



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

for

Blue Cross & Blue Shield of Rhode Island (Rhode Island)

July 1, 2022

Table of Contents

I. EXECUTIVE SUMMARY	3
II. BACKGROUND, OBJECTIVES, SCOPE, AND METHODOLOGY	5
III. RESULTS OF REVIEW	8
IV. FINDINGS AND OBSERVATIONS.....	10
V. 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	27

I. EXECUTIVE SUMMARY

Background

Blue Cross & Blue Shield of Rhode Island (BCBS of RI) is a health insurance issuer that offered qualified health plans (QHPs) in the individual market State-Based Exchange (SBE) in Rhode Island during the 2015 benefit year. The state of Rhode Island submitted BCBS of RI's final restated 2015 benefit year data in the July 2016 Enrollment and Payment Data Workbook (EPDW). The issuer received a total of \$30,379,581.99 in advance payments of the premium tax credit (APTC) from the Centers for Medicare & Medicaid Services (CMS) and the SBE reported a total of \$68,806,249.30 in premiums for the issuer's 2015 benefit year individual market plans.

This report is an assessment, conducted in coordination with the SBE, of BCBS of RI'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 audit¹ 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 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 on the final 2015 EPDW submitted by the SBE, and to analyze controls and policies of selected issuers pursuant to the authority defined in 45 CFR §§ 155.1210 and 156.480.

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 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 one (1) finding and six (6) observations for BCBS of RI. The net APTC financial impact of the one (1) finding is an understatement of \$114,248.43 in APTC in the final EPDW and therefore a payment to BCBS of RI of \$114,248.43 in APTC. The net premium impact of the six (6) observations is an understatement of \$277,490.16 in premiums in the final EPDW. The finding and observations include the following:

Finding:

1. Exclusion of APTC amounts for one (1) certified QHP in the July 2016 EPDW submitted by the SBE that were correctly reported in a Payment Desk Audit File containing subscriber level data from BCBS RI's systems.

Observations:

1. Exclusion of premium amounts for one (1) certified QHP in the July 2016 EPDW submitted by the SBE that were correctly reported in a Payment Desk Audit File containing subscriber level data from BCBS RI's systems;
2. Differences in premium and APTC amounts identified in the comparison of the issuer's data included in the July 2016 EPDW submitted by the SBE to a Payment Desk Audit File containing subscriber level data from BCBS of RI's systems;
3. Inclusion of full month enrollment, premium, and APTC payment data for six (6) duplicate subscribers in the Payment Desk Audit File;
4. Inclusion of premium amounts that were less than the APTC amounts for six (6) subscribers in the Payment Desk Audit File;
5. Exclusion of months of coverage for two (2) subscribers identified with premium amounts that were less than the APTC amounts and one (1) of the forty-five (45) selected subscribers, who was also one (1) of the fifteen (15) selected subscribers, in the Payment Desk Audit File; and
6. Inclusion of premium amounts in the Payment Desk Audit File that differed from the premium amounts reported in the July 2016 EPDW submitted by the SBE, SBE's PLR data, and invoices resulting from differences in premium calculation methods.

Please refer to section IV for details on the finding 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 2015-2017 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 submitters, including the state of Rhode Island, to submit enrollment and payment data on behalf of its issuers 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 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 SBE-generated EPDW data reported for premiums and the APTC program;
- (2) Identify potential CMS APTC payment errors resulting from issuer or SBE 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 BCBS of RI for an audit to assess the issuer's compliance with 45 CFR §§ 155.1210, 156.460 and 156.480. CMS evaluated BCBS of RI'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 July 2016 by the SBE to CMS to support APTC payments and premium amounts.

CMS sent BCBS of RI 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 BCBS of RI on February 20, 2019 that identified data requirements required to conduct the audit. CMS's audit contractor reviewed the audit data file submitted by BCBS of RI, as well as the final 2015 EPDW submitted by the

SBE 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.

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 procedures²:

- Validations of the Payment Desk Audit File data submitted to CMS:
 - EPDW Validations: Review and comparison of the SBE'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.

