



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

for

Highmark, Inc. (Highmark)

January 13, 2020

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I. EXECUTIVE SUMMARY

Background

Highmark, Inc. (Highmark) is a health insurance issuer that offered qualified health plans (QHPs) in the individual market Federally-facilitated Exchange (FFE) in Pennsylvania during the 2015 benefit year. Highmark submitted its final restated 2015 benefit year data in the October 2017 Enrollment and Payment Data Workbook (EPDW). The issuer received a total of \$255,589,757.12 in advance payments of the premium tax credit (APTC) from CMS and paid a total of \$17,121,567.70 in FFE user fees (UF) to CMS for its 2015 benefit year individual market plans.

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

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

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

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

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

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

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.

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

Results of Review

CMS identified seven (7) findings and one (1) observation for Highmark. The net financial impact of the seven (7) audit findings is a payment to CMS of \$379,800.05, consisting of \$65,390.28 in FFE user fees owed to CMS and \$314,409.77 in APTC owed 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 UF/APTC Desk Audit File containing subscriber level data from Highmark's systems;
2. Inclusion of enrollment and payment data in the UF/APTC Desk Audit File for three (3) subscribers with coverage that was not effectuated in the issuer's systems;
3. Inclusion of incorrectly prorated enrollment and payment data for one hundred and fifty-five (155) duplicate subscribers in the UF/APTC Desk Audit File;
4. Inclusion of full month enrollment and payment data for eighty-two (82) duplicate subscribers in the UF/APTC Desk Audit File;
5. Inclusion of premium amounts that were less than the APTC amounts for twenty-nine (29) subscribers in the UF/APTC Desk Audit File;
6. Inclusion of incorrect APTC amounts for one (1) of the forty-five (45) selected subscribers in the UF/APTC Desk Audit File; and
7. Inclusion of incorrect premium amounts for two (2) of the fifteen (15) selected subscribers in the UF/APTC Desk Audit File.

Observation:

1. Effectuation and provision of coverage for one (1) of the fifteen (15) selected subscribers in the UF/APTC Desk Audit File as a result of an invoicing error.

Please refer to sections 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;
- 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 Highmark for an audit on issuer compliance with the aforementioned regulations. CMS evaluated Highmark'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 October 2017 by the issuer to CMS to support APTC and FFE user fee collections.

CMS sent Highmark 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 Highmark on May 14, 2018 that identified data requirements required to conduct the audit. CMS's audit contractor reviewed the audit data file submitted by Highmark and used CMS's audit procedures to assess compliance with APTC and FFE user fee program rules and regulations.

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

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

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

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

III. RESULTS OF REVIEW

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

EPDW Validations

One (1) finding and no observations resulted from the comparison of the final 2015 EPDW to Highmark's UF/APTC 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 Highmark's UF/APTC Desk Audit File to determine if the subscribers reported on the file existed and their coverage was effectuated in the issuer's systems. 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 Highmark's UF/APTC Desk Audit File to verify that duplicate Exchange-assigned subscriber IDs were not reported on the file. Please refer to Finding No. 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 Highmark's UF/APTC Desk Audit File to verify that subscribers were not reported on the file with premium amounts that were less than the APTC amounts. Please refer to Finding No. 5 included in section IV for details on the finding.

Coverage Days Validation

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

Forty-five (45) Subscribers Sample Review

One (1) finding and no observations resulted from the review and comparison of the data from Highmark'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. Please refer to Finding No. 6 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 Highmark'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. 7 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 Highmark'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 seven (7) findings that resulted in a change to Highmark's reported EPDW for individual market plans for the 2015 benefit year. In light of the seven (7) 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	\$(17,121,567.70)	\$255,589,757.12
Finding No. 1 - EPDW Validations Adjustment	\$(66,756.01)	\$(283,238.32)
Finding No. 2 - Unreconciled Subscribers Review Adjustment	\$306.85	\$(8,117.74)
Finding No. 3 – Duplicate Exchange-assigned Subscriber IDs Check (Incorrect Proration) Adjustment	\$2.53	\$408.07
Finding No. 4 – Duplicate Exchange-assigned Subscriber IDs Check (Duplicate Records) Adjustment	\$1,823.37	\$(22,305.83)
Finding No. 5 - Premium Less than APTC Validation Adjustment	\$(678.13)	\$(880.95)

	FFE User Fees	APTC
Finding No. 6 – Forty-five (45) Subscribers Sample Review Adjustment	\$0.00	\$(275.00)
Finding No. 7 – Fifteen (15) Subscribers Sample Review Adjustment	\$(88.89)	\$0.00
EPDW As Recalculated	\$(17,186,957.98)	\$255,275,347.35
Total Financial Impact	\$(65,390.28)	\$(314,409.77)

Note: Positive values indicate funds owed to the issuer.

