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2015 Benefit Year (BY) Transitional Reinsurance (RI) Program Payment Audit Summary

May 8, 2024

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 2015, HHS operated the transitional RI program in all states and the District of Columbia except for Connecticut.[5,6]

[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 2015. See CMS Memo *RE: Transitional Reinsurance Program – CMS to Begin Operating on behalf of the State of Connecticut (effective April 7, 2017)* (April 28, 2023), available at: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Transitional-Reinsurance-Program-%E2%80%93-CMS-to-Begin-Operating-on-behalf-of-the-State-of-Connecticut.pdf. 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 S*ummary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2015 Benefit Year* (June 30, 2016), available at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/June-30-2016-RA-and-RI-Summary-Report-5CR-063016.pdf. Also see CMS Memo *Amendment to the Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2015 Benefit Year* (December 6, 2016), available at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/DDC_RevisedJune30thReport_v2_5CR_120516.pdf.

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 RI cap.[7]

Program Integrity Framework

The Centers for Medicare & Medicaid Services (CMS) takes 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.[9,10]
    - *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

[7] The final BY 2015 national RI payment parameters as established by the 2015 Payment Notice and updated in the 2016 Payment Notice consisted of a $45,000 attachment point, $250,000 cap, and a 50%coinsurance rate. Under 45 C.F.R. § 153.230, CMS set the national RI payment parameters in the annual HHS notice of benefit and payment parameters for each applicable benefit year with an allowance for a uniform adjustment to the national RI payments in the event the amount requested under the national RI payment parameters would not be equal to the amount of RI contributions collected for that benefit year. *See* the Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2015; Final Rule, 79 FR 13744 at 13778 (March 11, 2014) (2015 Payment Notice) and Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016; Final Rule, 80 FR 10749 at 10777 (February 27, 2015) (2015 Payment Notice). Note that, after accounting for adjustments, the final national RI payment parameters for BY 2015 consisted of a $45,000 attachment point, $250,000 cap, and an approximately 55.48% coinsurance rate. In other words, for BY 2015, the RI program reimbursed issuers for 55.28%of an issuer's aggregated total paid claim amount for enrollees that fell between $45,000 (the attachment point) and $250,000 (the cap). See CMS Memo *Amendment to the Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2015 Benefit Year* (December 6, 2016), available at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/DDC_RevisedJune30thReport_v2_5CR_120516.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) (2017 Payment Notice). For BY 2015, CMS developed a process by which issuers either submitted a discrepancy or provided confirmation to the accuracy of their EDGE data submission into a web form. *See Risk Adjustment (RA) and Reinsurance (RI) Attestation and Discrepancy Reporting Process for the 2015 Benefit Year* webinar presentation slides (presented on April 21, 2016 and April 28, 2016), available at: https://regtap.cms.gov/reg_library_openfile.php?id=1525&type=l. Also see *RARI Attestation and Discrepancy Reporting Guide for the 2015 Benefit Year* (May 3, 2016), available at: https://regtap.cms.gov/reg_library_openfile.php?id=1548&type=l.

[10] As part of the BY 2015 Attestation and Discrepancy Reporting Web Form 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. *See Risk Adjustment (RA) and Reinsurance (RI) Attestation and Discrepancy Reporting Process for the 2015 Benefit Year* webinar presentation slides (presented on April 21, 2016 and April 28, 2016), slide 42, available at: https://regtap.cms.gov/reg_library_openfile.php?id=1525&type=l.

have received for that BY.[11]

- *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.[12] 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 publication, in future calculation estimate reports.[13]
- *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 RI payment.[14]
- *Prior Benefit Year Discrepancy Reporting:* If an issuer of an RI-eligible plan identifies a previously unreported discrepancy for a prior BY, they must report the identified data discrepancy to CMS.[15] CMS evaluates prior BY reported discrepancies and may act on material overpayment discrepancies.[16]

- *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, for BY 2015, included verification of premiums, enrollment, and claims data for 100% of RI payment enrollees in RI-eligible plans for whom audited issuers received RI payments. CMS selects issuers for audit using targeted, risk-based, and random sampling approaches.