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

III. RESULTS OF REVIEW

CMS assessed issuer compliance with regulations using the following procedures: EPDW Validations, Unreconciled Subscribers Review, Duplicate Exchange-assigned Subscriber IDs Check, 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 two (2) observations resulted from the comparison of the final 2015 EPDW submitted by the SBE to BCBS of RI's Payment Desk Audit File. Please refer to Finding No. 1 and Observation No. 1 and Observation No. 2 included in section IV for details on the finding and observations.

Unreconciled Subscribers Review

No findings or observations resulted from the review of BCBS of RI's Payment Desk Audit File to determine if the subscribers reported in the file existed in the SBE's PLR data and their coverage was effectuated in the issuer's systems.

Duplicate Exchange-assigned Subscriber IDs Check

No findings and one (1) observation resulted from the review of BCBS of RI's Payment Desk Audit File to verify that duplicate Exchange-assigned subscriber IDs were not reported in the file. Please refer to Observation No. 3 included in section IV for details on the observation.

Premium Less than APTC Validation

No findings and three (3) observations resulted from the review of BCBS of RI'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. Two (2) of the observations were also identified as a result of the Forty-five (45) Subscribers Sample Review and the Fifteen (15) Subscribers Sample Review. Please refer to Observation No. 4, Observation No. 5, and Observation No. 6 included in section IV for details on the observations.

Coverage Days Validation

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

Forty-five (45) Subscribers Sample Review

No findings and two (2) observations resulted from the review and comparison of the data from

BCBS of RI'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. The two (2) observations were also identified as a result of the Premium Less than APTC Validation and the Fifteen (15) Subscribers Sample Review. 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 and two (2) observations resulted from the review of the data and documentation from BCBS of RI's systems to verify effectuation and the appropriate application of premium and APTC amounts to policies for a selected sample of fifteen (15) subscribers. The two (2) observations were also identified as a result of the Premium Less than APTC Validation and the Forty-five (45) Subscribers Sample Review. Please refer to Observation No. 5 and Observation No. 6 included in section IV for details on the observations.

Policy and Procedure Review

No findings or observations resulted from the review of BCBS of RI'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 one (1) finding that resulted in a change to the APTC amounts reported in BCBS of RI’s EPDW submitted by the SBE 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 one (1) observation that resulted in a change to the premium amounts reported in BCBS of RI’s EPDW submitted by the SBE for individual market plans for the 2015 benefit year and five (5) observations that did not result in a change to the premium amounts reported in BCBS of RI’s EPDW but that are noted for purposes of improving compliance in future program years.

In light of the one (1) finding 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 by the SBE in July 2016	\$30,379,581.99	\$68,806,249.30
Finding No. 1 and Observation No. 1 – EPDW Validations Adjustment (QHP Certification)	\$114,248.43	\$277,490.16
Observation No. 2 – EPDW Validations Adjustment	\$0.00	\$0.00
Observation No. 3 – Duplicate Exchange-assigned Subscriber IDs Check Adjustment	\$0.00	\$0.00
Observation No. 4 – Premium Less than APTC Validation Adjustment	\$0.00	\$0.00

	APTC	Premium (Observations)
Observation No. 5 – Premium Less than APTC Validation, Forty-five (45) Subscribers Sample Review and Fifteen (15) Subscribers Sample Review (Incorrect Coverage Period) Adjustment	\$0.00	\$0.00
Observation No. 6 – Premium Less than APTC Validation, Forty-five (45) Subscribers Sample Review and Fifteen (15) Subscribers Sample (Premium Rating) Review Adjustment	\$0.00	\$0.00
EPDW As Recalculated	\$30,493,830.42	\$69,083,739.46
Total Impact	\$114,248.43	\$277,490.16*

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

The net financial impact of the one (1) finding is a payment of \$114,248.43, consisting of APTC paid to BCBS of RI.

*Note: The premium impact is an understatement of \$277,490.16 in premiums. The premium impact is noted for purposes of improving compliance in future program years.

