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

*for*

*Cigna Health and Life Insurance Company (Colorado)*

*March 21, 2022*

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# I. EXECUTIVE SUMMARY

## Background

Cigna Health and Life Insurance Company (Cigna) 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 Cigna's final restated 2014 benefit year data in the November 2016 Enrollment and Payment Data Workbook (EPDW). The issuer received a total of $4,456,614.14 in advance payments of the premium tax credit (APTC) from CMS and the SBE reported a total of $15,811,508.79 in premiums for the issuer's 2014 benefit year individual market plans.

This report is an assessment, conducted in coordination with the SBE, of Cigna'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 on 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 five (5) findings and seven (7) observations for Cigna. The net APTC financial impact of the five (5) findings is an overstatement of $230,666.23 in APTC in the final EPDW submitted by the SBE and therefore a payment to CMS of $230,666.23 consisting of APTC owed to CMS. The net premium impact of the seven (7) observations is an overstatement of $1,036,148.08 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 Cigna's systems;
2. Inclusion of full month enrollment and APTC payment data for three (3) duplicate subscribers in the Payment Desk Audit File;
3. Inclusion of enrollment and APTC payment data for one (1) subscriber that was terminated retroactively in the Payment Desk Audit File;
4. Inclusion of extra months of enrollment in error and therefore overstated APTC amounts for six (6) subscribers, including two (2) of the forty-five (45) selected subscribers, in the Payment Desk Audit File; and
5. Reporting and billing of incorrect APTC amounts for one (1) of the fifteen (15) selected subscribers in the Payment Desk Audit File as the amounts were not adjusted following the reinstatement received from the SBE.

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 Cigna's systems;
2. Inclusion of full month enrollment and premium data for eight (8) duplicate subscribers in the Payment Desk Audit File;
3. Inclusion of enrollment and premium data for six (6) subscribers that were terminated retroactively in the Payment Desk Audit File;
4. Inclusion of extra months of enrollment in error and therefore overstated premium amounts for thirty-six (36) subscribers, including four (4) of the forty-five (45) selected subscribers, in the Payment Desk Audit File;
5. Inclusion of an incorrect 2014 benefit year premium amount for one (1) of the forty-five (45) selected subscribers as a result of a write-off;
6. Inclusion of incorrectly adjusted premium amounts for twenty (20) of the forty-five (45) selected subscribers, including four (4) of the fifteen (15) selected subscribers, in the Payment Desk Audit File; and

7. Reporting and billing of incorrect premium amounts for one (1) of the fifteen (15) selected subscribers in the Payment Desk Audit File as the amounts were not adjusted following the reinstatement received from the SBE.

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. Additionally, section 1311 of the PPACA allows the SBEs to charge participating issuers user fees to support SBE operations.

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 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 Programs

CMS established an audit protocol to assess health insurance issuers' compliance with the following regulations governing APTC and SBE user fee programs:

- 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 Cigna for an audit to assess the issuer's compliance with 45 CFR §§ 155.1210, 156.460 and 156.480. CMS evaluated Cigna'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 Cigna 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 Cigna on May 29, 2018 that identified data requirements required to conduct the audit. CMS's audit contractor reviewed the audit data file submitted by Cigna, 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, Cigna submitted an updated Payment Desk Audit File to include all individual market benefit year 2014 enrollments, regardless of whether or not APTC was applied to the enrollment. The procedures were re-performed using the updated Payment Desk Audit File. 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

One (1) finding and one (1) observation resulted from the comparison of the final 2014 EPDW submitted by the SBE to Cigna'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 Cigna's Payment Desk Audit File to determine if the subscribers reported on 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 Cigna's Payment Desk Audit File to verify that duplicate Exchange-assigned subscriber IDs were not reported on 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

No findings or observations resulted from the review of Cigna's Payment Desk Audit File to verify that subscribers were not reported on the file with premium amounts that were less than the APTC amounts.

### Coverage Days Validation

One (1) finding and one (1) observation observations resulted from the review of Cigna's Payment Desk Audit File to verify that enrollments of five (5) days or fewer reported on the file were effectuated and had active coverage in the issuer's systems. Please refer to Finding No. 3 and Observation No. 3 included in section IV for details on the finding and observation.

