Updated March 2016

MLR EXAMINATION REPORTING INSTRUCTIONS

Introduction

Under the Patient Protection and Affordable Care Act, health insurers are subject to an audit/examination of their medical loss ratio (MLR) reporting and related rebate obligations. The Code of Federal Regulation (CFR), Title 45, Part 158.403, allows the U.S. Department of Health and Human Services (HHS) to accept the finding of a State's audit/examination provided certain criteria are met.
(http://www.ecfr.gov/cgi-bin/ECFR?SID=2d78423088d3704e9ec236d6b5a41d3e&page=browse)
This option is designed to increase efficiencies by allowing regulators already familiar with the insurer and their operations to perform the procedures.

States' completion of audit/examination procedures of insurers' MLR reporting and rebate obligations and subsequent reporting to HHS is optional and should be determined by the individual State. The following instructions and related procedures serve as the framework for States completing the necessary procedures to report on the medical loss ratio as determined in 45 CFR §158.403. Deviation from these instructions and related procedures based on examiner judgment or other conditions is permissible, but may be subject to review by HHS prior to accepting the State's work to fulfill the audit/examination requirements. (Significant deviation could result in HHS not accepting the State's work/conclusions and result in HHS conducting a separate audit/examination.)

The MLR compliance procedures are designed to be completed by financial examiners. However, market conduct examiners or others within the State agency who possess the necessary skills may perform the procedures, as determined by the State. The procedures may be completed every 3-5 years in conjunction with the standard financial examination interval or more frequently, as deemed necessary. They may be applied as part of a full scope examination or on a targeted basis as a stand-alone review.

Communication with HHS

The determination by the State to perform the MLR reporting and rebate examination procedures should be communicated by the State to HHS as soon as possible. Early notification will make HHS aware of the reports they should expect to receive in any given year and thus may assist HHS when scheduling its audits/examinations. If the procedures will be completed in conjunction with a financial or market examination, the determination to conduct the MLR audit/examination procedures and subsequent communication to HHS and the company should be made no later than the time the examination is called. If the procedures will be performed independently of a scheduled State examination, the determination and communication should be made at least 45 days prior to the start of the audit/examination to both HHS and the company.

Please communicate this information to HHS at MLRQuestions@cms.hhs.gov or (301) 492-4457.

The determination by HHS to conduct an MLR audit/examination will also be communicated to the State of domicile for the insurer. Once companies are selected for examination by HHS, each State will be notified of the intent to perform the audit/examination and will be encouraged to coordinate reliance on MLR work performed by the State if applicable.

Completing the MLR Procedures Spreadsheet

Completion of the MLR Procedures Spreadsheet (Exhibit 1) is recommended to facilitate the completion of the public report required under 45 CFR §158.403. Application of the procedures contained in this spreadsheet is designed to allow HHS to place reliance on work performed by the State and reduce potential duplication of effort. If procedures are directed by the MLR Reporting Spreadsheet and shared with HHS upon request, the intention of HHS is to rely on the work performed by the State, without re-performance. In certain instances, primarily when an issue is identified, additional work may be necessary and will be determined on a case by case basis.

The spreadsheet should be made available to HHS upon request as a result of questions, identified issues, or the possibility of penalties assessed by HHS. When HHS requests the supporting work, a State may want to enter into a Non-Disclosure Agreement with HHS that addresses the use and confidentiality, to the extent permitted by law, of any shared workpapers and reports. This agreement should encompass the spreadsheet and referenced workpapers to ensure the confidentiality of detail work. Keeping this information within the spreadsheet and referenced workpapers will provide an easily accessible communication tool and limit the information accessed to procedures performed directly for the MLR report.

Purpose

The *Purpose* column directs the examiner to address each element of 45 CFR Part 158. While there may be reasons that procedures deviate from the template as discussed below, each purpose should be addressed unless it is clearly not applicable due to the circumstances of the insurer. If there are deviations from the listed procedures or if a procedure is not applicable, the description of work performed should include a brief statement explaining the deviation and/or the exclusion of that area.

Possible Compliance Procedures

This section contains the standard procedures for audit/examination of MLR and rebate reporting as developed by HHS in consultation with the NAIC. They are to be used as a base when performing procedures to satisfy the audit/examination requirements in 45 CFR §158.403. No revisions are necessary to this column and a full explanation of the procedures tailored to fit the needs of the insurer being examined should be included in the *Description of Work Performed* column.

Description of Work Performed

This section requires a customized description of the testing performed to satisfy the purpose defined for each applicable row. As the operations of each insurer may differ, modifications based on examiner judgment and knowledge of the insurer's processes may be necessary to appropriately complete this section. When applicable, the level of detail in this column must include sample size, population used for sampling or reviewing documents, titles of reports used, account numbers reviewed, etc. The procedures will typically closely follow the standards defined in the previous column. However, in some cases, an approach that includes control testing or other alternative testing may be appropriate. In such instances, there should be a description of how the control testing met the objective of the procedure that it replaced.

Any related workpapers should be referenced directly on this spreadsheet. This spreadsheet, along with the workpapers referenced, should encompass the complete testing of the medical loss ratio for reporting as defined by 45 CFR §158.403. This will enable the State to clearly define the supporting work utilized to report on the medical loss ratio and provide the work contained therein to HHS, if necessary, to use as a basis for further investigation and/or imposition of penalties.

Summary of Results
The results derived from completion of the specific procedures identified in the previous column, including any findings such as exceptions or deficiencies observed, should be stated in this column. They should be clearly stated to provide HHS with the information necessary to make judgments regarding compliance and future action, if any. The State is not responsible for confirming compliance with the federal regulation.

Reporting Requirements
Once the procedures are completed, the report should be prepared using the sample language provided (Exhibit 2). This language is designed for inclusion in the standard financial examination report, but can easily be adapted for inclusion in a market conduct examination report. To comply with 45 CFR §158.403 this report must be a public document. If the standard (financial) examination report is not a public document per state law, the State should work with HHS to determine if an alternative reporting method is feasible.

Under 45 CFR §158.403, HHS should receive the preliminary or draft exam report from the State within six months of the completion of fieldwork (unless the report has already been finalized and provided to HHS). Once the report is finalized, HHS is required to receive the final report from the State within 30 days.

