



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

for

Health New England, Inc. (Massachusetts)

March 21, 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	19
Appendix 1 – Issuer Management Response to Net Financial Adjustment	20
Appendix 2 – Applicable Regulations	21
Appendix 3 – Glossary of Terms and Acronyms	24

I. EXECUTIVE SUMMARY

Background

Health New England, Inc. (HNE) is a health insurance issuer that offered qualified health plans (QHPs) in the individual market State-Based Exchange (SBE) in Massachusetts during the 2015 benefit year. The state of Massachusetts submitted HNE's final restated 2015 benefit year data in the November 2016 Enrollment and Payment Data Workbook (EPDW). The issuer received a total of \$7,536,370.31 in advance payments of the premium tax credit (APTC) from CMS and the SBE reported a total of \$20,446,235.59 in premiums for the issuer's 2015 benefit year individual market plans.

This report is an assessment, conducted in coordination with the SBE, of HNE'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 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 SBE, and to analyze controls and policies of selected issuers pursuant to the authority defined in 45 CFR §§ 155.1210 and 156.480.

The findings and observations are documented below. If CMS found an instance of issuer non-compliance with APTC program requirements that requires correction to the APTC reported in

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 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 five (5) observations for HNE. The net APTC financial impact of the one (1) audit finding is an overstatement of \$218,255.28 in APTC in the final EPDW submitted by the SBE and therefore a payment to CMS of \$218,255.28, consisting of APTC owed to CMS. The net premium impact of the five (5) observations is an overstatement of \$690,775.89 in premiums in the final EPDW submitted by the SBE. The finding and observations include the following:

Finding:

1. Differences in APTC amounts identified in the comparison of the issuer's data included in the November 2016 EPDW submitted by the SBE to the updated amounts provided by the SBE. The SBE performs enrollment and billing on behalf of the issuers and submitted the EPDW on behalf of the issuers; therefore, CMS concluded that an adjustment will be made based on the comparison of the SBE provided updated amounts and the EPDW.

Observations:

1. Differences in premium amounts identified in the comparison of the issuer's data included in the November 2016 EPDW submitted by the SBE to the updated amounts provided by the SBE. The SBE performs enrollment and billing on behalf of the issuers and submitted the EPDW on behalf of the issuers; therefore, CMS concluded that an adjustment will be made based on the comparison of the SBE provided updated amounts and the EPDW;
2. Inclusion of full month enrollment and premium and/or APTC data for twenty-four (24) subscribers in the issuer's Payment Desk Audit File that did not result in a correction to the APTC reported in the final EPDW as an adjustment will be made based on the comparison of the SBE provided updated amounts and the EPDW;
3. Inclusion of premium amounts that were less than the APTC amounts for two (2) subscribers in the Payment Desk Audit File that did not result in a correction to the APTC reported in the final EPDW as an adjustment will be made based on the comparison of the SBE provided updated amounts and the EPDW;
4. Inclusion of enrollment and payment data for four (4) subscribers with a coverage period of five (5) days or fewer that was cancelled in the Payment Desk Audit File and that did not result in a correction to the APTC reported in the final EPDW as an adjustment will be made based on the comparison of the SBE provided updated amounts and the EPDW; and
5. 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 as the enrollment was not terminated.

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 Massachusetts, 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 HNE for an audit to assess the issuer's compliance with the 45 CFR §§ 155.1210, 156.460 and 156.480. CMS evaluated HNE'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 November 2016 by the SBE to CMS to support APTC payments and premium amounts.

CMS sent HNE 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 HNE on February 20, 2019 that identified data requirements required to conduct the audit. CMS's audit contractor reviewed the audit data file submitted by HNE, 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. During the discrepancy phase, HNE submitted an updated Payment Desk Audit File to include all individual market benefit year 2015 enrollments. The procedures were re-performed using the updated Payment Desk Audit File. 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 SBE to HNE'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 or observations resulted from the review of HNE'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 HNE's Payment Desk Audit File to verify that duplicate Exchange-assigned subscriber IDs were not reported in the file. Please refer Observation No. 2 included in section IV for details on the observation.

Premium Less than APTC Validation

No findings and one (1) observation resulted from the review of HNE'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 Observation No. 3 included in section IV for details on the observation.

