Benefit Year 2018 High-Cost Risk Pool (HCRP) Audit Report

for

Cigna Health and Life Insurance Company (Cigna)
HIOS Issuer ID 49375

April 15, 2022

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I. EXECUTIVE SUMMARY

The 2018 High-Cost Risk Pool (HCRP) Audit Report is an assessment of Cigna Health and Life Insurance Company's (Cigna) compliance with the applicable federal requirements related to benefit year (BY) 2018 payments made to Cigna under HCRP, part of the HHS-operated Risk Adjustment (RA) program established under section 1343 of the Patient Protection and Affordable Care Act (ACA)[1] and implementing regulations.[2,3] This report details the audit procedures[4] and the resulting findings and/or observations for the BY 2018 HCRP audit of Cigna.

Background

Cigna, HIOS Issuer ID (49375), is a health insurance issuer that received BY 2018 HCRP payments[5] consistent with the BY 2018 national HCRP payment parameters.[6] Cigna submitted enrollment (including premium), medical claims, and pharmacy claims data to its External Data Gathering Environment (EDGE) Server for calculation of the BY 2018 HCRP payments. The payments are reflected in the issuer's 2018 EDGE High Cost Risk Pool Detailed Enrollee (HCRPDE) Report. This issuer's total BY 2018 HCRP payments were $1,362,639.56

Audits to Determine Compliance with the Federal HCRP Payment Requirements

Under 45 C.F.R. § 153.620(c), the Department of Health and Human Services (HHS) may audit issuers to assess compliance with applicable federal requirements related to the HHS-operated RA program, including the HCRP. The Centers for Medicare & Medicaid Services (CMS), on behalf of HHS, operates the RA program and conducted these audits in pursuit of the following goals:

[1] The ACA (Pub. L. 111–148) was enacted on March 23, 2010. The Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152), which amended and revised several provisions of the ACA, was enacted on March 30, 2010. In this report, we refer to the two statutes collectively as the ''Patient Protection and Affordable Care Act'' or ''ACA.''

[2] See 42 U.S.C. § 18063. Also see 45 C.F.R. Part 153, Subparts A, B, D, G, and H. Consistent with section 1321(c)(1) of the ACA, the HHS Secretary is responsible for operating the program on behalf of any State that elected not to do so. See 42 U.S.C. § 18041(c)(1). For the 2018 benefit year, CMS, on behalf of HHS, operated the program in all 50 States and the District of Columbia.

[3] HHS added the HCRP to the HHS risk adjustment methodology beginning with the 2018 benefit year. See the HHS Notice of Benefit and Payment Parameters for 2018; Final Rule, 81 FR 94058 at 94080 – 94082 (December 22, 2016).

[4] Audit protocols allow for dialogue between auditor and issuer to identify and correct errors in audit data submissions that differ somewhat from some independence and reporting standards set forth 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.

[5] HCRP payments are funded by a percent of premium charge on all risk adjustment covered plans in the applicable national market risk pool. See 81 FR at 94080 – 94082. There are two national market risk pools in the HCRP– one for the individual market (including catastrophic and non-catastrophic plans, and merged market plans), and another for the small group market. Ibid.

[6] The final BY 2018 national HCRP payment parameters consisted of a $1,000,000 attachment point and a 60% coinsurance rate. See 81 FR at 94081. Also see Benefit Year 2018 High Cost Risk Pool Reference Guide available at: https://www.hhs.gov/guidance/sites/default/files/hhs-guidancedocuments/HCRP_IssuerReferenceGuide_100418_v1_5CR_102618.pdf.

- Safeguard federal funds;
- Instill confidence amongst regulated entities and stakeholders concerning quality, soundness, and robustness of data;
- Evaluate health insurance issuers' compliance with applicable federal RA program requirements; and
- Develop a successful and coordinated HCRP-based audit program that maximizes resources.

This audit is part of CMS's program to validate the BY 2018 enrollee-level enrollment (including premium) and claims data submitted to the issuer's EDGE server by April 30, 2019,[7] and to analyze the issuer's controls and policies related to BY 2018 HCRP payments. Additional HCRP payments will not be provided for claims identified during the course of this HCRP audit that are not reflected in the BY 2018 HCRPDE Report.[8]

CMS findings and observations for the BY 2018 HCRP payments made to Cigna are documented below.

- *Finding*: Results from cases of confirmed non-compliance or discovery of evidence suggesting non-compliance with applicable federal requirements related to HCRP payments, which require a recoupment of HCRP payments.
    - Example: Claim level discrepancies identified within the issuer's claims data extract and the issuer's BY 2018 HCRPDE Report, associated with an HCRP payment enrollee, that result in a recoupment of HCRP payments.
- *Observation*: Results from the identification of areas for improvement when there is no evidence of actual non-compliance with applicable federal requirements related to HCRP payments or when there may be evidence of non-compliance with applicable federal requirements related to HCRP payments that does not require recoupment of HCRP payments.
    - Example: Claim level discrepancies identified within the issuer's claims data extract and the issuer's BY 2018 HCRPDE Report, associated with HCRP payment enrollees where the claim adjustment would not result in a recoupment of HCRP payments.
    - Example: Premium discrepancies identified within the issuer's premium data extract and the issuer's BY 2018 EDGE server submissions.