The net financial impact of the seven (7) audit findings is a payment to CMS of \$379,800.05, consisting of \$65,390.28 in FFE user fees owed to CMS and \$314,409.77 in APTC owed to CMS.

For the seven (7) audit findings, CMS documented the criteria, cause, effect, corrective actions, and Highmark's responses as seen in the charts below.

Finding No. 1 - EPDW Validations	Condition:	<p>Premium and FFE User Fee Differences – For one or more months of 2015 benefit year enrollment in fifty-five (55) QHPs, the net "Total Premium Amount by QHP ID for effectuated enrollments" included in Highmark's EPDW was less than the total premium amount included in Highmark's updated UF/APTC Desk Audit File, resulting in an understatement of \$1,907,314.56 in premiums and therefore an underpayment of \$66,756.01 in FFE user fees. For the one or more months of 2015 benefit year in fifty-five (55) QHPs, the EPDW was understated by two thousand, seven hundred and twenty-six (2,726) enrollment groups and twenty-four thousand, eight hundred and ninety (24,890) members.</p> <p>APTC Differences – For one or more months of 2015 benefit year enrollment in fifty-two (52) QHPs, the net "Total APTC Amount by QHP ID for effectuated enrollments" included in Highmark's</p>
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		<p>EPDW was greater than the total APTC amount included in Highmark's updated UF/APTC Desk Audit File, resulting in an overpayment of \$283,238.32 in APTC. For the one or more months of 2015 benefit year in fifty-two (52) QHPs, the EPDW was understated by one thousand eight hundred and thirty-five (1,835) APTC enrollment groups and eighteen thousand and thirty-seven (18,037) APTC members.</p>
	Criteria:	<p>Per 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 UF/APTC 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 "The differences in Premium/User Fee Amounts are a result of appeals, HICS enrollment updates, retroactivity, and internal enrollment data cleanup efforts. As part of prior year enrollment, billing and accounts receivable internal cleanup efforts, issues were discovered related to the reconciliation of APTC, Premium, and User Fee amounts for the 2015 benefit year. In some cases, amounts submitted via the Final 2015 Manual Payment Process did not accurately reflect the member's actual amounts in our systems. These issues were resolved for this Desk Audit file, which</p>

		<p>resulted in different, but more accurate data for APTC, Premium, and User Fee amounts."</p> <p>The net understatements in enrollment groups and members identified in the condition represent aggregated differences, i.e., the aggregated understatements include QHP-level overstatements in some months and QHP-level understatements in other months. The differences may have resulted from incorrect reporting of the enrollment groups and members reported on the EPDW due to the lack of guidance, uncertainty around EPDW reporting requirements, and/or differences in the approaches for calculating and reporting enrollment groups and members on the EPDW versus the approaches for calculation and reporting enrollment groups and members for audit purposes.</p>
	Effect:	The premium/FFE user fee and APTC differences resulted in a change to Highmark's final, restated 2015 benefit year EPDW data.
	Corrective Action Required:	The net financial impact of this finding is a payment to CMS of \$349,994.33, consisting of \$66,756.01 in FFE user fees owed to CMS and \$283,238.32 in APTC owed to CMS. Highmark should confirm the financial impact and coordinate on resolution with CMS as indicated in section VI of this report.
	Management Response:	Agree