Coverage Days Validation

No findings and one (1) observation resulted from the review of HNE'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 one (1) observation resulted from the review and comparison of the data from

HNE'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 included in section IV for details on the observation.

Fifteen (15) Subscribers Sample Review

No findings or observations resulted from the review of the data and documentation from HNE'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 HNE'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, which resulted in a change to the APTC amounts reported in HNE’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 five (5) observations, consisting of one (1) observation that resulted in a change to the premium amounts reported in HNE’s EPDW submitted by the SBE for individual market plans for the 2015 benefit year and four (4) observations that did not result in a change to the premium amounts reported in HNE’s EPDW but that are noted for purposes of improving compliance in future program years.

In light of the one (1) finding and five (5) 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 November 2016	\$7,536,370.31	\$20,446,235.59
Finding No. 1 and Observation No. 1 - EPDW Validations Adjustment	\$(218,255.28)	\$(690,775.89)
Observation No. 2 – Duplicate Exchange-assigned Subscriber IDs Check Adjustment	\$0.00	\$0.00
Observation No. 3 – Premium Less Than APTC Validation Adjustment	\$0.00	\$0.00
Observation No. 4 – Coverage Days Validation Adjustment	\$0.00	\$0.00

	APTC	Premium (Observations)
Observation No. 5 – Forty-five (45) Subscribers Sample Review Adjustment	\$0.00	\$0.00
EPDW As Recalculated	\$7,318,115.03	\$19,755,459.70
Total Impact	\$(218,255.28)	\$(690,775.89)*

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

The net financial impact of the one (1) finding is a payment of \$218,255.28, consisting of APTC owed to CMS.

*Note: The premium impact of the five (5) observations is an overstatement of \$690,775.89 in premiums. The premium impact is noted for purposes of improving compliance in future program years.

For the one (1) finding and five (5) observations, CMS documented the criteria, cause, effect, corrective actions, and HNE’s responses as seen in the charts below.

Finding No. 1 and Observation No. 1 – EPDW Validations	
Condition:	<p>APTC Differences (Finding) – The net “Total APTC Amount by QHP ID for effectuated enrollments” included in HNE’s final 2015 benefit year EPDW submitted by the SBE was greater than the total APTC amount included in HNE’s Payment Desk Audit File, resulting in an overstatement of \$278,293.88 in APTC. The net “Total APTC Amount by QHP ID for effectuated enrollments” included in HNE’s final 2015 benefit year EPDW submitted by the SBE was greater than the total APTC amount included in the updated benefit year 2015 data from the SBE’s systems based on the PLR submissions, resulting in an overstatement of \$218,255.28 in APTC. The SBE performs enrollment and billing on behalf of the issuers; therefore, CMS concluded that an adjustment of \$218,255.28 will be made based on the comparison of the SBE provided updated amounts and the EPDW.</p> <p>Premium Differences (Observation) – The net “Total Premium Amount by QHP ID for effectuated enrollments” included in HNE’s EPDW submitted by the SBE was greater than the total premium amount included in HNE’s Payment Desk Audit File, resulting in an overstatement of \$452,096.09 in premiums. The net “Total Premium Amount by QHP ID for effectuated enrollments” included in HNE’s final 2015 benefit year EPDW submitted by the SBE was greater than the total premium amount included in the updated benefit year 2015</p>

Finding No. 1 and Observation No. 1 – EPDW Validations	
	data from the SBE’s systems based on the PLR submissions, resulting in an overstatement of \$690,775.89 in premiums.
Criteria:	<p>Per 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>As a result of the comparison of the Payment Desk Audit File provided by HNE and the EPDW submitted by the SBE in November 2016, it was noted that the EPDW was overstated by \$258,920.88 in APTC and \$413,507.01 in premiums. Based on the additional audit procedures performed, additional adjustments were applied to HNE’s Payment Desk Audit File (Please refer to Observations No. 2 – 4 for additional details on the adjustments). Therefore, it was noted that the EPDW was overstated by \$278,293.88 in APTC and \$452,096.09 in premiums as a result of the comparison of the adjusted Payment Desk Audit File and the EPDW submitted by the SBE in November 2016.</p> <p>The issuer indicated the following potential explanations for the premium and APTC differences:</p> <ol style="list-style-type: none"> 1) The state did not include members sent to HNE in a non 834 format, therefore HNE has to manually enter these members. This is primarily due to the fact that the 834 was not up and running when we first started with the exchange at the tail end of 2014 and into 2015. 2) Some members that the state provided but HNE did not were because HNE had them as Medicaid members and not exchange members. 3) The exchange switched IDs beginning with 10, Q8, Q9 & ZI (for example) to 70xxxxxxx type IDs early in 2015. Most times the tail end of those IDs matched up. Other times they did not, and we had issues trying to get a match to those that were different. 4) At the tail end of 2014 and into 2015 our 834 process was new and had some issues with locating the correct member. We found a few instances where one or more IDs were linked to the same plan instead of maintaining their own.

