Centers for Medicare & Medicaid Services (CMS)
Instructions for 2014 Risk Corridors Discrepancy Worksheet

Table of Contents

Centers for Medicare & Medicaid Services (CMS) 1
Instructions for 2014 Risk Corridors Discrepancy Worksheet 1
PURPOSE 3
METHOD OF SUBMISSION 3
GENERAL DEFINITIONS 4
GENERAL INSTRUCTIONS 5
Risk Corridors Discrepancy Worksheet—Claims Discrepancy Column Definitions 7
Claims Discrepancy Report (continued) 8
Claims Discrepancy Report (continued) 9
Claims Discrepancy Report (continued) 10
Claims Discrepancy Report (continued) 11
Claims Discrepancy Report (continued) 12
Claims Discrepancy Report (continued) 12
Claims Discrepancy Report (continued) 14
Claims Discrepancy Report (continued) 15
Claims Discrepancy Report (continued) 16
Premium Discrepancy Report 17
Premium Discrepancy Report (continued) 18
Premium Discrepancy Report (continued) 19
Premium Discrepancy Report (continued) 20
Premium Discrepancy Report (continued) 21
Premium Discrepancy Report (continued) 22
Premium Discrepancy Report (continued) 23
APPENDIX 1: MLR Risk Corridors Submission Checklist Template 26
APPENDIX 2: Draft Risk Corridors Discrepancy Worksheet 32

PRA Disclosure Statement

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PURPOSE

The Affordable Care Act created the medical loss ratio (MLR) program beginning for coverage provided beginning 2011 and the temporary risk corridors program for qualified health plan coverage provided 2014 through 2017. Regulations implementing the MLR program appear in 45 CFR Part 158, and regulations implementing the temporary risk corridors program appear in 45 CFR Part 153 Subpart F. These regulations require issuers to make a joint submission to CMS for the MLR and risk corridors programs. The information collection for risk corridors validation is approved by OMB under control number 0938-1155. CMS has conducted issuer outreach and appreciates the input we have received. CMS recognizes the differences in data submission requirements for MLR/risk corridors and the EDGE server. The focus of this data validation effort is to collect information necessary to quantify and explain the magnitude of these data differences.

Joint MLR and risk corridor submissions for coverage provided in 2014 (the 2014 benefit year) were due to CMS on July 31, 2015. This submission was the first to include information specific to the risk corridors program. It is also the first to reflect changes to insurance markets that occurred in 2014, including the single risk pool requirements and the risk adjustment and reinsurance program.

While conducting reviews of MLR and risk corridors submissions, CMS identified a number of material differences from data that issuers submitted for other programs, including reinsurance and risk adjustment. CMS also identified a number of errors that could lead to submissions that do not comply with CMS regulations or guidance. In order to resolve these differences, to ensure that the submissions comply with applicable guidance, and operate the MLR and risk corridors program accurately and effectively, CMS needs additional information to explain the data in issuers' MLR and risk corridors submission. Without this additional information, CMS will be unable to verify the accuracy of the submission and validate the data needed to operate the MLR and risk corridors programs.

METHOD OF SUBMISSION

The MLR and Risk Corridors Submission Checklist is a web-based form. Each company that submitted risk corridors data for the 2014 benefit year will be required to complete and attest to a checklist which identifies critical components of the risk corridors and MLR submission. Companies will receive an email with a unique web link to access the checklist and will use the online form to submit the checklist. The checklist will apply to all of a company's issuers (identified by 5-digit HIOS issuer ID) that are subject to the risk corridors program, such that each company will only submit one checklist. If a company has previously submitted a discrepancy report for its EDGE server data, it will indicate which of its issuers submitted a discrepancy by indicating each HIOS issuer ID for which a discrepancy was submitted, separated by a semicolon.

Information cannot be saved on the web form. Companies should plan accordingly.

The checklist can only be submitted through the web form. It cannot be completed in any other format (e.g., Microsoft Word or PDF), and it cannot be submitted via email, U.S. mail, or fax. A sample of the checklist is available on the CMS PRA website at https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing.html, and in Appendix 1 of these instructions.

Companies will receive emails with a unique pin number in order to verify that only the authorized company is able to access the data validation web form.

The Risk Corridors Discrepancy Worksheet is a web-based form. Companies will complete the Discrepancy Worksheet only if they have been instructed to do so by CMS in a letter dated August 31, 2015 and have been provided with a unique web link to access the form. Companies will receive an email with a unique web link to access the checklist and will use the online form to submit the discrepancy worksheet. The discrepancy worksheet will apply to all of a company's

QHP issuers (identified by 5-digit HIOS issuer ID) for which a material claims or premium difference has been identified based on its risk corridors and MLR submissions.

Information cannot be saved on the web form. Once the web form is accessed, the requested information, including uploads of applicable supplemental documents, must be completed for each issuer before submission will be considered successful. Companies should plan accordingly, and are encouraged to gather applicable data and documentation for each issuer before attempting to complete and attest to the web form.

The discrepancy worksheet can only be submitted through the web form. It cannot be completed in any other format (e.g., Microsoft Excel), and it cannot be submitted via email, U.S. mail, or fax. An illustration of the discrepancy worksheet is available in Appendix B and on the CMS PRA website at https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing.html.

GENERAL DEFINITIONS

Any terms that are not explicitly defined or referenced in these instructions have the definitions assigned to them in the MLR Form filing instructions or Title 45 of the Code of Federal Regulations. The terms below are solely for the purposes of the Risk Corridors Discrepancy Worksheet and do not apply for any other purpose.

Individual Market
All health insurance policies issued directly to an individual for self-only or dependent coverage. For the purposes of the risk corridors program, the individual market includes only plans that were compliant with ACA market reforms during the 2014 benefit year. Grandfathered plans and non-grandfathered plans that are not ACA-compliant do not participate in the risk corridors program and should be excluded from premium and claims data submitted for risk corridors. 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.

Small Group Market
All policies issued to small groups (including fully insured State and local government small groups), based on the definition of small group that applies for the purposes of the risk corridors program. 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 group is a small group.

For the purposes of the risk corridors program, the small group market includes only plans that were compliant with ACA market reforms during the 2014 benefit year.

Earned Premium
As defined at 45 CFR 153.500 and 45 CFR 158.130, all monies paid by a policyholder or subscriber as a condition of receiving coverage from the issuer, including any fees or other contributions associated with the health plan and reported on a direct basis. Earned premium includes the premium tax credit portion of the advanced payment amounts (APTC), as well as the enrollee portion of the premium. Please note that for the purposes of the risk corridors program, earned premium should be for reported for coverage in the 2014 MLR/risk corridors reporting year only.

Billed Premium
Total billable premium is the total premium charged for members in all policies that are written directly or acquired by the issuer during the full reporting year.

Paid Claims

Direct claims paid to or received by physicians and other non- physician clinical providers, including under capitation contracts with those providers, whose services are covered by the policy for clinical services or supplies covered by the policy. For the purposes of the risk corridors program, paid claims include claims incurred only during the 2014 MLR/risk corridors reporting year, paid from 1/01/2014 through 3/31/2015.

