



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

for

Cigna Health and Life Insurance Company (Cigna)

December 11, 2019

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I. EXECUTIVE SUMMARY

Background

Cigna Health and Life Insurance Company (Cigna) is a health insurance issuer that offered qualified health plans (QHPs) in the individual market Federally-facilitated Exchange (FFE) in Texas during the 2015 benefit year. Cigna submitted its final restated 2015 benefit year data in the October 2017 Enrollment and Payment Data Workbook (EPDW). The issuer received a total of \$48,750,506.33 in advance payments of the premium tax credit (APTC) from CMS and paid a total of \$3,947,686.13 in FFE user fees (UF) to CMS for its 2015 benefit year individual market plans.

This report is an assessment of Cigna'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 no observations for Cigna. The net financial impact of the seven (7) audit findings is a payment to CMS of \$34,515.06, consisting of \$316.91 in FFE user fees returned to Cigna and \$34,831.97 in APTC owed to CMS. The findings include the following:

1. Differences in premium/FFE user fee and APTC differences identified in the comparison of the data included in the EPDW to a UF/APTC Desk Audit File containing subscriber level data from Cigna's systems;
2. Inclusion of enrollment and payment data in the UF/APTC Desk Audit File for three hundred and nine (309) subscribers with coverage that was not effectuated in the issuer's systems;
3. Inclusion of full month enrollment and payment data for four (4) duplicate subscribers in the UF/APTC Desk Audit File;
4. Inclusion of incorrectly prorated payment data for ten (10) subscribers in the UF/APTC Desk Audit File;
5. Inclusion of premium amounts that were less than the APTC amounts for one hundred and thirty-four (134) subscribers in the UF/APTC Desk Audit File;
6. Inclusion of enrollment and payment data for thirty-two (32) subscribers with a coverage period of five (5) days or fewer that was not effectuated in the UF/APTC Desk Audit File; and
7. Inclusion of incorrect premium and APTC amounts resulting from adjustments for three (3) of the forty-five (45) selected subscribers in the UF/APTC desk Audit File.

Please refer to section IV for details on the findings 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 Cigna for an audit on issuer compliance with the aforementioned regulations. CMS evaluated Cigna'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 Cigna 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 Cigna on May 14, 2018 that identified data requirements required to conduct the audit. CMS's audit contractor reviewed the audit data file submitted by Cigna 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:
 - 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.

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

III. RESULTS OF REVIEW

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

One (1) finding and no observations resulted from the review of Cigna'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. Please refer to Finding No. 6 included in section IV for details on the finding.

Forty-five (45) Subscribers Sample Review

One (1) finding and no observations resulted from the review and comparison of the data from Cigna'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. 7 included in section IV for details on the finding.

Fifteen (15) Subscribers Sample Review

No findings or observations resulted from the review of the data and documentation from

Cigna's systems to verify effectuation and the appropriate application of premium and APTC amounts to policies for a selected sample of fifteen (15) subscribers.

Policy and Procedure Review

No findings or observations resulted from the review of Cigna'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 Cigna'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	\$(3,947,686.13)	\$48,750,506.33
Finding No. 1 - EPDW Validations Adjustment	\$(2,164.56)	\$42,086.58
Finding No. 2 - Unreconciled Subscribers Review Adjustment	\$2,819.10	\$(69,871.17)
Findings No. 3 - Duplicate Exchange-assigned Subscriber IDs Check (Duplicate Records) Adjustment	\$102.93	\$(1,467.46)
Findings No. 4 - Duplicate Exchange-assigned Subscriber IDs Check (Incorrect Proration) Adjustment	\$48.22	\$(334.91)
Findings No. 5 - Premium Less than APTC Validation Adjustment	\$(788.96)	\$(1,413.30)

	FFE User Fees	APTC
Findings No. 6 - Coverage Days Validation Adjustment	\$340.08	\$(5,023.77)
Findings No. 7 - Forty-five (45) Subscribers Sample Review Adjustment	\$(39.90)	\$1,192.06
EPDW As Recalculated	\$(3,947,369.22)	\$48,715,674.36
Total Financial Impact	\$316.91	\$(34,831.97)

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 \$34,515.06, consisting of \$316.91 in FFE user fees returned to Cigna and \$34,831.97 in APTC owed to CMS.

