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

Date: August 18, 2015

Subject: The Transitional Reinsurance Program Operational Guidance: Examples of Counting Methods for Contributing Entities – UPDATED FOR THE 2015 BENEFIT YEAR

Introduction

Section 1341 of the Affordable Care Act established a transitional reinsurance program to stabilize premiums in the individual market inside and outside of the Marketplaces. The transitional reinsurance program will collect contributions from health insurance issuers and certain self-insured group health plans (contributing entities) to fund reinsurance payments to issuers of non-grandfathered reinsurance-eligible individual market plans, the administrative costs of operating the reinsurance program, and the General Fund of the U.S. Treasury for the 2014, 2015, and 2016 benefit (calendar) years. We note that third party administrators (TPAs) and administrative services-only (ASO) contractors may complete the reinsurance contributions submission process on behalf of contributing entities; however, contributing entities are ultimately responsible to pay reinsurance contributions.

The purpose of this document is to provide operational guidance to contributing entities on how to calculate their annual enrollment counts for the purpose of the transitional reinsurance program. The Centers for Medicare & Medicaid Services (CMS) use the annual enrollment count to calculate a contributing entity's reinsurance contribution amount due for the applicable benefit year. This operational guidance describes and illustrates each of the counting methods permitted by 45 CFR 153.405.

For the 2015 benefit year, contributing entities are required to submit their annual enrollment count through https://pay.gov/public/home using the "2015 ACA Transitional Reinsurance Program Annual Enrollment and Contributions Submission Form"[1] no later than Monday, November 16, 2015 (as November 15, 2015, is a Sunday). The "2015 ACA Transitional Reinsurance Program Annual Enrollment and Contributions Submission Form" will auto-calculate the contribution amount owed based on the 2015 uniform contribution rate of $44 per reinsurance covered life. The annual enrollment count must identify the number of covered lives of reinsurance contribution enrollees during the 2015 benefit year for all of the contributing entity's "major medical coverage,"

[1] The 2015 ACA Transitional Reinsurance Program Annual Enrollment and Contributions Submission Form will be made available on https://pay.gov/public/home on October 1, 2015.

as defined under 45 CFR 153.20, unless one of the exceptions provided under 45 CFR 153.400 applies to such coverage.

Types of Contributing Entities

Pursuant to 45 CFR 153.20, for the 2015 and 2016 benefit years, a contributing entity is defined to include:

- A health insurance issuer; or
- A self-insured group health plan (including a group health plan that is partially self-insured and partially insured, where the health insurance coverage does not constitute major medical coverage) that uses a third-party administrator (TPA) in connection with claims processing or adjudication (including the management of internal appeals) or plan enrollment for services other than for pharmacy benefits or excepted benefits within the meaning of section 2791(c) of the PHS Act. Notwithstanding the foregoing, a self-insured group health plan that uses an unrelated third party to obtain provider network and related claim repricing services, or uses an unrelated third party for up to 5 percent of claims processing or adjudication or plan enrollment, will not be deemed to use a TPA, based on either the number of transactions processed by the third party, or the value of the claims processing and adjudication and plan enrollment services provided by the third party.

Pursuant to 45 CFR 153.405, the permitted counting methods vary depending on the type of contributing entity, that is, whether a contributing is:

- A health insurance issuer (45 CFR 153.405(d));
- A self-insured group health plan (including a group health plan that is partially self-insured and partially insured, where the health insurance coverage does not constitute major medical coverage) that uses a third-party administrator (TPA) in connection with claims processing or adjudication (including the management of internal appeals) or plan enrollment for services other than for pharmacy benefits or excepted benefits within the meaning of section 2791(c) of the PHS Act (45 CFR 153.405(e));
- A group health plan with a self-insured coverage option and an insured coverage option (45 CFR 153.405(f));
- Multiple group health plans, including an insured plan, that are maintained by the same plan sponsor, that collectively provide major medical coverage for the same covered lives simultaneously (45 CFR 153.405(g)(4)(i)); and
- Multiple group health plans, **NOT** including an insured plan, that are maintained by the same plan sponsor, that collectively provide major medical coverage for the same covered lives simultaneously (45 CFR 153.405(g)(4)(ii)).

