



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

***for***

***Louisiana Health Service & Indemnity Company (Louisiana Health)***

***January 13, 2020***

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## I. EXECUTIVE SUMMARY

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### Background

Louisiana Health Service & Indemnity Company (Louisiana Health) is a health insurance issuer that offered qualified health plans (QHPs) in the individual market Federally-facilitated Exchange (FFE) in Louisiana during the 2015 benefit year. Louisiana Health submitted its final restated 2015 benefit year data in the November 2016 Enrollment and Payment Data Workbook (EPDW). The issuer received a total of \$117,044,222.28 in advance payments of the premium tax credit (APTC) from CMS and paid a total of \$6,872,400.01 in FFE user fees (UF) to CMS for its 2015 benefit year individual market plans.

This report is an assessment of Louisiana Health's compliance with the APTC and FFE user fee programs established in sections 1311 and 1401 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.

### Audits to Determine Compliance with the Administration of APTC and FFE User Fee Programs

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<sup>1</sup> issuers that offer a QHP in the individual market through an Exchange to assess the degree of compliance with the APTC and FFE user fee program requirements. HHS designates the Centers for Medicare & Medicaid Services (CMS) to conduct these audits and to achieve the following:

- 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 2015 EPDW, and to analyze controls and policies of selected issuers pursuant to the authority defined in the regulations.

The findings and observations are documented below. If CMS found an instance of issuer non-compliance with APTC and FFE user fee program requirements that requires correction to

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<sup>1</sup> 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.

payment, then CMS classified it as a *finding*. If CMS found a deviation from APTC and FFE user fee program 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 one (1) observation for Louisiana Health. The net financial impact of the three (3) audit findings is a payment to CMS of \$113,870.59, consisting of \$8,980.52 in FFE user fees returned to Louisiana Health and \$122,851.11 in APTC owed to CMS. The one (1) observation does not require correction to payments. The findings and observation include the following:

### **Findings:**

1. Differences in premium/FFE user fee and APTC amounts identified in the comparison of the issuer's data included in the EPDW to a UF/APTC Desk Audit File containing subscriber level data from Louisiana Health's systems;
2. Inclusion of full month enrollment and payment data for forty-one (41) duplicate subscribers in the UF/APTC Desk Audit File; and
3. Inclusion of the incorrect coverage period for one (1) subscriber in the UF/APTC Desk Audit File.

### **Observation:**

1. Reporting of a benefit end date and provision of benefit coverage based off internal processing rules for one (1) of the forty-five (45) selected subscribers in the UF/APTC Desk Audit File.

Please refer to sections IV and V for details on the findings and observation listed above, including the condition, cause, effect, corrective actions, and the issuer's responses.

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## **II. BACKGROUND, OBJECTIVES, SCOPE, AND METHODOLOGY**

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### **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 FFEs to charge participating issuers user fees to support FFE operations.

CMS has the responsibility to confirm successful implementation of, and adherence to, the PPACA provisions and implementing regulations governing the APTC and FFE user fee programs. As such, CMS established this audit program.

#### **Interim Payment Process**

Since automated payment systems were not yet developed during the first years of FFE implementation, CMS implemented an interim payment process to calculate and make monthly payments of APTC and advance Cost-sharing Reduction (CSR) amounts. The interim payment process required issuers to self-report enrollment and payment data 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.

For the 2015 benefit year, CMS used this interim payment process to calculate and make monthly payments based on 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 FFE User Fee amount
9. Total effectuated enrollment groups
10. Total effectuated enrollment groups with APTC
11. Total effectuated enrollment groups with advance CSR
12. Total effectuated members
13. Total effectuated members with APTC
14. Total effectuated members with advance CSR

FFE issuers were required to calculate the QHP enrollment and payment amounts and submit that information on the EPDW template using their internal source data.

