| **No.** | **Regulation[[1]](#footnote-1)** | **Purpose** | **Proposed Compliance Procedures** | **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 (MLR Form) for every state for which they submitted the Supplemental Health Care Exhibit (SHCE).
2. Verify that the amounts reported on the MLR Form are consistent with the amounts reported on the SHCE. Use the NAIC’s MLR Reconciliation Report or similar tool to check for variations between the SHCE and the MLR Form.
 |  |  |
| **2** | §158.110§158.120§158.220 | Test accuracy of state and market classifications | 1. Reconcile summary level policy dataset with the relevant MLR Form amounts.
2. Select a representative sample of policies from all market segments entity-wide. Review supporting contract documents and general ledger accounts to verify that:
	1. Policies were assigned to the correct state, i.e. by situs with exceptions noted in the regulation.
	2. Policies were assigned to the correct line of business. Verify that:
		1. Business subject to the commercial MLR rule, including grandfathered and/or transitional plans,[[2]](#footnote-2) was reported in the Health Insurance Coverage columns.
		2. Business not subject to the commercial MLR rule was reported as government program plans, other health business, or uninsured plans.
		3. Policies with annual limits < $250,000 were reported separately as mini-med policies.
		4. Policies meeting the definition of Expatriate policies under §158.120(d)(4) were reported separately from other policies and either were aggregated nationally in the Expat columns or were included in Other Health columns.
		5. Policies in the student market were reported separately from other policies and aggregated nationally starting in 2013.
		6. Premium dollars are supported by billing invoice and subsequent payment information.
3. Evaluate the methodology/definition the issuer used to determine group size on both the SHCE and the MLR Form and note if they are different. (Federal law uses “the average number of employees on the business days of the calendar year preceding the coverage effective date) If the insurer utilizes a different definition than that in federal law, determine how it impacted determining group size and market classification.
4. Verify that policies are assigned to the correct market classification (individual, small group, large group). For the group markets, verify that:
	1. Group size is based on the number of employees and not the number of subscribers (i.e., all active employees counted even if they were not enrolled in the plan)[[3]](#footnote-3).
	2. Employers with ≥ 50 employees were assigned to the large group market. (Or other number, if applicable.[[4]](#footnote-4),[[5]](#footnote-5))
5. For issuers subject to the commercial Risk Corridors (RC) rule,[[6]](#footnote-6) verify that:
	1. Premium amounts reported in the RC columns of the MLR Form reconcile to the summary level policy data set provided by the issuer.
	2. Policies were assigned to the correct classification as either ACA-compliant or not ACA-compliant (for reporting in the RC columns of the MLR Form).[[7]](#footnote-7)
 |  |  |
| **3** | §158.120(c) | Test accuracy of reporting under the dual contracts option | 1. If an issuer opted to report an out-of-network issuer’s experience with the in-network issuer’s experience under the dual contract option, verify that:
2. 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.
3. The option was or will be consistently applied for at least three consecutive reporting years.
4. Corresponding adjustments were made to the MLR Form for the out-of-network issuer. *This will require obtaining the out-of-network issuer’s MLR Form.*

*[Dual Contracts=Pt 1 Dual Contract column]* |  |  |
| **4** | §158.121 | Test accuracy ofreporting for new business | 1. If an issuer opted to exclude new business from their MLR calculation,[[8]](#footnote-8) verify that:
2. 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.
3. The issuer excluded all components of the new business, including premiums, taxes and fees, claims, quality improvement expenses, and non-claims costs.

 *[Deferred Business CY=Pt 1 Deferred CY (subtract) column]*1. Obtain the issuer’s prior year MLR Form. If newly written business was excluded in the prior year, verify that:
2. The prior year’s deferred business was added back to the subsequent year’s MLR Form in the same state and market.
3. The criteria for deferral were met in the prior year.

