DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information & Insurance Oversight 200
Independence Avenue SW
Washington, DC 20201

2016 Benefit Year (BY) Transitional Reinsurance (RI) Program Payment Audit Summary

September 21, 2026

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 2016, HHS operated the transitional RI program in all states and the District of Columbia.[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 RI 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. *See also* 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). *See also* 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] For BY 2016, CMS operating the transitional RI program on behalf of all states and the District of Columbia. *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.

[7] The final BY 2016 national RI payment parameters as established by the 2016 Payment Notice consisted of a $90,000 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

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's integrity framework included the following elements:

- *Process controls:*[8] These controls include multiple levels of CMS review and require 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 have received for that benefit year.[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 benefit year or qualify an attestation with any identified discrepancies.[12] CMS conducted a

Parameters for 2016; Final Rule, 80 FR 10749 at 10777 (February 27, 2015) (2016 Payment Notice). Note that, after accounting for adjustments, the final national RI payment parameters for BY 2016 consisted of a $90,000 attachment point, $250,000 cap, and an approximately 52.9% coinsurance rate. In other words, for BY 2016, the transitional RI program reimbursed issuers for 52.9% of an issuer's aggregated total paid claim amount for enrollees that fell between $90,000 (the attachment point) and $250,000 (the cap). See *Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2016 Benefit Year*, available at: https://www.cms.gov/cciio/programs-and-initiatives/premium-stabilization-programs/downloads/summary-reinsurance-payments-risk-2016.pdf (June 30, 2017).

[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). Following the data submission deadline, CMS required issuers to submit a web form to attest to their final EDGE data submission and, if applicable, report any data discrepancies. *See Risk Adjustment (RA) and Reinsurance (RI) Attestation and Discrepancy Reporting Process for the 2016 Benefit Year* webinar presentation slides (presented on May 9, 2017 and May 11, 2017), available at: https://regtap.cms.gov/reg_librarye.php?i=2094. Also see *RA/RI Attestation & Discrepancy Reporting Guide for the 2016 Benefit Year*, available at: https://regtap.cms.gov/reg_librarye.php?i=2096.

[10] As part of the BY 2016 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 2016 Benefit Year* webinar presentation slides (presented on May 9, 2017 and May 11,2017), slide 46, available at: https://regtap.cms.gov/reg_librarye.php?i=2094.

[11] *See* 45 C.F.R. §§ 153.420 and 153.740(a). *See also Evaluation of EDGE Data Submissions for 2016 Benefit Year* (December 23, 2016) available at: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/EDGE-2016-Q_Q-Guidance_20161222v1.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 12234-12235 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 2016, the attestation and discrepancy reporting window was May 8, 2017 through May

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 benefit year, they must report the identified data discrepancy to CMS.[15] CMS evaluates prior benefit year 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 2016, 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 selected issuers for the transitional RI program payment 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, including requirements related to record retention and compliance with audit activities.[17] These audits were collaborative and involved coordination with issuers to resolve data discrepancies and identify process improvements.

22, 2017. *See Risk Adjustment (RA) and Reinsurance (RI) Attestation and Discrepancy Reporting Process for the 2016 Benefit Year* webinar presentation slides (presented on May 9, 2017 and May 11, 2017), slide 10, available at: https://regtap.cms.gov/reg_librarye.php?i=2094.

[13] *See* supra notes 9 and 10. *See also Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2016 Benefit Year* (June 30, 2017), available at https://www.cms.gov/cciio/programs-and-initiatives/premium-stabilization-programs/downloads/summary-reinsurance-payments-risk-2016.pdf.

[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 2016, the 30-day reconsideration window opened on June 30, 2017. *See 2016 Benefit Year Administrative Appeals Process for Risk Adjustment Transfers and Reinsurance Payments* webinar presentation slides (presented June 29, 2017, and July 11, 2017), available at https://regtap.cms.gov/reg_librarye.php?i=2154.

[15] *See* the 2022 Payment Notice, 86 FR 24140 at 24195 (May 5, 2021). *See also Distributed Data Collection (DDC) For Risk Adjustment (RA) Including High Cost Risk Pool (HCRP): EDGE Server Announcements*, August 18, 2020 announcement on "EDGE/RA Discrepancy Reporting: Prior Benefit Year Discrepancy Web Form," available at: https://regtap.cms.gov/reg_librarye.php?i=3357.

