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

for

Health Net Life Insurance Company (California)

May 23, 2022

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I. EXECUTIVE SUMMARY

Background

Health Net Life Insurance Company (Health Net) is a health insurance issuer that offered qualified health plans (QHPs) in the individual market State-Based Exchange (SBE) in California during the 2014 benefit year. The state of California submitted Health Net's final restated 2014 benefit year data in the November 2016 Enrollment and Payment Data Workbook (EPDW). The issuer received a total of $54,007,757.27 in advance payments of the premium tax credit (APTC) from the Centers for Medicare & Medicaid Services (CMS) and the SBE reported a total of $101,677,733.13 in premiums for the issuer's 2014 benefit year individual market plans.

This report is an assessment, conducted in coordination with the SBE, of Health Net'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 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 three (3) findings and three (3) observations for Health Net. The net APTC financial impact of the three (3) audit findings is an overstatement of $745,371.25 in APTC in the final EPDW submitted by the SBE and therefore a payment of $745,371.25, consisting of APTC owed to CMS. The net premium impact of the three (3) observations is an overstatement of $2,180,652.66 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 Health Net's systems;
2. Inclusion of full month enrollment and payment data for three (3) duplicate subscribers in the Payment Desk Audit File; and
3. Inclusion of premium amounts that were less than the APTC amounts resulting from incorrect premium amounts for one (1) subscriber in the Payment Desk Audit File.

Observations:

1. Differences in premium amounts identified in the comparison of the issuer's data included in the November 2016 EPDW submitted by the SBE to a Payment Desk Audit File containing subscriber level data from Health Net's systems;
2. Inclusion of full month enrollment and premium data for six (6) duplicate subscribers in the Payment Desk Audit File; and
3. Inclusion of incorrect premium amounts that were less than the APTC amounts for three (3) 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. 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 California, 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 program:

- 45 CFR § 155.1210: Maintenance of Records;
- 45 CFR § 156.460: Reduction of enrollee's share of premium to account for advance payments of the premium tax credit; and
- 45 CFR § 156.480: Oversight of the administration of the cost-sharing reductions and advance payments of the premium tax credit programs.

Please refer to Appendix 2 for the specific requirements established under the authorities listed above.

C. Objectives

The objectives of this audit are to:

(1) Evaluate the accuracy and integrity of SBE-generated EPDW data reported for premiums and the APTC program;
(2) Identify potential CMS APTC payment errors resulting from issuer or SBE data reporting errors;
(3) Test accuracy and integrity of issuer processes for reducing an enrollee's share of premium to account for APTCs.

D. Scope and Methodology

CMS selected Health Net for an audit to assess the issuer's compliance with the 45 CFR §§ 155.1210, 156.460 and 156.480. CMS evaluated Health Net'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 Health Net 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 Net 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 Net, 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. 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 Health Net'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 Health Net's Payment Desk Audit File to determine if the subscribers reported in the file existed in the SBE's PLR data and their coverage was effectuated in the issuer's systems.

Duplicate Exchange-assigned Subscriber IDs Check

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

Premium Less than APTC Validation

One (1) finding and one (1) observation resulted from the review of Health Net's Payment Desk Audit File to verify that subscribers were not reported in the file with premium amounts that were less than the APTC amounts. Please refer to Finding No. 3 and Observation No. 3 included in section IV for details on the finding and observation.

Coverage Days Validation

No findings or observations resulted from the review of Health Net's Payment Desk Audit File to verify that enrollments of five (5) days or fewer reported in the file were effectuated and had active coverage in the issuer's systems.

Forty-five (45) Subscribers Sample Review

No findings or observations resulted from the review and comparison of the data from Health Net's systems to the corresponding data included in the SBE's PLR data to determine accuracy of the reported enrollment months and the application of premium and APTC for a selected sample of forty-five (45) subscribers.

Fifteen (15) Subscribers Sample Review

No findings or observations resulted from the review of the data and documentation from Health Net'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

No findings or observations resulted from the review of Health Net's APTC policies and procedures.