*[Deferred Business PY=Pt 1 Deferred PY1 (Add) column]* |  |  |
| **5** | §158.130 | Test accuracy of reporting of earned premiums | See Procedure #2 for detailed documentation of the premium testing performed at the policyholder level.1. Verify that:
	1. 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.[[9]](#footnote-9)
	2. Earned premiums were reported on a direct basis.
	3. Earned premiums were adjusted to account for high risk pool assessments or subsidies, group conversion charges, and unearned premium.
	4. Experience rating refunds are reflected in claims rather than premiums.
	5. Written and unearned premium in the MLR and, if applicable, RC columns includes advance payments of the premium tax credit (APTC).
	6. Written and unearned premium in the MLR and, if applicable, RC columns does not reflect the impact of the Federal Transitional Reinsurance, Risk Corridors, or Risk Adjustment (premium stabilization programs)
	7. Earned premium on Pt 1 Ln 1.1 and Pt 3 Ln 2.1 is calculated correctly according to the formulas in the MLR Form Instructions for the applicable year (for both MLR and, if applicable, RC columns).
2. Obtain the MLR Forms for the previous two years and verify that the following amounts are accurate:
	1. Pt 3 Ln 2.1, Col PY2 *[MLR Form from two years prior:*

*2013 MLR Form: (Pt 1, Lns 1.1 + 1.2 + 1.3, Cols 3/31/YY + Deferred PY1 – Deferred CY) – (Pt 4 Ln 6.1a, Col CY);* *2014 MLR Form: (Pt 1, Lns 1.1 + 1.2 + 1.3, Cols 3/31/YY + Deferred PY1 – Deferred CY) – (Pt 3, Lns 1.5 + 1.6 + 1.7, Col CY) + (Pt 3 Ln 7.1a, Col PY1);**2015-2016 MLR Forms: (Pt 1, Lns 1.1 + 1.2 + 1.3, Cols 3/31/YY + Deferred PY1 – Deferred CY) – (Pt 3, Lns 1.5 + 1.6 + 1.7, Col CY)]** 1. Pt 3 Ln 2.1, Col PY1 *[MLR Form from one year prior: see PY2 formula for the applicable year]*
	2. Pt 3 Ln 2.1, Col CY *[Current MLR Form: see PY2 formula for the applicable year]*
	3. Pt 3 Ln 2.1, Col RC *[Current MLR Form, (Pt 1, Lns 1.1 + 1.2 + 1.3, Col [RC] 3/31/YY) – (Pt 3, Lns 1.5 + 1.6, Col RC)]*

