Audit Report

for

Medical Health Insuring Corporation of Ohio

June 26, 2018

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I. EXECUTIVE SUMMARY

Background

Medical Health Insuring Corporation of Ohio (Medical Mutual of Ohio) is a Federally-facilitated Exchange (FFE) issuer that offered Preferred Provider Organization (PPO) qualified health plans (QHPs) in the individual market in Ohio during the 2014 benefit year. Medical Mutual of Ohio submitted their final restated 2014 benefit year data in their November 2016 Enrollment and Payment Data Workbook (EPDW). The issuer received a total of $96,241,155.38 in advance premium tax credit (APTC) and advance cost sharing reductions (CSR) payments and paid a total of $5,301,263.50 in FFE user fees for its 2014 benefit year individual market plans.

This report presents the results of the work performed to assess Medical Mutual of Ohio's compliance with the APTC, advance CSR, and FFE user fee programs established in sections 1311, 1401 and 1402 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 and implementing regulations (collectively referred to throughout as PPACA).

Audits to Determine Compliance with the Administration of APTC, Advance CSR, and FFE User Fee Programs

Title 45 of the Code of Federal Regulations (CFR), sections 156.480 and 156.705, allow the Department of Health and Human Services (HHS) to conduct audits of issuers that offer a QHP in the individual market through an Exchange to assess compliance with the APTC, advance CSR, and FFE user fee program requirements. The audit supports the Centers for Medicare & Medicaid Services (CMS) objectives to:

- 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[1] is part of a program established by CMS to validate the enrollment and payment data reported on the final 2014 EPDW and analyze controls and policies of selected issuers pursuant to the authority defined in the regulations.

[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.

Results of Review

CMS's procedures identified one finding for Medical Mutual of Ohio involving the inclusion of enrollment and full month payment data for subscribers who were reported more than once in the same month.

II. BACKGROUND, OBJECTIVES, SCOPE, AND METHODOLOGY

A. Background

Sections 1401 and 1402 of the PPACA established the APTC and advance CSR programs to support the provision of affordable health care coverage to individuals. Additionally, section 1311 of the PPACA allowed the FFE to charge participating issuers user fees to support FFE operations.

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

Interim Payment Process

For the 2014 benefit year, CMS implemented a temporary process ("interim payment process") to calculate and make monthly payments of APTC and advance CSR amounts and to calculate and collect monthly FFE user fee amounts based on data submitted by issuers at the QHP level. On a monthly basis, CMS required submitters to use a standard template, *i.e.* the EPDW that CMS staff created and maintained, to submit payment data. The EPDW was preprogramed with individual submitter data that allowed the submitter to self-validate data prior to submission to CMS. The EPDW included the option to restate prior months' data or indicate no change in data since the last submission. CMS required submitters to send the following information at the QHP plan variant level via the password-protected template:

1. State
2. Tax Identification Number (TIN)
3. Health Insurance Oversight System (HIOS) ID
4. QHP ID
5. Total premium amount for all enrollments
6. Total APTC amount
7. Total advance CSR amount
8. Total FFE User Fee amount
9. Total effectuated enrollment groups
10. Total effectuated enrollment groups with APTC
11. Total effectuated enrollment groups with CSR
12. Total effectuated members
13. Total effectuated members with APTC
14. Total effectuated members with CSR

Issuers and State-based Exchanges (SBEs) on behalf of issuers were required to calculate the QHP level enrollment and payment amounts submitted on the EPDW using their internal source data.

B. Audits to Determine Compliance with the Administration of APTC, Advance CSR, and FFE User Fee Programs

CMS established an audit protocol that is organized around the following regulations governing APTC, advance CSR, and FFE user fee programs, and the procedures required to assess compliance with these applicable regulations:

- 45 CFR 156.50: Financial Support;
- 45 CFR 156.460: Reduction of enrollee's share of premium to account for advance payments of the premium tax credit;
- 45 CFR 156.480: Oversight of the administration of the cost-sharing reductions and advance payments of the premium tax credit programs;
- 45 CFR 156.705: Maintenance of records for Federally-facilitated Exchanges.

Refer to Appendix 1 for the specific requirements established under the authorities listed above.

C. Objectives

The objectives of these audits are to:

(1) Evaluate the accuracy and integrity of issuer-generated EPDW data reported for the APTC, advance CSR, and FFE user fee programs;
(2) Identify potential CMS payment errors resulting from issuer data reporting errors; and
(3) Test accuracy and integrity of processes for reducing an enrollee's share of premium to account for APTCs (45 CFR 156.460).

D. Scope and Methodology

CMS selected Medical Mutual of Ohio for an audit under the above-mentioned regulation(s). As established by CMS, the audit centered on evaluating activity at Medical Mutual of Ohio related to the 2014 benefit year (January 1, 2014, through December 31, 2014), individual market data reported on the final EPDW(s) submitted by the issuer to support APTC and advance CSR payments, and FFE user fee collections.

