



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

for

Blue Care Network of Michigan (Blue Care)

December 12th, 2022

Table of Contents

| | |
|--|-------------------------------------|
| I. EXECUTIVE SUMMARY | 3 |
| II. BACKGROUND, OBJECTIVES, SCOPE, AND METHODOLOGY..... | 5 |
| III.RESULTS OF REVIEW | 8 |
| IV.FINDINGS | 10 |
| V. OBSERVATIONS..... | 20 |
| VI.MANAGEMENT RESPONSES..... | 21 |
| Appendix 1 – Issuer Management Response to Net Financial Adjustment ... | Error! Bookmark not defined. |
| Appendix 2 – Applicable Regulations | Error! Bookmark not defined. |
| Appendix 3 – Glossary of Terms and Acronyms | Error! Bookmark not defined. |

I. EXECUTIVE SUMMARY

Background

Blue Care Network of Michigan (Blue Care) is a health insurance issuer that offered qualified health plans (QHPs) in the individual market Federally-facilitated Exchange (FFE) in Michigan during the 2015 benefit year. Blue Care submitted its final restated 2015 benefit year data in the October 2017 Enrollment and Payment Data Workbook (EPDW). The issuer received a total of \$276,288,140.15 in advance payments of the premium tax credit (APTC) from CMS and paid a total of \$15,407,672.06 in FFE user fees (UF) to CMS for its 2015 benefit year individual market plans.

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

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

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

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

This audit is part of CMS's program to validate the enrollment and payment data reported on the final 2015 EPDW, and to analyze controls and policies of selected issuers pursuant to the authority defined in the 45 CFR §§ 155.480 and 156.705.

The findings and observation are documented below. If CMS found an instance of issuer non-compliance with APTC and FFE user fee program requirements that requires correction to payment, then CMS classified it as a *finding*. If CMS found a deviation from APTC and FFE user fee program requirements that we are calling to the attention of management for purposes of

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 dialogue 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.

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 eight (8) findings and one (1) observation for Blue Care. The net financial impact of the eight (8) findings is a payment due to CMS of \$497,393.16, consisting of \$1,758.91 in FFE user fees to be returned to Blue Care and \$499,152.07 in APTC to be returned to CMS. The one (1) observation does not require corrections to payments. The findings and observation include the following:

Findings:

1. Differences in premium/FFE user fee and APTC amounts identified in the comparison of the issuer's data included in the EPDW to a Payment Desk Audit File containing subscriber level data from Blue Care's systems;
2. Inclusion of enrollment and payment data in the Payment Desk Audit File for twenty-one (21) subscribers with coverage that was not effectuated in the issuer's systems;
3. Inclusion of full month enrollment and payment data for eight (8) duplicate subscribers in the Payment Desk Audit File;
4. Inclusion of incorrectly prorated enrollment and payment data for eight hundred and twenty-two (822) duplicate subscribers in the Payment Desk Audit File;
5. Inclusion of premium amounts that were less than the APTC amounts for one hundred seventy-nine (179) subscribers in the Payment Desk Audit File;
6. Inclusion of enrollment and payment data for two (2) subscribers with a coverage period of five (5) days or fewer that was not effectuated in the Payment Desk Audit File;
7. Inclusion of incorrect premium amounts for eight (8) of the forty-five (45) selected subscribers in the Payment Desk Audit File; and
8. Inclusion of incorrect premium amounts in the Payment Desk Audit File for three (3) of the fifteen (15) selected subscribers.

Observation:

1. Provision of coverage for one (1) of the fifteen (15) selected subscribers in the Payment Desk Audit File with coverage that should have been cancelled.

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

II. BACKGROUND, OBJECTIVES, SCOPE, AND METHODOLOGY

A. Background

Sections 1401 and 1412 of the PPACA established the APTC program to support the provision of affordable health care coverage to individuals. Additionally, section 1311 of the PPACA allows the FFEs to charge participating issuers user fees to support FFE operations.