Results of Review

CMS identified no findings and one (1) observation during Cigna's BY 2018 HCRP audit. The results of the BY 2018 HCRP program audit do not require recoupment of amounts the issuer received for BY 2018 HCRP payments. The results of the no audit findings resulted in a total of $0.00 paid claim differences. All issuers' paid claims amounts, with the audit corrections applied, were aggregated for each enrollee, then the HCRP payment parameters were applied to recalculate the issuer's BY 2018 HCRP payments in the applicable national high-cost risk

[7] See 45 C.F.R. § 153.730.

[8] As communicated in the Entrance Conference, additional HCRP payments will not be provided for underpayments identified as a result of the BY 2018 HCRP Audits. In addition, HCRP charges will not be recalculated as a result of any premium discrepancies identified in these audits. However, HHS may recalculate HCRP charges as part of other audits or enforcement actions.

pools.[9,10] As a result, based on the findings identified in this report, a total recoupment payment is due to HHS of $0.00 for the BY 2018 HCRP payments, reflecting a recoupment of $0.00 for the individual market national high-cost risk pool and $0.00 for the BY 2018 HCRP payments for the small group market national high-cost risk pool.

The result of the one (1) observation does not require a recoupment of the issuer's BY 2018 HCRP payments. In some instances, an observation may also affect an enrollee who received an HCRP payment but not result in an impact to the HCRP payment for that enrollee (e.g., the issuer's aggregated paid claims for the enrollee, after correcting the observation and application of the BY 2018 HCRP payment parameters, results in the same or a larger[11] HCRP payment for the enrollee).

Please refer to Section II.D below for details on the observation noted above.

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[9] The HCRP calculations under the HHS RA methodology involve two national risk pools – one for the individual market (including catastrophic and non-catastrophic plans, and merged market plans), and another for the small group market. See 81 FR at 94080-94082.

[10] Please refer to Section II C. Findings to view the aggregated amount of paid claim differences associated with each audit procedure, used for calculating the "Total Financial Impact."

[11] Additional HCRP payments will not be provided for underpayments identified as a result of the BY 2018 HCRP audits.

II. HIGH-COST RISK POOL PAYMENT AUDIT

A. BACKGROUND, OBJECTIVES, SCOPE, and METHODOLOGY

1. Background

HHS has authority to conduct audits to confirm successful implementation of, and adherence to, the applicable federal requirements related to the HHS-operated RA program, including the HCRP.[12] As such, CMS, on behalf of HHS, established this audit program.

Section 1343 of the ACA established the RA program to stabilize premiums in the individual and small group markets inside and outside of the Exchanges. Consistent with section 1321(c) of the ACA, HHS is responsible for operating the RA program in any state that fails to do so. CMS, on behalf of HHS, operated the RA program in all 50 states and the District of Columbia for the BY 2018.

HHS established the HCRP as part of the HHS RA methodology beginning with BY 2018.[13] The HCRP calculations under the HHS RA methodology involve two national risk pools – one for the individual market (including catastrophic and non-catastrophic plans, and merged market plans), and another for the small group market.[14] The HCRP helps ensure that risk adjustment transfers better reflect average actuarial risk, while also stabilizing premiums and reimbursing issuers for a portion of costs for exceptionally high-cost enrollees. Under HCRP, issuers of RA covered plans receive payments for a percentage of covered claims (coinsurance rate) above the attachment point. For the BY 2018 HCRP, the attachment point was $1,000,000 and the coinsurance rate was 60%.[15] The HCRP also collects a percent of all premium charges by national market risk pool to fund HCRP payments to issuers of RA covered plans in the respective national market risk pool.

HHS implemented a distributed data collection (DDC) approach where issuers of RA covered plans are required to establish EDGE servers to make data accessible to support the calculation of transfers under the HHS-operated RA program.[16] Issuers are generally required to submit enrollee (including premium) and claims data to their EDGE servers by April 30th of the year following the applicable benefit year.[17] Non-orphan claims (i.e., those that are linked to enrollees in a valid individual and small group (including merged) market RA covered plan) were selected for the HCRP calculation and considered as a request for payment pursuant to 45 C.F.R. § 153.620. Each issuer's EDGE server calculated the issuer's HCRP payment for the applicable national market risk pool, while the EDGE Calculation Module (ECM), a CMS internal system, calculated the amount of each issuer's HCRP charge for the applicable national market risk pool.

CMS established audit protocols to assess health insurance issuers' compliance with the regulations governing the HHS-operated RA program, including HCRP, such as:

[12] See 45 C.F.R. § 153.620(c).
[13] See supra note 3.
[14] 81 FR at 94080-94082.
[15] See 81 FR at 94081.
[16] See 45 C.F.R. §§ 153.610(a) and 153.700.
[17] See supra note 7.

- 45 C.F.R. § 153.610: Risk Adjustment issuer requirements;
- 45 C.F.R. § 153.620: Compliance with risk adjustment standards; and
- 45 C.F.R. § 153.700: Distributed data environment.

Please refer to Appendix 2 for further details on these regulations.