CMS informed Medical Mutual of Ohio via electronic letter on November 16, 2016, that it would be audited. Medical Mutual of Ohio then received a letter on November 18, 2016, from CMS's audit contractor, identifying data requirements required to conduct the audit. CMS's audit contractor reviewed Medical Mutual of Ohio's information provided and performed the procedures to assess compliance with APTC, advance CSR and FFE user fee program rules and regulations as defined in the CMS protocols.

CMS's audit contractor applied audit protocol procedures to obtain sufficient and appropriate evidence to establish reasonable bases for the findings related to the audit objectives identified in section II.C of this report. CMS's audit contractor performed the following procedures:

- Validations of the APTC/CSR Desk Audit File[2] data submitted to CMS:
    - EPDW Validations: Comparison of the final 2014 EPDW submitted to CMS to the APTC/CSR Desk Audit File from Medical Mutual of Ohio's systems.
    - Duplicate Check: Review of the APTC/CSR Desk Audit File containing subscriber level data from Medical Mutual of Ohio's systems to verify that duplicate Exchange-assigned subscriber IDs (i.e. Exchange-assigned subscriber IDs that were reported on the file twice in the same month) were not reported on the file.
    - Unreconciled Subscribers Review: Review and comparison of the subscribers reported on the APTC/CSR Desk Audit File to the subscribers included in CMS's systems to determine if the subscribers existed and were effectuated (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) in CMS's systems.
- Validations on samples of issuer system data:
    - 45 Subscriber Review: Review and comparison of the data from the issuer's systems to the corresponding data included in CMS's systems for a selected sample of 45 subscribers.
    - 15 Subscriber 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 15 subscribers.
- Policy and Procedure Review: Review of issuer APTC policies and procedures for completeness and clarity.

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

III. RESULTS OF REVIEW

EPDW Validations

No findings resulted from the comparison of the final 2014 EPDW to Medical Mutual of Ohio's APTC/CSR Desk Audit File.

Duplicate Check

One finding resulted from the review of Medical Mutual of Ohio's APTC/CSR Desk Audit File to verify that duplicate Exchange-assigned subscriber IDs were not reported on the file. Refer to finding No. 1 included in section IV for details on the finding.

Unreconciled Subscribers Review

No findings resulted from the review of Medical Mutual of Ohio's APTC/CSR Desk Audit File to determine if the subscribers reported on the file existed and were effectuated in CMS's systems.

45 Subscriber Review

No findings resulted from the review and comparison of the data from Medical Mutual of Ohio's systems to the corresponding data included in CMS's systems for a selected sample of 45 subscribers.

15 Subscriber Review

No findings resulted from the analysis and review of the data and documentation from Medical Mutual of Ohio's systems to verify effectuation and the appropriate application of premium and APTC amounts to policies for a selected sample of 15 subscribers.

Policy and Procedure Review

No findings resulted from the review of Medical Mutual of Ohio's APTC policies and procedures.

IV. FINDINGS

A finding is an identification of an instance of issuer non-compliance with CMS requirements that requires corrective action. CMS's audit procedures identified one finding. The one finding resulted in a change to Medical Mutual of Ohio's reported EPDW for individual market plans for the 2014 benefit year. In light of the one finding, the adjusted 2014 benefit year EPDW APTC and advance CSR payments and FFE user fee amounts for individual market plans are shown in the following table.

Recalculated EPDW for Benefit Year 2014

	FFE User Fees	APTC	Advance CSR Payments*
EPDW As Filed in November 2016	$(5,301,263.50)	$85,854,700.52	$10,386,454.86*
Duplicate Subscribers Adjustment	$1,009.05	$(27,346.44)	$(160.49)*
EPDW As Recalculated	$(5,300,254.45)	$85,827,354.08	$10,386,294.37*
(Refund) from CMS / Payment to CMS	$(1,009.05)	$27,346.44	

* Note: The advance CSR financial impact is for informational purposes only.

The net financial impact of the one finding is a payment due to CMS of $26,337.39 consisting of $(1,009.05) in FFE user fees and $27,346.44 in APTC. The one audit finding along with the criteria, cause, effect, corrective action, and Medical Mutual of Ohio's response are as follows:

Finding No. 1 - Duplicate Subscribers Review	**Condition:**	Medical Mutual of Ohio overstated benefit year 2014 premiums, APTC and advance CSR (as applicable) by reporting enrollment and full month payment data for ten duplicate subscribers, i.e. subscribers who were reported more than once in the same month.
	Criteria:	Issuers cannot request payment from CMS for the same subscriber twice within a month.
	Cause:	The issuer indicated the following explanations for the ten identified subscribers:

		• "Policy ID X was effectuated. Members duplicate policy ID was Y and is now termed." • "Termination received from FFE, not processed on our system." • "We received a file to term policy X eff 8/10/14. No prior term request was sent." • "The term we received for policy ID X came over with a 5/18/14 term date." • "A file to term policy X was never received so the policy remained in effect." • "We received a file to term policy X eff 5/10/14. No prior term request was sent."
	Effect:	The inclusion of enrollment and payment data for the ten duplicate subscribers resulted in a change to Medical Mutual of Ohio's final, restated benefit year 2014 EPDW data.
	Corrective Action Required:	The net financial impact for this finding is a payment due to CMS of $26,337.39 consisting of $(1,009.05) in FFE user fees and $27,346.44 in APTC. Medical Mutual of Ohio should confirm this financial impact and coordinate with CMS on resolution. The advance CSR payment impact for this finding is an overstatement of $160.49; however, this is for informational purposes only as CSR reconciliation is outside the scope of the audits.
	Management Response:	We do agree with Finding #1.