Finding No. 1 and Observation No. 1 – EPDW Validations

- 5) In some cases retroactivity played a part in what our system thought was billed versus paid.
- 6) The state sends an add, then a term, then an add again for the same member. There are times when the state does not provide an end date and without that the member does not term correctly. There was also a mismatch between members and their dependents. (Prem Less than APTC)
- 7) HNE received cancelations back to the original effective date. (Coverage Days)
- 8) In some instances we did not receive the data from the state as we could not validate the data in any 834.
- 9) Member Picking Logic issues (our system matching demographic data on incoming electronic eligibility file to an existing HNE ID) and sometimes duplicates are created. (Duplicate Check).

During the audit, CMS coordinated with the SBE to obtain an explanation for the identified differences and/or a current snapshot of effectuated 2015 benefit year individual market enrollments from the SBE's systems. The SBE provided updated QHP level premium and APTC amounts that reflect a current snapshot of data that exists in their systems based on their latest PLR submission. As a result of the comparison of the updated amounts provided by the SBE and the EPDW submitted by the SBE in November 2016, it was noted that the EPDW was overstated by \$218,255.28 in APTC and \$690,775.89 in premiums (Note: The updated premium amounts provided by the SBE were based on PLR data and therefore may be understated as the data includes Essential Health Benefits (EHB) only premium amounts).

The SBE performs enrollment and billing on behalf of the issuers and submitted the EPDW on behalf of the issuers; therefore, CMS concluded that an APTC payment adjustment of \$218,255.28 will be made based on the comparison of the SBE provided updated amounts and the EPDW. The remaining unreconciled APTC amount difference between the issuer's adjusted Payment Desk Audit File and SBE updated amounts of \$60,038.60 (the difference between \$278,293.88 based on issuer's data and \$218,255.28 based on SBE's updated data) is noted for informational purposes to improve compliance in future program years.

Effect:

The APTC and premium differences resulted in a change to HNE's final, restated 2015 benefit year EPDW data submitted by the SBE. Pursuant to CMS audit procedures for SBEs that submitted workbooks to CMS, in the event that the issuer's Payment Desk Audit File and

Finding No. 1 and Observation No. 1 – EPDW Validations	
	audit response and the SBE’s audit response do not fully reconcile and the SBE performs enrollment and billing on behalf of the issuer, CMS will adjust payment by recouping the APTC overpayment that was derived based on the SBE provided updated amounts and notes the remaining unreconciled difference between the issuer’s data and SBE’s data for purposes of improving compliance in future program years.
Corrective Action Required:	<p>The net financial impact of this finding is a payment of \$218,255.28, consisting of APTC owed to CMS. HNE should confirm the financial impact by filling out Appendix 1. Additionally, CMS notes the remaining unreconciled APTC difference of \$60,038.60 between the SBE and issuer for purposes of improving compliance and issuer and SBE reconciliation in future program years.</p> <p>The premium impact of this observation is an overstatement of \$690,775.89 in premiums. CMS notes this observation for purposes of improving compliance in future program years.</p>
Management Response:	Management is in agreement with the finding and have instituted reconciliation controls designed to improve compliance.

