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

for

Blue Cross Blue Shield of Vermont (Vermont)

July 1, 2022

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I. EXECUTIVE SUMMARY

Background

Blue Cross Blue Shield of Vermont (BCBSVT) is a health insurance issuer that offered qualified health plans (QHPs) in the individual market State-Based Exchange (SBE) in Vermont during the 2016 benefit year. BCBSVT submitted its final restated 2016 benefit year data in the October 2018 Enrollment and Payment Data Workbook (EPDW). The issuer received a total of $64,647,938.15 in advance payments of the premium tax credit (APTC) from CMS and reported a total of $130,193,548.75 in premiums for its 2016 benefit year individual market plans.

This report is an assessment, conducted in coordination with the SBE, of BCBSVT'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 the Centers for Medicare & Medicaid Services (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.

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

[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 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 three (3) findings and seven (7) observations for BCBSVT. The net APTC financial impact of the three (3) audit findings is an understatement of $200,821.07 in APTC in the final EPDW and therefore a payment to BCBSVT of $200,821.07 in APTC. The net premium impact of the seven (7) observations is an understatement of $639,373.02 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 BCBSVT to a Payment Desk Audit File containing subscriber level data from BCBSVT's systems;
2. Inclusion of incorrectly prorated enrollment and APTC payment data for seven (7) subscribers with mid-month terminations and re-enrollments in the same month in the Payment Desk Audit File; and
3. Inclusion of incorrectly prorated APTC payment data for seven (7) subscribers with one (1) record reported for the month 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 BCBSVT to a Payment Desk Audit File containing subscriber level data from BCBSVT's systems;
2. Provision of coverage and reporting of enrollment and payment data for thirty-one (31) subscribers in the Payment Desk Audit File with enrollments that were cancelled in the SBE's systems;
3. Inclusion of incorrectly prorated premium data for one (1) subscriber with a mid-month terminations and re-enrollment in the same month in the Payment Desk Audit File;
4. Inclusion of full month premium data for one (1) duplicate subscriber in the Payment Desk Audit File;
5. Inclusion of incorrectly prorated premium data for four (4) subscribers with one (1) record reported for the month in the Payment Desk Audit File;
6. Inclusion of a premium amount that was less than the APTC amount and therefore an incorrect premium amount for one (1) subscriber in the Payment Desk Audit File; and
7. Provision of coverage and reporting of extra months of enrollment and payment data for three (3) of the forty-five (45) selected subscribers in the Payment Desk Audit File.

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 Vermont, 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 field for the QHP ID for each policy and separately submit the data to CMS for this purpose. CMS asked SBEs 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 BCBSVT for an audit to assess the issuer's compliance with 45 CFR §§ 155.1210, 156.460 and 156.480. CMS evaluated BCBSVT'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 BCBSVT 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 BCBSVT on December 20, 2019 that identified data requirements required to conduct the audit. CMS's audit contractor reviewed the audit data file submitted by BCBSVT, 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. Additional follow-up with the SBE was performed as necessary to confirm or resolve the identified audit findings. Below are the results of this review following the discrepancy phase.

EPDW Validations

One (1) finding and one (1) observation resulted from the comparison of the final 2016 EPDW submitted by the issuer to BCBSVT'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

One (1) observation resulted from the review of BCBSVT's Payment Desk Audit File to determine if the subscribers reported in the file existed in the SBE's PLR data and their coverage was effectuated in the issuer's systems. Please refer to Observation No. 2 included in section IV for details on the observation.

Duplicate Exchange-assigned Subscriber IDs Check

One (1) finding and two (2) observations resulted from the review of BCBSVT'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. 3, and Observation No. 4 included in section IV for details on the finding and observations.

Proration Check

One (1) finding and one (1) observation resulted from the review of BCBSVT's Payment Desk Audit File to verify that correctly prorated payment data, if applicable, was reported in the file. Please refer to Finding No. 3 and Observation No. 5 included in section IV for details on the finding and observation.

Premium Less than APTC Validation

One (1) observation resulted from the review of BCBSVT'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 Observation No. 6 included in section IV for details on the observation.

Coverage Days Validation

No findings or observations resulted from the review of BCBSVT'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

No findings and one (1) observation resulted from the review and comparison of the data from BCBSVT'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 Observation No. 7 included in section IV for details on the observation.

