2014 Transitional Reinsurance (RI) Audit Report

for

Health Tradition Health Plan (Health Tradition)
HIOS Issuer ID 47342

May 27, 2021

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I. EXECUTIVE SUMMARY

The 2014 Transitional Reinsurance (RI) Audit Report is an assessment of Health Tradition Health Plan's (Health Tradition) compliance with the applicable federal requirements related to payments made under the Transitional Reinsurance program established under section 1341 of the Patient Protection and Affordable Care Act (ACA)[1] and implementing regulations.[2,3] This report details the audit procedures[4] and the resulting findings and/or observations for the benefit year (BY) 2014 RI program audit of Health Tradition.

Background

Health Tradition, HIOS Issuer ID 47342, is a health insurance issuer that received BY 2014 RI payments consistent with the BY 2014 national RI payment parameters.[5] Health Tradition submitted enrollment, medical, and pharmacy claims data to its External Data Gathering Environment (EDGE) Server for calculation of the BY 2014 RI payments. The payments are reflected in the issuer's 2014 EDGE Reinsurance Detailed Enrollee Report (BY 2014 RIDE Report). This issuer's total BY 2014 RI payments were $4,487,321.80.

Audits to Determine Compliance with the Transitional RI Program

Under title 45 of the Code of Federal Regulations (CFR) § 153.410(d), the Department of Health and Human Services (HHS) may audit issuers to assess the degree of compliance with the federal RI program requirements. HHS designated CMS to conduct these audits to achieve the following:

- Safeguard federal funds;

[1] The ACA (Pub. L. 111–148) was enacted on March 23, 2010. The Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152), which amended and revised several provisions of the ACA, was enacted on March 30, 2010. In this report, we refer to the two statutes collectively as the ''Patient Protection and Affordable Care Act'' or ''ACA.''

[2] See 42 U.S.C. 18061. Also see 45 C.F.R. Part 153, Subparts A, C, E, H.

[3] Consistent with section 1321(c)(1) of ACA, the HHS Secretary is responsible for operating the transitional reinsurance program on behalf of any state that elected not to do so. For the 2014 benefit year, Connecticut was the only state to elect to operate the transitional reinsurance program. See the HHS Notice of Benefit and Payment Parameters for 2015; Final Rule, 79 FR 13743 at 13752 (March 11, 2014) (2015 Payment Notice).

[4] 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 dialogue between auditor and issuer to identify and correct errors in data submission that differ somewhat from some independence and reporting standards set forth 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.

[5] The final BY 2014 national RI payment parameters consisted of a $45,000 attachment point, $250,000 cap, and a 100% coinsurance rate. For BY 2014, the RI program reimbursed issuers for 100% of an issuer's aggregated total paid claim amount for enrollees that fell between $45,000 (the attachment point) and $250,000 (the cap). The maximum BY 2014 RI payment for an enrollee was $205,000. See CMS Memo *Transitional Reinsurance Program: Pro Rata Adjustment to the National Coinsurance Rate for the 2014 Benefit Year* (June 17, 2015), available at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/The-Transitional-Reinsurance-Program/Downloads/RI-Payments-National-Proration-Memo-With-Numbers-6-17-15.pdf.

- Instill confidence amongst regulated entities concerning data quality, soundness, and robustness;
- Evaluate health insurance issuers' compliance with federal program rules and regulations; and
- Develop a successful and coordinated risk-based audit program that maximizes resources.

This audit is part of CMS's program to validate the BY 2014 enrollee-level data submitted to the issuer's EDGE server by May 15, 2015,[6] and to analyze controls and policies related to BY 2014 RI payments. Additional RI payments will not be provided for claims identified during this audit that are not reflected in the BY 2014 RIDE Report.[7]

CMS findings and observations for the RI program are defined and documented below.

