



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

***for***

***Connecticare Benefits Inc. (Connecticut)***

***November 19, 2020***

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## **I. EXECUTIVE SUMMARY**

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### **Background**

Connecticare Benefits Inc. (Connecticare) is a health insurance issuer that offered qualified health plans (QHPs) in the individual market State-Based Exchange (SBE) in Connecticut during the 2014 benefit year. Connecticare submitted its final restated 2014 benefit year data in the November 2015 Enrollment and Payment Data Workbook (EPDW). The issuer received a total of \$112,337,321.02 in advance payments of the premium tax credit (APTC) from CMS and reported a total of \$149,475,024.86 in premiums for its 2014 benefit year individual market plans.

This report is an assessment, conducted in coordination with the SBE, of Connecticare'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 2014 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<sup>1</sup> 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.

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<sup>1</sup> To provide the flexibility needed when standing up a new oversight program and to ensure that issuers are able to provide CMS with their most accurate data, audit protocols allow for dialog between auditor and issuer to identify and correct errors in data submission that differ somewhat from some independence and reporting standards laid out under Generally Accepted Government Auditing Standards (GAGAS). These procedures were defined and executed consistent with the competence, integrity, and analytical discipline required for performance audits as defined by GAGAS.

This audit is part of CMS's program to validate the enrollment and payment data reported in the final 2014 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 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 two (2) findings and four (4) observations for Connecticare. The net APTC financial impact of the two (2) findings is an understatement of \$115,319.99 in APTC in the final EPDW and therefore a payment to Connecticare of \$115,319.99 in APTC. The net premium impact of the four (4) observations is an overstatement of \$64,455.40 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 November 2015 EPDW submitted by Connecticare to a Payment Desk Audit File containing subscriber level data from Connecticare's systems; and
2. Inclusion of full month enrollment and APTC payment data for one (1) duplicate subscriber in the Payment Desk Audit File.

### **Observations:**

1. Differences in premium amounts identified in the comparison of the issuer's data included in the November 2015 EPDW submitted by Connecticare to a Payment Desk Audit File containing subscriber level data from Connecticare's systems;
2. Provision of coverage and reporting of enrollment and payment data in the Payment Desk Audit File for three hundred and forty (340) unreconciled subscribers with specific cash receipt and/or 834 transaction patterns that caused the policies to be incorrectly flagged as effectuated;
3. Inclusion of full month enrollment and premium data for one (1) duplicate subscriber in the Payment Desk Audit File; and
4. Provision of coverage and reporting of enrollment and payment data in the Payment Desk Audit File for one hundred and twenty-eight (128) subscribers, including two (2) of the fifteen (15) selected subscribers, with coverage that was effectuated in error in the issuer's systems.

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.

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

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### **A. Background**

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

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 2014 benefit year, the interim payment process required SBE issuer submitters, including issuers in Connecticut, 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 2014 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 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 Connecticare for an audit to assess the issuer's compliance with 45 CFR §§ 155.1210, 156.460 and 156.480. CMS evaluated Connecticare's activities related to the 2014 benefit year (January 1, 2014 through December 31, 2014) individual market data reported in the final EPDW submitted in November 2015 by the issuer to CMS to support APTC payments and premium amounts.

CMS sent Connecticare an electronic letter on May 25, 2018 to notify them of the scope of this audit. CMS's audit contractor sent a follow-up letter to Connecticare on May 29, 2018 that identified data requirements required to conduct the audit. CMS's audit contractor reviewed the audit data file submitted by Connecticare, as well as the final 2014 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<sup>2</sup>.

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<sup>2</sup> data submitted to CMS:
  - EPDW Validations: Review and comparison of the issuer's final submitted 2014 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.
  - 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.

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

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

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CMS assessed issuer compliance with regulations using the following procedures: EPDW Validations, Unreconciled Subscribers Review, Duplicate Exchange-assigned Subscriber IDs Check, Premium Less than APTC Validation, Coverage Days Validation, Forty-five (45) Subscribers Sample Review, Fifteen (15) Subscribers Sample Review, and Policy and Procedure Review.

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 Validation**

One (1) finding and one (1) observation resulted from the comparison of the final 2014 EPDW submitted by the issuer to Connecticare'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 and one (1) observation resulted from the review of Connecticare'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. 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 one (1) observation resulted from the review of Connecticare'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 included in section IV for details on the finding and observation.