[16] *See* supra notes 13 and 15. See also *Issuer Resource: Late-Filed External Data Gathering Environment (EDGE) Data Discrepancies* (published March 17, 2026), available at https://regtap.cms.gov/reg_librarye.php?i=5277.

[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.

BY 2016 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 requirements related to the transitional RI program for BY 2016. CMS validated the accuracy of the BY 2016 (January 1, 2016, through December 31, 2016) enrollee- and claim-level data included in the BY 2016 Reinsurance Detailed Enrollee Report (BY 2016 RIDE Report). The BY 2016 RIDE Report represents data submitted by an issuer to its EDGE server as of May 1, 2017, the final BY 2016 EDGE data submission deadline,[18,19] and is the data CMS used to calculate the issuer's BY 2016 RI payments. In addition to the BY 2016 RIDE Report, the auditor collected other documentation from issuers necessary to conduct the audit, including BY 2016 claims data extracts from issuers' internal 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 2016 RI payments. The auditor reviewed issuer-submitted documentation and used the following audit procedures to assess compliance with applicable federal requirements related to the transitional RI program:

(1) **Unreconciled Claims Review**: Review the issuer's claims data extract to determine if the claims reported on the BY 2016 RIDE Report existed in the data extract.

(2) **RI-Eligible Plan[20] Review**: Review 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 2016 RIDE Report and if the claim was paid by an RI-eligible plan.

(3) **Claim Coverage Period Validation**: Review 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 the issuer's claims data extract to determine if the paid claim amount matched the corresponding claim paid amount in the issuer's BY 2016 RIDE Report.

(5) **BY 2016 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 related claims included in the issuer's claims data extract match the enrollee associated with the applicable claim on the EDGE server.

(8) **Issuer RI Policies and Procedures Review**: Review the issuer's RI policies and procedures

---

[18] *See* 45 C.F.R. § 153.420(b). For the BY 2016 data submission, issuers had until May 1, 2017, to submit and update EDGE server data. See *Evaluation of EDGE Data Submissions for 2016 Benefit Year* (December 23, 2016) available at: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/EDGE-2016-Q_Q-Guidance_20161222v1.pdf.

[19] *See* supra note 12. Issuers were required to submit attestations and report discrepancies for the BY 2016 EDGE submission from May 8 2017 to May 22, 2017. 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.

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 reviewed the documentation submitted for this BY 2016 RI payment audit.

(10) **Issuer Compliance with Maintenance of Records and Audit Requirements**: Review the issuer's compliance with the applicable CMS audit requirements, including an assessment of the completeness of audit documentation, and maintenance of records regulations for the BY 2016 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 requirements related to the transitional RI program, 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 requirements related to the transitional RI program, or when there may have been evidence of non-compliance with applicable federal requirements related to the transitional RI program that did not require recoupment of RI payments.

BY 2016 Transitional RI Program Payment Audit Results

CMS completed audits for all 50 issuers selected for BY 2016 RI payment audits. Thirty-four of the audited issuers received findings that resulted in financial impact, twelve issuers received only observations that resulted in no financial impact, and four issuers did not receive any findings or observations. Appendix A lists all issuers selected for audit for BY 2016, each issuer's original BY 2016 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 2016 RI payment. The claim-level differences were then aggregated at the enrollee level for final recalculation of an issuer's BY 2016 RI payments to determine total financial impact. The final financial impact of the findings for the 34 issuers that had findings resulted in recoupment of RI overpayments to issuers totaling $3,128,946.76, representing 0.57% of the total BY 2016 RI payments for all 50 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 2016 transitional RI program payments and the BY 2016 RI payment audits.

