

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**CMS DID NOT ALWAYS  
ACCURATELY AUTHORIZE  
FINANCIAL ASSISTANCE  
PAYMENTS TO QUALIFIED  
HEALTH PLAN ISSUERS IN  
ACCORDANCE WITH FEDERAL  
REQUIREMENTS DURING THE  
2014 BENEFIT YEAR**

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Inspector General**

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# *Office of Inspector General*

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## Report in Brief

Date: August 2018

Report No. A-02-15-02013

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES  
**OFFICE OF INSPECTOR GENERAL**



### Why OIG Did This Review

The Patient Protection and Affordable Care Act (ACA) established marketplaces to allow individuals and small businesses to shop for health insurance in all 50 States and the District of Columbia. The Centers for Medicare & Medicaid Services (CMS) operates the Federal marketplace and is responsible for reviewing, approving, and generating financial assistance payments (i.e., advance premium tax credits and advance cost-sharing reductions) for the Federal and State-based marketplaces. During the 2014 benefit year, CMS used an interim process for approving financial assistance payments. We previously reviewed CMS's internal controls under its interim process to ensure the accuracy of aggregate financial assistance payments and determined that the controls were not effective.

The objective of this review was to determine whether CMS accurately authorized financial assistance payments in accordance with Federal requirements for policies associated with individuals enrolled in qualified health plans (QHPs) operating through the Federal marketplace.

### How OIG Did This Review

We reviewed a stratified random sample of 140 policies for individuals who enrolled through the Federal marketplace and for whom financial assistance payments were made to QHP issuers during the 2014 benefit year. We obtained documentation from CMS and QHP issuers supporting these payments.

## CMS Did Not Always Accurately Authorize Financial Assistance Payments to Qualified Health Plan Issuers in Accordance With Federal Requirements During the 2014 Benefit Year

### What OIG Found

We found that of the 140 policies in our sample, CMS accurately authorized financial assistance payments for 109 policies; however, financial assistance payments for 26 policies were not accurately authorized in accordance with Federal requirements. For the remaining five policies, CMS authorized potentially improper financial assistance payments to QHP issuers that did not provide documentation to support that enrollees had paid their premiums, a requirement for receiving these payments.

On the basis of our sample results, we estimated that CMS authorized improper financial assistance payments totaling almost \$434.4 million for 461,127 policies that were not in accordance with Federal requirements and authorized potentially improper financial assistance payments totaling almost \$504.9 million for 183,983 policies during the 2014 benefit year. In 2016, CMS fully transitioned QHP issuers operating through the Federal marketplace to an automated payment system that makes financial assistance payments on an individual policy-level basis.

### What OIG Recommends and CMS's Comments

We recommend that CMS (1) work with the U.S. Department of the Treasury (Treasury) and QHP issuers to collect improper financial assistance payments, which we estimate to be almost \$434.4 million, for policies for which the payments were not authorized in accordance with Federal requirements; (2) work with Treasury and QHP issuers to resolve the potentially improper financial assistance payments, which we estimate to be almost \$504.9 million, for policies for which there was no documentation provided to verify enrollees had paid their premiums; and (3) clarify guidance with QHP issuers on Federal requirements for terminating an enrollee's coverage when the enrollee fails to pay his or her monthly premium.

CMS partially concurred with our first and second recommendations and concurred with our third recommendation. CMS stated that it will not require QHP issuers to return improper financial assistance payments for policies on which issuers acted in good faith, nor will it resolve potentially improper financial assistance payments for issuers that are out of business. CMS also provided documentation to support some payments to QHP issuers that we identified as improper in our draft report. After reviewing the documentation, we revised some findings but maintain that our recommendations are valid.

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## INTRODUCTION

### WHY WE DID THIS REVIEW

The Patient Protection and Affordable Care Act (ACA)<sup>1</sup> established health insurance exchanges (commonly referred to as “marketplaces”) to allow individuals and small businesses to shop for health insurance in all 50 States and the District of Columbia. A marketplace allows insurance companies (issuers) to offer individuals private health insurance plans, known as qualified health plans (QHPs), and enrolls individuals in those plans. The Centers for Medicare & Medicaid Services (CMS) operates the Federal marketplace and is responsible for reviewing, approving, and generating financial assistance payments (i.e., advance premium tax credits (APTCs) and advance cost-sharing reductions (CSRs)) for the Federal and State-based marketplaces (State marketplaces).

We previously reviewed CMS’s internal controls (i.e., its processes to prevent or detect any possible substantial errors) under an interim process for approving financial assistance payments to ensure the accuracy of aggregate financial assistance payments and determined that these controls were not effective.<sup>2</sup>

### OBJECTIVE

Our objective was to determine whether CMS accurately authorized financial assistance payments in accordance with Federal requirements for policies associated with individuals enrolled in QHPs operating through the Federal marketplace.

### BACKGROUND

#### Health Insurance Marketplaces

A marketplace is designed to serve as a one-stop shop at which individuals get information about their health insurance options; are evaluated for eligibility for a QHP and, when applicable, eligibility for financial assistance payments; and enroll in the QHP of their choice. QHPs are grouped into four “metal levels”: bronze, silver, gold, and platinum. An issuer may offer multiple QHPs through a marketplace.

Individuals in States without a State marketplace could choose a QHP through the CMS-administered Federal marketplace. States could also establish State-partnership marketplaces in which they share responsibilities for core functions with CMS or could establish a State

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<sup>1</sup> P.L. No. 111-148 (Mar. 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010, P.L. No. 111-152 (Mar. 30, 2010), is known as the Affordable Care Act.

