



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

*for*

*Blue Cross of Idaho (Idaho)*

*March 11, 2022*

## **Table of Contents**

<b>I. EXECUTIVE SUMMARY .....</b>	<b>3</b>
<b>II. BACKGROUND, OBJECTIVES, SCOPE, AND METHODOLOGY .....</b>	<b>5</b>
<b>III. RESULTS OF REVIEW .....</b>	<b>8</b>
<b>IV. FINDINGS AND OBSERVATIONS.....</b>	<b>10</b>
<b>V. MANAGEMENT RESPONSES .....</b>	<b>18</b>
<b>Appendix 1 – Issuer Management Response to Net Financial Adjustment .....</b>	<b>19</b>
<b>Appendix 2 – Applicable Regulations .....</b>	<b>20</b>
<b>Appendix 3 – Glossary of Terms and Acronyms .....</b>	<b>23</b>

---

---

## I. EXECUTIVE SUMMARY

---

---

### Background

Blue Cross of Idaho (Blue Cross of ID) is a health insurance issuer that offered qualified health plans (QHPs) in the individual market State-Based Exchange (SBE) in Idaho during the 2015 benefit year. Blue Cross of ID submitted its final restated 2015 benefit year data in the October 2017 Enrollment and Payment Data Workbook (EPDW). The issuer received a total of \$110,288,129.45 in advance payments of the premium tax credit (APTC) from CMS and reported a total of \$175,689,560.25 in premiums for its 2015 benefit year individual market plans.

This report is an assessment, conducted in coordination with the SBE, of Blue Cross of ID'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 2015 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.

This audit is part of CMS's program to validate the enrollment and payment data reported in the final 2015 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.

---

<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.

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 six (6) observations for Blue Cross of ID. The net APTC financial impact of the two (2) findings is an overstatement of \$2,530.42 in APTC in the final EPDW and therefore a payment to CMS of \$2,530.42, consisting of APTC owed to CMS. The net premium impact of the six (6) observations is an understatement of \$3,655.13 in premiums in the final EPDW. The findings and observations include the following:

#### **Findings:**

1. Differences in APTC amounts identified in the comparison of the issuer's data included in the October 2017 EPDW submitted by Blue Cross of ID to a Payment Desk Audit File containing subscriber level data from Blue Cross of ID's systems; and
2. Inclusion of premium amounts that were less than the APTC amounts and therefore incorrect APTC amounts for five (5) subscribers in the Payment Desk Audit File.

#### **Observations:**

1. Differences in premium amounts identified in the comparison of the issuer's data included in the October 2017 EPDW submitted by Blue Cross of ID to a Payment Desk Audit File containing subscriber level data from Blue Cross of ID's systems;
2. Provision of coverage and reporting of enrollment and payment data in the Payment Desk Audit File for one (1) subscriber with an enrollment for which no binder payment was received;
3. Inclusion of premium amounts that were less than the APTC amounts and therefore incorrect premium amounts for four (4) subscribers in the Payment Desk Audit File;
4. Provision of coverage and reporting of enrollment and payment data for four (4) subscribers with a coverage period of five (5) days or fewer that should have been cancelled in the Payment Desk Audit File;
5. Inclusion of incorrect premium amounts for one (1) of the forty-five (45) selected subscribers in the Payment Desk Audit File; and
6. Provision of coverage and reporting of enrollment and payment data for one (1) of the forty-five (45) selected subscribers in the Payment Desk Audit File with an enrollment that should have been cancelled.

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

---

---

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

---

---

### A. Background

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

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

#### Interim Payment Process

In 2015, 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 2015 benefit year, the interim payment process required SBE issuer submitters, including issuers in Idaho, 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 2015 benefit year in which CMS compared the EPDW data against the policy-level reporting (PLR) data submitted by the SBE. The PLR data was based on the monthly submissions that SBEs sent to the Internal Revenue Service (IRS) for reporting purposes and contained cumulative individual market enrollment APTC data. CMS requested that SBEs append an additional field for the QHP ID for each policy and separately submit the data to CMS for this purpose. CMS asked SBEs or SBE issuers to explain any outlier discrepancies between EPDW and PLR data and to re-submit the EPDW, if necessary, or to verify that payment data was accurate despite discrepancies with PLR data.