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,

[11] *See* 45 C.F.R. §§ 153.420 and 153.740(a). Also see CMS Memo *Evaluation of EDGE Data Submissions for 2015 Benefit Year* (March 18, 2016) available at: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Part-2-EDGE-Q_Q-Guidance_03182016.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) (2022 Payment Notice).

[12] *See* supra notes 9 and 10. For BY 2015, the attestation and discrepancy reporting window was May 3, 2016 through May 20, 2016. *See Risk Adjustment (RA) and Reinsurance (RI) Attestation and Discrepancy Reporting Process for the 2015 Benefit Year* webinar presentation slides (presented on April 21, 2016 and April 28, 2016), slide 11, available at: https://regtap.cms.gov/reg_library_openfile.php?id=1525&type=l.

[13] *See* supra notes 9 and 10. See also CMS Memo *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.

[14] *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 2015, the 30-day reconsideration window opened on June 30, 2016. https://regtap.cms.gov/reg_library_openfile.php?id=5279&type=l.

[15] *See* the2022 Payment Notice, 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.

[16] *See* supra notes 13 and 15.

including requirements related to record retention and compliance with audit activities.[17] These audits are collaborative and involve coordination with issuers to resolve data discrepancies and identify process improvements.

BY 2015 Transitional RI Program Payment Audit Scope and Methodology

CMS conducted audits of selected issuers to assess compliance by issuers of RI-eligible plans with the applicable federal transitional RI program requirements for BY 2015. CMS validated the accuracy of the BY 2015 (January 1, 2015, through December 31, 2015) enrollee and claim-level data included in the BY 2015 Reinsurance Detailed Enrollee Report (BY 2015 RIDE Report). The BY 2015 RIDE Report represents data submitted by an issuer to its EDGE server as of May 2, 2016, the final BY 2015 EDGE data submission deadline,[18,19] and is the data CMS used to calculate the issuer's BY 2015 RI payments. In addition to the BY 2015 RIDE Report, the auditor collected other documentation from issuers necessary to conduct the audit, including BY 2015 claims data extracts from issuer source systems and issuers' policies and procedures for the applicable period under audit.

The auditor performed audit procedures on 100% of on-Exchange enrollees and off-Exchange enrollees in the individual market for whom the selected issuer received BY 2015 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**: Reviews the issuers' claims data extract to determine if the claims reported on the BY 2015 RIDE Report existed in the data extract.

(2) **RI-Eligible Plan[20] Review**: Reviews the issuer's claims data extract to determine if the enrollee's plan ID matched the corresponding enrollee's plan ID reported in the issuer's BY 2015 RIDE Report and if the claim was paid by an RI-eligible plan.

(3) **Claim Coverage Period Validation**: Reviews the issuer's claims data extract to determine if the service begin date of claims were within the enrollee's coverage period.

(4) **Paid Claim Amount Validation**: Review of the issuer's claims data extract to determine if the claim paid amount matched the corresponding claim paid amount in the issuer's BY 2015 RIDE Report.

(5) **BY 2015 Cross Year Claim Validation**: Review the issuer's claims data extract to identify cross year claims and determine if the service end date of claims fell within the applicable benefit year.

(6) **Duplicate Claim Validation:** Review the issuer's claims data extract to determine if claims were reported more than once on the EDGE server.

(7) **Enrollee Validation**: Review the issuer's claims data extract to determine if the enrollee and

[17] *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.
[18] *See* 45 C.F.R. § 153.420(b). For the BY 2015 data submission, issuers had until May 2, 2016, to submit and update EDGE server data. See CMS Memo *Evaluation of EDGE Data Submissions for 2015 Benefit Year* (March 18, 2016) available at: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Part-2-EDGE-Q_Q-Guidance_03182016.pdf.
[19] *See* supra note 12. Issuers were required to submit attestations and report discrepancies for the BY 2015 EDGE submission from May 3, 2015 to May 20, 2015. To execute the procedures described in this audit report, CMS reviews an issuer's final BY data submission upon which final RI payments were calculated for the issuer.
[20] *See* supra note 3.

related claims included in the issuer's claims data extract matches the enrollee associated with the applicable claim on the EDGE server.

