



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

for

Time Insurance Company (Florida) (Time FL)

December 11, 2019

Table of Contents

I. EXECUTIVE SUMMARY	3
II. BACKGROUND, OBJECTIVES, SCOPE, AND METHODOLOGY	5
III. RESULTS OF REVIEW	8
IV. FINDINGS	10
V. OBSERVATIONS	21
VI. MANAGEMENT RESPONSES	22
Appendix 1 – Issuer Management Response to Net Financial Adjustment	23
Appendix 2 – Applicable Regulations	24
Appendix 3 – Glossary of Terms and Acronyms	26

I. EXECUTIVE SUMMARY

Background

Time Insurance Company (Florida) (Time FL) is a health insurance issuer that offered qualified health plans (QHPs) in the individual market Federally-facilitated Exchange (FFE) in Florida during the 2015 benefit year. Time FL submitted its final restated 2015 benefit year data in the November 2016 Enrollment and Payment Data Workbook (EPDW). The issuer received a total of \$117,077,203.56 in advance payments of the premium tax credit (APTC) from CMS and paid a total of \$6,893,048.51 in FFE user fees (UF) to CMS for its 2015 benefit year individual market plans. Time FL, a wholly-owned subsidiary of Assurant, Inc., discontinued writing individual and employer-sponsored small group major medical health insurance business and exited the individual and small group market effective January 1, 2016.

This report is an assessment of Time FL's compliance with the APTC and FFE user fee programs established in sections 1311 and 1401 of the Patient Protection and Affordable Care Act (Pub. L. 111–148) enacted on March 23, 2010 and further amended and revised by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152) enacted on March 30, 2010 (collectively referred to throughout as PPACA), and implementing regulations.

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

Under title 45 of the Code of Federal Regulations (CFR), sections §§ [156.480](#) and [156.705](#), the Department of Health and Human Services (HHS) may audit¹ issuers that offer a QHP in the individual market through an Exchange to assess the degree of compliance with the APTC and FFE user fee program requirements. HHS designates the Centers for Medicare & Medicaid Services (CMS) to conduct these audits and to achieve the following:

- Safeguard Federal funds;
- Instill confidence amongst regulated entities of data quality, soundness, and robustness;
- Evaluate health insurance issuer compliance with program rules and regulations; and
- Develop a successful and coordinated risk-based, multi-year audit program that maximizes resources.

This audit is part of CMS's program to validate the enrollment and payment data reported on the final 2015 EPDW, and to analyze controls and policies of selected issuers pursuant to the authority defined in the regulations.

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

The findings and observations are documented below. If CMS found an instance of issuer non-compliance with APTC and FFE user fee program requirements that requires correction to payment, then CMS classified it as a *finding*. If CMS found a deviation from APTC and FFE user fee program requirements that we are calling to the attention of management for purposes of improving compliance in future program years, but that does not require correction to payment, then CMS categorized it as an *observation*.

Results of Review

CMS identified three (3) findings and no observations for Time FL. The net financial impact of the three (3) audit findings is a payment to CMS of \$12,460.67, consisting of \$364.94 in FFE user fees returned to Time FL and \$12,825.61 in APTC owed to CMS. The findings include the following:

1. Inclusion of full month enrollment and payment data for six (6) duplicate subscribers in the UF/APTC Desk Audit File;
2. Inclusion of incorrectly prorated enrollment and payment data for fourteen (14) subscribers in the UF/APTC Desk Audit File; and
3. Inclusion of premium amounts that were less than the APTC amounts for nine (9) subscribers in the UF/APTC Desk Audit File.

Please refer to section IV for details on the findings 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. Additionally, section 1311 of the PPACA allows the FFEs to charge participating issuers user fees to support FFE operations.

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

Interim Payment Process

Since automated payment systems were not yet developed during the first years of FFE implementation, CMS implemented an interim payment process to calculate and make monthly payments of APTC and advance Cost-sharing Reduction (CSR) amounts, and to collect FFE user fees. The interim payment process required issuers to self-report enrollment and payment data on a monthly basis, including any adjustments to previous months' requests, via manual submission of an EPDW, and to attest to the accuracy of the data.