 *[Premiums=Pts 1 and 2, Sec 1; Pt 3 Sec 2]* |  |  |
| **6** | §158.130 | Test accuracy of reporting of reinsurance | If an issuer purchased/sold a block of business during the year, or had 100% indemnity reinsurance with an administrative agreement effective prior to March 23, 2010, obtain a list of all such reinsurance agreements that became effective during the MLR reporting year. Verify that:1. The list of reinsurance agreements is consistent with Schedule S/F of the issuer’s Annual Statement for that year.
2. The substance of the transaction was the purchase or sale of a line or block of business.
3. The issuer properly included/excluded premium, incurred claims, and unpaid claim reserve amounts for that business in the MLR Form in accordance with 45 CFR 158.130(a)(2) & (3), including for the portion of the MLR reporting year that preceded the purchase/sale.
 |  |  |
| **7** | §158.140§158.160 | Test accuracy of reporting of claims  | 1. Reconcile claim level dataset with the relevant MLR Form amounts.
2. Select a representative sample of claims from all market segments entity-wide and verify that:
3. The incurred date is between January 1st and December 31st of the reporting year for which the claim was reported on the MLR Form. Review supporting documents, such as the Explanation of Benefits (EOB), to verify the accuracy of the incurred date.
4. The claim was paid between January 1st of the MLR reporting year and March 31st of the year following the MLR reporting year for which the claim was reported on the MLR Form.
5. The claim was reported in the correct state based on the situs of the policy.
6. The amount paid is the amount reflected on the EOB and/or the provider’s remittance documents and payment support, and any member cost-sharing is not included in incurred claims.
7. The amount paid on the claim is reported on the MLR Form in the correct market classification as the policy under which it was processed.
8. Select a sample of issuer’s capitation payments and compare them to the provider’s capitation agreement. Verify that the issuer did not include amounts for issuer functions outsourced to the provider.
9. Select a sample of the issuer’s third-party vendor payment records (such as payments to PBMs and behavioral health companies). Compare issuer payments with the third party vendors’ provider reimbursement records to verify that vendor administrative costs were not reported as incurred claims in the MLR Form.
10. Review the following for indications that claims liabilities and reserves are incomplete, unreasonable, or recorded incorrectly:
11. Number and amount of due and unpaid claims.
12. Number and amount of claims in course of settlement.
13. Number and amount of incurred but not reported claims.
14. The relationships between claims liabilities, claims reserves, and claims payments.
15. Verify that:
16. Direct claims do not include non-claims costs.
17. Experience rating refunds and related reserves exclude federal and state MLR rebates.
18. Pharmacy rebates and incentives were deducted from incurred claims.
19. The claims-related portion of contingent benefit and lawsuit reserves was reported separately on Pt 2 Ln 2.13, and was not included in Pt 2 Lns 2.2 or 2.4.
20. Changes in contract reserves were properly reported and that contract reserves were calculated in accordance with MLR Form instructions.
21. Access the issuer’s MLR report for the previous two years. Verify that the following amounts are accurate:
22. Pt 3 Ln 1.1, Col PY2 *[MLR Form from two years prior, Pt 1 Lns 2.1 + 2.11 (prior to 2014, Pt 1 Ln 2.1 + Pt 2 Ln 2.17), Cols 3/31 + Deferred PY – Deferred CY]*
23. Pt 3 Ln 1.1, Col PY1 *[MLR Form from one year prior, Pt 1 Lns 2.1 + 2.11 (prior to 2014, Pt 1 Lns 2.1 + Pt 2 Ln 2.17), Cols 3/31 + Deferred PY1 – Deferred CY]*
24. Pt 3 Ln 1.2, Col CY *[Current MLR Form, Pt 1 Lns 2.1 + 2.11, Cols 3/31 + Deferred PY1 – Deferred CY]*
25. Pt 3 Ln 1.2, Col Total *[Pt 3 Ln 1.2, Cols PY2 + PY1 + CY]*
26. Pt 3 Ln 1.2, Col Total for 2014 Student Health Plans only *[If Pt 3 Ln 4.1, Col CY ≥ 75,000: Pt 3 Ln 1.2, Col CY; If Pt 3 Ln 4.1, Col CY < 75,000: Pt 3 Ln 1.2, Cols PY1 + CY]*
27. Pt 3 Ln 1.2, Col RC *[Current MLR Form, Pt 1 Lns 2.1 + 2.11, Col RC]*
28. Verify that Pt 1 Ln 2.1 and Pt 2 Lns 2.16 and 2.17 are calculated correctly according to the formula in the MLR Form Instructions for the applicable year (for both MLR and, if applicable, RC columns).
29. Review PY2 and PY1 claims run-out: Pt 3, Ln 1.1 vs. 1.2. Verify that claims liabilities and reserves are not consistently overstated. Conversely, if incurred claims have increased after run-out, verify that payments in fact exceeded liabilities and reserves.
30. Verify accuracy of Advance Payments of Cost-Sharing Reductions (CSRs):
	1. Reconcile amounts reported on MLR Form Pt 2 Ln 2.18 to statements issuer received from HHS. For 2014, if the issuer opted to use estimates, verify that the estimates comply with CCIIO June 19, 2015 guidance.[[10]](#footnote-10)
	2. Verify that CSR payments to providers were included in paid claims on Pt 2 Ln 2.1b; and that CSR receipt/receivable amounts were reported on both Pt 2 Ln 2.18 and Pt 3 Ln 1.4 of the MLR Form. Verify that CSR amounts were reported in all columns (both MLR and, if applicable, RC columns).
31. For issuers subject to the commercial RC rule, verify that:
	1. Claims amounts reported in the RC columns of the MLR Form reconcile to the summary level claims dataset provided by the issuer.
	2. Claims were assigned to the correct classification as being associated with either ACA-compliant (non-grandfathered or transitional), or non ACA-compliant policies (see Procedure #2 for additional details).

