

## 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](mailto: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.

No.	Regulation <sup>1</sup>	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	<ol style="list-style-type: none"> <li>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).</li> <li>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.</li> </ol>		
2	§158.110 §158.120 §158.220	Test accuracy of state and market classifications	<ol style="list-style-type: none"> <li>1) Reconcile summary level policy dataset with the relevant MLR Form amounts.</li> <li>2) Select a representative sample of policies from all market segments entity-wide. Review supporting contract documents and general ledger accounts to verify that:               <ol style="list-style-type: none"> <li>a. Policies were assigned to the correct state, i.e. by situs with exceptions noted in the regulation.</li> <li>b. Policies were assigned to the correct line of business. Verify that:                   <ol style="list-style-type: none"> <li>i. Business subject to the commercial MLR rule, including grandfathered and/or transitional plans,<sup>2</sup> was reported in the Health Insurance Coverage columns.</li> <li>ii. Business not subject to the commercial MLR rule was reported as government program plans, other health business, or uninsured plans.</li> <li>iii. Policies with annual limits &lt; \$250,000 were reported separately as mini-med policies.</li> <li>iv. Policies meeting the definition of Expatriate policies under §158.120(d)(4) were reported separately from other policies and either were</li> </ol> </li> </ol> </li> </ol>		

<sup>1</sup> Access the Federal MLR Regulation at <http://www.ecfr.gov/>.

<sup>2</sup> 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>.

No.	Regulation <sup>1</sup>	Purpose	Proposed Compliance Procedures	Description of Work Performed	Summary of Results
			<p>aggregated nationally in the Expat columns or were included in Other Health columns.</p> <ul style="list-style-type: none"> <li>v. Policies in the student market were reported separately from other policies and aggregated nationally starting in 2013.</li> <li>vi. Premium dollars are supported by billing invoice and subsequent payment information.</li> </ul> <p>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.</p> <p>4) Verify that policies are assigned to the correct market classification (individual, small group, large group). For the group markets, verify that:</p> <ul style="list-style-type: none"> <li>a. 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)<sup>3</sup>.</li> <li>b. Employers with ≥ 50 employees were assigned to the large group market. (Or other number, if applicable.<sup>4,5</sup>)</li> </ul> <p>5) For issuers subject to the commercial Risk Corridors (RC) rule,<sup>6</sup> verify that:</p> <ul style="list-style-type: none"> <li>a. Premium amounts reported in the RC columns of the MLR Form reconcile to the summary level policy data</li> </ul>		

<sup>3</sup> 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>.

<sup>4</sup> 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.

<sup>5</sup> **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.

<sup>6</sup> 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.

No.	Regulation <sup>1</sup>	Purpose	Proposed Compliance Procedures	Description of Work Performed	Summary of Results
			<p>set provided by the issuer.</p> <p>b. 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).<sup>7</sup></p>		
3	§158.120(c)	Test accuracy of reporting under the dual contracts option	<p>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:</p> <p>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.</p> <p>b. The option was or will be consistently applied for at least three consecutive reporting years.</p> <p>c. Corresponding adjustments were made to the MLR Form for the out-of-network issuer. <i>This will require obtaining the out-of-network issuer's MLR Form.</i></p> <p><i>[Dual Contracts=Pt 1 Dual Contract column]</i></p>		
4	§158.121	Test accuracy of reporting for new business	<p>1) If an issuer opted to exclude new business from their MLR calculation,<sup>8</sup> verify that:</p> <p>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.</p> <p>b. The issuer excluded all components of the new business, including premiums, taxes and fees, claims, quality improvement expenses, and non-claims costs.</p> <p><i>[Deferred Business CY=Pt 1 Deferred CY (subtract) column]</i></p>		

<sup>7</sup> 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.

<sup>8</sup> **Note:** issuers may not defer new business reporting for Risk Corridors purposes.