2. Objectives

The objectives of this audit are to:

(1) Evaluate enrollment (including premium) and claims files on the issuer's EDGE server against applicable federal requirements related to HCRP payments for compliance and completeness;
(2) Assess validity and compliance of issuer-submitted plan reference data and associated enrollee data with applicable federal requirements related to HCRP payments;
(3) Evaluate whether issuer supporting data and documentation confirms the information in the BY 2018 HCRPDE Report[18] and BY 2018 Enrollment File data at the enrollee and subscriber level;
(4) Evaluate accuracy of the issuer's HCRP payments, as calculated by the EDGE server,[19] in instances where there is a deviation between the issuer's audit data and the data on the issuer's EDGE server;
(5) Assess issuer controls, policies, and procedures surrounding HCRP data submissions to the issuer's EDGE server; and
(6) Assess the issuer's compliance with the maintenance of records requirements in 45 C.F.R. § 153.620(b) (i.e., 10 years of file retention).

3. Scope and Methodology

CMS selected Cigna for an audit to assess the issuer's compliance with the federal requirements related to BY 2018 HCRP payments. CMS evaluated Cigna's information and activities related to the BY 2018 (January 1, 2018 through December 31, 2018) enrollee (including premium) and claim-level data submitted to the issuer's EDGE server as of April 30, 2019, to verify the BY 2018 HCRP payments received.

CMS sent Cigna an electronic letter on April 12, 2021, to notify them of this audit. CMS's audit contractor sent a follow-up letter to Cigna on April 14, 2021, that identified the data and other requirements related to conducting the audit. CMS's audit contractor reviewed Cigna's documentation, including issuer-provided data extracts, and used CMS's applicable audit procedures to assess compliance with applicable federal HCRP program rules and regulations.

CMS's audit contractor applied CMS's audit protocols to identify findings and observations. The contractor performed audit procedures on data and information for 100% of known on-Exchange and off-Exchange enrollees in RA covered plans who received BY 2018 HCRP payments, as well as a random selection of subscribers to evaluate premiums. *(Note: Any discrepancies identified as a result of the premium validations will result in an observation and therefore will*

[18] The HCRPDE report contains issuer, market, enrollee-level plan, and claim details used for the HCRP payment calculations and is made available only to issuers through EDGE servers.
[19] Issuer EDGE servers process enrollment and claims data according to the EDGE Server Business Rules (ESBR) to select claims to be included in RA transfer calculations, including HCRP payment and charge calculations. See 45 C.F.R. §§ 153.610, 153.620, 153.700, 153.710, and 153.720.

not have financial impact as a result of these audits). CMS's audit procedures included the following[20]:

(1) **Unreconciled Claims Review**: Compare the unique claim IDs included in the issuer's BY 2018 HCRPDE Report to the unique claim IDs included in the issuer's claims data extract to determine existence.
(2) **RA Covered Plan Review**: Compare the issuer's claims in the claims data extract to those in the BY 2018 HCRPDE Report to validate whether the claim was paid by an RA covered plan and matches the plan ID reported in the issuer's BY 2018 HCRPDE Report.
(3) **Claim Coverage Period Validation**: Compare the issuer's claims in the claims data extract to the coverage period in the BY 2018 EDGE Enrollment File to determine whether the claim start date is within the enrollee's coverage period.
(4) **Paid Claim Amount Validation**: Review the issuer's claims in the claims data extract to validate the paid claim amount matches the paid claim amount in the issuer's BY 2018 HCRPDE Report.
(5) **BY 2018 Cross Year Claim Validation**: Review the issuer's claims end dates in the claims data extract to validate whether cross year claims fell within BY 2018 and were not from the prior or subsequent benefit years.
(6) **Duplicate Claim Validation**: Review the issuer's claims in the claims data extract and determine if duplicate claims were reported to the EDGE server.
(7) **Enrollee Validation**: Compare the unique enrollees and related claims included in the issuer's BY 2018 HCRPDE Report to the unique enrollee IDs and related claims included in the issuer's claims data extract to determine the accuracy of enrollees submitted to the EDGE server.
(8) **Premium Effectuation Validation:** Compare the issuer's initial premium payment documentation to the issuer's premium data extract to validate the accuracy of binder payment amount and appropriate effectuation.
(9) **Premium Amount Validation:** Compare the premium information in the issuer's premium data extract to premium information in the issuer's BY 2018 EDGE Enrollment File to validate the accuracy of the premium data reported to the EDGE server for all months of enrollment.
(10) **Issuer Policies and Procedures Review:** Determine whether the issuer's policies and procedures comply with applicable CMS rules, regulations, and policies related to HCRP.
(11) **Issuer Attestation Review**: Validate that the issuer provided a completed attestation signed by the Chief Executive Officer (CEO), Chief Financial Officer (CFO) or other authorized official who has reviewed the documentation submitted for this audit. This procedure is performed to substantiate the accuracy of the documentation submitted during the audit process and does not result in a finding or observation for the issuer.

B. RESULTS OF REVIEW

CMS assessed Cigna's compliance with applicable federal requirements related to the HCRP that is part of the HHS-operated RA program, using the following procedures: Unreconciled Claims Review, RA Covered Plan Review, Claim Coverage Period Validation, Paid Claim Amount

[20] Please see Appendix 4 for more information on each procedure's description, criteria, and effect.

Validation, BY 2018 Cross Year Claim Validation, Duplicate Claim Validation, Enrollee Validation, Premium Effectuation Validation, Premium Amount Validation, Issuer Policies and Procedures Review, and Issuer Attestation Review. Below are the results of this review.[21]

(1) Unreconciled Claims Review

No findings resulted from the review of Cigna's claims data extract to determine if the claims reported on the BY 2018 HCRPDE Report existed in the claims data extract.