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

Interim Payment Process

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

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

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

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

B. Regulations Governing APTC and FFE User Fee Programs

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

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

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

C. Objectives

The objectives of this audit are to:

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

D. Scope and Methodology

CMS selected Blue Care for an audit on issuer compliance with 45 CFR §§ 156.50, 156.460, 156.480 and 156.705. CMS evaluated Blue Care's activities related to the 2015 benefit year (January 1, 2015, through December 31, 2015) individual market data reported on the final EPDW submitted in July 2016 by the issuer to CMS to support APTC and FFE user fee collections.

CMS sent Blue Care an electronic letter on May 11, 2018, to notify them of the scope of this audit. CMS's audit contractor sent a follow-up letter to Blue Care on May 15, 2018 that identified data requirements required to conduct the audit. CMS's audit contractor reviewed the audit data file submitted by Blue Care and used CMS's audit procedures to assess compliance with APTC and FFE user fee program rules and regulations.

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

- Validations of the Payment Desk Audit File² data submitted to CMS:
 - EPDW Validations: Review and comparison of the issuer's final submitted 2015

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

EPDW to the Payment Desk Audit File from the issuer's systems.

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

III. RESULTS OF REVIEW

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

EPDW Validations

One (1) finding and no observations resulted from the comparison of the final 2015 EPDW to Blue Care's Payment Desk Audit File. Please refer to Finding No. 1 included in section IV for details on the finding.

Unreconciled Subscribers Review

One (1) finding and no observations resulted from the review of Blue Care's Payment Desk Audit File to determine if the subscribers reported on the file existed and their coverage was effectuated in the issuer's systems. Please refer to Finding No. 2 included in section IV for details on the finding.

Duplicate Exchange-assigned Subscriber IDs Check

Two (2) findings and no observations resulted from the review of Blue Care's Payment Desk Audit File to verify that duplicate Exchange-assigned subscriber IDs were not reported on the file. Please refer to Finding No. 3 and Finding No. 4 included in section IV for details on the findings.

Premium Less than APTC Validation

One (1) finding and no observations resulted from the review of Blue Care's Payment Desk Audit File to verify that subscribers were not reported on the file with premium amounts that were less than the APTC amounts. Please refer to Finding No. 5 included in section IV for details on the finding.

Coverage Days Validation

One (1) finding and no observations resulted from the review of Blue Care's Payment Desk Audit File to verify that enrollments of five (5) days or fewer reported on the file were effectuated and had active coverage in the issuer's systems. Please refer to Finding No. 6 included in section IV for details on the finding.

Forty-five (45) Subscribers Sample Review

One (1) finding and no observations resulted from the review and comparison of the data from Blue Care's systems to the corresponding data included in CMS's systems to determine accuracy of the reported enrollment months and the application of premium and APTC for a selected sample of forty-five (45) subscribers. Refer to Finding No. 7 included in section IV for details on the finding.

Fifteen (15) Subscribers Sample Review

One (1) finding and one (1) observation resulted from the review of the data and documentation

from Blue Care's systems to verify effectuation and the appropriate application of premium and APTC amounts to policies for a selected sample of fifteen (15) subscribers. Please refer to Finding No. 8 included in section IV for details on the finding and Observation No. 1 included in section V for details on the observation.

Policy and Procedure Review

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

IV. FINDINGS

A finding is an identification of an instance of issuer non-compliance with APTC and FFE user fee program requirements that requires correction to payment. CMS's audit procedures identified eight (8) findings that resulted in a change to Blue Care's reported EPDW for individual market plans for the 2015 benefit year. In light of the eight (8) findings, the adjusted 2015 benefit year EPDW APTC and FFE user fee amounts for individual market plans are shown in the following table.

