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

for

Medica Insurance Company

March 31, 2022

I. EXECUTIVE SUMMARY

Sections 1401 and 1412 of the Affordable Care Act (ACA) established the advance payments of the premium tax credit (APTC) program to support the provision of affordable health care coverage to individuals. Additionally, section 1311 of the ACA allows the Federally-facilitated Exchanges (FFEs) to charge participating issuers user fees to support FFE operations.

Under title 45 of the Code of Federal Regulations (CFR), sections §§ 156.480 and 156.705, the Department of Health and Human Services (HHS) may audit issuers that offer a Qualified Health Plan (QHP) in the individual market through an Exchange to assess the degree of compliance with the APTC and FFE user fee program requirements. The Centers for Medicare & Medicaid Services (CMS) established an audit protocol to assess health insurance issuers' compliance with the following regulations governing APTC and FFE user fee programs and other related applicable Exchange operational standards:

- 45 CFR § 155.400: Enrollment of qualified individuals into QHPs;
- 45 CFR § 155.430: Termination of Exchange enrollment or coverage;
- 45 CFR § 156.50: Financial support;
- 45 CFR § 156.270: Termination of coverage or enrollment for qualified individuals;
- 45 CFR § 156.460: Reduction of enrollee's share of premium to account for advance payments of the premium tax credit;
- 45 CFR § 156.480: Oversight of the administration of the cost-sharing reductions and advance payments of the premium tax credit programs; and
- 45 CFR § 156.705: Maintenance of records for Federally-facilitated Exchanges.

This report is an assessment of Medica Insurance Company (Medica Iowa (IA))'s compliance with the APTC and FFE user fee programs. Medica (IA) is a health insurance issuer that offered QHPs in the individual market on the FFE in Iowa during the 2016 benefit year. The issuer received a total of $4,259,085.86 in APTC from CMS and paid a total of $265,999.33 in FFE user fees to CMS for the 2016 benefit year. The payment amounts were calculated using CMS's automated payment system, policy-based payments (PBP).

Based on the assessment of Medica (IA)'s program participation, if CMS found any instances of issuer non-compliance with APTC and FFE user fee program requirements that requires correction to payment, then CMS classified it as a *finding* in section III. If CMS found a deviation from APTC and FFE user fee program requirements that does not require correction to payment, then CMS categorized it as an *observation* in section IV in order to call management's attention to the issue(s) for purposes of improving compliance in future program years.

II. BACKGROUND AND AUDIT METHODOLOGY

A. PBP Background

Starting in 2016, CMS implemented an automated PBP system to support the collection of FFE user fees and to make monthly payments of APTC. The PBP system calculates the payment and charge amounts based on enrollment information at the policy level. CMS and issuers use the X12 standard 834 enrollment transaction in real time to exchange FFE enrollment data. To confirm the accuracy and consistency of the FFE enrollment data that CMS uses to make automated payments, CMS also conducts a monthly enrollment reconciliation process. CMS provides a Pre-Audit File to issuers containing a snapshot of the FFE database for the benefit year, and issuers respond by submitting an Inbound Reconciliation (RCNI) File to CMS that contains the benefit year's enrollment data as reflected in the issuer's systems. As a part of the reconciliation processes, CMS reconciles the RCNI file with the Pre-Audit File using a set of business rules that reflect CMS's enrollment policy to determine whether updates were required. This process implements a complex set of business rules to determine which issuer enrollment updates are accepted or rejected. The output of the comparison, the Outbound Reconciliation (RCNO) File, is sent to issuers to show which records CMS anticipates updating in the FFE database and which records CMS is directing the issuer to update in their systems. CMS conducted this enrollment reconciliation process for the 2016 benefit year from December 2015 through April 2017.

CMS provided a final opportunity for issuers to compare their 2016 FFE individual enrollment data with the current 2016 enrollment data in the FFE database, via three (3) optional off-cycle enrollment reconciliation processes in June 2020, September 2020 and October 2020. Unlike typical enrollment reconciliation runs, CMS did not update FFE enrollment data based on the off-cycle enrollment reconciliation. Instead, issuers were encouraged to submit disputes for any outstanding discrepancies resulting from the off-cycle enrollment reconciliation processes that required updates to FFE data.

B. Audit Methodology

On December 19, 2019, Medica (IA) was notified by CMS that they were selected for audit for the 2016 benefit year. Once selected, CMS required the submission of a PBP Desk Audit File that contained the 2016 benefit year individual market enrollment data as currently reflected in the issuer's systems. CMS also required the submission of policies and procedures, policy documentation for selected samples of policies, and a Premium Payment Data Extract containing premium payment data from the issuer's system for a selected sample of policies. Using the issuer provided data files and documentation, the following audit procedures were performed to assess compliance with APTC and FFE user fee program rules and regulations.

Validations of PBP Payments/Charges based on Data Reported in CMS's Systems through Enrollment Reconciliation

Using the issuer provided PBP Desk Audit File, CMS executed audit procedures to identify the policies that have a financial impact listed in section III of this report. CMS performed reviews and comparisons of the issuer's PBP Desk Audit File against the latest CMS enrollment reconciliation run data for the 2016 benefit year. CMS referred to its enrollment policy and PBP requirements to develop the audit protocols that determine whether the discrepancies identified through these reviews and comparisons required

adjustment to payment[1]. Data differences between the issuer's enrollment records and the FFE data were reviewed and communicated to the issuer for resolution or confirmation as part of the audit process. Any policies with the following remaining confirmed data differences that required adjustment to payment after the completion of this process are detailed in an Excel file provided to Medica (IA) in conjunction with the draft report:

1) Coverage status: Policies that were effectuated in CMS's data but not the issuer's data or vice-versa (referred to as "CMS Unreconciled" or "Issuer Unreconciled", respectively);
2) Coverage dates: Policies where the dates of coverage did not align between CMS and the issuer (referred to as "CMS Extra Coverage" or "Issuer Extra Coverage"); and/or
3) Financial differences: Policies where premium and resulting FFE user fee and/or APTC amounts differed between CMS's data and the issuer's data (referred to as "Financial Differences with/without Coverage Differences").