RA Covered Plan Review

No findings and no observations resulted from the review of Cigna's claims data extract to determine if the enrollee's plan ID matched the corresponding enrollee's plan ID reported in the issuer's BY 2018 HCRPDE Report and if the claim was paid by an RA covered plan.

Claim Coverage Period Validation

No findings resulted from the review of Cigna's claims data extract to determine whether the claim start date fell within the enrollee's coverage period.

(2) Paid Claim Amount Validation

No findings and no observations resulted from the review of Cigna's claims data extract to determine if the claim paid amount matched the corresponding claim paid amount in the issuer's BY 2018 HCRPDE Report.

(3) BY 2018 Cross Year Claim Validation

No findings resulted from the review of Cigna's claims data extract to identify cross year claims and determine if the service end date of claims fell within BY 2018.

(4) Duplicate Claim Validation

No findings resulted from the review of Cigna's claims data extract to determine if claims were reported more than once on the EDGE server.

(5) Enrollee Validation

No findings resulted from the review of Cigna's claims data extract to determine if the enrollee and related claims included in the issuer's claims data extract matches the enrollee associated with the applicable claim on the EDGE server.

(6) Premium Effectuation Validation

No observations resulted from the review of Cigna's initial premium documentation to determine if the first month binder payment was received and/or differences were identified for the first month of enrollment in the issuer's premium data extract.

(7) Premium Amount Validation

One (1) observation resulted from the review of Cigna's premium data extract to determine if the issuer's premium amount matched the corresponding premium amount in the issuer's BY 2018 EDGE Enrollment File. Please refer to Observation No. 1 included in Section II.D below for

[21] This review primarily focused on the BY 2018 HCRPDE Report titled: 49375.HCRPDE.D20190501T025250.P.xml.

details on the observation.

(10) Issuer Policies and Procedures Review

No observations resulted from the review of Cigna's HCRP policies and procedures to determine compliance with applicable CMS rules, regulations, and policies.

(11) Issuer Attestation Review

No observations result from the review of Cigna's Attestation to validate that the issuer provided a completed attestation signed by the Chief Executive Officer (CEO), Chief Financial Officer (CFO) or other authorized official who has reviewed the documentation submitted for this audit.

C. FINDINGS

A finding results from cases of confirmed non-compliance or discovery of evidence suggesting non-compliance with applicable federal requirements related to HCRP payments, which requires a recoupment of HCRP payments. For BY 2018, an enrollee must have had claims paid by the issuer in an amount that exceeds the attachment point of $1,000,000 to be eligible for an HCRP payment. The paid amounts[22] reported in the issuer's BY 2018 HCRPDE Report, the 2018 Coinsurance rate of 60%, as well as the paid claim amount differences identified from the claim-level audit procedures, were considered for purposes of determining the financial impact of the findings in Cigna's BY 2018 HCRP audit. Please refer to the Findings Summary Results table below to view the aggregated amount of paid claim differences associated with each audit procedure.

Findings Summary Results:

Finding No.	Claim Level Procedure	Individual Market		Small Group Market		Total	
		Total Count of Claims	Total Claim Level Differences	Total Count of Claims	Total Claim Level Differences	Total Count of Claims	Total Claim Level Differences
No Findings Noted.							

Based on the claim-level audit procedures performed, no findings were identified for enrollees associated with a BY 2018 HCRP payment. These claim-level procedures resulted in a total of $0.00 paid claim amount differences, and the differences were further aggregated at the enrollee and national market risk pool level for final recalculation of the issuer's BY 2018 HCRP payments, which resulted in a total financial impact of $0.00. Please refer to the Findings Summary Results table above to view the aggregated amount of paid claim differences associated with each audit procedure used for calculating the "Total Financial Impact" amount shown in the table below.

[22] In BY 2018, the HCRP payment calculations did not include a CSR MOOP adjustment because HHS ceased making CSR payments in October 2017. *See* Op. Att'y Gen. (October 12, 2017), discussing *United States House of Representatives v. Burwell*, 185 F. Supp. 3d 165, 174 (D.D.C. 2016), which declared CSR payments by HHS impermissible absent an explicit congressional appropriation. *Available at* https://www.hhs.gov/sites/default/files/csr-payment-memo.pdf.

Financial Impact Summary Results:

	Total Individual Market Payment Amount	Total Small Group Market Payment Amount	Total HCRP Payment Amount
Total HCRP Payments per Cigna's BY 2018 HCRPDE Report	$1,362,639.56	$0.00	$1,362,639.56
Total HCRP Payments as Recalculated	$1,362,639.56	$0.00	$1,362,639.56
Total Financial Impact[23]	$0.00	$0.00	$0.00

The financial impact of the no findings is subject to recoupment by HHS in the amount of $0.00, reflecting a recoupment of $0.00 for the individual market national high-cost risk pool and $0.00 for the for the small group market national high-cost risk pool.

Please see Appendix 4 for more information on each procedure's description, criteria, and effect.

D. OBSERVATIONS

An observation results from the identification of areas for improvement when there is no evidence of actual non-compliance with applicable federal requirements related to HCRP payments or when there may be evidence of non-compliance with applicable federal requirements related to HCRP payments that does not require recoupment of HCRP payments. CMS is making Cigna's management aware of these areas by bringing the identified observation to their attention.