No.	Regulation <sup>1</sup>	Purpose	Proposed Compliance Procedures	Description of Work Performed	Summary of Results
			2) Obtain the issuer’s prior year MLR Form. If newly written business was excluded in the prior year, verify that: <ul style="list-style-type: none"> <li>a. The prior year’s deferred business was added back to the subsequent year’s MLR Form in the same state and market.</li> <li>b. The criteria for deferral were met in the prior year.</li> </ul> <i>[Deferred Business PY=Pt 1 Deferred PY1 (Add) column]</i>		
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. <ul style="list-style-type: none"> <li>1) Verify that:                             <ul style="list-style-type: none"> <li>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.<sup>9</sup></li> <li>b. Earned premiums were reported on a direct basis.</li> <li>c. Earned premiums were adjusted to account for high risk pool assessments or subsidies, group conversion charges, and unearned premium.</li> <li>d. Experience rating refunds are reflected in claims rather than premiums.</li> <li>e. Written and unearned premium in the MLR and, if applicable, RC columns includes advance payments of the premium tax credit (APTC).</li> <li>f. Written and unearned premium in the MLR and, if applicable, RC columns does not reflect the impact of</li> </ul> </li> </ul>		

<sup>9</sup> 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>.

No.	Regulation <sup>1</sup>	Purpose	Proposed Compliance Procedures	Description of Work Performed	Summary of Results
			<p>the Federal Transitional Reinsurance, Risk Corridors, or Risk Adjustment (premium stabilization programs)</p> <p>g. 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).</p> <p>2) Obtain the MLR Forms for the previous two years and verify that the following amounts are accurate:</p> <p>a. Pt 3 Ln 2.1, Col PY2 <i>[MLR Form from two years prior:</i>  <i>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);</i>  <i>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);</i>  <i>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)]</i></p> <p>b. Pt 3 Ln 2.1, Col PY1 <i>[MLR Form from one year prior: see PY2 formula for the applicable year]</i></p> <p>c. Pt 3 Ln 2.1, Col CY <i>[Current MLR Form: see PY2 formula for the applicable year]</i></p> <p>d. Pt 3 Ln 2.1, Col RC <i>[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)]</i></p> <p><i>[Premiums=Pts 1 and 2, Sec 1; Pt 3 Sec 2]</i></p>		
6	§158.130	Test accuracy of reporting of reinsurance	<p>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:</p> <p>1) The list of reinsurance agreements is consistent with</p>		

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			<p>Schedule S/F of the issuer’s Annual Statement for that year.</p> <p>2) The substance of the transaction was the purchase or sale of a line or block of business.</p> <p>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) &amp; (3), including for the portion of the MLR reporting year that preceded the purchase/sale.</p>		
7	§158.140 §158.160	Test accuracy of reporting of claims	<p>1) Reconcile claim level dataset with the relevant MLR Form amounts.</p> <p>2) Select a representative sample of claims from all market segments entity-wide and verify that:</p> <ul style="list-style-type: none"> <li>a. The incurred date is between January 1<sup>st</sup> and December 31<sup>st</sup> 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.</li> <li>b. The claim was paid between January 1<sup>st</sup> of the MLR reporting year and March 31<sup>st</sup> of the year following the MLR reporting year for which the claim was reported on the MLR Form.</li> <li>c. The claim was reported in the correct state based on the situs of the policy.</li> <li>d. 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.</li> <li>e. 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.</li> </ul> <p>3) 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</p>		

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			<p>outsourced to the provider.</p> <p>4) 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.</p> <p>5) Review the following for indications that claims liabilities and reserves are incomplete, unreasonable, or recorded incorrectly:</p> <ul style="list-style-type: none"> <li>a. Number and amount of due and unpaid claims.</li> <li>b. Number and amount of claims in course of settlement.</li> <li>c. Number and amount of incurred but not reported claims.</li> <li>d. The relationships between claims liabilities, claims reserves, and claims payments.</li> </ul> <p>6) Verify that:</p> <ul style="list-style-type: none"> <li>a. Direct claims do not include non-claims costs.</li> <li>b. Experience rating refunds and related reserves exclude federal and state MLR rebates.</li> <li>c. Pharmacy rebates and incentives were deducted from incurred claims.</li> <li>d. 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.</li> <li>e. Changes in contract reserves were properly reported and that contract reserves were calculated in accordance with MLR Form instructions.</li> </ul> <p>7) Access the issuer’s MLR report for the previous two years. Verify that the following amounts are accurate:</p> <ul style="list-style-type: none"> <li>a. Pt 3 Ln 1.1, Col PY2 [<i>MLR Form from two years prior, Pt 1 Lns 2.1 + 2.11 (prior to 2014, Pt 1 Ln 2.1 + Pt 2</i></li> </ul>		