IV. FINDINGS AND OBSERVATIONS

A finding is an identification of an instance of issuer non-compliance with APTC program requirements that requires correction to payment. CMS's audit procedures identified three (3) findings, which resulted in a change to the APTC amounts reported in Health Net's EPDW submitted by the SBE for individual market plans for the 2014 benefit year.

An observation is a deviation from CMS requirements that we are calling to the attention of management for purposes of improving compliance in future program years but that does not require correction to payment. CMS's audit procedures identified three (3) observations that resulted in a change to the premium amounts reported in Health Net's EPDW submitted by the SBE for individual market plans for the 2014 benefit year.

In light of the three (3) findings and three (3) 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	$54,007,757.27	$101,677,733.13
Finding No. 1 and Observation No. 1 - EPDW Validations Adjustment	$(744,688.01)	$(2,189,756.66)
Finding No. 2 and Observation No. 2 – Duplicate Exchange-assigned Subscriber IDs Check Adjustment	$(574.68)	$(1,724.00)
Finding No. 3 and Observation No. 3 – Premium Less Than APTC Validation Adjustment	$(108.56)	$10,828.00
EPDW As Recalculated	$53,262,386.02	$99,497,080.47
Total Impact	$(745,371.25)	$(2,180,652.66) *

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

The net financial impact of the three (3) audit findings is a payment of $745,371.25, consisting of APTC owed to CMS.

*Note: The premium impact of the three (3) audit observations is an overstatement of $2,180,652.66 in premiums. The premium impact is noted for purposes of improving compliance in future program years.

For the three (3) audit findings and three (3) observations, CMS documented the criteria, cause, effect, corrective actions, and Health Net'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 ten (10) QHPs, the net "Total APTC Amount by QHP ID for effectuated enrollments" included in Health Net's EPDW submitted by the SBE was greater than the total APTC amount included in Health Net's Payment Desk Audit File, resulting in an overpayment of $744,688.01 in APTC. For the one (1) or more months of 2014 benefit year enrollment in ten (10) QHPs, the total net enrollment in the EPDW was overstated by two thousand, five hundred and nineteen (2,519) APTC enrollment groups and two thousand, eight hundred and thirty (2,830) APTC members. **Premium Differences (Observation) –** For one (1) or more months of 2014 benefit year enrollment in eleven (11) QHPs, the net "Total Premium Amount by QHP ID for effectuated enrollments" included in Health Net's EPDW submitted by the SBE was greater than the total premium amount included in Health Net's Payment Desk Audit File, resulting in an overstatement of $2,189,756.66 in premiums. For the one (1) or more months of 2014 benefit year enrollment in eleven (11) QHPs, the total net enrollment in the EPDW was overstated by three thousand, seven hundred and fifty-nine (3,759) enrollment groups and five thousand, nine hundred and fifty-six (5,956) 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."
Cause:	The issuer indicated that the differences were due to scenarios where the policyholder group is on a different QHP identifier for a period of time and the policyholder exchange IDs could be different in our system compared to the CMS file or vice versa. There are also scenarios where the issuer terminated coverage for non-payment and the EPDW would still include the subscriber.