Incurred Claims

Claim amounts that reflect expected reimbursement for clinical services provided to an enrollee during the 2014 MLR/risk corridors reporting year.

Incurred But Not Reported (IBNR)

Claims incurred only during the 2014 MLR/risk corridors reporting year and not paid by 3/31/2015. Except where inapplicable, this amount includes reserve based on past experience, modified to reflect current conditions, such as changes in exposure.

GENERAL INSTRUCTIONS

MLR and Risk Corridors Submission Checklist

- The MLR Risk Corridors Submission Checklist must be completed and submitted in one sitting. Users cannot save the information for completion at a later time. This checklist is a required submission for all companies with issuers that submitted risk corridors data for the 2014 reporting year.
- The company should complete only one (1) MLR/Risk Corridors Submission Checklist for all issuers associated with a particular company (identified by FEIN, for which the point of contact will have received one email). The checklist pertains to the company's MLR and Risk Corridors submission for the 2014 benefit year. In the contact information section, the company should provide one primary contact for the MLR and risk corridors submissions, and one primary contact responsible for EDGE server submissions.
- **If a company determines that it is unable to attest to all of the elements included in the MLR Risk Corridors Submission Checklist, the company should resubmit its 2014 MLR and Risk Corridors data by September 8, 2015, or by September 14, 2015, as directed by CMS.** Prior to resubmitting, a representative of the company must contact CMS at MLRquestions@cms.hhs.gov and indicate that it intends to resubmit.
- A representative that can financially bind the company must attest to the data for all issuers included in the checklist before submission.

Risk Corridors Discrepancy Worksheet

- A company with issuers that has been identified by CMS as having a material difference in claims (not including IBNR) or premiums will be directed to complete a separate claims or premium report to quantify the difference for each issuer. Where the material difference in claims or premium can be quantified, the company must also upload documentation explaining the method by which it determined the amount of the difference. These instructions include definitions of what should be included as supporting documentation.
- If CMS has identified that the company's estimate of IBNR claims accounts for a high proportion of its overall claims liability, the company will be required to upload documentation that explains its method for determining IBNR. The system will only display the option of uploading

supplemental documentation explaining IBNR to those companies whose IBNR is a high proportion of paid claims. These instructions include definitions of what should be included as supporting documentation for IBNR.

- **It is not expected that issuers will need to submit claim-by-claim or enrollee-by-enrollee reconciliations to justify dollar quantifications. Rather, issuers are expected to provide detailed explanations and descriptions of methodologies, and underlying actuarial or financial assumptions or evidence sufficient for CMS to evaluate the reasonableness of dollar figures submitted as quantifications of the various explanatory elements offered. Those dollar figures are not required to be accurate to the dollar, but are expected to be accurate to one quarter of one percent of the claims or premium amount, as applicable.**
- The Risk Corridors Discrepancy Worksheet must be completed and submitted in one sitting. Users cannot save the information for completion at a later time. Please note there are some sections that are auto-populated for the issuer as indicated in these instructions.
- Only data pertaining to non-grandfathered, ACA-compliant plans should be reported on the worksheet. If a plan was compliant for only a portion of 2014, the company should report the experience for only the ACA-compliant portion.
- **Personally identifiable information (PII) and protected health information (PHI) should be excluded or removed/redacted from any written explanation that is submitted for claims discrepancy, premium discrepancy, or IBNR.**
- **Your company name or affiliation (or other clearly identifying information), including any company letterhead, should also be excluded from any such written explanation.**
- A representative that can financially bind the company must attest to the data for all issuers included in the worksheet before submission.

Companies should email questions about risk corridors data validation submissions to: ACAriskcorridors@cms.hhs.gov

Risk Corridors Discrepancy Worksheet—Claims Discrepancy Column Definitions

Table 1 - Summary of Individual Market Claims Reported to CMS

Column	Definition	Instructions
A. Company Name	The legal name of the issuer that corresponds to the HIOS issuer ID in column B.	This column is auto-populated for the user. This column does not accept data input.
B. HIOS Issuer ID	The 5-digit HIOS ID assigned to the issuer.	This column is auto-populated for the user. This column does not accept data input.
C. Claims Incurred During 2014, Paid Through 3/31/2015	Claims incurred only during 2014, paid during the period from 1/1/2014 – 3/31/2015. This column is equal to the data in Section 2, Line 2.1b, column 2A (Risk Corridors) in the MLR 2014 Annual Reporting Form.	This column is auto-populated for the user from data submitted by the issuer in its 2014 MLR Reporting Form. This column does not accept data input. This user will see this calculation in a summary table at the end of the claims discrepancy report.
D. Paid Claims Amount from EDGE server	Total individual market paid claims submitted to EDGE server, as indicated on the EDGE RISR Report. The amount reflects the total claims amount, not the total number of individual claim lines.	This column is auto-populated for the user from data submitted by the issuer to its EDGE server for the Reinsurance program. This column does not accept data input.
E. Dollar Difference	The actual dollar difference between paid claims reported for MLR (column C) and paid individual market claims submitted to EDGE server for the reinsurance program (column D).	This column is auto-populated for the user. This column does not accept data input.
F. Percentage of Total Claims Loaded to the EDGE Server, Excluding Orphan Claims (as of 5/15)	The percentage of total claims loaded to the EDGE server as of 5/15/2015, calculated as a proportion of the baseline claim data the issuer submitted to CMS. The claims percentage in this column excludes orphan claims that could not be tied to an enrollee, rejected claims, and other claims that were not loaded to the EDGE server	This column is auto-populated for the user. This column does not accept data input.

Table 2 - Sources of Discrepancy From MLR Form – Individual Market Claims Reporting

Column	Definition	Instructions
G. HIOS Issuer ID	The 5-digit HIOS ID assigned to the issuer.	This column is auto-populated for the user. This column does not accept data input.
H. Capitation – Internal Pricing Methodology	The internal methodology the issuer used for pricing encounters for which individual enrollee claims were not generated.	This is a header column. This column does not accept data input.
H1. Capitation – Internal Pricing Methodology, Dollar Amount	The difference between (a) the total amounts included in claims in the MLR submission with respect to services for which the issuer did not generate individual enrollee claims in the normal course of business (that is, capitation amounts), minus (b) the associated dollar amounts of individual market claims reported to the EDGE server for which the issuer did not generate individual enrollee claims in the normal course of business, and derived the cost of the provider encounter using its principal internal methodology for pricing the encounter, in accordance with the regulations at 45 CFR 153.710(d). Exclude from part (a) above, IBNR (that is, claims amounts that were incurred but not reported for the 2014 MLR/risk corridors reporting year).	User input of a positive value (if EDGE amounts are lower) or negative value (if EDGE amounts are higher) is required. This field is formatted for the user, such that amounts are rounded to the nearest dollar. If the issuer did not report any capitation amounts in the MLR/risk corridors submissions that meet the description in this row, the user should input "0" in this column.
H2. Capitation – Internal Pricing Methodology, Percentage of Total Claims Dollar Amount	The percentage of total paid claims reported for MLR/risk corridors attributable to different reporting requirements between EDGE and MLR/risk corridors for encounters involving capitated providers. This column equals column H1 divided by column C.	This column is auto-calculated for the user. This field is formatted for the user. This column does not accept data input. This user will see this calculation in a summary table at the end of the claims discrepancy report.