Observation No. 2 – Duplicate Exchange-assigned Subscriber IDs Check	
Condition:	HNE overstated the 2015 benefit year premium amounts for twenty-four (24) subscribers, and overstated the benefit year APTC amounts for nineteen (19) of those subscribers, in the Payment Desk Audit File by reporting enrollment and full month payment data for the subscribers more than once in the same month. Additionally, HNE overstated the 2015 benefit year APTC amounts for three (3) of those subscribers in the Payment Desk Audit File by reporting incorrect APTC payment data for the subscribers.
Criteria:	<p>Issuers cannot request full month payment from CMS for the same subscriber twice within a month.</p> <p>Per CMS guidance, the APTC amount reported in the EPDW and Payment Desk Audit File is the APTC amount toward the total premium amount for effectuated enrollments.</p>
Cause:	<p>The issuer indicated the following general explanations for the twenty-four (24) subscribers:</p> <ul style="list-style-type: none"> • “Member picking issues in 2015 (system matching of demographic data on an incoming electronic eligibility file to

Observation No. 2 – Duplicate Exchange-assigned Subscriber IDs Check	
	<p>an existing HNE ID and creation of a new HNE ID if an HNE existing ID cannot be located). (Eleven (11) subscribers)</p> <ul style="list-style-type: none"> • Multiple enrollment change and/or termination transactions were communicated by the SBE, which resulted in the creation of duplicate entries. (Ten (10) subscribers) • Multiple entries were created that could have been resolved by a change in the sort order. (Two (2) subscribers) • A mismatch in the policy ID that created duplicates when matching up in the code.” (One (1) subscriber)
Effect:	The inclusion of the twenty-four (24) duplicate subscribers and incorrect APTC data for three (3) of those subscribers resulted in an overstatement of \$17,686.00 in APTC and \$39,676.92 in premiums in HNE’s Payment Desk Audit File.
Corrective Action Required:	CMS notes this observation for purposes of improving compliance and issuer and SBE reconciliation in future program years as CMS will adjust payment based on the SBE provided updated amounts noted in Finding No. 1 and Observation No. 1.
Management Response:	Management is in agreement with the finding and have instituted reconciliation controls designed to improve compliance.

Observation No. 3 – Premium Less than APTC Validation	
Condition:	HNE reported 2015 benefit year premium amounts that were less than the APTC amounts for two (2) subscribers in the Payment Desk Audit File, resulting from HNE overstating the 2015 benefit year APTC amounts for two (2) subscribers and understating the 2015 benefit year premium amounts 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 indicated that multiple transactions were received for the subscribers and noted the following explanations for the two (2) subscribers:</p> <ul style="list-style-type: none"> • “[Issuer provided subscriber name] and dependent came through files from 1/1 - 11/3 with 2 different IDs. Given 2 different ID's and the similar dates, it looks like premium should have been sent as 190.21 with no APTC all along. So

Observation No. 3 – Premium Less than APTC Validation	
	<p>this was a result of the order in which dates and amounts were sent. However, there does not appear to be a correlation on the last ID/file to anything entered other than demographics. There was no prior add for that premium/APTC from Connector as well.”</p> <ul style="list-style-type: none"> • “It appears that this member was entered into the first plan [issuer provided policy ID] on 1/14/15. At that point in time the premium of 713.98 was entered. However, subsequent transactions created some confusion. It is only on that [issuer provided policy ID] record where we find an APTC of 475. On 11/21 we receive the 12/31/15 term for the [issuer provided policy ID] plan which contains the correct premium and APTC previously listed for that plan. So the premium and APTC had issue matching up due to the various plan/date combinations.” <p>The correct premium and APTC amounts were provided by the issuer for the two (2) subscribers.</p>
Effect:	The inclusion of the incorrect APTC and premium amounts for the two (2) subscribers resulted in an overstatement of \$991.00 in APTC and an understatement of \$2,913.68 in premiums in HNE’s Payment Desk Audit File.
Corrective Action Required:	CMS notes this observation for purposes of improving compliance and issuer and SBE reconciliation in future program years as CMS will adjust payment based on the SBE provided updated amounts noted in Finding No. 1 and Observation No. 1.
Management Response:	Management is in agreement with the finding and have instituted reconciliation controls designed to improve compliance.

Observation No. 4 – Coverage Days Validation	
Condition:	HNE overstated the 2015 benefit year premium amounts and APTC amounts for four (4) subscribers in the Payment Desk Audit File by incorrectly reporting enrollments that were cancelled.
Criteria:	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.