Finding No. 1 and Observation No. 1 – EPDW Validations	
	The SBE indicated "the initial launch of Covered California in 2014 was ambitious and certainly came with its share of technical and operational challenges. Covered California, by way of the California Healthcare Enrollment, Eligibility and Retention System (CalHEERS), determines program eligibility for all consumers and thereby serves as the source of truth for State Based Marketplace (SBM) enrollment. After an unprecedented level of integration with all participating insurance carriers in California, CalHEERS has gone through several enhancements since its start in 2014 to proactively monitor for data accuracy and consistency. These monitoring tools are used to identify data inconsistencies and apply best practices for implementing solutions. Similarly, since 2014 numerous data validations have been added to the IPR and Policy Based Payment (PBP) processes to maintain a high degree of accuracy and consistency. Upon review of the EPDW Validations discrepancy, the premium and APTC difference is reflective of those members within the Unreconciled Subscriber tab where the carrier is reporting coverage and Covered CA shows them as cancelled. Additionally, there are instances where the total APTC for the coverage duration is equal despite there being differences in only the monthly amount." Therefore, the SBE agreed with the discrepancy 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 Health Net'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 indicates that an overpayment was received, CMS will adjust payment by pulling back the unsubstantiated APTC overpayment
Corrective Action Required:	The net financial impact of this finding is a payment of $744,688.01 consisting of APTC owed to CMS. Health Net should confirm the financial impact by filling out Appendix 1. The premium impact of this observation is an overstatement of $2,189,756.66 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:	Health Net overstated the 2014 benefit year premium amounts for six (6) subscribers and overstated the 2014 benefit year APTC amounts for three (3) of those subscribers, in the Payment Desk Audit File by reporting enrollment and full month more than once in the same month.
Criteria:	Issuers cannot request full month payment from CMS for the same subscriber twice within a month.
Cause:	The issues confirmed duplicate coverage for five (5) subscribers and incorrect APTC and premium proration for one (1) subscriber.
Effect:	The inclusion of the six (6) duplicate subscribers resulted in a change to Health Net'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 $574.68 consisting of APTC owed to CMS. Health Net should confirm the financial impact by filling out Appendix 1. The premium impact of this observation is an overstatement of $1,724.00 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 - Premium Less than APTC Validation	
Condition:	Health Net reported 2014 benefit year premium amounts that were less than the APTC amounts for four (4) subscribers in the Payment Desk Audit File, resulting from Health Net understating the 2014 benefit year premium amount for three (3) subscribers, and overstating the 2014 benefit year APTC amount for one (1) subscriber in the Payment Desk Audit File.
Criteria:	Issuers cannot report an APTC amount that exceeds the premium amount for a policy.
Cause:	The issuer indicated the differences were the result of the premium amounts reported in its system not matching the premium amount

Finding No. 3 and Observation No. 3 - Premium Less than APTC Validation	
	billed for one (1) subscriber however the billed amount was correct. For another subscriber, the APTC was not adjusted to the correct effective date due to an enrollment change and the premium effective date was different from the enrollment begin date for two (2) subscribers thus resulting in the incorrect reporting of premium/APTC.
Effect:	The inclusion of the incorrect APTC and premium amounts for four (4) subscribers resulted in a change to Health Net'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 $108.56, consisting of APTC owed to CMS. Health Net should confirm the financial impact by filling out Appendix 1. The premium impact of this observation is an understatement of $10,828.00 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 three (3) findings and three (3) observations identified in the draft audit report and complete the attached Appendix 1 - Issuer Management Response to Net Financial Adjustment (Appendix 1), within thirty (30) calendar days from the draft audit report date. Management's response should indicate agreement or disagreement.

Agreement

If management agrees with the three (3) findings and three (3) 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 the three (3) findings and corrective actions and three (3) 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: 99110

Issuer Name: Health Net Life Insurance Company (Health Net)

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 $745,371.25 to CMS and:

(INITIAL) CB 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: Christy K Bosse

(Signature of authorized person acting on behalf of the issuer)

Printed Name: Christy K. Bosse

(Print name of signature)

Title: Senior Vice President & CA Compliance Officer

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

Telephone Number: (818) 679-7595

(Direct Telephone Number)

Date: June 23, 2022

Appendix 2 – Applicable Regulations

The following table identifies the specific regulatory requirements around which CMS has organized its audits.

Regulation	Rules
45 CFR § 155.1210 – Maintenance of Records	**(a) General.** The State Exchange must maintain and must ensure its contractors, subcontractors, and agents maintain for 10 years, documents and records (whether paper, electronic, or other media) and other evidence of accounting procedures and practices, which are sufficient to do the following: (1) Accommodate periodic auditing of the State Exchange's financial records; and (2) Enable HHS or its designee(s) to inspect facilities, or otherwise evaluate the State- Exchange's compliance with Federal standards. **(b) Records.** The State Exchange and its contractors, subcontractors, and agents must ensure that the records specified in paragraph (a) of this section include, at a minimum, the following: (1) Information concerning management and operation of the State Exchange's financial and other record keeping systems; (2) Financial statements, including cash flow statements, and accounts receivable and matters pertaining to the costs of operations; (3) Any financial reports filed with other Federal programs or State authorities; (4) Data and records relating to the State Exchange's eligibility verifications and determinations, enrollment transactions, appeals, and plan variation certifications; and (5) Qualified health plan contracting (including benefit review) data and consumer outreach and Navigator grant oversight information. **(c) Availability.** A State Exchange must make all records and must ensure its contractors, subcontractors, and agents must make all records in paragraph (a) of this section available to HHS, the OIG, the Comptroller General, or their designees, upon request.