*[Claims =Pts 1 and 2, Sec 2; Pt 3 Sec1]* |  |  |
| **8** | §158.150§158.151 | Test classification of activities that improve health care quality | 1. Verify that:
	1. Health care quality improving activities (QIA) reported on the MLR Form conform to the definition of same in 45 CFR 158.150-151.
	2. QIA expenses reported in Pt 1 and 2 of the MLR Form are consistent with the allocation method(s) reported in Pt 6 of the MLR Form.
	3. ICD-10 implementation expenses reported on Pt 1, Ln 4.6 of the MLR Form comply with the definition in 45 CFR 158.150(b)(2)(i)(A)(6) and (c)(5), including that they do not exceed the cap. Beginning with the 2016 MLR reporting year, confirm that ICD-10 implementation expenses were not included in QIA.
	4. QIA expenses have adequate support, including job descriptions and time studies to support salary expenses.
2. Verify reasonableness and accuracy of the allocation of QIA expenses among states, lines of business and markets, and among affiliated issuers within a holding company. Include states and markets where the entity has business that is not subject to the commercial MLR rule (i.e., government program plans, other health business, self-funded (uninsured) plans).
3. Verify the reasonableness and accuracy of allocations to the ACA-compliant segment in the RC columns, if applicable.

*[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 the regulation. Beginning with the 2016 MLR reporting year, confirm that employment taxes were not deducted from premium.
	1. Confirm that issuers reporting community benefit expenditures (CBE) report only amounts permitted for their FIT-exempt status; as well as report their FIT-exempt status correctly on the Company Information tab.
	2. Additionally, for issuers subject to the commercial RC rule:
		1. Confirm that income taxes reported in the RC columns (2A and 7A) exclude the impact of RC payments or charges on taxable income.
		2. Verify the reasonableness of the allocation methodology for taxes reported in the RC columns.
2. Taxes and fees reported in Pt 1 and 2 of the MLR Form are consistent with the taxes and fees described in Pt 6 of the MLR Form.
3. Obtain the MLR Forms for the previous two years and verify that the following amounts are accurate:
	1. Pt 3 Ln 2.2, Col PY2 *[MLR Form from two years prior:*

*2013 MLR Form:* *FIT-exempt issuers: (Pt 1, Lns 3.1a-c + 3.2a-c + 3.3, Cols 3/31 + Deferred PY – Deferred CY) – (Pt 4 Ln 6.1b, Col CY);**Non FIT-exempt issuers: (Pt 1, Lns 3.1a-c + 3.2a + (the higher of 3.2b or 3.2c) + 3.3, Cols 3/31 + Deferred PY – Deferred CY) – (Pt 4 Ln 6.1b, Col CY);**2014 MLR Form:* *FIT-exempt issuers: (Pt 1, Lns 3.1a-d + 3.2a-c + 3.3a-b, Cols 3/31 + Deferred PY – Deferred CY) + (Pt 3 Ln 7.1b, Col PY1);**Non FIT-exempt issuers: (Pt 1, Lns 3.1a-d + 3.2a + (the higher of 3.2b or 3.2c) + 3.3a-b, Cols 3/31 + Deferred PY – Deferred CY) + (Pt 3 Ln 7.1b, Col PY1);**2015-2016 MLR Form:* *FIT-exempt issuers: Pt 1, Lns 3.1a-d + 3.2a-c + 3.3a-b, Cols 3/31 + Deferred PY – Deferred CY;**Non FIT-exempt issuers: Pt 1, Lns 3.1a-d + 3.2a + (the higher of 3.2b or 3.2c) + 3.3a-b, Cols 3/31 + Deferred PY – Deferred CY]** 1. Pt 3 Ln 2.2, Col PY1 *[MLR Form from one year prior: see PY2 formula for the applicable year]*
	2. Pt 3 Ln 2.2, Col CY *[Current MLR Form: see PY2 formula for the applicable year]*
	3. Pt 3 Ln 2.2, Col Total *[Pt 3 Ln 2.2, Cols PY2 + PY1 + CY]*
	4. Pt 3 Ln 2.2, Col Total for 2014 Student Health Plans only *[If Pt 3 Ln 4.1, Col CY ≥ 75,000: Pt 3 Ln 1.2, Col CY; If Pt 3 Ln 4.1, Col CY < 75,000: Pt 3 Ln 1.2, Cols PY1 + CY]*
	5. Pt 3 Ln 2.2, Col RC *[Current MLR Form:*

*FIT-exempt issuers: Pt 1, Lns 3.1a-d + 3.2a-c + 3.3a-b, Col [RC] 3/31/YY;**Non FIT-exempt issuers: Pt 1, Lns 3.1a-d + 3.2a + (the higher of 3.2b or 3.2c) + 3.3a-b, Col [RC] 3/31/YY]*1. Verify that the Transitional Reinsurance Program contributions were reported in Pt 1 Ln 3.3a of the MLR Form, and that these amounts were accurate.