For the seven (7) audit findings, CMS documented the criteria, cause, effect, corrective actions, and Cigna'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 thirty-eight (38) QHPs, the net "Total Premium Amount by QHP ID for effectuated enrollments" included in Cigna's EPDW was less than the total premium amount included in Cigna's UF/APTC Desk Audit File, resulting in an understatement of \$61,844.50 in premiums and therefore an underpayment of \$2,164.56 in FFE user fees. For the one or more months of 2015 benefit year enrollment in thirty-eight (38) QHPs, the EPDW was understated by seventy-four (74) enrollment groups and overstated by eight hundred and seventy-five (875) members.</p> <p>APTC Differences – For one or more months of 2015 benefit year enrollment in thirty-four (34) QHPs, the net "Total APTC Amount by QHP ID for effectuated enrollments" included in Cigna's EPDW was less than the total APTC amount included in Cigna's UF/APTC Desk Audit File, resulting in an underpayment of \$42,086.58 in</p>
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		APTC. For the one or more months of 2015 benefit year enrollment in thirty-four (34) QHPs, the EPDW was understated by fifty-four (54) APTC enrollment groups and ninety-four (94) APTC members.
	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 UF/APTC Desk Audit File “reflects the current status of Cigna's membership for PY2015” and noted the EPDW Validation differences were due to “changes in QHP IDs” and “changes in dollars of QHP IDs found” after the EPDW submission. The issuer further indicated “we performed a change to our renewal processing that appears to have created a data problem. The policies associated to these IDs were inadvertently changed into 2016 QHPIDs for 2015 coverage period. From a service perspective the customers remained in the same plan and therefore experienced no change in benefits. We believe these amounts explain the discrepancies in the 2015 QHPIDs elsewhere.”</p>

		The net understatements and overstatements in enrollment groups and members identified in the condition represent aggregated differences, i.e., the aggregated understatements and overstatements 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.
	Effect:	The premium/FFE user fee and APTC differences resulted in a change to Cigna's final, restated 2015 benefit year EPDW data.
	Corrective Action Required:	The net financial impact of this finding is a payment to Cigna of \$39,922.02, consisting of \$2,164.56 in FFE user fees owed to CMS and \$42,086.58 in APTC paid to Cigna. Cigna 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:	<p>Cigna overstated the 2015 benefit year premium amounts for two hundred and seventy-one (271) subscribers, and overstated the 2015 benefit year APTC amounts for one hundred and eighty (180) of those subscribers, in the UF/APTC Desk Audit File by reporting enrollment and payment data for subscribers with coverage that was not effectuated.</p> <p>Cigna reported negative premium amounts for thirty-eight (38) subscribers with coverage that was not effectuated, and reported negative or positive APTC amounts for four (4) of those subscribers. Therefore, Cigna understated the 2015 benefit year</p>
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		premium amounts and understated or overstated the 2015 benefit year APTC amounts for those subscribers in the UF/APTC Desk Audit File.
	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 one of the following responses for each of the three hundred and nine (309) subscribers:</p> <ul style="list-style-type: none"> • “HPS data shows a passive renewal for this member enrollment, but current HPS enrollment data no longer shows any covered days.” (Two hundred and forty-one (241) subscribers) • “HPS data shows an active renewal for this member enrollment, but current HPS enrollment data no longer shows any covered days.” (Ten (10) subscribers) • “Negative Total Premium found on Desk Audit is invalid. The Total Premium can never be a negative value. These types of discrepancies in the financial data are typically due to adjustment errors.” (Twenty-nine (29) subscribers) • “Unable to locate current HPS enrollment data corresponding to data provided on Unreconciled Subscriber worksheet and/or Desk Audit data.” (Seventeen (17) subscribers) • “No” in the ‘Effectuated in Issuer’s System’ field with no corresponding explanation. (Twelve (12) subscribers)
	Effect:	The inclusion of the three hundred and nine (309) non-effectuated enrollments resulted in a change to Cigna’s final, restated 2015 benefit year EPDW data.