Table 1: BY 2016 Transitional RI Program Payment Audit – Summary Data

SUMMARY DATA ELEMENT		TOTALS
Number of Issuers Receiving RI Payments, Nationwide[22]		445
Dollar Value of BY 2016 RI Payment Requests[23]		Approximately $7.5 billion
Number of Issuers Audited for BY 2016 RI Payment Audits		50
Issuers with Only Findings with Financial Impact	*5*	
Issuers with At Least One Finding with Financial Impact and At Least One Observation	*29*	
Issuers with Only Observations and No Financial Impact	*12*	
Issuers with No Findings or Observations	*4*	
Dollar Value of BY 2016 RI Payments for Audited Issuers		$549,723,222
Total Financial Impact for All BY 2016 RI Payment Audits		$3,128,947
BY 2016 RI Payment Recoupment Percentage for All Audited Issuers		0.57%

Of the claim-level procedures where findings and observations were identified, most issues resulted from incorrect paid claim amounts identified through the Paid Claim Amount Validation (64% of audited issuers), most significantly caused by reprocessed claims and/or claim family adjustments that issuers did not submit to the EDGE server correctly (36% of audited issuers). Other significant causes for incorrect paid claim amounts identified through the Paid Claim Amount Validation were because issuers incorrectly included incentives, interest, and administrative fees in the claim amounts submitted to EDGE (10% of audited issuers) and because issuers did not submit interim bundled claims in compliance with EDGE Server Business Rules (ESBR) (10% of audited issuers).

The Unreconciled Claims Review resulted in the second highest number of issues identified (44% of audited issuers); the most significant causes were because issuers submitted claims to the EDGE server erroneously and because issuers were unable to provide a record in the BY 2016 claims data extract from the issuer's internal source system that corresponded to claims included in the issuer's BY 2016 RIDE Report (38% of audited issuers).

The audit also identified findings and observations under the Enrollee Validation, Duplicate Claim Validation, Cross-Year Claim Validation, and the RI-Eligible Plan Review.

[22] *See Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2016 Benefit Year* (June 30, 2017), available at: https://www.cms.gov/cciio/programs-and-initiatives/premium-stabilization-programs/downloads/summary-reinsurance-payments-risk-2016.pdf.
[23] *Ibid.*

Table 2 provides summary information about the BY 2016 RI payment audit results by audit procedure.

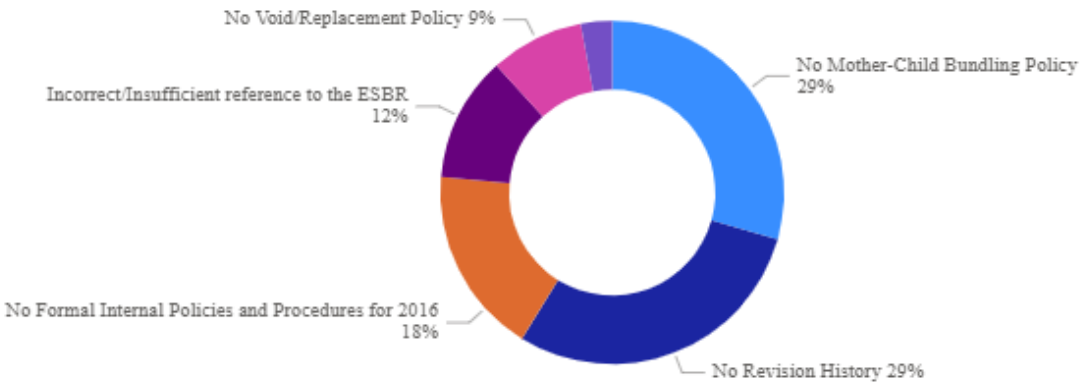
Table 2: BY 2016 Transitional RI Program Payment Audits – Summary Data by Audit Procedure

Procedure	Issuers with Finding[24]	Issuers with Observation[25]	Total Claims with Finding/Observation[26]
Unreconciled Claims Review	22	N/A	1730
RI-Eligible Plan Review	1	1	486
Claim Coverage Period Validation	0	N/A	0
Paid Claim Amount Validation	28	19	3,948
BY 2016 Cross-Year Claim Validation	6	N/A	30
Duplicate Claim Validation	4	N/A	6
Enrollee Validation	1	N/A	292
Issuer RI Policies and Procedures Review	N/A	39	N/A
Issuer Compliance with Maintenance of Records and Audit Requirements	N/A	18	N/A

Seventy-eight percent of audited issuers (39 out of 50) received observations under the Issuer RI Policies and Procedures Review. Figure 1 provides the Issuer RI Policies and Procedures Review's most common root causes and their frequency. Many issuers could not provide evidence they had controls in place to ensure the policies and procedures submitted for the audit were timely and applicable to the BY 2016 data submission (e.g., wrong version of the ESBR cited, no revision history, not reviewed on a timely basis). In addition, many issuers' policies and procedures lacked critical policies on how data should be submitted to their EDGE server (e.g., lacked mother-child bundle policy, lacked void/replacement policy) in a timely manner.