<sup>2</sup> CMS’s Internal Controls Did Not Effectively Ensure the Accuracy of Aggregate Financial Assistance Payments Made to Qualified Health Plan Issuers Under the Affordable Care Act, ([A-02-14-02006](#)), issued June 16, 2015.

marketplace—Federal platform in which States perform all core functions but rely on the Federal marketplace to enroll individuals. As of January 1, 2017, 39 States used the Federal marketplace,<sup>3</sup> and the other 12 States (including the District of Columbia) had State marketplaces.

### **CMS’s Processes for Reviewing, Approving, and Generating Financial Assistance Payments to Qualified Health Plan Issuers**

The ACA provides financial assistance payments to lower certain enrollees’ insurance premiums or out-of-pocket insurance costs or both. The Federal Government distributes financial assistance payments to QHP issuers on behalf of eligible enrollees:

- **Advance Premium Tax Credits:** APTCs are advance payments of premium tax credits (PTCs).<sup>4</sup> PTCs assist certain low-income enrollees with the cost of their premiums and are available at tax filing time or in advance.<sup>5</sup> For enrollees determined eligible for APTCs, the applicable marketplace determines the maximum APTC amount using the price of the second-lowest-priced silver-level plan available in the area in which the enrollee resides and the enrollee’s reported income and family size.<sup>6</sup> Eligible enrollees may opt to enroll in any plan, regardless of metal level.
- **Cost-Sharing Reductions:**<sup>7</sup> CSRs assist qualifying low-income enrollees with out-of-pocket costs, such as deductibles, coinsurance, and copayments.<sup>8</sup> To receive CSRs:

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<sup>3</sup> This includes six State-partnership marketplaces and five State marketplaces—Federal platform.

<sup>4</sup> ACA §§ 1401 and 1412, and 45 CFR § 155.20 (definition of “advance payment of the premium tax credit”).

<sup>5</sup> The Federal Government pays the APTC monthly to the QHP issuer on behalf of the enrollee to offset a portion of the cost of the premium. For example, if an enrollee who selects a QHP with a \$500 monthly insurance premium qualifies for a \$400 monthly APTC (and chooses to use it all as advance payment), the enrollee pays \$100 to the QHP issuer. The Federal Government pays the remaining \$400 to the QHP issuer.

<sup>6</sup> The maximum allowable amount of the credit is the total amount of the PTC for which an individual may be eligible in a benefit year (26 U.S.C. §§ 36B(a) and (b)). Enrollees may elect to receive any portion of the maximum allowable amount of the credit.

<sup>7</sup> During our audit period of January 1, 2014, to December 31, 2014, CMS authorized CSR payments to QHP issuers. However, on October 12, 2017, the Department of Health and Human Services (HHS) determined that it would no longer make CSR payments to QHP issuers. (See <https://www.hhs.gov/sites/default/files/csr-payment-memo.pdf>. Accessed on January 10, 2018). Accordingly, CMS stopped authorizing CSR payments as of that date. Nevertheless, to comply with ACA regulations, QHP issuers are required to offer plans with CSR benefits even though the Federal Government will not reimburse QHP issuers for these CSR payments. ACA § 1402(a).

<sup>8</sup> For example, an individual who visits a physician may be responsible for a \$30 copayment. If the individual qualifies for a CSR of \$20 for the copayment, the individual pays only \$10. The Federal Government pays the remaining \$20.

eligible enrollees must enroll in a silver-level plan, which generally covers 70 percent of covered medical services costs. CSRs assist these enrollees in paying a portion of their remaining costs. The Federal Government makes an advance monthly CSR payment to QHP issuers to cover the issuers' estimated CSR costs.<sup>9</sup>

During the 2014 benefit year, CMS used an interim process for approving financial assistance payments. Under this process, issuers submitted to CMS a monthly "Enrollment and Payment Data Template" (template) covering enrollees in all of the issuers' plans. Each template contained aggregate financial assistance amounts that the issuer submitted for reimbursement on the basis of its confirmed enrollment totals. Confirmed enrollees are defined as those who had paid their first month's premium to the QHP issuer and had their enrollment information approved by the issuer. CMS also required QHP issuers to submit attestation agreements stating that all template information was accurate and in compliance with Federal policies and regulations before CMS processed the issuers' payments.

As of May 2016, CMS had fully transitioned QHP issuers operating through the Federal marketplace to an automated payment system that makes financial assistance payments to QHP issuers on an individual policy-level basis. CMS plans to fully transition most QHP issuers operating through State marketplaces to the automated system in 2018.

### **Treasury's Processes for Paying Financial Assistance Payments and Reconciling Advance Premium Tax Credits**

HHS was required to establish a program to determine the amount of financial assistance payments to each QHP issuer and to submit these amounts to the U.S. Department of the Treasury (Treasury) for payment.<sup>10</sup>

HHS and Treasury have established a process that CMS uses to determine financial assistance payment amounts. After an eligibility determination is made by the marketplaces, CMS accesses Treasury's Secure Payment System to authorize financial assistance payments to QHP issuers. Treasury is responsible for ensuring that sufficient funds are available at the beginning of the fiscal year and that sufficient funding has been transferred into an account that the Treasury's Internal Revenue Service (IRS) and CMS jointly established to disburse financial assistance payments. Treasury is required to ensure that all unobligated funds for financial assistance payments are returned to its account at the end of the benefit year. The IRS is responsible for reconciling APTC payments made to QHP issuers on behalf of confirmed enrollees to enrollees' individual taxpayer returns.<sup>11</sup>

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<sup>9</sup> CMS makes these advance CSR payments to protect QHP issuers from being required to bear the entire financial burden of providing CSRs over a benefit year (78 Fed. Reg. 15410, 15486 (March 11, 2013)).

<sup>10</sup> ACA § 1412.