Fifteen (15) Subscribers Sample Review

No findings or observations resulted from the review of the data and documentation from BCBSVT'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 BCBSVT'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 three (3) findings, which resulted in a change to the APTC amounts reported in BCBSVT'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 seven (7) observations, consisting of five (5) observations that resulted in a change to the premium amounts reported in BCBSVT's EPDW for individual market plans for the 2016 benefit year and two (2) observations that did not result in a change to the premium amounts reported in BCBSVT's EPDW but that are noted for purposes of improving compliance in future program years.

In light of the three (3) findings and seven (7) 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	$64,647,938.15	$130,193,548.75
Finding No. 1 and Observation No. 1 - EPDW Validations Adjustment	$196,814.54	$642,487.71
Observation No. 2 - Unreconciled Subscribers Review Adjustment	$0.00	$0.00
Finding No. 2 and Observation No. 3 – Duplicate Exchange-assigned Subscriber IDs Check Adjustment (Incorrect Proration)	$1,163.50	$(750.18)
Observation No. 4 – Duplicate Exchange-	$0.00	$(2,534.60)

	APTC	Premium (Observations)
assigned Subscriber IDs Check Adjustment (Full Month Data)		
Finding No. 3 and Observation No. 5 – Proration Check Adjustment	$2,843.03	$(222.35)
Observation No. 6 – Premium Less Than APTC Validation Adjustment	$0.00	$392.44
Observation No. 7 – Forty-five (45) Subscribers Sample Review Adjustment	$0.00	$0.00
EPDW As Recalculated	$64,848,759.22	$130,832,921.77
Total Impact	**$200,821.07**	**$639,373.02***

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

The net financial impact of the three (3) findings is a payment of $200,821.07, consisting of APTC paid to BCBSVT.

*Note: The premium impact of the seven (7) observations is an understatement of $639,373.02 in premiums. The premium impact is noted for purposes of improving compliance in future program years.

For the three (3) findings and seven (7) observations, CMS documented the criteria, cause, effect, corrective actions, and BCBSVT'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 twenty-one (21) QHPs, the net "Total APTC Amount by QHP ID for effectuated enrollments" included in BCBSVT's EPDW was less than the total APTC amount included in BCBSVT's Payment Desk Audit File, resulting in an underpayment of $196,814.54 in APTC. For the one (1) or more months of 2016 benefit year enrollment in twenty-one (21) QHPs, the total net enrollment in the EPDW was understated by four hundred and fifty-one (451) APTC

Finding No. 1 and Observation No. 1 – EPDW Validations	
	enrollment groups and four hundred and seventy-eight (478) APTC members. **Premium Differences (Observation) –** For one (1) or more months of 2016 benefit year enrollment in twenty-two (22) QHPs, the net "Total Premium Amount by QHP ID for effectuated enrollments" included in BCBSVT's EPDW was less than the total premium amount included in BCBSVT's Payment Desk Audit File, resulting in an understatement of $642,487.71 in premiums. For the one (1) or more months of 2016 benefit year enrollment in twenty-two (22) QHPs, the net total enrollment in the EPDW was understated by nine hundred and ninety-two (992) enrollment groups and one thousand, two hundred and sixty-eight (1,268) 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." 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 “During the creation of the data extract for this audit, BCBSVT found an error in the coding for the generation of the template for CMS. In BCBSVT's enrollment system, to allow for separate billing for the member responsibility and for APTC, each subsidized household was given two account numbers. These records are maintained separately from the enrollment records. When joining the data to combine enrollment to premium, some records were missed due to inaccurate programing to populate the CMS template. For example, if a member changes their PCP selection on March 15, the enrollment system would show two records, one for January 1 to March 14 and one from March 15 to December 31. The premium record would be un-impacted and only have one record for January 1 to December 31. This caused some records to be dropped from the original templates sent to CMS. BCBSVT corrected the error for this audit. BCBSVT also changed the method to calculate proration to align the output data to the billing system. The premium and APTC data from the enrollment system doesn’t show the proration from the billing system. The data used to calculate proration in the template truncates the fraction of the month to the second decimal. By using this data field instead of the exact days in the month proration done in the billing system created some discrepancies in the template provided to CMS.”