For the one (1) finding and six (6) observations, CMS documented the criteria, cause, effect, corrective actions, and BCBS of RI’s responses as seen in the charts below.

Finding No. 1 and Observation No. 1 – EPDW Validations (QHP Certification)	
Condition:	APTC Differences (Finding) –BCBS of RI’s Payment Desk Audit File included twelve (12) months of 2015 benefit year enrollment in QHP ID 15287RI068000101 with a total APTC amount of \$114,248.43 while BCBS of RI’s EPDW submitted by the SBE did not include any enrollments in QHP ID 15287RI068000101. Therefore, for the twelve (12) months of 2015 benefit year enrollment in QHP ID 15287RI068000101, the EPDW the understated by \$114,248.43 in APTC and the total net enrollment in the EPDW was understated by

Finding No. 1 and Observation No. 1 – EPDW Validations (QHP Certification)	
	<p>three hundred and seventy-nine (379) APTC enrollment groups and five hundred and fifty-one (551) APTC members.</p> <p>Premium Differences (Observation) – BCBS of RI’s Payment Desk Audit File included twelve (12) months of 2015 benefit year enrollment in QHP ID 15287RI068000101 with a total premium amount of \$277,490.16 in premiums while BCBS of RI’s EPDW submitted by the SBE did not include any enrollments in QHP ID 15287RI068000101. Therefore, for the twelve (12) months of 2015 benefit year enrollment in QHP ID 15287RI068000101, the EPDW was understated \$277,490.16 in premiums and the total net enrollment in the EPDW was understated by six hundred and thirty-four (634) enrollment groups and eight hundred and ninety-six (896) members.</p>
Criteria:	<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>
Cause:	<p>It was noted that QHP ID 15287RI068000101 was included in the issuer’s Payment Desk Audit File with a total premium amount of \$277,490.16 and total APTC amount of \$114,248.43; however, this QHP ID was not included in the July 2016 EPDW submitted by the SBE.</p> <p>During the audit, CMS coordinated with the issuer to determine whether the enrollments associated with QHP ID 15287RI068000101 should be included in the Payment Desk Audit File and therefore the 2015 EPDW, and the issuer indicated “This was a plan available in 2015 only. It should be included in the files.” The issuer further indicated "Coverage was provided to any member enrolled in this plan during 2015. BCBSRI worked with the state throughout 2015 and 2016 to work through discrepancies but recognized that not all discrepancies were completely resolved. This plan was added to our portfolio after annual rate filing at the request of HealthSource RI. We worked with the state to make sure that this last-minute addition was approved by the Rhode Island Office of the Health Insurance Commissioner and HealthSource. "</p> <p>The SBE indicated, “HSRI agrees with BCBS response above, discrepancies are minimal. Plan HIOS ID - 15287RI068000101 (highlighted in yellow) was certified and added to the exchange after</p>

Finding No. 1 and Observation No. 1 – EPDW Validations (QHP Certification)	
	<p>the normal cycle. The plan errored out in the EPDW submission due to unknown plan ID and the plan was not processed by CMS. BCBS has correctly reported it.”</p> <p>Therefore, CMS concluded the premium and APTC amounts reported in the EPDW were understated as the issuer’s Payment Desk Audit File correctly included effectuated enrollments for QHP ID 15287RI068000101 that were not reported in the EPDW.</p>
Effect	The APTC and premium differences resulted in a change to HMSA’s final, restated 2015 benefit year EPDW data.
Corrective Action Required:	<p>The net financial impact of this finding is a payment to the issuer of \$114,248.43, consisting of APTC owed to the issuer. BCBS of RI should confirm the financial impact by filling out Appendix 1.</p> <p>The premium impact of this observation is an understatement of \$277,490.16 in premiums. CMS notes this observation for purposes of improving compliance in future program years.</p>
Management Response:	