Based on the claim-level audit procedures performed, no observations were identified for enrollees associated with a BY 2018 HCRP payment. Based on the premium-related audit procedures performed, one (1) observation was identified for subscribers with enrollment in BY 2018. Additionally, no observations were identified for the Issuer Policies and Procedures Review. Please see the Observations Summary Results table below for more information on the observation identified.

[23] Financial impact derived from BY 2018 HCRP Program audits only includes findings where funds are subject to recoupment by HHS. These amounts will be collected as part of the next available monthly payment cycle consistent with 45 C.F.R. § 156.1210 and the netting regulation at 45 C.F.R. § 156.1215 after this report is finalized. If all or part of the recoupment amount is unable to be netted, the remaining amount is a determination of a debt that is owed to the federal government. 45 C.F.R. § 156.1215(c).

Observations Summary Results:

Observation No.	Claim Level Procedure	Individual Market	Small Group Market	Total
		Total Count of Claims	Total Count of Claims	Total Count of Claims
No Observations Noted.				
Observation No.	**Premium Procedure**	**Total Count of Subscribers**	**Total Count of Subscribers**	**Total Count of Subscribers**
Observation No. 1	Premium Amount Validation	2	0	2
Observation No.	**Policies and Procedures**			
No Observations Noted.				

III. ISSUER MANAGEMENT RESPONSES

Cigna's completed attached Appendix 1 - Issuer Management Response to Financial Recoupment Adjustment (Appendix 1), **is due within thirty (30) calendar days from the date of this draft audit report.** If CMS does not receive Cigna's management response within this timeframe, we will assume your management's agreement and issue the final audit report.

Agreement

If Cigna's management agrees with the reported observation, and recoupment amount (if applicable) the issuer should initial "Agree", sign, and submit the attached Appendix 1.

Disagreement

If Cigna's management disagrees with the reported observation, and recoupment amount (if applicable) and requests a review of additional information that may impact the results of the audit, the issuer should initial "Disagree" and sign the attached Appendix 1. If this option is selected, CMS will consider this draft only a preliminary audit report and you must provide a written explanation with any such additional documentation within thirty (30) calendar days of the date of this draft audit report along with a completed Appendix 1. CMS will review the written explanation and supporting documentation submitted as part of your response to this report to determine if the report can be amended in a mutually acceptable manner. CMS maintains discretion to determine whether amendments to the report are appropriate. Your response(s) to this report will be included in the final published audit report.

Regardless of whether the issuer agrees or disagrees with the reported finding(s) and observation(s), Cigna's management should review and return the draft audit report, including completed Appendix 1, within thirty (30) calendar days from the date of this draft audit report. Review of this draft report is the final opportunity to provide information to correct any inaccuracies before it is finalized. CMS will provide Cigna a copy of the final audit report and publish the final report on the Center for Consumer Information and Insurance Oversight (CCIIO) website[24], including the recoupment amount(s) (if applicable) along with an updated Appendix 1, after receipt of Cigna's management's response. CMS will finalize and process the recoupment amount(s) (if applicable) consistent with 45 C.F.R. § 156.1210 and the netting regulation at 45 C.F.R. § 156.1215 in the next available monthly payment cycle. If all or part of the recoupment amount(s) is unable to be netted, the remaining amount is a determination of a debt that is owed to the federal government. See 45 C.F.R. § 156.1215(c).

[24] https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Exams_Audits_Reviews_Issuer_Resources-.

Appendix 1 – Issuer Management Response

Issuer ID: 49375

Issuer Name: Cigna Health and Life Insurance Company

Issuer Address:

The undersigned Chief Executive Officer (CEO), Chief Financial Officer (CFO) or other individual with authority to legally and financially bind this issuer has reviewed the information included in the Audit Report of the issuer's compliance with applicable federal requirements related to HCRP payments made through the HHS-RA program for BY 2018. This audit resulted in no payment adjustment.

Agreement/Disagreement

(INITIAL) LL Agrees with the audit recoupment amount above for this issuer's BY 2018 HCRP payment audit, confirming the observation as such this report will be considered a final audit report and will be published. If this option is selected, you must return this response within 30 calendar days of the date of this draft audit report.

Or

(INITIAL)______Disagrees and requests a review of additional information that may impact the audit observation and recoupment amount (if applicable) resulting from the BY 2018 HCRP payment audit. If a review is requested, CMS will consider this draft only a preliminary audit report. If this option is selected, you must provide a written explanation with any additional support documentation that may impact the results of the audit when you return this response within 30 calendar days of the date of this draft audit report. CMS will review the written explanation and any supporting documentation submitted as part of your response to this report to determine if the report can be amended in a mutually acceptable manner. CMS maintains discretion to determine whether amendments to the report are appropriate. Your response(s) to this report will be included in the final published audit report.

Signed: [signature]
(Signature of authorized person acting on behalf of the issuer)

Printed Name: Lisa Lough
(Print name of signature)

Title: President, IFP

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

Telephone number: 860.907.5472
(Direct Telephone number)

Date: 5/5/2022

Appendix 2 – Applicable Federal Regulations

The following table outlines select federal regulatory requirements related to HCRP payments applicable to these audits.