Recalculated EPDW for the 2015 Benefit Year

| | FFE User Fees | APTC |
|---|-------------------|------------------|
| EPDW as Filed in October 2017 | \$(15,407,672.06) | \$276,288,140.15 |
| Finding No. 1 – EPDW Validations Adjustment | \$552.87 | \$(411,622.08) |
| Finding No. 2 – Unreconciled Subscribers Review Adjustment | \$512.41 | \$(8,324.14) |
| Finding No. 3 – Duplicate Exchange-assigned Subscriber IDs Check (Full Month Payment Data) Adjustment | \$955.84 | \$(11,402.00) |
| Finding No. 4 – Duplicate Exchange-assigned Subscriber IDs Check (Incorrectly Prorated Payment Data) Adjustment | \$871.05 | \$(17,346.44) |
| Finding No. 5 – Premium Less than APTC Validation Adjustment | \$(1,161.31) | \$(50,436.70) |
| Finding No. 6 – Coverage Days Validation Adjustment | \$1.52 | \$(20.71) |

| | FFE User Fees | APTC |
|--|-------------------|-----------------------|
| Finding No. 7 – Forty-five (45) Subscribers Sample Review Adjustment | \$20.14 | \$0.00 |
| Finding No. 8 – Fifteen (15) Subscribers Sample Review Adjustment | \$6.39 | \$0.00 |
| EPDW As Recalculated | \$(15,405,913.15) | \$275,788,988.08 |
| Total Financial Impact | \$1,758.91 | \$(499,152.07) |

Note: Positive values indicate funds owed to the issuer.

The net financial impact of the (8) eight findings is a payment due to CMS of \$497,393.16, consisting of \$1,758.91 in FFE user fees to be returned to Blue Care and \$499,152.07 in APTC to be returned to CMS.

For the eight (8) findings, CMS documented the criteria, cause, effect, corrective actions, and Blue Care's responses as seen in the charts below.

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| Finding No. 1 – EPDW Validations | Condition: | <p>Premium and FFE User Fee Differences – For one (1) or more months of 2015 benefit year enrollment in seventy (70) QHPs, the net “Total Premium Amount by QHP ID for effectuated enrollments” included in Blue Care’s EPDW was greater than the total premium amount included in Blue Care’s Payment Desk Audit File, resulting in an overstatement of \$15,796.35 in premiums and therefore an overpayment of \$552.87 in FFE user fees. For the one (1) or more months of 2015 benefit year enrollment in seventy (70) QHPs, the total net enrollment in the EPDW was understated by four hundred and three (403) enrollment groups and two hundred and fifteen (215) members.</p> <p>APTC Differences – For one (1) or more months of 2015 benefit year enrollment in fifty-six (56) QHPs, the net “Total APTC Amount by QHP ID for effectuated enrollments” included in Blue Care’s EPDW was greater than the total APTC amount included in Blue Care’s Payment Desk Audit File, resulting in an overpayment of \$411,622.08 in APTC. For the one (1) or more</p> |
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| | | months of 2015 benefit year enrollment in fifty-six (56) QHPs, the total net enrollment in the EPDW was understated by two hundred and fifty-four (254) APTC enrollment groups and overstated by one hundred and eighteen (118) APTC members. |
| | Criteria: | <p>Pursuant to CMS guidance and EPDW submission requirements:</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” and the Total User Fee Amount by QHP ID is "the total FFE user fee amount the issuer can expect to incur for participation in the Federally-facilitated Exchange.”</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>Additionally, the premium and APTC amounts reported in the EPDW and in the enrollment group enrollment records of the Payment Desk Audit File must be prorated using the proration formulas set forth in the 2015 payment notice and outlined in 45 CFR § 155.240.</p> |
| | Cause: | <p>The issuer indicated “In 2015, Blue Care followed CMS guidelines to prorate premium and advanced premium tax credits for partial coverage spans. The user fee was not prorated due to a system process. The process applied the monthly total prorated user fee to each coverage span instead of the respective portion of user fee for the month. This process generated a report which was used to pay user fee to CMS. This was isolated to the 2015 plan year.</p> <p>The pro-ration issue described above also affected APTC collection. In 2015, Blue Care Network followed CMS guidelines to prorate premium and advanced premium tax credits for partial coverage spans. As previously reported to CMS, a system process inadvertently applied the monthly total prorated APTC to each corresponding coverage span instead of the respective portion of APTC for</p> |