Observation No. 2 – EPDW Validations	
Condition:	<p>APTC Differences (Observation) – For one (1) or more months of 2015 benefit year enrollment in twenty (20) QHPs, the net “Total APTC Amount by QHP ID for effectuated enrollments” included in BCBS of RI’s EPDW submitted by the SBE was less than the total APTC amount included in BCBS of RI’s Payment Desk Audit File, resulting in an understatement of \$166,133.42 in APTC. For the one (1) or more months of 2015 benefit year enrollment in twenty (20) QHPs, the total net enrollment in the EPDW was understated by six hundred and two hundred and forty-five (245) APTC enrollment groups and three hundred and ninety-four (394) APTC members.</p> <p>Premium Differences (Observation) – For one (1) or more months of 2015 benefit year enrollment in twenty-four (24) QHPs, the net “Total Premium Amount by QHP ID for effectuated enrollments” included in BCBS of RI’s EPDW submitted by the SBE was greater than the total premium amount included in BCBS of RI’s Payment Desk Audit File, resulting in an overstatement of \$1,407,771.12 in premiums. For the</p>

Observation No. 2 – EPDW Validations	
	<p>one (1) or more months of 2015 benefit year enrollment in twenty-four (24) QHPs, the EPDW was overstated by thirty-six thousand, seven hundred and twenty-seven (6,727) enrollment groups and fifty-three thousand, eight hundred and thirty-seven (53,837) members.</p>
Criteria:	<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>
Cause:	<p>For all QHPs identified with differences except for QHP ID 15287RI068000101 (refer to Finding No.1 and Observation No.1 for additional details regarding QHP ID 15287RI068000101), the issuer indicated, “HealthSource RI (HSRI) is the system of record for premium billing, collection and APTC calculation. Blue Cross & Blue Shield of Rhode Island (BCBSRI) believes most of the discrepancies are the result of retroactive changes which may not have updated our billing system. While HSRI is the system of record for premium calculations, our system does calculate a rate in our system which is what is reflected in the data and may result in de minimis discrepancies.” CMS noted that these differences in premium calculation methods, also noted in the Premium Less than APTC Validation, Forty-five (45) Subscribers Sample Review, and Fifteen (15) Subscribers Sample Review, may be a potential cause of the premium difference of \$1,407,771.12 noted as a result of the EPDW Validations. Please refer to Observation No. 6 – Premium Less than APTC Validation, Forty-five (45) Subscribers Sample Review, and Fifteen (15) Subscribers Sample Review (Premium Rating) for details on the premium calculation differences.</p>
Effect:	<p>The APTC and premium differences identified did not result in a change to BCBS of RI’s final, restated 2015 benefit year EPDW data submitted by the SBE. Pursuant to CMS audit procedures for SBEs that submitted workbooks to CMS, CMS will not make additional APTC payments to SBE issuers based on the issuer’s and SBE’s audit responses, unless the SBE or issuer also provide additional documentation to support those payments. Therefore, CMS will continue to use the SBE-submitted EPDW as the final source of truth for payment and will not make adjustments based on the issuer’s</p>

Observation No. 2 – EPDW Validations	
	Payment Desk Audit File that includes additional enrollments and APTC that did not exist in the SBE-submitted EPDW.
Corrective Action Required:	CMS notes this observation for purposes of improving compliance and issuer and SBE reconciliation in future program years.
Management Response:	

Observation No. 3 – Duplicate Exchange-assigned Subscriber IDs Check	
Condition:	BCBS of RI overstated the 2015 benefit year premium amounts for six (6) subscribers, and overstated the benefit year APTC amounts for three (3) of those subscribers, in the Payment Desk Audit File by reporting 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>For each of the six (6) subscribers, two (2) duplicate records were included in the Payment Desk Audit File with full month payment data in the same month. The issuer noted that the two (2) records represented mid-month terminations and re-enrollments and indicated that, “BCBSRI system prorates based on the number of days in each month. We have calculated what we would have expected based on this proration. HealthSource RI's systems would be the system of truth for proration and BCBSRI would write off the differences as appropriate.”</p> <p>In addition, the issuer indicated the appropriate period of coverage for the enrollment record and provided the applicable correct prorated premium and APTC amounts for the each of the duplicate records.</p>
Effect:	<p>The inclusion of the six (6) duplicate subscribers resulted in an overstatement of \$491.60 in APTC and \$2,221.02 in premiums in BCBS of RI’s Payment Desk Audit File.</p> <p>The duplicate subscribers were not enrolled in QHP ID 15287RI068000101 and therefore, as noted in Observation 2, CMS will not make additional APTC payments to SBE issuers based on the issuer’s and SBE’s audit responses, unless the SBE or issuer also provide additional documentation to support those payments. CMS will therefore continue to use the SBE-submitted EPDW as the final</p>