- *Finding*: Results from the discovery of evidence suggesting non-compliance with applicable RI program federal requirements, in addition to cases of confirmed non-compliance and requires a recoupment of RI payments.
    - Example: Claim level discrepancies identified within the issuer's claims data extract and the issuer's BY 2014 RIDE Report, associated with a RI payment enrollee, that result in a recoupment of RI payments.
- *Observation*: Results from the identification of areas for improvement when there is no evidence of actual non-compliance with applicable RI program federal requirements or when there may be evidence of non-compliance with applicable RI program federal requirements that does not require recoupment of RI payments.
    - Example: Claim level discrepancies identified within the issuer's claims data extract and the issuer's BY 2014 RIDE Report, associated with RI eligible enrollees or RI payment enrollees where the claim adjustment would not result in a recoupment of RI payments.[8]

Results of Review

CMS identified one (1) finding and one (1) observation for Health Tradition's BY 2014 RI program audit. The finding and observation include the following:

Finding:

1. Inclusion of claim data for 31 claims, totaling $1,001.39, in the issuer's BY 2014 RIDE Report that the issuer could not substantiate in its claims system of record.

The results of the one (1) audit finding resulted in a total of $1,001.39 paid claim differences that the issuer has not substantiated. All issuer's paid claims amounts for an enrollee, with the audit corrections, were aggregated for each enrollee, then the RI payment parameters were applied to

[6] CMS provided a grace period until May 15, 2015, for issuers to submit and update EDGE server data for BY 2014. See https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/EDGE_Data_Grace_Period_Guidance4-27-15.pdf.

[7] As communicated in the Entrance Conference, additional RI payments will not be provided for underpayments identified as a result of the BY 2014 RI Audits.

[8] See supra note 7.

recalculate the issuer's BY 2014 RI payments.[9] Consistent with the findings identified in this report, a recoupment payment is due to HHS of $1,001.39 for the BY 2014 RI payments. Therefore, HHS will recoup this amount as part of the monthly netting process where applicable.[10]

Observation:

1. Inclusion of claim data for five (5) claims, totaling $87.41, in the issuer's BY 2014 RIDE Report that the issuer could not substantiate in its claims system of record.

The one (1) observation does not require a recoupment of the issuer's BY 2014 RI payments. In some instances, an observation may also affect an enrollee who received an RI payment but not result in an impact to the RI payment for that enrollee (e.g., the issuer's aggregated paid claims for the enrollee, after correcting the observation and application of the BY2014 RI payment parameters, results in the same RI payment for the enrollee).

Please refer to Sections II.C and II.D below for details on the finding and observation listed above, including the condition, cause, effect, corrective actions, and the issuer's responses.

[9] Please refer to Appendix 4 to view the aggregated amount of paid claim differences associated with each audit procedure, as well as the enrollee level results used for calculating the "Total Financial Impact."

[10] See 45 C.F.R. § 156.1215. If all or part of the adjustment amount was unable to be netted, the remaining adjustment amount is a determination of a debt that is owed to the federal government. See 45 C.F.R. § 156.1215(c).

II. REINSURANCE PAYMENT PROGRAM ASSESSMENT

A. BACKGROUND, OBJECTIVES, SCOPE, and METHODOLOGY

1. Background

HHS has authority to conduct audits to confirm successful implementation of, and adherence to, the applicable federal requirements related to the RI program.[11] As such, CMS established this audit program.

Section 1341 of ACA established a transitional RI program to stabilize premiums in the individual market inside and outside of the Exchanges for benefits years 2014 through 2016.[12] The transitional RI program collected contributions from contributing entities to fund RI payments to issuers of non-grandfathered individual market reinsurance-eligible plans,[13] the administrative costs of operating the program, and the General Fund of the U.S. Treasury. The program helped reduce the uncertainty of insurance risk in the individual market as the federal ACA insurance market requirements and Exchanges were implemented by partially offsetting issuer's claims associated with high-cost enrollees.[14] Under the program, payments were made to issuers of reinsurance-eligible plans for a percentage of covered claims (coinsurance rate) above the attachment point and below the reinsurance cap.[15] For BY 2014, the attachment point was $45,000, the reinsurance cap was $250,000, and the final coinsurance rate was 100%.[16]

HHS implemented a distributed data collection (DDC) approach where issuers of reinsurance-eligible plans were required to establish external data gathering environment (EDGE) servers to make accessible data required to calculate RI payments when HHS was responsible for operating the RI program.[17,18] Issuers were required to submit enrollee and claims data on their EDGE servers by April 30th of the year following the applicable benefit year.[19] Non-orphan claims (i.e., those that are linked to enrollees in a valid individual market reinsurance-eligible plan) were selected for the RI calculation and considered as a request for payment pursuant to 45 C.F.R. § 153.410. Each issuer's EDGE server calculated the issuer's estimated RI payment, while the EDGE Calculation Module (ECM), a CMS internal system, calculated the amount of each issuer's actual RI payment taking into consideration total available RI contributions.