Alternative Option
At the State's discretion, an alternative reporting method may be used, such as preparing a stand-alone report independent of the standard financial examination report. If this or any other alternative report format is chosen, the State should work directly with HHS to establish a public reporting method acceptable to both parties.

Additional Recommendations for Completion

Utilizing the Work of Others
The examiner must first consider the scope of work performed by a third party (i.e., external audit/examination, internal audit/examination, other State work, etc.) to determine whether, and to what extent, she or he can rely on the work performed. When work performed by a third party is deemed applicable to a given procedure, this work may be utilized within the spreadsheet to support the report provided to HHS. All third party work used for this purpose must be referenced directly to the MLR Reporting Spreadsheet and be available for review if necessary. The examiner must clearly state the purpose and conclusions of the third party testing performed and define the procedures within the MLR Reporting Spreadsheet. No re-testing is required; however, the examiner must perform a review with enough depth to ensure the procedures appropriately address the sub-activity and purpose set forth.

Multi-state Entities

When procedures are performed for entities that write business in multiple states or are part of a holding company system, the state calling the examination should conduct the MLR procedures on the MLR report submitted to HHS. This includes all MLR Form filings (State/Market) associated with the MLR Report to the Secretary. For example, if an issuer provides health insurance coverage in several State/Market combinations other than the domiciliary State, the audit/examination should include all the States/Markets for the purposes of reporting on "an issuer's MLR reporting and rebate obligations." If the State chooses to apply procedures only to the business in the domiciliary state, HHS will work with the State to rely on the procedures performed, but may perform additional testing to fulfill the federal audit requirements. Examination of the allocation of holding group expenses is also a necessary part of an examination in order to be accepted under 45 CFR Part 158. The State should make an effort to coordinate with other states whenever possible and notify them that the MLR procedures will be part of the examination.

Recommendations for Specific Procedure Steps (as numbered on the Procedures Spreadsheet)
The following suggestions have been offered up by various State regulators in an effort to share knowledge of the review process. The following suggestions should not be considered required in any way, but instead, a helpful tool if deemed appropriate for the circumstances of a specific insurer.

Item No. 2: Include a detailed description of the procedure specific to the insurer, such as general ledger accounts reviewed, and the sample size that was deemed appropriate. To determine procedures and samples, the following is recommended:

1) Request the data by MLR segment (individual, small group, large group);

2) Base the sample of policies on the total premiums/claims reported per MLR segment; and

3) Ensure proper fields are included in your data request, such as number of employees, to verify small group/large group. Typically, an insurer defines large and small group by the number of subscribers enrolled rather than the total number of employees. In this situation, a reclassification or re-segmentation adjustment entry may have been made to comply with the federal definition of group size. This journal entry may provide the starting point to test the accuracy of the data aggregation.

Item Nos. 20 and 22: When requesting data, consider requesting a report with the following minimum fields: policy number, subscriber or group number, line-of-business, premium, rebate amount, date paid, check number, etc.

Exhibit 1: MLR Examination Procedures Spreadsheet

Procedure Number	Regulation 45 CFR Part 158	Purpose	Proposed Compliance Procedures[1]	Description of Work Performed	Summary of Results
1	§158.110	Test accuracy of reporting and reconcile with the Supplemental Health Care Exhibit	1) Verify that the issuer completed the federal MLR Annual Reporting Form for every state for which they submitted the Supplemental Health Care Exhibit (SHCE) and that the MLR Annual Reporting Form was submitted in a timely manner. 2) Verify that the amounts reported on the MLR Annual Reporting Form are consistent with the amounts reported on the SHCE. Check for significant variances between the SHCE and the MLR Annual Reporting Form.		
2	§158.103 §158.110 §158.120 §158.130 §158.220	Test accuracy of state and market classifications	Reconcile summary-level policy dataset with the written premium reported on Part 2, Line 1.1 of the corresponding MLR Annual Reporting Forms. Ensure reconciling items are properly recorded as adjustments to written premium, in accordance with the requirements of §158.130 and the MLR Annual Reporting Form Filing Instructions. 1) Select a representative sample of policies from each commercial, state and market segment that is subject to the MLR requirements. Use the following minimums as a guideline for the number of policies to randomly select in each state and market (additional samples may be added based on the examiner's judgment): 2) Individual market: 25 samples 3) Small Group market: 25 samples 4) Large Group market: 25 samples 5) Student Health Plans: 8 samples If a block of business has fewer than 1,000 life-years or enrollees, the sample size can be reduced to 6-8 policies, or 25% of the total, whichever is less. Review each contract's/policy's supporting documents and general ledger accounts to verify that: a. Policies were assigned to the correct state, i.e., by situs.		

[1]These AUPs are intended to be used in conjunction with 45 CFR Part 158, the federal MLR regulation, which can be accessed here: http://www.ecfr.gov/, and the MLR Annual Reporting Form Instructions. Users should have either an electronic or printed version of each document. E-CFR contains the most current version of the MLR regulation; make sure to review any notes at the end of each regulation section that indicates the date(s) that any changes were effective. The MLR Annual Reporting Form Instructions are updated and re-posted annually. Please ensure you are referring to the Instructions that are from the year that is the same as the MLR Reporting Year being audited.

Exhibit 1: MLR Examination Procedures Spreadsheet

Procedure Number	Regulation 45 CFR Part 158	Purpose	Proposed Compliance Procedures[1]	Description of Work Performed	Summary of Results
			b. Policies were assigned to the correct line of business. Verify that: i. Business subject to 45 CFR Part 158, the commercial MLR rule, including grandfathered and/or transitional plans,[2] was reported in the Health Insurance Coverage columns. ii. Business not subject to 45 CFR Part 158, the commercial MLR rule, such as government programs/plans (i.e., Medicare Parts A and B, Medicaid, CHIP, Tricare), other health business (e.g., Medicare Supplemental, stand-alone vision and dental, disability income, specified disease coverage, and fixed indemnity), Medicare Advantage, and self-funded/uninsured plans, is <u>not</u> reported in the Health Insurance Coverage columns. iii. Policies with annual limits < $250,000 were reported separately as "mini-med" policies. iv. Policies in the student market were reported separately from other policies and are aggregated nationally. v. Premium dollars are supported by billing invoices and subsequent payment information. vi. Individual market business sold through an association or trust is reported in the state where the certificate of coverage was issued. vii. Employer business issued through a group trust or multiple employer welfare association (MEWA) was reported in the state where the employer (if sold through a trust) or the MEWA (if the MEWA is the policyholder) has its principal place of business. 6) Evaluate the methodology/definition the issuer used to determine group size on both the SHCE and the MLR Annual Reporting Form and note if they are different. Federal law requires the use of "the average total number of employees on the business days of the calendar year preceding the coverage effective date" (ATNE) for determining group size, including all full-time, part-time, and seasonal employees. However, beginning with the 2017		