Observation No. 3 – Duplicate Exchange-assigned Subscriber IDs Check	
	source of truth for payment and will not make any adjustments based on the higher total payment amount in BCBS RI’s Payment Desk Audit File discussed in Observation 2.
Corrective Action Required:	CMS notes this observation for purposes of improving compliance and issuer and SBE reconciliation in future program years.
Management Response:	

Observation No. 4 – Premium Less than APTC Validation	
Condition:	BCBS of RI reported 2015 benefit year premium amounts that were less than the APTC amounts for six (6) subscribers in the Payment Desk Audit File, resulting from BCBS of RI overstating the 2015 benefit year APTC amounts for five (5) of those subscribers and understating the 2015 benefit year premium amount for one (1) of those subscribers in the Payment Desk Audit File.
Criteria:	Issuers cannot report an APTC amount that exceeds the premium amount for a policy.
Cause:	<p>The issuer or SBE indicated the following explanations for the five (5) subscribers with incorrect APTC amounts:</p> <ul style="list-style-type: none"> • “BCBSRI confirmed that the APTC was reduced after the dependent terminated from the account. This happened retroactively and our billing system did not update.” • “The APTC was retroactively reduced to \$0 for the month of November but our system was not correctly updated to reflect that.” • “BCSBRI verified that the APTC was incorrectly applied to both the subscriber but also to the dependent in the BCBSRI system which doubled the amount in our reporting.” • “In November, the account terminated the dependent. For both the months of November and December the APTC was \$0.” • “FMS shows premium of \$1,504.86 w/ APTCs of \$1,061.58 from 1/1/14 to 4/30/14. Premium of \$733.89 from 5/1/14 to 12/31/14, no APTCs. Premium of \$641.91 from 1/1/15 to 12/31/15, no APTCs.” <p>For the one (1) subscriber with an incorrect premium amount reported in the Payment Desk Audit File, the issuer indicated, “BCBSRI</p>

Observation No. 4 – Premium Less than APTC Validation	
	system shows that both the subscriber and dependent were enrolled through June 2015 but for some reason the dependents premium was not charged for the month of June. This likely has to do with retroactivity and our billing system not updating as the account was cancelled.” The issuer provided the correct premium amount for the subscriber.
Effect:	<p>The inclusion of the incorrect APTC amounts for the five (5) subscribers and incorrect premium amount for the one (1) subscriber resulted in an overstatement of \$15,088.56 in APTC and understatement of \$250.02 in premiums in BCBS of RI’s Payment Desk Audit File.</p> <p>The incorrect amounts were not reported for subscribers enrolled in QHP ID 15287RI068000101 and therefore, as noted in Observation 2, CMS will not make additional APTC payments to SBE issuers based on the issuer’s and SBE’s audit responses, unless the SBE or issuer also provide additional documentation to support those payments. CMS will therefore continue to use the SBE-submitted EPDW as the final source of truth for payment and will not make any adjustments based on the higher total payment amount in BCBS RI’s Payment Desk Audit File discussed in Observation 2.</p>
Corrective Action Required:	CMS notes this observation for purposes of improving compliance and issuer and SBE reconciliation in future program years.
Management Response:	