[11] See 45 C.F.R. § 153.410(d).
[12] See supra note 3.
[13] See 45 C.F.R. § 153.20 for a definition of "reinsurance-eligible plan."
[14] See, e.g., Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014 and Amendments to the HHS Notice of Benefit and Payment Parameters for 2014; Final Rules; Patient Protection and Affordable Care Act; Establishment of Exchange and Qualified Health Plans; Small Business Health Options Program; Proposed Rule, 78 FR 15410 (March 11, 2013) (2014 Payment Notice); and the 2015 Payment Notice, 79 FR 13743.
[15] See supra notes 5 and 14.
[16] See supra note 5.
[17] See 45 C.F.R. §§ 153.420 and 153.700.
[18] While Connecticut elected to operate the RI program for BY 2014, issuers in Connecticut leveraged the EDGE server data submission process.
[19] See 45 C.F.R. § 153.420(b). CMS extended the BY 2014 deadline to May 15, 2015; see supra note 6.

HHS established audit protocols to assess health insurance issuers' compliance with the following regulations governing the RI program:

- 45 C.F.R. § 153.410: Requests for reinsurance payment;
- 45 C.F.R. § 153.420: Data collection; and
- 45 C.F.R. § 153.700, et seq.: Distributed data collection for HHS-Operated Programs.

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

2. Objectives

The objectives of this audit are to:

(1) Evaluate issuer-submitted enrollment and claims files against applicable federal RI program requirements for compliance and completeness;
(2) Assess validity and compliance of issuer-submitted plan reference data and associated enrollee data;
(3) Evaluate whether issuer-submitted data supports the BY 2014 RIDE Report[20] data at the enrollee level;
(4) Evaluate accuracy of the RI payments (not including the coinsurance rate), as calculated by the EDGE server,[21] in instances where there is a deviation in the detailed enrollee and claims submission to the EDGE server;
(5) Assess issuer controls, policies, and procedures surrounding RI data submissions to the EDGE server; and
(6) Assess compliance with maintenance of records requirements in 45 C.F.R. § 153.410(c) (i.e., 10 years of file retention).

3. Scope and Methodology

CMS selected Health Tradition for an audit to assess the issuer's compliance with the aforementioned federal transitional RI program regulations. CMS evaluated Health Tradition's activities related to the BY 2014 (January 1, 2014 through December 31, 2014) enrollee and claim-level data included in the BY 2014 RIDE Report, based on data submitted to the issuer's EDGE server prior to or on May 15, 2015, to support RI payments received.

CMS sent Health Tradition an electronic letter on November 29, 2018, to notify them of the scope of this audit. CMS's audit contractor sent a follow-up letter to Health Tradition on November 30, 2018, that identified data requirements for conducting the audit. CMS's audit contractor reviewed Health Tradition's documentation, including an issuer-provided data extract, and used CMS's applicable audit procedures to assess compliance with applicable federal transitional RI program rules and regulations.