No.	Regulation <sup>1</sup>	Purpose	Proposed Compliance Procedures	Description of Work Performed	Summary of Results
			<p><i>Ln 2.17), Cols 3/31 + Deferred PY – Deferred CY]</i></p> <p>b. Pt 3 Ln 1.1, Col PY1 <i>[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]</i></p> <p>c. Pt 3 Ln 1.2, Col CY <i>[Current MLR Form, Pt 1 Lns 2.1 + 2.11, Cols 3/31 + Deferred PY1 – Deferred CY]</i></p> <p>d. Pt 3 Ln 1.2, Col Total <i>[Pt 3 Ln 1.2, Cols PY2 + PY1 + CY]</i></p> <p>e. Pt 3 Ln 1.2, Col Total for 2014 Student Health Plans only <i>[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 &lt; 75,000: Pt 3 Ln 1.2, Cols PY1 + CY]</i></p> <p>f. Pt 3 Ln 1.2, Col RC <i>[Current MLR Form, Pt 1 Lns 2.1 + 2.11, Col RC]</i></p> <p>8) 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).</p> <p>9) 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.</p> <p>10) Verify accuracy of Advance Payments of Cost-Sharing Reductions (CSRs):</p> <p>a. 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.<sup>10</sup></p> <p>b. Verify that CSR payments to providers were included</p>		

<sup>10</sup> [https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Advance-CSR-Payment-and-RC-MLR-submission\\_6192015.pdf](https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Advance-CSR-Payment-and-RC-MLR-submission_6192015.pdf)

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			<p>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).</p> <p>11) For issuers subject to the commercial RC rule, verify that:</p> <ul style="list-style-type: none"> <li>a. Claims amounts reported in the RC columns of the MLR Form reconcile to the summary level claims dataset provided by the issuer.</li> <li>b. 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).</li> </ul> <p><i>[Claims =Pts 1 and 2, Sec 2; Pt 3 Sec1]</i></p>		
8	§158.150 §158.151	Test classification of activities that improve health care quality	<p>1) Verify that:</p> <ul style="list-style-type: none"> <li>a. Health care quality improving activities (QIA) reported on the MLR Form conform to the definition of same in 45 CFR 158.150-151.</li> <li>b. 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.</li> <li>c. 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.</li> <li>d. QIA expenses have adequate support, including job descriptions and time studies to support salary expenses.</li> </ul> <p>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</p>		

No.	Regulation <sup>1</sup>	Purpose	Proposed Compliance Procedures	Description of Work Performed	Summary of Results
			<p>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).</p> <p>3) Verify the reasonableness and accuracy of allocations to the ACA-compliant segment in the RC columns, if applicable.</p> <p><i>[QIA expenses=Pt 1 Sec 4; Pt 3 Ln 1.3; Pt 6 Sec 3]</i></p>		
9	§158.161 §158.162	Test accuracy of reporting of taxes and regulatory fees	<p>Obtain documentation for assessments, fees, and taxes (including inter-company tax allocation agreements) and verify that:</p> <p>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.</p> <p>a. 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.</p> <p>b. Additionally, for issuers subject to the commercial RC rule:</p> <p>i. Confirm that income taxes reported in the RC columns (2A and 7A) exclude the impact of RC payments or charges on taxable income.</p> <p>ii. Verify the reasonableness of the allocation methodology for taxes reported in the RC columns.</p> <p>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.</p> <p>3) Obtain the MLR Forms for the previous two years and verify that the following amounts are accurate:</p> <p>a. Pt 3 Ln 2.2, Col PY2 <i>[MLR Form from two years prior:</i></p>		

No.	Regulation <sup>1</sup>	Purpose	Proposed Compliance Procedures	Description of Work Performed	Summary of Results
			<p><i>2013 MLR Form:</i>  <i>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);</i>  <i>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);</i></p> <p><i>2014 MLR Form:</i>  <i>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);</i>  <i>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);</i></p> <p><i>2015-2016 MLR Form:</i>  <i>FIT-exempt issuers: Pt 1, Lns 3.1a-d + 3.2a-c + 3.3a-b, Cols 3/31 + Deferred PY – Deferred CY;</i>  <i>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]</i></p> <p>b. Pt 3 Ln 2.2, Col PY1 [<i>MLR Form from one year prior: see PY2 formula for the applicable year</i>]</p> <p>c. Pt 3 Ln 2.2, Col CY [<i>Current MLR Form: see PY2 formula for the applicable year</i>]</p> <p>d. Pt 3 Ln 2.2, Col Total [<i>Pt 3 Ln 2.2, Cols PY2 + PY1 + CY</i>]</p> <p>e. Pt 3 Ln 2.2, Col Total for 2014 Student Health Plans only [<i>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 &lt; 75,000: Pt 3 Ln 1.2, Cols PY1 + CY</i>]</p> <p>f. Pt 3 Ln 2.2, Col RC [<i>Current MLR Form:</i>  <i>FIT-exempt issuers: Pt 1, Lns 3.1a-d + 3.2a-c + 3.3a-b, Col [RC] 3/31/YY;</i>  <i>Non FIT-exempt issuers: Pt 1, Lns 3.1a-d + 3.2a + (the</i></p>		