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| | | the month. This process generated a report which was used to determine APTC payment amounts from CMS, and the pro-ration error caused an over-collection of APTC of \$411,622.42 as reflected in the data below. This process was isolated to the 2015 plan year.” |
| | Effect: | The premium/FFE user fee and APTC differences resulted in a change to Blue Care’s final, restated 2015 benefit year EPDW data. |
| | Corrective Action Required: | The net financial impact of this finding is a payment due to CMS of \$411,069.21 consisting of \$552.87 in FFE user fees to be returned to Blue Care and \$411,622.08 in APTC to be returned to CMS. Blue Care should confirm the financial impact by filling out Appendix 1. |
| | Management Response: | [Agree and see Appendix 1] |

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| Finding No. 2 – Unreconciled Subscribers Review | Condition: | Blue Care overstated the 2015 benefit year premium and APTC amounts for twenty-one (21) subscribers in the Payment Desk Audit File by reporting enrollment and payment data for subscribers with coverage that was not effectuated. |
| | Criteria: | Pursuant to CMS guidance and EPDW submission requirements, the EPDW should include data for effectuated enrollments where an effectuated enrollment is defined as “any enrollment in which the amount the enrollment group is responsible to pay toward the total premium amount has been paid in full by the enrollment group.” |
| | Cause: | The issuer indicated “No” in the “Effectuated in Issuer’s Systems” field and provided explanations surrounding error in effectuation, coverage erroneously not cancelled, non-sufficient funds and non-payment terminations for the twenty-one (21) unreconciled subscribers in the Payment Desk Audit File. |

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| | Effect: | The inclusion of the twenty-one (21) non-effectuated enrollments resulted in a change to Blue Care's final, restated 2015 benefit year EPDW data. |
| | Corrective Action Required: | The net financial impact of this finding is a payment due to CMS of \$7,811.73, consisting of \$512.41 in FFE user fees to be returned to Blue Care and \$8,324.14 in APTC to be returned to CMS. Blue Care should confirm the financial impact by filling out Appendix 1. |
| | Management Response: | [Agree and see Appendix 1] |

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| Finding No. 3 – Duplicate Exchange-assigned Subscriber IDs Check (Full Month Payment Data) | Condition: | Blue Care overstated the 2015 benefit year premium and APTC amounts for eight (8) 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. |
| | Criteria: | Issuers cannot request full month payment from CMS for the same subscriber twice within a month. |
| | Cause: | The issuer indicated that the subscribers were enrolled under two (2) issuer-assigned subscriber IDs in their system and that the coverage under the duplicate contract should not be reported. |
| | Effect: | The inclusion of the eight (8) duplicate subscribers resulted in a change to Blue Care's final, restated 2015 benefit year EPDW data. |
| | Corrective Action Required: | The net financial impact of this finding is a payment due to CMS of \$10,446.16, consisting of \$955.84 in FFE user fees to be returned to Blue Care and \$11,402.00 in APTC to be returned to CMS. Blue Care should confirm the financial impact by filling out Appendix 1. |
| | Management Response: | [Agree and see Appendix 1] |

