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

for

Medica Health Plans of Wisconsin (Minnesota)

March 30, 2022

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I. EXECUTIVE SUMMARY

Background

Medica Health Plans of Wisconsin (Medica) is a health insurance issuer that offered qualified health plans (QHPs) in the individual market State-Based Exchange (SBE) in Minnesota during the 2016 benefit year. Medica submitted its final restated 2016 benefit year data in the October 2018 Enrollment and Payment Data Workbook (EPDW). The issuer received a total of $29,949,359.23 in advance payments of the premium tax credit (APTC) from the Centers for Medicare & Medicaid Services (CMS) and reported a total of $71,726,053.06 in premiums for its 2016 benefit year individual market plans.

This report is an assessment, conducted in coordination with the SBE, of Medica's compliance with the APTC program established in sections 1401 and 1412 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. This report also details the results of the assessment of premiums for information purposes only as CMS did not charge user fees to issuers offering QHPs through SBEs during the 2016 benefit year.

Audits to Determine Compliance with the Administration of APTC Program

Under title 45 of the Code of Federal Regulations (CFR) sections §§ 155.1210 and 156.480, the Department of Health and Human Services (HHS) may audit[1] issuers that offer a QHP in the individual market through an Exchange to assess the degree of compliance with the APTC program requirements. HHS designates CMS to conduct these audits and to achieve the following objectives:

- 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 in the final 2016 EPDW submitted by the issuer, and to analyze controls and policies of selected issuers pursuant to the authority defined in 45 CFR §§ 155.1210 and 156.480.

[1] 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.

The findings and observations are documented below. If CMS found an instance of issuer non-compliance with APTC program requirements that requires correction to the APTC reported in the final EPDW, then CMS classified it as a *finding*. If CMS found a deviation from CMS or Exchange 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 four (4) findings and four (4) observations for Medica. The net APTC financial impact of the four (4) findings is an overstatement of $43,138.43 in APTC in the final EPDW and therefore a payment to CMS of $43,138.43, consisting of APTC owed to CMS. The net premium impact of the four (4) observations is an understatement of $2,202.79 in premiums in the final EPDW. The findings and observations include the following:

Findings:

1. Differences in APTC amounts identified in the comparison of the issuer's data included in the October 2018 EPDW submitted by Medica to a Payment Desk Audit File containing subscriber level data from Medica's systems;
2. Inclusion of enrollment and full month APTC payment data for one duplicate subscriber in the Payment Desk Audit File;
3. Inclusion of premium amounts that were less than the APTC amounts and therefore incorrect APTC amounts for thirty-four (34) subscribers in the Payment Desk Audit File; and
4. Inclusion of an incorrect APTC amount in error for one (1) of the forty-five (45) selected subscribers in the Payment Desk Audit File.

Observations:

1. Differences in premium amounts identified in the comparison of the issuer's data included in the October 2018 EPDW submitted by Medica to a Payment Desk Audit File containing subscriber level data from Medica's systems;
2. Inclusion of enrollment and full month premium data for one duplicate subscriber in the Payment Desk Audit File;
3. Inclusion of premium amounts that were less than the APTC amounts and therefore incorrect premium amounts for one (1) subscriber in the Payment Desk Audit File; and
4. Billing of $0.00 premiums and reporting of premium amounts that were less than the APTC amounts for two (2) subscribers in the Payment Desk Audit File as the issuer received an incorrect premium rate and did not receive an updated APTC amount from the SBE.

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

II. BACKGROUND, OBJECTIVES, SCOPE, AND METHODOLOGY

A. Background

Sections 1401 and 1412 of the PPACA established the APTC program to support the provision of affordable health care coverage to individuals.

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

Interim Payment Process

In 2014, CMS implemented a temporary process ("interim payment process") to calculate and make monthly payments of APTC and advance cost-sharing reduction (CSR) amounts. CMS used this interim payment process to calculate payments for all SBE issuers for the 2014-2017 benefit years. CMS transitioned most SBE issuers to policy-based payments (PBP) in 2018 and transitioned the last SBE to PBP in 2020.

For the 2016 benefit year, the interim payment process required SBE issuer submitters, including issuers in Minnesota, 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. SBE issuer submitters were required to calculate the QHP enrollment and payment amounts and to submit that information in the EPDW using their internal source data.