[2] See CMS Nov. 14, 2013 Letter to State Insurance Commissioners, available at https://www.cms.gov/CCIIO/Resources/Letters/Downloads/commissioner-letter-11-14-2013.pdf, and subsequent CMS Bulletins extending the transitional policy, the latest of which is available at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Limited-Non-Enforcement-Policy-Extension-Through-CY2020.pdf.

Exhibit 1: MLR Examination Procedures Spreadsheet

Procedure Number	Regulation 45 CFR Part 158	Purpose	Proposed Compliance Procedures[1]	Description of Work Performed	Summary of Results
			reporting year, issuers may elect to use the applicable State counting method for counting the number of employees, unless the State method does not take into account non-full-time employees. In that circumstance, the issuer would be required to utilize the full-time equivalent method described in section 4980H(c)(2) of the Internal Revenue Code, or the federal method described above.[3] If the insurer utilizes a different definition than the above, determine if it was correct and if not, whether/how it impacted determining group size and market classification. 7) Verify that policies are assigned to the correct market classification (individual, small group, large group). For the group markets, verify that: a. Group size is based on the ATNE and not the number of subscribers (i.e., all active employees counted even if they were not enrolled in the plan)[4], unless the state counting method, as noted above, is an acceptable method. b. Employers with ≥50 (or other number, if applicable[5]) ATNE were assigned to the large group market).		
3	§158.120(c)	Test accuracy of reporting under the dual contracts option	1) If an issuer opted to report an affiliated issuer's out-of-network issuer's experience with the in-network issuer's experience under the dual contract option, verify that: a. The in-network issuer reported all components of the out-of-network experience, including premiums, taxes and fees, claims, quality improving expenses, and non-claims costs. b. The option was or will be consistently applied for at least three consecutive reporting years. c. The issuer reported the name of the affiliated out-of-network issuer on Part 5, Additional Responses.		

[3] See CCIIO's April 9, 2018 bulletin at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/MLR-Guidance-Employee-Counting-Method-2018.pdf.
[4] See CCIIO's April 20, 2012 Guidance, Q&A #28, addressing employers with employees in multiple states and/or multiple policies, and which can be found at https://www.cms.gov/CCIIO/Resources/Files/Downloads/dwnlds/mlr-qna-04202012.pdf.
[5] States may substitute "100" employees for "50" employees to differentiate the small and large group markets, provided they do so for all purposes and not just for MLR reporting. As of 2023, the states of CA, CO, NY and VT have chosen to utilize 100 as the upper limit for the small group market.

Exhibit 1: MLR Examination Procedures Spreadsheet

Procedure Number	Regulation 45 CFR Part 158	Purpose	Proposed Compliance Procedures[1]	Description of Work Performed	Summary of Results
			d. Corresponding adjustments were made to the MLR Annual Reporting Form for the out-of-network issuer. *This will require obtaining documentation from the out-of-network issuer, including, but not limited to, the corresponding MLR Annual Reporting Form.* *[Dual Contracts=Pts 1 and 2 Dual Contract column; Pt 5 Ln 3]*		
4	§158.121	Test accuracy of reporting for new business	1) If an issuer opted to defer reporting and exclude new business from its MLR calculation, verify that: a. 50% or more of the total earned premiums for the MLR reporting year is attributable to policies newly issued and with 12 or fewer months of experience in that MLR reporting year. b. The issuer excluded all components of the new business, including premiums, taxes and fees, claims, quality improving expenses, and non-claims costs. c. The issuer excluded all new business and did not exclude any renewing business. d. If the issuer has renewing business, verify the reasonableness and accuracy of the allocation of all components of business, including premiums, risk adjustment, taxes and fees, claims, quality improving expenses, and non-claims costs, between deferred and non-deferred business, if applicable. *[Deferred Business CY=Pts 1 and 2 Deferred CY (subtract) column]* 2) Obtain the issuer's prior year MLR Annual Reporting Form. If newly written business was excluded in the prior year, verify that: a. The prior year's deferred business was added back to the subsequent year's MLR Annual Reporting Form in the same state and market. b. The criteria for deferral were met in the prior year. *[Deferred Business PY=Pts 1 and 2 Deferred PY1 (Add) column]*		
5	§158.130	Test accuracy of reporting of earned premiums	See Procedure #2 for detailed instructions for premium testing to perform at the policyholder level. 1) Verify that:		

Exhibit 1: MLR Examination Procedures Spreadsheet

Procedure Number	Regulation 45 CFR Part 158	Purpose	Proposed Compliance Procedures[1]	Description of Work Performed	Summary of Results
			a. All non-premium revenue, such as agent and broker fees and commissions, have been included in premium and reported as a non-claims cost. Determine whether any adjustments to premium revenue have been made as a result of this treatment and whether or not there is any resulting impact on the MLR calculation. If agent/broker fees/commissions have not been reported, confirm use of, and payment to, the agent/broker were not a condition of purchasing the policy.[6] b. Earned premiums were reported on a direct basis. c. Earned premiums were adjusted to account for high-risk pool assessments or subsidies, group conversion charges, and unearned premium. d. Experience rating refunds are reflected in claims rather than premiums. e. Written and unearned premium includes advance payments of the premium tax credit (APTC). f. Written and unearned premium does not reflect the impact of the Federal Risk Adjustment program. g. Earned premium on Pt 1 Ln 1.1 and Pt 3 Ln 2.1 is calculated correctly and according to the formulas in the MLR Annual Reporting Form Instructions for the applicable year. 2) Obtain the MLR Annual Reporting Forms for the previous two years and verify that the following amounts are accurate and properly reported in the prior year columns on Part 3 of the current year filing, in accordance with the corresponding MLR Annual Reporting Form Filing Instructions: a. Pt 3 Ln 2.1, Col PY2 *[and the corresponding Pt 3 Ln 2.1, Col CY amount on the MLR Annual Reporting Form from two years prior].* b. Pt 3 Ln 2.1, Col PY1 *[and the corresponding Pt 3 Ln 2.1, Col CY amount on the MLR Annual Reporting Form from one year prior].*		

[6] See CCIIO's May 27, 2015 Guidance, Q&A #64, addressing such fees/commissions, at: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/MLR-Guidance-Earned-Premium-and-APTC-Rebates-20150527.pdf.