No.	Regulation <sup>1</sup>	Purpose	Proposed Compliance Procedures	Description of Work Performed	Summary of Results
			<p><i>higher of 3.2b or 3.2c) + 3.3a-b, Col [RC] 3/31/YY]</i></p> <p>4) 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.</p> <p><i>[Taxes and regulatory fees=Pt 1 Sec 3; Pt 3 Ln 2.2; Pt 6 Sec 2]</i></p>		
10	§158.170 §153.520	Test reasonableness and accuracy of expense allocations	<p>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).</p> <p>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.</p> <p>3) Verify that the issuer’s allocation methods are consistent with the narrative provided in Pt 6 of the MLR Form.</p> <p>4) For issuers subject to the commercial RC rule, verify the following:</p> <ul style="list-style-type: none"> <li>a. 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.</li> <li>b. That the non-claims costs reported in MLR Form Pt 1 Sec 5 are accurate and consistent with the methodology adopted by the issuer.</li> </ul> <p><i>[Expense allocation=Pt 6]</i></p>		
11	§158.210 §158.211	Test accuracy of the MLR standard	<p>1) Verify that the issuer used the correct MLR standard for every state and market. The MLR standard should be one of the following:</p>		

No.	Regulation <sup>1</sup>	Purpose	Proposed Compliance Procedures	Description of Work Performed	Summary of Results
			<ul style="list-style-type: none"> <li>a. 80% in the individual and small group markets, and 85% in the large group market;</li> <li>b. A higher standard as prescribed by state law<sup>11</sup>; or</li> <li>c. The adjusted state standard in the individual market approved by the Secretary under 45 CFR 158 Subpart C.<sup>12</sup></li> </ul> <p><i>[MLR standard=Pt 3 Ln 6.1]</i></p>		
12	§158.210 §158.211 §158.220	Test aggregation of data in the MLR numerator	<ul style="list-style-type: none"> <li>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:               <ul style="list-style-type: none"> <li>a. 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. <i>[FAQ #58 in CMS Technical Guidance published 4/5/2013.<sup>13</sup>]</i></li> <li>b. 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).</li> <li>c. 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</li> </ul> </li> </ul>		

<sup>11</sup> 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.

<sup>12</sup> 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.

<sup>13</sup> MLR regulatory guidance is available at <http://www.cms.gov/ccio/resources/regulations-and-guidance/index.html#Medical Loss Ratio>.

No.	Regulation <sup>1</sup>	Purpose	Proposed Compliance Procedures	Description of Work Performed	Summary of Results
			<p>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.<sup>14</sup></p> <p>d. For 2014-2016, for issuers that were eligible for and chose to apply the optional multiplier(s):</p> <p>i. For issuers that provided transitional coverage in the individual and/or small group markets in 2014, verify that the sum of <u>2014</u> incurred claims and QIA (not the entire numerator) was multiplied by 1.0001, before adding this sum to MLR numerator.</p> <p>ii. 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.</p> <p>iii. 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.</p> <p><b>Note:</b> Issuers may not use these multipliers in the RC columns.</p> <p><i>[MLR numerator=Pt 3 Lns 1.8, 1.9]</i></p>		
13	§158.220	Test aggregation of data in the MLR denominator	<p>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:</p> <p>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</p>		

<sup>14</sup> 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.