## **B. Regulations Governing APTC and FFE User Fee Programs**

CMS established an audit protocol to assess health insurance issuers' compliance with the following regulations governing APTC and FFE user fee programs:

- 45 CFR § [156.50](#): Financial Support;
- 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;
- 45 CFR § [156.705](#): Maintenance of records for Federally-facilitated Exchanges.

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 issuer-generated EPDW data reported for the APTC and FFE user fee programs;
- (2) Identify potential CMS APTC payment and FFE user fee collection errors resulting from issuer data reporting errors; and
- (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 Louisiana Health for an audit on issuer compliance with the aforementioned regulations. CMS evaluated Louisiana Health's activities related to the 2015 benefit year (January 1, 2015 through December 31, 2015) individual market data reported on the final EPDW submitted in November 2016 by the issuer to CMS to support APTC and FFE user fee collections.

CMS sent Louisiana Health an electronic letter on May 11, 2018 to notify them of the scope of this audit. CMS's audit contractor sent a follow-up letter to Louisiana Health on May 14, 2018 that identified data requirements required to conduct the audit. CMS's audit contractor reviewed the audit data file submitted by Louisiana Health and used CMS's audit procedures to assess compliance with APTC and FFE user fee program rules and regulations.

CMS's audit contractor applied CMS's audit protocol to identify the findings and observations listed in sections IV and V of this report. CMS's audit contractor performed the following procedures:

- Validations of the UF/APTC Desk Audit File<sup>2</sup> data submitted to CMS:
  - EPDW Validations: Review and comparison of the issuer's final submitted 2015 EPDW to the UF/APTC Desk Audit File from the issuer's systems.
  - Unreconciled Subscribers Review: Review and comparison of the subscribers reported on the UF/APTC Desk Audit File to the subscribers included in CMS's systems 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 UF/APTC 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 on the file twice in the same month with full month or incorrectly prorated payment data) were not reported on the file.
  - Premium Less than APTC Validation: Review of the UF/APTC Desk Audit File to verify that the subscribers' premium amounts reported on the file were not less than the APTC amounts reported on the file.
  - Coverage Days Validation: Review of the UF/APTC Desk Audit File to verify that enrollments of five (5) days or fewer reported on 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 CMS's systems 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.

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<sup>2</sup> The UF/APTC Desk Audit File is CMS's standard document for issuers to provide information in support of this audit.

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### **III. RESULTS OF REVIEW**

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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. Below are the results of this review.

#### **EPDW Validations**

One (1) finding and no observations resulted from the comparison of the final 2015 EPDW to Louisiana Health's UF/APTC Desk Audit File. Please refer to Finding No. 1 included in section IV for details on the finding.

#### **Unreconciled Subscribers Review**

No findings or observations resulted from the review of Louisiana Health's UF/APTC Desk Audit File to determine if the subscribers reported on the file existed and their coverage was effectuated in the issuer's systems.

#### **Duplicate Exchange-assigned Subscriber IDs Check**

One (1) finding and no observations resulted from the review of Louisiana Health's UF/APTC Desk Audit File to verify that duplicate Exchange-assigned subscriber IDs were not reported on the file. Please refer to Finding No. 2 included in section IV for details on the finding.

#### **Premium Less than APTC Validation**

No findings or observations resulted from the review of Louisiana Health's UF/APTC Desk Audit File to verify that subscribers were not reported on the file with premium amounts that were less than the APTC amounts.

#### **Coverage Days Validation**

One (1) finding and no observations resulted from the review of Louisiana Health's UF/APTC Desk Audit File to verify that enrollments of five (5) days or fewer reported on the file were effectuated and had active coverage in the issuer's systems. Please refer to Finding No. 3 included in section IV for details on the finding.

#### **Forty-five (45) Subscribers Sample Review**

No findings and one (1) observation resulted from the review and comparison of the data from Louisiana Health's systems to the corresponding data included in CMS's systems to determine accuracy of the reported enrollment months and the application of premium and APTC for a selected sample of forty-five (45) subscribers. Please refer to Observation No. 1 included in section V for details on the observation.