Exhibit 1: MLR Examination Procedures Spreadsheet

Procedure Number	Regulation 45 CFR Part 158	Purpose	Proposed Compliance Procedures[1]	Description of Work Performed	Summary of Results
			Follow up with the Company for any amounts in the PY2 and PY1 column that do not match the premium amount from the initial corresponding filing by a material amount. *[Premiums=Pts 1 and 2, Sec 1; Pt 3 Sec 2]*		
6	§158.130	Test accuracy of reporting of reinsurance	Determine if an issuer purchased or sold a block of business during the MLR Reporting Year, either pursuant to a 100% assumption reinsurance agreement (with a novation), or pursuant to a 100% indemnity reinsurance agreement (with an administrative services agreement) that was in effect prior to March 23, 2010. 1) If the reinsurance arrangement meets the exact criteria of one of these two types, the acquiring issuer is responsible for reporting the cedant's MLR experience for the entire Reporting Year. Verify that the experience under the agreement was reported by the assuming issuer as direct business and was not reported by the ceding issuer. 2) Verify that the issuer properly included/excluded premium, incurred claims, and unpaid claim reserve amounts for that business on the MLR Form, in accordance with 45 CFR 158.130(a)(2) & (3), and the MLR Annual Reporting Form Filing Instructions, including for the portion of the MLR reporting year that preceded the purchase/sale. If the reinsurance arrangement does not meet the exact criteria specified above, the experience under that reinsurance arrangement must be reported on a direct basis by the ceding issuer and not by the assuming issuer, as required by the MLR Annual Reporting Form Filing Instructions.		
7	§158.140 §158.160	Test accuracy of reporting of claims	1) Reconcile claim-level dataset for the current year with the paid claims reported on Part 2, Line 2.1b of the corresponding MLR Annual Reporting Form. Ensure reconciling items are properly recorded as adjustments to paid claims, as required by §158.140 and the MLR Annual Reporting Form Filing Instructions. 2) Select a representative sample of claims from each market segment, company-wide, that is subject to the MLR reporting and rebate requirements and verify that: a. The incurred date is between January 1st and December 31st of the reporting year for which the claim was reported on the MLR Annual		

Exhibit 1: MLR Examination Procedures Spreadsheet

Procedure Number	Regulation 45 CFR Part 158	Purpose	Proposed Compliance Procedures[1]	Description of Work Performed	Summary of Results
			Reporting Form. Review supporting documents, such as the Explanation of Benefits (EOB), to verify the accuracy of the incurred date. b. The claim was paid between January 1st of the MLR reporting year and March 31st of the year following the MLR reporting year, in the year of which the claim was reported on the MLR Annual Reporting Form. c. The claim was reported in the correct state, based on the situs of the policy. d. The amount paid is the amount reflected as the issuer's responsibility on the EOB, or the provider's remittance documents and payment support, and doesn't include inappropriate amounts, such as payment of administrative fees to claims re-pricers, late payment interest, unpaid provider withholds, etc. e. The amount paid on the claim is reported on the MLR Annual Reporting Form in the correct market and is consistent with the market in which the policy pursuant to which it was processed was issued. 3) Select a sample of the issuer's capitation payments and compare them to the capitation agreement with each provider. Verify that the issuer did not include amounts for issuer functions that it outsourced to the provider, such as network development or claims processing. 4) Select a sample of the issuer's third-party vendor (TPV) payment records (such as payments to PBMs, behavioral health companies, claims re-pricers/secondary networks, and laboratory networks). Compare issuer payments with the TPV's provider reimbursement records to verify that the vendor's administrative costs were not reported in incurred claims on the MLR Annual Reporting Form. Ask the issuer if the TPV provided them with a breakdown as to the amount the TPV paid to clinicians of the total amount the TPV was paid by the issuer. If not, or if claim-by-claim amounts were not provided by the TPV to the issuer, ask the issuer how it determined and removed from incurred claims the spread/margin paid in excess of the amounts paid to the clinicians for each market and state. 5) Review the relationships between claims liabilities, claims reserves, and claims payments, for indications that that claims liabilities and reserves are not consistently misstated.		

Exhibit 1: MLR Examination Procedures Spreadsheet

Procedure Number	Regulation 45 CFR Part 158	Purpose	Proposed Compliance Procedures[1]	Description of Work Performed	Summary of Results
			a. Review PY2 and PY1 claims run-out (Part 3, Line 1.1 vs. 1.2) to determine if incurred claims reflect significant subsequent year development, positive or negative, which may indicate that the reported claims liabilities or reserves for prior years were excessively high or low. b. Instances of zero development between Line 1.1 and 1.2, in either the PY2 or PY1 column, should be deemed a violation of the MLR Annual Reporting Form Filing Instructions and be investigated. The expectation is that Line 1.2 should always be different than Line 1.1 in each respective prior year column, reflecting additional claims payments and other adjustments to claims liabilities that occurred subsequent to the applicable year of the year the MLR Annual Reporting Form was initially filed. c. If prior year incurred claims have increased after the initial filing for either prior year, verify that payments made subsequent to the initial filing in fact exceeded the initial liabilities and reserves recorded in the initial filing for each prior incurred year on the three-year aggregation of the MLR Annual Reporting Form being examined. In addition, verify that that claims liabilities for each prior year have been appropriately reduced and do not include overly conservative margins for adverse deviation. d. If prior year incurred claims have decreased significantly after the initial filings for either prior year, investigate whether the company may have included consistently overestimated estimates for IBNR, etc., in the initial filings. Significant reductions of prior year incurred claims often indicates that a company may have included overly conservative margins for adverse deviation in its calculation of incurred claims, which the MLR Annual Reporting Form Filing Instructions prohibit. A company's restatement of overly conservative margins in claims liabilities, after additional run-off periods, can lead to significant decreases in the development of incurred claims. 6) Verify that: a. Direct claims do not include non-claims cost, such as amounts paid to third-party vendors for administration or secondary network savings,		