For the 2015 benefit year, CMS used this interim payment process to calculate and make monthly payments based on QHP data submitted in the EPDW. While using this interim process, CMS designed and implemented a robust set of internal controls within a larger program integrity framework to ensure payment accuracy. CMS required submitters to send the following QHP plan information at the variant level via the password-protected template:

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

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

B. Regulations Governing APTC and FFE User Fee Programs

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

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

Please refer to Appendix 2 for the specific requirements established under the authorities listed above.

C. Objectives

The objectives of this audit are to:

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

D. Scope and Methodology

CMS selected Time FL for an audit on issuer compliance with the aforementioned regulations. CMS evaluated Time FL's activities related to the 2015 benefit year (January 1, 2015 through December 31, 2015) individual market data reported on the final EPDW submitted in November 2016 by the issuer to CMS to support APTC and FFE user fee collections.

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

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

- Validations of the UF/APTC Desk Audit File² data submitted to CMS:

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

- EPDW Validations: Review and comparison of the issuer's final submitted 2015 EPDW to the UF/APTC Desk Audit File from the issuer's systems.
- Unreconciled Subscribers Review: Review and comparison of the subscribers reported on the UF/APTC Desk Audit File to the subscribers included in CMS's systems to determine if the subscribers existed and their coverage was effectuated in the issuer's system (i.e., the amount the subscriber is responsible to pay toward the first month's total premium amount has been paid in full by the subscriber).
- Duplicate Exchange-assigned Subscriber IDs Check: Review of the UF/APTC Desk Audit File containing subscriber level data from the issuer's systems to verify that duplicate Exchange-assigned subscriber IDs (i.e., Exchange-assigned subscriber IDs that were reported on the file twice in the same month with full month or incorrectly prorated payment data) were not reported on the file.
- Premium Less than APTC Validation: Review of the UF/APTC Desk Audit File to verify that the subscribers' premium amounts reported on the file were not less than the APTC amounts reported on the file.
- Coverage Days Validation: Review of the UF/APTC Desk Audit File to verify that enrollments of five (5) days or fewer reported on the file were effectuated and had active coverage in the issuer's systems.
- Validations on samples of issuer's systems data:
 - Forty-five (45) Subscribers Sample Review: Review and comparison of the coverage periods, premium and APTC amounts from the issuer's systems to the corresponding data included in CMS's systems for a selected sample of forty-five (45) subscribers.
 - Fifteen (15) Subscribers Sample Review: Analysis and review of data and documentation from the issuer's systems to verify effectuation and the appropriate application of premium and APTC amounts to policies for a selected sample of fifteen (15) subscribers.
- Policy and Procedure Review: Review of issuer APTC policies and procedures for completeness and clarity.

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, Premium Less than APTC Validation, Coverage Days Validation, Forty-five (45) Subscribers Sample Review, Fifteen (15) Subscribers Sample Review, and Policy and Procedure Review. Below are the results of this review.

EPDW Validations

No findings or observations resulted from the comparison of the final 2015 EPDW to Time FL's UF/APTC Desk Audit File.

Unreconciled Subscribers Review

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

Duplicate Exchange-assigned Subscriber IDs Check

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

Premium Less than APTC Validation

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

Coverage Days Validation

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

Forty-five (45) Subscribers Sample Review

No findings or observations resulted from the review and comparison of the data from Time FL's systems to the corresponding data included in CMS's systems to determine accuracy of the reported enrollment months and the application of premium and APTC for a selected sample of forty-five (45) subscribers.

Fifteen (15) Subscribers Sample Review

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

IV. FINDINGS

A finding is an identification of an instance of issuer non-compliance with APTC and FFE user fee program requirements that requires correction to payment. CMS's audit procedures identified three (3) findings that resulted in a change to Time FL's reported EPDW for individual market plans for the 2015 benefit year. In light of the three (3) findings, the adjusted 2015 benefit year EPDW APTC and FFE user fee amounts for individual market plans are shown in the following table.