CMS's audit contractor applied CMS's audit protocol to identify findings and observations. The contractor performed audit procedures on 100% of on-Exchange and off-Exchange enrollees

[20] The RIDE report contains enrollee-level plan and claim details used for the RI payment calculation and is made available only to issuers through EDGE servers.
[21] Issuer EDGE servers process enrollment and claims data according to the EDGE Server Business Rules (ESBR) to select claims to be included in RI payment calculations. See 45 C.F.R. §§ 153.410, 153.420, 153.700, 153.710, and 153.720.

who received BY 2014 RI payments, as well as, on 10% of the issuer's total RI-eligible enrollee population who did not receive RI payments. *(Note: Any discrepancies identified for RI-eligible enrollees who did not receive RI payments will result in an observation and therefore do not have financial impact).* CMS's audit procedures included the following:

(1) **Unreconciled Claims Review**: Review and comparison of the unique claim IDs included in the issuer's BY 2014 RIDE Report to the unique claim IDs included in the issuer's data extract to determine existence.
(2) **RI Eligible Plan[22] Review**: Review the issuer's claims in the data extract to those in the BY 2014 RIDE Report to validate whether the claims were associated with an RI eligible plan.
(3) **BY 2014 Claim Validation**: Review the issuer's claims start and end dates in the data extract to validate whether the claims fell within BY 2014 and were not cross-year claims from a prior year.
(4) **Claim Paid Date Validation**: Review the issuer's claims data extract payment date to validate the BY 2014 claims were paid as of CMS's BY 2014 extended deadline for EDGE data submissions of May 15, 2015.
(5) **Claim Coverage Period Validation**: Review the issuer's claims in the data extract to the coverage period in the BY 2014 RIDE Report to determine whether the claim start date is within the enrollee's coverage period.
(6) **Paid Claim Amount Validation**: Review the issuer's claims in the data extract to validate the paid claim amount matches the paid claim amount in the issuer's BY 2014 RIDE Report.
(7) **Issuer Policies and Procedures Review**: Determine whether the issuer's policies and procedures comply with applicable CMS rules, regulations, and policies related to the transitional RI program.
(8) **Issuer Attestation Review:** Validate that the issuer provided a completed attestation signed by the Chief Executive Officer (CEO), Chief Financial Officer (CFO) or other authorized official who has reviewed the documentation submitted for this audit. This procedure was reviewed to substantiate the accuracy of the documentation submitted during the audit process and did not result in a finding or observation for the issuer.

B. RESULTS OF REVIEW

CMS assessed Health Tradition's compliance with applicable federal rules and regulations related to the transitional RI program using the following procedures: Unreconciled Claims Review, RI Eligible Plan Review, Benefit Year 2014 Claim Validation, Claim Paid Date Validation, Claim Coverage Period Validation, Paid Claim Amount Validation, and Issuer RI Policies and Procedures Review. Below are the results of this review.[23]

(1) Unreconciled Claims Review

One (1) finding and one (1) observation resulted from the review of Health Tradition's data extract to determine if the claims reported on the BY 2014 RIDE Report existed in the data

[22] See supra note 13.
[23] This review was based on the BY 2014 RIDE Report titled: 47342.RIDE.D20150518T114621.P.xml.

extract. Please refer to Finding No. 1 and Observation No. 1 included in Sections II.C and II.D below for details on the finding and observation.

(2) RI Eligible Plan Review

No observations resulted from the review of Health Tradition's data extract to determine if the plan ID was for an RI-eligible plan and matched the plan ID reported in the issuer's BY 2014 RIDE Report.

(3) BY 2014 Claim Validation

No findings and no observations resulted from the review of Health Tradition's data extract to determine if claims were incurred in BY 2014.

(4) Claim Paid Date Validation

No findings and no observations resulted from the review of Health Tradition's data extract to determine if the BY 2014 claim was paid by the issuer before the EDGE Server cut-off date of May 15, 2015.

(5) Claim Coverage Period Validation

No findings and no observations resulted from the review of Health Tradition's data extract to determine if the service begin date of claims were within the enrollee's coverage period.

(6) Paid Claim Amount Validation

No findings and no observations resulted from the review of Health Tradition's data extract to determine if the claim paid amount matched the corresponding claim paid amount in the issuer's BY 2014 RIDE Report.

(7) Issuer RI Policies and Procedures Review

No observations resulted from the review of Health Tradition's RI policies and procedures to determine compliance with applicable CMS rules, regulations, and policies.

