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2014 Benefit Year (BY) Transitional Reinsurance (RI) Program Payment Audit Summary

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Section 1341 of the Patient Protection and Affordable Care Act (ACA) established the transitional Reinsurance (RI) program to stabilize premiums in the individual market inside and outside of the Exchanges in each State and the District of Columbia for benefit years (BYs) 2014 through 2016.[1] The transitional RI program collected contributions from contributing entities[2] to fund the RI payments to health insurance issuers (issuers) of non-grandfathered individual market RI-eligible plans,[3] the administrative costs of operating the program, and the General Fund of the U.S. Treasury.[4] The program helped ensure market stability for issuers and thereby reduce premiums for individual market enrollees as the new federal ACA consumer protections and Exchanges were implemented in 2014 by partially offsetting issuers' claims associated with high-cost enrollees. For BY 2014, HHS operated the transitional RI program in all states and the District of Columbia with the exception of Connecticut.[5,6]

Under the transitional RI program, payments were made to issuers of RI-eligible plans for a percentage of covered claims (coinsurance rate) above the attachment point and below the reinsurance cap.[7]

[1] The ACA (Pub. L. 111–148) was enacted on March 23, 2010. The Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152), which amended and revised several provisions of the ACA, was enacted on March 30, 2010. In this report, we refer to the two statutes collectively as the "Patient Protection and Affordable Care Act" or "ACA".

[2] *See* 45 C.F.R. § 153.20 for a definition of "contributing entity."

[3] *See* 45 C.F.R. § 153.20 for a definition of "reinsurance-eligible plan."

[4] *See* section 1341(b)(3)(B) of the ACA. Also see 45 C.F.R. § 153.220(b).

[5] *See* section 1321(c) of the ACA (directing the HHS Secretary to, among other things, establish and operate the transitional RI program in states that elect not to do so). Also see 45 C.F.R. § 153.210(c) and Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014 and Amendments to the HHS Notice of Benefit and Payment Parameters for 2014; Final Rules; Patient Protection and Affordable Care Act; Establishment of Exchange and Qualified Health Plans; Small Business Health Options Program; Proposed Rule, 78 FR 15410 at 15453 (March 11, 2013) (2014 Payment Notice).

[6] Connecticut was the only state that elected to operate an RI program for BY 2014. Connecticut issuers leveraged the EDGE server data submission process; therefore, to provide a comprehensive view of the transitional RI program, CMS included the RI payment amounts for Connecticut issuers in the *Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2014 Benefit Year* (revised Sept. 17, 2015), available at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RI-RA-Report-REVISED-9-17-15.pdf.

[7] *See*, e.g., the 2014 Payment Notice, 78 FR at 15467-15468. The final BY 2014 national RI payment parameters consisted of a $45,000 attachment point, $250,000 cap, and a 100 percent coinsurance rate. In other words, for BY 2014, the RI program reimbursed issuers for 100 percent of an issuer's aggregated total paid claim amount for enrollees that fell between $45,000 (the attachment point) and $250,000 (the cap). Note that the final BY 2014 coinsurance rate was increased to 100 percent because RI contributions exceeded the total requests for RI payments for BY 2014. The maximum BY 2014 RI

Program Integrity Framework

The Centers for Medicare & Medicaid Services (CMS) take the stewardship of taxpayer dollars and its program integrity responsibilities seriously. CMS's program integrity framework for the HHS-operated transitional RI program includes multiple layers of review to validate the accuracy of the data used to calculate RI payments administered by CMS. This program integrity framework included the following elements:

- *Process controls:*[8] These controls include multiple levels of review by CMS and requiring issuers of RI-eligible plans to confirm the accuracy of their data.[9]
    - *External Data Gathering Environment (EDGE) Quantity & Quality Evaluations:* CMS closely monitored the submission of issuer data to their respective EDGE servers throughout the applicable data submission window to ensure issuers' data submissions met minimum quantity and quality requirements; issuers that did not fulfill these requirements may have forgone RI payments that they otherwise might have received for that BY.[10]
    - *Attestation and Discrepancy Reporting:* Issuers of RI-eligible plans were required to attest to the accuracy of their EDGE data submissions for the applicable BY or qualify an attestation with any identified discrepancies.[11] CMS conducted a discrepancy resolution process, and remediated discrepancies were either observed as part of the final payment reports or, if not resolved before the final report

payment for an enrollee was $205,000. See CMS Memo *Transitional Reinsurance Program: Pro Rata Adjustment to the National Coinsurance Rate for the 2014 Benefit Year* (June 17, 2015), available at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/The-Transitional-Reinsurance-Program/Downloads/RI-Payments-National-Proration-Memo-With-Numbers-6-17-15.pdf.