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

No findings or observations resulted from the review of Connecticare'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.

#### **Coverage Days Validation**

No findings or observations resulted from the review of Connecticare'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 or observations resulted from the review and comparison of the data from Connecticare'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.

**Fifteen (15) Subscribers Sample Review**

No findings and one (1) observation resulted from the review of the data and documentation from Connecticare's systems to verify effectuation and the appropriate application of premium and APTC amounts to policies for a selected sample of fifteen (15) subscribers. Please refer to Observation No. 4 included in section IV for details on the observation.

**Policy and Procedure Review**

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

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#### IV. FINDINGS AND OBSERVATIONS

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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 two (2) findings, which resulted in a change to the APTC amounts reported in Connecticare's EPDW for individual market plans for the 2014 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 two (2) observations that resulted in a change to the premium amounts reported in Connecticare's EPDW for individual market plans for the 2014 benefit year and two (2) observations that did not result in a change to the amounts reported in Connecticare's EPDW but that are noted for purposes of improving compliance in future program years.

In light of the two (2) findings and four (4) observations, the adjusted 2014 benefit year EPDW APTC and premium amounts for individual market plans are shown in the following table.

##### **Recalculated EPDW for the 2014 Benefit Year**

	<b>APTC</b>	<b>Premium (Observations)</b>
EPDW as Filed in November 2015	\$112,337,321.02	\$149,475,024.86
Finding No. 1 and Observation No. 1 - EPDW Validations Adjustment	\$118,264.99	\$(61,460.70)
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	\$(2,945.00)	\$(2,994.70)
Observation No. 4 – Fifteen (15) Subscribers Sample Review Adjustment	\$0.00	\$0.00

	APTC	Premium (Observations)
EPDW As Recalculated	\$112,452,641.01	\$149,410,569.46
<b>Total Impact</b>	<b>\$115,319.99</b>	<b>\$(64,455.40)*</b>

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

The net financial impact of the two (2) findings is a payment of \$115,319.99, consisting of APTC paid to Connecticare.

\*Note: The premium impact of the four (4) observations is an overstatement of \$64,455.40 in premiums. The premium impact is noted for purposes of improving compliance in future program years.

For the two (2) findings and four (4) observations, CMS documented the criteria, cause, effect, corrective actions, and Connecticare's responses as seen in the charts below.

<b>Finding No. 1 and Observation No. 1 – EPDW Validations</b>	
<b>Condition:</b>	<p><b>APTC Differences (Finding)</b> – For one (1) or more months of 2014 benefit year enrollment in nine (9) QHPs, the net “Total APTC Amount by QHP ID for effectuated enrollments” included in Connecticare’s EPDW was less than the total APTC amount included in Connecticare’s Payment Desk Audit File, resulting in an underpayment of \$118,264.99 in APTC. For the one (1) or more months of 2014 benefit year enrollment in nine (9) QHPs, the total net enrollment in the EPDW was overstated by three hundred and sixty (360) APTC enrollment groups and thirty-two thousand, one hundred and twenty-three (32,123) APTC members.</p> <p><b>Premium Differences (Observation)</b> – For one (1) or more months of 2014 benefit year enrollment in nine (9) QHPs, the net “Total Premium Amount by QHP ID for effectuated enrollments” included in Connecticare’s EPDW was greater than the total premium amount included in Connecticare’s Payment Desk Audit File, resulting in an overstatement of \$61,460.70 in premiums. For the one (1) or more months of 2014 benefit year enrollment in nine (9) QHPs, the total net enrollment in the EPDW was understated by thirty-one thousand, one hundred and fifteen (31,115) enrollment groups and overstated by two hundred and forty-three (243) members.</p>
<b>Criteria:</b>	<p>Pursuant to CMS guidance and EPDW submission requirements:</p> <p>The “Total APTC amount by QHP ID for effectuated enrollments” submitted on the EPDW is the “total APTC toward the total premium amount for effectuated enrollments within a 16-digit QHP ID.”</p>

