DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

Date: May 16, 2019

Subject: Closing Benefit Year Advance Payment of the Premium Tax Credit (APTC) and User Fee Restatements, Exceptions Process, and Administrative Appeals Process

The Centers for Medicare & Medicaid Services (CMS) conducted its final manual workbook restatement opportunity for the 2014, 2015, and 2016 benefit years in October 2016, October 2017, and October 2018, respectively. Under limited circumstances and as a necessary part of the appeals process, CMS will permit adjustments to 2014, 2015, and 2016 benefit year APTCs and User Fees through the exceptions process described below. As issuers on the Federally-facilitated Exchanges were paid through the Policy-Based Payments (PBP) system for the 2016 benefit year, the 2016 exceptions process will apply only for issuers in State-based Exchanges.

Exceptions Process: CMS has an exceptions process to allow issuers to request payment adjustments in order to resolve enrollment, APTC, and user fee discrepancies for the 2014, 2015, and 2016 benefit years. CMS does not intend to reopen workbooks for the 2014 through 2016 benefit years. Rather, issuers may request an exception to a previously submitted workbook for one of the satisfactory reasons outlined below by submitting a request and justification via email. The exceptions process does not apply to off-Exchange plans.

In order for issuers to request payment adjustments through the exceptions process after the manual workbook process has ended, the issuer must have a satisfactory reason. Satisfactory reasons include:

1. For the 2014 and 2015 benefit years, Federally-facilitated Exchange (FFE) issuers:
    a. Cases where a consumer won an eligibility and enrollment appeal and received retroactive coverage
    b. Other non-appeal cases where CMS sent an issuer a Health Insurance Casework System (HICS) case with a retroactive change to coverage.
    c. Changes to FFE enrollment processed as a result of the Form 1095-A discrepancy process.
    d. Issuer error resulting in an issuer owing money to CMS.
    e. Issuer error identified through a CMS- or issuer-initiated audit process resulting in CMS owing money to an issuer. Requests for exceptions under

this reason must be submitted by November 30, 2019 for the 2014 benefit year and November 30, 2020 for the 2015 benefit year.

2. For State-based Exchange (SBE) issuers or SBEs submitting workbooks to CMS directly for benefit years 2014, 2015, or 2016
    a. Cases where a consumer won an eligibility and enrollment appeal and received retroactive coverage
    b. SBE error or change where SBE provides enrollment updates to the issuer (analogous to the types of changes initiated through FFE HICS cases)
    c. Changes to enrollment processed as a result of the Form 1095-A discrepancy process.
    d. SBE errors resulting in an issuer owing money to CMS.
    e. SBE or issuer errors identified through an issuer-initiated audit process resulting in CMS owing money to an issuer. Issuers that identify an SBE workbook submission error with payment impact to the issuer should first work with the SBE to submit the exceptions request to CMS. Requests for exceptions under this reason will be time-limited and will only be considered for the duration of the SBE audit schedule. Additional information about the SBE audit schedule is forthcoming.

An issuer must submit a request for payment adjustments through the exceptions process by emailing the information below to marketplacepayments@cms.hhs.gov with a subject line of "Request for Exceptions Process." For requests stemming from an Exchange-initiated enrollment change (reasons 1a-c and 2a-c above), the request must be submitted within the quarter following the Exchange's initiation of the change. The email request must include the following information:

1. Health Insurance Oversight System (HIOS) ID
2. Payee Group ID
3. Reason(s) for request for adjustment/confirmation
4. For each Qualified Health Plan (QHP) ID for which adjusted payment is requested:
    a. Total previous APTC and user fee payment from CMS for that QHP for the 2014 and 2015 benefit years (as submitted in final manual workbook)
    b. Corrected APTC and user fee for that QHP for the 2014 and 2015 benefit years
    c. Total requested adjustment to APTC and user fee requested (*i.e.*, b less a; positive = payment to the issuer)
5. In addition to items 1-4 above, for requests due to updated information from CMS (reasons 1a-c above)
    a. Exchange assigned policy IDs triggering the change
    b. Final or corrected start and end dates of coverage period for each policy ID
6. In addition to items 1-4 above, for requests due to issuer or SBE error (reasons 1d, 1e, or 2 a-e above)

a. Detailed background and any available supporting documentation on the cause of the error
b. A description of how the error was discovered
c. SBE issuer requests based on SBE error should include documentation from the SBE of the nature of the error

CMS will notify the issuer (and SBE, if applicable) by email of the result of the request for an exceptions process and the requested payment adjustment, if applicable. If a payment is owed to the issuer or a refund is due to CMS, CMS will initiate a payment or charge to the issuer during the next quarterly adjustment period.

CMS will review and process exceptions and manual adjustments on a quarterly basis. Requests are due in December for processing in the February payment cycle, March for processing in May, June for processing in August and September for processing in November. All requests are due for review one month prior to the processing dates. To receive payment adjustments issuers must submit the exceptions request to CMS within the quarter after the quarter in which the issuer receives the enrollment change from the FFE or SBE. **Changes must be submitted no later than the quarter after they are received.**

Administrative Appeal Process for Final 2014, 2015 and 2016 APTC or User Fee: After issuance of a Final Exceptions Decision or CMS's denial of an FFE issuer's participation in the exceptions process, if an FFE issuer believes CMS made a processing error, incorrectly applied the relevant methodology, or made a mathematical error, an issuer may request reconsideration by emailing CMS at ACAfinancialappeals@cms.hhs.gov with a subject line of "APTC or User Fee Request for Reconsideration." **FFE issuers have 60 calendar days from the date of the Final Exceptions Decision or CMS's denial of an FFE issuer's participation in the exceptions process to request reconsideration if the issuer believes that CMS erred.** In this email, the issuer must explain the CMS error and provide documentation supporting its request for reconsideration. Pursuant to 45 C.F.R. § 156.1220(a)(2), a materiality threshold must be met, which means that an issuer cannot request reconsideration for an amount that is less than 1 percent of the APTC or user fee amount for the 2014 and 2015 benefit years or less than $10,000, whichever is less.