CMS calculated and made monthly payments based on the 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 effectuated enrollment groups
9. Total effectuated enrollment groups with APTC
10. Total effectuated enrollment groups with advance CSR
11. Total effectuated members
12. Total effectuated members with APTC
13. Total effectuated members with advance CSR

CMS conducted a SBE payment close-out process for the 2016 benefit year in which CMS compared the EPDW data against the policy-level reporting (PLR) data submitted by the SBE. The PLR data was based on the monthly submissions that SBEs sent to the Internal Revenue Service (IRS) for reporting purposes and contained cumulative individual market enrollment APTC data. CMS requested that SBEs append an additional filed for the QHP ID for each policy and separately submit these data to CMS for this purpose. CMS asked SBE or SBE issuers to explain any outlier discrepancies between EPDW and PLR data and to re-submit the EPDW, if necessary, or to verify that payment data was accurate despite discrepancies with PLR data.

B. Regulations Governing APTC Program

CMS established an audit protocol to assess health insurance issuers' compliance with the following regulations governing APTC program:

- 45 CFR § 155.1210: Maintenance of Records;
- 45 CFR § 156.460: Reduction of enrollee's share of premium to account for advance payments of the premium tax credit; and
- 45 CFR § 156.480: Oversight of the administration of the cost-sharing reductions and advance payments of the premium tax credit programs.

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 premiums and the APTC program;
(2) Identify potential CMS APTC payment errors resulting from issuer data reporting errors;
(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 Medica for an audit to assess the issuer's compliance with 45 CFR §§ 155.1210, 156.460 and 156.480. CMS evaluated Medica's activities related to the 2016 benefit year (January 1, 2016 through December 31, 2016) individual market data reported in the final EPDW submitted in October 2018 by the issuer to CMS to support APTC payments and premium amounts.

CMS sent Medica an electronic letter on December 19, 2019 to notify them of the scope of this audit. CMS's audit contractor sent a follow-up letter to Medica on December 20, 2019 that identified data requirements required to conduct the audit. CMS's audit contractor reviewed the audit data file submitted by Medica, as well as the final 2016 EPDW submitted by the issuer to CMS and the PLR data submitted by the SBE to CMS, and used CMS's audit procedures to assess compliance with APTC program rules and regulations[2].

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

- Validations of the Payment Desk Audit File[2] data submitted to CMS:
    - EPDW Validations: Review and comparison of the issuer's final submitted 2016 EPDW to the Payment Desk Audit File from the issuer's systems.
    - Unreconciled Subscribers Review: Review and comparison of the subscribers reported in the Payment Desk Audit File to the subscribers included in the SBE's PLR data 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 Payment 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 in the file twice in the same month with full month or incorrectly prorated payment data) were not reported in the file.
    - Proration Check: Review of the Payment Desk Audit File to verify that the subscribers' premium and APTC amounts reported in the file for partial months of enrollment were appropriately prorated, if applicable (i.e., if the issuer applied proration for the 2016 benefit year).
    - Premium Less than APTC Validation: Review of the Payment Desk Audit File to verify that the subscribers' premium amounts reported in the file were not less than the APTC amounts reported in the file.
    - Coverage Days Validation: Review of the Payment Desk Audit File to verify that enrollments of five (5) days or fewer reported in 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 the SBE's PLR data 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.

[2] The Payment Desk Audit File is CMS's standard document for issuers to provide information in support of this audit.

III. RESULTS OF REVIEW

CMS assessed issuer compliance with regulations using the following procedures: EPDW Validations, Unreconciled Subscribers Review, Duplicate Exchange-assigned Subscriber IDs Check, Proration 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.

To build collaborative relationships and identify process improvements that support program integrity goals, CMS conducted a discrepancy phase following the review of the initial audit data submission to work with the issuer to resolve or reduce audit findings, thereby improving compliance. For the 2016 benefit year, the SBE indicated "MNsure relied on carrier enrollment data to produce 1095A forms for 2016, and thus carrier workbook data is the "source of truth" for enrollment data for that year." Below are the results of this review following the discrepancy phase.

EPDW Validation

One (1) finding and one (1) observation resulted from the comparison of the final 2016 EPDW submitted by the issuer to Medica's Payment Desk Audit File. Please refer to Finding No. 1 and Observation No. 1 included in section IV for details on the finding and observation.