*[Taxes and regulatory fees=Pt 1 Sec 3; Pt 3 Ln 2.2; Pt 6 Sec 2]* |  |  |
| **10** | §158.170§153.520 | Test reasonableness and accuracy of expense allocations | 1. Verify reasonableness and accuracy of the allocation of taxes and expenses among states, lines of business and markets, and among affiliated issuers within a holding company. Include states and markets where the entity has business that is not subject to the commercial MLR rule (i.e., government program plans, other health business, self-funded (uninsured) plans).
2. Verify that allocations of fraud reduction expenses (if applicable) are based on fair and reasonable standards and that the total amount of the allowable fraud reduction expense reported in the MLR Form does not exceed total recoveries.
3. Verify that the issuer’s allocation methods are consistent with the narrative provided in Pt 6 of the MLR Form.
4. For issuers subject to the commercial RC rule, verify the following:
	1. The reasonableness and accuracy of allocations to the ACA-compliant segment in the RC columns, including the reasonableness of the non-claims cost allocation methodology.
	2. That the non-claims costs reported in MLR Form Pt 1 Sec 5 are accurate and consistent with the methodology adopted by the issuer.

*[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:
	1. 80% in the individual and small group markets, and 85% in the large group market;
	2. A higher standard as prescribed by state law[[11]](#footnote-11); or
	3. The adjusted state standard in the individual market approved by the Secretary under 45 CFR 158 Subpart C.[[12]](#footnote-12)

*[MLR standard=Pt 3 Ln 6.1]* |  |  |
| **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 Form 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:
	1. For states in which different MLR standards applied to different reporting years, an issuer may add to the numerator the difference between the MLR standards for the current and each of the two prior reporting years, multiplied by the adjusted premium for the earlier year. *[FAQ #58 in CMS Technical Guidance published 4/5/2013.[[13]](#footnote-13)]*
	2. For Mini-Med and Student Health Plans, the multiplier for the respective year is applied to the MLR numerator in the respective column (PY2, PY1, or CY); but the Total column only applies the multiplier for the current reporting year (e.g. multiplies the sum of PY2+PY1+CY incurred claims and QIA by the CY multiplier).
	3. In states that require the individual and small group markets to be merged for MLR purposes (e.g., MA and beginning in 2015 for the 2014 and later MLR reporting years , 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.[[14]](#footnote-14)
	4. For 2014-2016, for issuers that were eligible for and chose to apply the optional multiplier(s):
		1. For issuers that provided transitional coverage in the individual and/or small group markets in 2014, verify that the sum of 2014 incurred claims and QIA (not the entire numerator) was multiplied by 1.0001, before adding this sum to MLR numerator.
		2. For issuers that participated in the federal and state Marketplaces in 2014, verify that the sum of 2014 incurred claims and QIA (not the entire numerator) by 1.0004, before adding this sum to MLR numerator.
		3. For issuers who qualified for and chose to use both multipliers, verify that the sum of 2014 incurred claims and QIA (not the entire numerator) was multiplied by 1.0001 x 1.0004, before adding this sum to MLR numerator.

**Note:** Issuers may not use these multipliers in the RC columns.*[MLR numerator=Pt 3 Lns 1.8, 1.9]* |  |  |
| **13** | §158.220  | Test aggregation of data in the MLR denominator | 1. Verify that the MLR denominator is calculated correctly according to the formula in the MLR Form 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:
	1. 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 amounts.
	2. For 2014-2016: If on its 2013 MLR Form, the issuer excluded premium collected in 2013 toward its ACA section 9010 fee liability payable in 2014 (reported in Pt 4 Ln 6.1a and excluded from Ln 2.1, CY column), verify that on its 2013 MLR Form, the issuer also excluded from Ln 2.2, CY column the associated taxes and fees in Ln 6.2b.Further, verify that on its 2014-2016 MLR Forms, the issuer reported these amounts in Pt 3 Lns 7.1a-b and added them to 2014 premium and taxes in Lns 2.1 and 2.2.