No.	Regulation <sup>1</sup>	Purpose	Proposed Compliance Procedures	Description of Work Performed	Summary of Results
			<p>is the sum of the individual and small group amounts.</p> <p>b. 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.</p> <p><i>[MLR denominator=Pt 3 Ln 2.3]</i></p>		
14	§158.221	Test accuracy of the MLR calculation	<p>1. Verify that:</p> <p>a. The preliminary MLR reported on the issuer’s MLR Form is accurate and unrounded. <i>[Preliminary MLR=Pt 3 Ln 5.1a-b]</i></p> <p>b. The credibility-adjusted MLR is accurate and rounded to three decimal places. <i>[Credibility-adjusted MLR=Pt 3 Ln 5.3, Total column]</i></p> <p><i>If exceptions were noted for any element of the MLR, recalculate the federal MLR based on the accurate numbers obtained during the examination.</i></p>		
15	§158.230 (b)	Test accuracy of life-years	<p>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. <i>[Member months=Pt 1 Ln 7.4]</i></p> <p>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. <i>[Number of life years=Pt 1 Ln 7.5]</i></p> <p><i>If exceptions were noted for the number of member months, recalculate life-years based on the accurate numbers obtained</i></p>		

No.	Regulation <sup>1</sup>	Purpose	Proposed Compliance Procedures	Description of Work Performed	Summary of Results
			<i>during the examination.</i>		
16	§158.231	Test aggregation of life-years	<p>Verify that the Total column for the life-years is the sum of the PY2, PY1, and CY columns, except that:</p> <ol style="list-style-type: none"> <li>1) For the 2014 reporting year, Student Health Plans only, if the issuer’s 2014 life-years are &lt;75,000, the aggregate number of life-years is the sum of life-years from the 2013 and the 2014 reporting years.</li> <li>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.</li> </ol> <p><i>[Life-years=Pt 3 Ln 4.1]</i></p>		
17	§158.230 §158.231 §158.232(b)	Test accuracy of the base credibility factor	<ol style="list-style-type: none"> <li>1) Verify that the issuer used the correct aggregate number of life-years to calculate the base credibility factor.</li> <li>2) If aggregated life-years are <math>\geq 1,000</math> and <math>&lt; 75,000</math>, 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.</li> <li>3) If aggregated life-years are <math>&lt; 1,000</math> or <math>\geq 75,000</math>, verify that the base credibility factor is 0.</li> <li>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: <ol style="list-style-type: none"> <li>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</li> <li>b. 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.</li> </ol> </li> </ol> <p><i>[Base credibility factor=Pt 3 Ln 4.2]</i></p>		

No.	Regulation <sup>1</sup>	Purpose	Proposed Compliance Procedures	Description of Work Performed	Summary of Results
			<p><i>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.</i></p>		
18	§158.232 (c)	Test accuracy of the deductible factor	<p>1) Select a sample of states and markets with a base credibility factor &gt; 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.<sup>15</sup></p> <p>2) Verify that the average deductible calculated above matches the amount reported on the issuer's MLR Form. [<i>Average Deductible =Pt 3 Ln 4.3</i>]</p> <p>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. [<i>Deductible factor=Pt 3 Ln 4.4</i>]</p> <p><i>If exceptions were noted in the issuer's average deductible, recalculate the deductible factor using the accurate numbers obtained during examination.</i></p>		
19	§158.232(a)	Test accuracy of the credibility adjustment	<p>Multiply the base credibility factor by the deductible factor and verify that the credibility adjustment reported on the MLR Form is accurate and unrounded. [<i>Credibility Adjustment=Pt 3 Ln 5.2</i>].</p> <p><i>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.</i></p>		
20	§158.240 §158.241 §158.242	Test accuracy of rebate payments	<p>1) Verify that the issuer paid rebates in every state/ market in which a rebate was owed.</p> <p>2) Select a sample of rebate payments and verify that:</p> <p>a. The total rebate amount for the state/market is correct.</p>		

<sup>15</sup> 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.

No.	Regulation <sup>1</sup>	Purpose	Proposed Compliance Procedures	Description of Work Performed	Summary of Results
			<p><i>[Total rebate amount=Pt 3 Lns (6.1 - 6.2) x 6.3]</i></p> <p>b. 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.</p> <p>c. For rebates distributed via premium credit, the rebate was fully applied before any new cash was paid by the enrollee. <i>[Premium credit=Pt 4 Ln 3.c]</i></p> <p>3) 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.</p> <p><i>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.</i></p>		
21	§158.243	Test accuracy of the distribution of <i>de minimis</i> rebates	<p>1) If an issuer did not provide rebates to subscribers/ policyholders whose rebate were <i>de minimis</i>, verify that the issuer accurately classified <i>de minimis</i> rebates as rebate payments &lt;\$5 in the individual market and &lt;\$20 in the small and large group markets.</p> <p>2) Select a sample of the issuer’s non-<i>de minimis</i> rebate payments and verify that they include a pro-rata portion of the aggregated <i>de minimis</i> rebates.</p> <p><i>[De minimis rebates=Pt 4 Ln 3.b]</i></p>		
22	§158.240 §158.244 §158.250	Test compliance with rebate disbursement requirements	<p>Select a sample of all subscribers/policyholders to whom a rebate is due and verify that:</p> <p>1) The rebate was paid.</p> <p>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).</p>		