<b>Finding No. 1 and Observation No. 1 – EPDW Validations</b>	
	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.”
<b>Cause:</b>	The issuer indicated that the differences are “due to restatement of enrollment and data cleanup that has occurred in the normal course of business between the submission of the Final 1A and the Desk Audit File.” The issuer further indicated that the significant changes in member differences are due to the fact that “the original 1A included duplicate member counts not currently included in our 1A logic.”
<b>Effect:</b>	The APTC and premium differences resulted in a change to Connecticare’s final, restated 2014 benefit year EPDW data.
<b>Corrective Action Required:</b>	<p>The net financial impact of this finding is a payment of \$118,264.99, consisting of APTC paid to Connecticare. Connecticare should confirm the financial impact and coordinate on resolution with CMS.</p> <p>The premium impact of this observation is an overstatement of \$61,460.70 in premiums. CMS notes this observation for purposes of improving compliance in future program years.</p>
<b>Management Response:</b>	<p>Agreed.</p> <p>Summary member counts have been corrected for future years and remedied systematically. This issue was resolved on a go forward basis for the 2017 plan year.</p>

<b>Observation No. 2 – Unreconciled Subscribers Review</b>	
<b>Condition:</b>	Connecticare reported 2014 benefit year premium amounts for three hundred and forty (340) subscribers, and reported 2014 benefit year APTC amounts for three hundred (300) of those subscribers, in the Payment Desk Audit File with enrollments that did not exist in the SBE’s PLR data and that were effectuated in error.
<b>Criteria:</b>	Pursuant to CMS guidance and EPDW submission requirements, the EPDW should include data for effectuated enrollments where an effectuated enrollment is described as “any enrollment in which the amount the enrollment group is responsible to pay toward the total premium amount has been paid in full by the enrollment group.”
<b>Cause:</b>	The issuer indicated that the three hundred and forty (340) subscribers had enrollments that were effectuated in error. The issuer indicated

<b>Observation No. 2 – Unreconciled Subscribers Review</b>	
	<p>“These policies have specific cash receipt and/or 834 transaction patterns that caused the policies to be incorrectly flagged as effectuated. The variances include instances of bounced checks being applied to balances that triggered an effectuation transaction to occur. Specifically, this occurred when the cash was applied prior to the monthly effectuation job and the NSF notice was worked after the process had been completed.” The issuer further indicated “while these subscribers do not meet effectuation requirements, coverage was extended.”</p> <p>The issuer’s Payment Desk Audit File included a total premium amount of \$465,975.64 and total APTC amount of \$305,523.95 for the three hundred and forty (340) subscribers.</p>
<b>Effect:</b>	The issuer did not follow CMS enrollment guidance and requirements as the issuer provided coverage for three hundred and forty (340) subscribers with enrollments that were effectuated in error.
<b>Corrective Action Required:</b>	CMS notes this observation for purposes of improving compliance in future program years.
<b>Management Response:</b>	<p>Agreed.</p> <p>Improved identification of effectuation has since been put in place with the exclusion of NSF transactions. Additionally, a system conversion occurring for the 2021 Plan Year eliminates the potential for this scenario going forward.</p>

<b>Finding No. 2 and Observation No. 3 - Duplicate Exchange-assigned Subscriber IDs Check</b>	
<b>Condition:</b>	Connecticare overstated the 2014 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.
<b>Criteria:</b>	Issuers cannot request full month payment from CMS for the same subscriber twice within a month.
<b>Cause:</b>	The issuer indicated “True Duplicate, 834 Term Transaction was not received for Policy ID [issuer provided policy ID].”

<b>Finding No. 2 and Observation No. 3 - Duplicate Exchange-assigned Subscriber IDs Check</b>	
<b>Effect:</b>	The inclusion of one (1) duplicate resulted in a change to Connecticare's final, restated 2014 benefit year EPDW data.
<b>Corrective Action Required:</b>	<p>The net financial impact of this finding is a payment of \$2,945.00, consisting of APTC owed to CMS. Connecticare should confirm the financial impact and coordinate on resolution with CMS.</p> <p>The premium impact of this observation is an overstatement of \$2,994.70 in premiums. CMS notes this observation for purposes of improving compliance in future program years.</p>
<b>Management Response:</b>	<p>Agreed.</p> <p>We did not receive an 834 transaction for this subscriber on the initial policy; therefore, it remained opened while the policy to replace it was put in place. A more robust reconciliation process was implemented in November 2018 that captures these 834 related issues which are reviewed and resolved in cooperation with the SBE on an ongoing basis.</p>