Finding No. 1 and Observation No. 1 – EPDW Validations	
	Therefore, the issuer indicated the Payment Desk Audit File correctly reflected the enrollment and payment data and that EPDW ("template") was incorrect due to coding and proration errors.
Effect:	The APTC and premium differences resulted in a change to BCBSVT's final, restated 2016 benefit year EPDW data.
Corrective Action Required:	The net financial impact of this finding is a payment of $196,814.54, consisting of APTC paid to BCBSVT. BCBSVT should confirm the financial impact and coordinate on resolution with CMS. The premium impact of this observation is an understatement of $642,487.71 in premiums. CMS notes this observation for purposes of improving compliance in future program years.
Management Response:	We agree with the findings/ observations and calculated adjustments as presented. The 2016 benefit year reflects work performed in the first few years of onboarding our state-based marketplace/exchange. Processes were still being worked out with the state and a weekly reconciliation process was later developed and implemented. In 2019, our Plan sunset the enrollment and claim processing system used and audited during the 2016 benefit year audit and migrated to a new system which resulted in significant pr cess overhaul and improvement. In addition, in 2022 the Plan has assumed responsibility for premium billing from the state-based marketplace.

Observation No. 2 – Unreconciled Subscribers Review	
Condition:	BCBSVT provided coverage and reported enrollment and payment data for thirty-one (31) subscribers in the Payment Desk Audit File with enrollments that were cancelled in the SBE's systems.
Criteria:	The Vermont SBE handled premium billing/processing for the 2015 benefit year and pursuant to the SBE policies and procedures "initial enrollment information and payment is not forwarded to carriers by Vermont Health Connect until full payment is received for all plan selections." The SBE indicated it followed CMS rules and regulations detailed in 45 CFR 155.400(e), where Exchanges may, and the Federally-facilitated Exchanges will require payment of the first month's premium to effectuate an enrollment.

Observation No. 2 – Unreconciled Subscribers Review	
Cause:	The issuer confirmed that coverage was provided for the thirty-one (31) subscribers; however, the SBE indicated the following for the thirty-one (31) subscribers: • "Coverage was cancelled in SBE." (Twenty (20) subscribers) • "Subscriber never had coverage in SBE System." (Eleven (11) subscribers) The issuer indicated, "We do not agree with the SBE's indication that the enrollments were cancelled/there was no coverage and therefore they should not be reported in the desk audit file." The issuer further indicated, "When looking at the comments "subscriber never had coverage in SBE system" or "coverage was cancelled in SBE system" we were likely still managing some level of access to care and trying to not cancel people without being sure we should – so some of those lingering enrollments are likely part of something like that. For cases where the state shows cancelled but we do not then it would seem as though we perhaps didn't get notified of the correct cancel date somehow. We were managing a lot of data through spreadsheets still at that time so both scenarios are entirely plausible and most likely to be the case.". During the audit, the issuer provided documentation supporting provision of coverage for the thirty-one (31) subscribers.
Effect:	The issuer did not follow CMS enrollment guidance and requirements as the issuer provided coverage to enrollments that were cancelled in the SBE's systems.
Corrective Action Required:	CMS notes this observation for purposes of improving compliance in future program years.
Management Response:	We agree with the findings/ observations and calculated adjustments as presented. The 2016 benefit year reflects work performed in the first few years of onboarding our state-based marketplace/exchange. Processes were still being worked out with the state and a weekly reconciliation process was later developed and implemented. In 2019, our Plan sunset the enrollment and claim processing system used and audited during the 2016 benefit year audit and migrated to a new system which resulted in significant pr cess overhaul and improvement. In addition, in 2022 the Plan has assumed responsibility for premium billing from the state-based marketplace.

Finding No. 2 and Observation No. 3 – Duplicate Exchange-assigned Subscriber IDs Check (Incorrect Proration)	
Condition:	For six (6) subscribers with a mid-month termination and re-enrollment in the same month in the Payment Desk Audit File, BCBSVT reported correctly prorated 2016 benefit year premium amounts but reported incorrectly prorated 2016 benefit year APTC amounts and, as a result, understated the 2016 benefit year APTC amounts. Additionally, for one (1) subscriber with a mid-month termination and re-enrollment in the same month in the Payment Desk Audit File, BCBSVT reported an incorrect 2016 benefit year premium and APTC amount for the partial month of enrollment.
Criteria:	Per the issuer-provided state-specific proration guidelines, the premium amount is divided by the number of days in the month and then multiplied by the number of days covered and a similar calculation is performed to derive the prorated APTC amounts.
Cause:	The issuer indicated there were changes in the identified months for the seven (7) subscribers. During the audit, the issuer provided the correct APTC and premium amounts that should be reported in the Payment Desk Audit File for the subscribers.
Effect:	The inclusion of the incorrect premium and APTC amounts for the seven (7) subscribers with mid-month terminations and re-enrollments in the same month resulted in a change to BCBSVT's final, restated 2016 benefit year EPDW data.
Corrective Action Required:	The net financial impact of this finding is a payment of $1,163.50 consisting of APTC paid to BCBSVT. BCBSVT should confirm the financial impact and coordinate on resolution with CMS. The premium impact of this observation is an overstatement of $750.18 in premiums. CMS notes this observation for purposes of improving compliance in future program years.
Management Response:	We agree with the findings/ observations and calculated adjustments as presented. The 2016 benefit year reflects work performed in the first few years of onboarding our state-based marketplace/exchange. Processes were still being worked out with the state and a weekly reconciliation process was later developed and implemented. In 2019, our Plan sunset the enrollment and claim processing system used and audited during the 2016 benefit year audit and migrated to a new system which resulted in significant pr cess overhaul and improvement. In addition, in 2022 the Plan has assumed responsibility for premium billing from the state-based marketplace.