Regulation	Rules
45 CFR § 156.460 - Reduction of enrollee's share of premium to account for advance payments of the premium tax credit	**(a) Reduction of enrollee's share of premium to account for advance payments of the premium tax credit.** A QHP issuer that receives notice from the Exchange that an individual enrolled in the issuer's QHP is eligible for an advance payment of the premium tax credit must— (1) Reduce the portion of the premium charged to or for the individual for the applicable month(s) by the amount of the advance payment of the premium tax credit; (2) Notify the Exchange of the reduction in the portion of the premium charged to the individual in accordance with§ 156.265(g); and (3) Include with each billing statement, as applicable, to or for the individual the amount of the advance payment of the premium tax credit for the applicable month(s), and the remaining premium owed.
45 CFR § 156.480 - Oversight of the administration of the cost-sharing reductions and advance payments of the premium tax credit programs.	**(a) Maintenance of records.** An issuer that offers a QHP in the individual market through a State Exchange must adhere to, and ensure that any relevant delegated entities and downstream entities adhere to, the standards set forth in § 156.705 concerning maintenance of documents and records, whether paper, electronic, or in other media, by issuers offering QHPs in a Federally-facilitated Exchange, in connection with cost-sharing reductions and advance payments of the premium tax credit. **(b) Annual reporting requirements.** For each benefit year, an issuer that offers a QHP in the individual market through an Exchange must report to HHS, in the manner and timeframe required by HHS, summary statistics specified by HHS with respect to administration of cost-sharing reduction and advance payments of the premium tax credit programs, including any failure to adhere to the standards set forth under § 156.410(a) through (d), § 156.425(a) through (b), and § 156.460(a) through (c) of this Part. **(c) Audits.** HHS or its designee may audit an issuer that offers a QHP in the individual market through an Exchange to assess compliance with the requirements of this subpart.

Regulation	Rules
45 CFR § 156.705 – Maintenance of records for Federally-facilitated Exchanges	**(a)** ***General standard.*** Issuers offering QHPs in a Federally-facilitated Exchange must maintain all documents and records (whether paper, electronic, or other media) and other evidence of accounting procedures and practices, necessary for HHS to do the following: **(1)** Periodically audit financial records related to QHP issuers' participation in a Federally-facilitated Exchange, and evaluate the ability of QHP issuers to bear the risk of potential financial losses; and **(2)** Conduct compliance reviews or otherwise monitor QHP issuers' compliance with all Exchange standards applicable to issuers offering QHPs in a federally-facilitated Exchange as listed in this part. **(b)** ***Records.*** The records described in paragraph (a) of this section include the sources listed in § 155.1210(b)(2), (3), and (5) of this subchapter. **(c)** ***Record retention timeframe.*** Issuers offering QHPs in a Federally-facilitated Exchange must maintain all records referenced in paragraph (a) of this section for 10 years. **(d)** ***Record availability.*** Issuers offering QHPs in a Federally-facilitated Exchange must make all records in paragraph (a) of this section available to HHS, the OIG, the Comptroller General, or their designees, upon request.

Appendix 3 – Glossary of Terms and Acronyms

Terms & Acronyms	Definition
APTC	Advance Payments of the Premium Tax Credit
CEO	Chief Executive Officer
CFO	Chief Financial Officer
CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
CSR	Cost-sharing Reduction
DHHS	Department of Health and Human Services
EPDW	Enrollment and Payment Data Workbook
GAGAS	Generally Accepted Government Auditing Standards
HIOS	Health Insurance Oversight System
IRS	Internal Revenue Service
PPACA	Patient Protection and Affordable Care Act
PLR	Policy-level Reporting
QHP	Qualified Health Plan
SBE	State-based Exchange
TIN	Tax Identification Number