Unreconciled Subscribers Review

No findings or observations resulted from the review of Medica's Payment Desk Audit File to determine if the subscribers reported in the file existed and their coverage was effectuated in the issuer's systems.

Duplicate Exchange-assigned Subscriber IDs Check

One (1) finding and one (1) observation resulted from the review of Medica's Payment Desk Audit File to verify that duplicate Exchange-assigned subscriber IDs were not reported in the file. Please refer to Finding No. 2 and Observation No. 2 included in section IV for details on the finding and observation.

Proration Check

No findings or observations resulted from the review of Medica's Payment Desk Audit File to verify that correctly prorated payment data, if applicable, was reported in the file.

Premium Less than APTC Validation

One (1) finding and two (2) observations resulted from the review of Medica's Payment Desk Audit File to verify that subscribers were not reported in the file with premium amounts that were less than the APTC amounts. Please refer to Finding No. 3 and Observation No. 3 and Observation No. 4 included in section IV for details on the finding and observations.

Coverage Days Validation

No findings or observations resulted from the review of Medica's Payment Desk Audit File to verify that enrollments of five (5) days or fewer reported in the file were effectuated and had active coverage in the issuer's systems.

Forty-five (45) Subscribers Sample Review

One (1) finding and no observations resulted from the review and comparison of the data from Medica's systems to the corresponding data included in the SBE's PLR data 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 Finding No. 4 included in section IV for details on the finding.

Fifteen (15) Subscribers Sample Review

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

IV. FINDINGS AND OBSERVATIONS

A finding is an identification of an instance of issuer non-compliance with APTC program requirements that requires correction to payment. CMS's audit procedures identified four (4) findings, which resulted in a change to the APTC amounts reported in Medica's EPDW for individual market plans for the 2016 benefit year.

An observation is a deviation from CMS or Exchange 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 four (4) observations, consisting of three (3) observations that resulted in a change to the premium amounts reported in Medica's EPDW for individual market plans for the 2016 benefit year and one (1) observation that did not result in a change to the premium amounts reported in Medica's EPDW but that is noted for purposes of improving compliance in future program years.

In light of the four (4) findings and four (4) observations, the adjusted 2016 benefit year EPDW APTC and premium amounts for individual market plans are shown in the following table.

Recalculated EPDW for the 2016 Benefit Year

	APTC	Premium (Observations)
EPDW as Filed in October 2018	$29,949,359.23	$71,726,053.06
Finding No. 1 and Observation No. 1 - EPDW Validations Adjustment	$2,496.58	$3,035.60
Finding No. 2 and Observation No. 2 – Duplicate Exchange-assigned Subscriber IDs Check Adjustment	$(1,055.66)	$(1,271.34)
Finding No. 3 and Observation No. 3 – Premium Less Than APTC Validation Adjustment	$(43,737.45)	$438.53
Observation No. 4 – Premium Less Than APTC Validation Adjustment	$0.00	$0.00

	APTC	Premium (Observations)
Finding No. 4 – Forty-five (45) Subscribers Sample Review Adjustment	$(841.90)	$0.00
EPDW As Recalculated	$29,906,220.80	$71,728,255.85
Total Impact	**$(43,138.43)**	**$2,202.79***

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

The net financial impact of the four (4) findings is a payment of $43,138.43, consisting of APTC owed to CMS.

*Note: The premium impact of the four (4) observations is an understatement of $2,202.79 in premiums. The premium impact is noted for purposes of improving compliance in future program years.

For the four (4) findings and four (4) observations, CMS documented the criteria, cause, effect, corrective actions, and Medica's responses as seen in the charts below.

Finding No. 1 and Observation No. 1 – EPDW Validations	
Condition:	**APTC Differences (Finding) –** For one (1) or more months of 2016 benefit year enrollment in two (2) QHPs, the net "Total APTC Amount by QHP ID for effectuated enrollments" included in Medica's EPDW was less than the total APTC amount included in Medica's Payment Desk Audit File, resulting in an underpayment of $2,496.58 in APTC. For the one or more months of 2016 benefit year enrollment in two (2) QHPs, the total net enrollment in the EPDW was overstated by one (1) APTC enrollment group and five (5) APTC members. **Premium Differences (Observation) –** For one (1) or more months of 2016 benefit year enrollment in two (2) QHPs, the net "Total Premium Amount by QHP ID for effectuated enrollments" included in Medica's EPDW was less than the total premium amount included in Medica's Payment Desk Audit File, resulting in an understatement of $3,035.60 in premiums. For the one or more months of 2016 benefit year enrollment in two (2) QHPs, the total net enrollment in the EPDW was understated by two (2) enrollment groups and four (4) members.
Criteria:	Pursuant to CMS guidance and EPDW submission requirements: 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."