<sup>11</sup> ACA § 1401(a); Internal Revenue Code (IRC) § 36B(f)(2).

## HOW WE CONDUCTED THIS REVIEW

Our review covered 2,959,262 policies<sup>12</sup> for individuals enrolled through the Federal marketplace with financial assistance payments totaling \$11,962,621,282 from January 1, 2014, through December 31, 2014, known as the 2014 benefit year. We reviewed a stratified random sample of 140 policies and the financial assistance payments made to QHP issuers on behalf of all enrollees in these policies.<sup>13</sup> For the 2014 benefit year, the IRS reconciled APTC payments based on personal tax returns filed in 2015. We worked with the Treasury's Inspector General for Tax Administration (TIGTA) to estimate the total amount of improper payments associated with these policies during the 2014 benefit year using APTC reconciliation data.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our audit scope and methodology, Appendix B contains our statistical sampling methodology, and Appendix C contains our sample results and estimates.

## FINDINGS

CMS did not always accurately authorize financial assistance payments to QHP issuers in accordance with Federal requirements. Of the 140 policies in our sample, CMS accurately authorized financial assistance payments for 109 policies; however, financial assistance payments for 26 policies were not accurately authorized in accordance with Federal requirements. For the remaining five policies, CMS authorized potentially improper financial assistance payments to QHP issuers that did not provide documentation supporting that the associated enrollees had paid their premiums, a requirement for receiving financial assistance payments.

CMS did not have an effective process in place to ensure that financial assistance payments were made only for confirmed enrollees and in the correct amounts. Instead, CMS relied on QHP issuers to verify that their enrollees were confirmed and to attest that the financial

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<sup>12</sup> A policy can comprise one or more individuals. For the purposes of this report, we define a policy as all policies associated with an enrollment application. For example, an individual in our sample was enrolled in one policy from May through October 2014 before being terminated from that policy and was enrolled in a different policy from November through December 2014. We included the two policies associated with this enrollment application as one sample unit.

<sup>13</sup> We did not review whether an enrollee was eligible to receive financial assistance payments. This work is detailed in *Not All of the Federally Facilitated Marketplace's Internal Controls Were Effective in Ensuring That Individuals Were Properly Determined Eligible for Qualified Health Plans and Insurance Affordability Programs (A-09-14-01011)*, issued August 6, 2015.

assistance payment information they reported on their templates was accurate. CMS obtained financial assistance payment information for the 2014 benefit year on an aggregate basis rather than on a policy-level basis. As a result, it was unable to verify the amounts QHP issuers attested to and the amounts requested for each policy. If CMS had been able to obtain financial assistance payment data on a policy-level basis, it could review financial assistance payments to ensure QHP issuers requested payments on behalf of confirmed enrollees and in the correct amounts.

On the basis of our sample results, we estimated that CMS authorized improper financial assistance payments totaling \$434,398,168 for 461,127 policies that were not in accordance with Federal requirements and authorized potentially improper financial assistance payments totaling \$504,889,518 related to 183,983 policies.<sup>14</sup>

## **CMS AUTHORIZED INACCURATE FINANCIAL ASSISTANCE PAYMENTS**

### **Qualified Health Plan Issuers Received Payments on Behalf of Ineligible Enrollees**

To be eligible for financial assistance payments, individuals must enroll in a QHP through one of the marketplaces.<sup>15</sup> In addition, the marketplace must allow an enrollee to pay directly to the QHP issuer any applicable premium owed.<sup>16</sup> CMS is responsible for ensuring that financial assistance payments are made only for confirmed enrollees.<sup>17</sup> As described earlier, confirmed enrollees are defined as those who have paid their first month's premium to the QHP issuer and had their enrollment information approved by the issuer.

Enrollees who receive APTC payments and have paid at least 1 full month's premium during the benefit year but then fail to pay their monthly premiums are provided a 3-consecutive-month grace period to pay any outstanding premiums.<sup>18</sup> If the 3-month grace period lapses without the enrollee paying all outstanding premiums, the QHP issuer must return to Treasury the APTC payment for the second and third month of the grace period, while the enrollee is responsible for paying back the first month's APTC payment through his or her Federal tax return.<sup>19</sup>

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<sup>14</sup> The 90-percent confidence interval is \$104,566,655 to \$764,229,682 for the improper financial assistance payments and \$106,643,599 to \$903,135,437 for the potentially improper financial assistance payments.

<sup>15</sup> 26 CFR § 1.36B-2(a)(1) and 45 CFR § 156.410(b)(1).

<sup>16</sup> 45 CFR § 155.240(a).

<sup>17</sup> *MOU Between IRS and CMS*; CMS control numbers MOU 13-150 (effective January 31, 2013) and MOU 14-127 (effective January 17, 2014).

<sup>18</sup> ACA § 1412(c)(2)(B)(iv)(II).

<sup>19</sup> 45 CFR § 156.270(e)(2) and 77 Fed. Reg. 18310, 18429 (Mar. 27, 2012).

For 21 of the 140 sampled policies, QHP issuers requested and CMS authorized financial assistance payments on behalf of enrollees who were not eligible to receive such payments. Specifically:

- For 15 sampled policies, CMS authorized payments to QHP issuers for enrollees who did not pay their first month's premium and, therefore, were not confirmed enrollees. For example, for one sampled policy, individuals were enrolled in a QHP through the marketplace with a plan start date of May 2014. The enrollees associated with this policy did not pay their first month's premium until August 2014. However, CMS authorized financial assistance payments for this policy even though payment was not made on time to effectuate the policy.
- For five sampled policies, the 3-month grace period ended, but QHP issuers did not return APTC payments authorized by CMS for the second and third months of the grace period, as required. For example, CMS authorized APTC payments for one sampled policy during a 3-month grace period from June 2014 through August 2014. After the grace period ended, the enrollees had not paid all outstanding premiums; however, the QHP issuer did not return the July 2014 APTC payment made on behalf of the enrollees associated with this policy, which represented the second month of the 3-month grace period.<sup>20</sup>
- For one sampled policy, CMS authorized payments to a QHP issuer for 5 months after the QHP issuer terminated the policy. Specifically, the QHP issuer terminated coverage in July 2014, but CMS authorized payments for August through December 2014.