### Forty-five (45) Subscribers Sample Review

One (1) finding and three (3) observations resulted from the review and comparison of the data from Cigna'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. Please refer to Finding No. 4 and Observation No. 4, Observation No. 5, and Observation No. 6 included in section IV for details on the finding and observations.

**Fifteen (15) Subscribers Sample Review**

One (1) finding and two (2) observations resulted from the review of the data and documentation from Cigna'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. 6, and Finding No. 5 and Observation No. 7 included in section IV for details on the finding and observations.

**Policy and Procedure Review**

No findings or observations resulted from the review of Cigna'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 five (5) findings, which resulted in a change to the APTC amounts reported in Cigna's EPDW submitted by the SBE 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 seven (7) observations that resulted in a change to the premium amounts reported in Cigna's EPDW submitted by the SBE for individual market plans for the 2014 benefit year.

In light of the five (5) findings and seven (7) 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 | $4,456,614.14 | $15,811,508.79 |
| Finding No. 1 and Observation No. 1 - EPDW Validations Adjustment | $(225,137.95) | $(1,005,786.40) |
| Finding No. 2 and Observation No. 2 – Duplicate Exchange-assigned Subscriber IDs Check Adjustment | $(2,277.39) | $(9,354.69) |
| Finding No. 3 and Observation No. 3 – Coverage Days Validation Adjustment | $(276.56) | $(3,167.04) |
| Finding No. 4 and Observation No. 4 – Forty-five (45) Subscribers Sample Review (Extra Months) Adjustment | $(1,280.16) | $(18,713.52) |

| | APTC | Premium (Observations) |
|---|---|---|
| Observation No. 5 – Forty-five (45) Subscribers Sample Review (Write-offs) Adjustment | $0.00 | $(181.65) |
| Observation No. 6 – Forty-five (45) Subscribers Sample Review and Fifteen (15) Subscribers Sample Adjustment | $0.00 | $3,219.39 |
| Finding No. 5 and Observation No. 7 – Fifteen (15) Subscribers Sample Adjustment | $(1,694.17) | $(2,164.17) |
| EPDW As Recalculated | $4,225,947.91 | $14,775,360.71 |
| **Total Impact** | **$(230,666.23)** | **$(1,036,148.08)*** |

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

The net financial impact of the five (5) findings is a payment of $230,666.23, consisting of APTC owed to CMS.

*Note: The premium impact of the seven (7) observations is an overstatement of $1,036,148.08 in premiums. The premium impact is noted for purposes of improving compliance in future program years.

For the five (5) findings and seven (7) observations, CMS documented the criteria, cause, effect, corrective actions, and Cigna'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 twenty-seven (27) QHPs, the net "Total APTC Amount by QHP ID for effectuated enrollments" included in Cigna's EPDW submitted by the SBE was greater than the total APTC amount included in Cigna's Payment Desk Audit File, resulting in an overpayment of $225,137.95 in APTC. For the one (1) or more months of 2014 benefit year enrollment in twenty-seven (27) QHPs, the total net enrollment in the EPDW was overstated by one thousand, one |

| Finding No. 1 and Observation No. 1 – EPDW Validations | |
|---|---|
| | hundred and fifty (1,150) APTC enrollment groups and one thousand, eight hundred and fifty-seven (1,857) APTC members.<br><br>**Premium Differences (Observation) –** For one (1) or more months of 2014 benefit year enrollment in thirty-one (31) QHPs, the net "Total Premium Amount by QHP ID for effectuated enrollments" included in Cigna's EPDW submitted by the SBE was greater than the total premium amount included in Cigna's Payment Desk Audit File, resulting in an overstatement of $1,005,786.40 in premiums. For the one (1) or more months of 2014 benefit year enrollment in thirty-one (31) QHPs, the total net enrollment in the EPDW was overstated by eleven thousand, six hundred and thirty-five (11,635) enrollment groups and fifteen thousand, five hundred and fifty-four (15,554) members. |
| **Criteria:** | Pursuant to CMS guidance and EPDW submission requirements:<br><br>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."<br><br>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, "HPS/Cigna have reviewed the contents within the Cigna 2014 desk Audit generated and deemed all records are correctly represented as per what is in the HPS system for premiums. QHP validation contained 100% QHP ID's from final 1A submission, no fallouts. All QHP ID's are correct for 2014 plan year. In addition a complete Cash Distribution and Payment/cash query run has been performed for all records on the Commission Premium and Member Premium included in the desk audit file with no discrepancies found. Please note: 2014 1A's were prepared and submitted to CMS by the State of Colorado to facilitate APTC payments to Cigna. No case by case discrepancy analysis was performed because HPS/Cigna does not have the case details filled by C4 to CMS."<br><br>During the Forty-five (45) Subscribers Sample Review, CMS noted differences between the premium amounts reported in the issuer's Payment Desk Audit File and the premium amounts reported in the SBE's PLR data for twenty (20) of the forty-five (45) subscribers, which included four (4) of the fifteen (15) selected subscribers. Cigna noted the differences were a result of the issuer adjusting the premium amounts "to match the "Collected Amount" due to the issuer having no opportunity to restate or dispute the APTC payment amount." The |

