all 834 transactions received are processed accordingly. The reconciliation will match all of the data elements within the 834 against what's within the enrollment and billing system. • Daily – all transactions received are put through a scrubbing process to ensure data integrity prior to being loaded into the system. Any issues identified will be reported as a fallout rejection which will then be reviewed, corrected and reprocessed by a manual user. • Weekly – a secondary report is generated every week to ensure that the data within the enrollment system is in sync with the

Finding No. 1 and Observation No. 3 - Premium Less than APTC Validation	
	834s received in the previous week. The report serves as a supplemental mechanism to "catch" anything that may have been missed by the daily scrubbing process. Additionally, new system logic was implemented to compare the billed premium rate versus the 834-listed premium rate to ensure there are no discrepancies. If the APTC amount is greater than the total premium – it will show as a negative balance which will kick out onto a discrepancy report for review and further investigation. Furthermore, an internal APTC reconciliation is performed monthly to ensure payment integrity between all stakeholders involved – the issuer, the exchange and CMS. The reconciliation will identify any missed or invalid payments as well as any missed or invalid payments as well as any questionable variances and disparities for review and correction.

Observation No. 4 - Forty-five (45) Subscribers Sample Review	
Condition:	Health Insurance Plan understated the 2014 benefit year premium amounts for one (1) of the forty-five (45) selected subscribers in the Payment Desk Audit File by reporting the incorrect coverage period.
Criteria:	Pursuant to CMS guidance, the issuer must create a single Inbound Payment Desk Audit File consisting of detailed enrollment group effectuated enrollment records (one per enrollment group, per month) with the corresponding payment data. Additionally, pursuant to CMS guidance, the premium amount reported in the EPDW and the Payment Desk Audit File is the premium amount by 16 digit QHP ID for the effectuated enrollment within a qualified health plan.
Cause:	The issuer's desk audit file included enrollment from 11/1/2014 through 1/31/2015 for the subscriber. The issuer indicated "The Issuer Benefit Start Date and End Date is given incorrectly as 11/1/2014 and 1/31/2015. The policy began on 3/1/2014 as individual coverage, but a dependent was added onto the account as of 11/1/2014. The account was then subsequently terminated for 11/30/2014 due to non-payment, but later reinstated. Therefore, the start and end dates should be given as 3/1/2014 and 12/31/2014 respectively." The issuer further indicated "The policy was active from 12/1/2014 to 12/31/2014 as a result of a retroactive reinstatement processed on 5/19/2015. The SBE system was incapable of accepting any retroactive reinstatements at the time

Observation No. 4 - Forty-five (45) Subscribers Sample Review	
	and thus an 834 transaction could not be transmitted. The functionality finally went live and was implemented in January 2019. Additionally, the premium amount from 3/1/2014 to 10/31/2014 was given as $554.22 according to [issuer provided transaction number] received on 2/28/2014." During the audit, CMS coordinated with the issuer to confirm the correct premium and APTC amounts and the correct coverage period. The issuer noted that the subscriber had a premium amount of $554.22 and APTC amount of $0.00 for March through October and confirmed the coverage was reinstated for December 2014. CMS coordinated with the SBE and they noted "The $554.22 = premium for individual tier." As a result, CMS concluded the Payment Desk Audit File did not include the enrollment and payment data for March through October and therefore was understated by $4,433.76 in premiums. CMS also coordinated with the issuer to determine whether the inclusion of the incorrect coverage period impacted other enrollments reported in the Payment Desk Audit File and the issuer indicated "No, none that we're aware of."
Effect:	The inclusion of the incorrect coverage period resulted in a change to the premium amounts reported in Health Insurance Plan's final, restated 2014 benefit year EPDW data.
Corrective Action Required:	The premium impact of this observation is an understatement of $4,433.76 in premiums. CMS notes this observation for purposes of improving compliance in future program years.
Management Response:	All Payment Desk Audit Files must first go through a data validation process followed by 2 subsequent data quality assurance reviews (primary & secondary) prior to submission. The process matches all the data elements within the file against the information within the enrollment and billing system to identify any discrepancies for correction.

Observation No. 5 – Forty-five (45) Subscribers Sample Review and Fifteen (15) Subscribers Sample Review	
Condition:	Health Insurance Plan billed and reported the incorrect APTC amount for one (1) of the fifteen (15) selected subscribers, which was also one (1) of the forty-five (45) selected subscribers, in the Payment Desk Audit File as a change received from the SBE was never processed.

Observation No. 5 – Forty-five (45) Subscribers Sample Review and Fifteen (15) Subscribers Sample Review	
	Additionally, Health Insurance Plan billed the incorrect APTC amount for one (1) of the fifteen (15) selected subscribers in the Payment Desk Audit File as the plan change was processed but the APTC amounts were never updated.
Criteria:	Pursuant to 45 CFR § 156.460, 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 reduce the portion of the premium charged to or for the individual for the applicable months by the amount of the advance payment of the premium tax credit and notify the Exchange of the reduction in the portion of the premium charged to the individual.
Cause:	The issuer indicated the following for the two (2) subscribers: • "The APTC was supposed to be adjusted to $0.00 beginning 10/1/2014 according to [issuer provided transaction number]. However, the change was never processed on QCARE thus the member was incorrectly billed with the APTC amount of $378.00 on the invoices from 10/1/2014 to 12/31/2014." CMS coordinated with the SBE and they noted "Enrollment in Family tier effective 1/1/14 had $1313.42 premium and $378.00 APTC. Enrollment tier changed to Couple effective 10/1/14 with $921.70 premium ($0 APTC)." The issuer further indicated "This was a manual error according to our review. The 834 transaction that was supposed to update the APTC amount as of 10/1/2014 was rejected by the system upon receipt. The standard protocol in the event of a rejection is to review the error and manually make the correction in order to update the system. However, the processor who reviewed this rejection failed to identify the change in APTC value and thus left the previous value intact. The processor is no longer with the organization, but all of the current as well as any new processors are always trained to review the APTC value for all 834 transactions received. Additionally, QA audits are performed on their work to ensure that it is accurate and up to standards." • "The policy was initially fully subsidized at the time of the original enrollment. However, an 834 transaction was received on 8/8/2014 to adjust the tier of the plan and to switch the policy from fully subsidized to full premium going back to the original effective date of 5/1/2014. The tier change (88582NY016000101) was processed, but the APTC and subsidy amounts were never updated thus the member