[8] Some of these process controls are documented in CMS's annual Cycle Memo and reviewed through CMS's annual Office of Management and Budget (OMB) Circular A-123 review. These reviews concluded controls were operating effectively.

[9] The issuer must confirm with HHS that the information in the final report accurately reflects the data to which the issuer has provided access to HHS through its distributed data gathering environment (i.e., the issuer's EDGE server). *See* 45 C.F.R. § 153.710(d), which was redesignated from § 153.710(e) in the 2017 Payment Notice. *See* the Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017; Final Rule, 81 FR 12203 at 12223 (March 8, 2016). For BY 2014, CMS developed a manual process by which issuers either submitted a discrepancy or provided confirmation to the accuracy of their EDGE data submission by emailing an attestation letter. Also see *Technical Guidance for FORMAL Discrepancy Reporting Procedures Regarding EDGE Server Outbound Risk Adjustment and Reinsurance Program Estimate Reports* (March 16, 2015), available at: https://regtap.cms.gov/reg_library_openfile.php?id=837&type=l. As part of the attestation submitted to CMS via email for the BY 2014 manual process, issuers acknowledged that the data submitted to their EDGE servers and made available for the transitional RI program established under section 1341 of the ACA may be subject to the False Claims Act.

[10] *See* 45 C.F.R. §§ 153.420 and 153.740(a). Also see CMS Memo *Evaluation of EDGE Data Submissions* (April 24, 2015) available at: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/EDGE-guidance-42415-final.pdf. This process was codified in 45 C.F.R. § 153.710(f) in the 2017 Payment Notice and was redesignated to its current location at § 153.710(g) in the 2022 Payment Notice. *See* 81 FR at 12234-12234 and the Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2022 and Pharmacy Benefit Standards; Updates to State Innovation Waiver (Section 1332 Waiver) Implementing Regulations; Final Rule, 86 FR 24140 at 24194-24195 (May 5, 2021).

[11] *See* supra note 9. For BY 2014, the attestation and discrepancy reporting window was open from May 18, 2015 through June 2, 2015. See https://regtap.cms.gov/reg_library_openfile.php?id=4293&type=l.

publication, in future calculation estimate reports.[12]

- *Reconsideration process:* Issuers of RI-eligible plans could file a reconsideration request to contest a processing error by HHS, HHS's incorrect application of the relevant methodology, or HHS's mathematical error with respect to the amount of a reinsurance payment.[13]
- *Prior Benefit Year Discrepancy Reporting:* If an issuer of RI-eligible plan identifies a previously unreported discrepancy for a prior BY, they must report the identified data discrepancy to CMS.[14] CMS evaluates prior BY reported discrepancies and may take action on material overpayment discrepancies.[15]

- *Transitional RI Program Payment Audits*: Consistent with 45 C.F.R. § 153.410(d), CMS developed an audit process to validate the accuracy of the data submitted by issuers of RI-eligible plans to their respective EDGE servers that were used to calculate RI payments, which includes verification of premiums, enrollment, and claims data for 100 percent of RI payment enrollees in RI-eligible plans for whom issuers received RI payments. In addition, in the BY 2014 audits, CMS audited a sample of enrollees in RI-eligible plans for whom the issuer did not receive RI payment. CMS conducted the sample of non-payment enrollees to identify any additional data integrity issues in the data submitted to issuers' EDGE servers, inform issuers of additional errors that need to be corrected, and help CMS improve data submission expectations for future submissions.

Transitional RI Program Payment Audit Program

CMS established an audit program to confirm the accuracy of payments and the successful implementation of, and adherence to, CMS rules and regulations governing the transitional RI program, including record retention requirements.[16] These audits are collaborative and involve coordination with issuers to resolve data discrepancies and identify process improvements.