<b>Observation No. 4 - Fifteen (15) Subscribers Sample Review</b>	
<b>Condition:</b>	Connecticare provided coverage and reported 2014 benefit year premium and APTC amounts for one hundred and twenty-eight (128) subscribers, including two (2) of the fifteen (15) selected subscribers, in the Payment Desk Audit File with enrollments that were effectuated in error as late payments or no payments were received.
<b>Criteria:</b>	Pursuant to 45 CFR § 156.270, a QHP issuer must return advance payments of the premium tax credit paid on the behalf of such enrollee for the second and third months of the grace period if the enrollee exhausts the grace period. Additionally, if an enrollee receiving advance payments of the premium tax credit exhausts the 3-month grace period in paragraph (d) of this section without paying all outstanding premiums, the QHP issuer must terminate the enrollee's enrollment through the Exchange on the effective date described in 155.430(d)(4) of this subchapter (i.e., the last day of the first month of the 3-month grace period).
<b>Cause:</b>	For one (1) of the fifteen (15) selected subscribers, a late binder payment was received but the issuer provided coverage and reported enrollment and payment data in the Payment Desk Audit File. The

#### Observation No. 4 - Fifteen (15) Subscribers Sample Review

issuer indicated “Effectuation Flag for this Member was incorrect as cash applied in error triggering effectuation and was later reversed. For the selected subscriber there was a cash receipt for the December 2014 coverage month which was received on 1/30/2015 and processed 2/2/2015 triggering effectuation. However, that payment was voided on 2/17/2015 due to insufficient funds as the check bounced (see details of original payment and void below). Subsequent to that, on 3/30/2015, another check was received and applied to the open balance.”

For one of the fifteen (15) selected subscribers, no payments were received but the issuer provided coverage and reported enrollment and payment data in the Payment Desk Audit File. The issuer indicated “Effectuation Flag for this Member was incorrect as cash applied in error triggering effectuation and was later reversed.” The issuer also indicated that reasons for cash being applied in error could include “instances of bounced checks being applied to balances that triggered an effectuation transaction to occur.”

During the audit, CMS coordinated with the issuer to determine whether the effectuation error impacted other enrollments reported in the Payment Desk Audit File that were not already identified as a result of the Unreconciled Subscribers Review. The issuer provided a file detailing one hundred and twenty-six (126) additional subscribers reported in the Payment Desk Audit File that were incorrectly effectuated. The issuer indicated “These policies should have been voided for non-effectuation and were missed for some reason by systematic processes thus requiring write offs. However, the coverage spans remained open until write-offs and terminations were manually processed.”

For the one hundred and twenty (128) total subscribers, the issuer further indicated “As a business practice, member ID cards are sent to members shortly after receipt of the enrollment information from ACHT (State Exchange) allowing for access to benefits, and we have confirmed that ID cards were sent to these members. Following an effectuation transaction, membership kits are mailed or emailed to members, and we have confirmed that membership kits were sent to these members. Additionally, we identified that claims were processed and paid for members in this cohort within the windows of the coverage period identified.”

The issuer’s Payment Desk Audit File included a total premium amount of \$209,908.11 and total APTC amount of \$151,374.14 for the one hundred and twenty-eight (128) subscribers with enrollments that were effectuated in error.

<b>Observation No. 4 - Fifteen (15) Subscribers Sample Review</b>	
<b>Effect:</b>	The issuer did not follow CMS enrollment guidance and requirements as the issuer provided coverage for enrollments that were effectuated in error.
<b>Corrective Action Required:</b>	CMS notes this observation for purposes of improving compliance in future program years.
<b>Management Response:</b>	<p>Agreed.</p> <p>Consistent with earlier responses, the system conversion occurring for the 2021 Plan Year eliminates the potential for this scenario going forward as effectuation occurs prior to active spans being generated.</p>



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## **V. MANAGEMENT RESPONSES**

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Please provide management's response to the two (2) 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 two (2) 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 either of the two (2) 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: 76962

Issuer Name: Connecticare Benefits Inc. (Connecticare)

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 2014 benefit year APTC program participation, resulting in a payment of \$115,319.99 to Connecticare and:

(INITIAL) JFO 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 2014 benefit year audit. If review is requested, CMS will consider this draft only a preliminary audit report. If the review option is selected, you must provide a written explanation with any additional documentation when you return this response within thirty (30) calendar days of the date of this draft audit report. CMS will review the written explanation and any supporting documentation to determine if the report can be amended in a mutually acceptable manner. If you and CMS are unable to come to a mutually acceptable result, your response to this report will be included in the final published audit report.