Recalculated EPDW for the 2015 Benefit Year

	FFE User Fees	APTC
EPDW as filed in November 2016	\$(6,893,048.51)	\$117,077,203.56
Finding No. 1 - Duplicate Exchange-assigned Subscriber IDs Check (Duplicate Records) Adjustment	\$492.48	\$(11,484.75)
Finding No. 2 - Duplicate Exchange-assigned Subscriber IDs Check (Incorrect Proration) Adjustment	\$(2.15)	\$(366.94)
Finding No. 3 - Premium Less than APTC Validation Adjustment	\$(125.39)	\$(973.92)
EPDW As Recalculated	\$(6,892,683.57)	\$117,064,377.95
Total Financial Impact	\$364.94	\$(12,825.61)

Note: Positive values indicate funds owed to the issuer.

The net financial impact of the three (3) audit findings is a payment to CMS of \$12,460.67, consisting of \$364.94 in FFE user fees returned to Time FL and \$12,825.61 in APTC owed to CMS.

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

Finding No. 1 - Duplicate Exchange-assigned Subscriber IDs Check (Duplicate Records)	Condition:	Time FL overstated the 2015 benefit year premium amounts for six (6) subscribers, and overstated the 2015 benefit year APTC amounts for three (3) of those subscribers, in the UF/APTC Desk Audit File by reporting enrollment and full month payment data for the subscribers more than once in the same month.
	Criteria:	Issuers cannot request full month payment from CMS for the same subscriber twice within a month.
	Cause:	<p>The issuer indicated the following explanations for each of the six (6) subscribers:</p> <ul style="list-style-type: none"> • For one (1) subscriber with three records reported in the same month, consisting of one (1) record with full month payment data and two (2) records with correctly prorated payment data, the issuer indicated "The first record associated with policy ID X should be removed. The record associated with policy ID X for month 06 should include a premium amount of \$527.93 and APTC amount of \$0.00." Based on this feedback, CMS concluded the first record with full month payment data was considered the duplicate. • For one (1) subscriber with two records reported in the same month, consisting of one (1) record with full months payment data and one (1) record with prorated payment data, the issuer indicated "Policy x was originally set to term 12/31/2015; however, it was termed 12/16/2015. We had already collected premium for December. Row 124 shows the corrected calculation of premium for the 15 days the policy was effective: $\\$1084.96 / 31 \times 15 = \\524.98". Based on this feedback, CMS concluded the record with full month payment data was considered the duplicate as the enrollment was terminated 12/16/2015 and therefore the

		<p>second record with correctly prorated payment data was correctly reported.</p> <ul style="list-style-type: none"> • For one (1) subscriber with two (2) records reported in months 03-05 with full month payment data, the issuer indicated “For policy X, our records indicate the subscriber ID for the primary insured was A and the member ID was B The spouse's subscriber ID was also B and the member ID was C. The spouse only then had policy Y. The subscriber ID was D and the member ID was D.” Based on this feedback, CMS concluded the records associated with policy X were considered the duplicate records. • For one (1) subscriber with two (2) records reported in months 02-12 with full month payment data, the issuer indicated “Policy X is the duplicate; no premium was paid as the APTC was listed same as the premium; no claims were processed under this policy. All claims for this member were processed under policy Y.” Based on this feedback, CMS concluded the records associated with policy X were considered the duplicate records. • For one (1) subscriber with two (2) records reported in month 04 with full month payment data, the issuer indicated “Our system showed policy X was active until 11/20/15, when it was updated to reflect that policy was to be replaced by policy Y, and that the effective date for policy Y was to be 4/1/2015. Duplicate submission for April may actually have been what we originally reported for policy Y. Our records indicate premium was \$590.66 for both policies.” Based on this feedback, CMS concluded the record with a premium amount of \$511.91 in April was considered the duplicate record. • For one (1) subscriber with two (2) records reported in month 07 with the same full month premium amounts, the issuer indicated “Our system showed policy X was active until 11/9/2015, when it was updated
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		to reflect that policy was to be replaced by policy Y and the effective of policy X was to be 6/13/2015. The duplicate submission for July may actually have been what was originally reported as policy X. There was no APTC for policy X.” Based on this feedback, CMS concluded that a duplicate record was reported for the month of July.
	Effect:	The inclusion of the six (6) duplicate subscribers resulted in a change to Time FL’s final, restated 2015 benefit year EPDW data.
	Corrective Action Required:	The net financial impact of this finding is a payment to CMS of \$10,992.27, consisting of \$492.48 in FFE user fees returned to Time FL and \$11,484.75 in APTC owed to CMS. Time FL should confirm the financial impact and coordinate on resolution with CMS as indicated in section VI of this report.
	Management Response:	Agree.