BY 2014 Transitional RI Program Payment Audit Scope and Methodology

CMS conducted audits to assess compliance by issuers of RI-eligible plans with the applicable federal transitional RI program requirements for BY 2014. CMS validated the accuracy of the BY 2014 (January 1, 2014 through December 31, 2014) enrollee and claim-level data included in the BY 2014

[12] *See Technical Guidance for FORMAL Discrepancy Reporting Procedures Regarding EDGE Server Outbound Risk Adjustment and Reinsurance Program Estimate Reports* (March 16, 2015), available at: https://regtap.cms.gov/reg_library_openfile.php?id=837&type=l.

[13] *See* 45 C.F.R. §§ 153.240(b) and 156.1220(a). Requests for reconsideration must be filed within 30 days after notification by HHS of the RI payments under the national payment parameters. For BY 2014, reconsideration requests were required to be filed by July 31, 2015.

[14] *See* the Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2022 and Pharmacy Benefit Standards; Updates to State Innovation Waiver (Section 1332 Waiver) Implementing Regulations; Final Rule, 86 FR 24140 at 24195 (May 5, 2021). Also see 08/18/20 EDGE Server Announcements on "EDGE/RA Discrepancy Reporting: Prior Benefit Year Discrepancy Web Form" available at: https://regtap.cms.gov/reg_librarye.php?prog=3&page=1&i=3357.

[15] *See* supra notes 12 and 14.

[16] *See* 45 C.F.R. § 153.410(d). In the 2022 Payment Notice, CMS amended 45 C.F.R. §153.410(d) and the amended regulation applies to audits commenced on or after July 6, 2021. See 86 FR at 24189-24191.

Reinsurance Detailed Enrollee Report (BY 2014 RIDE Report). The BY 2014 RIDE Report represents data submitted by an issuer to its EDGE server as of May 15, 2015, the final BY 2014 EDGE data submission deadline,[17,18] and is the data CMS used to calculate the issuer's BY 2014 RI payments. In addition to the BY 2014 RIDE Report, the auditor collected other documentation from issuers necessary to conduct the audit, including BY 2014 claims data extracts from issuer source systems and issuers' policies and procedures for the applicable time period under audit.

The auditor performed audit procedures on 100 percent of on-Exchange enrollees and off-Exchange enrollees in the individual market for whom the issuer received BY 2014 RI payments and 10 percent of the issuer's enrollee population in RI-eligible plans, up to 1,500 enrollees, for whom the issuer did not receive BY 2014 RI payments. The auditor reviewed issuer-submitted documentation and used the following audit procedures to assess compliance with applicable federal transitional RI program requirements:

(1) **Unreconciled Claims Review**: Review and comparison of the unique claim IDs included in the issuer's BY 2014 RIDE Report to the unique claim IDs included in the issuer's data extract to determine existence.

(2) **RI Eligible Plan[19] Review**: Review the issuer's claims in the data extract to those in the BY 2014 RIDE Report to validate whether the claims were associated with an RI eligible plan.

(3) **BY 2014 Claim Validation**: Review the issuer's claims start and end dates in the data extract to validate whether the claims fell within BY 2014 and were not cross-year claims from a prior year.

(4) **Claim Paid Date Validation**: Review the issuer's claims data extract payment date to validate the BY 2014 claims were paid as of CMS's BY 2014 extended deadline for EDGE data submissions of May 15, 2015.

(5) **Claim Coverage Period Validation**: Review the issuer's claims in the data extract to the coverage period in the BY 2014 RIDE Report to determine whether the claim start date is within the enrollee's coverage period.

(6) **Paid Claim Amount Validation**: Review the issuer's claims in the data extract to validate the paid claim amount matches the paid claim amount in the issuer's BY 2014 RIDE Report.

(7) **Issuer Policies and Procedures Review**: Determine whether the issuer's policies and procedures comply with applicable CMS rules, regulations, and policies related to the transitional RI program.

