

Audit Report

for

Dean Health Plan

May 10, 2018

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I. EXECUTIVE SUMMARY

Background

Dean Health Plan is a Federally-facilitated Exchange (FFE) issuer that offered Exclusive Provider Organization (EPO), Health Maintenance Organization (HMO), Point-of-Service (POS), Preferred Provider Organization (PPO) and other qualified health plans (QHPs) in the individual market in Wisconsin during the 2014 benefit year. Dean Health Plan submitted their final restated 2014 benefit year data in their July 2015 Enrollment and Payment Data Workbook (EPDW). The issuer received a total of $67,273,373.73 in advance premium tax credit (APTC) and advance cost sharing reductions (CSR) payments and paid a total of $2,635,499.41 in FFE user fees for its 2014 benefit year individual market plans.

This report presents the results of the work performed to assess Dean Health Plan's compliance with the APTC, advance CSR, and FFE user fee programs established in sections 1311, 1401 and 1402 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 and implementing regulations (collectively referred to throughout as PPACA).

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

Title 45 of the Code of Federal Regulations (CFR), sections 156.480 and 156.705, allow the Department of Health and Human Services (HHS) to conduct audits of issuers that offer a QHP in the individual market through an Exchange to assess compliance with the APTC, advance CSR, and FFE user fee program requirements. The audit supports the Centers for Medicare & Medicaid Services (CMS) objectives to:

- 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[1] is part of a program established by CMS to validate the enrollment and payment data reported on the final 2014 EPDW and analyze controls and policies of selected issuers pursuant to the authority defined in the regulations.

[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.

Results of Review

CMS's procedures identified three findings for Dean Health Plan. The findings involve the following:

- Premium/user fee, APTC and advance CSR differences identified as a result of the comparison of the data included in the EPDW against an APTC/CSR Desk Audit File containing subscriber level data from the issuer's systems;
- Inclusion of enrollment and payment data for subscribers who were not effectuated in the issuer's systems; and
- Inclusion of an incorrect premium amount for one of the 15 selected subscribers resulting from a premium rating defect.

II. BACKGROUND, OBJECTIVES, SCOPE, AND METHODOLOGY

A. Background

Sections 1401 and 1402 of the PPACA established the APTC and advance CSR programs to support the provision of affordable health care coverage to individuals. Additionally, section 1311 of the PPACA allowed the FFE 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, advance CSR, and FFE user fee programs. As such, CMS established this audit program.

Interim Payment Process

For the 2014 benefit year, CMS implemented a temporary process ("interim payment process") to calculate and make monthly payments of APTC and advance CSR amounts and to calculate and collect monthly FFE user fee amounts based on data submitted by issuers at the QHP level. On a monthly basis, CMS required submitters to use a standard template, *i.e.* the EPDW that CMS staff created and maintained, to submit payment data. The EPDW was preprogramed with individual submitter data that allowed the submitter to self-validate data prior to submission to CMS. The EPDW included the option to restate prior months' data or indicate no change in data since the last submission. CMS required submitters to send the following information at the QHP plan 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 CSR
12. Total effectuated members
13. Total effectuated members with APTC
14. Total effectuated members with CSR

Issuers and State-based Exchanges (SBEs) on behalf of issuers were required to calculate the QHP level enrollment and payment amounts submitted on the EPDW using their internal source data.

B. Audits to Determine Compliance with the Administration of APTC, Advance CSR, and FFE User Fee Programs

CMS established an audit protocol that is organized around the following regulations governing APTC, advance CSR, and FFE user fee programs, and the procedures required to assess compliance with these applicable regulations:

- 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.

Refer to Appendix 1 for the specific requirements established under the authorities listed above.

C. Objectives

The objectives of these audits are to:

(1) Evaluate the accuracy and integrity of issuer-generated EPDW data reported for the APTC, advance CSR, and FFE user fee programs;
(2) Identify potential CMS payment errors resulting from issuer data reporting errors; and
(3) Test accuracy and integrity of processes for reducing an enrollee's share of premium to account for APTCs (45 CFR 156.460).

D. Scope and Methodology

CMS selected Dean Health Plan for an audit under the above-mentioned regulation(s). As established by CMS, the audit centered on evaluating activity at Dean Health Plan related to the 2014 benefit year (January 1, 2014, through December 31, 2014), individual market data reported on the final EPDW(s) submitted by the issuer to support APTC and advance CSR payments, and FFE user fee collections.