### **Qualified Health Plan Issuers Inappropriately Terminated Enrollees' Coverage**

QHP issuers must provide a grace period of 3 consecutive months for an enrollee who receives APTC and has paid at least 1 full month's premium during the benefit year.<sup>21</sup> If the 3-month grace period lapses without the enrollee paying all outstanding premiums, the issuer must terminate the enrollee's coverage, retroactive to the last day of the first month of the grace period.<sup>22</sup>

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<sup>20</sup> The QHP issuer did return the August 2014 payment.

<sup>21</sup> 45 CFR § 156.270(d).

<sup>22</sup> 45 CFR §§ 156.270(g), 155.430(d)(4).

For six sampled policies,<sup>23</sup> QHP issuers inappropriately terminated enrollees' coverage before the end of the 3-month grace period. For example, as the figure below illustrates, coverage for one policy was confirmed after the enrollee paid her first month's premium for March 2014. The enrollee also paid her April and May 2014 premiums but did not pay the June and July 2014 premiums. The QHP issuer terminated coverage for this policy in July 2014. According to Federal regulations, the enrollee should have been granted a 3-month grace period from June through August 2014 to make a premium payment, during which time CMS should have authorized financial assistance payments. The QHP issuer was required to terminate coverage if the enrollee did not make *all outstanding* premium payments by the end of August 2014.

**Figure: Example of Qualified Health Plan Issuer's Timeline for Inappropriately Terminating Enrollees Early**

Month	Enrollee's Portion of Premium Paid to QHP Issuer	3-Consecutive-Month Grace Period in Effect	APTC Payments Made to QHP Issuer on Behalf of Enrollees	APTC Payments Should Have Been Made to QHP Issuer on Behalf of Enrollees
March 2014	Yes	No	Yes	Yes
April 2014	Yes	No	Yes	Yes
May 2014	Yes	No	Yes	Yes
June 2014	No	Yes	Yes	Yes
July 2014	No	Yes	No*	Yes
August 2014	No	Yes	No	Yes
September 2014	No	No**	No	No

\* The QHP issuer terminated the policy as of July 15, 2014. As such, CMS did not authorize the APTC payments that should have been made to the QHP issuer during the remainder of the grace period (i.e., July and August 2014).

\*\* The grace period should have ended in September 2014 if the QHP issuer had not received all outstanding premium payments by August 2014. The QHP issuer should have terminated the policy after this date, not on July 15, 2014.

QHP issuers inappropriately terminating enrollees' coverage before the end of the 3-month grace period could result in individuals and families being without medical coverage during a time in which they were entitled to such coverage.

<sup>23</sup> One of these sampled policies is also included in our prior finding related to QHP issuers that requested and for which CMS authorized financial assistance payments on behalf of enrollees who were not eligible to receive such payments. There were no improper payments associated with the remaining five sampled policies because the QHP issuers terminated these policies.

## **QUALIFIED HEALTH PLAN ISSUERS DID NOT PROVIDE DOCUMENTATION TO VERIFY THAT ENROLLEES PAID THEIR MONTHLY PREMIUMS**

Issuers offering QHPs in the Federal marketplace must maintain, for 10 years, documents and records that are sufficient to enable CMS or its designees to evaluate the marketplaces' compliance with Federal requirements.<sup>24</sup> CMS is also responsible for ensuring that financial assistance payments are made only for confirmed enrollees.

For 5 of 140 sampled policies, QHP issuers did not provide documentation to verify that enrollees paid their monthly premium to be eligible to receive financial assistance payments. Specifically:

- For three sampled policies, we attempted to contact the QHP issuers; however, they were out of business and no longer offering health insurance plans through the Federal marketplace. Accordingly, we were unable to obtain information to verify that the enrollees paid their premiums to be eligible to receive financial assistance payments.
- For two sampled policies, despite our multiple attempts to obtain documentation to verify that the enrollees associated with these policies made their premium payments, the QHP issuers did not provide any documentation.

Without this documentation, we could not determine whether enrollees associated with the sampled policies were confirmed and whether CMS should have authorized financial assistance payments to QHP issuers on behalf of the enrollees associated with these policies, resulting in potential inappropriate Federal expenditures.

## **CMS PROCESS DID NOT ENSURE THAT IT AUTHORIZED ACCURATE FINANCIAL ASSISTANCE PAYMENTS FOR THE 2014 BENEFIT YEAR**

CMS did not have an effective system in place to ensure that financial assistance payments were made only for confirmed enrollees and in the correct amounts for the 2014 benefit year. Instead, CMS relied on QHP issuers to verify that their enrollees were confirmed and to attest that the financial assistance payment information they reported on their templates was accurate. CMS obtained financial assistance payment information for the 2014 benefit year on an aggregate basis rather than on a policy-level basis. As a result, it was unable to verify the amounts QHP issuers attested to and the amounts requested for each policy. If CMS had been able to obtain financial assistance payment data on a policy-level basis, it could perform tests on financial assistance payments to ensure that QHP issuers requested payments on behalf of confirmed enrollees and in the correct amounts. It should be noted that as of May 2016, CMS had fully transitioned QHP issuers operating through the Federal marketplace to an automated payment system that makes financial assistance payments to QHP issuers on an individual

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<sup>24</sup> 45 CFR § 156.705.

policy-level basis. CMS plans to fully transition most QHP issuers operating through State marketplaces to the automated system in 2018.