Exhibit 1: MLR Examination Procedures Spreadsheet

Procedure Number	Regulation 45 CFR Part 158	Purpose	Proposed Compliance Procedures[1]	Description of Work Performed	Summary of Results
			network development, late claims interest payments, administrative fees, claims processing, etc. or that claims do include amounts paid to a provider for compensation or reimbursement for any items other than covered services provided to an enrollee. b. Experience rating refunds and related reserves do not include federal and state MLR rebates and premium stabilization reserves. c. Pharmacy rebates, volume discounts, bonuses, coupons or any other price concessions and incentives/remunerations received from manufacturers or other parties were properly deducted from incurred claims and were distributed to legal entities, states, and markets based on actual utilization of prescription drugs, or allocated in a manner consistent with 45 CFR 158.170 (i.e., allocated based on a method that yields the most accurate result). d. For 2022 and later MLR Annual Reporting Forms, verify that prescription drug rebates and other price concessions that were received or are receivable and/or retained by an entity providing PBM services to the issuer, and are associated with administering the issuer's prescription drug benefits, are deducted from incurred claims. (Effective with the 2022 MLR Reporting Year, issuers must deduct from claims prescription drug rebates and other similar amounts, even if they are retained by the PBM and are not actually paid to the issuer.) e. The issuer did not include in its incurred claims the amounts paid by a third-party vendor that exceeds the reimbursement to the provider (including, but not limited to, PBM payments to the retail pharmacy). f. Paid medical incentive pools and bonuses, as well as the accrued amounts for the MLR reporting year, were properly reported on Part 2, Lines 2.11a and 2.11b, respectively, and were properly included in the calculation of total incurred claims on Part 2, Line 2.17 in accordance with the MLR Annual Reporting Form Filing Instructions. Beginning with the 2022 MLR reporting year, verify the amount of incentive and bonus payments made to providers are tied to clearly defined, objectively measurable, and well-documented clinical or quality		

Exhibit 1: MLR Examination Procedures Spreadsheet

Procedure Number	Regulation 45 CFR Part 158	Purpose	Proposed Compliance Procedures[1]	Description of Work Performed	Summary of Results
			improvement standards that apply to providers, as required by 45 CFR §158.140. g. The claims-related portion of contingent benefit and lawsuit reserves was reported separately on Part 2 Line 2.13, and was not included in Part 2 Lines 2.2 or 2.4. h. Changes in contract reserves were properly reported and calculated in accordance with MLR Annual Reporting Form Filing Instructions. Determine if inclusion of contract reserves may have had an impact on MLR rebates. i. If the company reported an amount for Blended Rate Adjustment on Part 2, Line 2.15, obtain supporting documentation and review for reasonableness and compliance with 158.140(b)(5)(i), as well as with the MLR Annual Reporting Form Filing Instructions. 7) Access the issuer's MLR Reporting Form for the current year and previous two years and verify that the amounts on Part 3, Line 1.1 in the PY2 and PY1 columns are accurate and calculated in accordance with the required formulas per the MLR Annual Reporting Form Filing Instructions. 8) Verify that the amounts reported on Part 3, Line 1.2, for the PY2, PY1, CY and Total columns are accurate and calculated in accordance with the required formulas and the MLR Annual Reporting Form Filing Instructions. 9) Verify that Part 1, Line 2.1 is equal to the figure on Part 2, Line 2.17, and that Part 2, Line 2.17 was calculated correctly and according to the formula in the MLR Annual Reporting Form Filing Instructions for the applicable year. 10) Verify that the company is properly reporting claims payment recoveries collected from providers or others as a reduction to incurred claims, in an accurate and timely manner. 11) If the issuer wrote business in a state that had a state reinsurance program, as listed in the MLR Annual Reporting Form Filing Instructions, verify the expected receipts were accurately reported on Part 2, Line 2.16. *[Claims =Pts 1 and 2, Sec 2; Pt 3 Sec1]*		

Exhibit 1: MLR Examination Procedures Spreadsheet

Procedure Number	Regulation 45 CFR Part 158	Purpose	Proposed Compliance Procedures[1]	Description of Work Performed	Summary of Results
8	§158.150 §158.151	Test classification of activities that improve health care quality	Verify that: a. QIA expenses reported on the MLR Annual Reporting Form conform to the definition of QIA at 45 CFR §158.150-151, including, but not limited to, expenditures that are directly related to activities that improve health care quality, and do not include indirect expenses or corporate overhead not related to the specific activities that qualify as QIA. b. The expenses reported in Part 1 of the MLR Annual Reporting Form are consistent with the activities described and allocation method(s) reported in Part 6 of the MLR Annual Reporting Form. c. The QIA expenses are supported with adequate documentation, including job descriptions and time studies to support salary expenses, and otherwise provide quantifiable support for the percentage of such costs reported as qualifying QIA. d. Verify the reasonableness and accuracy of the allocation of QIA expenses among states, lines of business and markets, and among affiliated issuers within a holding company. Analysis should include states and markets where the issuer has (or had) business that is not subject to the commercial MLR rule (i.e., government program plans, other health business, Medicare plans, and self- funded/uninsured plans). *[QIA expenses=Pt 1 Sec 4; Pt 3 Ln 1.3; Pt 6 Sec 3]*		
9	§158.161 §158.162	Test accuracy of reporting of taxes and regulatory fees	Obtain documentation for assessments, fees, and taxes (including inter-company tax allocation agreements) and verify that: 1) Taxes and fees were accurate and reported in accordance with 45 CFR Part 158 of the MLR regulation and the MLR Annual Reporting Form Instructions. a. For federal and state income taxes, obtain the corresponding tax provision supporting schedules and compare it to the amounts reported in the annual statement for the corresponding year; verify inclusion of only tax amounts attributed to the applicable MLR reporting year (i.e., excluding impacts related to prior period tax adjustments, deferred taxes, and other adjustments related to prior or future taxable years or deductible amounts, etc.). Ensure income tax amounts are calculated		