C. FINDINGS

A finding results from the discovery of evidence confirming or suggesting non-compliance with applicable federal[24] requirements and requires a recoupment of all or part of the RI payment. For BY 2014, an enrollee must have had claims paid by the issuer in an amount that fell between the attachment point of $45,000 and the cap of $250,000. The amount of total paid claims was then required to be adjusted downward for enrollees for whom the issuer was also receiving a 2014 advance CSR payment [a process collectively referred to as the CSR Maximum Out-of-Pocket (MOOP) adjustment]. CMS's audit contractor considered both the MOOP adjustment amounts reported in the issuer's BY 2014 RIDE Report, as well as the paid claim amount differences identified from the claim-level audit procedures, for purposes of determining Health Tradition's RI financial impact.

Based on the claim-level audit procedures performed, one (1) finding was identified for enrollees associated with a BY 2014 RI payment. These claim-level procedures resulted in a total of $1,001.39 paid claim amount differences, and the differences were further aggregated at the

[24] See supra note 21.

enrollee level for final recalculation of the issuer's BY 2014 RI payments, which resulted in a financial impact of $1,001.39. Please refer to Appendix 4 to view the aggregated amount of paid claim differences associated with each audit procedure, as well as the enrollee level results used for calculating the "Total Financial Impact" amount shown in the table below.

	Total RI Payment Amount
Total RI Payments per Health Tradition's BY 2014 RIDE Report	$4,487,321.80
Total RI Payments as Recalculated	$4,486,320.41
Total Financial Impact[25]	$1,001.39

The financial impact of the one (1) finding is subject to recoupment by HHS in the amount of $1,001.39.

CMS's audit contractor documented the condition, criteria, cause, effect, and corrective action for these findings as shown in the table below. The issuer's management response will be added once the issuer has reviewed the report and provided its response.

[25] Financial impact derived from BY2014 RI Program audits only includes findings where funds are subject to recoupment by HHS. These amounts will be collected as part of the monthly payment cycle consistent with 45 C.F.R. § 156.1210 and the netting regulation at 45 C.F.R. § 156.1215. If all or part of the adjustment amount was unable to be netted, the remaining adjustment amount is a determination of a debt that is owed to the federal government. 45 C.F.R. § 156.1215(c). Please refer to Appendix 4 for additional details on this computation.

Finding No. 1 – Unreconciled Claims Review	
Condition:	Health Tradition's BY 2014 RIDE Report include 31 claims that were not reported in Health Tradition's data extract, resulting in a difference of $1,001.39 in claim paid amounts.
Criteria:	Eligible claims submitted to the EDGE Server for RI payment only include claims the issuer can substantiate in its claims system. See 45 C.F.R. §§ 153.410, 153.420 and 153.710. See the 2014 Payment Notice.
Cause:	The issuer indicated, "Health Tradition is unable to find RX claim within our claims database. Claim may have been reprocessed." The issuer could not provide supporting documentation to determine the existence of these claims, and therefore they should not have been submitted to the EDGE server.
Effect:	The inclusion of the 31 unreconciled claims in the BY 2014 RIDE Report resulted in a change to the issuer's final BY 2014 RI payments.
Corrective Action Required:	The financial impact of this finding includes a total of $1,001.39 in claim paid amount differences. Please refer to the RI Financial Impact table and Appendix 4 for further details on the calculation of the final financial impact including the differences noted from each finding and the related RI payment impact. Health Tradition should confirm this financial impact and its agreement (or disagreement) with this finding, as indicated in Section III of this report. If finalized, HHS will recoup the adjustment amount as part of the monthly payment cycle consistent with 45 C.F.R. § 156.1210 and the netting regulation at 45 C.F.R. § 156.1215. If all or part of the adjustment amount was unable to be netted, the remaining adjustment amount is a determination of a debt that is owed to the federal government. See 45 C.F.R. § 156.1215(c).
Issuer Management Response:	We acknowledge and agree with the findings.

D. OBSERVATIONS

An observation results from the identification of areas for improvement when there is no evidence of actual non-compliance with applicable federal requirements or when there may be evidence of non-compliance with applicable RI program federal requirements that does not require recoupment of RI payments. For example, observations include claim level discrepancies identified within the issuer's claims data extract and the issuer's BY 2014 RIDE Report, associated with RI eligible enrollees or RI payment enrollees where the claim adjustment would not result in recoupment of RI payments. We are making Health Tradition's management aware by bringing the identified observation to their attention.