Finding No. 2 - Duplicate Exchange-assigned Subscriber IDs Check (Incorrect Proration)	Condition:	Time FL incorrectly prorated the 2015 benefit year premium amounts for four (4) subscribers and incorrectly prorated the 2015 benefit year APTC amounts for ten (10) subscribers in the UF/APTC Desk Audit File.
	Criteria:	Per the HHS Notice of Benefit and Payment Parameters for 2015 and 45 CFR §155.240, in a Federally-facilitated Exchange, the premium for coverage lasting less than one month must equal the product of (i) The premium for one month of coverage divided by the number of days in the month; and (ii) The number of days for which coverage is being provided in the month.
	Cause:	The issuer indicated the following explanations for each of the fourteen (14) subscribers: <ul style="list-style-type: none"> For one (1) subscriber with two (2) records where the issuer correctly prorated the first

		<p>record but incorrectly prorated the second record, the issuer indicated "Policy X was effective for 11 days in April, while Policy Y was effective for 19 days in April; therefore, APTC was prorated for Policy X as $\\$485.00 / 30 \times 11 = \\177.83, and APTC was prorated for Policy Y as $\\$716 / 30 \times 19 = \\453.47. Based on information readily available, the Total APTC for April was \$631.30 and the Premium for the Policy was \$747.16."</p> <ul style="list-style-type: none"> • For one (1) subscriber with two (2) records where the issuer correctly prorated the first record but incorrectly prorated the second record, the issuer indicated "Policy X was effective for 19 days in April with a prorated premium amount of $\\$739.23/30 \times 19 = \\468.18. The prorated APTC amount was calculated as $\\$571.00/30 \times 19 = \\361.63. The prorated APTC amount should have been \$361.63 rather than \$371.63, which is included on the desk audit file." • For one (1) subscriber with two (2) records where the issuer incorrectly prorated the first record but correctly prorated the second record, the issuer indicated "Premium for Policy X was \$691.57; however, the policy was only effective for 17 days in May. APTC for Policy X was \$578.00; therefore, APTC was prorated as $\\$578/31 \times 17 = \\316.97. APTC for Policy Y was \$534.00; therefore, APTC was prorated as $\\$534/31 \times 14 = \\241.16. Based on information readily available, the Total APTC for May was \$558.13; $\\$558.13/31 \times 17 = \\306.07." • For one (1) subscriber with two (2) records where the issuer correctly prorated the first record but incorrectly prorated the second record, the issuer indicated "Policy X was effective for 28 days in June with a prorated premium amount of $\\$1498.68 / 30 \times 28 = \\1398.77. It appears the APTC amount was calculated using 27 days rather than 28 days.
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		<p>The correct APTC calculation is $\\$1184 / 30 \times 28 = \\1106.07.”</p> <ul style="list-style-type: none"> • For one (1) subscriber with two (2) records where the issuer incorrectly prorated the first record but correctly prorated the second record, the issuer indicated “Policy X was replaced by policy Y effective 6/9/2015. Policy X was effective for 8 days in June; therefore, premium was prorated with the proration calculation as $\\$1414.64 / 30 \times 8 = \\377.24. Our records indicate that there was no APTC for Policy Y.” • For one (1) subscriber with two (2) incorrectly prorated records, the issuer indicated “Premium for Policy X was \$707.91; however, the policy was only effective for 3 days in May 2015; therefore, the premium was calculated as $\\$707.91 / 31 \times 3 = \\68.51. Based on the information readily available, APTC was \$0.00. Our system showed that Policy X was active until 8/4/2015, when it was updated to reflect that it was to be replaced by Policy Y, and the effective date of Policy Y was to be 5/4/2015. The calculations were based on the full month of May; however, based on the information available for review, it appears that the premium received for Policy Y was only enough to cover 9 days, so the policy was termed 5/13/2015. APTC for Policy X was \$503.00; therefore, the prorated amount was calculated as $\\$503.00 / 31 \times 28 = \\454.32. Based on the information readily available, and using the same day count, the prorated premium calculates to $\\$707.91 / 31 \times 28 = \\639.41.” • For one (1) subscriber with two (2) records where the issuer incorrectly prorated the first record but correctly prorated the second record, the issuer indicated “Policy X was effective for 27 days in April with a prorated premium amount of $\\$934.90 / 30 \times 27 = \\841.41. Based on information readily available, APTC is calculated as $\\$763.00 / 30 \times 27 = \\686.70. Our records indicate the