Finding No. 2 - Unreconciled Subscribers Review	Condition:	Highmark overstated the 2015 benefit year premium and APTC amounts for three (3) subscribers in the UF/APTC Desk Audit File by reporting enrollment and payment data for subscribers with coverage that was not effectuated.
	Criteria:	Per 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:	<p>The issuer indicated “In 2015, we experienced several processing issues in which Effectuations were not being properly communicated in some cases. This is due to issues with both the IC834 and RCNI processes. Since 2015, we have implemented multiple technology updates and several process improvements for both the daily IC834, and the monthly RCNI, as well as the ER&R dispute process. We have implemented controls on effectuations to ensure anything that is not effectively communicated via IC834 is captured on the RCNI, and anything not resolved through the monthly reconciliation process is addressed via Enrollment Dispute.</p> <p>As our reconciliation process in 2015 was not as robust as it is today over outbound files, all but 3 subscribers on the below list are flagged as enrolled and effectuated in our system. It should be noted that the member’s access to care date was never compromised despite how it appears in the report. The 3 subscribers that are not showing up as effectuated are explained as follows:</p> <p>Subscriber ID X and Subscriber ID Y - For both subscribers, we received a HICS case indicating that the subscriber passed away and the dependent should be made the subscriber. Both are fully subsidized members (APTC = Premium), but we experienced internal processing issues tracking effectuations systematically in this scenario. Those issues have been resolved as part of process improvement efforts since 2015.</p> <p>Subscriber Z - Our enrollment system is showing the wrong Exchange-Assigned ID, which resulted in incorrect effectuation tracking. The member did effectuate, but should be reflected under Exchange-Assigned Subscriber ID of A.”</p> <p>Based on the feedback that the enrollments for the three (3) subscribers were effectuated in error, CMS concluded that the 2015 benefit year premium and</p>

		APTC amounts in the UF/APTC Desk Audit File were overstated.
	Effect:	The inclusion of the three (3) non-effectuated enrollments resulted in a change to Highmark's final, restated 2015 benefit year EPDW data.
	Corrective Action Required:	The net financial impact of this finding is a payment to CMS of \$7,810.89, consisting of \$306.85 in FFE user fees returned to Highmark and \$8,117.74 in APTC owed to CMS. Highmark should confirm the financial impact and coordinate on resolution with CMS as indicated in section VI of this report.
	Management Response:	Agree.

Finding No. 3 - Duplicate Exchange-assigned Subscriber IDs Check (Incorrect Proration)	Condition:	Highmark incorrectly prorated the 2015 benefit year premium amounts for one hundred and twenty-four (124) subscribers, and incorrectly prorated the 2015 benefit year APTC amounts for sixty (60) of those subscribers, in the UF/APTC Desk Audit File. Additionally, Highmark correctly prorated the 2015 benefit year premium amounts but incorrectly prorated the 2015 benefit year APTC amounts for thirty-one (31) subscribers in the UF/APTC Desk Audit File.
	Criteria:	Per the HHS Notice of Benefit and Payment Parameters for 2015 and 45 CFR § 155.240, in a Federally-facilitated Exchange, the premium for coverage lasting less than one month must equal the product of (i) The premium for one month of coverage divided by the number of days in the month; and (ii) The number of days for which coverage is being provided in the month.
	Cause:	The issuer indicated "For the blue rows, we experienced an issue on the Desk Audit file with the proration calculation for records with mid-month changes. We were unintentionally removing a day from the proration calculation for both Premium

		<p>and APTC. A coding change will be made and a corrected Desk Audit file submitted.”</p> <p>Highmark provided an updated UF/APTC Desk Audit File; however, the proration issues were still noted. CMS coordinated with Highmark to determine the correct prorated payment amounts for the applicable records identified in the updated UF/APTC Desk Audit File and the issuer noted "Highmark requests that the calculation of financial impact based on number of days and financial amounts reported on the pre-audit file is applied.” CMS calculated the proration financial impact for the applicable records based on the number of days and financial amounts reported on the pre-audit file per Highmark’s request.</p>
	Effect:	The inclusion of the incorrectly prorated payment data for the one hundred and fifty-five (155) subscribers resulted in a change to Highmark’s final, restated 2015 benefit year EPDW data.
	Corrective Action Required:	The net financial impact of this finding is a payment to Highmark of \$410.60, consisting of \$2.53 in FFE user fees returned to Highmark and \$408.07 in APTC owed to Highmark. Highmark should confirm the financial impact and coordinate on resolution with CMS as indicated in section VI of this report.
	Management Response:	Agree.