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| Finding No. 4 – Duplicate Exchange-assigned Subscriber IDs Check (Incorrectly Prorated Payment Data) | Condition: | Blue Care reported incorrect 2015 benefit year premium and APTC amounts for one hundred and sixty-two (162) subscribers, incorrect 2015 benefit year premium amounts only for one hundred and seventy-four (174) subscribers, and incorrect 2015 benefit year APTC amounts only for four hundred and eighty-six (486) subscribers in the Payment Desk Audit File by reporting enrollment and incorrectly prorated payment data for mid-month enrollments or terminations. |
| | Criteria: | Pursuant to the HHS Notice of Benefit and Payment Parameters for 2015 and 45 CFR § 156.240, for a Federally-facilitated Exchange, the premium for coverage lasting less than one month must equal the product of (i) The premium for one month of coverage divided by the number of days in the month; and (ii) The number of days for which coverage is being provided in the month. |
| | Cause: | The issuer indicated “Per the 834 files from CMS, premiums were pro-rated mid-month; however, APTC would not change until the first of the next month. While the premium was calculated effectively, the APTC was not. This resulted in an overcharge of APTC. The other issues were primarily due to processing errors, such as adding dependents and date of birth changes.” |
| | Effect: | The inclusion of incorrectly prorated payment data for the eight hundred and twenty-two (822) duplicate subscribers resulted in a change to Blue Care’s final, restated 2015 benefit year EPDW data. |
| | Corrective Action Required: | The net financial impact of this finding is a payment due to CMS of \$16,475.39, consisting of \$871.05 in FFE user fees to be returned to Blue Care and \$17,346.44 in APTC to be returned to CMS. Blue Care should confirm the financial impact by filling out Appendix 1. |
| | Management Response: | [Agree and see Appendix 1] |

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| Finding No. 5 – Premium Less than APTC Validation | Condition: | Blue Care reported 2015 benefit year premium amounts that were less than the APTC amounts for one hundred and seventy-nine (179) subscribers in the Payment Desk Audit File, resulting from Blue Care understating the 2015 benefit year premium amounts for thirty-three (33) subscribers and understating the 2015 benefit year APTC amounts for two (2) of those subscribers, and overstating the 2015 benefit year premiums amounts for ten (10) subscribers and overstating the 2015 benefit year APTC amounts for the same subscribers and one hundred and thirty-six (136) additional subscribers. in the Payment Desk Audit file. |
| | Criteria: | Issuers cannot report an APTC amount that exceeds the premium amount for a policy. |
| | Cause: | The issuer indicated that the differences were due to processing errors and changes in the issuer's systems. The issuer provided the correct premium and/or APTC amounts that should be reported in the Payment Desk Audit File for the subscribers. |
| | Effect: | The inclusion of the incorrect premium and APTC amounts for the one hundred and seventy-nine (179) subscribers resulted in a change to Blue Care's final, restated 2015 benefit year EPDW data. |
| | Corrective Action Required: | The net financial impact of this finding is a payment due to CMS of \$51,598.01, consisting of \$1,161.31 in FFE user fees to be paid to CMS and \$50,436.70 in APTC to be returned to CMS. Blue Care should confirm the financial impact by filling out Appendix 1. |
| | Management Response: | [Agree and see Appendix 1] |

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| Finding No. 6 – Coverage Days Validation | Condition: | Blue Care overstated the 2015 benefit year premium and APTC amounts for two (2) subscribers in the Payment Desk Audit File by incorrectly reporting enrollments that were not effectuated. |
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| | Criteria: | Pursuant to CMS guidance and EPDW submission requirements, the EPDW should include data for effectuated enrollments where an effectuated enrollment is defined as “any enrollment in which the amount the enrollment group is responsible to pay toward the total premium amount has been paid in full by the enrollment group.” |
| | Cause: | The issuer indicated “Did not effectuate” for the two (2) subscribers. |
| | Effect: | The inclusion of the enrollment and payment data for the two (2) subscribers resulted in a change to Blue Care’s final, restated 2015 benefit year EPDW data. |
| | Corrective Action Required: | The net financial impact of this finding is a payment due to CMS of \$19.19, consisting of \$1.52 in FFE user fees to be returned to Blue Care and \$20.71 in APTC to be returned to CMS. Blue Care should confirm the financial impact by filling out Appendix 1. |
| | Management Response: | [Agree and see Appendix 1] |