CMS informed Dean Health Plan via electronic letter on November 16, 2016, that it would be audited. Dean Health Plan then received a letter on November 18, 2016, from CMS's audit contractor, identifying data requirements required to conduct the audit. CMS's audit contractor reviewed Dean Health Plan's information provided and performed the procedures to assess compliance with APTC, advance CSR and FFE user fee program rules and regulations as defined in the CMS protocols.

CMS's audit contractor applied audit protocol procedures to obtain sufficient and appropriate evidence to establish reasonable bases for the findings related to the audit objectives identified in section II.C of this report. CMS's audit contractor performed the following procedures:

- Validations of the APTC/CSR Desk Audit File[2] data submitted to CMS:
    - EPDW Validations: Comparison of the final 2014 EPDW submitted to CMS to the APTC/CSR Desk Audit File from Dean Health Plan's systems.
    - Duplicate Check: Review of the APTC/CSR Desk Audit File containing subscriber level data from Dean Health Plan'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) were not reported on the file.
    - Unreconciled Subscribers Review: Review and comparison of the subscribers reported on the APTC/CSR Desk Audit File to the subscribers included in CMS's systems to determine if the subscribers existed and were effectuated (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) in CMS's systems.
- Validations on samples of issuer system data:
    - 45 Subscriber Review: Review and comparison of the data from the issuer's systems to the corresponding data included in CMS's systems for a selected sample of 45 subscribers.
    - 15 Subscriber 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 15 subscribers.
- Policy and Procedure Review: Review of issuer APTC policies and procedures for completeness and clarity.

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

III. RESULTS OF REVIEW

EPDW Validations

One finding resulted from the comparison of the final 2014 EPDW to Dean Health Plan's APTC/CSR Desk Audit File. Refer to Finding No. 1 included in section IV for details on the finding.

Duplicate Check

No findings resulted from the review of Dean Health Plan's APTC/CSR Desk Audit File to verify that duplicate Exchange-assigned subscriber IDs were not reported on the file.

Unreconciled Subscribers Review

One finding resulted from the review of Dean Health Plan's APTC/CSR Desk Audit File to determine if the subscribers reported on the file existed and were effectuated in CMS's systems. Refer to Finding No. 2 included in section IV for details on the finding.

45 Subscriber Review

No findings resulted from the review and comparison of the data from Dean Health Plan's systems to the corresponding data included in CMS's systems for a selected sample of 45 subscribers.

15 Subscriber Review

One finding resulted from the analysis and review of the data and documentation from Dean Health Plan's systems to verify effectuation and the appropriate application of premium and APTC amounts to policies for a selected sample of 15 subscribers. Refer to Finding No. 3 included in section IV for details on the finding.

Policy and Procedure Review

No findings resulted from the review of Dean Health Plan's APTC policies and procedures.

IV. FINDINGS

A finding is an identification of an instance of issuer non-compliance with CMS requirements that requires corrective action. CMS's audit procedures identified three findings. The three findings resulted in a change to Dean Health Plan's reported EPDW for individual market plans for the 2014 benefit year. In light of the three findings, the adjusted 2014 benefit year EPDW APTC and advance CSR payments and FFE user fee amounts for individual market plans are shown in the following table.

Recalculated EPDW for Benefit Year 2014

	FFE User Fees	APTC	Advance CSR Payments*
EPDW As Filed in July 2015	$(2,635,499.41)	$53,317,941.89	$13,955,431.84
EPDW Validations Adjustment	$1,213.30	$(23,801.63)	$(3,796.51)*
Unreconciled Subscribers Review Adjustment	$343.87	$(8,796.12)	$(1,755.61)*
15 Subscriber Review	$0.80**	$0.00	$0.00*
EPDW As Recalculated	$(2,633,941.44)	$53,285,344.14	$13,949,879.72*
(Refund) from CMS / Payment to CMS	$(1,557.17)**	$32,597.75	

* Note: The advance CSR financial impact is for informational purposes only.

** Note: No corrective action is required for the 15 Subscriber Review finding. Therefore, the finding is for informational purposes only and the financial impact is not included in the Refund from CMS.

The net financial impact of the two audit findings is a payment due to CMS of $31,040.58 consisting of $(1,557.17) in FFE user fees and $32,597.75 in APTC. The three audit findings along with the criteria, cause, effect, corrective actions, and Dean Health Plan's responses are as follows:

Finding No. 1 - EPDW Validations	**Condition:**	**Premium and FFE User Fee Differences -** For 15 QHPs and applicable months of benefit year 2014, the "Total premium amount by QHP ID for effectuated enrollments" included on Dean Health Plan's EPDW did not match the total premium amount include on Dean Health Plan's APTC/CSR Desk Audit File, resulting in a total net difference of $34,667.41 in premiums. This net premium difference translates to a net difference of $1,213.30 in FFE user fees. For the 14 QHPs and applicable months of benefit year 2014, there was a corresponding net difference of 60 enrollment groups and 85 members. **APTC Differences -** For 14 QHPs and applicable months of benefit year 2014, the "Total APTC amount by QHP ID for effectuated enrollments" included on Dean Health Plan's EPDW did not match the total APTC amount on Dean Health Plan's APTC/CSR Desk Audit File, resulting in a total net difference of $23,801.63 in APTC. For the 14 QHPs and applicable months of benefit year 2014, there was a corresponding net difference of 58 APTC enrollment groups and 79 APTC members. **Advance CSR Differences -** For 9 QHPs and applicable months of benefit year 2014, the "Total CSR amount by QHP ID for effectuated enrollments" included on Dean Health Plan's EPDW did not match the total advance CSR amount on Dean Health Plan's APTC/CSR Desk Audit File, resulting in a total net difference of $3,796.51 in advance CSR. For the 9 QHPs and applicable months of benefit year 2014, there was a corresponding net difference of 34 CSR enrollment groups and 46 CSR members.
	Criteria:	Per CMS guidance and EPDW submission requirements: 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 FFM user fee amount the issuer can expect to incur for participation in the Federally-facilitated Marketplace." 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." The "Total CSR amount by QHP ID for effectuated enrollments" submitted on the EPDW is the "total monthly advance CSR amount the issuer can expect to receive for all effectuated enrollments within a 16-digit QHP ID."
	Cause:	The issuer indicated the differences were a result of "Members that no longer showed coverage in effect for a specific month or months in 2014 were ultimately removed from the final restated 2014 EPDW. The desk audit file will be lower in all those instances. This variance was expected due to small amounts of retroactivity that still occurred after our final 2014 benefit year restate."
	Effect:	The premium/user fee, APTC and advance CSR differences resulted in a change to Dean Health Plan's final, restated benefit year 2014 EPDW data.
	Corrective Action Required:	The net financial impact for this finding is a payment due to CMS of $22,588.33 consisting of $(1,213.30) in FFE user fees and $23,801.63 in APTC. Dean Health Plan should confirm this financial impact and coordinate with CMS on resolution. The advance CSR payment impact for this finding is an overstatement of $3,796.51; however, this is for informational purposes only.
	Management Response:	Small amounts of retroactivity in the ACA population can and do occur many months or even years after effectuated enrollments are in place.

		This results in premium/user fee, APTC, and CSR variances from a previously stated point in time. In this case, July of 2015 for benefit year 2014. The net financial impact listed in the Corrective Action is reasonable and was expected based on our analysis of the original data file in July of 2015 and the restated data from the audit. We are in agreement with the required corrective action.

Finding No. 2 - Unreconciled Subscribers Review	**Condition:**	Dean Health Plan overstated 2014 benefit year premiums, APTC and advance CSR by reporting enrollment and payment data for two subscribers who were not effectuated.
	Criteria:	Per CMS guidance and EPDW submission requirements, the EPDW should include data for effectuated enrollments where an effectuated enrollment is defined as "any enrollment in which the amount the enrollment group is responsible to pay toward the total premium amount has been paid in full by the enrollment group."
	Cause:	The issuer indicated for the first subscriber that there was "No 2014 Covg" and for the second subscriber that there were "Multiple Exch ids".
	Effect:	The inclusion of the two non-effectuated enrollments resulted in a change to Dean Health Plan's final, restated benefit year 2014 EPDW data.
	Corrective Action Required:	The net financial impact for this finding is payment due to CMS of $8,452.25 consisting of $(343.87) in FFE user fees and $8,796.12 in APTC. Dean Health Plan should confirm this financial impact and coordinate with CMS on resolution. The advance CSR payment impact for this finding is an overstatement of $1,755.61; however, this is for informational purposes only as CSR payments are prohibited unless and until a valid appropriation exists.
	Issuer Management Response:	This finding also relates to retroactivity and members with more than one exchange id on file. The two subscribers initially reported with effectuated coverage had enrollment changes after

		the final submission in July of 2015. We are in agreement with the required corrective action.