Finding No. 4 - Duplicate Exchange-assigned Subscriber IDs Check (Duplicate Records)	Condition:	Highmark overstated the 2015 benefit year premium amounts for eighty-two (82) subscribers, and overstated the 2015 benefit year APTC amounts for forty-two (42) of those subscribers, in the UF/APTC Desk Audit File by reporting full month enrollment and payment data for the subscribers more than once in the same month.
	Criteria:	Issuers cannot request full month payment from CMS for the same subscriber twice within a month.

	Cause:	<p>The issuer indicated:</p> <p>“(1) The way data is stored in our enrollment system resulted in dual coverage and/or extra APTC rows. We will need to build a workaround into our Desk Audit file code to account for these data issues.</p> <p>(2) Voided APTC rows in our enrollment system are being placed on the file. This is a coding defect on the Desk Audit file that will be corrected.”</p> <p>During the audit, the issuer provided an updated UF/APTC Desk Audit File to correct the duplicate check issues originally identified. Upon review of the updated UF/APTC Desk Audit File, the duplicates noted in the condition of the finding were confirmed duplicates by the issuer. We coordinated with the issuer to determine which records were considered the duplicates and the issuer noted "Duplicate Value. Data/Code issue. Highmark requests that the default decision is applied, where the duplicate record is the record that would have the least financial impact.”</p>
	Effect:	The inclusion of the eighty-two (82) duplicate subscribers resulted in a change to Highmark’s final, restated 2015 benefit year EPDW data.
	Corrective Action Required:	The net financial impact of this finding is a payment to CMS of \$20,482.46, consisting of \$1,823.37 in FFE user fees returned to Highmark and \$22,305.83 in APTC owed to CMS. Highmark should confirm the financial impact and coordinate on resolution with CMS as indicated in section VI of this report.
	Management Response:	Agree.

Finding No. 5 - Premium Less than APTC Validation	Condition:	Highmark reported premium amounts that were less than the APTC amounts for twenty-nine (29) subscribers in the UF/APTC Desk Audit File. As a result, Highmark understated the 2015 benefit year premium amounts for twenty-seven (27) of the
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		<p>twenty-nine (29) subscribers, understated the 2015 benefit year APTC amounts for one (1) of those subscribers and overstated the 2015 benefit year APTC amounts for one (1) of those subscribers, in the UF/APTC Desk Audit File. Additionally, Highmark overstated the 2015 benefit year APTC amounts for two (2) of the twenty-nine (29) subscribers, and overstated the 2015 benefit year premium amounts for one (1) of those subscribers, in the UF/APTC Desk Audit File.</p>
	Criteria:	<p>Issuers cannot report a premium amount that is less than an APTC amount. Per CMS guidance, the premium amount reported on the EPDW is the premium amount by 16 digit QHP ID for the effectuated enrollment within a qualified health plan.</p>
	Cause:	<p>The issuer indicated one of the following responses for each of the twenty-nine (29) subscribers:</p> <ul style="list-style-type: none"> • "The premium of [issuer provided premium amount of \$X for the subscriber] is showing in ECS, the [issuer provided premium amount of \$X for the subscriber] is from 2014 rate." (Four (4) subscribers) • "Proration issue." (Three (3) subscribers) • "Pre-audit file has incorrect SSN and rate." (One (1) subscriber) • "Member DOB change." (One (1) subscriber) • "Incorrect rate in enrollment system." (Three (3) subscribers) • "Dependent added [issuer provided date of X/X/14 for the subscriber] via [issuer provided HICS case ID of EXXXXXXXXXX for the subscriber], rate was not updated." (Two (2) subscribers) • "[issuer provided premium rate of \$X for the subscriber] is the rate for 2014, rate was not updated in enrollment system." (Thirteen (13) subscribers) • "[issuer provided date of X/X/2015 for the subscriber] coverage backdated to [issuer provided date of X/X/2015 for the

		<p>subscriber], premium not updated in enrollment system." (Two (2) subscribers)</p> <p>Based on the feedback that the incorrect rates were used, CMS concluded that the incorrect 2015 benefit year premium and APTC amounts were reported for twenty-nine (29) subscribers in the UF/APTC Desk Audit File. During the audit, the issuer provided the correct premium and APTC amounts to inform the financial impact.</p>
	Effect:	The inclusion of the incorrect premium and APTC amounts for the twenty-nine (29) subscribers resulted in a change to Highmark's final, restated 2015 benefit year EPDW data.
	Corrective Action Required:	The net financial impact of this finding is a payment to CMS of \$1,559.08, consisting of \$678.13 in FFE user fees owed to CMS and \$880.95 in APTC owed to CMS. Highmark should confirm the financial impact and coordinate on resolution with CMS as indicated in section VI of this report.
	Management Response:	Agree.