No.	Regulation <sup>1</sup>	Purpose	Proposed Compliance Procedures	Description of Work Performed	Summary of Results
			<p>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.</p> <p><i>[Rebate Disbursement=Pt 4]</i></p>		
23	§158.130 §158.140	Verify accuracy of premium stabilization program amounts	<p>1) Verify accuracy of Transitional Reinsurance payments used in MLR and, if applicable, RC calculations:</p> <ul style="list-style-type: none"> <li>a. 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,<sup>16</sup> or to updated amounts communicated by CMS to issuer (obtain supporting documentation).</li> <li>b. 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).</li> </ul> <p>2) Verify accuracy of Risk Adjustment payments / (charges) used in MLR and, if applicable, RC calculations:</p> <ul style="list-style-type: none"> <li>a. 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.</li> <li>b. 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).</li> </ul>		

<sup>16</sup> CMS Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers is available annually from the Announcements section of the CCIHO website, <https://www.cms.gov/CCIHO/Programs-and-Initiatives/Premium-Stabilization-Programs/index.html>.

No.	Regulation <sup>1</sup>	Purpose	Proposed Compliance Procedures	Description of Work Performed	Summary of Results
			3) Verify accuracy of Risk Corridors payments / (charges) used in MLR calculations: <ul style="list-style-type: none"> <li>a. Verify that if Pt 3, Ln 3.8 (for 2014, Ln 3.10) is &lt;97% or &gt;103% then Pt 3, Ln 3.10 (for 2014, Ln 3.12) is not zero or blank.</li> <li>b. 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.</li> </ul>		
24	§153.500	Verify accuracy of risk corridors allowable costs and target amount calculations	For issuers subject to the commercial RC rule, verify that: <ul style="list-style-type: none"> <li>1) Allowable costs are calculated correctly. <i>[Allowable costs=MLR Form, Pt 3 Ln 3.1, Col [RC] 3/31/YY]</i></li> <li>2) Administrative costs reported in MLR Form Part 3 Line 3.2 are calculated correctly. <i>[Pt 1 Lns 5.1 + 5.2 + 5.3 + 5.4 + 5.5a + 5.5b + 5.6, Col [RC] 3/31/YY]</i></li> <li>3) The transitional adjustment percentage was applied correctly:               <ul style="list-style-type: none"> <li>a. For 2014: if the issuer used a transitional adjustment percentage on Pt 3 Ln 3.4, verify that:                   <ul style="list-style-type: none"> <li>i) the issuer operated in a transitional state;<sup>17</sup></li> <li>ii) Ln 3.3 equals at least 80%; and</li> <li>iii) Ln 3.4 equals the percentage specified by CMS.<sup>18</sup></li> </ul> </li> <li>b. For 2015: verify that the issuer used 2%.</li> </ul> </li> <li>4) Profit for risk corridors calculation and its component lines are calculated correctly.               <p><i>[For 2014: Profit=Pt 3 Ln 3.5; Earned profit=Pt 3 Ln 3.5a;</i></p> </li> </ul>		

<sup>17</sup> 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.

<sup>18</sup> For 2014, see CCHIO 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](https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/RC_TransitionalAdjGuidance_5CR_041715.pdf).

No.	Regulation <sup>1</sup>	Purpose	Proposed Compliance Procedures	Description of Work Performed	Summary of Results
			<p><i>Capped profit=Pt 3 Ln 3.5b (w/ adjustment);</i></p> <p><i>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)]</i></p> <p>5) Allowable administrative costs and their component lines are calculated correctly.</p> <p><i>[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);</i></p> <p><i>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)]</i></p> <p>6) Risk corridors target amounts are calculated correctly.</p> <p><i>[For 2014: Target amount=Pt 3 Ln 3.7 (w/ adjustment) and Ln 3.9 (w/o adjustment);</i></p> <p><i>For 2015: Target amount=Pt 3 Ln 3.5 (w/ adjustment) and Ln 3.7 (w/o adjustment)]</i></p>		

## 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 1<sup>st</sup> 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.