Finding No. 1 and Observation No. 1 – EPDW Validations	
	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."
Cause:	The issuer indicated the following explanations: • For the subscriber with APTC differences of $52.10 for three (3) months of enrollment that resulted in a total APTC overstatement in the EPDW of $156.30, the issuer indicated "Medica's 2016 EPDW file which was last restated in October of 2018, is showing that [issuer provided name] had an APTC of $52.10 during the months of April, May and June 2016. On 9/28/2016, after the data was already collected for the last EPDW extract, MNsure instructed Medica to add a dependent to [issuer provided name]'s plan effective 4/6/2016, and reduce his APTC to $0.00 also beginning 4/6/2016, and continuing through the months of May and June 2016. The data for the last EPDW file sent in October of 2016 was collected in Mid-September 2016, therefore, the file from MNsure instructing the dependent addition and APTC reduction which arrived on 9/28/2016, was not captured. This data is however reflected in our systems as of today." • For the subscriber that was excluded from the October 2018 EPDW but correctly included in the Payment Desk Audit File for two (2) months of enrollment and that therefore resulted in a total premium understatement in the EPDW of $2,994.44 and APTC understatement in the EPDW of $2,652.88, the issuer indicated "[Issuer provided name] was included in our February 2020 submission as having coverage in Nov. and Dec. of 2016 with an premium of $1,497.22 [and APTC amount of $1,326.44], however she was not included at all in the 2018 EPDW submission for 2016. Upon review, it was discovered that on 2/1/2018, [issuer provided name]'s policy was erroneously terminated back to 11/1/2016 as it was thought that she had not paid her binder / initial plan payment. On 3/22/2018, it was determined that the termination for 11/1/2016 was performed in error, as [issuer provided name] had indeed paid her binder payment on 12/12/2016. The policy was restored with no break in coverage. Because the 2018 EPDW data pull for 2016 was pulled between her termination and the reinstatement or restoration of her policy (2/21/18-8/22/18), she was not reflected as being an active member for that data pull." • For the subscriber with premium differences of $3.43 for twelve (12) months of enrollment that resulted in a total premium understatement in the EPDW of $41.16, the issuer indicated

Finding No. 1 and Observation No. 1 – EPDW Validations	
	"On 10/2/2018, a Medica representative erroneously accepted an address change from [issuer provided name] over the phone, which changed her residential address", which cause a change in premium from $846.83 to $850.26 a month. The issuer further indicated "At the time [issuer provided name] contacted Medica to report her change in address, she should have been directed back to MNsure to update her residential address."
Effect:	The APTC and premium differences resulted in a change to Medica's final, restated 2016 benefit year EPDW data.
Corrective Action Required:	The net financial impact of this finding is a payment of $2,496.58, consisting of APTC paid to Medica. Medica should confirm the financial impact by filling out Appendix 1. The premium impact of this observation is an understatement of $3,035.60 in premiums. CMS notes this observation for purposes of improving compliance in future program years.
Management Response:	Medica agrees with Finding No. 1 and Observation No. 1 – EPDW Validations.

Finding No. 2 and Observation No. 2 - Duplicate Exchange-assigned Subscriber IDs Check	
Condition:	Medica overstated the 2016 benefit year premium and APTC amounts for one (1) subscriber in the Payment Desk Audit File by reporting enrollment and full month payment data for the subscriber more than once in the same month.
Criteria:	Issuers cannot request full month payment from CMS for the same subscriber twice within a month.
Cause:	The issuer indicated that "[Issuer provided name] and [issuer provided name] were covered by Medica on a family plan from 1/1/2016 through 9/30/2016 with monthly premiums of $1,264.67 and an APTC of $1,207.38. On 9/23/2016, Medica received a file from MNsure, instructing us to terminate the family policy effective 9/30/2016, at Mr. [issuer provided name]'s request, because he became eligible for Medicare. On 7/27/2016, Medica received a file from MNsure instructing us to enroll [issuer provided name] on an individual plan of her own beginning 8/1/2016 with a premium of $635.67 and an APTC of $442.00. That policy was active from 8/1/2016 through 12/31/2016.