## RECOMMENDATIONS

We recommend that CMS:

- work with Treasury and QHP issuers to collect improper financial assistance payments, which we estimate to be \$434,398,168, for policies for which the payments were not authorized in accordance with Federal requirements;
- work with Treasury and QHP issuers to resolve the potentially improper financial assistance payments, which we estimate to be \$504,889,518, for policies for which there was no documentation provided to verify enrollees had paid their premiums; and
- clarify guidance for QHP issuers on Federal requirements for terminating an enrollee's coverage when the enrollee fails to pay his or her monthly premium.

## CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, CMS partially concurred with our first and second recommendations and concurred with our third recommendation. CMS stated that it is conducting audits of 2014 financial assistance payments to issuers and adjusting financial assistance payments to issuers for any overpayments or underpayments found. However, CMS indicated that it will not require QHP issuers to return improper financial assistance payments for policies on which issuers provided coverage in 2014 while acting in good faith and does not plan to resolve the potentially improper financial assistance payments for issuers that are out of business. CMS also stated that it has strengthened its guidance on terminating coverage for failure to pay premiums through updates to its enrollment manual.<sup>25</sup> CMS further stated that it will continue to review its processes to ensure it provides QHP issuers with reliable and transparent data on terminations of enrollee coverage for nonpayment of premiums. Finally, CMS provided additional documentation under separate cover to support some payments to QHP issuers that we identified as improper in our draft report.

Regarding our first recommendation, CMS stated that it developed a coordinated, risk-based audit process to determine the accuracy and integrity of 2014 financial assistance payments. According to CMS, the audits it is conducting will cover 49 percent of the total financial assistance payments authorized to QHP issuers operating in the Federal marketplace during the 2014 benefit year. The audits conducted so far have found a net payment error rate of around 0.1 percent. CMS stated that it is adjusting financial assistance payments to QHP issuers for any

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<sup>25</sup> CMS, *FFM* [Federally Facilitated Marketplace] and *FF-SHOP* [Federally Facilitated Small Business Health Options Program] *Enrollment Manual*. Available at [https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/ENR\\_FFMSHOP\\_Manual\\_080916.pdf](https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/ENR_FFMSHOP_Manual_080916.pdf). Accessed on July 3, 2018.

overpayments or underpayments found as part of these audits. CMS also noted that QHP issuers faced technical challenges during the first year that the Federal marketplace began operating; therefore, CMS allowed issuers various “flexibilities” for approving financial assistance payments. Because of the first-year technical challenges and those flexibilities, CMS accepted issuer attestations for confirmed enrollees’ coverage dates. Therefore, CMS disagreed with our analysis regarding effective dates and financial assistance payments and stated that it does not plan to require QHP issuers to return financial assistance payments for policies for which they provided coverage in 2014 while acting in good faith based on CMS’s above-referenced flexibilities.

In response to our second recommendation, CMS stated that it has received documentation from QHP issuers included in its audits and plans to adjust the issuers’ financial assistance payments accordingly. CMS further stated that many of the QHP issuers associated with the financial assistance payments we identified as potentially improper were no longer in business or were experiencing financial distress or liquidation. To make the most efficient use of its audit resources, CMS stated that it does not plan to audit QHP issuers no longer in business.

After reviewing the additional documentation provided, we revised our determinations for financial assistance payments for 10 policies identified in our draft report as not accurately authorized. However, two of these policies did not meet Federal requirements for another reason; therefore, we continue to question the financial assistance payments made for these policies. We revised our findings and first recommendation to reflect our revised determination that the remaining eight policies were accurately authorized. We maintain that our findings and recommendations, as revised, are valid. Specifically, CMS did not provide any information related to its risk-based audit process; therefore, we cannot determine whether its audits will identify the deficiencies we identified. In addition, although 2014 was the first year the marketplace was in effect, CMS was still responsible for ensuring that it accurately authorized financial assistance payments in accordance with Federal requirements. Therefore, it is responsible for ensuring any improper or potentially improper financial assistance payments made to QHP issuers during the first year of the marketplace—and any period thereafter—are resolved and collected.

CMS also provided technical comments, which we addressed as appropriate. CMS’s comments, excluding the technical comments, are included as Appendix D.

## **OTHER MATTERS: CMS IS NOT REQUIRED TO IDENTIFY AND RECOVER POTENTIALLY INAPPROPRIATE COST-SHARING REDUCTIONS**

The IRS is responsible for reconciling APTC payments made on behalf of confirmed enrollees to individual taxpayer returns and to verify that the PTCs were correctly calculated.<sup>26</sup> As such, taxpayers must reconcile—or compare—their APTC payments with their allowable PTC. If the calculations differ, taxpayers must increase or reduce their taxes accordingly.<sup>27</sup> However, the ACA does not require CMS to similarly identify and recover CSR payments made to QHP issuers on behalf of enrollees whose income for the benefit year exceeded the maximum allowable amount to be eligible to receive these payments.

At present, CMS is not making CSR payments. If CMS were to make such payments in the future, we would encourage CMS to consider methods to identify potentially inappropriate CSR payments made on behalf of enrollees whose income for the benefit year exceeded the maximum amount allowed to be eligible for these payments and to recover inappropriate payments.

Because CMS is not required to identify potentially inappropriate CSR payments, it has not implemented a process to recover those payments. As a result, there is a risk that some of the \$2,160,409,204 in CSR payments that CMS authorized during the 2014 benefit year were made on behalf of ineligible enrollees.