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[17] *See* 45 C.F.R. § 153.420(b). For the BY 2014 data submission, CMS provided a grace period until May 15, 2015, for issuers to submit and update EDGE server data. See https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/EDGE_Data_Grace_Period_Guidance4-27-15.pdf.

[18] Issuers were required to submit attestations and report discrepancies for the BY 2014 EDGE submission from May 18, 2015, to June 2, 2015. See https://regtap.cms.gov/reg_library_openfile.php?id=4293&type=l. To execute the procedures described in this audit report, CMS will always review an issuer's final BY data submission upon which final RI payments were calculated for the issuer.

[19] *See* supra note 3.

(8) **Data Extract Validation:** Validate accuracy of the incurred claims data reported on the issuer's data extract using actual claims/explanation of benefits (EOBs) for fifteen (15) selected subscribers.

(9) **Issuer Attestation Review:** Validate that the issuer provided a completed attestation signed by the Chief Executive Officer (CEO), Chief Financial Officer (CFO) or other authorized official who has reviewed the documentation submitted for this audit. This procedure was reviewed to substantiate the accuracy of the documentation submitted during the audit process and did not result in a finding or observation for the issuer.

Upon application of CMS's audit protocols, the auditor identified findings and observations.

- A *finding* resulted from cases of confirmed non-compliance or discovery of evidence suggesting non-compliance with applicable federal transitional RI program requirements, which required a recoupment of RI payments; while
- An *observation* resulted from the identification of areas for improvement when there was no evidence of actual non-compliance with applicable federal transitional RI program requirements, or when there may have been evidence of non-compliance with applicable federal transitional RI program requirements that did not require recoupment of RI payments.

2014 BY Transitional RI Program Payment Audit Results

CMS completed audits for all 59 issuers selected for BY 2014 RI payment audits.

Of the claim-level procedures where findings or observations were identified, the vast majority of issues resulted from incorrect paid claim amounts identified through the Paid Claim Amount Validation (70 percent of total claim-level issues identified), unreconciled claims identified through the Unreconciled Claims Review (16 percent of total claim-level issues identified), and claims for enrollees found to not be associated with an RI-eligible plan identified through the RI Eligible Plan Review (12 percent of total claim-level issues identified). Findings and observations were also identified under the Claim Paid Date Validation, the Claim Coverage Period Validation, and the BY 2014 Claim Validation procedures. Table 1 provides summary information about the BY 2014 RI payment audit results by audit procedure.

Table 1: BY 2014 Transitional RI Program Payment Audit – Issuer Summary Data by Audit Procedure

Procedure	Issuers with Finding[20]	Issuers with Observation
Unreconciled Claims Review	16	21
RI Eligible Plan Review	0	15
Claim Paid Date Validation	6	8
Paid Claim Amount Validation	38	42
Claim Coverage Period Validation	5	9
BY 2014 Claim Validation	1	1
Issuer Policies and Procedures Review	N/A	0
Issuer Attestation Review	N/A	0

[20] Not applicable ("N/A") is indicated in the "Issuers with Finding" column for the following audit procedures because issues identified under these procedures can only result in an observation: Issuer Policies and Procedures Review and Issuer Attestation Review.

Forty-one issuers received findings that resulted in financial impact, 18 issuers received observations that resulted in no financial impact, and 9 issuers received no findings or observations.[21] To determine financial impact of the findings, CMS first determined paid claim amount differences for enrollees associated with a BY 2014 RI payment. The claim-level differences were then aggregated at the enrollee level for final recalculation of issuers' BY 2014 RI payments to determine total financial impact. The final financial impact of the findings for all 41 issuers that had findings resulted in overpayments to issuers totaling $9,350,553.05, representing 0.31 percent of the total BY 2014 RI payments for all 59 issuers audited.[22]

Table 2 lists summary information regarding the BY 2014 RI payment audits. Table 3 lists all issuers selected for audit for BY 2014, each issuer's original BY 2014 RI payment, and the financial impact identified through the audit for each issuer, where applicable. The reports detailing findings and observations from each of these issuer audits are available on the CCIIO web page.[23]