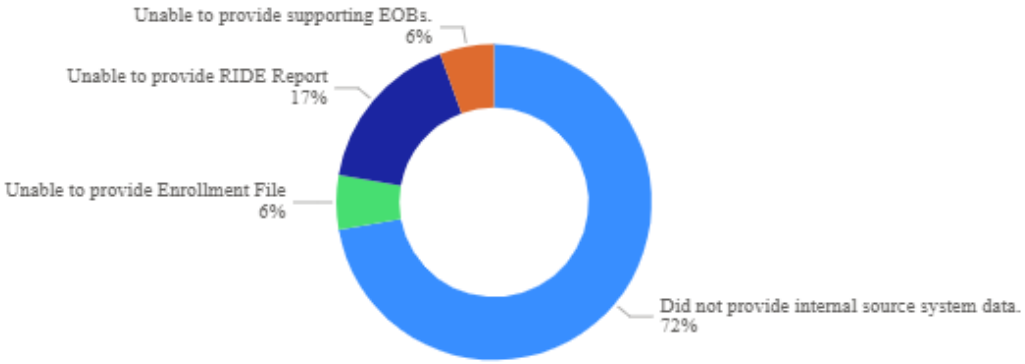
[24] Not applicable ("N/A") is indicated in the "Issuers with Finding" column for the following audit procedures because issues identified under these procedures only result in an observation: Issuer RI Policies and Procedures Review and Issuer Compliance with Maintenance of Records and Audit Requirements.
[25] 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 2016 Cross-Year Claim Validation, Duplicate Claim Validation, and Enrollee Validation.
[26] This total reflects the aggregate claims for all issuers with findings or observations under the applicable procedure. Not applicable ("N/A") is indicated for non-claims-level procedures.

Figure 1 – Cause of Issuer RI Policies and Procedures Review Observations



Thirty-six percent of audited issuers (18 of 50) received observations under the Issuer Compliance with Maintenance of Records and Audit Requirements procedure. Figure 2 provides the Issuer Compliance with Maintenance of Records and Audit Requirements procedure's most common root causes and their frequency. Issuers received these observations due to their inability to efficiently respond or provide data or other information in the format and manner required by the audit, resulting in audit delays and re-audits. 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 requirements related to the transitional RI program.

Figure 2 – Cause of Issuer Compliance with Maintenance of Records and Audit Requirements Observations



Appendix A: BY 2016 Transitional RI Program Payment Audit – Recoupment Amount by Issuer