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		<p>premium for Policy Y was \$518.15. The policy was effective for 3 days in April and calculated as $\\$518.15 / 30 \times 3 = \\51.82. The APTC for Policy Y is calculated as $\\$763.00/30 \times 27 = \\686.70.”</p> <ul style="list-style-type: none"> • For one (1) subscriber with two (2) records where the issuer incorrectly prorated the first record but correctly prorated the second record, the issuer indicated “Our records indicate the APTC for policy X was \$0.00 from 6/1/2015-6/24/2015. The APTC amount was changed to \$491.00 effective 6/24/2015, and then changed to \$501.00 effective 6/29/2015. The prorated APTC amounts were calculated as $\\$491.00/ 30 \times 5 = \\81.83, $\\$501.00/ 30 \times 2 = \\33.40, and, $\\$81.83 + \\$33.40 = \\$115.23$ for the total APTC for June. Based on information readily available, the premium was \$835.20; therefore, the prorated premium calculates to $\\$835.20/ 30 \times 23 = \\640.32.” • For one (1) subscriber with two (2) records where the issuer correctly prorated the first record but incorrectly prorated the second record, the issuer indicated “Policy X was effective for 15 days in June; therefore, premium was prorated as $\\$1565.81/ 30 \times 15 = \\782.92. Based on information readily available, APTC was \$635.00; therefore, the prorated APTC calculates as $\\$635.00/ 30 \times 15 = \\317.50.” • For one (1) subscriber with two (2) records where the issuer incorrectly prorated the first record but correctly prorated the second record, the issuer indicated “Based on information readily available, the premium amount for Policy X was calculated as $\\$590.66/ 31 \times 9 = \\171.48.” • For one (1) subscriber with two (2) records where the issuer incorrectly prorated the first record but correctly prorated the second record, the issuer indicated “Our records indicate that Policy X terminated on 4/28/2015. The premium was prorated as $\\$1047.42/ 30 \times 27 = \\942.68. It appears that
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		<p>the APTC calculation was based on 28 days rather than 27. It should have been prorated as $\\$675.00 / 30 \times 27 = \\607.50.”</p> <ul style="list-style-type: none"> • For one (1) subscriber with two (2) records where the issuer incorrectly prorated the first record but correctly prorated the second record, the issuer indicated “Our system showed Policy X was active until 11/9/2015, when it was updated to reflect that it was to be replaced by Policy Y and the effective date of Policy X was to be 6/13/2015. The duplicate submission for July may actually have been what was originally reported as Policy X. There was no APTC for Policy X. Based on information readily available, the prorated premium for Policy X is calculated as $\\$463.98 / 30 \times 18 = \\278.39.” • For one (1) subscriber with two (2) records where the issuer incorrectly prorated the first record but correctly prorated the second record, the issuer indicated “Our records indicate that Policy X was replaced by Policy Y effective 6/30/2015. Policy Y was effective from 6/30/2015-7/1/2015.” • For one (1) subscriber with two (2) records where the issuer incorrectly prorated the first record but correctly prorated the second record, the issuer indicated “Child was removed from Policy X effective 3/1/2015. Premium was \$776.26 as of 3/1/2015; therefore, the premium was calculation as $\\$776.26 / 31 \times 3 = \\75.12. Our records indicate that the APTC was changed to \$550.00 effective 3/1/2015; therefore, the APTC was calculation as $\\$550.00 / 31 \times 3 = \\53.23.” <p>Based on the feedback and issuer provided calculations and dates, CMS concluded that the incorrect 2015 benefit year premium and, if applicable, APTC amounts were reported in the UF/APTC Desk Audit File for the fourteen (14) subscribers.</p>
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	Effect:	The inclusion of the incorrectly prorated premium and APTC amounts for the fourteen (14) subscribers resulted in a change to Time FL's final, restated 2015 benefit year EPDW data.
	Corrective Action Required:	The net financial impact of this finding is a payment to CMS of \$369.09, consisting of \$2.15 in FFE user fees owed to CMS and \$366.94 in APTC owed to CMS. Time FL should confirm the financial impact and coordinate on resolution with CMS as indicated in section VI of this report.
	Management Response:	Agree.