Regulation	Guidance
45 C.F.R § 153.20 – Definitions	***Risk adjustment covered plan*** means, for the purpose of the risk adjustment program, any health insurance coverage offered in the individual or small group market with the exception of grandfathered health plans, group health insurance coverage described in § 146.145(b) of this subchapter, individual health insurance coverage described in § 148.220 of this subchapter, and any plan determined not to be a risk adjustment covered plan in the applicable Federally certified risk adjustment methodology.
45 C.F.R. § 153.610 - Risk adjustment issuer requirements.	**(a)** ***Data requirements.*** An issuer that offers risk adjustment covered plans must submit or make accessible all required risk adjustment data for those risk adjustment covered plans in accordance with the risk adjustment data collection approach established by the State, or by HHS on behalf of the State. **(b)** ***Risk adjustment data storage.*** An issuer that offers risk adjustment covered plans must store all required risk adjustment data in accordance with the risk adjustment data collection approach established by the State, or by HHS on behalf of the State. **(c)** ***Issuer contracts.*** An issuer that offers risk adjustment covered plans may include in its contract with a provider, supplier, physician, or other practitioner, provisions that require such contractor's submission of complete and accurate risk adjustment data in the manner and timeframe established by the State, or HHS on behalf of the State. These provisions may include financial penalties for failure to submit complete, timely, or accurate data. **(d)** ***Assessment of charges.*** An issuer that offers risk adjustment covered plans that has a net balance of risk adjustment charges payable, including adjustments made pursuant to § 153.350(c), will be notified by the State, or by HHS on behalf of the State, of those net charges, and must

Regulation	Guidance
	remit those risk adjustment charges to the State, or to HHS on behalf of the State, as applicable. **(e)** ***Charge submission deadline.*** An issuer must remit net charges to the State, or HHS on behalf of the State, within 30 days of notification of net charges payable by the State, or HHS on behalf of the State. **(f)** ***Assessment and collection of user fees for HHS risk adjustment operations.*** Where HHS is operating risk adjustment on behalf of a State, an issuer of a risk adjustment covered plan (other than a student health plan or a plan not subject to 45 CFR 147.102, 147.104, 147.106, 156.80, and subpart B of part 156) must, for each benefit year - (1) Submit or make accessible to HHS its monthly enrollment for the risk adjustment covered plan for the benefit year through the risk adjustment data collection approach established at § 153.610(a), in a manner and timeframe specified by HHS; and (2) Remit to HHS an amount equal to the product of its monthly billable enrollment in the risk adjustment covered plan multiplied by the per-enrollee-per-month risk adjustment user fee specified in the annual HHS notice of benefit and payment parameters for the applicable benefit year.
45 C.F.R. § 153.620 - Compliance with risk adjustment standards.	**(a)** ***Issuer support of data validation*.** An issuer that offers risk adjustment covered plans must comply with any data validation requests by the State or HHS on behalf of the State. **(b)** ***Issuer records maintenance requirements.*** An issuer that offers risk adjustment covered plans must also maintain documents and records, whether paper, electronic, or in other media, sufficient to enable the evaluation of the issuer's compliance with applicable risk adjustment standards, for each benefit year for at least 10 years, and must make those documents and records available upon request to HHS, the OIG, the Comptroller General, or their designees, or in a State where the State is operating risk adjustment, the State or its designee to any such entity, for purposes of verification, investigation, audit or other review. **(c)** ***Audits and compliance reviews.*** HHS or its designee may audit or conduct a compliance review of an issuer of a risk adjustment covered plan to assess its compliance with respect to the applicable requirements in this subpart and subpart H of this

Regulation	Guidance
	part. Compliance reviews conducted under this section will follow the standards set forth in § 156.715 of this subchapter. (1) Notice of audit. HHS will provide at least 30 calendar days advance notice of its intent to conduct an audit of an issuer of a risk adjustment covered plan. (i) Conferences. All audits will include an entrance conference at which the scope of the audit will be presented and an exit conference at which the initial audit findings will be discussed. (2) Compliance with audit activities. To comply with an audit under this section, the issuer must: (i) Ensure that its relevant employees, agents, contractors, subcontractors, downstream entities, and delegated entities cooperate with any audit or compliance review under this section; (ii) Submit complete and accurate data to HHS or its designees that is necessary to complete the audit, in the format and manner specified by HHS, no later than 30 calendar days after the initial audit response deadline established by HHS at the audit entrance conference described in paragraph (c)(1)(i) of this section for the applicable benefit year; (iii) Respond to all audit notices, letters, and inquiries, including requests for supplemental or supporting information, as requested by HHS, no later than 15 calendar days after the date of the notice, letter, request, or inquiry; and (iv) In circumstances in which an issuer cannot provide the requested data or response to HHS within the timeframes under paragraphs (c)(2)(ii) or (iii) of this section, as applicable, the issuer may make a written request for an extension to HHS. The extension request must be submitted within the timeframe established under paragraphs (c)(2)(ii) or (iii) of this section, as applicable, and must detail the reason for the extension request and the good cause in support of the request. If the extension is granted, the issuer must respond within the timeframe specified in HHS's notice granting the extension of time. (3) Preliminary audit findings. HHS will share its preliminary audit findings with the issuer, who will then have 30 calendar days to respond to such findings in the format and manner specified by HHS. (i) If the issuer does not dispute or otherwise respond to the preliminary findings, the audit findings will become final.