#### **Fifteen (15) Subscribers Sample Review**

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

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## IV. FINDINGS

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A finding is an 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 three (3) findings that resulted in a change to Louisiana Health's reported EPDW for individual market plans for the 2015 benefit year. In light of the three (3) findings, the adjusted 2015 benefit year EPDW APTC and FFE user fee amounts for individual market plans are shown in the following table.

### Recalculated EPDW for the 2015 Benefit Year

	FFE User Fees	APTC
EPDW as Filed in November 2016	\$(6,872,400.01)	\$117,044,222.28
Finding No. 1 - EPDW Validations Adjustment	\$6,560.72	\$(72,048.28)
Finding No. 2 – Duplicate Exchange-assigned Subscriber IDs Check Adjustment	\$2,429.95	\$(51,005.09)
Finding No. 3 - Coverage Days Validation Adjustment	\$(10.15)	\$202.26
EPDW As Recalculated	\$(6,863,419.49)	\$116,921,371.17
<b>Total Financial Impact</b>	<b>\$8,980.52</b>	<b>\$(122,851.11)</b>

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

The net financial impact of the three (3) audit findings is a payment to CMS of \$113,870.59, consisting of \$8,980.52 in FFE user fees returned to Louisiana Health and \$122,851.11 in APTC owed to CMS.

For the three (3) audit findings, CMS documented the criteria, cause, effect, corrective actions, and Louisiana Health's responses as seen in the charts below.

<b>Finding No. 1 - EPDW Validations</b>	<b>Condition:</b>	<p><b>Premium and FFE User Fee Differences</b> – For one or more months of 2015 benefit year enrollment in twenty-nine (29) QHPs, the net "Total Premium Amount by QHP ID for effectuated enrollments" included in Louisiana Health's EPDW was greater than the total premium amount included in Louisiana Health's UF/APTC Desk Audit File, resulting in an overstatement of \$187,449.05 in premiums and therefore an overpayment of \$6,560.72 in FFE user fees. For the one or more months of 2015 benefit year enrollment in twenty-nine (29) QHPs, the EPDW was overstated by two hundred and eighty-eight (288) enrollment groups and three hundred and eighty-five (385) members.</p> <p><b>APTC Differences</b> – For one or more months of 2015 benefit year enrollment in twenty-two (22) QHPs, the net "Total APTC Amount by QHP ID for effectuated enrollments" included in Louisiana Health's EPDW was greater than the total APTC amount included in Louisiana Health's UF/APTC Desk Audit File, resulting in an overpayment of \$72,048.28 in APTC. For the one or more months of 2015 benefit year enrollment in twenty-two (22) QHPs, the EPDW was overstated by one hundred and ten (110) APTC enrollment groups and one hundred and fifty-six (156) APTC members.</p>
	<b>Criteria:</b>	<p>Per CMS guidance and EPDW submission requirements:</p> <p>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" and the Total User Fee Amount by QHP ID is "the total FFE user fee amount the issuer can expect to incur for participation in the Federally-facilitated Exchange."</p> <p>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."</p>

		Additionally, the premium and APTC amounts reported in the EPDW and in the enrollment group enrollment records of the UF/APTC Desk Audit File must be prorated using the proration formulas set forth in the 2015 payment notice and outlined in 45 CFR § 155.240.
	<b>Cause:</b>	The issuer indicated that “The reasons for these discrepancies are very likely to be timing related. Retroactive adjustments to enrollment data occur frequently and can often times continue years into the future after the end of a benefit year. Therefore, these types of timing differences are expected when there is such a big difference in the timing of the data cuts. Specifically, the final, restated 2015 benefit year EPDW workbook was created by BCBSLA and was submitted to CMS in November of 2016. On the other hand, the UF/APTC Desk Audit File was created and submitted in mid-2018.”
	<b>Effect:</b>	The premium/FFE user fee and APTC differences resulted in a change to Louisiana Health’s final, restated 2015 benefit year EPDW data.
	<b>Corrective Action Required:</b>	The net financial impact of this finding is a payment to CMS of \$65,487.56, consisting of \$6,560.72 in FFE user fees returned to Louisiana Health and \$72,048.28 in APTC owed to CMS. Louisiana Health should confirm the financial impact and coordinate on resolution with CMS as indicated in section VI.
	<b>Management Response:</b>	In 2015, APTC policies were not rebilled timely. In 2016, process documents were updated to include a rebill step for any manual or electronic change to an on-exchange policy with a subsidy.

