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

for

Providence Health Plan

August 5, 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.

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 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 program 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 (FFE).

This report is an assessment of Providence Health Plan (PHP)'s compliance with the APTC program. 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 State-based Exchanges (SBEs) on the Federal Platform (SBE-FP) during the 2016 benefit year. PHP is a health insurance issuer that offered QHPs in the individual market on the SBE-FP in Oregon during the 2016 benefit year[1]. The issuer received a total of $128,074,056.02 in APTC from CMS and reported a total of $253,209,021.71 in premiums for the 2016 benefit year. The payment amount was calculated using CMS's automated payment system, policy-based payments (PBP). Additionally, the issuer received a total of $28,832.44 in APTC from CMS for its 2016 benefit year Unaffiliated Issuer Enrollments (UIEs) that could not be resolved through the standard FFE reconciliation and resolution process.

Based on the assessment of PHP's program participation, if CMS found any instance of issuer non-compliance with APTC program requirements in which PHP's reporting to CMS did not match the coverage provided to the enrollee, leading to inaccuracies in CMS's premium data and/or APTC payment, then CMS classified it as a *finding* in section III. If CMS found a deviation from APTC program requirements in which the issuer failed to follow CMS's enrollment or coverage policy, but 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.

[1] SBE-FP enrollment and payment data is maintained in the FFE (PBP) enrollment and payment system. References to FFE enrollment data include SBE-FP enrollment data.

II. BACKGROUND AND AUDIT METHODOLOGY

A. PBP Background

Starting in 2016, CMS implemented an automated PBP system 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 2016 benefit year, and issuers respond by submitting an Inbound Reconciliation (RCNI) File to CMS that contains the 2016 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 was 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, PHP 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 program rules and regulations.

Validations of PBP Payments 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[2]. 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 PHP 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.

[2] 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 program requirements in which the issuer's reporting to CMS did not match the coverage the issuer provided to the enrollee, leading to inaccuracies in CMS's premium and/or APTC data. Findings that lead to errors in APTC payments require correction to those payments. CMS's audit procedures identified data differences that resulted in a change to the total APTC payment made to PHP and the total premium amounts reported by PHP for individual market plans during the 2016 benefit year. The APTC financial impact and the premium impact are shown in the following table.

APTC Payment and Premium Impact

	Number of Policies Impacted	APTC Payment	Premium Impact*
Policies where CMS owes the Issuer APTC	352	$379,212.52	$(528,123.20)
Policies where the Issuer owes CMS APTC	680	$(670,401.95)	$990,367.20
Premium Only Policies where CMS Data was Overstated	740	N/A	$1,246,348.41
Premium Only Policies where CMS Data was Understated	520	N/A	$(634,592.64)
Total Impact	2,292	$(291,189.43)	$1,073,999.77 *

Note: Positive values indicate APTC funds owed to the issuer and overstated premiums in CMS data; negative values indicate APTC amounts owed to CMS and understated premiums in CMS data.

*For informational purposes only, the premium impact is an overstatement of $1,073,999.77 in premiums.

The net financial impact is a payment from PHP to CMS of $291,189.43, consisting of $291,189.43 in APTC to be returned to CMS. The policies impacted and the associated financial impact are detailed in an Excel file provided to PHP in conjunction with the draft report.

The APTC 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.[3]

[3] 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 program requirements that is called to the attention of management for purposes of improving compliance with CMS's enrollment regulations or guidance in future program years. Observations do not require correction to payment. CMS's audit procedures identified the following one (1) observation:

- PHP received the binder payment within the issuer's threshold of $5.00 but not within thirty (30) calendar days from the coverage effective date for two (2) of the eighty-nine (89) policies reviewed in the Issuer Unreconciled Policy Review. The issuer indicated the following for the two (2) policies:
  - "PHP approved an exception to accept the late binder payment. Enrollee made the check and setup an automatic payment payable to US Bank instead of PHP. Enrollee paid all the outstanding retro-active premium on 20160509."
  - "PHP approved an exception to accept the late binder payment. Enrollee paid on 20160203, but PHP did not process the payment until 20160330."

  Pursuant to 45 CFR § 155.400(e), for first month (or binder payment) premiums, premium payment deadlines must be no earlier than the coverage effective date, but no later than thirty (30) calendar days from the coverage effective date.

Appendix 1 – Issuer Management Response to Net Financial Adjustment

Issuer HIOS ID: 56707

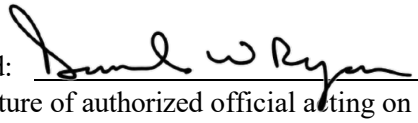
Issuer Name: Providence Health Plan (PHP)

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 program, resulting in a payment to be returned to CMS of $291,189.43 in APTC, and:

(INITIAL)__DR__ 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: 
(Signature of authorized official acting on behalf of the Issuer)

Printed Name: Daniel Ryan
(Print name of signature)

Position Title: Chief Financial Officer
(Title of authorized official acting on behalf of the Issuer)

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