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

Printed Name: Joseph Oldakowski  
(Print name of signature)

Title: VP Finance & Controller  
(Title of authorized person acting on behalf of the Issuer)

Telephone Number: 860-409-2449  
(Direct Telephone Number)

Date: 12/21/2020

## Appendix 2 – Applicable Regulations

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

Regulation	Rules
<b>45 CFR § 155.1210 – Maintenance of Records</b>	<p><b>(a) General.</b> 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:</p> <ul style="list-style-type: none"><li>(1) Accommodate periodic auditing of the State Exchange's financial records; and</li><li>(2) Enable HHS or its designee(s) to inspect facilities, or otherwise evaluate the State- Exchange's compliance with Federal standards.</li></ul> <p><b>(b) Records.</b> 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:</p> <ul style="list-style-type: none"><li>(1) Information concerning management and operation of the State Exchange's financial and other record keeping systems;</li><li>(2) Financial statements, including cash flow statements, and accounts receivable and matters pertaining to the costs of operations;</li><li>(3) Any financial reports filed with other Federal programs or State authorities;</li><li>(4) Data and records relating to the State Exchange's eligibility verifications and determinations, enrollment transactions, appeals, and plan variation certifications; and</li><li>(5) Qualified health plan contracting (including benefit review) data and consumer outreach and Navigator grant oversight information.</li></ul> <p><b>(c) Availability.</b> 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.</p>

Regulation	Rules
<p><b>45 CFR § 156.460 - Reduction of enrollee's share of premium to account for advance payments of the premium tax credit</b></p>	<p><b>(a) Reduction of enrollee's share of premium to account for advance payments of the premium tax credit.</b> A QHP issuer that receives notice from the Exchange that an individual enrolled in the issuer's QHP is eligible for an advance payment of the premium tax credit must—</p> <p>(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;</p> <p>(2) Notify the Exchange of the reduction in the portion of the premium charged to the individual in accordance with § 156.265(g); and</p> <p>(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.</p>
<p><b>45 CFR § 156.480 - Oversight of the administration of the cost-sharing reductions and advance payments of the premium tax credit programs.</b></p>	<p><b>(a) Maintenance of records.</b> An issuer that offers a QHP in the individual market through a State Exchange must adhere to, and ensure that any relevant delegated entities and downstream entities adhere to, the standards set forth in § 156.705 concerning maintenance of documents and records, whether paper, electronic, or in other media, by issuers offering QHPs in a Federally-facilitated Exchange, in connection with cost-sharing reductions and advance payments of the premium tax credit.</p> <p><b>(b) Annual reporting requirements.</b> For each benefit year, an issuer that offers a QHP in the individual market through an Exchange must report to HHS, in the manner and timeframe required by HHS, summary statistics specified by HHS with respect to administration of cost-sharing reduction and advance payments of the premium tax credit programs, including any failure to adhere to the standards set forth under § 156.410(a) through (d), § 156.425(a) through (b), and § 156.460(a) through (c) of this Part.</p> <p><b>(c) Audits.</b> HHS or its designee may audit an issuer that offers a QHP in the individual market through an Exchange to assess compliance with the requirements of this subpart.</p>

Regulation	Rules
<p><b>45 CFR § 156.705 – Maintenance of records for Federally-facilitated Exchanges</b></p>	<p>(a) <b>General standard.</b> Issuers offering QHPs in a Federally-facilitated Exchange must maintain all documents and records (whether paper, electronic, or other media) and other evidence of accounting procedures and practices, necessary for HHS to do the following:</p> <p>(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</p> <p>(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.</p> <p>(b) <b>Records.</b> The records described in paragraph (a) of this section include the sources listed in § 155.1210(b)(2), (3), and (5) of this subchapter.</p> <p>(c) <b>Record retention timeframe.</b> Issuers offering QHPs in a Federally-facilitated Exchange must maintain all records referenced in paragraph (a) of this section for 10 years.</p> <p>(d) <b>Record availability.</b> Issuers offering QHPs in a Federally-facilitated Exchange must make all records in paragraph (a) of this section available to HHS, the OIG, the Comptroller General, or their designees, upon request.</p>

### Appendix 3 – Glossary of Terms and Acronyms

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