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

*for*

*Humana Medical Plan of Michigan, Inc.*

*February 28, 2023*

# 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 Humana Medical Plan of Michigan, Inc. (Humana (MI))'s compliance with the APTC and FFE user fee programs. Humana (MI) is a health insurance issuer that offered QHPs in the individual market on the FFE in Michigan during the 2017 benefit year. The issuer received a total of $10,414,513.03 in APTC from CMS and paid a total of $823,990.30 in FFE user fees to CMS for the 2017 benefit year. The payment amounts were calculated using CMS's automated payment system, policy-based payments (PBP).

Based on the assessment of Humana (MI)'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.

As noted in the Payment Policy and Financial Management Group (PPFMG) External Audit Communication letter dated July 19, 2019, consistent with the expiration of the good faith policy at 45 CFR § 156.800(c), CMS may begin imposing civil money penalties (CMPs) for observations identified beginning with benefit year 2020 audits.

# 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 2017 benefit year from December 2016 through March 2018.

CMS provided a final opportunity for issuers to compare their 2017 FFE individual enrollment data with the current 2017 enrollment data in the FFE database, via an optional off-cycle enrollment reconciliation process. 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 March 16, 2021, Humana (MI) was notified by CMS that they were selected for audit for the 2017 benefit year. Once selected, CMS required the submission of a new RCNI file that contained the 2017 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

For purposes of the audit, the issuer submitted an updated RCNI file that reflected a current snapshot of individual market enrollment data for the 2017 benefit year. During the audit, CMS reconciled the issuer provided RCNI file with the Pre-Audit File representing the most recent FFE data as of the beginning of the audit to identify any data differences and used the output of the comparison (the audit RCNO file) as the basis for performing the checks in its audit procedures to validate PBP payments. CMS executed audit procedures to identify the policies that have a financial impact listed in section III of this report. 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 identified between the issuer's enrollment records and the FFE data in the audit RCNO file 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 Humana (MI) 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 the Forty-Five (45) Subscriber Sample Policy-level Documentation Review, Premium Payment Data Extract Validation, and Policies and Procedures Review.

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 Humana (MI) and the total FFE user fees collected from Humana (MI) for individual market plans during the 2017 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** | 11 | $9,508.99 | $(533.03) | $8,975.96 |
| **Policies where the Issuer owes CMS APTC** | 24 | $(33,209.15) | $2,221.44 | $(30,987.71) |
| **User Fee Only Policies where CMS owes the Issuer FFE UF** | 21 | N/A | $1,100.07 | $1,100.07 |
| **User Fee Only Policies where the Issuer owes CMS FFE UF** | 9 | N/A | $(239.60) | $(239.60) |
| **Total Impact** | 65 | $(23,700.16) | $2,548.88 | $(21,151.28) |

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

The net financial impact is a payment from Humana (MI) to CMS of $21,151.28, which consists of $23,700.16 in APTC to be returned to CMS and $2,548.88 in FFE user fees to be returned to Humana (MI). The policies impacted and the associated financial impact are detailed in an Excel file provided to Humana (MI) 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 or imposing CMPs for observations for the audit of the 2017 benefit year, we note issuer deviations from CMS's enrollment regulations or guidance where applicable. As noted in the PPFMG External Audit Communication letter dated July 19, 2019, consistent with the expiration of the good faith policy at 45 CFR § 156.800(c), CMS may begin imposing CMPs for observations identified beginning with benefit year 2020 audits. CMS's audit procedures identified the following two (2) observations:

- Humana (MI) continued to provide coverage despite not receiving the full outstanding premium balance within the three (3) month grace period for four (4) of the eight hundred and seventy-six (876) policies reviewed in the Premium Payment Data Extract Validations. The issuer indicated the following for the four (4) policies:
    - For one (1) policy with partial premium payments received for months 1-3, the issuer indicated, "The issuer received a financial change file from CMS on 02/06/17 giving subscriber APTC beginning 03/01/2017 for $66. The subscriber did not make the full premium payment amount for month 01-02 causing them to be in the 90-day grace period and term back to 03/31/2017. Issuer wrote off a balance of $132.00 as a loss for months 01-03."
    - For one (1) policy with late premium payments received for months 1-3, the issuer indicated, "Subscriber paid all their premium payments for months 01-12. Subscriber made a payment of $400.00 on 04/30/2017 and a payment on 05/01/2017 for $299.17 that covered months 01-05 then made remaining payment timely for months 06-12."
    - For one (1) policy with no premium payments received for months 4-12, the issuer indicated, "Due to a billing error the coverage was never termed to 03/31/2017 and showed continuous coverage till 12/31/2017 in the issuer's system. The issuer wrote off a total of uncollectable debt of $1,318.80 for months the issuer did not receive premium payments."
    - For one (1) policy with late premium payments received for months 2-5, the issuer indicated, "The subscriber should have been termed back to 02/01/2017 due to not making initial premium payment within grace period time frame of 30 days. The subscriber made all premium payments for months 3-11. Issuer wrote off a balance for $131.36."

  Pursuant to 45 CFR § 156.270(g), if an enrollee receiving APTC exhausts the three (3) month grace period without paying all outstanding premiums, the QHP issuer must terminate the enrollee's enrollment through the Exchange on the last day of the first month of the three (3) month grace period.

- For eight (8) of the eight hundred seventy-six (876) policies reviewed in in the Premium Payment Data Extract Validations, and for one (1) policy reviewed in the Forty-five (45) Subscriber Sample Policy-level Documentation Review, who were in the grace period and did not pay all outstanding premiums, Humana (MI) did not terminate based on the earlier of the termination date received from CMS or the date the enrollee's coverage is terminated for non-payment of premiums if the enrollee fails to pay all outstanding premiums. The issuer indicated the following for the nine (9) policies:
    - For six (6) policies, the issuer indicated, "Subscriber had continuous coverage since 2016. The subscriber was in their 90-day grace period. The issuer received a term file from CMS on [issuer provided date] to term plan for [issuer provided date] while subscriber was in their

Grace Period. Issuer wrote off a balance owed in the amount of $[issuer provided amount] as a loss."

- For two (2) policies, the issuer indicated, "Subscriber did not make payment for months 8 and 9. The subscriber was in their 90-day grace period. The issuer received a term file from CMS on [issuer provided date] to term coverage for [issuer provided date] while still in grace period. Issuer wrote off $[issuer provided amount] as a loss for months 08 and 09."
- For one (1) policy, the issuer indicated, "Subscriber had continuous coverage from beginning date of 01/01/2015. The last premium payment received was for month 12 of 2016 coverage. Subscribers have a 90-day grace period from the last day a payment is received to catch up their monthly premium payments. Once the 90-day grace period was over, coverage was termed, and the issuer wrote off a balance of $176.71 as a loss to the company. Coverage was termed for 02/09/17 before grace period ended due to receiving a term file from CMS to term coverage. File was received on 01/26/2017."

Pursuant to CMS guidance outlined in the CMS FFE and Federally-Facilitated Small Business Health Options Program (FF-SHOP) Enrollment Manual for the 2017 benefit year, "if an enrollee seeks to voluntarily terminate coverage while he or she is in a grace period due to non-payment of premiums, the effective date of termination is the earlier of: (1) the enrollee's voluntary termination date, or (2) the date the enrollee's coverage is terminated for non-payment of premiums (involuntary termination date) if the enrollee fails to pay all outstanding premiums or an amount within the tolerance of any applicable premium payment threshold, before the end of the applicable grace period."

## Appendix 1 – Issuer Management Response to Net Financial Adjustment

Issuer HIOS ID: 46275

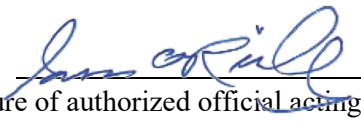
Issuer Name: Humana Medical Plan of Michigan, Inc. (Humana (MI))

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 2017 benefit year APTC and FFE user fee program, resulting in a payment to CMS of $21,151.28, consisting of $23,700.16 in APTC to be returned to CMS and $2,548.88 in FFE user fees to be returned to Humana (MI), and:

(INITIAL) SJO 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: Sean J. O'Reilly
(Print name of signature)

Position Title: SVP, Chief Compliance Officer
(Title of authorized official acting on behalf of the Issuer)

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