Finding No. 3 - Premium Less than APTC Validation	Condition:	Time FL reported premium amounts that were less than the APTC amounts for nine (9) subscribers in the UF/APTC Desk Audit File. As a result, Time FL understated the 2015 benefit year premium amounts for six (6) of the nine (9) subscribers and overstated the 2015 benefit year APTC amounts for three (3) of the nine (9) subscribers in the UF/APTC Desk Audit File.
	Criteria:	Issuers cannot report a premium amount that is less than an APTC amount. Per CMS guidance, the premium amount reported on the EPDW is the premium amount by 16 digit QHP ID for the effectuated enrollment within a qualified health plan.
	Cause:	<p>The issuer indicated the following explanations for each of the nine (9) subscribers:</p> <ul style="list-style-type: none"> • "Our records indicate policy X was terminated 6/1/2015 and replaced by policy Y. Policy Y was terminated 7/1/2015 and replaced by policy X. The premium for months 11 and 12 was reversed. The member passed away on 10/23/2015." • "Our records indicate the APTC was changed from \$534.82 to \$259.00 effective 5/15/2015. The new APTC amount was

		<p>effective for 17 days in May; therefore, APTC was prorated as follows: $\\$534.82/31 \times 14 = \\241.53 $\\$259.00/31 \times 17 = \\142.03 Total APTC $\\$142.03 + \\$241.53 = \\$383.56$. Spouse termed from policy 5/14/2015, so she was on the policy for 13 days in May. Premium changed from \$534.82 to \$267.41. Premium was prorated as follows: $\\$534.82/31 \times 13 = \\224.28 $\\$267.41/31 \times 17 = \\155.27 $\\$224.28 + \\$155.27 = \\$379.55$ total premium for May.”</p> <ul style="list-style-type: none"> • "Our records indicate the premium was changed to \$490.60 and APTC was changed to \$377.00 effective 9/3/2015, when newborn was added to the policy. The new APTC amount was effective for 28 days in September; therefore, APTC was prorated as follows: $\\$248.00/30 \times 2 = \\16.53 $\\$377.00/30 \times 28 = \\351.87 Total APTC $\\$16.53 + \\$351.87 = \\$368.40$ Based on information readily available, prorated premium calculates as follows: $324.98/30 \times 2 = \\$21.67$ $490.60/28 \times 2 = \\$457.89$ Total premium $\\$5.42 + \\$457.89 = \\$479.56$." • "As of 1/1/2016, our system reflects the premium was \$999.76 and APTC was \$904.00." • "Our records indicate policy X was effective from 1/1/2015 to 5/1/2015. Premium was \$1306.24 and APTC was \$1175.00." • "Per MP report, policy should have a gap in coverage from 1/22/2015-2/1/2015. Policy was effective for 21 days in January; therefore premium was prorated as follows: $\\$726.21/31 \times 21 = \\491.95." • "Our records indicate premium was \$1261.40 and APTC was \$886.00 until 7/10/2015 when newborn was added. Effective 7/10/15, premium was \$1261.40 and APTC was \$1096.00."
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		<ul style="list-style-type: none"> • "Our records indicate we were notified by MP in May 2015 to remove the child from the plan effective 2/1/2015. Premium without the child was \$360.38." • "Our records indicate the premium was \$580.96 and APTC was \$520.00." <p>Based on the feedback and issuer provided financial amounts, CMS concluded that the incorrect 2015 benefit year premium or APTC amounts were reported in the UF/APTC Desk Audit File for the nine (9) subscribers.</p>
	Effect:	The inclusion of the incorrect premium and APTC amounts for the nine (9) subscribers resulted in a change to Time FL's final, restated 2015 benefit year EPDW data.
	Corrective Action Required:	The net financial impact of this finding is a payment to CMS of \$1,099.31, consisting of \$125.39 in FFE user fees owed to CMS and \$973.92 in APTC owed to CMS. Time FL should confirm the financial impact and coordinate on resolution with CMS as indicated in section VI of this report.
	Management Response:	Agree.