Observation No. 4 – Coverage Days Validation	
Cause:	<p>The issuer indicated the following explanations for the four (4) subscribers:</p> <ul style="list-style-type: none"> • “The 11/1 one day listing is due to a cancellation back to the original effective date for this plan change. It should not have been selected.” (Two (2) subscribers) • “The 12/1 one day listing is due to a cancellation back to the original effective date for this plan change. It should not have been selected.” (Two (2) subscribers)
Effect:	The inclusion of the enrollment and payment data for the four (4) subscribers resulted in an overstatement of \$696.00 in APTC and \$1,825.84 in premiums in HNE’s Payment Desk Audit File.
Corrective Action Required:	CMS notes this observation for purposes of improving compliance and issuer and SBE reconciliation in future program years as CMS will adjust payment based on the SBE provided updated amounts noted in Finding No. 1 and Observation No. 1.
Management Response:	Management is in agreement with the finding and have instituted reconciliation controls designed to improve compliance.

Observation No. 5 – Forty-five (45) Subscribers Sample Review	
Condition:	HNE provided coverage and reported four (4) extra months of enrollment and payment data for one (1) of the forty-five (45) selected subscribers in the Payment Desk Audit File.
Criteria:	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 § 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.

Observation No. 5 – Forty-five (45) Subscribers Sample Review	
Cause:	<p>For the one (1) subscriber, the Payment Desk Audit File included enrollment from January through December while the SBE’s PLR data included enrollment from January through August. The issuer indicated, “A term was never received for this Subscriber. Per a remark in the core system tied to this Sub, there was not a term for the year end renewal as well, and the family was manually termed for 12/31/15 before the 1/1/2016 adds came in. A quick search in the 2015 archives came up with one transaction set in the 8/21/15 file where the Subscriber was changed but kept active and the spouse (only) was termed. The child dependent was not touched and left active.” The issuer further indicated “Coverage was provided for the contract holder for the entire year. One dependent was not covered but we also didn’t receive a change of rates so the amount stayed the same.”</p> <p>The SBE performs enrollment and billing on behalf of the issuers and indicated, “The coverage end date provided in latest PLR is 08/31/2015.”</p>
Effect:	The issuer did not follow CMS requirements as the issuer provided extra coverage for an enrollment that was terminated by the SBE.
Corrective Action Required:	CMS notes this observation for purposes of improving compliance and issuer and SBE reconciliation in future program years.
Management Response:	Management is in agreement with the finding and have instituted reconciliation controls designed to improve compliance.

V. MANAGEMENT RESPONSES

Please provide management's response to the one (1) finding and five (5) 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 five (5) observations, complete the "Management Response" field of the finding 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 corrective action and five (5) observations, complete the "Management Response" field of the finding 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 finding 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: 34484

Issuer Name: Health New England, Inc. (HNE)

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 \$218,255.28 to CMS and:

(INITIAL) JR 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: Jason Rio
Jason Rio (Apr 26, 2022 16:50 EDT)

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

Printed Name: Jason Rio
(Print name of signature)

Title: Sr. Director Revenue Assurance and Risk Management
(Title of authorized person acting on behalf of the Issuer)

Telephone Number: 508-287-9179
(Direct Telephone Number)

Date: Apr 26, 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) General standard. Issuers offering QHPs in a Federally-facilitated Exchange must maintain all documents and records (whether paper, electronic, or other media) and other evidence of accounting procedures and practices, necessary for HHS to do the following:</p> <p>(1) Periodically audit financial records related to QHP issuers' participation in a Federally-facilitated Exchange, and evaluate the ability of QHP issuers to bear the risk of potential financial losses; and</p> <p>(2) Conduct compliance reviews or otherwise monitor QHP issuers' compliance with all Exchange standards applicable to issuers offering QHPs in a federally-facilitated Exchange as listed in this part.</p> <p>(b) Records. The records described in paragraph (a) of this section include the sources listed in § 155.1210(b)(2), (3), and (5) of this subchapter.</p> <p>(c) Record retention timeframe. Issuers offering QHPs in a Federally-facilitated Exchange must maintain all records referenced in paragraph (a) of this section for 10 years.</p> <p>(d) Record availability. Issuers offering QHPs in a Federally-facilitated Exchange must make all records in paragraph (a) of this section available to HHS, the OIG, the Comptroller General, or their designees, upon request.</p>

Appendix 3 – Glossary of Terms and Acronyms

Terms & Acronyms	Definition
APTC	Advance Payments of the Premium Tax Credit
CEO	Chief Executive Officer
CFO	Chief Financial Officer
CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
CSR	Cost-sharing Reduction
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