## **B. Regulations Governing APTC Program**

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

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

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

## **C. Objectives**

The objectives of this audit are to:

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

## **D. Scope and Methodology**

CMS selected Blue Cross of ID for an audit to assess the issuer's compliance with 45 CFR §§ 155.1210, 156.460 and 156.480. CMS evaluated Blue Cross of ID's activities related to the 2015 benefit year (January 1, 2015 through December 31, 2015) individual market data reported in the final EPDW submitted in October 2017 by the issuer to CMS to support APTC payments and premium amounts.

CMS sent Blue Cross of ID an electronic letter on February 15, 2019 to notify them of the scope of this audit. CMS's audit contractor sent a follow-up letter to Blue Cross of ID on February 20, 2019 that identified data requirements required to conduct the audit. CMS's audit contractor reviewed the audit data file submitted by Blue Cross of ID, as well as the final 2015 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 2015 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.

---

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

---

---

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

---

---

CMS assessed issuer compliance with regulations using the following procedures: EPDW Validations, Unreconciled Subscribers Review, Duplicate Exchange-assigned Subscriber IDs Check, 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 2015 EPDW submitted by the issuer to Blue Cross of ID'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 Blue Cross of ID'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**

No findings or observations resulted from the review of Blue Cross of ID's Payment Desk Audit File to verify that duplicate Exchange-assigned Subscriber IDs were not reported in the file.

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

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

#### **Coverage Days Validation**

No findings and one (1) observation resulted from the review of Blue Cross of ID'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. Please refer to Observation No. 4 included in section IV for details on the observation.

#### **Forty-five (45) Subscribers Sample Review**

No findings and two (2) observations resulted from the review and comparison of the data from Blue Cross of ID's systems to the corresponding data included in the SBE's PLR data to

determine accuracy of the reported enrollment months and the application of premium and APTC for a selected sample of forty-five (45) subscribers. Please refer to Observation No. 5 and Observation No. 6 included in section IV for details on the observations.

**Fifteen (15) Subscribers Sample Review**

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

---

## IV. FINDINGS AND OBSERVATIONS

---

A finding is an identification of an instance of issuer non-compliance with APTC program requirements that requires correction to payment. CMS’s audit procedures identified two (2) findings, which resulted in a change to the APTC amounts reported in Blue Cross of ID’s EPDW for individual market plans for the 2015 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 six (6) observations, consisting of three (3) observations that resulted in a change to the premium amounts reported in Blue Cross of ID’s EPDW for individual market plans for the 2015 benefit year and three (3) observations that did not result in a change to the premium amounts reported in Blue Cross of ID’s EPDW but that are noted for purpose of improving compliance in future program years.

In light of the two (2) findings and six (6) observations, the adjusted 2015 benefit year EPDW APTC and premium amounts for individual market plans are shown in the following table.

### Recalculated EPDW for the 2015 Benefit Year

	APTC	Premium (Observations)
EPDW as Filed in October 2017	\$110,288,129.45	\$175,689,560.25
Finding No. 1 and Observation No. 1 - EPDW Validations Adjustment	\$(1,234.66)	\$2,965.96
Observation No. 2 – Unreconciled Subscribers Review Adjustment	\$0.00	\$0.00
Finding No. 2 and Observation No. 3 – Premium Less Than APTC Validation Adjustment	\$(1,295.76)	\$611.41
Observation No. 4 – Coverage Days Validation	\$0.00	\$0.00

	APTC	Premium (Observations)
Observation No. 5 – Forty-five (45) Subscribers Sample Review Adjustment (Incorrect Premium Amounts)	\$0.00	\$77.76
Observation No. 6 – Forty-five (45) Subscribers Sample Review Adjustment (Coverage Error)	\$0.00	\$0.00
EPDW As Recalculated	\$110,285,599.03	\$175,693,215.38
<b>Total Impact</b>	<b>\$(2,530.42)</b>	<b>\$3,655.13*</b>

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

The net financial impact of the two (2) findings is a payment of \$2,530.42, consisting of APTC owed to CMS.

\*Note: The premium impact of the six (6) observations is an understatement of \$3,655.13 in premiums. The premium impact is noted for purposes of improving compliance in future program years.