Finding No. 6 - Forty-five (45) Subscribers Sample Review	Condition:	Highmark overstated the 2015 benefit year APTC amounts for one (1) of the forty-five (45) selected subscribers in the UF/APTC Desk Audit File by incorrectly processing an 834 transaction.
	Criteria:	Per CMS guidance, the APTC amount reported on the EPDW and UF/APTC Desk Audit File is the APTC amount toward the total premium amount for effectuated enrollments.
	Cause:	<p>The issuer indicated "Our enrollment system reflects the incorrect APTC amount for the 8/1/2015-12/31/2015 coverage span due to incorrect processing of the I834 transaction."</p> <p>Based on the feedback that the incorrect processing occurred, CMS concluded that the 2015 benefit year</p>

		APTC amounts reported for the one (1) subscriber in the UF/APTC Desk Audit File were overstated.
	Effect:	The inclusion of the incorrect APTC amounts for the subscriber resulted in a change to Highmark's final, restated 2015 benefit year EPDW data.
	Corrective Action Required:	The net financial impact of this finding is a payment to CMS of \$275.00, consisting of APTC owed to CMS. Highmark should confirm the financial impact and coordinate on resolution with CMS as indicated in section VI of this report.
	Management Response:	Agree.

Finding No. 7 – Fifteen (15) Subscribers Sample Review	Condition:	Highmark understated the 2015 benefit year premium amounts for two (2) of the fifteen (15) selected subscribers in the UF/APTC Desk Audit File by reporting the incorrect rates.
	Criteria:	<p>Per CMS guidance, the issuer must create a single Inbound UF/APTC Desk Audit File consisting of detailed enrollment group effectuated enrollment records (one per enrollment group, per month) with the corresponding payment data. Issuers are to submit records for any effectuated enrollments and terminated enrollments (those enrollments that were effectuated and had some period of active coverage).</p> <p>Per CMS guidance, the premium amount reported on the EPDW and the UF/APTC Desk Audit File is the premium amount by 16 digit QHP ID for the effectuated enrollment within a qualified health plan.</p>
	Cause:	<p>The issuer indicated the following for the two (2) subscribers with incorrect premium amounts:</p> <ul style="list-style-type: none"> Subscriber Number 1: “Member has a 1.22 credit from 2014 that was applied towards the initial payment for 2015 making the first payment owed 73.75 (Sample1Exhibit1.pdf). Payments for 74.97

		<p>were received throughout 2015 (Sample1Exhibit2.pdf). When the member passively enrolled for 2015 the correct rate was not loaded into the Enrollment Communication System. We billed the member 509.51 which is the correct rate. (See Sample1Exhibit3.pdf for rate and Sample1Exhibit4.pdf for invoice)."</p> <p>During the audit, we coordinated with the issuer to determine the correct premium amount and whether the issue impacts other enrollments reported in the UF/APTC Desk Audit File. The issuer noted "(1) The desk audit file should indicate \$509.51 for all months. The desk audit file reflects what is in our enrollment system, and not our billing system. We have since updated the enrollment system to match the billing system for this record. (2) This issue does not impact any other enrollments reported on our desk audit file other than Number 4 below".</p> <ul style="list-style-type: none"> Subscriber Number 4: "789.93 is the 2014 rate. This policy was a passive enrollment and the Enrollment Communication System was not loaded with the correct rate of 927.58 for 2015 (see Sample4Exhibit1.pdf for ECS and Sample4Exhibit2.pdf for rate). On 3/5/15 the policy was voided in error then the coverage was reinstated on 4/21/15 (Sample4Exhibit3.pdf). The invoice that generated on 3/5 backed out of the 3 mos. we had billed @ 449.58, when coverage was reinstated (invoiced 4/28) charges for those 3 months plus 2 additional (April and May) were invoiced (see Sample4Exhibit4.pdf)." <p>During the audit, we coordinated with the issuer to determine the correct premium amount and whether the issue impacts other enrollments in the UF/APTC Desk Audit File. The issuer noted "(1) The desk audit file should indicate \$927.58 for all months.</p>
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		The desk audit file reflects what is in our enrollment system, and not our billing system. We have since updated the enrollment system to match the billing system for this record. (2) This issue does not impact any other enrollments reported on our desk audit file other than Number 1 above."
	Effect:	The inclusion of the incorrect premium amounts for the two (2) subscribers resulted in a change to Highmark's final, restated 2015 benefit year EPDW data.
	Corrective Action Required:	The net financial impact of this finding is a payment to CMS of \$88.89, consisting of FFE user fees owed to CMS. Highmark should confirm the financial impact and coordinate on resolution with CMS as indicated in section VI of this report.
	Management Response:	Agree.