| Finding No. 1 and Observation No. 1 – EPDW Validations | |
|---|---|
| | premium adjustment issue could impact additional enrollments reported in the issuer's Payment Desk Audit File and therefore is a potential cause of the premium differences noted as a result of the EPDW Validations. Refer to Observation No. 6 for additional information on the adjusted premiums.<br><br>The SBE did not provide 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 Cigna'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 $225,137.95, consisting of APTC owed to CMS. Cigna should confirm the financial impact by filling out Appendix 1.<br><br>The premium impact of this observation is an overstatement of $1,005,786.40 in premiums. CMS notes this observation for purposes of improving compliance in future program years. |
| **Management Response:** | Agree |

| Finding No. 2 and Observation No. 2 – Duplicate Exchange-assigned Subscriber IDs Check | |
|---|---|
| **Condition:** | Cigna overstated the 2014 benefit year premium amounts for eight (8) subscribers, and overstated the benefit year APTC amounts for three (3) 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. |

| Finding No. 2 and Observation No. 2 – Duplicate Exchange-assigned Subscriber IDs Check | |
|---|---|
| **Cause:** | The issuer indicated, "Multiple enrollment case records in issuer's system with coverage overlap" for the eight (8) subscribers.<br><br>During the audit, CMS coordinated with the SBE to determine the correct enrollment records. The SBE indicated, "SBE system has effectuation start and end dates: [SBE provided begin and end dates]. SBE system indicated enrollment in QHP ID from [SBE provided begin date] to [SBE provided end date]" for the subscribers.<br><br>The issuer followed up and indicated which of the two (2) duplicate records for the eight (8) subscribers was the true enrollment record. |
| **Effect:** | The inclusion of enrollment and full month payment data for the eight (8) duplicate subscribers resulted in a change to Cigna'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 $2,277.39, consisting of APTC owed to CMS. Cigna should confirm the financial impact by filling out Appendix 1.<br><br>The premium impact of this observation is an overstatement of $9,354.69 in premiums. CMS notes this observation for purposes of improving compliance in future program years. |
| **Management Response:** | Agree |

| Finding No. 3 and Observation No. 3 – Coverage Days Validation | |
|---|---|
| **Condition:** | Cigna overstated the 2014 benefit year premium amounts for six (6) subscribers, and overstated the 2014 benefit year APTC amounts for one (1) of those subscribers, in the Payment Desk Audit File by incorrectly reporting enrollments with five (5) days or fewer of coverage that were terminated retroactively and had no coverage. |
| **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. |
| **Cause:** | The issuer indicated the following for the six (6) subscribers: |

| Finding No. 3 and Observation No. 3 – Coverage Days Validation | |
|---|---|
| | • "Member effectuated [issuer provided date]. Coverage was terminated retro-actively to [issuer provided date] (never in force) on [issuer provided transaction date]." (Five (5) subscribers)<br>• "Member enrollment received 08/26/2014 effective 06/01/2014. Binder payment not received, no effectuation. Cancelled effective 05/31/2014. Member re-enrolled and effectuated 10/30/2014 effective 04/13/2014. Coverage was terminated retro-actively effective 04/12/2014 on 12/04/2014." (One (1) subscriber) |
| **Effect:** | The inclusion of the enrollment and payment data for the six (6) subscribers resulted in a change to Cigna'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 $276.56, consisting of APTC owed to CMS. Cigna should confirm the financial impact by filling out Appendix 1.<br>The premium impact of this observation is an overstatement of $3,167.04 in premiums. CMS notes this observation for purposes of improving compliance in future program years. |
| **Management Response:** | Agree |