(8) **Issuer RI Policies and Procedures Review**: Review of the issuer's RI policies and procedures to determine compliance with applicable CMS rules, regulations, and policies.

(9) **Issuer RI Attestation Review:** Review the issuer's RI Attestation to 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.

(10) **Issuer Compliance with CMS RI Payment Audit Requirements**: Review of the issuer's compliance with the applicable CMS audit requirements, including an assessment of the completeness of audit documentation, for the BY 2015 RI payment audit.

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.
- 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.

2015 BY Transitional RI Program Payment Audit Results

CMS completed audits for all 42 issuers selected for BY 2015 RI payment audits. Twenty-seven of the audited issuers received findings that resulted in financial impact, nine issuers received only observations that resulted in no financial impact, and six issuers did not receive any findings or observations. Appendix A lists all issuers selected for audit for BY 2015, each issuer's original BY 2015 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.[21] To determine financial impact of the findings, CMS first determined paid claim amount differences for enrollees associated with a BY 2015 RI payment. The claim-level differences were then aggregated at the enrollee level for final recalculation of an issuer's BY 2015 RI payments to determine total financial impact. The final financial impact of the findings for the 27 issuers that had findings resulted in recoupment of RI overpayments to issuers totaling $4,369,619.08, representing 0.54% of the total BY 2015 RI payments for all 42 issuers audited.

[21] See Transitional Reinsurance Program Audits available at: https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Exams_Audits_Reviews_Issuer_Resources-#Transitional_Reinsurance_Program_Audits.

Table 1 lists summary information regarding the BY 2015 transitional RI program payments and the BY 2015 RI payment audits.

Table 1: BY 2015 Transitional RI Program Payment Audit – Summary Data

SUMMARY DATA ELEMENT	TOTALS
Number of Issuers Receiving RI Payments, Nationwide[22]	497
Dollar Value of BY 2015 RI Payment Requests[23]	Approximately $7.8 billion
Number of Issuers Audited for the BY 2015 RI Payment Audits	42
Number of Issuers Audited for the BY 2015 RI Payment Audits with At Least One Finding or Observation[24]	36
Number of Issuers Audited for the BY 2015 RI Payment Audits with No Findings or Observations	6
Number of Issuers Audited for the BY 2015 RI Payment Audits with Findings with Financial Impact	27
Number of Issuers Audited for the BY 2015 RI Payment Audits with No Findings and No Financial Impact	15
Dollar Value of BY 2015 RI Payments for Audited Issuers	$813,355,785
Total Financial Impact for All BY 2015 RI Payment Audits	$4,369,619
BY 2015 RI Payment Recoupment Percentage for All Audited Issuers	0.54%

Of the claim-level procedures where findings or observations were identified, most issues resulted from incorrect paid claim amounts identified through the Paid Claim Amount Validation (62% of audited issuers); most significantly caused by reprocessed claims and/or claim family/adjustments that were not submitted to the EDGE server correctly (36% of audited issuers). The second most significant cause for incorrect paid claim amounts identified through the Paid Claim Amount Validation was incentives, interest, and administrative fees that were incorrectly included in the claim amounts submitted to EDGE (14% of audited issuers).

The Unreconciled Claims Review resulted in the second highest number of issues identified; the most significant causes were claims submitted to the EDGE server erroneously and claims in the issuer's BY 2015 RIDE report for which the issuer was unable to provide a corresponding record in the issuer's BY 2015 claims data extract from the issuer's source system (21% of audited issuers), and the Coverage Period Validation resulted in the third highest number of issues (10% of audited issuers). Findings and observations were also identified under the Enrollee Validation, Duplicate Claim Validation, Cross Year Claim Validation, and the RI-Eligible Plan Review.

[22] See S*ummary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2015 Benefit Year* (June 30, 2016), available at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/June-30-2016-RA-and-RI-Summary-Report-5CR-063016.pdf. Also see CMS Memo A*mendment to the Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2015 benefit year* (December 6, 2016), available at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/DDC_RevisedJune30thReport_v2_5CR_120516.pdf.