Finding No. 2 and Observation No. 2 - Duplicate Exchange-assigned Subscriber IDs Check	
	Therefore, [issuer provided name] was indeed double covered on two policies from 8/1/2016 through 9/30/2016. [Issuer provided name] contacted Medica about the two policies and he was advised to contact MNsure with his request to adjust the effective date for his wife. Medica has not ever received any further instruction from MNsure to adjust [issuer provided name]'s individual policy begin date." CMS concluded the Payment Desk Audit File was overstated as the file included full month payment data for the same individual twice during the months of August and September.
Effect:	The inclusion of the duplicate subscriber resulted in a change to Medica's final, restated 2016 benefit year EPDW data.
Corrective Action Required:	The net financial impact of this finding is a payment of $1,055.66, consisting of APTC owed to CMS. Medica should confirm the financial impact by filling out Appendix 1. The premium impact of this observation is an overstatement of $1,271.34 in premiums. CMS notes this observation for purposes of improving compliance in future program years.
Management Response:	Medica agrees with Finding No. 2 and Observation No. 2 – Duplicate Exchange-assigned Subscriber IDs Check

Finding No. 3 and Observation No. 3 - Premium Less than APTC Validation	
Condition:	Medica reported 2016 benefit year premium amounts that were less than the APTC amounts for thirty-five (35) subscribers in the Payment Desk Audit File, resulting from Medica overstating the 2016 benefit year APTC amounts for thirty-four (34) subscribers and understating the 2016 benefit year premium amounts for one (1) subscriber in the Payment Desk Audit File.
Criteria:	Issuers cannot report an APTC amount that exceeds the premium amount for a policy.
Cause:	The issuer indicated the following explanations for the thirty-five (35) subscribers: • "Change manual file received in [issuer provided month and year] for partial termination of spouse effective [issuer provided date]. Medica did not update the APTC amount,

Finding No. 3 and Observation No. 3 - Premium Less than APTC Validation	
	which resulted in billing the member a $0.00 premium from [issuer provided coverage period], when the billed premium should have been [issuer provided premium amount] with an APTC of [issuer provided APTC amount] effective [issuer provided coverage period].” (Twenty (20) subscribers) • “File received in [issuer provided month and year] effective 1/1/2016 with an APTC of [issuer provided APTC amount] from [issuer provided coverage period]. APTC changed to [issuer provided APTC amount] effective [issuer provided date] when spouse was added to policy.” (Five (5) subscribers) • “Change manual file received in [issuer provided month and year] for partial termination of spouse effective [issuer provided date]. APTC was updated to [issuer provided APTC amount] effective [issuer provided coverage period]. (Three (3) subscribers) • “Change manual file received in [issuer provided month and year] and again in [issuer provided month and year] effective 3/1/2016 with an APTC of [issuer provided APTC amount] from [issuer provided coverage period].” (Two (2) subscribers) • “Change manual file received in Dec 2015 effective 1/1/2016 with an APTC of $133.96 from 1/1/2016 - 2/29/2016. APTC changed to $722.07 effective 3/1/2016 when spouse was added to policy.” (One (1) subscriber) • “File received in Jan 2016 showing that the spouse was effective 1/1/2016 and APTC was updated from 1/1/2016 - 12/31/2016. Medica didn't add spouse until 2/1/2016, which resulted in billing the member a $0.00 premium from 1/1/2016 - 1/31/2016, when the billed premium should have been $940.04 with an APTC of $574.64 from 1/1/2016 - 1/31/2016.” (One (1) subscriber) • “File received in Dec 2015 effective 1/1/2016 with an APTC of $701.68 from 1/1/2016 - 2/29/2016. APTC changed to $1,122.63 effective 3/1/2016 when dependents were added to policy.” (One (1) subscriber) • “Report was received in April 2016 for a partial termination of spouse effective 1/1/2016. Medica did not update the APTC amount, which resulted in billing the member a $0.00 premium from 1/1/2016 - 1/31/2016, when the billed premium should have been $648.18 with an APTC of $340.26 effective 1/1/2016 - 1/31/2016.” (One (1) subscriber) • “Spouse was termed effective 1/1/2016. Medica did not update the APTC amount, which resulted in billing the member a $0.00 premium from 1/1/2016 - 1/31/2016, when the billed