Table 2: BY 2014 Transitional RI Program Payment Audit – Summary Data

SUMMARY DATA ELEMENT	TOTALS
Number of Issuers Receiving Reinsurance Payments, Nationwide[24]	437
Dollar Value of BY 2014 Reinsurance Payment Requests[25]	Approximately $7.9 billion
Number of Issuers Audited for the BY 2014 RI Payment Audits	59
Number of Issuers Audited for the BY 2014 RI Payment Audits with At Least One Finding or Observation[26]	50
Number of Issuers Audited for the BY 2014 RI Payment Audits with No Findings or Observations	9
Number of Issuers Audited for the BY 2014 RI Payment Audits with Findings with Financial Impact	41
Number of Issuers Audited for the BY 2014 RI Payment Audits with No Findings and No Financial Impact	18
Dollar Value of BY 2014 Reinsurance Payments for Audited Issuers	$2,995,188,425
Total Financial Impact for All BY 2014 RI Payment Audits	$9,350,553
BY 2014 RI Payment Recoupment Percentage for All Audited Issuers	0.31%

Table 3: BY 2014 Transitional RI Program Payment Audit – Recoupment Amount by Issuer

HIOS ID	Issuer Name	State	BY 2014 RI Payment	BY 2014 RI Audit Financial Impact	BY 2014 RI Financial Impact Percentage
64844	Aetna Health Inc. (a PA corp.)	PA	$1,280,386.05	$0.00	0.00%

[21] Issuers that received both findings and observations are counted separately in each category.
[22] Financial impact derived from the BY 2014 RI payment audits only includes findings where funds are subject to recoupment by HHS. Additional RI payments are not provided for underpayments identified as a result of these audits.
[23] See https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Exams_Audits_Reviews_Issuer_Resources-.
[24] See *Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2014 Benefit Year* (revised Sept. 17, 2015), available at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RI-RA-Report-REVISED-9-17-15.pdf.
[25] Ibid.
[26] See supra note 21.

HIOS ID	Issuer Name	State	BY 2014 RI Payment	BY 2014 RI Audit Financial Impact	BY 2014 RI Financial Impact Percentage
17210	Aetna Life Insurance Company	NY	$14,885,554.32	$13,419.83	0.09%
33906	Aetna Life Insurance Company	PA	$2,951,625.54	$0.00	0.00%
91716	Aetna Life Insurance Company	TX	$14,609,683.22	$0.00	0.00%
77606	AmeriHealth HMO, Inc	NJ	$14,451,039.66	$56,955.76	0.39%
28162	AultCare Insurance Company	OH	$3,286,427.05	$26,139.83	0.80%
11512	Blue Cross and Blue Shield of NC	NC	$263,657,626.53	$894.18	0.00%*
87571	Blue Cross Blue Shield of Oklahoma	OK	$58,988,045.78	$0.00	0.00%
33602	Blue Cross Blue Shield of Texas	TX	$549,029,026.67	$0.00	0.00%
27603	Blue Cross of California (Anthem BC)	CA	$401,126,393.31	$367.00	0.00%*
49526	BlueCross BlueShield of Western New York	NY	$3,203,677.59	$0.00	0.00%
82569	Boston Medical Center Health Plan, Inc.	MA	$130,830.24	$7,896.37	6.04%
53732	BridgeSpan Health Company	WA	$3,714,808.43	$38.75	0.00%*
41047	Buckeye Community Health Plan, Inc.	OH	$311,415.92	$59.18	0.02%
70285	CA Physician's Service dba Blue Shield of CA	CA	$363,050,264.53	$200,452.18	0.06%
28137	CareFirst BlueChoice, Inc.	MD	$33,674,052.57	$0.00	0.00%
94788	CDPHP	NY	$5,393,821.37	$18,659.53	0.35%
48121	Cigna Health and Life Insurance Company	FL	$75,559,934.98	$563,996.12	0.75%
49375	Cigna Health and Life Insurance Company	CO	$10,847,936.42	$85,342.65	0.79%
63312	Colorado Choice Health Plans	CO	$6,252,605.70	$370.47	0.01%
18581	Community Health Plan of Washington	WA	$9,099,895.43	$0.00	0.00%
99483	Contra Costa Health Plan	CA	$2,293,366.91	$79,450.05	3.46%
81914	Coventry Health Care of Delaware, Inc.	DE	$628,973.12	$0.00	0.00%
57451	Coventry Health Care of Florida, Inc.	FL	$63,556,095.78	$144,975.58	0.23%
88806	Fallon Community Health Plan, Inc.	MA	$2,543,005.00	$233,753.94	9.19%
22444	Geisinger Health Plan	PA	$14,765,963.46	$441,339.66	2.99%
85408	GlobalHealth, Inc.	OK	$2,086,448.06	$3,297.86	0.16%
99110	Health Net Life Insurance Company	CA	$96,305,759.81	$636,758.81	0.66%
47342	Health Tradition Health Plan	WI	$4,487,321.80	$1,001.39	0.02%
91237	Healthfirst PHSP, Inc.	NY	$4,031,460.89	$1,612.80	0.04%
70194	Highmark Health Insurance Company	PA	$59,657,176.61	$69,958.86	0.12%
76680	HMO Colorado Inc (Anthem BCBS)	CO	$12,493,994.43	$1,044.49	0.01%