| Finding No. 4 and Observation No. 4 – Forty-five (45) Subscribers Sample Review (Extra Months) | |
|---|---|
| **Condition:** | Cigna overstated the 2014 benefit year premium amounts for thirty-six (36) subscribers, including four (4) of the forty-five (45) selected subscribers, and overstated the 2014 benefit APTC amounts for six (6) of those subscribers, including two (2) of the forty-five (45) selected subscribers, in the Payment Desk Audit File by reporting extra months of enrollment for which no coverage was provided. |
| **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. |
| **Cause:** | For the four (4) subscribers included in the Forty-five (45) Subscribers Sample Review, the issuer reported a month of enrollment in the |

| Finding No. 4 and Observation No. 4 – Forty-five (45) Subscribers Sample Review (Extra Months) | |
|---|---|
| | Payment Desk Audit File that did not exist in the SBE's PLR data. The issuer and SBE indicated the following for the four (4) subscribers:<br>• For the subscriber with months 5-9 included in the Payment Desk Audit File but that did not exist in the SBE's PLR data, the issuer indicated, "Benefit start and end dates are 20140101 - 20140331."<br>• For the subscriber with month 12 included in the Payment Desk Audit File but that did not exist in the SBE's PLR data, the issuer indicated, "No, month 12 should not be included in the desk audit file. Policy terminated for nonpayment of premiums after 90-day grace period on 03/03/2015 effective 12/31/2014. Policy termination date was revised from 12/31/2014 to 11/30/2014 on 07/29/2015." The SBE indicated, "SBE system indicates member was enrolled from 1/01/2014 - 11/30/2014. The 1095A reflected the same information."<br>• For the subscriber with month 1 included in the Payment Desk Audit File but that did not exist in the SBE's PLR data, the issuer indicated, "No, month 1 should not be included on the desk audit file. Original Inception Date was 01/1/14 per 01/15/14 File. Inception date was changed to 02/01/14 on roster dated 03/24/14 File below. As the data was present at time of original audit it was pulled into the data. The policy data shows no Jan 2014 billing in Cigna's system." The SBE indicated, "The SBE system has the member's enrollment starting 2/1/2014."<br>• For the subscriber with month 12 included in the Payment Desk Audit File but that did not exist in the SBE's PLR data, the issuer indicated, "No, month 12 should not be included on the desk audit file. Per internal Cigna ET log, Market place termed the policy effective 09/30/2014 due to moving outside the coverage area." The SBE indicated "Enrolled 2/1/2014 - 9/30/2014."<br>During the audit, CMS coordinated with the issuer to determine whether extra months of enrollment were included for additional subscribers reported in the Payment Desk Audit File. The issuer confirmed that incorrect months of enrollment were reported for thirty-two (32) additional subscribers and indicated the billing for the identified month(s) was incorrect and has been adjusted and the month(s) should not have been reported in the desk audit file. Additionally, the issuer provided the correct benefit start and end dates for the thirty-two (32) subscribers. |

| Finding No. 4 and Observation No. 4 – Forty-five (45) Subscribers Sample Review (Extra Months) | |
|---|---|
| | Therefore, CMS concluded that the Payment Desk Audit File included extra months of enrollment for thirty-six (36) subscribers, resulting in an overstatement of $1,280.16 in APTC amounts and an overstatement of $18,713.52 in premium amounts. |
| **Effect:** | The inclusion of the extra month of enrollment for the thirty-six (36) subscribers resulted in a change to Cigna'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 $1,280.16, consisting of APTC owed to CMS. Cigna should confirm the financial impact by filling out Appendix 1.<br>The premium impact of this observation is an overstatement of $18,713.52 in premiums. CMS notes this observation for purposes of improving compliance in future program years. |
| **Management Response:** | Agree |