Regulation	Guidance
	(ii) If the issuer responds and disputes the preliminary findings, HHS will review and consider such response and finalize the audit findings after such review. (4) Final audit findings. If an audit results in the inclusion of a finding in the final audit report, the issuer must comply with the actions set forth in the final audit report in the manner and timeframe established by HHS, and the issuer must complete all of the following: (i) Within 45 calendar days of the issuance of the final audit report, provide a written corrective action plan to HHS for approval. (ii) Implement that plan. (iii) Provide to HHS written documentation of the corrective actions once taken. (5) Failure to comply with audit activities. If an issuer fails to comply with the audit activities set forth in this subsection in the manner and timeframes specified by HHS: (i) HHS will notify the issuer of the risk adjustment (including high-cost risk pool) payments that the issuer has not adequately substantiated; and (ii) HHS will notify the issuer that HHS may recoup any risk adjustment (including high-cost risk pool) payments identified in paragraph (c)(5)(i) of this section.
45 C.F.R. § 153.700(a) – Distributed data environment	**(a)** ***Dedicated distributed data environments.*** For each benefit year in which HHS operates the risk adjustment or reinsurance program on behalf of a State, an issuer of a risk adjustment covered plan or a reinsurance-eligible plan in the State, as applicable, must establish a dedicated data environment and provide data access to HHS, in a manner and timeframe specified by HHS, for any HHS-operated risk adjustment and reinsurance program.
45 C.F.R. § 153.710(a)-(d) – Data requirements	**(a)** ***Enrollment, claims, and encounter data.*** An issuer of a risk adjustment covered plan or a reinsurance-eligible plan in a State in which HHS is operating the risk adjustment or reinsurance program, as applicable, must provide to HHS, through the dedicated data environment, access to enrollee-level plan enrollment data, enrollee claims data, and enrollee encounter data as specified by HHS.

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	(b) ***Claims data*** All claims data submitted by an issuer of a risk adjustment covered plan or a reinsurance-eligible plan in a State in which HHS is operating the risk adjustment or reinsurance program, as applicable, must have resulted in payment by the issuer (or payment of cost sharing by the enrollee). **(c)** ***Claims data from capitated plans.*** An issuer of a risk adjustment covered plan or a reinsurance-eligible plan in a State in which HHS is operating the risk adjustment or reinsurance program, as applicable, that does not generate individual enrollee claims in the normal course of business must derive the costs of all applicable provider encounters using its principal internal methodology for pricing those encounters. If the issuer does not have such a methodology, or has an incomplete methodology, it must supplement the methodology in a manner that yields derived claims that are reasonable in light of the specific service and insurance market that the plan is serving. **(d)** ***Final dedicated distributed data environment report.*** Within 15 calendar days of the date of the final dedicated distributed data environment report from HHS, the issuer must, in a format specified by HHS, either: (1) Confirm to HHS that the information in the final report accurately reflects the data to which the issuer has provided access to HHS through its dedicated distributed data environment in accordance with § 153.700(a) for the benefit year specified in the report; or (2) Describe to HHS any discrepancy it identifies in the final dedicated distributed data environment report.
45 C.F.R. § 153.730 – Deadline for Submission of Data	A risk adjustment covered plan or a reinsurance-eligible plan in a State in which HHS is operating the risk adjustment or reinsurance program, as applicable, must submit data to be considered for risk adjustment payments and charges and reinsurance payments for the applicable benefit year by April 30 of the year following the applicable benefit year.

Appendix 3 – Acronyms

Terms & Acronyms	Definition
ACA	Patient Protection and Affordable Care Act
BY	Benefit Year
CCIIO	Center for Consumer Information and Insurance Oversight
CEO	Chief Executive Officer
CFO	Chief Financial Officer
CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
ECM	EDGE Calculation Module
EDGE	External Data Gathering Environment
ESBR	EDGE Server Business Rules
GAGAS	Generally Accepted Government Auditing Standards
HCRP	High-Cost Risk Pool
HCRPDE	HCRP Detail Enrollee
HHS	Department of Health and Human Services
HIOS	Health Insurance Oversight System
MOOP	Maximum Out of Pocket
QHP	Qualified Health Plan
RA	Risk Adjustment

Appendix 4 – Audit Procedure Description, Criteria, and Effect

Procedure	Description	Criteria	Effect
Unreconciled Claims Review	Review and comparison of the unique claim IDs included in the issuer's BY 2018 HCRPDE Report to the unique claim IDs included in the issuer's claims data extract to determine existence.	HCRP eligible claims submitted to the EDGE server only include claims the issuer can substantiate in its claims system. See 45 C.F.R. §§ 153.610, 153.620, 153.700, and 153.710. See the HCRP Reference Guide (Version 1.0 September 1, 2018).[25]	The inclusion of unreconciled claims in the BY 2018 HCRPDE Report result in a change to the issuer's BY 2018 HCRP payments.
RA Covered Plan Review	Review the issuer's claims in the claims data extract to those in the BY 2018 HCRPDE Report to validate whether the claim was paid by an RA covered plan and matches the plan ID reported in the issuer's BY 2018 HCRPDE Report.	HCRP eligible claims submitted to the EDGE server only include claims incurred and paid by an applicable RA covered plan. See 45 C.F.R. §§ 153.610, 153.620, 153.700, and 153.710. See the HCRP Reference Guide (Version 1.0 September 1, 2018).[26]	The inclusion of claims that were not paid by an RA covered plan result in a change to the issuer's BY 2018 HCRP payments and claims reported as paid by an incorrect RA covered plan result in an observation and no change to the issuer's BY 2018 HCRP payments.
Claim Coverage Period Validation	Review the issuer's claims in the claims data extract to the coverage period in the BY 2018 HCRPDE Report to determine whether the claim start date is within the enrollee's coverage period.	HCRP eligible claims submitted to the EDGE server only include claims incurred during the active enrollment period for the enrollee within the applicable BY. See 45 C.F.R. §§ 153.610, 153.620, 153.700, and 153.710. See the HCRP Reference Guide (Version 1.0 September 1, 2018).[27]	The inclusion of claims that were not incurred within the enrollee's coverage period result in a change to the issuer's BY 2018 HCRP payments.