V. OBSERVATIONS

An observation is a deviation from APTC and FFE user fee program requirements that we are calling to the attention of management for purposes of improving compliance in future program years but that does not require correction to payment. CMS's audit procedures identified no observations.

VI. MANAGEMENT RESPONSES

Please provide management's response to the three (3) findings 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, complete the "Management Response" field of the findings in the draft audit report, and initial "Agree" and sign the attached Appendix 1. Return the draft audit report including Appendix 1 within thirty (30) calendar days from the draft audit report date. Upon receipt of the signed Appendix 1, CMS will finalize and publish the report. CMS will process the final adjustment amount in the next available monthly payment cycle.

Disagreement

If management disagrees with any of the three (3) findings and corrective actions, complete the "Management Response" field of the findings 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 any supporting documentation to determine if the report can be amended in a mutually acceptable manner. If you and CMS are unable to come to a mutually acceptable result, your response to this report will be included in the final published audit report.

CMS will provide an updated audit report, including the stated final adjustment amount along with an updated Appendix 1, following receipt and review of management's response. Please return the updated audit report with management responses and signed Appendix 1 within fifteen (15) calendar days. Upon receipt of the signed Appendix 1, CMS will finalize and publish the report and process the final adjustment amount in the next available monthly payment cycle.

Appendix 1 – Issuer Management Response to Net Financial Adjustment

Issuer HIOS ID: 62662

Issuer Name: Time Insurance Company Florida (Time FL)

The undersigned Chief Executive Officer (CEO), Chief Financial Officer (CFO) or other individual who can legally and financially bind this issuer has reviewed the information included in the audit report of the issuer's 2015 benefit year APTC and FFE UF program participation, resulting in a payment to CMS of \$12,460.67, consisting of \$364.94 in FFE user fees returned to Time FL and \$12,825.61 in APTC owed to CMS, and:

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

Or

(INITIAL) _____ Disagrees and requests a review of additional information that may impact the audit net adjustment amount resulting from the 2015 benefit year audit. If review is requested, CMS will consider this draft only a preliminary audit report. If the review option is selected, you must provide a written explanation with any additional documentation when you return this response within thirty (30) calendar days of the date of this draft audit report. CMS will review the written explanation and any supporting documentation to determine if the report can be amended in a mutually acceptable manner. If you and CMS are unable to come to a mutually acceptable result, your response to this report will be included in the final published audit report.

Signed: _____

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

Printed Name: GORDON ROWELL

(Print name of signature)

Title: CHIEF OPERATING OFFICER

(Title of authorized person acting on behalf of the Issuer)

Telephone Number: 787-919-0762

(Direct Telephone Number)

Date: 01/10/20

Appendix 2 – 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	<p>(a) Definitions. The following definitions apply for the purposes of this section:</p> <p><i>Participating issuer</i> means any issuer offering a plan that participates in the specific function that is funded by user fees. This term may include: health insurance issuers, QHP issuers, issuers of multi-State plans (as defined in § 155.1000(a) of this subchapter), issuers of stand-alone dental plans (as described in § 155.1065 of this subtitle), or other issuers identified by an Exchange.</p> <p>(b) 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.</p> <p>(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.</p>
45 CFR §156.460 - Reduction of enrollee's share of premium to account for advance payments of the premium tax credit	<p>(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—</p> <ol style="list-style-type: none">(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.

Regulation	Guidance
<p>45 CFR § 156.480 - Oversight of the administration of the cost-sharing reductions and advance payments of the premium tax credit programs.</p>	<p>(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.</p> <p>(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.</p> <p>(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.</p>
<p>45 CFR §156.705 – Maintenance of records for Federally-facilitated Exchanges</p>	<p>(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:</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) 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.</p> <p>(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.</p> <p>(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.</p>

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
EPDW	Enrollment and Payment Data Workbook
FFE	Federally-facilitated Exchange
GAGAS	Generally Accepted Government Auditing Standards
HHS	Department of Health and Human Services
HIOS	Health Insurance Oversight System
PPACA	Patient Protection and Affordable Care Act
QHP	Qualified Health Plan
SBE	State-based Exchange
TIN	Tax Identification Number