| Observation No. 5 – Forty-five (45) Subscribers Sample Review (Write-offs) | |
|---|---|
| **Condition:** | Cigna reported an incorrect 2014 benefit year premium amount for one (1) of the forty-five (45) selected subscribers in the Payment Desk Audit File by including the premium responsibility amount twice in the total premium amount field in error. |
| **Criteria:** | Pursuant to CMS guidance, the premium amount reported on 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:** | For the one (1) subscriber's enrollment for month 11, the Payment Desk Audit File included a premium amount of $474.30 and APTC amount of $111.00 while the SBE's PLR data included a premium amount of $292.65, APTC amount of $111.00 and therefore premium responsibility amount of $181.65. The issuer noted the "policy entered delinquency (90-day grace period) 11-2014 and was terminated due to non-payment of premium on 02/03/2015." The issuer further indicated premium of $474.30 was due to the systems not being synced for the $181.65 premium responsibility write-off that occurred for month 11 as the write-off was duplicated due to manual error and added to the |

| Observation No. 5 – Forty-five (45) Subscribers Sample Review (Write-offs) | |
|---|---|
| | premium amount reported in the system for month 11. The issuer noted, "policy has been identified for pending cleanup that is being performed."<br><br>The SBE indicated "SBE system indicates the policy was in effect from 6/1/2014 -12/31/2014 with a premium of $292.65 and APTC of $111.00. The customer's 1095 A reflected the same information." During the audit, CMS coordinated with the issuer to confirm the coverage period and the issuer indicated, "the case terminated on 11/31/2014 for non-payment."<br><br>As a result, CMS concluded that the total premium amount of $474.30 reported in the Payment Desk Audit File incorrectly included the premium responsibility amount of $181.65 twice (APTC amount of $111.00 + premium responsibility amount of $181.65 + premium responsibility amount of $181.65) and the correct premium amount was $292.65 (APTC amount of $111 + premium responsibility amount of $181.65). |
| **Effect:** | The inclusion of the incorrect premium amount for the subscriber resulted in a change to Cigna's final, restated 2014 benefit year EPDW data submitted by the SBE. |
| **Corrective Action Required:** | The premium impact of this observation is an overstatement of $181.65 in premiums. CMS notes this observation for purposes of improving compliance in future program years. |
| **Management Response:** | Agree |

| Observation No. 6 – Forty-five (45) Subscribers Sample Review and Fifteen (15) Subscribers Sample Review | |
|---|---|
| **Condition:** | Cigna reported incorrect 2014 benefit year premium amounts for twenty (20) of the forty-five (45) selected subscribers, including four (4) of the fifteen (15) selected subscribers, by incorrectly adjusting the premium amounts. |
| **Criteria:** | 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. |

| **Observation No. 6 – Forty-five (45) Subscribers Sample Review and Fifteen (15) Subscribers Sample Review** | |
|---|---|
| **Cause:** | For fifteen (15) subscribers, CMS noted minor premium differences of $0.11 or less between the premium amounts reported in the Payment Desk Audit File and the premium amounts reported in the SBE's PLR data. For five (5) additional subscribers, CMS noted larger premium differences between the premium amounts reported in the Payment Desk Audit File and the premium amounts reported in the SBE's PLR data. For the twenty (20) subscribers, the issuer provided information on the premium and APTC amounts received from the SBE, but indicated that the APTC payment received from the SBE differed from the original APTC amount and therefore APTC debits were applied to the premium amounts. The issuer further indicated that APTC debits and credits were applied to eliminate any excess billed amount to match the collected amount as the issuer did not have the opportunity to restate or dispute the APTC payment amount.<br><br>The SBE indicated, "SBE system = premium of [SBE provided premium amount] and APTC of [SBE provided APTC amount]. The premium is correct at [SBE provided premium amount]. Premiums were uploaded to the SBE system through a 3rd party organization by the carrier." Therefore, the SBE indicated that the premium and APTC amounts reported in the PLR data were correct.<br><br>CMS concluded that the inclusion of the negatively and positively adjusted premium amounts that differed from the premium amounts reported in the SBE's PLR data could have impacted additional enrollments reported in the Payment Desk Audit File. Additionally, the premium adjustment issue could have been a potential cause of the premium differences noted as a result of the EPDW Validations. Refer to Finding No. 1 and Observation No. 1 – EPDW Validations. |
| **Effect:** | The inclusion of the adjusted premium amounts for the twenty (20) subscribers resulted in a change to Cigna's final, restated 2014 benefit year EPDW data submitted by the SBE. |
| **Corrective Action Required:** | The premium impact of this observation is an understatement of $3,219.39 in premiums. CMS notes this observation for purposes of improving compliance in future program years. |
| **Management Response:** | Agree |