*[MLR denominator=Pt 3 Ln 2.3]* |  |  |
| **14** | §158.221 | Test accuracy of the MLR calculation | 1. Verify that:
	1. The preliminary MLR reported on the issuer’s MLR Form is accurate and unrounded. *[Preliminary MLR=Pt 3 Ln 5.1a-b]*
	2. The credibility-adjusted MLR is accurate and rounded to three decimal places. *[Credibility-adjusted MLR=Pt 3 Ln 5.3, Total column]*

*If exceptions were noted for any element of the MLR, recalculate the federal MLR based on the accurate numbers obtained during the examination.*  |  |  |
| **15** | §158.230 (b) | Test accuracy of life-years | 1. Access the population of policy/contract records used to support the MLR 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=Pt 1 Ln 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=Pt 1 Ln 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 | Verify that the Total column for the life-years is the sum of the PY2, PY1, and CY columns, except that:1. For the 2014 reporting year, Student Health Plans only, if the issuer’s 2014 life-years are <75,000, the aggregate number of life-years is the sum of life-years from the 2013 and the 2014 reporting years.
2. 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 amounts.

*[Life-years=Pt 3 Ln 4.1]* |  |  |
| **17** | §158.230§158.231§158.232(b) | Test accuracy of the base credibility factor  | 1. Verify that the issuer used the correct aggregate number of life-years to calculate the base credibility factor.
2. If aggregated life-years are ≥ 1,000 and < 75,000, use the MLR Calculator for the applicable year on the CMS website or similar tool to verify that the base credibility factor is accurate and unrounded.
3. If aggregated life-years are < 1,000 or ≥ 75,000, verify that the base credibility factor is 0.
4. Beginning with the 2013 reporting year (2015 for Student Health Plans), verify that the base credibility factor is 0 when both of the following conditions are met:
5. The current MLR reporting year and each of the two previous MLR reporting years included experience of at least 1,000 life-years; and
6. Without applying any credibility adjustment, the issuer’s MLR for the current MLR reporting year and each of the two previous MLR reporting years were below the applicable MLR standard for each year as established under §158.210.

*[Base credibility factor=Pt 3 Ln 4.2]**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. Use the issuer’s data records, including policy forms, group contracts, and enrollment data from the current and two previous MLR reporting years to calculate the average health plan deductible.[[15]](#footnote-15)
2. Verify that the average deductible calculated above matches the amount reported on the issuer’s MLR Form. *[Average Deductible =Pt 3 Ln 4.3]*
3. Use the MLR Calculator for the applicable year on the CMS website or similar tool to verify that the deductible factor is accurate and unrounded. *[Deductible factor=Pt 3 Ln 4.4]*

*If exceptions were noted in the issuer’s average deductible, recalculate the deductible factor using the accurate numbers obtained during examination.*  |  |  |
| **19** | §158.232(a) | Test accuracy of the credibility adjustment  | 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=Pt 3 Ln 5.2].**If exceptions were noted in the issuer’s base credibility factor or deductible factor, recalculate the credibility adjustment using the accurate numbers obtained during examination.*  |  |  |
| **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:
3. The total rebate amount for the state/market is correct. *[Total rebate amount=Pt 3 Lns (6.1 - 6.2) x 6.3]*
4. The amount of the rebate 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.
5. For rebates distributed via premium credit, the rebate was fully applied before any new cash was paid by the enrollee. *[Premium credit=Pt 4 Ln 3.c]*
6. Verify that payment was made on or before September 30 subsequent to the end of 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 or 10% annually, whichever is higher.

*If exceptions were noted in the issuer’s MLR numerator, denominator, or MLR standard, recalculate the rebate amount using the accurate numbers obtained 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 <$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=Pt 4 Ln 3.b]* |  |  |
| **22** | §158.240§158.244§158.250 | Test compliance with rebate disbursement requirements | Select a sample of all subscribers/policyholders to whom a rebate is 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).
3. The issuer made all reasonable efforts to locate subscribers/policyholders with unclaimed rebates; tracked the amount of unclaimed rebates for subscribers/policyholders that could not be located; and escheated unclaimed rebates in accordance with state law.