Exhibit 1: MLR Examination Procedures Spreadsheet

Procedure Number	Regulation 45 CFR Part 158	Purpose	Proposed Compliance Procedures[1]	Description of Work Performed	Summary of Results
			based on either the applicable corporate tax rate, or the effective tax rate specific to the company. b. Confirm that employment taxes (e.g., FICA, FUTA, SUTA, etc.) were not deducted from premium. c. Verify that the Company's contributions to state-based reinsurance programs, if any, are properly reported on Part 1, Line 3.2a, and in accordance with the applicable MLR Annual Reporting Form Filing Instructions. d. Beginning with the 2021 MLR reporting year, confirm that the ACA section 9010 fees, which were repealed, were not included in taxes and correspondingly, deducted from premium. e. Confirm that issuers reporting community benefit expenditures (CBE), as defined in 45 CFR 158.162(c), report only amounts permitted for their federal income tax (FIT)-exempt status, in accordance with the MLR Annual Reporting Form Filing Instructions; as well as reported their FIT-exempt status correctly on the Company Information tab of the MLR Annual Reporting Form, and the relevant premium tax rate in the state on Part 5, Line 1, if any. f. Ensure that none of the following were included in the taxes and fees that were deducted from premium: taxes on investment income and capital gains; fines and penalties; and federal and state employment taxes (e.g., FICA, FUTA, SUTA, etc.). 2) Taxes and fees reported in Part 1 of the MLR Annual Reporting Form are consistent with the taxes and fees described in Part 6 of the MLR Annual Reporting Form. 3) Obtain the MLR Annual Reporting Forms for the previous two years and verify that the amounts reported in the PY2, PY1, CY, and Total columns on Part 3, Line 2.2 are accurately calculated and in accordance with the MLR Annual Reporting Form Filing Instructions for Part 3, Line 2.2. *[Taxes and regulatory fees=Pt 1 Sec 3; Pt 3 Ln 2.2; Pt 6 Sec 2]*		
10	§158.170 §153.520	Test reasonableness	1) Verify the reasonableness and accuracy of the allocation of taxes and expenses among states, lines of business and markets, and among affiliated		

Exhibit 1: MLR Examination Procedures Spreadsheet

Procedure Number	Regulation 45 CFR Part 158	Purpose	Proposed Compliance Procedures[1]	Description of Work Performed	Summary of Results
		and accuracy of expense allocations	issuers within a holding company in a manner that yields the most accurate results, as required by §158.170. For example, the most appropriate allocation method for premium taxes would likely be based on the pro-rata proportion of earned premium attributable to each state/market. In addition to the commercial markets, allocations should include states and markets where the issuer has business that is not subject to the commercial MLR rule (i.e., government program plans, other health business, Medicare plans, and self-funded/self-insured plans). 2) For federal and state income taxes, ensure amounts are properly allocated among states and markets based on the pre-tax underwriting gain/(loss), which should reflect all relevant revenue and expenses for each state and market, including cost-sharing reduction amounts, premium stabilization program amounts, and administrative expenses, in accordance with the MLR Annual Reporting Form Filing Instructions. If the issuer is party to a tax-sharing agreement, ensure that the allocation amount for any state/market segment with an underwriting loss is recorded as a negative income tax (tax benefit) on Part 1, Lines 3.1a or 3,2a of the MLR, as applicable. 3) Verify that allocations of fraud reduction expenses (if applicable) are based on an allocation method that yields the most accurate results and that the total amount of the allowable fraud reduction expense reported in the MLR Annual Reporting Form does not exceed total recoveries. 4) Verify that the issuer's allocation methods are consistent with the narratives provided in Part 6 of the MLR Annual Reporting Form. *[Expense allocation=Pt 6]*		
11	§158.210 §158.211	Test accuracy of the MLR standard	1) Verify that the issuer used the correct MLR standard for every state and market. The MLR standard should be one of the following: a. 80% in the individual and small group markets, and 85% in the large group market; b. A higher standard as prescribed by state law[7]; or		

[7] Massachusetts has a higher state MLR standard of 88% in the individual and small group markets. New York has a higher state MLR standard of 82% in the individual and small group markets. New Mexico had a higher state MLR standard of 85% in the small group market in 2019 and prior. Beginning with the 2020 MLR Reporting year, the New Mexico MLR standard was revised to equal the same as the Federal standard for the small group market (80%).

Exhibit 1: MLR Examination Procedures Spreadsheet

Procedure Number	Regulation 45 CFR Part 158	Purpose	Proposed Compliance Procedures[1]	Description of Work Performed	Summary of Results
			c. The adjusted state standard in the individual market approved by the Secretary under 45 CFR 158 Subpart C. (As of January 2024, no such state adjustments are in effect.) *[MLR standard=Pt 3 Ln 5.1]*		
12	§158.210 §158.211 §158.220	Test aggregation of data in the MLR numerator	1) Verify that the MLR numerator is calculated correctly according to the formula in the MLR Annual Reporting Form Filing Instructions for the applicable year; and that the Total column for the MLR numerator is the sum of the PY2, PY1, and CY columns, except that: a. In states that require the individual and small group markets to be merged for MLR purposes (e.g., MA, DC, and VT), verify that the numerator for both the individual and small group markets is the sum of the individual and small group amounts.[8] *[MLR numerator=Pt 3 Lines 1.8 and 1.9]*		
13	§158.220	Test aggregation of data in the MLR denominator	1) Verify that the MLR denominator is calculated correctly and according to the formula in the MLR Reporting Form Filing Instructions for the applicable year, and that the Total column for the MLR denominator is the sum of the PY2, PY1, and CY columns, except that: a. In states that require issuers to merge the individual and small group markets for MLR purposes, verify that the denominator for the individual and small group markets is the sum of the individual and small group market amounts. *[MLR denominator=Pt 3 Ln 2.3]*		
14	§158.221	Test accuracy of the MLR calculation	1) Verify that: a. The preliminary MLR reported on the issuer's MLR Annual Reporting Form is accurate and unrounded. *[Preliminary MLR=Part 3 Line 4.1]* b. The credibility-adjusted MLR is accurate and rounded to three decimal places. *[Credibility-adjusted MLR=Part 3 Lines 4.3 and 5.2, Total column]*		

[8] Massachusetts and, beginning with the 2014 MLR Reporting Year, the District of Columbia and Vermont, require that issuers merge experience of the individual and small group markets for the purposes of calculating the MLR. Beginning with the 2022 MLR Reporting Year, Vermont no longer merges the individual and small group experience.