Observation No. 5 – Premium Less than APTC Validation, Forty-Five (45) Subscribers Sample Review and Fifteen (15) Subscribers Sample Review (Incorrect Coverage Period)	
Condition:	BCBS of RI reported the incorrect 2015 benefit year coverage for two (2) subscribers identified in the Premium Less than APTC Validation and one (1) of the forty-five (45) selected subscribers, who was also one (1) of the fifteen selected subscribers, in the Payment Desk Audit File.
Criteria:	<p>Issuers cannot report an APTC amount that exceeds the premium amount for a policy.</p> <p>Pursuant to CMS guidance and 45 CFR § 156.270, QHP issuers must abide by the termination of coverage or enrollment effective dates described in § 155.430(d) of subchapter B. Pursuant to 45 CFR §</p>

Observation No. 5 – Premium Less than APTC Validation, Forty-Five (45) Subscribers Sample Review and Fifteen (15) Subscribers Sample Review (Incorrect Coverage Period)

	<p>155.430, the Exchange may establish operational instructions as to the form, manner and method for addressing a cancellation which is a specific type of termination action that ends a qualified individual's enrollment through the Exchange on the date such enrollment became effective resulting in enrollment through the Exchange never having been effective, and for addressing a terminations which is an action taken after a coverage effective date that ends an enrollee's enrollment through the Exchange for a date after the original coverage effective date, resulting in a period during which the individual was enrolled in coverage through the Exchange.</p>
<p>Cause:</p>	<p>The issuer indicated the following explanations:</p> <ul style="list-style-type: none"> • For the subscriber identified in the Premium Less than APTC Validation with APTC amounts that exceeded the premium amounts in January through July and December, the issuer indicated, “BCBSRI has also identified that this member was enrolled for the entire year but a bug in our code caused it to appear that they were not enrolled for August through November. BCBSRI has added the missing rows to this spreadsheet for your review. BCBSRI is continuing review this case but suspect that retroactivity has occurred which happened after our billing system had run.” • For the subscriber identified in the Premium Less than APTC Validation with APTC amounts that exceeded the premium amounts in January through October and December, the issuer indicated, “BCBSRI has identified a coding issue and the line for November appears to be missing from your report. In November, the account terminated the dependent. For both the months of November and December the APTC was \$0. BCBSRI has added the missing row to this spreadsheet for your review.” • For the subscriber identified in the Forty-five (45) Subscribers Sample Review and Fifteen (15) Subscribers Sample Review, the Payment Desk Audit File included enrollment in February, April, and May while the policy level documentation reflected that the subscriber was invoiced for January through May, the issuer indicated, “The member was only active in the months listed. Our system billed \$0 for the inactive months when it ran.” The SBE indicated, “HSRI does the billing (not the carrier), the carrier does not have the authority to determine if someone should or should not be effectuated. Acct #12871: FMS shows premium of \$408.06 w/ \$186.49 APTCs for 1/1/15 to 1/31/15. Premium of \$477.02 w/ \$186.49 APTCs for

Observation No. 5 – Premium Less than APTC Validation, Forty-Five (45) Subscribers Sample Review and Fifteen (15) Subscribers Sample Review (Incorrect Coverage Period)	
	<p>2/1/15 to 2/28/15. Premium of \$489.96 w/ \$167.68 APTCs for 4/1/15 to 5/31/15.”</p> <p>It was noted that the exclusion of certain months of enrollment may impact additional enrollments reported in BCBS of RI’s Payment Desk Audit File; however, the SBE performs enrollment and billing on behalf of the issuers and submitted the EPDW on behalf of the issuers and therefore, CMS will continue to use the SBE-submitted EPDW as the final source of truth for payment and will not make adjustments based on the issuer’s Payment Desk Audit File that includes additional enrollments and APTC that did not exist in the SBE-submitted EPDW.</p>
Effect:	<p>The exclusion of months of enrollment for the three (3) subscribers resulted in an understatement of \$186.49 in APTC and understatement of \$3,775.90 in premiums in BCBS of RI’s Payment Desk Audit File.</p> <p>The subscribers were not enrolled in QHP ID 15287RI068000101 and therefore, as noted in Observation 2, CMS will not make additional APTC payments to SBE issuers based on the issuer’s and SBE’s audit responses, unless the SBE or issuer also provide additional documentation to support those payments. CMS will therefore continue to use the SBE-submitted EPDW as the final source of truth for payment and will not make any adjustments based on the higher total payment amount in BCBS RI’s Payment Desk Audit File discussed in Observation 2.</p>
Corrective Action Required:	CMS notes this observation for purposes of improving compliance and issuer and SBE reconciliation in future program years.
Management Response:	