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| Finding No. 7 – Forty-five (45) Subscribers Sample Review | Condition: | Blue Care overstated the 2015 benefit year premium amounts for eight (8) of the forty-five (45) selected subscribers in the Payment Desk Audit File. |
| | Criteria: | Pursuant to CMS guidance, the premium amount reported in the EPDW and the Payment Desk Audit File is the premium amount by 16-digit QHP ID for the effectuated enrollment within a qualified health plan. |
| | Cause: | The issuer indicated “Discrepancy relates to calculations referenced in CCIIO, CMS enrollment bulletin 8 guidance issued on March 13, 2014. Member charged correct premium, but the incorrect amount was sent on RCNI due to an issuer system limitation. Ages in the Desk Audit file are being calculated based on the start of the plan year or the start of the member’s enrollment in the plan year. In |

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| | | 2015, issuer calculated age rating based on the members age as of 1/1/15. Therefore, this leads to a different rate.” |
| | Effect: | The inclusion of incorrect premium amounts for the eight (8) subscribers resulted in a change to Blue Care’s final, restated 2015 benefit year EPDW data. |
| | Corrective Action Required: | The net financial impact of this finding is a payment due to Blue Care of \$20.14 in FFE user fees to be returned to Blue Care. Blue Care should confirm the financial impact by filling out Appendix 1. |
| | Management Response: | [Agree and see Appendix 1] |

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| Finding No. 8 – Fifteen (15) Subscribers Sample Review | Condition: | Blue Care overstated the 2015 benefit year premium amounts for three (3) of the fifteen (15) selected subscribers in the Payment Desk Audit File. |
| | 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. |
| | Cause: | <p>The issuer indicated the following for the three (3) subscribers:</p> <ul style="list-style-type: none"> For the subscriber included in the Payment Desk Audit File with a premium amount of \$657.94 for April through December, the issuer indicated “Total premium in issuer system matches 834 CMS value of \$656.52. APTC matches CMS.” For the subscriber included in the Payment Desk Audit File with a premium amount of \$1,137.70 for August through December, the issuer indicated “Contract effectuated. Total premium in issuer system is correct at \$1135.61. CMS erroneously rerated spouse for a total premium of \$1137.70. APTC matches CMS.” |

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| | | <ul style="list-style-type: none"> For the subscriber included in the Payment Desk Audit File with a premium amount of \$603.23 for May through December, the issuer indicated “Contract effectuated. Total premium in issuer system matches 834 CMS value of \$583.30. APTC matches CMS.” <p>The issuer also indicated that “for the three (3) subscribers noted, these discrepancies appear to relate to system limitations that required BCN to employ logic to pro-rate mid-year changes in premium /APTC to create the monthly breakdown at a subscriber level. Though the underlying billing information used to bill members is accurate (as shown in screenshots provided), the logic used to pull the Payment Desk Audit file didn’t populate the second premium during the span accurately.”</p> |
| | Effect: | The inclusion of incorrect premium amounts for the three (3) subscribers resulted in a change to Blue Care’s final, restated 2015 benefit year EPDW data. |
| | Corrective Action Required: | The net financial impact of this finding is a payment due to Blue Care of \$6.39 in FFE user fees to be returned to Blue Care. Blue Care should confirm the financial impact by filling out Appendix 1. |
| | Management Response: | [Agree and see Appendix 1] |

V. OBSERVATIONS

An observation is a deviation from APTC and FFE user fee program requirements that we are calling to the attention of management for purposes of improving compliance in future program years but that does not require correction to payment. CMS's audit procedures identified one (1) observation.