For the one (1) observation identified, CMS documented the condition, criteria, cause, and effect as shown in the tables below. The issuer's management response will be added once the issuer has reviewed the report and provided its response.

Observation No. 1 – Unreconciled Claims Review	
Condition:	Health Tradition's BY 2014 RIDE Report included five (5) claims that were not reported in Health Tradition's data extract. There is no impact to the BY 2014 RI payment attributable to the enrollee for these claims because the total paid claims amount did not meet the RI payment parameters, the paid claims were not selected for the BY 2014 RI calculations or would not otherwise result in a recoupment of BY 2014 RI payments.
Criteria:	Eligible claims submitted to the EDGE Server for RI payment only include claims the issuer can substantiate in its claims' system. See 45 C.F.R. §§ 153.410, 153.420 and 153.710. See the 2014 Payment Notice.
Cause:	The issuer indicated, "Health Tradition is unable to find RX claim within our claims database. Claim may have been reprocessed." The issuer could not provide supporting documentation to determine the existence of these claims, and therefore they should not have been submitted to the EDGE server.
Effect:	The inclusion of the five (5) unreconciled claims in the BY 2014 RIDE Report resulted in an observation and no change to the issuer's final BY 2014 RI payments.
Issuer Management Response:	We acknowledge and agree with the findings.

III. ISSUER MANAGEMENT RESPONSES

Health Tradition's management's response to the one (1) finding and one (1) observation identified in the draft audit report and the completed attached Appendix 1 - Issuer Management Response to Financial Recoupment Adjustment (Appendix 1), **is due within thirty (30) calendar days from the date of this draft audit report.** Health Tradition's management's response should indicate agreement or disagreement. If CMS does not receive Health Tradition's management response within this timeframe, we will assume your management's agreement and issue the final published audit report.

Agreement

If Health Tradition's management agrees with the reported finding and observation, the issuer should complete the respective "Issuer Management Response" field in the draft audit report, and initial "Agree" and sign the attached Appendix 1.

Disagreement

If Health Tradition's management disagrees with the reported finding and corrective actions and the observation, the issuer should complete the respective "Issuer Management Response" field in the draft audit report, and initial "Disagree" and sign the attached Appendix 1.

CMS will review the written explanations in the "Issuer Management Response" field of the findings and observations to determine if the report can be amended in a mutually-acceptable manner. If the issuer and CMS are unable to come to a mutually-acceptable result, the issuer's response to this report will be included in the final published audit report. CMS maintains final discretion to determine whether amendments to the report are appropriate.

Regardless of whether the issuer agrees or disagrees with the reported finding(s) and observation(s), Health Tradition's management should return the draft audit report including Appendix 1 within thirty (30) calendar days from the date of this draft audit report. This report will be the final opportunity to provide information to correct any inaccuracies in the report before it is finalized. CMS will provide a final audit report and publish the report on the Center for Consumer Information and Insurance Oversight (CCIIO) website, including the stated final adjustment recoupment amount along with an updated Appendix 1, after receipt of Health Tradition's management's response. CMS will finalize and process the final adjustment recoupment amount consistent with 45 C.F.R. § 156.1210 and the netting regulation at 45 C.F.R. § 156.1215 in the next available monthly payment cycle. If all or part of the adjustment amount was unable to be netted, the remaining adjustment amount is a determination of a debt that is owed to the federal government. See 45 C.F.R. § 156.1215(c).

Appendix 1 – Issuer Management Response to Financial Recoupment Adjustment

Issuer ID: 47342

Issuer Name: Health Tradition Health Plan

Issuer Address:

The undersigned Chief Executive Officer (CEO), Chief Financial Officer (CFO), or other individual who possesses authority to legally and financially bind this issuer has reviewed the information included in the Audit Report of the issuer's compliance with applicable federal transitional RI program requirements for BY 2014 resulting in a recoupment amount of $1,001.39 related to the RI program.