<b>Finding No. 2 - Duplicate Exchange-assigned</b>	<b>Condition:</b>	Louisiana Health overstated the 2015 benefit year premium amounts for forty-one (41) subscribers, and overstated the 2015 benefit year APTC amounts for thirty-nine (39) of those subscribers, in the UF/APTC Desk Audit File by reporting
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<b>Subscriber IDs Check</b>		enrollment and full month payment data for the subscribers more than once in the same month.
	<b>Criteria:</b>	Issuers cannot request full month payment from CMS for the same subscriber twice within a month. Additionally, per the HHS Notice of Benefit and Payment Parameters for 2015 and 45 CFR § 155.240, in a Federally-facilitated Exchange, the premium for coverage lasting less than one month must equal the product of (i) The premium for one month of coverage divided by the number of days in the month; and (ii) The number of days for which coverage is being provided in the month.
	<b>Cause:</b>	<p>The issuer indicated the following responses for each of the forty-one (41) subscribers:</p> <ul style="list-style-type: none"> <li>• “Both contracts are for the same member. [Issuer provided contract A] was active from [issuer provided coverage period of X/X/201X-X/X/2015]. [Issuer provided contract B] was active from [issuer provided coverage period of X/X/201x-X/X/2015]. [Issuer provided contract X] was the duplicate contract (with the subsidy of \$[issuer provided dollar value]).” (Thirteen (13) subscribers)</li> <li>• “[Issuer provided contract A] was active from [issuer provided coverage period of X/X/201X-X/X/2015]. [Issuer provided contract B] was active from [issuer provided coverage period of X/X/201X-X/X/2015]. [Issuer provided contract X] was the duplicate contract (with the subsidy amount of \$[issuer provided dollar value]).” (Twenty-eight (28) subscribers)</li> </ul> <p>Based on the feedback, CMS concluded that the 2015 benefit year premium and APTC amounts reported for the forty-one (41) subscribers in the UF/APTC Desk Audit File were overstated. The issuer indicated which contract was the confirmed duplicate to inform the financial impact.</p>
	<b>Effect:</b>	The inclusion of the forty-one (41) duplicate subscribers resulted in a change to Louisiana

		Health's final, restated 2015 benefit year EPDW data.
	<b>Corrective Action Required:</b>	The net financial impact of this finding is a payment to CMS of \$48,575.14, consisting of \$2,429.95 in FFE user fees returned to Louisiana Health and \$51,005.09 in APTC owed to CMS. Louisiana Health should confirm the financial impact and coordinate on resolution with CMS as indicated in section VI of this report.
	<b>Management Response:</b>	<p>The following example summarizes the primary cause of this issue:</p> <p>Two policies were received for Jane and Jack with a 1/1/2015 effective date. One policy identified Jane as the subscriber, the other Jack as the subscriber. Jane's policy terminated on 1/31/2015 for non-payment of premiums.</p> <p>In 2019, CMS reported a possible Subscriber Swap Issue during Open Enrollment. At this time, a duplicate policy report was created to correct these scenarios.</p>

<b>Finding No. 3 - Coverage Days Validation</b>	<b>Condition:</b>	Louisiana Health understated the 2015 benefit year premium and APTC amounts for one (1) subscriber in the UF/APTC Desk Audit File by reporting the incorrect coverage period.
	<b>Criteria:</b>	Per CMS guidance and EPDW submission requirements, the issuer must create a single Inbound UF/APTC Desk Audit File consisting of detailed enrollment group effectuated enrollment records (one per enrollment group, per month) with the corresponding payment data.
	<b>Cause:</b>	The issuer indicated "Issuer error-Policy should have been termed for 01/31/2015 but was termed 01/01/2015." The issuer further indicated "This was a manual keying error we don't suspect it impacts any other enrollments. Premium amount was \$299.78 and the APTC amount was \$209."