Claims Discrepancy Report (continued)

Table 2 - Sources of Discrepancy From MLR Form – Individual Market Claims Reporting (continued)

Column	Definition	Instructions
J. Orphan, Rejected and Claims not loaded to EDGE	Claims reported for MLR/risk corridors that were not accepted by the EDGE server (rejected claims), were not associated with an enrollee (orphan claims), or were not otherwise loaded to the EDGE server.	This is a header column. This column does not accept data input.
J1. Orphan, Rejected and Claims not loaded to EDGE	The dollar value of claims reported for MLR/risk corridors that were not accepted by the EDGE server (rejected claims), were not associated with an enrollee (orphan claims), or were not otherwise loaded to the EDGE server. Exclude: Claims that were rejected from the Edge server for being duplicate claims. Exclude: Claims amounts that were incurred but not reported for the 2014 MLR/risk corridors reporting year (IBNR).	User input of a positive value is required. This field is formatted for the user, such that amounts are rounded to the nearest dollar. If the issuer did not report any individual market claims for MLR/risk corridors that meet the description in this row, the user should input "0" in this column.
J2. Orphan, Rejected and Claims not loaded to EDGE , Percentage of Total Claims Dollar Amount	The percentage of total paid claims reported for MLR/RC that were either not accepted by the EDGE server (rejected claims), were not associated with an enrollee (orphan claims), or were not otherwise loaded to the EDGE server. This column equals column J1 divided by column C.	This column is auto-calculated for the user. This field is formatted for the user. This column does not accept data input. This user will see this calculation in a summary table at the end of the claims discrepancy report.
J3. Orphan, Rejected and Claims not loaded to EDGE , Percentage of Claims Difference	The percentage of the claims difference in Column E that is attributable to claims reported for MLR/RC that were not accepted by the EDGE server (rejected claims), were not associated with an enrollee (orphan claims), or were not otherwise loaded to the EDGE server. This column equals the absolute value of column J1 divided by column E.	This column is auto-calculated for the user. This field is formatted for the user. This column does not accept data input. This user will see this calculation in a summary table at the end of the claims discrepancy report.

Claims Discrepancy Report (continued)

Table 2 - Sources of Discrepancy From MLR Form – Individual Market Claims Reporting (continued)

Column	Definition	Instructions
K. Paid Claims for Hospital Stays That Crossed Benefit Years (not already included in IBNR)	Paid claims for inpatient hospital stays that began in 2014 but were not discharged by 12/31/2014.. These claims were reported for 2014 MLR/RC but were not submitted to the EDGE server for 2014 (due to EDGE reporting rules). These columns should not include IBNR amounts.	This is a header column. This column does not accept data input.
K1. Paid Claims for Hospital Stays That Crossed Benefit Years (not already included in IBNR), Dollar Amount	The dollar value of claims reported for 2014 MLR/risk corridors that is attributable to inpatient hospital stays that began in 2014, were not discharged by 12/31/2014, but were paid by 3/31/2015. Exclude: Claims that were not paid by 3/31/2015, because these amounts are reflected in IBNR for the 2014 MLR/risk corridors reporting year.	User input of a positive value is required. This field is formatted for the user, such that amounts are rounded to the nearest dollar. If the issuer did not report any individual market claims for MLR/risk corridors that meet the description in this row, the user should input "0" in this column.
K2. Paid Claims for Hospital Stays That Crossed Benefit Years (not already included in IBNR), Percentage of Total Claims Dollar Amount	The percentage of total paid claims reported for MLR/RC attributable to inpatient hospital stays that began in 2014 but were not discharged by 12/31/2014. This column equals column K1 divided by column C.	This column is auto-calculated for the user. This field is formatted for the user. This column does not accept data input. This user will see this calculation in a summary table at the end of the claims discrepancy report.
K3. Paid Claims for Hospital Stays That Crossed Benefit Years (not already included in IBNR), Percentage of Claims Difference	The percentage of the claims difference in column E that is attributable to inpatient hospital stays that began in 2014 but were not discharged by 12/31/2014. This column equals column K1 divided by column E.	This column is auto-calculated for the user. This field is formatted for the user. This column does not accept data input. This user will see this calculation in a summary table at the end of the claims discrepancy report.

Table 2 - Sources of Discrepancy From MLR Form – Individual Market Claims Reporting (continued)

Column	Definition	Instructions
L. Adjustment(s) to Be Made in Voluntary Resubmission	Adjustments to MLR/RC claims data that the issuer intends to make in a voluntary resubmission. This column is exclusive of amounts reported in other columns.	This is a header column. This column does not accept data input.
L1. Adjustment(s) to Be Made in Voluntary Resubmission – Dollar Amount	The dollar value of adjustments to paid claims that the issuer intends to make in a voluntary resubmission of MLR/RC data. Exclude: Any amounts reported in Columns H1, J1, or K1.	A positive value represents an increase in paid claims; a negative value represents a decrease in paid claims. This field is formatted for the user, such that amounts are rounded to the nearest dollar. If the issuer did not report any individual market claims for MLR/risk corridors that meet the description in this row, the user should input "0" in this column.
L2. Adjustment(s) to Be Made in Voluntary Resubmission – Percentage of Total Claims Dollar Amount	The adjustment to paid claims reported for MLR/RC that the issuer intends to make in a voluntary resubmission of MLR/risk corridors data as a percentage of total paid claims. This column equals column L1 divided by column C.	This column is auto-calculated for the user. This field is formatted for the user. This column does not accept data input. This user will see this calculation in a summary table at the end of the claims discrepancy report.

Table 2 - Sources of Discrepancy From MLR Form – Individual Market Claims Reporting (continued)

Column	Definition	Instructions
L3. Adjustment(s) to Be Made in Voluntary Resubmission – Percentage of Claims Difference	The adjustment to paid claims that the issuer intends to make in a voluntary resubmission of MLR/RC data as a percentage of the claims difference in Column E. This column equals column L1 divided by column E.	This column is auto-calculated for the user. This field is formatted for the user. This column does not accept data input. This user will see this calculation in a summary table at the end of the claims discrepancy report.
M. Total Discrepancy Accounted For	The total claims discrepancy accounted for in columns H, J, K, and L.	This is a header column. This column does not accept data input.
M1. Total Discrepancy Accounted For, Dollar Amount	The dollar amount of the total claims discrepancy accounted for in columns H1, J1, K1, and, L1. This column is the sum of columns H1, J1, K1, and L1.	This column is auto-calculated for the user. This field is formatted for the user. This column does not accept data input. This user will see this calculation in a summary table at the end of the claims discrepancy report.
M2. Total Discrepancy Accounted For, Percentage of Total Claims	The total claims discrepancy accounted for in columns H1, J1, K1, and L1, as a percentage of total paid claims reported for MLR/risk corridors. This column equals column M1 divided by column C.	This column is auto-calculated for the user. This field is formatted for the user. This column does not accept data input. This user will see this calculation in a summary table at the end of the claims discrepancy report.