(INITIAL) DMW Agrees with the audit adjustment recoupment amount above for this issuer's BY 2014 RI payment audit, confirming the audit finding(s), and as such this report will be considered a final audit report and will be published. If this option is selected, you must return this response within 30 calendar days of the date of this draft audit report.

Or

(INITIAL)_____Disagrees and requests a review of additional information that may impact the audit findings and adjustment recoupment amount resulting from the BY 2014 RI payment audit. If review is requested, CMS will consider this draft only a preliminary audit report. If this option is selected, you must provide a written explanation with any additional support documentation that could resolve the findings noted in this report, when you return this response within 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. CMS maintains final discretion to determine whether amendments to the report are appropriate.

Signed: Dawn M. Witek
(Signature of authorized person acting on behalf of the issuer)

Printed Name: Dawn M. Witek
(Print name of signature)

Title: Vice President of Accounting & Finance
(Title of authorized person acting on behalf of the issuer)

Telephone Number: 608-661-6784
(Direct Telephone Number)

Date: June 29, 2021

Appendix 2 – Applicable Regulations

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

Regulation	Guidance
45 C.F.R. § 153.410 – Requests for Reinsurance Payments	**(a)** ***General requirement.*** An issuer of a reinsurance-eligible plan may make a request for payment when that issuer's claims costs for an enrollee of that reinsurance-eligible plan has met the criteria for reinsurance payment set forth in subpart B of this part and the HHS notice of benefit and payment parameters and State notice of benefit and payment parameters for the applicable benefit year, if applicable. **(b)** ***Manner of request.*** An issuer of a reinsurance-eligible plan must make requests for payment in accordance with the requirements of the annual HHS notice of benefit and payment parameters for the applicable benefit year or the State notice of benefit and payment parameters described in subpart B of this part, as applicable. **(c)** ***Maintenance of records.*** An issuer of a reinsurance-eligible plan must maintain documents and records, whether paper, electronic, or in other media, sufficient to substantiate the requests for reinsurance payments made pursuant to this section for a period of at least 10 years, and must make those documents and records available upon request from HHS, the OIG, the Comptroller General, or their designees, or, in a State where the State is operating reinsurance, the State or its designee, to any such entity, for purposes of verification, investigation, audit, or other review of reinsurance payment requests. **(d)** ***Audits.*** HHS or its designee may audit an issuer of a reinsurance-eligible plan to assess its compliance with the requirements of this subpart and subpart H of this part. The issuer must ensure that its relevant contractors, subcontractors, or agents cooperate with any audit under this section. If an audit results in a finding of material weakness or significant deficiency with respect to compliance with any requirement of this subpart or subpart H, the issuer must complete all of the following: **(1)** Within 30 calendar days of the issuance of the final audit report, provide a written corrective action plan to HHS for approval.

Regulation	Guidance
	(2) Implement that plan. **(3)** Provide to HHS written documentation of the corrective actions once taken.
45 C.F.R. § 153.420 – Data Collection	**(a)** ***Data requirement.*** To be eligible for reinsurance payments, an issuer of a reinsurance-eligible plan must submit or make accessible all required reinsurance data in accordance with the reinsurance data collection approach established by the State, or by HHS on behalf of the State. **(b)** ***Deadline for submission of data.*** An issuer of a reinsurance-eligible plan must submit or make accessible data to be considered for reinsurance payments for the applicable benefit year by April 30 of the year following the end of the applicable benefit year.
45 C.F.R. § 153.700(a) – Distributed data environment	**(a)** ***Dedicated distributed data environments.*** For each benefit year in which HHS operates the risk adjustment or reinsurance program on behalf of a State, an issuer of a risk adjustment covered plan or a reinsurance-eligible plan in the State, as applicable, must establish a dedicated data environment and provide data access to HHS, in a manner and timeframe specified by HHS, for any HHS-operated risk adjustment and reinsurance program.
45 C.F.R. § 153.710(a)-(d) – Data requirements	**(a)** ***Enrollment, claims, and encounter data.*** An issuer of a risk adjustment covered plan or a reinsurance-eligible plan in a State in which HHS is operating the risk adjustment or reinsurance program, as applicable, must provide to HHS, through the dedicated data environment, access to enrollee-level plan enrollment data, enrollee claims data, and enrollee encounter data as specified by HHS. **(b).** ***Claims data*** All claims data submitted by an issuer of a risk adjustment covered plan or a reinsurance-eligible plan in a State in which HHS is operating the risk adjustment or reinsurance program, as applicable, must have resulted in payment by the issuer (or payment of cost sharing by the enrollee). **(c)** ***Claims data from capitated plans*****.** An issuer of a risk adjustment covered plan or a reinsurance-eligible plan in a State in which HHS is operating the risk adjustment or reinsurance program, as applicable, that does not generate individual enrollee claims in the normal course of business must derive the costs of all applicable provider encounters using its principal