Observation No. 4 – Duplicate Exchange-assigned Subscriber IDs Check (Full Month Data)	
Condition:	BCBSVT overstated the 2016 benefit year premium 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 report full month enrollment data for the same subscriber twice within a month.
Cause:	The issuer indicated, "Member moved to Med supplement policy eff 3/1. After member change was processed VHC sent a transaction for the 1/1-2/29 period causing the med supplement membership to create an exchange span for 1/1-2/29 incorrectly. Lines 7 & 8 are the correct exchange membership. Lines 9 & 10 should be reversed."
Effect:	The inclusion of one (1) duplicate subscriber resulted in a change to BCBSVT's final, restated 2016 benefit year EPDW data.
Corrective Action Required:	The premium impact of this observation is an overstatement of $2,534.60 in premiums. CMS notes this observation for purposes of improving compliance in future program years.
Management Response:	We agree with the findings/ observations and calculated adjustments as presented. The 2016 benefit year reflects work performed in the first few years of onboarding our state-based marketplace/exchange. Processes were still being worked out with the state and a weekly reconciliation process was later developed and implemented. In 2019, our Plan sunset the enrollment and claim processing system used and audited during the 2016 benefit year audit and migrated to a new system which resulted in significant pr cess overhaul and improvement. In addition, in 2022 the Plan has assumed responsibility for premium billing from the state-based marketplace.

Finding No. 3 and Observation No. 5 – Proration Check	
Condition:	BCBSVT reported incorrectly prorated 2016 benefit year APTC amounts for seven (7) subscribers and incorrectly prorated 2016 benefit year premium amounts for four (4) subscribers, including three (3) of the seven (7) subscribers with incorrectly prorated APTC

Finding No. 3 and Observation No. 5 – Proration Check	
	amounts, in the Payment Desk Audit File with one (1) record reported for the month of enrollment.
Criteria:	Per the issuer provided state-specific proration guidelines, the premium amount is divided by the number of days in the month and then multiplied by the number of days covered and a similar calculation is performed to derive the prorated APTC amounts.
Cause:	For eight (8) of the nine (9) subscribers, the issuer reported the correct premium and APTC amounts for all months of enrollment except for the month with a mid-month termination. For seven (7) of the eight (8) subscribers, the issuer reported a $0.00 APTC amount for the partial month of enrollment and therefore understated the APTC amounts for those subscribers and, for two (2) of those subscribers, the issuer reported incorrectly prorated premium amounts for the partial month of enrollment. For one (1) of the eight (8) subscribers, the issuer reported incorrectly prorated premium and APTC amounts for the partial month of enrollment. For one (1) of the nine (9) subscribers with enrollment from 1/1/2016 through 1/14/2016 and no APTC, the issuer reported the full month premium amount in the Payment Desk Audit File for the partial month of enrollment. The issuer provided the correct APTC and premium amounts that should be reported in the Payment Desk Audit File for the nine (9) subscribers.
Effect:	The inclusion of the incorrectly prorated payment data for the nine (9) subscribers resulted in a change to BCBSVT's final, restated 2016 benefit year EPDW data.
Corrective Action Required:	The net financial impact of this finding is a payment of $2,843.03, consisting of APTC paid to BCBSVT. BCBSVT should confirm the financial impact and coordinate on resolution with CMS. The premium impact of this observation is an overstatement of $222.35 in premiums. CMS notes this observation for purposes of improving compliance in future program years.
Management Response:	We agree with the findings/ observations and calculated adjustments as presented. The 2016 benefit year reflects work performed in the first few years of onboarding our state-based marketplace/exchange. Processes were still being worked out with the state and a weekly reconciliation process was later developed and implemented. In 2019, our Plan sunset the enrollment and claim processing system used and

Finding No. 3 and Observation No. 5 – Proration Check	
	audited during the 2016 benefit year audit and migrated to a new system which resulted in significant pr cess overhaul and improvement. In addition, in 2022 the Plan has assumed responsibility for premium billing from the state-based marketplace.