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| Observation No. 1 – Fifteen (15) Subscribers Sample Review | Condition: | Blue Care provided coverage and reported 2015 benefit year premium and APTC amounts for one (1) of the fifteen (15) selected subscribers in the Payment Desk Audit File with coverage that should have been cancelled. |
| | Criteria: | Pursuant to 45 CFR § 156.270, a QHP issuer may only terminate coverage as permitted by the Exchange in accordance with § 155.430 and QHP issuers must abide by the termination of coverage effective dates described in § 155.430(d). |
| | Cause: | The issuer indicated "Subscriber's coverage should have been cancelled on 12/31/14, but coverage was provided for January 2015. Voided 2015 coverage for dependent causing a lower premium. No payment received." |
| | Effect: | The issuer did not follow CMS enrollment and termination guidance and requirements set forth in 45 CFR § 156.270 as the issuer provided coverage for one (1) subscriber for coverage that should have been cancelled. |
| | Management Response: | [Agree and see Appendix 1] |

VI. MANAGEMENT RESPONSES

Please provide management's response to the eight (8) findings and one (1) observation 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 eight (8) findings and one (1) observation, complete the "Management Response" field of the findings and observation in the draft audit report, and initial "Agree" and sign the attached Appendix 1. Return the draft audit report including Appendix 1 within thirty (30) calendar days from the draft audit report date. Upon receipt of the signed Appendix 1, CMS will finalize and publish the report. CMS will process the final adjustment amount in the next available monthly payment cycle.

Disagreement

If management disagrees with any of the eight (8) findings and corrective actions or the one (1) observation, complete the "Management Response" field of the findings in the draft audit report, and initial "Disagree" and sign the attached Appendix 1. Return the draft audit report including Appendix 1 and any supporting documentation that substantiates management's response within thirty (30) calendar days from the draft audit report date. This will be the final opportunity to provide information or supporting documentation to correct any inaccuracies in the report before it is finalized.

CMS will review the written explanations in the "Management Response" field of the findings and any supporting documentation to determine if the report can be amended in a mutually acceptable manner. If you and CMS are unable to come to a mutually acceptable result, your response to this report will be included in the final published audit report.

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

Appendix 1 – Issuer Management Response to Net Financial Adjustment

Issuer HIOS ID: 98185

Issuer Name: Blue Care Network of Michigan (Blue Care)

The undersigned Chief Executive Officer (CEO), Chief Financial Officer (CFO) or other individual who can legally and financially bind this issuer has reviewed the information included in the audit report of the issuer's 2015 benefit year APTC and FFE UF program participation, resulting in a payment due to CMS of \$497,393.16 consisting of \$1,758.91 in FFE user fees to be returned to Blue Care and \$499,152.07 in APTC to be returned to CMS, and:

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

Or

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

Signed: _____

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

Printed Name: Brian A. Weicker

(Print name of signature)

Title: Director, Compliance Office

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

Telephone Number: (313) 225-9571

(Direct Telephone Number)

Date: 1/12/2023

Appendix 2 – Applicable Regulations

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

| Regulation | Rules |
|--|--|
| 45 CFR § 156.50 – Financial Support | <p>(a) Definitions. The following definitions apply for the purposes of this section: <i>Participating issuer</i> means any issuer offering a plan that participates in the specific function that is funded by user fees. This term may include health insurance issuers, QHP issuers, issuers of multi-State plans (as defined in § 155.1000(a) of this subchapter), issuers of stand-alone dental plans (as described in § 155.1065 of this subtitle), or other issuers identified by an Exchange.</p> <p>(b) Requirement for State-based Exchange user fees. A participating issuer must remit user fee payments, or any other payments, charges, or fees, if assessed by a State-based Exchange under § 155.160 of this subchapter.</p> <p>(c) Requirement for Federally-facilitated Exchange user fee. To support the functions of Federally-facilitated Exchanges, a participating issuer offering a plan through a Federally-facilitated Exchange must remit a user fee to HHS each month, in the timeframe and manner established by HHS, equal to the product of the monthly user fee rate specified in the annual HHS notice of benefit and payment parameters for the applicable benefit year and the monthly premium charged by the issuer for each policy under the plan where enrollment is through a Federally-facilitated Exchange.</p> |
| 45 CFR § 156.460 - Reduction of enrollee's share of premium to account for advance payments of the premium tax credit | <p>(a) Reduction of enrollee's share of premium to account for advance payments of the premium tax credit. A QHP issuer that receives notice from the Exchange that an individual enrolled in the issuer's QHP is eligible for an advance payment of the premium tax credit must—</p> <ol style="list-style-type: none"> (1) Reduce the portion of the premium charged to or for the individual for the applicable month(s) by the amount of the advance payment of the premium tax credit; (2) Notify the Exchange of the reduction in the portion of the premium charged to the individual in accordance with § 156.265(g); and (3) Include with each billing statement, as applicable, to or for the individual the amount of the advance payment of the premium tax credit for the applicable month(s), and the remaining premium owed. |