V. OBSERVATIONS

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

Observation No. 1 – Fifteen (15) Subscribers Sample Review	Condition:	Highmark did not receive a binder payment but provided coverage for one (1) of the fifteen (15) selected subscribers in the UF/APTC Desk Audit File. This enrollment therefore should not have been effectuated because a valid binder payment was not received.
	Criteria:	<p>Per CMS guidance, the issuer must create a single Inbound UF/APTC Desk Audit File consisting of detailed enrollment group effectuated enrollment records (one per enrollment group, per month) with the corresponding payment data. Issuers are to submit records for any effectuated enrollments and terminated enrollments (those enrollments that were effectuated and had some period of active coverage).</p> <p>Additionally, per 45 CFR § 155.400(e), Exchanges may require payment of a binder payment to effectuate an enrollment or to add coverage retroactively to an already effectuated enrollment.</p>
	Cause:	For the one (1) subscriber, the issuer noted "Member was identified as part of Accounts Receivable clean-up project in October 2015. Received a future group change during the member's initial invoice period that resulted in a invoicing error removing the member from the delinquency process. Due to this error the member's February election did not cancel appropriately. Since the error was not discovered by the Plan until October we did not void the member's coverage so as not to negatively impact the member, but the write off performed in the system resulted in triggering the system to effectuate the coverage in error." The issuer further indicated "We did provide coverage from 2/1/2015

		<p>through 2/28/2015. The member did not have any claims during that time.”</p> <p>During the audit, CMS coordinated with Highmark to determine whether the issue impacts other enrollments reported in the UF/APTC Desk Audit File. The issuer noted "The desk audit file does not include other enrollments that were written off as part of the AR cleanup project in October 2015."</p>
	Effect:	The issuer did not follow CMS enrollment guidance and requirements set forth in 45 CFR § 155.400(e) as the issuer effectuated the enrollment in error due to an invoicing error that removed the member from the delinquency process.
	Management Response:	Agree.

VI. MANAGEMENT RESPONSES

Please provide management's response to the seven (7) 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 seven (7) 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 seven (7) findings and corrective actions or the one (1) observation, complete the "Management Response" field of the findings and observation 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 observation 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: 33709

Issuer Name: Highmark, Inc. (Highmark)

The undersigned Chief Executive Officer (CEO), Chief Financial Officer (CFO) or other individual who can legally and financially bind this issuer has reviewed the information included in the audit report of the issuer's 2015 benefit year APTC and FFE UF program participation, resulting in a payment to CMS of \$379,800.05, consisting of \$65,390.28 in FFE user fees owed to CMS and \$314,409.77 in APTC owed to CMS, and:

(INITIAL) BS 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: Brian Setzer
(Signature of authorized person acting on behalf of the issuer.)

Printed Name: Brian Setzer
(Print name of signature)

Title: Executive Vice President Government Market, Health Plan
(Title of authorized person acting on behalf of the Issuer)

Telephone Number: 412-544-4177
(Direct Telephone Number)

Date: 1-28-2020

Appendix 2 – Applicable Regulations

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

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

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

Appendix 3 – Glossary of Terms and Acronyms

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