For the two (2) findings and six (6) observations, CMS documented the criteria, cause, effect, corrective actions, and Blue Cross of ID'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 2015 benefit year enrollment in seven (7) QHPs, the net "Total APTC Amount by QHP ID for effectuated enrollments" included in Blue Cross of ID's EPDW was greater than the total APTC amount included in Blue Cross of ID's Payment Desk Audit File, resulting in an overpayment of \$1,234.66 in APTC. For the one (1) or more months of 2015 benefit year enrollment in seven (7) QHPs, the total net enrollment in the EPDW was understated by nine hundred and five (905) APTC enrollment groups and four (4) APTC members.</p> <p><b>Premium Differences (Observation):</b> For one (1) or more months of 2015 benefit year enrollment in nine (9) QHPs, the net "Total Premium Amount by QHP ID for effectuated enrollments" included in Blue Cross of ID's EPDW was less than the total premium amount included in Blue Cross of ID's Payment Desk Audit File, resulting in an</p>

<b>Finding No. 1 and Observation No. 1 – EPDW Validations</b>	
	understatement of \$2,965.96 in premiums. For the one (1) or more months of 2015 benefit year enrollment in nine (9) QHPs, the total net enrollment in the EPDW was understated by one thousand, seven hundred and forty-nine (1,749) enrollment groups and seventeen (17) members.
<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> <p>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.”</p>
<b>Cause:</b>	<p>The issuer indicated the following explanations for the APTC differences:</p> <ul style="list-style-type: none"> <li>• “APTC correction in 6/2018”;</li> <li>• “Class was incorrectly changed in 2018, corrected back today”;</li> <li>• “Correction in 7/17, class for 2015 was added back”;</li> <li>• “Entry error corrected in 2017 for APTC previously given”;</li> <li>• “Entry error corrected in 2018. We gave APTC in error before”;</li> <li>• “Entry issue that was corrected 7/2017”;</li> <li>• “Retro termed policy to match loss of APTC date.”</li> </ul> <p>The issuer indicated the following explanations for the premium differences:</p> <ul style="list-style-type: none"> <li>• “Correction in 7/17, class for 2015 was added back”;</li> <li>• “Dependent rating capping variance - corrected”;</li> <li>• “DOB correction in 2017 which affected 2015”;</li> <li>• “Entry error, effective date was typed over to 2017, corrected today”;</li> <li>• “Entry issue that was corrected 7/2017”;</li> <li>• “There are 6 children on a responsible party policy.”</li> </ul> <p>Therefore, CMS concluded that the premium and APTC differences identified as a result of the EPDW Validations procedure were due to retroactive changes that occurred after the issuer submitted their final EPDW.</p>
<b>Effect:</b>	The APTC and premium differences resulted in a change to Blue Cross of ID’s final, restated 2015 benefit year EPDW data.

<b>Finding No. 1 and Observation No. 1 – EPDW Validations</b>	
<b>Corrective Action Required:</b>	<p>The net financial impact of this finding is a payment of \$1,234.66, consisting of APTC owed to CMS. Blue Cross of ID should confirm the financial impact and coordinate on resolution with CMS.</p> <p>The premium impact of this observation is an understatement of \$2,965.96 in premiums. CMS notes this observation for purposes of improving compliance in future program years.</p>
<b>Management Response:</b>	Agree

<b>Observation No. 2 – Unreconciled Subscribers Review</b>	
<b>Condition:</b>	Blue Cross of ID did not receive a binder payment but effectuated the enrollment in error and provided coverage for one (1) subscriber reported in the Payment Desk Audit File.
<b>Criteria:</b>	Pursuant to Idaho SBE guidance, “Consistent with Idaho insurance code, consumers are required to make an initial premium payment to bind coverage (i.e., initial binder payment). The Idaho Department of Insurance (DOI) will provide carriers with guidance on initial binder payments. For payments during the plan year, each carrier sets their own tolerance levels for minimum acceptable partial payments before the carrier cancels coverage for non-payment. Consumers can cancel before the coverage effective date and up to 10 days after the coverage effective date, even if the carrier has received confirmation of enrollment (e.g., binder payment). This is also commonly referred to as the "10-day lookback." If a consumer has a delinquency on their account and enrolls with the same carrier within 12 months, the carrier can choose to not effectuate any new enrollments until the consumer's delinquency is satisfied. Carriers must provide consumers the opportunity to make delinquency payments and must provide adequate noticing prior to denying the new enrollment.”
<b>Cause:</b>	The SBE indicated “Canceled not in effect (NIE) for nonpayment by carrier.” The issuer noted the enrollment was effectuated and coverage was provided; however, no payment was received for the one (1) month of enrollment.
<b>Effect:</b>	The issuer did not follow SBE enrollment guidance and requirements as the issuer provided coverage and effectuated enrollment when the first month’s binder payment was not received.