Observation No. 5 – Forty-five (45) Subscribers Sample Review and Fifteen (15) Subscribers Sample Review	
	continued to retain a $0.00 balance due each month for the remainder of the policy." The issuer further indicated “this was also a manual error. The 834 transaction that was supposed to update the plan tier and the APTC amount as of 5/1/2014 was rejected by the system upon receipt. The processor who reviewed this rejection updated the plan tier, but missed the change in the APTC value. This processor is also no longer with the organization.”
Effect:	The issuer did not follow the CMS enrollment guidance and requirements as the issuer did not adjust the subscribers’ accounts to include the correct APTC amount based on a transaction received from the SBE.
Corrective Action Required:	CMS notes this observation for purposes of improving compliance in future program years.
Management Response:	The same control mechanisms from Finding # 1 and Observation # 3 are applicable to Observation # 5.

Observation No. 6 - Fifteen (15) Subscribers Sample Review	
Condition:	Health Insurance Plan did not receive premium payments for the last few months of enrollment but provided coverage and reported 2014 benefit year premium and APTC amounts for sixty (60) subscribers, including one (1) of the fifteen (15) selected subscribers, in the Payment Desk Audit File.
Criteria:	Pursuant to 45 CFR § 156.270, a QHP issuer must return advance payments of the premium tax credit paid on the behalf of such enrollee for the second and third months of the grace period if the enrollee exhausts the grace period. Additionally, if an enrollee receiving advance payments of the premium tax credit exhausts the 3-month grace period in paragraph (d) of this section without paying all outstanding premiums, the QHP issuer must terminate the enrollee's enrollment through the Exchange on the effective date described in 155.430(d)(4) of this subchapter (i.e., the last day of the first month of the 3-month grace period).
Cause:	For the one (1) subscriber with enrollment from January through October that was included in the Fifteen (15) Subscribers Sample Review, the issuer indicated “No payments were received from

Observation No. 6 - Fifteen (15) Subscribers Sample Review	
	8/1/2014 onwards. Therefore, the policy should have been terminated for 8/31/2014, but was never processed." As a result, it was noted that two extra months of coverage were provided and reported in the Payment Desk Audit File with a total premium amount of $770.62 and a total APTC amount of $488.00. During the audit, CMS coordinated with the issuer to determine whether other enrollments reported in the Payment Desk Audit File included extra grace period months for which coverage was provided. The issuer provided a list of fifty-nine (59) additional subscribers that had extra months of enrollment reported in the Payment Desk Audit File as no payments were received and therefore the enrollment should have been terminated retroactively to the last day of the first month of the grace period. For the issuer provided list, the issuer indicated "Column G (i.e., issuer provided Correct END_DATE) is the date that the member should have stopped receiving coverage. For example, if Column G has 9/1/2014 then it means the members should have been terminated for 8/31/2014 for non-payment. Please refer to Column E (i.e., issuer provided BENEFIT_START_DT) & F (i.e. issuer provided BENEFIT_END_DT) for the actual begin and end dates where coverage was provided." As a result, CMS noted that extra months of coverage were provided and reported for fifty-nine (59) additional subscribers reported in the Payment Desk Audit File with a total premium amount of $129,882.03 and total APTC amount of $66,574.73. The Payment Desk Audit File included a total premium amount of $130,652.65 and a total APTC amount of $67,062.73 for the extra months of enrollment for the sixty (60) subscribers. The issuer confirmed the subscribers were provided coverage and claims were paid during the extra months of enrollment even though payments were not received.
Effect:	The issuer did not follow CMS enrollment guidance and requirements set forth in 45 CFR § 156.270 as the issuer provided extra months of coverage and did not terminate the enrollments on the last day of the first month of the exhausted three month grace period.
Corrective Action Required:	CMS notes this observation for purposes of improving compliance in future program years.
Management Response:	The same control mechanisms from Observation # 2 are applicable to Observation # 6.

Observation No. 6 - Fifteen (15) Subscribers Sample Review	
	Additionally, a report of all outstanding receivables is generated monthly for review to ensure that there are no delinquent accounts that remain active beyond the expiration of its grace period.

V. MANAGEMENT RESPONSES

Please provide management's response to the one (1) finding and six (6) 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 one (1) finding and six (6) observations, complete the "Management Response" field of the finding 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 the one (1) finding and corrective action or any of the six (6) observations, complete the "Management Response" field of the finding 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 finding 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: 88582

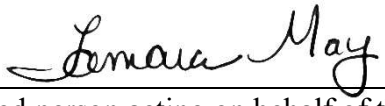
Issuer Name: Health Insurance Plan of Greater New York (Health Insurance Plan)

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 $61,899.82 to CMS and:

(INITIAL)___TM___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: Tamara May
(Print name of signature)

Title: Vice President of Case Installation & Maintenance

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

Telephone Number: 631-844-2559

(Direct Telephone Number)

Date: 11/24/2020

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
EPDW	Enrollment and Payment Data Workbook
GAGAS	Generally Accepted Government Auditing Standards
HHS	Department of Health and Human Services
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