Observation No. 6 – Premium Less than APTC Validation, Forty-five (45) Subscribers Sample Review and Fifteen (15) Subscribers Sample Review (Premium Rating)	
Condition:	BCBS of RI included premium amounts in the Payment Desk Audit File that were different from the premium amounts that were calculated and reported in BCBS of RI’s final 2015 benefit year EPDW submitted by the SBE, the SBE’s PLR data, and the invoices that were generated by the SBE.

Observation No. 6 – Premium Less than APTC Validation, Forty-five (45) Subscribers Sample Review and Fifteen (15) Subscribers Sample Review (Premium Rating)

<p>Criteria:</p>	<p>Issuers cannot report an APTC amount that exceeds the premium amount for a policy. Additionally, pursuant to CMS guidance, the premium amount reported in the EPDW and Payment Desk Audit File is the total monthly premium amount for the effectuated enrollment within a qualified health plan.</p>
<p>Cause:</p>	<p>For the nine (9) subscribers that were identified in the Premium Less than APTC Validation with incorrect premium amounts, the issuer indicated the following:</p> <ul style="list-style-type: none"> • “While HSRI is the system of record for premium billing and collections, BCBSRI's premium is calculated by our system. There are minimal discrepancies that may have occurred due to differences in how each system calculates the age and rates. BCBSRI populates the APTC based on the information provided by HealthSource RI.” (Eight (8) subscribers) • “BCSBRI verified that the dependent was termed effective 12/30/2015 which resulted in our system adjusting the member's premium. BCBSRI believes that HSRI incorrectly termed the member the day before the end of the year.” (One (1) subscriber) <p>Additionally, as a result of the Forty-five (45) Subscribers Sample Review, minor premium differences were noted between the premium amounts included in the issuer’s Payment Desk Audit File and the premium amounts reported in the SBE’s PLR data for seven (7) of the forty-five (45) selected subscribers. Five (5) of those subscribers were also included in the Fifteen (15) Subscribers Sample Review and minor premium differences were also noted between the premium amounts included in the issuer’s Payment Desk Audit File and the premium amounts reported in the invoices that were generated by the SBE and billed to the subscriber. For the (7) subscribers, the issuer or SBE indicated one of the following explanations:</p> <ul style="list-style-type: none"> • “Per our contract with HealthSource RI they are the system of record for premiums and enrollment, so yes I would use their systems.” (Four (4) subscribers) • “While HSRI is the system of record for premium calculations, BCBSRI's system does calculate a rate in our system which is what is reflected in the data and may result in de minimis discrepancies.” (Two (2) subscribers) • “FMS shows premium of \$408.06 w/ \$186.49 APTCs for 1/1/15 to 1/31/15. Premium of \$477.02 w/ \$186.49 APTCs for