Issuer Management Response to the Draft Audit Report Findings (See Appendix 3)

Please provide management's response to the finding identified in the draft audit report and complete the attached Appendix 3, Issuer Management Response to Net Financial Adjustment, within 30 calendar days from the draft audit report date. Management's response should indicate agreement or disagreement.

Agreement

If management agrees with the one finding, complete the "Issuer Management Response" field of the finding in the draft audit report, and initial "Agree" and sign the attached Appendix 3 -

Issuer Response to Net Financial Adjustment. Return the draft audit report including Appendix 3 within 30 calendar days from the draft audit report date. Upon receipt of the signed Issuer Response to Net Financial Adjustment, CMS will finalize and publish the report. CMS will process the final adjustment amount in the next available monthly payment cycle. [3]

Disagreement

If management disagrees with the one finding and corrective action plan, complete the "Issuer Management Response" field of the finding in the draft audit report, and initial "Disagree" and sign the attached Appendix 3 - Issuer Response to Net Financial Adjustment. Return the draft audit report including Appendix 3 and any supporting documentation that substantiates management's response within 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 explanation in the "Issuer Management Response" field of the finding and any supporting documentation to determine if the report can be amended in a mutually-acceptable manner. If you and CMS are unable to come to a mutually-acceptable result, your response to this report will be included in the final published audit report.

CMS will provide a final audit report, including the stated final adjustment amount along with an updated Appendix 3 - Issuer Response to Net Financial Adjustment within 30 calendar days after receipt of management's response. Please return the updated Appendix 3 - Issuer Response to Net Financial Adjustment within 15 calendar days. Upon receipt of the signed Issuer Response to Net Financial Adjustment, CMS will finalize and publish the report. CMS will process the final adjustment amount in the next available monthly payment cycle.[3]

[3] CSR payments are prohibited unless and until a valid appropriation exists.

Appendix 1 – Applicable Regulations

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

Regulation	Guidance
45 CFR §156.50 – Financial Support	**(a)** ***Definitions.*** The following definitions apply for the purposes of this section: *Participating issuer* means any issuer offering a plan that participates in the specific function that is funded by user fees. This term may include: health insurance issuers, QHP issuers, issuers of multi-State plans (as defined in § 155.1000(a) of this subchapter), issuers of stand-alone dental plans (as described in § 155.1065 of this subtitle), or other issuers identified by an Exchange. **(b)** ***Requirement for State-based Exchange user fees.*** A participating issuer must remit user fee payments, or any other payments, charges, or fees, if assessed by a State-based Exchange under § 155.160 of this subchapter. **(c)** ***Requirement for Federally-facilitated Exchange user fee.*** To support the functions of Federally-facilitated Exchanges, a participating issuer offering a plan through a Federally-facilitated Exchange must remit a user fee to HHS each month, in the timeframe and manner established by HHS, equal to the product of the monthly user fee rate specified in the annual HHS notice of benefit and payment parameters for the applicable benefit year and the monthly premium charged by the issuer for each policy under the plan where enrollment is through a Federally-facilitated Exchange.
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	**(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

payments of the premium tax credit programs.	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.
45 §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 assess 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 2 – Acronyms

Terms & Acronyms	Definition
APTC	Advance Premium Tax Credit
CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
CSR	Cost-sharing Reduction
EPDW	Enrollment and Payment Data Workbook
FFE	Federally-facilitated Exchange
GAGAS	Generally Accepted Government Auditing Standards
HHS	Department of Health and Human Services
PPACA	Patient Protection and Affordable Care Act
PPO	Preferred Provider Organization
QHP	Qualified Health Plan
SBE	State-based Exchange

Appendix 3 – Issuer Response to Net Financial Adjustment

Issuer HIOS ID: 99969

Issuer Name: Medical Health Insuring Corporation of Ohio

Issuer Address: 2060 East Ninth Street, Cleveland OH 44115-1355

The undersigned Chief Executive Officer (CEO), Chief Financial Officer (CFO) or other individual who possesses authority to legally and financially bind this issuer has reviewed the information included in the audit report of the issuer's 2014 benefit year, resulting in a payment to CMS of $26,337.39 and:

(INITIAL)_____ Agrees with the audit net adjustment amount above, confirming the audit finding(s), and as such this report will be considered final and published.

Signed: _____
(Signature of authorized person acting on behalf of the issuer.)

Name: Raymond Mueller

Title: EVP, Chief Financial Officer

Telephone Number: 216.687.7828

Date: 7/11/18

Please email this response to us-advcmsfmapmo@kpmg.com by July 24, 2018.