[23] Ibid.

[24] Of these, nine received at least one observation, but no findings.

Table 2 provides summary information about the BY 2015 RI payment audit results by audit procedure.

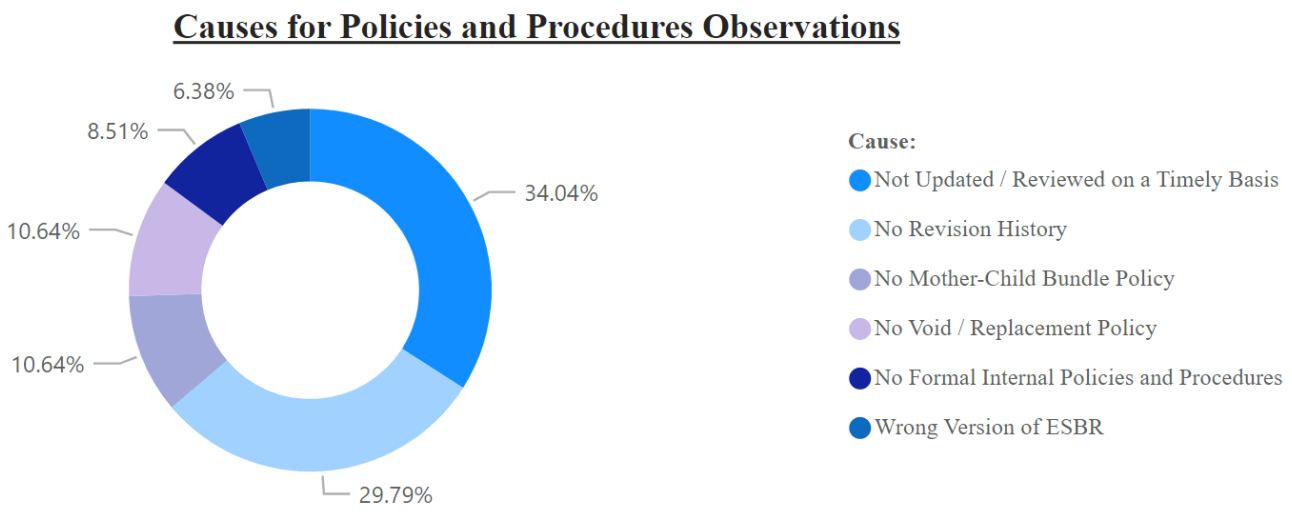
Table 2: BY 2015 Transitional RI Program Payment Audits –Summary Data by Audit Procedure

Procedure	Issuers with Finding[25]	Issuers with Observation[26]	Total Claims with Finding/Observation[27]
Unreconciled Claims Review	9	N/A	345
RI-Eligible Plan Review	0	3	217
Claim Coverage Period Validation	4	N/A	1,309
Paid Claim Amount Validation	24	21	10,888
BY 2015 Cross Year Claim Validation	1	N/A	2
Duplicate Claim Validation	2	N/A	5
Enrollee Validation	1	N/A	11
Issuer RI Policies and Procedures Review	N/A	27	N/A
Issuer Compliance with CMS RI Payment Audit Requirements	N/A	5	N/A

Approximately 64% of audited issuers (27 out of 42) received observations under the Issuer RI Policies and Procedures Review. Figure 1 provides the most common root causes and frequency of the Issuer RI Policies and Procedures Review observation. Many issuers were not able to provide evidence they had controls in place to ensure the policies and procedures, submitted for the audit, were timely and applicable to the BY 2015 data submission (e.g., wrong version of the EDGE Server Business Rules (ESBR) cited, no revision history, not reviewed on a timely basis). In addition, many issuers' policies and procedures did not include critical policies that explained how data was to be submitted to their EDGE server (e.g., lacked mother-child bundle policy, lacked void/replacement policy) in a timely manner.