	Corrective Action Required:	The net financial impact of this finding is a payment to CMS of \$67,052.07, consisting of \$2,819.10 in FFE user fees returned to Cigna and \$69,871.17 in APTC owed to CMS. Cigna 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 (Duplicate Records)	Condition:	Cigna overstated the 2015 benefit year premium amounts for four (4) subscribers, and overstated the 2015 benefit year APTC amounts for three (3) of those subscribers, in the UF/APTC Desk Audit File by reporting enrollment and full month payment data for the subscribers more than once in the same month.
	Criteria:	Issuers cannot request full month payment from CMS for the same subscriber twice within a month.
	Cause:	<p>The issuer indicated one of the following responses for the duplicate subscribers:</p> <ul style="list-style-type: none"> • “Value in question is not supported by current enrollment data. Case will be evaluated for cleanup” (Three (3) subscribers) • “Multiple member enrollment coverage records (HPS detail cases) with overlap in coverage” (One (1) subscriber) <p>During the audit, CMS coordinated with the issuer to determine which records were the true enrollment records and which records were the duplicates for the subscribers to inform the financial impact.</p>
	Effect:	The inclusion of the four (4) duplicate subscribers resulted in a change to Cigna’s final, restated 2015 benefit year EPDW data.

	Corrective Action Required:	The net financial impact of this finding is a payment to CMS of \$1,364.53, consisting of \$102.93 in FFE user fees returned to Cigna and \$1,467.46 in APTC owed to CMS. Cigna 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 (Incorrect Proration)	Condition:	Cigna reported the incorrect 2015 benefit year premium and APTC amounts for ten (10) subscribers in the UF/APTC Desk Audit File by reporting incorrectly prorated premium and APTC amounts for mid-month terminations and re-enrollments.
	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:	<p>The issuer indicated one of the following responses for the subscribers:</p> <ul style="list-style-type: none"> • "Confirmed overlapping coverage spans. This will require cleanup of enrollment record". (One (1) subscriber) • "Value in question is not supported by current enrollment data. Case will be evaluated for cleanup." The issuer further confirmed the correct coverage periods and prorated amounts for the records. (Six (6) subscribers) • "Multiple member enrollment coverage records (HPS detail cases) with overlap in coverage". (Three (3) subscribers)

		During the audit, CMS coordinated with the issuer to determine the correct coverage spans and prorated amounts for the enrollments.
	Effect:	The inclusion of the incorrectly prorated amounts for the ten (10) subscribers resulted in a change to Cigna's final, restated 2015 benefit year EPDW data.
	Corrective Action Required:	The net financial impact of this finding is a payment to CMS of \$286.69, consisting of \$48.22 in FFE user fees returned to Cigna and \$334.91 in APTC owed to CMS. Cigna 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:	Cigna reported premium amounts that were less than the APTC amounts for one hundred and thirty-four (134) subscribers in the UF/APTC Desk Audit File. As a result, Cigna understated the 2015 benefit year premium amounts for one hundred and thirty-one (131) of the one hundred and thirty-four (134) subscribers, and understated the 2015 benefit year APTC amounts for one (1) of those subscribers, in the UF/APTC Desk Audit File. Additionally, Cigna overstated the 2015 benefit year APTC amounts for three (3) of the one hundred and thirty-four (134) subscribers in the UF/APTC Desk Audit File.
	Criteria:	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.
	Cause:	The issuer indicated one of the following responses for each of the one hundred and thirty-four (134) subscribers: <ul style="list-style-type: none"> • "Manual Adjustment Error"