HIOS ID	Issuer Name	State	BY 2016 RI Payment $	BY 2016 RI Audit Financial Impact $	BY 2016 RI Audit Financial Impact %
18558	Blue Cross and Blue Shield of Kansas	KS	$11,854,127.80	$89.41	0.00%*
15560	BCBS of Michigan	MI	$46,035,652.31	$0.00	0.00%
18628	Aetna Health (FL)	FL	$6,492,133.48	$6,458.05	0.10%
19304	Maine Community Health Options	NH	$3,752,853.61	$63,647.03	1.70%
20126	HealthSpan Integrated Care	OH	$1,407,370.95	$0.00	0.00%
22444	Geisinger Health	PA	$5,033,323.35	$40,398.85	0.80%
23671	UnitedHealthcare of Kentucky	KY	$929,488.25	$26,936.53	2.90%
27248	Community Health Choice	TX	$9,692,626.85	$97,635.87	1.01%
29497	Aetna Life	DE	$1,006,832.53	$0.00	0.00%
31112	UnitedHealthcare of the Mid-Atlantic	MD	$1,201,039.44	$41,920.81	3.49%
32754	Managed Health Sciences	WI	$919,979.99	$59,522.01	6.47%
33602	Blue Cross Blue Shield of Texas	TX	$136,212,350.34	$0.00	0.00%
33931	UnitedHealthcare of Ohio	OH	$4,060,594.86	$89,425.67	2.20%
36373	All Savers Insurance Company	IN	$11,209,891.50	$360,472.41	3.22%
37160	Blue Cross Blue Shield of North Dakota	ND	$7,211,472.89	$336.16	0.00%*
38499	UnitedHealthcare of Louisiana	LA	$9,494,546.72	$400,857.52	4.22%
39924	All Savers Insurance Company	WI	$10,132,189.10	$187,704.83	1.85%
42261	University of Utah Health Insurance Plans	UT	$1,130,021.88	$1,079.55	0.10%
43070	UnitedHealthcare Life Insurance Company	IN	$10,084,981.75	$78,689.65	0.78%
43802	UnitedHealthcare of Georgia	GA	$10,133,872.29	$197,266.09	1.95%
48834	Oxford Health Plans (NJ)	NJ	$3,315,635.23	$32,777.72	0.99%
49526	BlueCross BlueShield of Western New York	NY	$2,322,759.03	$19,475.49	0.84%
50328	CareSource West Virginia	WV	$359,340.21	$181.01	0.05%
50816	Physicians Health Plan of Northern Indiana	IN	$2,295,220.73	$0.00	0.00%
55409	Cigna Health and Life Insurance Company	TX	$11,132,154.01	$40,245.27	0.36%
58288	Humana Health Plan	IL	$892,618.00	$1,235.27	0.14%
59765	Bridge Span Health Company	ID	$1,024,784.18	$0.00	0.00%
60536	Avera Health Plans	SD	$5,874,620.00	$0.00	0.00%
63141	Humana Insurance Company	TX	$40,981,763.01	$336,582.09	0.82%
63474	Bridge Span Health Company	OR	$171,362.81	$0.00	0.00%
64353	Molina Healthcare of Ohio	OH	$1,268,712.41	$23,337.97	1.84%

HIOS ID	Issuer Name	State	BY 2016 RI Payment $	BY 2016 RI Audit Financial Impact $	BY 2016 RI Audit Financial Impact %
65817	UnitedHealthcare of Arkansas	AR	$881,826.60	$11,745.13	1.33%
69443	UnitedHealthcare Insurance Company	TN	$6,429,104.42	$194,245.83	3.02%
72160	Wellmark	IA	$10,419,956.81	$0.00	0.00%
74289	Oscar Insurance Corporation	NY	$19,762,375.29	$5,785.29	0.03%
74313	Paramount Insurance Company	OH	$889,181.98	$6,430.05	0.72%
78463	Harken Health Insurance Company	IL	$12,272,904.28	$0.00	0.00%
80627	Medical Mutual of Ohio	OH	$18,120,146.47	$143,096.98	0.79%
83198	Sierra Health and Life Ins Company	NV	$8,241,348.24	$0.00	0.00%
83761	Alliant Health Plans	GA	$4,857,166.33	$68,228.15	1.40%
83978	Aetna Life	GA	$7,237,366.12	$0.00	0.00%
85654	HealthPartners Insurance Company	MN	$6,958,786.77	$0.00	0.00%
88806	Fallon Community Health Plan, Inc.	MA	$919,068.23	$31,437.57	3.42%
92815	Local Initiative Health Authority for Los Angeles	CA	$24,651.58	$0.00	0.00%
94248	Blue Cross and Blue Shield of Kansas City	KS	$10,577,273.52	$77,148.71	0.73%
94815	ConnectiCare Insurance Company	CT	$11,567,410.12	$0.00	0.00%
96601	Coventry Health	IL	$14,324,867.44	$186,578.57	1.30%
97176	Louisiana Health Service & Indemnity Company	LA	$27,218,808.97	$0.00	0.00%
97879	Rocky Mountain HMO	CO	$8,211,519.55	$2,158.58	0.03%
99110	Healthnet	CA	$23,175,139.60	$295,816.64	1.28%

**The BY 2016 RI Audit Financial Impact divided by the BY 2016 RI Audit Payment does not round to at least one hundredth of one percent.*