<b>Observation No. 2 – Unreconciled Subscribers Review</b>	
<b>Corrective Action Required:</b>	CMS notes this observation for purposes of improving compliance in future program years.
<b>Management Response:</b>	Agree

<b>Finding No. 2 and Observation No. 3 – Premium Less than APTC Validation</b>	
<b>Condition:</b>	Blue Cross of ID reported 2015 benefit year premium amounts that were less than the APTC amounts for nine (9) subscribers in the Payment Desk Audit File, resulting from Blue Cross of ID overstating the 2015 benefit year APTC amounts for five (5) subscribers and understating the 2015 benefit year premium amounts for four (4) subscribers in the Payment Desk Audit File.
<b>Criteria:</b>	Issuers cannot report an APTC amount that exceeds the premium amount for a policy.
<b>Cause:</b>	<p>The issuer indicated the following explanations for the nine (9) subscribers:</p> <ul style="list-style-type: none"> <li>• “Spouse was added for April but APTC was increased for March in error.” (One (1) subscriber)</li> <li>• “The correct APTC amount for month 2-3 is \$199.00. Incorrect APTC amount was allotted to member for these months by issuer.” (One (1) subscriber)</li> <li>• “APTC increased for March due to intended dependent add.” (One (1) subscriber)</li> <li>• “Dependent removed for November, should have been December. APTC is correct for November.” (One (1) subscriber)</li> <li>• “Dependent added for March. APTC was increased for January in error.” (Two (2) subscribers)</li> <li>• “2 dependents were to be added for December but only APTC was increased. Entry error.” (One (1) subscriber)</li> <li>• “Entry error, incorrect APTC entered for October, November, and December from Premium amount on 834.” (One (1) subscriber)</li> <li>• “APTC for month 2 would have been \$168.00 per 834 however SBE sent 834 changing the effective date of the</li> </ul>

<b>Finding No. 2 and Observation No. 3 – Premium Less than APTC Validation</b>	
	<p>policy from 2/1/15 to 3/1/15 and issuer did not remove coverage for month 2.” (One (1) subscriber)</p> <p>The issuer also provided the correct APTC and premium amounts for each of the nine (9) subscribers.</p>
<b>Effect</b>	<p>The inclusion of the incorrect APTC amounts for the five (5) subscribers and incorrect premium amounts for the four (4) subscribers resulted in a change to Blue Cross of ID’s final, restated 2015 benefit year EPDW data.</p>
<b>Corrective Action Required:</b>	<p>The net financial impact of this finding is a payment of \$1,295.76, consisting of APTC owed to CMS. Blue Cross of ID should confirm the financial impact and coordinate on resolution with CMS.</p> <p>The premium impact of this observation is an understatement of \$611.41 in premiums. CMS notes this observation for purposes of improving compliance in future program years.</p>
<b>Management Response:</b>	<p>Agree</p>

<b>Observation No. 4 – Coverage Days Validation</b>	
<b>Condition:</b>	<p>Blue Cross of ID provided coverage and reported enrollment and payment data for four (4) subscribers, who were also identified during the Unreconciled Subscribers Review, in the Payment Desk Audit File with coverage periods of five (5) days or fewer that should have been cancelled.</p>
<b>Criteria:</b>	<p>Pursuant to Idaho SBE guidance, “Consistent with Idaho insurance code, consumers are required to make an initial premium payment to bind coverage (i.e., initial binder payment). The Idaho Department of Insurance (DOI) will provide carriers with guidance on initial binder payments. For payments during the plan year, each carrier sets their own tolerance levels for minimum acceptable partial payments before the carrier cancels coverage for non-payment. Consumers can cancel before the coverage effective date and up to 10 days after the coverage effective date, even if the carrier has received confirmation of enrollment (e.g., binder payment). This is also commonly referred to as the "10-day lookback." If a consumer has a delinquency on their account and enrolls with the same carrier within 12 months, the carrier can choose to not effectuate any new enrollments until the consumer's</p>

<b>Observation No. 4 – Coverage Days Validation</b>	
	<p>delinquency is satisfied. Carriers must provide consumers the opportunity to make delinquency payments and must provide adequate noticing prior to denying the new enrollment.”</p> <p>Additionally, pursuant to 45 CFR § 156.270, QHP issuers must abide by the termination of coverage or enrollment effective dates described in § 155.430(d) of subchapter B.</p>
<b>Cause:</b>	For the four (4) subscribers, the issuer indicated “Canceled NIE before benefit begin date. Issuer provided coverage for 2 days (1/1/15-1/2/15) in error as SBE 834 showed term date of 1/1/15.” The SBE indicated the enrollments did not exist and were not effectuated in their systems.
<b>Effect:</b>	The issuer did not follow SBE enrollment guidance and requirements as the issuer provided coverage for four (4) subscribers with enrollments that should have been cancelled.
<b>Corrective Action Required:</b>	CMS notes this observation for purposes of improving compliance in future program years.
<b>Management Response:</b>	Agree