Observation No. 6 – Premium Less Than APTC Validation	
Condition:	BCBSVT reported a 2016 benefit year premium amount that was less than the APTC amount for one (1) month of enrollment for one (1) subscriber in the Payment Desk Audit File, resulting from BCBSVT understating the 2016 benefit year premium amount for the 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 provided the correct premium amount of $1,361.42 that was loaded into their systems for the one (1) month of enrollment.
Effect:	The inclusion of the incorrect premium amount for the one (1) subscriber resulted in a change to BCBSVT's final, restated 2016 benefit year EPDW data.
Corrective Action Required:	The premium impact of this observation is an understatement of $392.44 in premiums. CMS notes this observation for purposes of improving compliance in future program years.
Management Response:	We agree with the findings/ observations and calculated adjustments as presented. The 2016 benefit year reflects work performed in the first few years of onboarding our state-based marketplace/exchange. Processes were still being worked out with the state and a weekly reconciliation process was later developed and implemented. In 2019, our Plan sunset the enrollment and claim processing system used and audited during the 2016 benefit year audit and migrated to a new system which resulted in significant pr cess overhaul and improvement. In addition, in 2022 the Plan has assumed responsibility for premium billing from the state-based marketplace.

Observation No. 7 – Forty-five (45) Subscribers Sample Review	
Condition:	BCBSVT provided extra months of coverage that did not exist as coverage months in the SBE's systems for three (3) of the forty-five (45) selected subscribers in the Payment Desk Audit File.
Criteria:	Pursuant to CMS guidance and 45 CFR § 156.270, QHP issuers must abide by the termination of coverage or enrollment effective dates described in § 155.430(d) of subchapter B.
Cause:	The issuer and SBE indicated the following for the three (3) subscribers: • For the subscriber with coverage from January through December in the issuer's Payment Desk Audit File and coverage from January through November in the SBE's systems, the issuer indicated, "End date for this member is 12/31/2016." The SBE indicated, "The customer sent in a payment on another account that was not applied to her account. WEX shows that her coverage closed 11/30/2016." • For the subscriber with coverage from August through December in the issuer's Payment Desk Audit File and coverage from August through October in the SBE's systems, the issuer indicated, "End date for this member is 12/31/2016." The SBE indicated, "No premiums were paid for Nov, Dec. Coverage was terminated as of 10/31/2016." • For the subscriber with coverage from March through September and November through December in the issuer's Payment Desk Audit File and coverage from March through September only in the SBE's systems, the issuer indicated, "Member was covered for Nov and Dec." The SBE indicated, "Member's QHP coverage that started 11/1/2016 was terminated due to non-payment. Customer was enrolled into MCA starting 10/1/2016." During the audit, the issuer provided documentation supporting provision of additional coverage for the three (3) subscribers.
Effect:	The issuer did not follow CMS guidance and requirements as the issuer provided extra months of coverage that did not exist as coverage months in the SBE's systems.
Corrective Action Required:	CMS notes this observation for purposes of improving compliance in future program years.

Observation No. 7 – Forty-five (45) Subscribers Sample Review	
Management Response:	We agree with the findings/ observations and calculated adjustments as presented. The 2016 benefit year reflects work performed in the first few years of onboarding our state-based marketplace/exchange. Processes were still being worked out with the state and a weekly reconciliation process was later developed and implemented. In 2019, our Plan sunset the enrollment and claim processing system used and audited during the 2016 benefit year audit and migrated to a new system which resulted in significant pr cess overhaul and improvement. In addition, in 2022 the Plan has assumed responsibility for premium billing from the state-based marketplace.

V. MANAGEMENT RESPONSES

Please provide management's response to the three (3) findings and seven (7) 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 three (3) findings and seven (7) 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 three (3) findings and corrective actions or any of the seven (7) 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: 13627

Issuer Name: Blue Cross Blue Shield of Vermont (BCBSVT)

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 $200,821.07 to BCBSVT and:

(INITIAL) RTG 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: Ruth Greene
(Signature of authorized person acting on behalf of the issuer)

Printed Name: Ruth Greene
(Print name of signature)

Title: VP, Treasurer and Chief Financial Officer
(Title of authorized person acting on behalf of the Issuer)

Telephone Number: (802) 371-3210
(Direct Telephone Number)

Date: July 13, 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