[25] https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/HCRP_IssuerReferenceGuide_100418_v1_5CR_102618.pdf.
[26] See supra note 26.
[27] See supra note 26.

Procedure	Description	Criteria	Effect
Paid Claim Amount Validation	Review the issuer's claims in the claims data extract to validate the paid claim amount matches the paid claim amount in the issuer's BY 2018 HCRPDE Report.	HCRP eligible claims submitted to the EDGE server only include the amounts paid by the issuer. See 45 C.F.R. §§ 153.610, 153.620, 153.700, and 153.710. See the HCRP Reference Guide (Version 1.0 September 1, 2018).[28]	The inclusion of claims with overstated paid claim amounts result in a change to the issuer's BY 2018 HCRP payments and claims with understated paid claim amounts result in an observation and no change to the issuer's BY 2018 HCRP payments.
BY 2018 Cross Year Claim Validation	Review the issuer's claims end dates in the claims data extract to validate whether cross year claims fell within BY 2018 and were not from the prior or subsequent BYs.	HCRP eligible claims submitted to the EDGE server only include claims that have a service end date within the applicable BY. See 45 C.F.R. §§ 153.610, 153.620, 153.700, and 153.710. See the 2018 HCRP Reference Guide (Version 1.0 September 1, 2018)[29]	The inclusion of claims that were reported in the incorrect BY result in a change to the issuer's BY 2018 HCRP payments.
Duplicate Claim Validation	Review the issuer's claims in the claims data extract and determine if duplicate claims were reported to the EDGE server.	HCRP eligible claims submitted to the EDGE server only include claims the issuer can substantiate in its claims system and should only be reported one time. See 45 C.F.R. §§ 153.610, 153.620, 153.700, and 153.710. See the 2018 HCRP Reference Guide (Version 1.0 September 1, 2018)[30]	The inclusion of duplicate claims result in a change to the issuer's BY 2018 HCRP payments.
Enrollee Validation	Review and comparison of the unique enrollees and related claims included in the issuer's BY 2018 HCRPDE Report to the unique enrollee IDs and related claims included in the	HCRP eligible claims submitted to the EDGE server should only include claims associated with the appropriate eligible enrollee ID.	The inclusion of claims associated with an enrollee that does not match the enrollee reported to the BY 2018 HCRPDE Report result in a change to the issuer's

[28] See supra note 26.
[29] See supra note 26.
[30] See supra note 26.

Procedure	Description	Criteria	Effect
	issuer's data claims extract to determine the accuracy of enrollees submitted to the EDGE server.	See 45 C.F.R. §§ 153.610, 153.620, 153.700, and 153.710. See the 2018 HCRP Reference Guide (Version 1.0 September 1, 2018).[31]	BY 2018 HCRP payments.
Premium Effectuation Validation	Review and comparison of the issuer's initial premium payment documentation to the issuer's premium data extract to validate the accuracy of binder payment amount and appropriate effectuation.	Eligible subscriber premiums submitted to the EDGE server only include premiums associated with the current BY. See 45 C.F.R. §§ 153.610, 153.620, 153.700, and 153.710. See the 2018 HCRP Reference Guide (Version 1.0 September 1, 2018).[32]	The inclusion of subscribers with first month binder payments that were not effectuated and/or contained premium amount differences result in an observation and no change to the issuer's BY 2018 HCRP payments.
Premium Amount Validation	Review and comparison of the premium information in the issuer's premium data extract to premium information in the issuer's BY 2018 EDGE Enrollment File to validate the accuracy of the premium data reported to the EDGE server for all months of enrollment.	Eligible subscriber premiums submitted to the EDGE server only include premiums associated with the current BY. See 45 C.F.R. §§ 153.610, 153.620, 153.700, and 153.710. See the 2018 HCRP Reference Guide (Version 1.0 September 1, 2018).[33]	The inclusion of subscribers with premium amount differences result in an observation and no change to the issuer's BY 2018 HCRP payments.
Issuer Policies and Procedures Review	Determine whether the issuer's policies and procedures comply with applicable CMS rules, regulations, and policies related to HCRP.	Issuers should implement policies and procedures that adequately address and document their implementation and compliance with the federal requirements related to HCRP payments and EDGE submission processes. Issuers must maintain documents and records for each benefit year for at least 10 years and must make those documents and records available to	The absence of documentation regarding the issuer's HCRP policies and procedures result in an observation and no change to the issuer's BY 2018 HCRP payments.

[31] See supra note 26.
[32] See supra note 26.
[33] See supra note 26.

Procedure	Description	Criteria	Effect
		substantiate the request for HCRP payments. See 45 C.F.R. § 153.620.	