		<p>Case can be corrected either manually or by applying Automated Reconciliation Tool (ART) corrections." (Forty-three (43) subscribers)</p> <ul style="list-style-type: none"> • "The Symptomatic cause for the difference on these cases is that the sum of billed plus Adjusted total a negative amount or a credit to the Member premium. (Example: Dec 2015 member was billed 100.00 then credited -145.00 resulting in a total due for Dec 2015 as negative -\$45.00.) Root Cause: Member premium and Fees are separated within the billing system and reported on separately. These cases all have a \$45.00 fee that was applied in error. When a systematic process to remove the Fee was applied a Member premium adjustment code was used. This left the bill period in question with a Member premium amount of -\$45.00, and a Fee amount of +\$45.00. The net result to the member was 0.00. If the Fee adjustments would have been taken into account these cases would not have been identified as having an issue." (Seventy-nine (79) subscribers) • "The Symptomatic cause for the difference on these cases is that the sum of billed plus Adjusted total a negative amount or a credit to the Member premium. (Example: Dec 2015 member was billed 100.00 then credited -145.00 resulting in a total due for Dec 2015 as negative -\$45.00.) Root Cause: These cases were terminated by request to a mid month date that falls within the last bill period that produced a bill. This triggered systematic prorated termination credits that removed billed amount due after term date. Subsequent to the termination it was verified the policy was terminated to an incorrect date and needed to be terminated to a date further back in time." (One (1) subscriber) • These cases are impacted by manual adjustment errors as well as the following issue: The Symptomatic cause for the
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		<p>difference on these cases is that the sum of billed plus Adjusted total a negative amount or a credit to the Member premium. (Example: Dec 2015 member was billed 100.00 then credited -145.00 resulting in a total due for Dec 2015 as negative -\$45.00.) Root Cause: Member premium and Fees are separated within the billing system and reported on separately. These cases all have a \$45.00 fee that was applied in error. When a systematic process to remove the Fee was applied a Member premium adjustment code was used. This left the bill period in question with a Member premium amount of -\$45.00, and a Fee amount of +\$45.00. The net result to the member was 0.00. If the Fee adjustments would have been taken into account these cases would not have been identified as having an issue." (Eleven (11) subscribers)</p> <p>Based on the feedback that fees and adjustments were reported in the UF/APTC Desk Audit File, CMS concluded the 2015 benefit year premium amounts were understated for one hundred and thirty-four (134) subscribers and the 2015 benefit year APTC amounts were understated for one (1) of those subscribers and overstated for three (3) of those subscribers.</p>
	Effect:	The inclusion of the incorrect premium and APTC amounts for the one hundred and thirty-four (134) subscribers resulted in a change to Cigna's final, restated 2015 benefit year EPDW data.
	Corrective Action Required:	The net financial impact of this finding is a payment to CMS of \$2,202.26, consisting of \$788.96 in FFE user fees owed to CMS and \$1,413.30 in APTC owed to CMS. Cigna 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 - Coverage Days Validation	Condition:	Cigna overstated the 2015 benefit year premium amounts for thirty-two (32) subscribers, and overstated the 2015 benefit year APTC amounts for twelve (12) of those subscribers, in the UF/APTC Desk Audit File by incorrectly reporting enrollments that were not effectuated.
	Criteria:	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.
	Cause:	The issuer indicated that the "Enrollment span was not effectuated" for each of the thirty-two (32) subscribers.
	Effect:	The inclusion of the enrollment and payment data for the thirty-two (32) subscribers resulted in a change to Cigna's final, restated 2015 benefit year EPDW data.
	Corrective Action Required:	The net financial impact of this finding is a payment to CMS of \$4,683.69, consisting of \$340.08 in FFE user fees returned to Cigna and \$5,023.77 in APTC owed to CMS. Cigna 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 – Forty-five (45) Subscribers Sample Review	Condition:	Cigna understated the 2015 benefit year premium and APTC amounts for two (2) of the forty-five (45) selected subscribers in the UF/APTC Desk Audit File by incorrectly adjusting accounts as a result of an incident and Health Insurance Casework System (HICS) case. Cigna overstated the 2015 benefit year APTC amounts for one (1) of the forty-five (45) selected subscribers in the
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		UF/APTC Desk Audit File by incorrectly reporting an adjustment.
	Criteria:	<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> <p>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.</p>
	Cause:	<p>The issuer indicated the following for the three (3) subscribers:</p> <ul style="list-style-type: none"> <p>"Per Pre-Audit file dated 07/15/2018 member eligibility effective 01/01/2015. APTC: \$533.78 / Member Indv. Responsible: \$224.29 / Total Premium: \$758.07.</p> <p>Per EDI File received on 12/16/2014 member eligibility updated effective 01/01/2015 for passive renewal. APTC: \$533.78 / Member Indv. Responsible: \$224.29 / Total Premium: \$758.07.</p> <p>System is reflecting 2014 APTC status in the amount of \$535.72 as of 02/26/2014. APTC did not correctly update from file receipt mentioned above to \$533.78, causing the \$1.94 discrepancy."</p> <p>"Member is reflected in system with effective date 09/01/2015 and benefit end date 12/31/2015 per requested files. However, 2 HICS complaints have been received for this Exchange Sub ID. Incorrect adjustments were placed when manually adjusting premium in response to the to the HICS complaints," and,</p> <p>"Per Pre-Audit file dated 07/18/2018 - Enrollment is listed as followed: Span: 09/01/2015 - 09/30/2015 Total Premium: \$819.14 Member Responsible Amount: \$279.14 APTC: \$540.00</p>