Finding No. 3 and Observation No. 3 - Premium Less than APTC Validation	
	premium should have been $772.44 with an APTC of $578.14 effective 1/1/2016 - 1/31/2016." (One (1) subscriber) The issuer provided the correct APTC amounts for the thirty-four (34) subscribers and the correct premium amounts for the one (1) subscriber.
Effect:	The inclusion of the incorrect APTC and premium amounts for thirty-five (35) subscribers resulted in a change to Medica's final, restated 2016 benefit year EPDW data.
Corrective Action Required:	The net financial impact of this finding is a payment of $43,737.45, consisting of APTC owed to CMS. Medica should confirm the financial impact by filling out Appendix 1. The premium impact of this observation is an understatement of $438.53 in premiums. CMS notes this observation for purposes of improving compliance in future program years.
Management Response:	Medica agrees with Finding No. 3 and Observation No. 3 – Premium Less than APTC Validation

Observation No. 4 - Premium Less than APTC Validation	
Condition:	Medica billed a $0.00 premium and reported 2016 benefit year premium amounts that were less than the APTC amounts for two (2) subscribers in the Payment Desk Audit File as the issuer received an incorrect premium rate from the SBE for one (1) subscriber and did not receive an updated APTC amount from the SBE for one (1) subscriber.
Criteria:	Issuers cannot report an APTC amount that exceeds the premium amount for a policy.
Cause:	The issuer indicated the following explanations for the two (2) subscribers: • "File received in Mar 2016 for the effective date of 4/1/2016 has the spouses premium at the age of 54, when actually the spouse is the age of 53 effective 4/1/2016. Due to this we billed a $0.00 premium from 4/1/2016 - 12/31/2016." (One (1) subscriber) • "Spouse was termed effective 12/1/2016 due to having their own MNSure policy effective 12/1/2016. We don't show

Observation No. 4 - Premium Less than APTC Validation	
	receiving a file to update APTC from 12/1/2016 - 12/31/2016 and that is why we billed a $0.00 premium from 12/1/2016 - 12/31/2016." (One (1) subscriber)
Effect:	The issuer did not follow CMS enrollment guidance and requirements as the issuer reported an APTC amount that exceeds the premium amount for a policy.
Corrective Action Required:	CMS notes this observation for purposes of improving compliance in future program years.
Management Response:	Medica agrees with Observation No. 4 - Premium Less than APTC Validation

Finding No. 4 - Forty-five (45) Subscribers Sample Review	
Condition:	Medica overstated the 2016 benefit year APTC amount for one (1) of the forty-five (45) selected subscribers in the Payment Desk Audit File by reporting the incorrect APTC amount in error.
Criteria:	Pursuant to 45 CFR § 156.460, 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 reduce the portion of the premium charged to or for the individual for the applicable months by the amount of the advance payment of the premium tax credit and notify the Exchange of the reduction in the portion of the premium charged to the individual.
Cause:	For one (1) subscriber, the Payment Desk Audit File included an APTC amount of $1,122.63 for months 1-12 while the SBE'S PLR data included an APTC amount of $701.68 for months 1-2 and an APTC amount of $1,122.63 for months 3-12. The issuer indicated that a new enrollment was received on 12/23/2015 for an effective date of 1/1/2016 and APTC amount of $701.68 and an updated file was received on 3/21/2016 adding two dependents for an effective date of 3/1/2016 and APTC amount of $1,122.63. The issuer further indicated "After additional research, we determined that the dollar amount originally reported in the desk audit file was incorrect due to a non-systemic database issue. For this member, we found that the additional subsidy associated with 2 additional dependents beginning in March, and continued through December, was applied inadvertently to January and February as well, which is

Finding No. 4 - Forty-five (45) Subscribers Sample Review	
	why the dollar amount showed $1,122.63. Upon further review of this member's account, the correct amount of APTC in January and February was $701.68. As a result of this inquiry, we have completed a review of all the records in the desk audit file and found no other discrepancies." The SBE indicated "MNsure relied on carrier enrollment data to produce 1095A forms for 2016, and thus carrier workbook data is the "source of truth" for enrollment data for that year."
Effect:	The inclusion of the incorrect APTC resulted in a change to Medica's final, restated 2016 benefit year EPDW data.
Corrective Action Required:	The net financial impact of this finding is a payment of $841.90, consisting of APTC owed to CMS. Medica should confirm the financial impact by filling out Appendix 1.
Management Response:	Medica agrees with Finding No. 4 - Forty-five (45) Subscribers Sample Review