Exhibit 1: MLR Examination Procedures Spreadsheet

Procedure Number	Regulation 45 CFR Part 158	Purpose	Proposed Compliance Procedures[1]	Description of Work Performed	Summary of Results
			If adjustments are necessary due to incorrectly recorded amounts for any element of the MLR, recalculate the federal MLR based on the accurate numbers obtained during the examination, using the MLR Calculator for the applicable year from the CMS website.		
15	§158.230(b)	Test accuracy of life-years	1) Access the population of policy/contract records used to support the MLR Annual Reporting Form and verify that the months of coverage were accurately reported for each state and market. This may require the use of ACL. *[Member months=Part 1 Line 7.4]* 2) Calculate the number of life-years by dividing the number of member months by 12. Verify the accuracy of the life-years reported for each state and market. *[Number of life years=Part 1 Line 7.5]* *If exceptions were noted for the number of member months, recalculate life-years based on the accurate numbers obtained during the examination.*		
16	§158.231	Test aggregation of life-years	1) Verify that the Total column for the life-years in Part 3 is the sum of the PY2, PY1, and CY columns, except that: a. In states that require issuers to merge the individual and small group markets for MLR purposes, verify that the life-years for the individual and small group markets is the sum of the individual and small group market amounts. *[Life-years=Pt 3 Ln 3.1]*		
17	§158.230 §158.231 §158.232(b)	Test accuracy of the base credibility factor	Verify that the issuer used the correct three-year aggregate number of life-years to calculate the base credibility factor. 1) If the three-year aggregate life-years are ≥ 1,000 and < 75,000, use the MLR Calculator for the applicable year on the CMS website or similar tool for linear interpolation to verify that the base credibility factor is accurate and unrounded. 2) If the three-year aggregate life-years are < 1,000 or ≥ 75,000, verify that the reported base credibility factor is 0. *[Base credibility factor=Part 3 Line 3.2]*		

Exhibit 1: MLR Examination Procedures Spreadsheet

Procedure Number	Regulation 45 CFR Part 158	Purpose	Proposed Compliance Procedures[1]	Description of Work Performed	Summary of Results
			If exceptions were noted in the issuer's aggregate number of life-years, recalculate the base credibility factor using the accurate numbers obtained during examination.		
18	§158.232 (c)	Test accuracy of the deductible factor	1) Select a sample of states and markets with a base credibility factor > 0 and a deductible factor > 1.0. Obtain and review calculation support from the company for the current and two previous MLR reporting years to ensure the proper calculation of the average health plan deductible in accordance with §158.232(c) and the MLR Annual Reporting Form Filing Instructions.[9] 2) Verify that the average deductible calculated matches the amount reported on the issuer's MLR Annual Reporting Form. *[Average Deductible =Part 3 Line 3.3]* 3) Use the MLR Calculator for the applicable year (which is on CMS' website at https://www.cms.gov/marketplace/resources/forms-reports-other#Medical_Loss_Ratio), or similar tool for linear interpolation, to verify that the deductible factor is accurate and unrounded. *[Deductible factor=Part 3 Line 3.4]* 4) If exceptions were noted in the issuer's average deductible, recalculate the deductible factor using the correct numbers determined during the examination.		
19	§158.232(a) and (d)	Test accuracy of the credibility adjustment	1) Multiply the base credibility factor by the deductible factor, and verify that the credibility adjustment reported on the MLR Form is accurate and unrounded. [Credibility Adjustment=Part 3 Line 3.5]. 2) If exceptions were noted in the issuer's base credibility factor or deductible factor, recalculate the credibility adjustment using the correct numbers determined during the examination. 3) Verify that the credibility factor is 0 when, after applying all examination adjustments, both of the following conditions are met:		

[9] To calculate the average deductible:1) multiply the per-person deductible(s) by the applicable number of life-years; 2) divide the aggregate by the total number of life-years in the state and market for all of the issuer's policies that have the same per-person deductible level. The per-person deductible for a family policy is the lesser of: the individual deductible, or one-half of the family deductible. If the issuer has products with different deductibles, use the same process to calculate the average deductible across all deductible levels, weighted by life-years, for each year in the three-year aggregation.

Exhibit 1: MLR Examination Procedures Spreadsheet

Procedure Number	Regulation 45 CFR Part 158	Purpose	Proposed Compliance Procedures[1]	Description of Work Performed	Summary of Results
			a. The current MLR reporting year, and each of the two previous MLR reporting years, included experience of at least 1,000 life-years; and b. Without applying any credibility adjustment, the issuer's preliminary MLR for the current MLR reporting year, and each of the two previous MLR reporting years (*after applying adjustments to correct all reporting errors found during the examination*), were below the applicable MLR standard for each year, as required by §158.210.		
20	§158.240 §158.241 §158.242	Test accuracy of rebate payments	1) Verify that the issuer paid rebates in every state/market in which a rebate was owed. 2) Select a sample of rebate payments and verify that: a. The total rebate amount for the state/market is correct. *[Total rebate amount=Part 3 Lines (5.1 - 5.2) x 5.3]* b. Beginning in the 2016 MLR reporting year, some issuers have the option to limit the total rebate payable for each year in the aggregation, as stated in 158.240(d). The option generally benefits new or rapidly growing issuers whose MLRs initially fall below the standard but increase over time. If the issuer chose this option (which would result in a lower rebate amount reported in the Total column of Line 5.8 than the rebates calculated, including the three-year aggregation in the Total column of Line 5.4), ensure that the rebate payment for each specific year reported on Line 5.8 was calculated correctly and in accordance with the MLR Annual Reporting Form Filing Instructions. This includes, but is not limited to, ensuring that the rebate liability for each specific year was reduced by any rebate payments paid for, or applied against, the prior MLR reporting year(s). c. The amount of the rebate paid to the subscriber/policyholder is equal to the difference between the issuer's total rebate amount in the state/market, multiplied by the ratio of subscriber/policyholder's premium to issuer's total premium in the state/market. d. For rebates distributed via premium credit, the rebate was fully applied before any new payment was made by the enrollee. *[Premium credit=Part 4 Line 3.c]*		