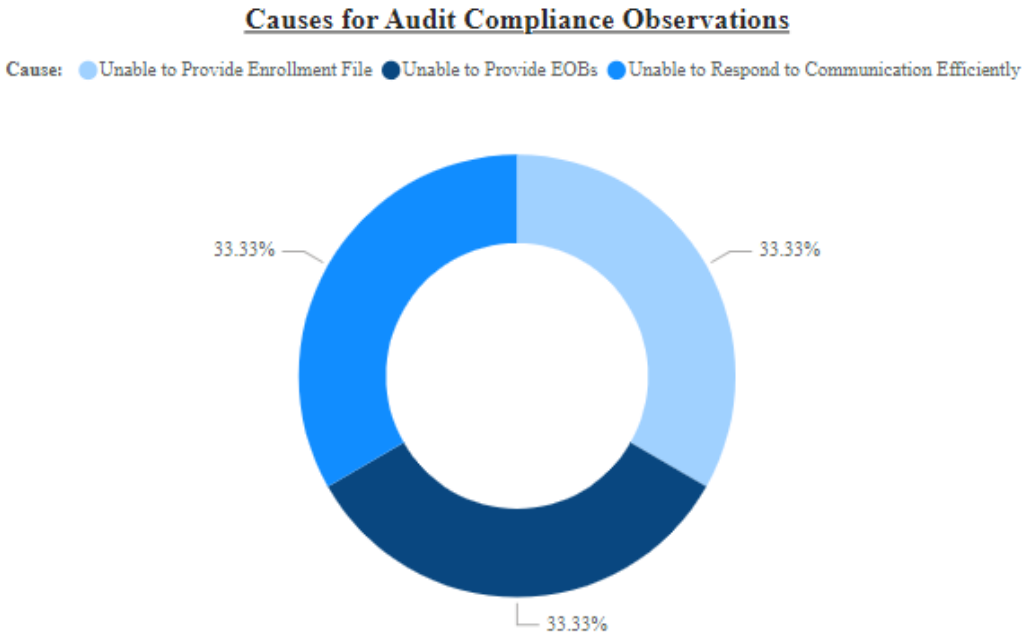
Figure 1 – Issuer Policies and Procedures Review Observation – Common Root Causes and Frequency

[25] Not applicable ("N/A") is indicated in the "Issuers with Finding" column for the following audit procedures because issues identified under these procedures only result in an observation: Issuer RI Policies and Procedures Review, Issuer Attestation Review, and Issuer Compliance with CMS RI Payment Audit Requirement.
[26] Not applicable ("N/A") is indicated in the "Issuers with Observation" column for the following audit procedures because issues identified under these procedures only result in a finding: Unreconciled Claims Review, Claim Coverage Period Validation, By 2015 Cross Year Claim Validation, Duplicate Claim Review, and Enrollee Validation.
[27] This total is aggregated for all "Issuers with Findings and Observations" for the procedure.



Approximately 12% of audited issuers (5 out of 42) received observations under the Issuer Compliance with CMS RI Payment Audit Requirements procedure. Figure 2 provides the most common root causes and frequency of the Issuer Compliance with CMS RI Payment Audit Requirements observation. Issuers received these observations due to their inability to efficiently respond or provide data or other information in the manner required by the audit, resulting in audit delays. Despite these deficiencies, all audited issuers were able to provide sufficient documentation for HHS to complete its evaluation under the audit procedures and assess compliance with applicable federal transitional RI program requirements.

Figure 2 – Issuer Audit Compliance Observation – Common Root Causes and Frequency



Appendix A: BY 2015 Transitional RI Program Payment Audit – Recoupment Amount by Issuer