V. MANAGEMENT RESPONSES

Please provide management's response to the four (4) findings and four (4) observations 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 four (4) findings and four (4) observations, complete the "Management Response" field of the findings and observations 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 on the CCIIO webpage. CMS will process the final payment adjustment amount in the next available monthly payment cycle.

Disagreement

If management disagrees with any of the four (4) findings and corrective actions or any of the four (4) observations, complete the "Management Response" field of the findings and observations 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 observations 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.

Please return the updated Appendix 1 within fifteen (15) calendar days. Upon receipt of the signed Appendix 1, CMS will finalize and publish the report on the CCIIO webpage. CMS will process the final payment adjustment amount in the next available monthly payment cycle.

Appendix 1 – Issuer Management Response to Net Financial Adjustment

Issuer HIOS ID: 65847

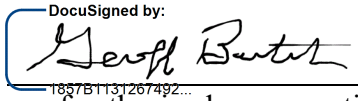
Issuer Name: Medica Health Plans of Wisconsin (Medica)

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 2016 benefit year APTC program participation, resulting in a payment of $43,138.43 to CMS and:

(INITIAL) __X___ 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 2016 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: DocuSigned by:  1857B1131267492...
(Signature of authorized person acting on behalf of the issuer)

Printed Name: Geoff Bartsh
(Print name of signature)

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

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

Date: 4/27/2022

Appendix 2 – Applicable Regulations

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

Regulation	Rules
45 CFR § 155.1210 – Maintenance of Records	**(a) General.** The State Exchange must maintain and must ensure its contractors, subcontractors, and agents maintain for 10 years, documents and records (whether paper, electronic, or other media) and other evidence of accounting procedures and practices, which are sufficient to do the following: (1) Accommodate periodic auditing of the State Exchange's financial records; and (2) Enable HHS or its designee(s) to inspect facilities, or otherwise evaluate the State- Exchange's compliance with Federal standards. **(b) Records.** The State Exchange and its contractors, subcontractors, and agents must ensure that the records specified in paragraph (a) of this section include, at a minimum, the following: (1) Information concerning management and operation of the State Exchange's financial and other record keeping systems; (2) Financial statements, including cash flow statements, and accounts receivable and matters pertaining to the costs of operations; (3) Any financial reports filed with other Federal programs or State authorities; (4) Data and records relating to the State Exchange's eligibility verifications and determinations, enrollment transactions, appeals, and plan variation certifications; and (5) Qualified health plan contracting (including benefit review) data and consumer outreach and Navigator grant oversight information. **(c) Availability.** A State Exchange must make all records and must ensure its contractors, subcontractors, and agents must make all records in paragraph (a) of this section available to HHS, the OIG, the Comptroller General, or their designees, upon request.

Regulation	Rules
45 CFR § 156.460 - Reduction of enrollee's share of premium to account for advance payments of the premium tax credit	**(a) Reduction of enrollee's share of premium to account for advance payments of the premium tax credit.** 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— (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; (2) Notify the Exchange of the reduction in the portion of the premium charged to the individual in accordance with§ 156.265(g); and (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.
45 CFR § 156.480 - Oversight of the administration of the cost-sharing reductions and advance payments of the premium tax credit programs.	**(a) Maintenance of records.** 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. **(b) Annual reporting requirements.** 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. **(c) Audits.** 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.

Regulation	Rules
45 CFR § 156.705 – Maintenance of records for Federally-facilitated Exchanges	**(a)** ***General standard.*** 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: **(1)** 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 **(2)** 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. **(b)** ***Records.*** The records described in paragraph (a) of this section include the sources listed in § 155.1210(b)(2), (3), and (5) of this subchapter. **(c)** ***Record retention timeframe.*** Issuers offering QHPs in a Federally-facilitated Exchange must maintain all records referenced in paragraph (a) of this section for 10 years. **(d)** ***Record availability.*** 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.

Appendix 3 – Glossary of Terms and Acronyms

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