*[Rebate Disbursement=Pt 4]* |  |  |
| **23** | §158.130§158.140 | Verify accuracy of premium stabilization program amounts | 1. Verify accuracy of Transitional Reinsurance payments used in MLR and, if applicable, RC calculations:
	1. Validate amounts reported on MLR Form, Pt 2 Ln 1.9 to CMS Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the applicable benefit year,[[16]](#footnote-16) or to updated amounts communicated by CMS to issuer (obtain supporting documentation).
	2. Verify that Transitional Reinsurance payments were reported on both Pt 2 Ln 1.9 and Pt 3 Ln 1.5 (for both MLR and, if applicable, RC columns).
2. Verify accuracy of Risk Adjustment payments / (charges) used in MLR and, if applicable, RC calculations:
	1. Validate amounts reported on MLR Form, Pt 2 Ln 1.10 to CMS Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the applicable benefit year, or to updated amounts communicated by CMS to issuer (obtain supporting documentation). Verify that amounts reported on MLR Form include both regular payments / (charges) as well as any Risk Adjustment Default charges and Risk Adjustment Default Charge Allocation amounts.
	2. Verify that Risk Adjustment payments / (charges) were reported on both Pt 2 Ln 1.10 and Pt 3 Ln 1.6 (for both MLR and, if applicable, RC columns).
3. Verify accuracy of Risk Corridors payments / (charges) used in MLR calculations:
	1. Verify that if Pt 3, Ln 3.8 (for 2014, Ln 3.10) is <97% or >103% then Pt 3, Ln 3.10 (for 2014, Ln 3.12) is not zero or blank.
	2. Verify that Risk Corridors payments / (charges) were reported on both Pt 2 Ln 1.11 and Pt 3 Ln 1.7, MLR columns, consistently with MLR Form Instructions for the applicable year.
 |  |  |
| **24** | §153.500 | Verify accuracy of risk corridors allowable costs and target amount calculations | For issuers subject to the commercial RC rule, verify that:1. Allowable costs are calculated correctly. *[Allowable costs=MLR Form, Pt 3 Ln 3.1, Col [RC] 3/31/YY]*
2. Administrative costs reported in MLR Form Part 3 Line 3.2 are calculated correctly. *[Pt 1 Lns 5.1 + 5.2 + 5.3 + 5.4 + 5.5a + 5.5b + 5.6, Col [RC] 3/31/YY]*
3. The transitional adjustment percentage was applied correctly:
	1. For 2014: if the issuer used a transitional adjustment percentage on Pt 3 Ln 3.4, verify that:
		1. the issuer operated in a transitional state;[[17]](#footnote-17)
		2. Ln 3.3 equals at least 80%; and
		3. Ln 3.4 equals the percentage specified by CMS.[[18]](#footnote-18)
	2. For 2015: verify that the issuer used 2%.
4. Profit for risk corridors calculation and its component lines are calculated correctly.

*[For 2014: Profit=Pt 3 Ln 3.5; Earned profit=Pt 3 Ln 3.5a; Capped profit=Pt 3 Ln 3.5b (w/ adjustment);**For 2015: Profit=Pt 3 Ln 3.3 (w/ adjustment) and Ln 3.6a (w/o adjustment); Earned profit=Pt 3 Ln 3.3a; Capped profit=Pt 3 Ln 3.5b (w/ adjustment) and Ln 3.5c (w/o adjustment)]*1. Allowable administrative costs and their component lines are calculated correctly.

*[For 2014: Allowable admin costs=Pt 3 Ln 3.6 (w/ adjustment) and Ln 3.8 (w/o adjustment); Profit and admin costs=Pt 3 Ln 3.6a; Capped admin costs=Pt 3 Ln 3.6b (w/ adjustment) and Ln 3.6c (w/o adjustment);**For 2015: Allowable admin costs=Pt 3 Ln 3.4 (w/ adjustment) and Ln 3.6 (w/o adjustment); Profit and admin costs=Pt 3 Ln 3.4a (w/ adjustment) and Ln 3.6b (w/o adjustment); Capped admin costs=Pt 3 Ln 3.4b (w/ adjustment) and Ln 3.6c (w/o adjustment)]*1. Risk corridors target amounts are calculated correctly.