HIOS ID	Issuer Name	State	BY 2014 RI Payment	BY 2014 RI Audit Financial Impact	BY 2014 RI Financial Impact Percentage
60156	HMO Colorado Inc dba HMO NV (Anthem BCBS)	NV	$4,285,648.85	$0.00	0.00%
91661	Horizon Healthcare Services, Inc	NJ	$68,139,576.15	$18,697.01	0.03%
93332	Humana Employers Health Plan of Georgia, Inc	GA	$194,926,953.76	$437,519.91	0.21%
99791	Humana Insurance Company	IN	$15,014,843.87	$23,553.92	0.15%
56764	Humana Medical Plan of Utah, Inc.	UT	$3,555,669.52	$2,098.41	0.06%
35783	Humana Medical Plan, Inc.	FL	$119,899,412.27	$345,632.39	0.28%
18029	Independent Health Benefits Corporation	NY	$2,847,602.18	$0.00	0.00%
40513	Kaiser Foundation Health Plan, Inc.	CA	$240,031,290.84	$0.00	0.00%
60612	Kaiser Foundation Health Plan, Inc.	HI	$4,687,278.77	$0.00	0.00%
38498	LifeWise Health Plan of WA	WA	$37,535,881.13	$3,895.97	0.01%
92815	Local Initiative Health Authority for Los Angeles County	CA	$347,123.67	$0.00	0.00%
73836	Moda Health Plan, Inc.	AK	$13,102,419.34	$0.00	0.00%
84481	Molina Healthcare of Washington, Inc.	WA	$1,345,029.79	$0.00	0.00%
11555	New Health Ventures Inc	CO	$205,000.00	$0.00	0.00%
93091	New Mexico Health Connections	NM	$3,178,238.43	$575.14	0.02%
25303	New York State Catholic Health Plan, Inc.	NY	$13,745,380.71	$28,576.82	0.21%
74289	Oscar Insurance Corporation	NY	$17,524,068.75	$1,320,556.00	7.54%
26420	Oxford Health Plans (NY), Inc.	NY	$37,810,243.67	$0.00	0.00%
74313	Paramount Insurance Company	OH	$1,327,983.05	$6,037.01	0.45%
45495	Peach State Health Plan	GA	$752,278.28	$7,523.67	1.00%
70525	QCA Health Plan, Inc.	AR	$4,262,438.76	$5,668.18	0.13%
91058	Quartz Health Plan Corporation (formerly known as Gundersen Health Plan, Inc.)	WI	$5,727,641.40	$500.86	0.01%
97879	Rocky Mountain HMO	CO	$54,104,079.51	$4,555,418.39	8.42%
92499	Sharp Health Plan	CA	$10,986,209.85	$328.47	0.00%*
52664	Summa Insurance Company, Inc.	OH	$4,527,307.52	$3,064.10	0.07%
39060	Time Insurance Company	CO	$16,138,881.92	$118.55	0.00%*
93689	Western Health Advantage	CA	$5,847,162.74	$3,002.96	0.05%

**The BY 2014 RI Audit Financial Impact divided by the issuer's BY 2014 RI Audit Payment does not round to at least one hundredth of one percent.*