Claims Discrepancy Report (continued)

Table 2 - Sources of Discrepancy From MLR Form – Individual Market Claims Reporting (continued)

Column	Definition	Instructions
M3. Total Discrepancy	The total claims discrepancy accounted for in columns H1, J1, K1, and L1, as a percentage of the claims difference in column E. This column equals column M1 divided by column E.	This column is auto-calculated for the user. This field is formatted for the user. This column does not accept data input. This user will see this calculation in a summary table at the end of the claims discrepancy report.

Table 3 - Written Explanations of Claims Discrepancies

Column	Definition	Instructions
N. HIOS Issuer ID	The 5-digit HIOS ID assigned to the issuer.	This is a header column. This column does not accept data input.

Table 3 - Written Explanations of Claims Discrepancies (continued)

Column	Column	Column
O. Capitation – Internal Pricing Methodology	Written explanation of the difference between (a) the total amounts included in claims in the MLR submission with respect to services for which the issuer did not generate individual enrollee claims in the normal course of business (that is, capitation amounts), minus (b) the associated dollar amounts of individual market claims reported to the EDGE server for which the issuer did not generate individual enrollee claims in the normal course of business, and derived the cost of the provider encounter using its principal internal methodology for pricing the encounter, in accordance with the regulations at 45 CFR 153.710(d). Include: A detailed description of your internal pricing methodology. Please indicate whether this reflects your principal internal pricing methodology or a reasonable methodology because you do not have a complete internal pricing methodology. Include: A detailed description of the provider payment arrangements that are in whole or in part capitated. To the extent different providers have different provider payment arrangements, each arrangement should be described. Include: Data on the per capita and total payment amounts and corresponding amounts calculated under the internal pricing methodology, and the actuarial or financial assumptions underlying the quantification of this discrepancy. Please describe why the company believes the internal pricing methodology did not capture the value of the payment amounts. Please describe the major differences in the internal pricing methodology between claims reported to Edge and claims for purposes of MLR.	Only if the user has input a dollar amount other than "0" in Column H— the user should upload a written description of the actuarial or financial assumptions underlying its internal methodology for pricing encounters with capitated providers, and should cite evidence, whether derived from the company's internal systems or otherwise, supporting those assumptions. The system will accept the following document formats only: pdf, doc, doc(x), xls, and xlsx.

Table 3 - Written Explanations of Claims Discrepancies (continued)

Column	Column	Column
P. Orphan, Rejected and Claims not loaded to EDGE	Written explanation of the claims discrepancy due to claims reported for MLR/RC that were not accepted by the EDGE server (rejected claims), were not associated with an enrollee (orphan claims), or were not otherwise loaded to the EDGE server. Include: The reason that your reported number and value of claims were rejected, orphan, or otherwise not loaded. Please reference any EDGE server discrepancy filed in connection with these orphan or rejected claims, along with the discrepancy numbers.	Only if the user has input a dollar amount other than "0" in Column J1— the user should upload a document that contains a written explanation of the claims discrepancy, including specific data on the number and dollar value of rejected and orphan claims and rejection codes, if available, and the number and dollar value of claims that were not otherwise loaded to the EDGE server. The system will accept the following document formats only: pdf, doc, doc(x), xls, and xlsx.
Q. Paid Claims for Hospital Stays That Crossed Benefit Years (not already included in IBNR)	Written explanation of the claims discrepancy that is attributable to inpatient hospital stays that began in 2014, were not discharged by 12/31/2014, but were paid by 3/31/2015. Include: The number and dollar value of these claims.	Only if the user has input a dollar amount other than "0" in Column K1—the user should upload a document that contains a written explanation of the claims discrepancy, including specific data on the number of these stays if available. The system will accept the following document formats only: pdf, doc, doc(x), xls, and xlsx.
R. Adjustments to be Made in Voluntary Resubmission	If you wish to provide additional information about adjustments made in a voluntary resubmission, you may do so; however, an explanation is not necessary. If you do not wish to provide an explanation, upload a blank document.	Only if the user has input a dollar amount other than "0" in Column L1— the user should upload a document that contains a written explanation of the adjustment(s) to be made to paid claims. The system will accept the following document formats only: pdf, doc, doc(x), xls, and xlsx.

Table 3 - Written Explanations of Claims Discrepancies (continued)

Column	Definition	Instructions
S. Remaining Discrepancy NOT Accounted For	A detailed explanation of the claims discrepancy not accounted for in the other categories. Such explanation should include actuarial or financial assumptions or evidence, as applicable, and should permit CMS to reasonably evaluate the explanation. Also include the dollar amount of any remaining discrepancy unaccounted for.	Only if the percentage is in column M3 is less than 100% should the user should upload a document that contains a written explanation of the remaining discrepancies not accounted for. The system will accept the following document formats only: pdf, doc, doc(x), xls, and xlsx.
T. IBNR Calculation	Written explanation including a detailed explanation of your methodology for calculating IBNR. You may also indicate that you intend to voluntarily resubmit your MLR/risk corridors submission with a lower IBNR amount, and provide a justification consistent with that amount. Include: Information on at least your past two years of IBNR rates for MLR, and an explanation of why your assumptions for this year differ, if applicable. Include: Actuarial or financial assumptions or evidence, as applicable, underlying this calculation, and an explanation, if applicable, why this rate may be higher than might be the case for other issuers or other years. Include: The dollar amount of any adjustments to the IBNR amount reported in the MLR/risk corridors submission that the issuer intend to make in a voluntary resubmission.	The system will only display the option of uploading supplemental documentation to those companies whose IBNR is a high proportion of paid claims. Users that are presented with an upload field for the IBNR calculation must upload the supporting documentation. The system will accept the following document formats only: pdf, doc, doc(x), xls, and xlsx.

Premium Discrepancy Report

Table 1 – Summary of Individual Market and Small Group Market Premiums Reported to CMS

Column	Definition	Instructions
A. Company Name	For the individual and small group markets, respectively, the legal name of the issuer that corresponds to the HIOS issuer ID in column B.	This column is auto-populated for the user. This column does not accept data input.
B. HIOS Issuer ID	For the individual and small group markets, respectively, the 5-digit HIOS ID assigned to the issuer.	This column is auto-populated for the user. This column does not accept data input.
C. Premium Earned including Federal and State High Risk Pool Programs	For the individual and small group markets, respectively, the earned premium reported in Part 3, Line 2.1 of the 2014 MLR Reporting Form. The premium for individual market is the amount reported in risk corridors column 4A (Part 3, Line 2.1 of MLR Reporting Form), and the small group premium is the amount in risk corridors column 8A (Part 3, Line 2.1 of MLR Reporting Form).	This column is auto-populated for the user from data submitted by the issuer in its 2014 MLR Reporting Form. This column does not accept data input.
D. Plan Average Premium Amount * Billable Member Months	For the individual and small group markets, respectively, the total billable premium in the individual market or small group market calculated based on per-member-per-month premium and billable member months submitted to the EDGE server. Premium as indicated on the EDGE RATEE report.	This column is auto-populated for the user from data submitted by the issuer to its EDGE server. This column does not accept data input.
E. Dollar Difference	The actual dollar difference between earned premium reported for MLR (column C) and billable premium data from the EDGE server (column D).	This column is auto-populated for the user. This column does not accept data input.