| Finding No. 5 and Observation No. 7 – Fifteen (15) Subscribers Sample Review | |
|---|---|
| **Condition:** | Cigna billed and reported the incorrect premium and APTC amounts for one (1) of the fifteen (15) selected subscribers in the Payment Desk Audit File as the account was not adjusted following the reinstatement received from the SBE. |
| **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.<br><br>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:** | For the one (1) subscriber with a premium amount of $1,863.00 and APTC amount of $1,232.26 for January through April and a premium amount of $1,246.87 and APTC amount of $616.13 for May, the issuer indicated that it received a change report on 7/14/2014 that included enrollment effective 1/1 to 5/31 with a premium amount of $1,306.94 and APTC amount of $770.20. The issuer indicated that, "Policy was reinstated on 07/30/2014 capturing the new APTC presented. Per this change report Spouse was to be enrolled from 01/01/2014 – 05/31/2014. APTC was not billed during billing cycles 01-05 due to the update being received on 07/14/2014 and not billed after reinstatement.<br><br>Based upon our review the premium amounts provided on the desk audit file are not matching the CO PLR data because:<br><br>1. Member coverage was not updated in our system due to missing Colorado file feed.<br>2. Some EDI file, change report, and file roaster updates received were not processed in our systems.<br>3. A member coverage update was processed but the billing was not adjusted accordingly by the time the desk audit file was pulled and submitted. Additional billing adjustments have since been made on the case starting 04/2019.<br><br>In response to the recent findings, Cigna is reviewing and updating both the coverage history and billing of this case. The case will show the following premiums after processing all updates received: Covered |

| Finding No. 5 and Observation No. 7 – Fifteen (15) Subscribers Sample Review | |
|---|---|
| | period Jan - May 2014. Total Premium - $1,306.94 APTC: - $770.20 and Member Rep: - $536.74." |
| **Effect:** | The inclusion of the incorrect premium and APTC amounts for the subscriber resulted in a change to Cigna'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 $1,694.17, consisting of APTC owed to CMS. Cigna should confirm the financial impact by filling out Appendix 1.<br>The premium impact of this observation is an overstatement of $2,164.17 in premiums. CMS notes this observation for purposes of improving compliance in future program years. |
| **Management Response:** | Agree |

## V. MANAGEMENT RESPONSES

Please provide management's response to the five (5) findings and seven (7) 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 five (5) findings and seven (7) 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 five (5) findings and corrective actions or any of the seven (7) 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: 49375

Issuer Name: Cigna Health and Life Insurance Company (Cigna)

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 $230,666.23 to CMS and:

(INITIAL) LH 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: Lisa Lough
(Print name of signature)

Title: President, Individual & Family Plans
(Title of authorized person acting on behalf of the Issuer)

Telephone Number: 860.907.5472
(Direct Telephone Number)

Date: 4/19/2022

**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:<br>(1) Accommodate periodic auditing of the State Exchange's financial records; and<br>(2) Enable HHS or its designee(s) to inspect facilities, or otherwise evaluate the State- Exchange's compliance with Federal standards.<br>**(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:<br>(1) Information concerning management and operation of the State Exchange's financial and other record keeping systems;<br>(2) Financial statements, including cash flow statements, and accounts receivable and matters pertaining to the costs of operations;<br>(3) Any financial reports filed with other Federal programs or State authorities;<br>(4) Data and records relating to the State Exchange's eligibility verifications and determinations, enrollment transactions, appeals, and plan variation certifications; and<br>(5) Qualified health plan contracting (including benefit review) data and consumer outreach and Navigator grant oversight information.<br>**(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—<br>(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;<br>(2) Notify the Exchange of the reduction in the portion of the premium charged to the individual in accordance with§ 156.265(g); and<br>(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.<br>**(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.<br>**(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:<br>**(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<br>**(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.<br>**(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.<br>**(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.<br>**(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 |