*[For 2014: Target amount=Pt 3 Ln 3.7 (w/ adjustment) and Ln 3.9 (w/o adjustment);**For 2015: Target amount=Pt 3 Ln 3.5 (w/ adjustment) and Ln 3.7 (w/o adjustment)]* |  |  |

1. Access the Federal MLR Regulation at [http://www.ecfr.gov/](http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=1&SID=acfbd058866841eaf71c3d8800255450&ty=HTML&h=L&n=45y1.0.1.2.73&r=PART). [↑](#footnote-ref-1)
2. See CMS Nov. 14, 2013 Letter to State Insurance Commissioners, available at <http://www.cms.gov/CCIIO/Resources/Letters/Downloads/commissioner-letter-11-14-2013.pdf>, and CMS March 5, 2014 Bulletin extending the transitional policy, available at <https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/transition-to-compliant-policies-03-06-2015.pdf>. [↑](#footnote-ref-2)
3. 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>. [↑](#footnote-ref-3)
4. States may substitute “100” employees for “50” employees to differentiate the small and large group markets, if they do so for all purposes and not just MLR. [↑](#footnote-ref-4)
5. **Note:** For the purposes of the Risk Corridors program, the definition of employer size and the employee counting method applicable under State law will determine whether a plan is considered to be offered in the small group market. [↑](#footnote-ref-5)
6. Issuers that offered QHPs on the Marketplace are subject to Risk Corridors and must include all ACA-compliant business in the Risk Corridors columns. Issuers that did not offer QHPs on the Marketplace are not subject to Risk Corridors and do not need to complete the Risk Corridors columns. [↑](#footnote-ref-6)
7. ACA-compliant business includes both QHPs and non-QHPs, whether sold on- or off-Marketplace; and excludes grandfathered and transitional plans. Grandfathered plans are plans that were in effect on March 23, 2010, and that have not been changed in ways that substantially reduce benefits or increase cost-sharing for consumers, pursuant to the regulations at 45 CFR Part 147.140. Transitional plans are non-grandfathered, non ACA-compliant plans that issuers were allowed to continue in 2014 and, in certain states, renew through policy years beginning up to Oct. 1, 2016. [↑](#footnote-ref-7)
8. **Note:** issuers may not defer new business reporting for Risk Corridors purposes. [↑](#footnote-ref-8)
9. 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>. [↑](#footnote-ref-9)
10. <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Advance-CSR-Payment-and-RC-MLR-submission_6192015.pdf>. [↑](#footnote-ref-10)
11. Massachusetts has a higher state MLR standard of 88% - 90% in the individual and small group markets, depending on the reporting year. New York has a higher state MLR standard of 82% in the individual and small group markets. New Mexico has a higher state MLR standard of 85% in the small group market. [↑](#footnote-ref-11)
12. The Secretary granted adjustments to the MLR standard in the individual market in Georgia, Iowa, Kentucky, North Carolina, Nevada, Massachusetts, Maine, and New Hampshire for 2011 and/or 2012. [↑](#footnote-ref-12)
13. MLR regulatory guidance is available at [http://www.cms.gov/cciio/resources/regulations-and-guidance/index.html#Medical Loss Ratio](http://www.cms.gov/cciio/resources/regulations-and-guidance/index.html%23Medical%20Loss%20Ratio). [↑](#footnote-ref-13)
14. Massachusetts and, beginning with the 2014 reporting year, District of Columbia and Vermont, require that issuers merge experience of the individual and small group markets for the purposes of calculating the MLR. [↑](#footnote-ref-14)
15. To calculate the average deductible, multiply the per-person deductibles by the applicable number of life-years, aggregate the results, and then divide by the total number of life-years in the state and market for all of the issuer’s policies with the same per-person deductible level. The per-person deductible for a family policy is the lesser of the individual deductibles or one-half of the family deductible. If the issuer has products with differing deductibles, use a similar process to calculate the average deductible across all deductible levels weighted by life-years. [↑](#footnote-ref-15)
16. CMS Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers is available annually from the Announcements section of the CCIIO website, <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/index.html>. [↑](#footnote-ref-16)
17. For 2014, the transitional states were: Alabama, Alaska, Arizona, Arkansas, California (small group only), Colorado, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Michigan, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, West Virginia, Wisconsin, and Wyoming. [↑](#footnote-ref-17)
18. For 2014, see CCIIO Apr. 17, 2015 technical guidance on Transitional Adjustment for 2014 Risk Corridors Program, <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/RC_TransitionalAdjGuidance_5CR_041715.pdf>. [↑](#footnote-ref-18)