		<p>Span: 10/01/2015 - 12/31/2015 Total Premium: \$801.18 Member Responsible Amount: \$217.18 APTC: \$584.00"</p> <ul style="list-style-type: none"> "Incorrect adjustments applied to customer while trying to accommodate changes and resolve an incident. All premium including APTC was moved to member responsibility then the member responsibility was adjusted/reduced to meet the correct member expectations. The premium was reversed rather than being re-allocated to APTC," and, "Per file dated 04/22/2015 - Enrollment is listed as followed: Month: 05 Total Premium: \$801.18 Member Responsible Amount: \$235.18 APTC: \$566.00 This is in alignment with the most recent Pre-Audit record received 07/15/2018. The issue resulted when attempting to resolve an incident and therefore is considered stand alone."
	Effect:	The inclusion of incorrect premium and APTC amounts for the three (3) subscribers resulted in a change to Cigna Health and Life's final, restated 2015 benefit year EPDW data.
	Corrective Action Required:	The net financial impact of this finding is a payment to Cigna of \$1,152.16, consisting of \$39.90 in FFE user fees owed to CMS and \$1,192.06 in APTC paid to Cigna. Cigna 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 no observations.

VI. MANAGEMENT RESPONSES

Please provide management's response to the seven (7) findings 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, complete the "Management Response" field of the findings 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, complete the "Management Response" field of the findings in the draft audit report, and initial "Disagree" and sign the attached Appendix 1. Return the draft audit report including Appendix 1 and any supporting documentation that substantiates management's response within thirty (30) calendar days from the draft audit report date. This will be the final opportunity to provide information or supporting documentation to correct any inaccuracies in the report before it is finalized.

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

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

Appendix 1 – Issuer Management Response to Net Financial Adjustment

Issuer HIOS ID: 55409

Issuer Name: Cigna Health and Life Insurance (Cigna)

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 \$34,515.06, consisting of \$316.91 in FFE user fees returned to Cigna and \$34,831.97 in APTC owed to CMS, and:

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

Or

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

Signed: _____

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

Printed Name: Manish Naik

(Print name of signature)

Title: General Manager, Individual and Family Plans

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

Telephone Number: 860.902.4430

(Direct Telephone Number)

Date: _____

12/19/19

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
HICS	Health Insurance Casework System
HIOS	Health Insurance Oversight System
PPACA	Patient Protection and Affordable Care Act
QHP	Qualified Health Plan
SBE	State-based Exchange
TIN	Tax Identification Number