Regulation	Guidance
	internal methodology for pricing those encounters. If the issuer does not have such a methodology, or has an incomplete methodology, it must supplement the methodology in a manner that yields derived claims that are reasonable in light of the specific service and insurance market that the plan is serving. **(d)** ***Final dedicated distributed data environment report.*** Within 15 calendar days of the date of the final dedicated distributed data environment report from HHS, the issuer must, in a format specified by HHS, either: (1) Confirm to HHS that the information in the final report accurately reflects the data to which the issuer has provided access to HHS through its dedicated distributed data environment in accordance with §153.700(a) for the benefit year specified in the report; or (2) Describe to HHS any discrepancy it identifies in the final dedicated distributed data environment report.
45 C.F.R. § 153.730 – Deadline for submission of data	A risk adjustment covered plan or a reinsurance-eligible plan in a State in which HHS is operating the risk adjustment or reinsurance program, as applicable, must submit data to be considered for risk adjustment payments and charges and reinsurance payments for the applicable benefit year by April 30 of the year following the applicable benefit year.

Appendix 3 – Acronyms

Terms & Acronyms	Definition
ACA	**Patient Protection and Affordable Care Act**
BY	Benefit Year
CEO	Chief Executive Officer
CFO	Chief Financial Officer
CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
CSR	Cost-Sharing Reduction
ECM	EDGE Calculation Module
EDGE	External Data Gathering Environment
ESBR	EDGE Server Business Rules
EOB	Explanation of Benefits
GAGAS	Generally Accepted Government Auditing Standards
HHS	Department of Health and Human Services
HIOS	Health Insurance Oversight System
MOOP	Maximum Out of Pocket
QHP	Qualified Health Plan
RI	Reinsurance
RIDE	RI Detail Enrollee

Appendix 4 – Enrollee-Level Calculation of RI Financial Impact

Based on the audit procedures performed, the identified paid claim amount differences have been aggregated to the enrollee level for calculation of the total financial impact to Health Tradition's RI payments for BY 2014. If CMS determined that an enrollee's total MOOP-adjusted paid claims fell below the BY 2014 attachment point of $45,000 after accounting for findings identified in the claim-level audit procedures, then the full amount of the enrollee's RI payment is subject to recoupment. If CMS determined there was a difference in the amount of paid claims for an enrollee, but the enrollee's total MOOP-adjusted paid claims remained between the attachment point and the cap after accounting for findings identified in the claim-level audit procedures, then the aggregate amount of the paid claim differences (MOOP adjusted) identified is subject to recoupment. If CMS determined that an enrollee's total MOOP-adjusted paid claims remained above the cap after accounting for findings identified in the claim-level audit procedures, then there was no change to the enrollee's RI payment and the enrollee's claims were not subject to recoupment (i.e., the enrollee remained eligible for the maximum BY 2014 RI payment of $205,000[26]). The results of the enrollee-level RI recalculations and the aggregated, total amounts are displayed in the table below.[27]

Summary Results:

	Financial Impact -Unreconciled Claims	**Final RI Payment Financial Impact**	
Total Claim Level Differences:	**$1,001.39**	**Total Financial Impact:**	**$1,001.39**

[26] The difference between the BY 2014 RI cap ($250,000) and the BY 2014 RI attachment point ($45,000) = $205,000. This is the maximum payment an issuer could receive for any RI Eligible enrollee for the BY 2014.

[27] See supra note 7.