		Based on the feedback that there was a manual keying error, CMS concluded that the 2015 benefit year premium and APTC amounts reported for the one (1) subscriber in the UF/APTC Desk Audit File were understated. The issuer provided the correct premium and APTC amounts and coverage period to inform the financial impact.
	<b>Effect:</b>	The inclusion of the incorrect benefit end date for the subscriber resulted in a change to Louisiana Health's final, restated 2015 benefit year EPDW data.
	<b>Corrective Action Required:</b>	The net financial impact of this finding is a payment to Louisiana Health of \$192.11, consisting of \$10.15 in FFE user fees owed to CMS and \$202.26 in APTC paid to Louisiana Health. Louisiana Health should confirm the financial impact and coordinate on resolution with CMS as indicated in section VI of this report.
	<b>Management Response:</b>	In 2015, our process document was updated to follow the termination date provided by CMS.

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## V. OBSERVATIONS

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An observation is a deviation from APTC and FFE user fee program 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 one (1) observation.

<b>Observation No. 1 – Forty-five (45) Subscribers Sample Review</b>	<b>Condition:</b>	Louisiana Health reported a benefit end date and provided benefit coverage for one (1) of the forty-five (45) selected subscribers in the UF/APTC Desk Audit File based off internal processing rules instead of CMS enrollment and termination guidance.
	<b>Criteria:</b>	<p>Per CMS guidance, the issuer must create a single Inbound UF/APTC Desk Audit File consisting of detailed enrollment group effectuated enrollment records (one per enrollment group, per month) with the corresponding enrollment and payment data.</p> <p>Per 45 CFR § 156.270, a QHP issuer may only terminate coverage as permitted by the Exchange in accordance with § 155.430 and QHP issuers must abide by the termination of coverage effective dates described in § 155.430(d).</p>
	<b>Cause:</b>	<p>The issuer indicated that "CMS sent a transaction to term the policy effective 01/20/2015. However, at the time we were only terming policies for the last day (01/31) of the month or the 14th (01/14) which is what we considered mid-month. We were not terming policies for odd term dates example: 01/20, so the policy was termed effective 01/31/2015."</p> <p>The issuer also noted that "Proration is based on the termination effective date that is in our system, however, that date does not always match up to the termination date received from CMS due to Blue Cross using the internal processing rules for Off Exchange Termination dates in error instead of using the exact termination date CMS submitted. This process has since been fixed." Upon review of the issuer's UF/APTC Desk Audit File, it was noted that mid-month termination dates were reported for other enrollments reported on the file.</p>



		The issuer further clarified that "the desk audit should not include an end date of 1/20/15 with the prorated financial amounts but should match what is currently in our Enrollment/Billing system of 1/31/15. The information in the desk audit file matches our Enrollment/Billing System. Generally, applying mid-month terminations are not the norm in these instances. We are unaware of any other subscribers with incorrect end dates. The desk audit file should include what is currently reported which matches our Enrollment/Billing System."
	<b>Effect:</b>	The issuer did not follow CMS enrollment and termination guidance and requirements as the enrollee had coverage through the termination date as established by internal processing rules for termination dates.
	<b>Management Response:</b>	In 2015, our process document was updated to follow the termination date provided by CMS.

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## **VI. MANAGEMENT RESPONSES**

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Please provide management's response to the three (3) findings and one (1) observation 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 one (1) observation, complete the "Management Response" field of the findings and observation 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. CMS will process the final adjustment amount in the next available monthly payment cycle.