Exhibit 1: MLR Examination Procedures Spreadsheet

Procedure Number	Regulation 45 CFR Part 158	Purpose	Proposed Compliance Procedures[1]	Description of Work Performed	Summary of Results
			3) Verify that payment was made on or before September 30 of the year after the MLR reporting year. For rebate payments disbursed after September 30 (except rebates distributed by premium credit), verify that the payment included interest at the Federal Reserve Board lending rate at the time, or 10% annually, whichever is higher. For rebates distributed by premium credit, the credit must be applied in the first month's premium that is due on or after September 30. *If exceptions were noted in the issuer's MLR numerator, denominator, or MLR standard, recalculate the rebate amount using the corrected/accurate numbers determined during examination.*		
21	§158.243	Test accuracy of the distribution of *de minimis* rebates	1) If an issuer did not provide rebates to subscribers/ policyholders whose rebate were *de minimis*, verify that the issuer accurately classified *de minimis* rebates as rebate payments that were <$5 in the individual market, and <$20 in the small and large group markets. 2) Select a sample of the issuer's non-*de minimis* rebate payments and verify that they include a pro-rata portion of the aggregated *de minimis* rebates. *[De minimis rebates=Part 4 Line 3.b]*		
22	§158.240 §158.241 §158.244 §158.250	Test compliance with rebate disbursement requirements	Select a sample of all subscribers/policyholders to whom a rebate was due and verify that: 1) The rebate was paid. 2) The rebate notice was issued in the prescribed form and contained all required disclosures to the policyholder (and also to the subscribers in the group markets) in accordance with §158.250. (Note that CMS updated the Rebate Notice templates in 2023 and issuers should have begun using them beginning with the 2023 MLR Reporting Year. The notices are located here: https://www.cms.gov/marketplace/resources/forms-reports-other#Medical_Loss_Ratio.) 3) The issuer made all reasonable efforts to: locate subscribers/policyholders whose rebates were unclaimed; track the amount of unclaimed rebates for subscribers/policyholders that could not be located; and, escheat unclaimed rebates in accordance with state law. *[Rebate Disbursement=Part 4]*		

Exhibit 1: MLR Examination Procedures Spreadsheet

Procedure Number	Regulation 45 CFR Part 158	Purpose	Proposed Compliance Procedures[1]	Description of Work Performed	Summary of Results
23	§158.130 §158.140	Verify accuracy of risk adjustment payments / (charges)	1) Verify the accuracy of Risk Adjustment payments / (charges) reported on the MLR Annual Reporting Form: a. Verify that amounts reported on MLR Annual Reporting Form, Part 2 Line 1.10 include all required components of the Risk Adjustment program, as required by the MLR Annual Reporting Form Filing Instructions, including: i. Expected net payments from HHS, or charges paid or due to HHS (also known as Risk Adjustment transfer amounts) according to the CMS Summary Report on Permanent Risk Adjustment Transfers; ii. Risk Adjustment default charges, or default charge allocations; iii. High-cost risk pool payment or charges, if any; and, iv. HHS-Risk Adjustment Data Validation (HHS-RADV) adjustments, and default data validation charges and allocations.[10] b. Verify that Risk Adjustment payments / (charges) were reported on both Part 2 Line 1.10, and Part 3 Line 1.6.		

[10] Examiner should ensure that adjustments for HHS-RADV are properly reported in the year stated in the MLR Annual Reporting Form Filing Instructions. For example, HHS-RADV adjustments for the 2018, 2019, 2020, and 2021 benefit years are required to be included in the Risk Adjustment amount reported on the 2022 MLR Annual Reporting Form.

EXHIBIT 2 – SAMPLE MLR SUPPLEMENTAL REPORT LANGUAGE

Medical Loss Ratio Reporting

The Affordable Care Act (ACA) requires insurers to spend a minimum percentage of premium dollars on medical services and activities designed to improve health care quality and submit a medical loss ratio (MLR) report to present this information. The Department reviewed the components of the MLR Report filings by utilizing the MLR Procedures Spreadsheet provided by the Center for Consumer Information and Insurance Oversight to review and test, as deemed appropriate, the following items in accordance with 45 CFR Part 158: validity of the data regarding expenses and premiums that the issuer reported to the Secretary, including the appropriateness of the allocations of expenses used in such reporting, whether the activities associated with the issuer's reported expenditures for quality improving activities meet the definition of such activities, the accuracy of rebate calculations, and the timeliness and accuracy of rebate payments as applicable.

Per our review, no items came to our attention indicating an exception or finding that requires additional disclosure [with the exception of the following:].

Sample Comments / Findings
(*Only complete if exceptions were identified*)

The Company's MLR form filing was not filed by the required date of June 1st and/or in the manner prescribed by HHS for the MLR reporting year examined.

Financial data elements tested related to the MLR numerator (total incurred claims, deductible fraud and quality improving activities) as defined within 45 CFR Part 158, were not properly reported… (provide details, note financial reporting impact on the MLR calculation).

Quality improving activities tested do not meet the definition of such activities under 45 CFR Part 158… (provide details, note financial reporting impact on the MLR calculation).

Financial data elements tested related to the MLR denominator (total earned premium and taxes) as defined within 45 CFR Part 158, were not properly reported … (provide details, note financial reporting impact on the MLR calculation).

Concerns were identified in regard to the Company's expense allocation methodology used to report to HHS… (provide details, note financial reporting impact on the MLR calculation).

(Include only if rebate calculation is wrong due to noted errors)
The (error/errors) noted above, (resulted/did not result) in a change in MLR calculation and the MLR rebates to be paid to enrollees in the following states and markets (List States and markets).

Summary of Recommendations
(*Only complete if exceptions were identified*)

It is recommended that the Company develop controls and business processes sufficient to mitigate risk associated with the reporting and payment requirements of 45 CFR Part 158.