Finding No. 3 - 15 Subscriber Review – Rating Defect	**Condition:**	For one of the 15 selected subscribers, Dean Health Plan overstated the benefit year 2014 premiums as the subscriber's premium amount reported on the APTC/CSR Desk Audit File was greater than the subscriber's premium amount reported in the invoice.
	Criteria:	Per CMS guidance and EPDW submission requirements, 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"
	Cause:	The issuer noted "Dean Health Plan has the correct premium. The rating discrepancy is due to a difference in rate for the spouse on the policy, and was caused by a rating defect in the Marketplace at this time. The spouse on the policy was "rated up" incorrectly by the marketplace 9/1/2014 when a new dependent was added to the existing policy. Her original effective date was March 1, 2014, her birth date is in May. This was a defect widely reported by many issuers at this time and acknowledged by the FFM."
	Effect:	The premium/FFE user fee difference resulted in a change to Dean Health Plan's final, restated benefit year 2014 EPDW data.
	Corrective Action Required:	The net financial impact for this finding is an overstatement of $0.80 in FFE user fees. No corrective action is required as the issuer reported the correct premium amounts for the subscriber during enrollment reconciliation.
	Management Response:	We are in agreement with the finding and the corrective action required, which states that nothing further from Dean Health Plan is needed at this time. Correct premium amounts for the subscriber were reported during the enrollment reconciliation.

Issuer Management Response to the Draft Audit Report Findings (See Appendix 3)

Please provide management's response to the findings identified in the draft audit report and complete the attached Appendix 3, Issuer Management Response to Net Financial Adjustment, within 30 calendar days from the draft audit report date. Management's response should indicate agreement or disagreement.

Agreement

If management agrees with the three findings, complete the "Issuer Management Response" field of the finding in the draft audit report, and initial "Agree" and sign the attached Appendix 3 Issuer Response to Net Financial Adjustment. Return the draft audit report including Appendix 3 within 30 calendar days from the draft audit report date. Upon receipt of the signed Issuer Response to Net Financial Adjustment, CMS will finalize and publish the report. CMS will process the final adjustment amount in the next available monthly payment cycle. [3]

Disagreement

If management disagrees with the three findings and corrective actions, complete the "Issuer Management Response" field of the finding in the draft audit report, and initial "Disagree" and sign the attached Appendix 3 Issuer Response to Net Financial Adjustment. Return the draft audit report including Appendix 3 and any supporting documentation that substantiates management's response within 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 explanation in the "Issuer 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 a final audit report, including the stated final adjustment amount along with an updated Appendix 3 - Issuer Response to Net Financial Adjustment within 30 calendar days after receipt of management's response. Please return the updated Appendix 3 - Issuer Response to Net Financial Adjustment Draft Response within 15 calendar days. Upon receipt of the signed Issuer Response to Net Financial Adjustment Draft Response, CMS will finalize and publish the report. CMS will process the final adjustment amount in the next available monthly payment cycle.[3]

[3] CSR payments are prohibited unless and until a valid appropriation exists.

Appendix 1 – 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	**(a) *Definitions.*** The following definitions apply for the purposes of this section: *Participating issuer* 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. **(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. **(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.
45 CFR §156.460 - Reduction of enrollee's share of premium to account for advance payments of the premium tax credit	**(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— (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.
45 CFR § 156.480 - Oversight of the administration of the cost-sharing reductions and advance	**(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

payments of the premium tax credit programs.	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. **(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. **(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.
45 §156.705 – Maintenance of records for Federally-facilitated Exchanges	**(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: **(1)** Periodically assess 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 **(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. **(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. **(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. **(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.

Appendix 2 – Acronyms

Terms & Acronyms	Definition
APTC	Advance Premium Tax Credit
CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
CSR	Cost-sharing Reduction
EPDW	Enrollment and Payment Data Workbook
EPO	Exclusive Provider Organization
FFE	Federally-facilitated Exchange
GAGAS	Generally Accepted Government Auditing Standards
HHS	Department of Health and Human Services
HMO	Health Maintenance Organization
PPACA	Patient Protection and Affordable Care Act
POS	Point-of-Service
PPO	Preferred Provider Organization
QHP	Qualified Health Plan
SBE	State-based Exchange

Appendix 3 – Issuer Response to Net Financial Adjustment

Appendix 3 – Issuer Response to Net Financial Adjustment

Issuer HIOS ID:

Issuer Name:

Issuer Address:

The undersigned Chief Executive Officer (CEO), Chief Financial Officer (CFO) or other individual who possesses authority to legally and financially bind this issuer has reviewed the information included in the audit report of the issuer's 2014 benefit year, resulting in a payment to CMS of $31,040.58 and:

(INITIAL) RJR Agrees with the audit net adjustment amount above, confirming the audit finding(s), 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 2014 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 30 calendar days of this draft audit report date. 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: Randy Ruplinger
(PRINT Name of signature)

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

Telephone Number: 608-827-4030
(Direct Telephone Number)

Date: 6/4/2018

Please email this response to us-advcmsfmapmo@kpmg.com by June 11, 2018.