### **Disagreement**

If management disagrees with any of the three (3) findings and corrective actions or the one (1) observation, complete the "Management Response" field of the findings and observation 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 observation 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 will provide an updated audit report, including the stated final adjustment amount along with an updated Appendix 1, following receipt and review of management's response. Please return the updated audit report with management responses and signed Appendix 1 within fifteen (15) calendar days. Upon receipt of the signed Appendix 1, CMS will finalize and publish the report and process the final adjustment amount in the next available monthly payment cycle.

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

Issuer HIOS ID: 97176


Issuer Name: Louisiana Health Service & Indemnity Company (Louisiana Health)

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 2015 benefit year APTC and FFE UF program participation, resulting in a payment to CMS of \$113,870.59, consisting of \$8,980.52 in FFE user fees returned to Louisiana Health and \$122,851.11 in APTC owed to CMS, and:

(INITIAL) BL 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 2015 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:   
(Signature of authorized person acting on behalf of the issuer.)

Printed Name: Bryan Camerlinck  
(Print name of signature)

Title: Executive Vice President & Chief Financial & Operations Executive  
(Title of authorized person acting on behalf of the Issuer)

Telephone Number: 225-295-2537  
(Direct Telephone Number)

Date: 2 / 11 / 2020

## Appendix 2 – Applicable Regulations

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

Regulation	Guidance
<b>45 CFR § 156.50 – Financial Support</b>	<p><b>(a) Definitions.</b> The following definitions apply for the purposes of this section:</p> <p><i>Participating issuer</i> means any issuer offering a plan that participates in the specific function that is funded by user fees. This term may include: health insurance issuers, QHP issuers, issuers of multi-State plans (as defined in § 155.1000(a) of this subchapter), issuers of stand-alone dental plans (as described in § 155.1065 of this subtitle), or other issuers identified by an Exchange.</p> <p><b>(b) Requirement for State-based Exchange user fees.</b> A participating issuer must remit user fee payments, or any other payments, charges, or fees, if assessed by a State-based Exchange under § 155.160 of this subchapter.</p> <p><b>(c) Requirement for Federally-facilitated Exchange user fee.</b> To support the functions of Federally-facilitated Exchanges, a participating issuer offering a plan through a Federally-facilitated Exchange must remit a user fee to HHS each month, in the timeframe and manner established by HHS, equal to the product of the monthly user fee rate specified in the annual HHS notice of benefit and payment parameters for the applicable benefit year and the monthly premium charged by the issuer for each policy under the plan where enrollment is through a Federally-facilitated Exchange.</p>
<b>45 CFR § 156.460 - Reduction of enrollee's share of premium to account for advance payments of the premium tax credit</b>	<p><b>(a) Reduction of enrollee's share of premium to account for advance payments of the premium tax credit.</b> 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—</p> <ol style="list-style-type: none"> <li>(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;</li> <li>(2) Notify the Exchange of the reduction in the portion of the premium charged to the individual in accordance with § 156.265(g); and</li> <li>(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.</li> </ol>

Regulation	Guidance
<p><b>45 CFR § 156.480 - Oversight of the administration of the cost-sharing reductions and advance payments of the premium tax credit programs.</b></p>	<p><b>(a) Maintenance of records.</b> 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.</p> <p><b>(b) Annual reporting requirements.</b> 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.</p> <p><b>(c) Audits.</b> 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.</p>
<p><b>45 CFR § 156.705 – Maintenance of records for Federally-facilitated Exchanges</b></p>	<p><b>(a) General standard.</b> 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:</p> <p><b>(1)</b> 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</p> <p><b>(2)</b> 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.</p> <p><b>(b) Records.</b> The records described in paragraph (a) of this section include the sources listed in § 155.1210(b)(2), (3), and (5) of this subchapter.</p> <p><b>(c) Record retention timeframe.</b> Issuers offering QHPs in a Federally-facilitated Exchange must maintain all records referenced in paragraph (a) of this section for 10 years.</p> <p><b>(d) Record availability.</b> 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.</p>

### Appendix 3 – Glossary of Terms and Acronyms

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