HIOS ID	Issuer Name	State	BY 2015 RI Payment	BY 2015 RI Audit Financial Impact	BY 2015 RI Financial Impact Percentage
10091	PacificSource	OR	$8,527,256.74	$94,488.73	1.11%
11269	Blue Cross Blue Shield of Wyoming	WY	$12,782,742.28	$0.00	0.00%
18350	HMSA	HI	$16,281,376.23	$0.00	0.00%
22444	Geisinger Health Plan	PA	$9,257,794.27	$195,711.13	2.11%
25768	Group Health	WA	$5,574,133.63	$164.68	0.00%*
26420	Oxford Health Plans (NY), Inc.	NY	$37,245,174.19	$0.00	0.00%
30613	Humana Inc.	MO	$4,935,922.04	$25,971.63	0.53%
30751	Health Care Service Corporation	MT	$29,414,652.01	$0.00	0.00%
31195	Sanford Health Plan	SD	$1,922,711.72	$0.00	0.00%
38128	Montana Health Cooperative	ID	$7,047,613.89	$42,240.88	0.60%
38166	Security Health Plan of Wisconsin, Inc.	WI	$31,649,940.71	$11.10	0.00%*
38344	Premera Blue Cross Blue Shield of Alaska	AK	$14,730,977.10	$0.00	0.00%
40025	Cigna	CA	$17,677,642.87	$333,425.67	1.89%
40308	Group Hospitalization and Medical Services	VA	$8,475,394.36	$0.00	0.00%
43070	UnitedHealthcare Life Insurance Company	IN	$11,785,755.41	$68,657.29	0.58%
45127	Capital Advantage Assurance Company	PA	$4,570,224.90	$0.00	0.00%
46275	Humana Inc.	MI	$5,264,435.54	$58,724.33	1.12%
47342	Health Tradition Health Plan	WI	$6,004,222.44	$2,334.65	0.04%
47783	Aetna Health Inc. GA	GA	$20,422,454.12	$85,035.84	0.42%
48121	Cigna	FL	$83,139,789.15	$1,254,717.21	1.51%
49650	UnitedHealthcare Insurance Company	CT	$1,802,189.82	$616.21	0.03%
51485	Health Net Life Insurance Company	AZ	$46,454,469.25	$486,282.12	1.05%
53901	Blue Cross Blue Shield of Arizona	AZ	$52,089,367.72	$33,188.20	0.06%
56764	Humana Inc.	UT	$2,414,010.51	$95,385.60	3.95%
60597	PacificSource	ID	$811,656.57	$1,082.54	0.13%
64353	Molina Healthcare of Ohio, Inc.	OH	$883,644.78	$0.00	0.00%
67190	Aetna Health Inc.	DE	$733,385.43	$0.00	0.00%
68303	Humana Inc.	IL	$3,797,733.04	$37,939.51	1.00%
70194	Highmark Health Insurance Company	PA	$37,459,272.14	$4,340.00	0.01%
73836	Moda Health Plan, Inc.	AK	$26,441,623.47	$21,907.44	0.08%
74289	Oscar Insurance Corp	NY	$19,873,402.56	$2,551.17	0.01%
76680	HMO Colorado, Inc. (Anthem BCBS)	CO	$9,067,701.26	$0.00	0.00%
77263	Oxford Health Insurance, Inc.	NJ	$16,345,429.98	$0.00	0.00%
82569	BMCHP	MA	$1,957,524.37	$4,289.23	0.22%
84251	Aetna Life Insurance Company	AZ	$1,622,658.85	$7,134.93	0.44%

HIOS ID	Issuer Name	State	BY 2015 RI Payment	BY 2015 RI Audit Financial Impact	BY 2015 RI Financial Impact Percentage
88582	EmblemHealth	NY	$11,987,173.78	$0.00	0.00%
91661	Horizon Healthcare Services, Inc.	NJ	$86,006,145.23	$0.00	0.00%
91716	Aetna Life Insurance Company	TX	$19,176,288.48	$143,094.26	0.75%
92815	Local Initiative Health Authority for Los Angeles County	CA	$174,243.66	$0.00	0.00%
97879	Rocky Mountain Health Maintenance Organization, Inc.	CO	$33,063,396.24	$390,781.20	1.18%
99110	Health Net Life Insurance Company	CA	$94,835,369.14	$764,988.11	0.81%
99791	Humana, Inc.	IN	$9,648,885.56	$214,555.42	2.22%

**The BY 2015 RI Audit Financial Impact divided by the issuer's BY 2015 RI Audit Payment does not round to at least one hundredth of one percent.*