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<sup>26</sup> ACA § 1401(a); IRC § 36B(f)(2).

<sup>27</sup> If taxpayers' APTC payments total more than their PTC, that will increase the taxes they owe or reduce their tax refund. If their PTC is greater than their total APTC payments, they can increase their tax refund or lower their balance due by the difference (IRS Publication 5120 (Rev. 1-2016)).

## APPENDIX A: AUDIT SCOPE AND METHODOLOGY

### SCOPE

Our audit covered policies for individuals who enrolled through the Federal marketplace and for whom financial assistance payments were made to QHP issuers during the 2014 benefit year.

We limited our review of internal controls to those applicable to our objective. Our objective did not require an understanding of all internal controls related to enrolling in a QHP or the eligibility of enrollees to receive financial assistance payments. Accordingly, our scope did not include a broad review of CMS's controls over eligibility for enrollment in a QHP operating through the Federal marketplace. Prior Office of Inspector General (OIG) work assessed those controls.<sup>12</sup>

### METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and other requirements related to the administration of financial assistance payments;
- obtained from CMS databases of all policies with individuals who elected to have APTCs and advance CSRs paid to QHP issuers operating through the Federal marketplace and the associated payments for the 2014 benefit year;
- obtained from CMS the financial assistance payment amounts it should have authorized based on its enrollment system and the total amount of financial assistance payments disbursed for the 2014 benefit year and reconciled these amounts;
- created a sampling frame of 2,959,262 policies from CMS's Multidimensional Insurance Data Analytics System (MIDAS) with applied financial assistance payment amounts totaling \$11,962,621,282;
- selected a stratified random sample of 140 policies for which CMS authorized financial assistance payments to QHP issuers operating through the Federal marketplace during the 2014 benefit year;
- for each of the sampled policies, obtained from CMS the associated electronic health insurance records detailing PTC and CSR amounts determined by the Federal

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<sup>12</sup> We did not review whether enrollees were eligible to receive financial assistance payments. That work is detailed in *Not All of the Federally Facilitated Marketplace's Internal Controls Were Effective in Ensuring That Individuals Were Properly Determined Eligible for Qualified Health Plans and Insurance Affordability Programs (A-09-14-01011)*, issued August 6, 2015.

marketplace and the associated Form 1095A, Health Insurance Marketplace Statement, detailing the amount of PTCs determined by the Federal marketplace and any APTCs paid to QHP issuers related to each policy for the 2014 benefit year;

- interviewed officials from 80 QHP issuers to obtain an understanding of their procedures for documenting their receipt of premium payments from enrollees and requesting reimbursement of financial assistance payments from CMS;
- obtained and reviewed documentation supporting advance financial assistance payments made to QHP issuers for each sample item and:
  - verified that the Federal marketplace transmitted the correct financial assistance payment amounts to QHP issuers,
  - confirmed that enrollees paid their monthly premiums to be eligible to receive financial assistance payments,
  - identified any subsequent changes in eligibility status that could affect the amount of financial assistance payments enrollees could receive, and
  - identified any discrepancy between the advance financial assistance payments enrollees were eligible to receive and the actual amounts paid to QHP issuers on their behalf;
- estimated the total number of policies not in accordance with Federal requirements;
- obtained from TIGTA the calculation of the total amount of improper financial assistance payments using APTC reconciliation data (i.e., Federal tax information (FTI)) for the 140 sampled policies and the estimated total amount of improper financial assistance payments authorized during the 2014 benefit year;<sup>28</sup>
- estimated the total number of policies for which QHP issuers received potentially improper financial assistance payments and the total amount of potentially improper financial assistance payments authorized to QHP issuers during the 2014 benefit year; and
- discussed the results of our review with CMS officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain

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<sup>28</sup> Because we did not have the authority to access FTI for this review, TIGTA used an Office of Audit Services' (OAS's) calculation tool in conjunction with enrollees' FTI to determine the estimated total amount of improper financial assistance payments. We did not obtain any FTI for enrollees associated with our sampled policies.

sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

## **APPENDIX B: STATISTICAL SAMPLING METHODOLOGY**

### **TARGET POPULATION**

The target population consisted of all health insurance coverage policies for individuals enrolled through the Federal marketplace and for whom CMS authorized financial assistance payments from January 1, 2014, through December 31, 2014.

### **SAMPLING FRAME**

The sampling frame consisted of Access databases containing 2,959,262 policies with applied financial assistance payment amounts totaling \$11,962,621,282. The data for the enrollment applications were obtained from CMS's MIDAS.

### **SAMPLE UNIT**

The sample unit was a policy.

### **SAMPLE DESIGN**

We used a stratified random sample:

- Stratum 1: policies CMS identified as confirmed with applied payment amounts of less than \$3,942.02.
- Stratum 2: policies CMS identified as confirmed with applied payment amounts of greater than or equal to \$3,942.02 and less than \$7,065.24.
- Stratum 3: policies CMS identified as confirmed with applied payment amounts of greater than or equal to \$7,065.24.
- Stratum 4: policies CMS identified as canceled policies.

### **SAMPLE SIZE**

We selected a sample of 140 policies, as follows:

- 37 policies from stratum 1,
- 37 policies from stratum 2,
- 36 policies from stratum 3, and
- 30 policies from stratum 4.

## **SOURCE OF RANDOM NUMBERS**

We generated the random numbers using the OIG/OAS statistical software.

## **METHOD FOR SELECTING SAMPLE UNITS**

We consecutively numbered the policies within each stratum. After generating the random numbers for each of these strata, we selected the corresponding policies in the sampling frame for our sample.