Validations of the Correct Application of CMS Enrollment Policy

Using the policy documentation, data files, and policies and procedures provided by the issuer, CMS executed audit procedures to identify the observations listed in section IV of this report. The reviews include policy-level analysis of issuer Unaffiliated Issuer Enrollments, Issuer Update (I) and FFE Update (F) Flag Review, Fifteen (15) Subscriber Sample Policy-level Documentation Review, Premium Payment Data Extract Validations, and review of policies and procedures.

CMS conducted a discrepancy phase following execution of the audit procedures detailed above to work with the issuer to resolve or reduce data differences identified. CMS adjudicated the issuer follow-up and, after the analysis, issued this report.

[1] Enrollment Reconciliation rules are available on https://www.regtap.info/

III. SUMMARY OF FINDINGS WITH FINANCIAL IMPACT

A finding is the identification of an instance of issuer non-compliance with APTC and FFE user fee program requirements that requires correction to payment. CMS's audit procedures identified data differences that resulted in a change to the total APTC payment made to Medica (IA) and the total FFE user fees collected from Medica (IA) for individual market plans during the 2016 benefit year. The APTC and FFE user fee financial impact is shown in the following table.

APTC Payment and FFE User Fee Collection Financial Impact

	Number of Policies Impacted	APTC Payment	FFE User Fee Payment	Total
Policies where CMS owes the Issuer APTC	6	$3,456.42	$(140.18)	$3,316.24
Policies where the Issuer owes CMS APTC	41	$(45,264.39)	$2,692.41	$(42,571.98)
User Fee Only Policies where CMS owes the Issuer FFE UF	14	N/A	$350.05	$350.05
User Fee Only Policies where the Issuer owes CMS FFE UF	6	N/A	$(146.72)	$(146.72)
Total Impact	67	$(41,807.97)	$2,755.56	$(39,052.41)

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

The net financial impact is a payment from Medica (IA) to CMS of $39,052.41, which consists of $41,807.97 in APTC paid to CMS and $2,755.56 in FFE user fees returned to Medica (IA). The policies impacted and the associated financial impact are detailed in an Excel file provided to Medica (IA) in conjunction with the draft report.

The APTC payment and user fee payment adjustments will be processed in the monthly payment cycle and netted against any other payments or charges as indicated by CMS's netting rules.[2]

[2] For more information on CMS's payment and collections processes, please visit https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-156/subpart-M/section-156.1215.

IV. SUMMARY OF OBSERVATIONS

An observation is a deviation from APTC and FFE user fee program requirements that is called to the attention of management for purposes of improving compliance in future program years but that does not require correction to payment. While CMS is not adjusting APTC payment, we note issuer deviations from CMS's enrollment regulations or guidance where applicable. CMS's audit procedures identified the following observation:

- Medica (IA) provided coverage but received premium payments that were less than the premium responsibility amounts and therefore did not receive all outstanding premiums prior to the end of the three (3) month grace period for one (1) of the forty-five (45) policies reviewed in the Issuer Update (I) and FFE Update (F) Flag Review. For the policy with a premium responsibility amount of $571.08 for months 7-9, the issuer indicated, "Based on our analysis for months 7-9, the subscriber made payments of $305.00 which was below the correct premium responsibility of $571.08." Therefore, CMS concluded the full outstanding balance was not received within the issuer's threshold of 95% and within the three (3) month grace period, and therefore the enrollment should have been terminated due to non-payment on the last day of the first month of the three (3) month grace period (i.e., end of month 7). Pursuant to 45 CFR 156.270(g), if an enrollee receiving APTC exhausts the 3-month grace period without paying all outstanding premiums, the QHP issuer must terminate the enrollee's coverage on the effective date described in §155.430(d)(4) of this subchapter (last day of the first month of the 3-month grace period).

Appendix 1 – Issuer Management Response to Net Financial Adjustment

Issuer HIOS ID: 93078

Issuer Name: Medica Insurance Company (Medica (IA))

The undersigned Chief Executive Officer (CEO), Chief Financial Officer (CFO) or other authorized official who can legally and financially bind this issuer has reviewed the information included in the audit report of the issuer's 2016 benefit year APTC and FFE user fee program, resulting in a payment to CMS of $39,052.41, consisting of $41,807.97 in APTC paid to CMS and $2,755.56 in FFE user fees returned to Medica (IA), and:

(INITIAL) __X___ Agrees with the audit net adjustment amount above, confirming the audit financial impact and observation(s), if applicable, and as such this report will be considered final and published.

Or

(INITIAL) _____ Disagrees and requests a review of additional information that may impact the audit net adjustment amount resulting from the audit. As you requested a review, CMS will consider this draft only a preliminary audit report. As the review option was selected, you must provide a written explanation with any additional documentation when you return this response within thirty (30) calendar days of the date of this draft audit report. CMS will review the written explanation and any supporting documentation to determine if the report can be amended in a mutually acceptable manner. If you and CMS are unable to come to a mutually acceptable result, your response to this report will be included in the final published audit report.

Signed: DocuSigned by: Geoff Bartsh 1857B1131267492...
(Signature of authorized official acting on behalf of the Issuer)

Printed Name: Geoff Bartsh
(Print name of signature)

Title: SVP, Markets Growth and Retention GM
(Title of authorized person acting on behalf of the Issuer)

Telephone Number: 952-992-2461
(Direct Telephone Number)

Date: 4/27/2022