Premium Discrepancy Report (continued)

Table 2 – Sources of Discrepancy From MLR Form – Individual and Small Group Market Premium Reporting

Column	Definition	Instructions
F. HIOS Issuer ID	For the individual and small group markets, respectively, the 5-digit HIOS ID assigned to the issuer.	This column is auto-populated for the user. This column does not accept data input.
G. Difference between Premium Billed and Earned in 2014	The total premium difference for the 2014 MLR/risk corridors reporting year that is attributable to the difference between billable member premium reported to the EDGE server, and earned premium reported for MLR/risk corridors.	This is a header column. This column does not accept data input.
G1. Difference between Premium Earned and Billed in 2014, Dollar Amount	The dollar amount of total premium difference for the 2014 MLR/risk corridors reporting year that is attributable to the difference between earned premium reported for MLR/risk corridors and billable member premium reported to the EDGE server.	A positive value means that the MLR/risk corridors earned premium amount is greater than the billable premium submitted to EDGE; a negative value means that the earned premium reported for MLR/risk corridors is smaller. This field is formatted for the user, such that amounts are rounded to the nearest dollar. If the issuer did not report any individual market or small group market premium difference that meets the description in this row, the user should input "0" in this column.
G2. Difference between Premium Earned and Billed in 2014, Percentage of Total Premium Dollar Amount	The percentage of total premium difference for MLR/risk corridors attributable to different requirements for reporting premium between EDGE and MLR/risk corridors. This column equals column G1 divided by column C.	This column is auto-calculated for the user. This field is formatted for the user. This column does not accept data input. This user will see this calculation in a summary table at the end of the premium discrepancy report.
G3. Difference between Premium Earned and Billed in 2014, Percentage of Premium Difference	The percentage of the premium difference in column E attributable to different requirements for reporting premium between EDGE and MLR/risk corridors. This column equals column G1 divided by column E.	This column is auto-calculated for the user. This field is formatted for the user. This column does not accept data input. This user will see this calculation in a summary table at the end of the claims discrepancy report.

Table 2 – Sources of Discrepancy From MLR Form – Individual and Small Group Market Premium Reporting (continued)

Column	Definition	Instructions
H. Premium Not Collected for QHP Enrollees during the Grace Period	The total premium difference for the 2014 MLR/risk corridors reporting year that is attributable to premium that was not collected for QHP enrollees during the 3 month grace period, but was reported as billable premium to the EDGE server.	This is a header column. This column does not accept data input.
H1. Premium Not Collected for QHP Enrollees during the Grace Period, Dollar Amount	The dollar amount of total premium difference for the 2014 MLR/risk corridors reporting year that is attributable to premium that was not collected for QHP enrollees during the 3 month grace period, but was reported as billable premium to the EDGE server. Exclude: For the individual market, the dollar amount of premium not collected should exclude the premium tax credit portion of advance payment amounts (APTCs) received by the issuer, because those amounts were collected by the issuer.	User input of a positive value is required. This field is formatted for the user, such that amounts are rounded to the nearest dollar. If the issuer did not report any individual market or small group market premium difference that meets the definition in this row, the user should input "0" in this column.
H2. Premium Not Collected for QHP Enrollees during the Grace Period, Percentage of Total Premium Dollar Amount	The percentage of total premium difference for MLR/risk corridors attributable to premium that was not collected for QHP enrollees during the 3 month grace period, but was reported as billable premium to the EDGE server. This column equals column H1 divided by column C.	This column is auto-calculated for the user. This field is formatted for the user. This column does not accept data input. This user will see this calculation in a summary table at the end of the premium discrepancy report.
H3. Premium Not Collected for QHP Enrollees during the Grace Period, Percentage of Premium Difference	The percentage of the premium difference in column E that is attributable to premium that was not collected for QHP enrollees during the 3 month grace period, but was reported as billable premium to the EDGE server. This column equals column H1 divided by column E.	This column is auto-calculated for the user. This field is formatted for the user. This column does not accept data input. This user will see this calculation in a summary table at the end of the premium discrepancy report.

Table 2 – Sources of Discrepancy From MLR Form – Individual and Small Group Market Premium Reporting (continued)

Column	Definition	Instructions
I. Premium Impact Resulting from Retroactive Enrollment Changes After EDGE Deadline	Premium difference for the 2014 MLR/risk corridors reporting year that is attributable to retroactive enrollment changes after the EDGE deadline.	This is a header column. This column does not accept data input.
I1. Premium Impact Resulting from Retroactive Enrollment Changes After EDGE Deadline, Dollar Amount	The dollar amount of total premium difference for the 2014 MLR/risk corridors reporting year that is attributable to retroactive enrollment changes after the EDGE deadline.	A positive value means that the retroactive enrollment changes resulted in higher MLR/risk corridors earned premiums compared to billed premiums on EDGE; a negative value means that they resulted in lowerMLR/risk corridors earned premiums compared to billed premiums on EDGE. . This field is formatted for the user, such that amounts are rounded to the nearest dollar. If the issuer did not report any individual market or small group market premium difference that meets the description in this row, the user should input "0" in this column.
I2. Premium Impact Resulting from Retroactive Enrollment Changes After EDGE Deadline, Percentage of Total Premium Dollar Amount	The percentage of total premium difference for MLR/risk corridors attributable to retroactive enrollment changes after the EDGE deadline. This column equals column I1 divided by column C.	This column is auto-calculated for the user. This field is formatted for the user. This column does not accept data input. This user will see this calculation in a summary table at the end of the premium discrepancy report.
I3. Premium Impact Resulting from Retroactive Enrollment Changes After EDGE Deadline, Percentage of Premium Difference	The percentage of the premium difference in column E that is attributable to retroactive enrollment changes after the EDGE deadline. This column equals column I1 divided by column E.	This column is auto-calculated for the user. This field is formatted for the user. This column does not accept data input. This column is auto-calculated for the user. This field is formatted for the user. This column does not accept data input. This user will see this calculation in a summary table at the end of the premium discrepancy report.

Premium Discrepancy Report (continued)

Table 2 – Sources of Discrepancy From MLR Form – Individual and Small Group Market Premium Reporting (continued)

Column	Definition	Instructions
J. Partial Month Proration Differences in 2014	Partial month proration differences that led to premium amounts on the EDGE server that differed from earned premium reported for MLR/risk corridors.	This is a header column. This column does not accept data input.
J1. Partial Month Proration Differences, Dollar Amount	The dollar amount of total premium difference for the 2014 MLR/risk corridors reporting year that is attributable to partial month proration differences that were applied to premiums submitted to the EDGE server, but not included in earned premium reported for MLR/risk corridors.	A positive value means that the proration differences led to higher MLR/risk corridors earned premium amounts as compared to billed premium on EDGE; a negative value means that they led to lower MLR/risk corridors earned premium amounts as compared to billed premium on EDGE. . This field is formatted for the user, such that amounts are rounded to the nearest dollar. If the issuer did not report any individual market or small group market premium difference for MLR/risk corridors that meets the description in this row, the user should input "0" in this column.
J2. Partial Month Proration Differences, Percentage of Total Premium Dollar Amount	The percentage of total premium difference for MLR/risk corridors attributable to different reporting requirements for partial month premium between EDGE and MLR/risk corridors. This column equals column J1 divided by column C.	This column is auto-calculated for the user. This field is formatted for the user. This column does not accept data input. This column is auto-calculated for the user. This field is formatted for the user. This user will see this calculation in a summary table at the end of the premium discrepancy report.
J3. Partial Month Proration Differences, Percentage of Premium Difference	The percentage of the premium difference in column E that is attributable to different reporting requirements for partial month premium between EDGE and MLR/risk corridors. This column equals column J1 divided by column E.	This column is auto-calculated for the user. This field is formatted for the user. This column does not accept data input. This user will see this calculation in a summary table at the end of the premium discrepancy report.