## **ESTIMATION METHODOLOGY**

We used the OIG/OAS statistical software to estimate (1) the total number of policies not in accordance with Federal requirements and the total value of the resulting improper financial assistance payments and (2) the total number of policies with potentially improper payments and the potentially improper financial assistance payment amount. We also used this software to calculate the corresponding lower and upper limits of the two-sided 90-percent confidence intervals.

Using a calculation tool in an Excel spreadsheet we provided, TIGTA used APTC reconciliation data (i.e., FTI) in conjunction with our results to calculate the estimate of the total improper financial assistance payment amount. TIGTA also used this calculation tool to provide the corresponding lower and upper limit of the two-sided 90-percent confidence interval.

**APPENDIX C: SAMPLE RESULTS AND ESTIMATES**

**Table 1: Sample Detail and Results for Improper Payments and Policies Not in Accordance with Federal Requirements**

<b>Stratum</b>	<b>Policies in Frame</b>	<b>Value of Frame</b>	<b>Sample Size</b>	<b>Value of Sample</b>	<b>Number of Policies Not in Accordance With Federal Requirements</b>	<b>Value of Improper Payments Not Including Reconciled APTC Amounts</b>
1	1,726,826	\$3,610,490,178	37	\$91,697	6	\$6,165
2	813,444	4,278,241,812	37	188,830	7	4,331
3	406,362	4,001,203,058	36	356,728	2	7,746
4	12,630	72,686,234	30	141,424	11	37,476
<b>Totals</b>	<b>2,959,262</b>	<b>\$11,962,621,282</b>	<b>140</b>	<b>\$778,679</b>	<b>26</b>	<b>\$55,718</b>

**Table 2: Sample Detail and Results for Policies With Potentially Improper Financial Assistance Payments**

<b>Stratum</b>	<b>Policies in Frame</b>	<b>Value of Frame</b>	<b>Sample Size</b>	<b>Value of Sample</b>	<b>Number of Policies With Potentially Improper Payments</b>	<b>Value of Payments for Policies With Potentially Improper Payments</b>
1	1,726,826	\$3,610,490,178	37	\$91,697	3	\$6,065
2	813,444	4,278,241,812	37	188,830	2	10,090
3	406,362	4,001,203,058	36	356,728	0	0
4	12,630	72,686,234	30	141,424	0	0
<b>Totals</b>	<b>2,959,262</b>	<b>\$11,962,621,282</b>	<b>140</b>	<b>\$778,679</b>	<b>5</b>	<b>\$16,155</b>

## ESTIMATES

**Table 3: Estimated Number of Policies Not in Accordance With Federal Requirements and the Estimated Value of Improper Financial Assistance Payments<sup>29</sup>**  
*(Limits Calculated at the 90-Percent Confidence Level)*

	<b>Total Number of Policies Not in Accordance With Federal Requirements</b>	<b>Total Value of Improper Payments Not Including Reconciled APTC Amounts<sup>30</sup></b>	<b>Total Value of Improper Payments Including Reconciled APTC Amounts</b>
Point estimate	461,127	\$ 486,168,679	\$434,398,168
Lower limit	264,281	146,812,055	104,566,655
Upper limit	657,973	825,525,304	764,229,682

**Table 4: Estimated Number of Policies With Potentially Improper Financial Assistance Payments and Value of Associated Payments**  
*(Limits Calculated at the 90-Percent Confidence Level)*

	<b>Total Number of Policies With Potentially Improper Payments</b>	<b>Total Value of Payments Associated With These Policies</b>
Point estimate	183,983	\$504,889,518
Lower limit	45,276	106,643,599
Upper limit	322,690	903,135,437

<sup>29</sup> Reconciled APTC amounts were included in the calculation of the total value of payments associated with these policies based on the calculation tool used by TIGTA referenced in Appendices A and B.

<sup>30</sup> We calculated these values using the OIG/OAS statistical software. However, because these values do not include reconciled APTC amounts, we did not use them for the statistical estimate in this report.

## APPENDIX D: CMS COMMENTS



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW  
Washington, DC 20201

**DATE:** MAY - 3 2018

**TO:** Daniel R. Levinson  
Inspector General

**FROM:** Seema Verma   
Administrator

**SUBJECT:** Office of Inspector General (OIG) Draft Report: CMS Did Not Always Accurately Authorize Financial Assistance Payments to Qualified Health Plan Issuers in Accordance with Federal Requirements During the 2014 Benefit Year (A-02-15-02013)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report on financial assistance payments for individuals enrolled through the Federally-facilitated Exchange (FFE). CMS is committed to working with qualified health plan (QHP) issuers to ensure the accuracy of financial assistance payments.

CMS takes the stewardship of tax dollars seriously and has implemented a series of payment and system controls to assist in making accurate and timely financial assistance payments to issuers. In May 2016, CMS fully transitioned issuers operating through the FFE to an automated payment system, allowing for the processing of financial assistance payments on a policy-level basis. The automated system allows CMS, the FFE, and issuers to share enrollment and health insurance information, such as individuals included in a policy, the QHP selected, the associated premium amount, and the financial assistance payment amount, if applicable. CMS is transitioning most State-based Exchanges (SBEs) over to the automated payment system in 2018.

Both the Government Accountability Office (GAO) and the OIG have previously reviewed the automated payment system, with GAO reporting that CMS properly designed and implemented control activities related to the accuracy of advance payments of premium tax credits (APTC) made to certified issuers<sup>1</sup> and OIG indicating that CMS can independently verify financial assistance payment data.<sup>2</sup> In addition, under CMS's Office of Management and Budget A-123 internal controls review over financial reporting, key controls surrounding the payment process were tested and determined to be operating effectively. Moreover, an independent certified public accounting firm conducted its review of the payment process and reported no significant issues. Lastly, CMS has undergone an Agreed Upon Procedures review to evaluate the payments and controls under the payment processes. These reports are shared with GAO and the Internal Revenue Service annually. No major findings were noted during fiscal years 2014-2017.