| Regulation | Rules |
|--|--|
| <p>45 CFR § 156.480 - Oversight of the administration of the cost-sharing reductions and advance payments of the premium tax credit programs.</p> | <p>(a) Maintenance of records. An issuer that offers a QHP in the individual market through a State Exchange must adhere to and ensure that any relevant delegated entities and downstream entities adhere to, the standards set forth in § 156.705 concerning maintenance of documents and records, whether paper, electronic, or in other media, by issuers offering QHPs in a Federally-facilitated Exchange, in connection with cost-sharing reductions and advance payments of the premium tax credit.</p> <p>(b) Annual reporting requirements. For each benefit year, an issuer that offers a QHP in the individual market through an Exchange must report to HHS, in the manner and timeframe required by HHS, summary statistics specified by HHS with respect to administration of cost-sharing reduction and advance payments of the premium tax credit programs, including any failure to adhere to the standards set forth under § 156.410(a) through (d), § 156.425(a) through (b), and § 156.460(a) through (c) of this Part.</p> <p>(c) Audits. HHS or its designee may audit an issuer that offers a QHP in the individual market through an Exchange to assess compliance with the requirements of this subpart.</p> |
| <p>45 CFR § 156.705 – Maintenance of records for Federally-facilitated Exchanges</p> | <p>(a) General standard. Issuers offering QHPs in a Federally-facilitated Exchange must maintain all documents and records (whether paper, electronic, or other media) and other evidence of accounting procedures and practices, necessary for HHS to do the following:</p> <p>(1) Periodically audit financial records related to QHP issuers' participation in a Federally-facilitated Exchange, and evaluate the ability of QHP issuers to bear the risk of potential financial losses; and</p> <p>(2) Conduct compliance reviews or otherwise monitor QHP issuers' compliance with all Exchange standards applicable to issuers offering QHPs in a federally-facilitated Exchange as listed in this part.</p> <p>(b) Records. The records described in paragraph (a) of this section include the sources listed in § 155.1210(b)(2), (3), and (5) of this subchapter.</p> <p>(c) Record retention timeframe. Issuers offering QHPs in a Federally-facilitated Exchange must maintain all records referenced in paragraph (a) of this section for 10 years.</p> <p>(d) Record availability. Issuers offering QHPs in a Federally-facilitated Exchange must make all records in paragraph (a) of this section available to HHS, the OIG, the Comptroller General, or their designees, upon request.</p> |

Appendix 3 – Glossary of Terms and Acronyms

| Terms & Acronyms | Definition |
|-----------------------------|--|
| APTC | Advance Payments of the Premium Tax Credit |
| CEO | Chief Executive Officer |
| CFO | Chief Financial Officer |
| CFR | Code of Federal Regulations |
| CMS | Centers for Medicare & Medicaid Services |
| CSR | Cost-sharing Reduction |
| EPDW | Enrollment and Payment Data Workbook |
| FFE | Federally-facilitated Exchange |
| GAGAS | Generally Accepted Government Auditing Standards |
| HHS | Department of Health and Human Services |
| HIOS | Health Insurance Oversight System |
| PPACA | Patient Protection and Affordable Care Act |
| QHP | Qualified Health Plan |
| SBE | State-based Exchange |
| TIN | Tax Identification Number |