Premium Discrepancy Report (continued)

Table 2 – Sources of Discrepancy From MLR Form – Individual and Small Group Market Premium Reporting (continued)

Column	Definition	Instructions
K. Adjustment(s) to Be Made in Voluntary Resubmission	Adjustments to MLR/risk corridors premium data that the issuer intends to make in a voluntary resubmission. This column is exclusive of amounts reported in other columns.	This is a header column. This column does not accept data input.
K1. Adjustment(s) to Be Made in Voluntary Resubmission – Dollar Amount	The dollar value of adjustments to premiums that the issuer intends to make in a voluntary resubmission of MLR/risk corridors data Exclude: Any amounts reported in Columns G1, H1, or J1.	A positive value indicates the voluntary resubmission will increase MLR/risk corridors earned premiums; a negative value indicates it will decrease MLR/risk corridors earned premiums. This field is formatted for the user, such that amounts are rounded to the nearest dollar. If the issuer did not report any individual market or small group premium difference that meets the description in this row, the user should input "0" in this column.
K2. Adjustment(s) to Be Made in Voluntary Resubmission – Percentage of Total Premium Amount	The adjustment to premiums reported for MLR/RC that the issuer intends to make in a voluntary resubmission of MLR/risk corridors data as a percentage of total premiums. This column equals column K1 divided by column C.	This column is auto-calculated for the user. This field is formatted for the user. This column does not accept data input. This user will see this calculation in a summary table at the end of the premium discrepancy report.

Table 2 – Sources of Discrepancy From MLR Form – Individual and Small Group Market Premium Reporting (continued)

Column	Definition	Instructions
K3. Adjustment(s) to Be Made in Voluntary Resubmission – Percentage of Premium Difference	The adjustment to premiums that the issuer intends to make in a voluntary resubmission of MLR/risk corridors data, as a percentage of the premium difference in Column E. This column equals column K1 divided by column E.	This column is auto-calculated for the user. This field is formatted for the user. This column does not accept data input. This user will see this calculation in a summary table at the end of the premium discrepancy report.
L. Total Discrepancy Accounted For	The total premium discrepancy accounted for in columns G, H, I, J, and K.	This is a header column. This column does not accept data input.
L1. Total Discrepancy Accounted For, Dollar Amount	The dollar amount of the total premium discrepancy accounted for in columns G1, H1, I1, J1, and K1. This column is the sum of columns G1, H1, I1, J1, and K1.	This column is auto-calculated for the user. This field is formatted for the user. This column does not accept data input. This user will see this calculation in a summary table at the end of the premium discrepancy report.
L2. Total Discrepancy Accounted For, Percentage of Total Claims	The total premium discrepancy accounted for in columns G1, H1, I1, J1, and K1, as a percentage of total premiums reported for MLR/risk corridors. This column equals column L1 divided by column C.	This column is auto-calculated for the user. This field is formatted for the user. This column does not accept data input This user will see this calculation in a summary table at the end of the premium discrepancy report.
L3. Total Discrepancy	The total premium discrepancy accounted for in columns G1, H1, I1, J1, and K1, as a percentage of the claims difference in column E. This column equals column L1 divided by column E.	This column is auto-calculated for the user. This field is formatted for the user. This column does not accept data input. This user will see this calculation in a summary table at the end of the premium discrepancy report.

Premium Discrepancy Report (continued)

Table 3 – Written Explanations of Premium Discrepancies

Column	Definition	Instructions
L. HIOS Issuer ID	For the individual and small group markets, respectively, the 5-digit HIOS ID assigned to the issuer.	This is a header column. This column does not accept data input.
M. Difference between Premium Earned and Billed Premium in 2014	A written explanation of this discrepancy, including the dollar value of this difference, and an explanation of the magnitude of this difference.	Only if the user has input a dollar amount other than "0" in Column G1 should the user upload a written description of the difference. The system will accept the following document formats only: pdf, doc, doc(x), xls, and xlsx.
N. Premium Not Collected for QHP Enrollees during the Grace Period	A written explanation of this discrepancy, including the number of instances and dollar value of the uncollected premiums, and an explanation of the magnitude of this difference. This does not need to reflect enrollee-by-enrollee reconciliation, but should provide information sufficient to understand the magnitude of this impact.	Only if the user has input a dollar amount other than "0" in Column H1 should the user upload a written description of the difference. The system will accept the following document formats only: pdf, doc, doc(x), xls, and xlsx.
O. Premium Impact Resulting from Retroactive Enrollment Changes After EDGE Deadline	A written explanation of this discrepancy, including the dollar value of this difference, and an explanation of the magnitude of this difference. This does not need to reflect enrollee-by-enrollee reconciliation, but should provide information sufficient to understand the magnitude of this impact.	Only if the user has input a dollar amount other than "0" in Column I1 should the user upload a written description of the difference. The system will accept the following document formats only: pdf, doc, doc(x), xls, and xlsx.

Premium Discrepancy Report (continued)

Table 3 – Written Explanations of Premium Discrepancies

Column	Definition	Instructions
P. Adjustment(s) to Be Made in Voluntary Resubmission	If you wish to provide additional information about adjustments made in a voluntary resubmission, you may do so; however, an explanation is not necessary. If you do not wish to provide an explanation, upload a blank document.	Only if the user has input a dollar amount other than "0" in Column K1 should the user upload a document that contains a written explanation of the adjustment(s) to be made to paid claims. The system will accept the following document formats only: pdf, doc, doc(x), xls, and xlsx.
Q. Remaining Discrepancy NOT Accounted For	A further detailed explanation of the premium discrepancy not included in the other categories. Such explanation should include actuarial or financial assumptions or evidence, as applicable, a quantification of the discrepancy (including directionality) and should permit CMS to reasonably evaluate the explanation. Include also the dollar amount of any remaining discrepancy unaccounted for.	Only if the percentage is in column L3 is less than 100% should the user should upload a document that contains a written explanation of the remaining discrepancies not accounted for. The system will accept the following document formats only: pdf, doc, doc(x), xls, and xlsx.
R. Partial Month Proration Differences	A written description of your proration methodology, the number of instances and the dollar value (and directionality) attributable to the different proration methodologies, and relevant actuarial or financial assumptions or evidence backing up this calculation.	Only if the user has input a dollar amount other than "0" in Column J1 should the user upload a document that contains a written explanation of the adjustment. The system will accept the following document formats only: pdf, doc, doc(x), xls, and xlsx.