<b>Observation No. 5 – Forty-five (45) Subscribers Sample Review (Incorrect Premium Amounts)</b>	
<b>Condition:</b>	Blue Cross of ID understated the 2015 benefit year premium amounts for one (1) of the forty-five (45) selected subscribers in the Payment Desk Audit File.
<b>Criteria:</b>	<p>Pursuant to CMS guidance, the issuer must create a single Inbound Payment Desk Audit File consisting of detailed enrollment group effectuated enrollment records (one per enrollment group, per month) with the corresponding payment data.</p> <p>Pursuant to CMS guidance, the premium amount reported in the EPDW and the Payment Desk Audit File is the premium amount by 16 digit QHP ID for the effectuated enrollment within a qualified health plan.</p>
<b>Cause:</b>	For the subscriber with a premium amount of \$484.09 for month 1 and months 8-12 and a premium amount of \$471.13 for months 2-7 in the Payment Desk Audit File, the issuer indicated “Issuer changed premium per DOB correction to \$484.09 retroactive to 1/11/15.

<b>Observation No. 5 – Forty-five (45) Subscribers Sample Review (Incorrect Premium Amounts)</b>	
	Premium is \$480.09 months 2 - 9 as well.” The SBE indicated “Gross Premium should have been \$484 since 1/1/2015.”
<b>Effect:</b>	The inclusion of the incorrect premium amounts for the one (1) subscriber resulted in a change to Blue Cross of ID’s final, restated 2015 benefit year EPDW data.
<b>Corrective Action Required:</b>	The premium impact of this observation is an understatement of \$77.76 in premiums. CMS notes this observation for purposes of improving compliance in future program years.
<b>Management Response:</b>	Agree

<b>Observation No. 6 – Forty-five (45) Subscribers Sample Review (Coverage Error)</b>	
<b>Condition:</b>	Blue Cross of ID provided coverage in error and reported enrollment and payment data for one (1) of the forty-five (45) selected subscribers in the Payment Desk Audit File with an enrollment that should have been cancelled.
<b>Criteria:</b>	Pursuant to 45 CFR § 156.270, QHP issuers must abide by the termination of coverage or enrollment effective dates described in § 155.430(d) of subchapter B.
<b>Cause:</b>	The issuer indicated that “Policy ID <<REDACTED>> was canceled NIE by SBE. Issuer gave coverage in error.” The issuer also confirmed that the subscriber was billed and paid the premium responsibility amount for all months of enrollment.  The SBE indicated that “Per Your Health Idaho (YHI), the consumer didn't have coverage during 1/1/2015 - 3/31/2015.”
<b>Effect:</b>	The issuer did not follow CMS enrollment guidance and requirements as the issuer provided coverage for a subscriber with an enrollment that should have been cancelled.
<b>Corrective Action Required:</b>	CMS notes this observation for purposes of improving compliance in future program years.
<b>Management Response:</b>	Agree

---

---

## V. MANAGEMENT RESPONSES

---

---

Please provide management's response to the two (2) findings and six (6) 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 six (6) 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 six (6) 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: 61589

Issuer Name: Blue Cross of Idaho (Blue Cross of ID)

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 program participation, resulting in a payment of \$2,530.42 to CMS and:

(INITIAL) WJ 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: Melvin A. Pearson  
(Signature of authorized person acting on behalf of the issuer)

Printed Name: MELVIN A. PEARSON  
(Print name of signature)

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

Telephone Number: 986-224-3922  
(Direct Telephone Number)

Date: 5 April 2022

## Appendix 2 – Applicable Regulations

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

Regulation	Rules
<p><b>45 CFR § 155.1210 – Maintenance of Records</b></p>	<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> <ul style="list-style-type: none"> <li>(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;</li> <li>(2) Notify the Exchange of the reduction in the portion of the premium charged to the individual in accordance with § 156.265(g); and</li> <li>(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.</li> </ul>
<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><b>(a) 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><b>(1)</b> 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><b>(2)</b> 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><b>(c) 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><b>(d) 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>DHHS</b>	Department of Health and Human Services
<b>EPDW</b>	Enrollment and Payment Data Workbook
<b>GAGAS</b>	Generally Accepted Government Auditing Standards
<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

---