Observation No. 6 – Premium Less than APTC Validation, Forty-five (45) Subscribers Sample Review and Fifteen (15) Subscribers Sample Review (Premium Rating)	
	<p>2/1/15 to 2/28/15. Premium of \$489.96 w/ \$167.68 APTCs for 4/1/15 to 5/31/15.” (One (1) subscriber)</p> <p>The SBE performed billing and enrollment on behalf of the issuer and therefore the inclusion of the premium amounts that existed in the issuer’s systems that differed from the premium amounts reported and billed by the SBE could impact additional enrollments reported in the Payment Desk Audit File. Therefore, the differences in premium calculations may be a potential cause of the premium difference that were noted as a result of the EPDW Validations. Refer to Observation No. 2 – EPDW Validations.</p>
Effect:	<p>The issuer included premium amounts that were calculated by their systems in the Payment Desk Audit File instead of the premium amounts that were billed and reported by the SBE, which resulted in the minor premium differences identified as a result of the Premium Less than APTC Validation, Forty-five (45) Subscribers Sample Review, and Fifteen (15) Subscribers Sample Review.</p> <p>As noted in Observation 2, CMS will not make additional APTC payments to SBE issuers based on the issuer’s and SBE’s audit responses, unless the SBE or issuer also provide additional documentation to support those payments. CMS will therefore continue to use the SBE-submitted EPDW as the final source of truth for payment and will not make any adjustments based on the higher total payment amount in BCBS RI’s Payment Desk Audit File discussed in Observation 2.</p>
Corrective Action Required:	<p>CMS notes this observation for purposes of improving compliance and issuer and SBE reconciliation in future program years.</p>
Management Response:	

V. MANAGEMENT RESPONSES

Please provide management's response to the one (1) finding 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 one (1) finding 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 the one (1) finding and 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: 15287

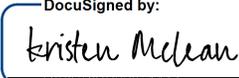
Issuer Name: Blue Cross & Blue Shield of Rhode Island (BCBS of RI)

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 \$114,248.43 to BCBS of RI and:

(INITIAL) ^{ksm} _____ 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: ^{DocuSigned by:}  _____
7C3B50C660B1444...
(Signature of authorized person acting on behalf of the issuer)

Printed Name: Kristen McLean
(Print name of signature)

Title: VP & General Counsel
(Title of authorized person acting on behalf of the Issuer)

Telephone Number: (401)459-1383
(Direct Telephone Number)

Date: 7/21/2022

Appendix 2 – Applicable Regulations

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

Regulation	Rules
<p>45 CFR § 155.1210 – Maintenance of Records</p>	<p>(a) General. The State Exchange must maintain and must ensure its contractors, subcontractors, and agents maintain for 10 years, documents and records (whether paper, electronic, or other media) and other evidence of accounting procedures and practices, which are sufficient to do the following:</p> <ul style="list-style-type: none"> (1) Accommodate periodic auditing of the State Exchange's financial records; and (2) Enable HHS or its designee(s) to inspect facilities, or otherwise evaluate the State- Exchange's compliance with Federal standards. <p>(b) Records. The State Exchange and its contractors, subcontractors, and agents must ensure that the records specified in paragraph (a) of this section include, at a minimum, the following:</p> <ul style="list-style-type: none"> (1) Information concerning management and operation of the State Exchange's financial and other record keeping systems; (2) Financial statements, including cash flow statements, and accounts receivable and matters pertaining to the costs of operations; (3) Any financial reports filed with other Federal programs or State authorities; (4) Data and records relating to the State Exchange's eligibility verifications and determinations, enrollment transactions, appeals, and plan variation certifications; and (5) Qualified health plan contracting (including benefit review) data and consumer outreach and Navigator grant oversight information. <p>(c) Availability. A State Exchange must make all records and must ensure its contractors, subcontractors, and agents must make all records in paragraph (a) of this section available to HHS, the OIG, the Comptroller General, or their designees, upon request.</p>

Regulation	Rules
<p>45 CFR § 156.460 - Reduction of enrollee's share of premium to account for advance payments of the premium tax credit</p>	<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> <ul 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.
<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>

Regulation	Rules
<p>45 CFR § 156.705 – Maintenance of records for Federally-facilitated Exchanges</p>	<p>(a) <i>General standard.</i> 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) <i>Records.</i> 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) <i>Record retention timeframe.</i> 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) <i>Record availability.</i> 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
DHHS	Department of Health and Human Services
EPDW	Enrollment and Payment Data Workbook
GAGAS	Generally Accepted Government Auditing Standards
HIOS	Health Insurance Oversight System
IRS	Internal Revenue Service
PPACA	Patient Protection and Affordable Care Act
PLR	Policy-level Reporting
QHP	Qualified Health Plan
SBE	State-based Exchange
TIN	Tax Identification Number