APPENDIX 1: MLR Risk Corridors Submission Checklist Template

This checklist and the accompanying attestation should be completed by following the web link that will be provided uniquely to each issuer shortly.

Federal Employer Identification Number (FEIN):_____

Please complete the following, and sign on the signature line below. Your signature will serve as an attestation to all of the elements below. The elements of this form should be reviewed by a senior officer of your company, and any documents necessary to establish the attestation should be retained for future audits, consistent with 45 C.F.R. §153.520(e) and 45 C.F.R. §158.502. This attestation and checklist applies to the following issuer HIOS IDs:

[INSERT ISSUER HIOS IDS HERE]

2014 MLR/Risk Corridors Submission Checklist (Items refer to columns 4A (Individual Market) and 8A (Small Group Market) of Part 3 of the 2014 MLR Reporting Form unless otherwise noted.)[1]	Applicable Regulation or Guidance	If the element is accurate, mark "Y." If the element in the original submission is not accurate, but will be accurate upon resubmission, mark "R." If the element is not accurate and no resubmission will be made because there is no impact on the amount of risk corridors payments or charges or MLR rebates, mark "N" and provide an explanation as directed below.
Reinsurance and Risk Adjustment amounts in Part 2, Lines 1.9 and 1.10 (Columns 2/2A/7/7A) and Part 3 Lines 1.5 and 1.6 (Columns 4-4A/7-8A) match Reinsurance and Risk Adjustment amounts reported by HHS on June 30, 2015 (subject to any later instructions as to these amounts from CMS). These amounts are applied as adjustments to	45 CFR 153.530; 45 CFR 158.130; MLR Reporting Form Instructions, pp. 28 (Part 2, Lines 1.9 and 1.10), 37 (Part 3, Lines 1.5 and 1.6)	

[1] MLR 2014 Annual Reporting Form is posted at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/2014-mlr-reporting-form-20150528c.xlsx and the MLR 2014 Annual Reporting Form Instructions can be found at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/2014-MLR-Annual-Reporting-Form-Instructions-20150528c.pdf

2014 MLR/Risk Corridors Submission Checklist (Items refer to columns 4A (Individual Market) and 8A (Small Group Market) of Part 3 of the 2014 MLR Reporting Form unless otherwise noted.)[1]	Applicable Regulation or Guidance	If the element is accurate, mark "Y." If the element in the original submission is not accurate, but will be accurate upon resubmission, mark "R." If the element is not accurate and no resubmission will be made because there is no impact on the amount of risk corridors payments or charges or MLR rebates, mark "N" and provide an explanation as directed below.
MLR numerator / Risk Corridors allowable costs.		
Premium earned in Part 3, Line 2.1 does *not* include any actual or estimated Reinsurance, Risk Adjustment, or Risk Corridors amounts.	45 CFR 153.530(a); 45 CFR 158.130(a); MLR Reporting Form Instructions, p. 40 (Part 3, Line 2.1)	
Premium earned in Part 3, Line 2.1, Columns 4A and 8A includes premium earned for *all* ACA-compliant plans (QHP and non-QHP)in the individual and small group markets, and *excludes* premium earned for grandfathered and non-grandfathered coverage that does not comply with the 2014 ACA market reforms.	45 CFR 153.500; 45 CFR 158.130; MLR Reporting Form Instructions pp. 8 (Individual and Small Group Health Insurance), 40 (Part 3, Line 2.1)	
Premium earned in Part 3, Line 2.1 includes both the premium tax credit portion of the advance payment amounts (APTC), as well as the enrollee portion.	45 CFR 153.500; 45 CFR 158.130	

2014 MLR/Risk Corridors Submission Checklist (Items refer to columns 4A (Individual Market) and 8A (Small Group Market) of Part 3 of the 2014 MLR Reporting Form unless otherwise noted.)[1]	Applicable Regulation or Guidance	If the element is accurate, mark "Y." If the element in the original submission is not accurate, but will be accurate upon resubmission, mark "R." If the element is not accurate and no resubmission will be made because there is no impact on the amount of risk corridors payments or charges or MLR rebates, mark "N" and provide an explanation as directed below.
Premium earned in Part 3, Line 2.1 includes 2014 new business experience that was deferred for MLR reporting purposes.	45 CFR 153.500; 45 CFR 158.130	
Premium earned in Part 3, Line 2.1 of the MLR Form matches Total Premium Earned in Table 1 of the Risk Corridors Plan-level Data Form[2], for both the Individual and Small Group markets	45 CFR 153.500; REGTAP FAQ 11034	
Adjusted incurred claims in Part 3, Line 1.2 includes either the cost-sharing reduction (CSR) portion of the advanced premium amounts or a certified estimate of the amount of CSR included in 2014. CSRs are separately reported on Part 2, Line 2.18 and Part 3, Line 1.4; and are subtracted from incurred claims in calculating the MLR numerator / Risk	45 CFR 158.140; MLR Reporting Form Instructions, pp. 34 (Part 2, Line 2.18), 36 (Part 3, Line 1.2), 37 (Part 3, Line 1.4)	

[2] Risk Corridors 2014 Plan-Level Data Form is posted at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/2014-risk-corridors-plan-level-data-form-20150528.xlsx and the Risk Corridors Plan Level Instructions is posted at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/2014-Risk-Corridor-Plan-Level-Instructions-20150528.pdf

2014 MLR/Risk Corridors Submission Checklist (Items refer to columns 4A (Individual Market) and 8A (Small Group Market) of Part 3 of the 2014 MLR Reporting Form unless otherwise noted.)[1]	Applicable Regulation or Guidance	If the element is accurate, mark "Y." If the element in the original submission is not accurate, but will be accurate upon resubmission, mark "R." If the element is not accurate and no resubmission will be made because there is no impact on the amount of risk corridors payments or charges or MLR rebates, mark "N" and provide an explanation as directed below.
Corridors allowable costs.		
Adjusted incurred claims in Part 3, Line 1.2 includes claims for all plan benefits, not only essential health benefits (EHBs).	45 CFR 153.500; 45 CFR 158.130	
Risk corridors allowable costs and target amounts were correctly copied over from MLR Form, Part 3, Lines 3.1, 3.7, and 3.9 to Risk Corridors Plan-Level Data Form, Part 3, Lines 2, 3, and 7, respectively.	Risk Corridors Plan-Level Data Form Instructions, p. 15	
Risk corridors amount in Part 3, Line 10 of the Risk Corridors Plan-Level Data Form was correctly copied to MLR Form, Part 3, Line 3.12. This amount was *also* correctly copied to MLR Form Part 2, Line 1.11, Columns 2/7 and Part 3, Line 1.7, Columns 3-4/7-8; *and* was used in MLR and rebate calculations.	MLR Reporting Form Instructions pp. 28 (Part 2, Line 1.11), 38 (Part 3, Line 1.7), 43 (Part 3, Line 3.12)	
Income taxes reported in Part 1, Section 3, Columns 2A and 7A exclude the impact of actual or estimated risk corridors	HHS Notice and Benefit and Payment Parameters	