<sup>1</sup> "IMPROPER PAYMENTS: Improvements Needed in CMS and IRS Controls over Health Insurance Premium Tax Credit" (GAO-17-467, Released July 13, 2017)

<sup>2</sup> "Initial Review of the Centers for Medicare & Medicaid Services' Automated System for Processing Financial Assistance Payments" (A-02-17-02001, Released May 8, 2017)

Instituting strong program safeguards to ensure that only individuals who are eligible are enrolled in Exchange coverage, and that they are only receiving the amount of financial assistance they are eligible for, is essential to ensuring that the Exchanges operate as intended. In order to better protect consumers and taxpayer dollars, CMS is implementing a number of initiatives to enhance operations with a focus on program integrity. CMS has expertise in preventing and detecting fraud, waste, and abuse from its other programs and is applying program integrity best practices to the FFE through its Center for Program Integrity. As recommended by the GAO,<sup>3</sup> CMS's Center for Program Integrity is conducting an Exchange Fraud Risk Assessment, leveraging the GAO's fraud risk framework.<sup>4</sup> The GAO's framework identifies leading practices for managing fraud risks and was developed to help managers combat fraud and preserve integrity in government agencies and programs. CMS is using this framework to identify and prioritize key areas for potential risk in the Exchange. In addition, CMS has developed a coordinated, risk-based audit process to determine the accuracy and integrity of past years' financial assistance payments to issuers. CMS is auditing 49 percent of 2014 FFE payments and plans to audit both 2014 SBE and 2015 FFE payments in 2018.

OIG's recommendations and CMS' responses are below.

#### **Recommendation**

CMS should work with Treasury and QHP issuers to collect improper financial assistance payments, which we estimate to be \$642,785,910 for policies for which the payments were not authorized in accordance with Federal requirements.

#### **CMS Response**

CMS partially concurs with this recommendation. CMS has developed a coordinated, risk-based audit process to determine the accuracy and integrity of 2014 financial assistance payments to issuers, which includes verification of premium payment for a sample of issuer records. These audits cover 49 percent of total FFE payments to issuers for 2014 and have found a net payment error rate of around 0.1 percent. We note that these payment audits conducted certain checks for consistency with FFE records on a sample of 100 percent of each of the selected issuer's enrollment records. For any errors identified in a sample of records, the issuer was required to identify all other cases of the same error across their records for purposes of quantifying overall impact. CMS considers this method of assessing total error more robust than extrapolation. CMS is adjusting financial assistance payments to issuers for any overpayments or underpayments found.

It is also important to note that because 2014 was the first year of Exchange coverage, the FFE and issuers faced technological challenges and often had to create multiple policies per individual/family, process enrollment or updates retroactively, and perform manual workarounds. CMS communicated with issuers through a number of channels about additional flexibilities in enforcing premium payment dates and threshold payment amounts in cases of very small amounts owed by the consumer, which could include a single payment date for the full premium or an initial payment date for a threshold amount of the premium with subsequent payment dates for the remaining amounts. Due to these first-year technical challenges and flexibilities, CMS accepted issuer attestation for effectuation of coverage dates, including for those consumers receiving APTC. We therefore disagree with the OIG's analysis regarding effective dates and financial assistance payments and do not plan to require issuers to return

<sup>3</sup> "Patient Protection and Affordable Care Act: CMS Should Act to Strengthen Enrollment Controls and Manage Fraud Risk" (GAO-16-29, released February 2016)

<sup>4</sup> "A Framework for Managing Fraud Risks in Federal Programs" (GAO-15-593SP, released July 2015)

APTC payment for policies on which they provided coverage in 2014 while acting in good faith on the basis of CMS-provided flexibility.

**Recommendation**

CMS should work with Treasury and QHP issuers to resolve the potentially improper financial assistance payments, which we estimate to be \$504,889,518 for policies for which there was no documentation provided to verify enrollees had paid their premiums.

**CMS Response**

CMS partially concurs with this recommendation. As discussed above, CMS is conducting audits of 2014 financial assistance payments to issuers and adjusting financial assistance payments to issuers for any overpayments or underpayments found. All issuers selected in these audits have provided documentation to CMS as requested. Many of the cases OIG identified as potentially improper, and subsequently extrapolated from, were either out of business or undergoing financial distress or liquidation. To make the most efficient use of its audit resources, CMS does not plan to audit issuers that are out of business, given the minimal return on investment.

**Recommendation**

CMS should clarify guidance for QHP issuers on Federal requirements for terminating an enrollee's coverage when the enrollee fails to pay his or her monthly premium.

**CMS Response**

CMS concurs with this recommendation. CMS has strengthened guidance to issuers on terminating coverage for failure to pay premiums through updates to the Enrollment Manual. Issuers are required to collect the first month's "binder" premium (or an amount within the premium payment threshold if the issuer utilizes such a threshold) to effectuate coverage, and observe a three consecutive month grace period before terminating coverage for those enrollees who are eligible for and have elected to receive the benefit of APTC. If an individual fails to pay their premium, the issuer terminates the individual for failure to pay a premium after the appropriate grace period and notifies the FFE. Adjustments to APTC are subsequently processed and made within 1-2 payment cycles from when the FFE is updated with the termination. CMS has developed a coordinated, risk-based audit process to determine the accuracy and integrity of 2014 financial assistance payments to issuers, including review of grace periods. CMS will continue to review its processes to ensure it has reliable and transparent data on terminations of enrollee coverage for nonpayment of premiums in order to protect the integrity of the Exchanges.