2014 MLR/Risk Corridors Submission Checklist (Items refer to columns 4A (Individual Market) and 8A (Small Group Market) of Part 3 of the 2014 MLR Reporting Form unless otherwise noted.)[1]	Applicable Regulation or Guidance	If the element is accurate, mark "Y." If the element in the original submission is not accurate, but will be accurate upon resubmission, mark "R." If the element is not accurate and no resubmission will be made because there is no impact on the amount of risk corridors payments or charges or MLR rebates, mark "N" and provide an explanation as directed below.
amounts on taxable income.	for 2014 (78 FR 15472)	

Please list any HIOS ID for which your organization has submitted a discrepancy report pursuant to 45 CFR 153.710(e)(1) (if you have submitted no discrepancy report(s), please indicate N/A):	

If the company answered "R" please indicate the date of the resubmission or expected resubmission. If the company answered "N" to any of the criteria above, please describe the reason (limit 200 characters).	

I certify that, as of the date indicated below, to the best of my information, knowledge, and belief, my organization's responses to the MLR and Risk Corridors Submission Checklist [and 2014 Risk Corridors Discrepancy Worksheet (including any information uploaded in connection with the worksheet)] are accurate and consistent with my organization's own internal claims, premium, and enrollment data. If my organization becomes aware that any such data are inaccurate or incomplete, it will promptly inform CMS, and will be prepared to correct its submission. I acknowledge that the provisions of the Affordable Care Act specifically make payments made by or in connection with an Exchange subject to the False Claims Act if those payments include any federal funds. This includes the temporary risk corridors program established under Section 1342 of the Affordable Care Act. I further certify that I am authorized to legally and financially bind my organization.

_____

Signature

_____

Name, Title

_____

Company

_____

Date

_____

Email Address

_____

Phone Number

APPENDIX 2: Draft Risk Corridors Discrepancy Worksheet

CLAIMS DISCREPANCY

HIOS ID: ##### **Company Name**:

SUMMARY OF INDIVIDUAL MARKET CLAIMS REPORTED TO CMS

2.1b Claims Incurred During 2014, paid through of 3/31/2015 (Column 4A)	Paid Claims Amount from EDGE RISR Report (Individual)	Difference($)	Percent of Total Individual Market Claims Loaded to the EDGE Server Excluding Orphan Claims (as of 5/15)

INDIVIDUAL MARKET CLAIMS REPORTING

Capitation $ _____
Orphan/Rejected/Not Loaded to EDGE Server $ _____
Incurred but not Discharged $ _____
Voluntary $ _____
Total (Calculated) _____
Unaccounted for (Calculated: Difference – Total Entered) _____
View Summary Table

Written Explanation of Claims Discrepancy
Attachment Type Picklist (Values: Capitation, Orphan/Rejected/Not Submitted, Incurred but not Discharged, Remaining Discrepancy NOT Accounted For)

File Name	Attachment Type

AUTO-CALCULATED SUMMARY TABLE

	Dollar Amount	**Percentage of Total Claims Dollar Amount**	**Percentage of Claims Difference**	**Percentage of Total Claims Volume**
Capitation - Internal Pricing Methodology				
Orphan, Rejected, or Claims Not Loaded on EDGE				
Claims Incurred but Not Discharged by 12/31 (not already included in IBNR)				
Adjustment(s) to Be Made in Voluntary Resubmission				
Remaining Discrepancy NOT Accounted For				
Total Discrepancy Accounted For				

PREMIUM INDIVIDUAL DISCREPANCY

HIOS ID: ##### **Company Name**:

SUMMARY OF INDIVIDUAL MARKET PREMIUMS REPORTED TO CMS

2.1 Premium Earned including Federal and State High Risk Pool Programs (Individual RC, Column 4A)	**Individual Plan Average Premium Amount * Billable Member Months**	**Difference($)**

INDIVIDUAL GROUP MARKET PREMIUM REPORTING

Difference between Premium Earned and Billed in 2014 $ _____
Premium Not Collected for QHP Enrollees during the Grace Period $ _____
Premium Impact Retroactive Enrollment Changes After EDGE Deadline $ _____
Partial Month Proration Differences $ _____
Adjustment(s) to Be Made in Voluntary Resubmission $ _____
Total (Calculated) _____
Unaccounted for (Calculated: Difference – Total Entered) _____
View Summary Table
Written Explanation of Premium Discrepancy

Attachment Type Picklist (Values: Difference between Premium Earned and Billed in 2014, Premium Not Collected for QHP Enrollees during the Grace Period, Premium Impact Retroactive Enrollment Changes After EDGE Deadline, Partial Month Proration Differences, Remaining Discrepancy NOT Accounted For)

File Name	**Attachment Type**

AUTO-CALCULATED SUMMARY TABLE

	Dollar Amount	Percentage of Total Premium Dollar Amount	Percentage of Premium Difference
Difference between Premium Earned and Billed in 2014			
Premium Not Collected for QHP Enrollees during the Grace Period			
Premium Impact Resulting from Retroactive Enrollment Changes After EDGE Deadline			
Partial Month Proration Differences			
Adjustment(s) to Be Made in Voluntary Resubmission			
Remaining Discrepancy NOT Accounted For			
Total Discrepancy Accounted For			

PREMIUM SMALL GROUP DISCREPANCY

HIOS ID: ##### **Company Name**:

SUMMARY OF SMALL GROUP MARKET PREMIUMS REPORTED TO CMS

2.1 Premium Earned including Federal and State High Risk Pool Programs (Small Group RC, Column 8A)	Small Group Plan Average Premium Amount * Billable Member Months	Difference($)

SMALL GROUP MARKET PREMIUM REPORTING

Difference between Earned Premium and Billed in 2014 $ _____
Premium Not Collected for QHP Enrollees during the Grace Period $ _____
Premium Impact Retroactive Enrollment Changes After EDGE Deadline $ _____
Partial Month Proration Differences $ _____
Adjustment(s) to Be Made in Voluntary Resubmission $ _____
Total (Calculated) _____
Unaccounted for (Calculated: Difference – Total Entered) _____
View Summary Table

Written Explanation of Premium Discrepancy

Attachment Type Picklist (Values: Difference between Earned and Billed Premium in 2014, Premium Not Collected for QHP Enrollees during the Grace Period, Premium Impact Retroactive Enrollment Changes After EDGE Deadline, Partial Month Proration Differences, Remaining Discrepancy NOT Accounted For)

File Name	Attachment Type

AUTO-CALCULATED SUMMARY TABLE

	Dollar Amount	Percentage of Total Premium Dollar Amount	Percentage of Premium Difference
Difference between Premium Earned and Billed in 2014			
Premium Not Collected for QHP Enrollees during the Grace Period			
Premium Impact Resulting from Retroactive Enrollment Changes After EDGE Deadline			
Partial Month Proration Differences			
Adjustment(s) to Be Made in Voluntary Resubmission			
Remaining Discrepancy NOT Accounted For			
Total Discrepancy Accounted For			