Counting Methods for Determining the Number of Reinsurance Covered Lives

In order to calculate the number of covered lives of reinsurance contribution enrollees for a benefit year, CMS set forth certain permitted counting methods in 45 CFR 153.405. These counting methods are: (1) the actual count method; (2) the snapshot count method; (3) the

snapshot factor method; (4) the Member Months or State Form method; and (5) the Form 5500 method. The permitted counting method depends on whether the contributing entity is a health insurance issuer or a self-insured group health plan, and whether, in the case of a group health plan that is a contributing entity, the plan offers more than one coverage option. The following table shows the specific counting methods available for health insurance issuers and self-insured group health plans:

Table 1: Counting Methods Available to Health Insurance Issuers and Self-Insured Group Health Plans

Counting Method	Health Insurance Issuers	Self-insured Group Health Plans
Actual Count	✓	✓
Snapshot Count	✓	✓
Snapshot Factor		✓
Member Months or State Form	✓	
Form 5500		✓

Group health plan with a self-insured coverage option and an insured coverage option:[2] Pursuant to 45 CFR 153.405(f), a group health plan with a self-insured coverage option and an insured coverage option may choose to report its annual enrollment count on either an aggregated or separate basis.

- Aggregate Reporting: The group health plan must use either the actual count or snapshot count method if it chooses aggregate reporting of enrollment under its coverage options.

- Separate Reporting: The group health plan may use any of the counting methods specified for health insurance issuers or self-insured group health plans, as applicable to each coverage option, if it determines the number of covered lives of reinsurance contribution enrollees under each coverage option separately as if each coverage option provided major medical coverage.[3] [4]

[2] Pursuant to 45 CFR 153.405(f)(2), a group health plan with a self-insured coverage option and an insured coverage option does not need to treat as providing major medical coverage any coverage option that consists solely of excepted benefits as defined by section 2791(c) of the PHS Act, that only provides benefits related to prescription drugs, or that is a health reimbursement arrangement (HRA), health savings account (HSA), or health flexible spending arrangement.
[3] If the group health plan treats each coverage option as its own plan for reinsurance contribution purposes, for any fully insured coverage option, the plan may use the following counting methods: actual count, snapshot count, or Member Months or State Form. For any self-insured coverage option, the group health plan may use the following counting methods: actual count, snapshot count, snapshot factor, or Form 5500.
[4] If there is a group health plan with a self-insured coverage option and an insured coverage option and the group health plan chooses to aggregate its reporting under 45 CFR 153.405(f)(1), the group health plan cannot claim the self-insured, self-administered exemption in light of the insured coverage option. However, if the group health plan chooses to report

Multiple group health plans maintained by the same plan sponsor:[5] Pursuant to 45 CFR 153.405(g)(1), if there are multiple group health plans maintained by the same plan sponsor (including one or more insured group health plans) that collectively provide major medical coverage for the same covered lives simultaneously, the plan sponsor may choose to report its annual enrollment count on either an aggregated or separate basis.

- Aggregate Reporting: The plan sponsor must use the actual count or snapshot count method if it chooses to aggregate the multiple group health plans and at least one of the group health plans is an insured plan. The plan sponsor must use the actual count, snapshot count, or snapshot factor method if it chooses to aggregate the multiple group health plans and none of the group health plans are an insured plan.[6]

- Separate Reporting: The plan sponsor may use any of the counting methods specified for health insurance issuers or self-insured group health plans, as applicable to each coverage option, if it treats the multiple plans as separate group health plans and determines the number of covered lives of reinsurance contribution enrollees under each separate group health plan as if the separate group health plan provided major medical coverage (that is, as its own plan for which reinsurance contributions are required).[7] [8]

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each coverage option separately under 45 CFR 153.405(f)(2), that is, to treat the multiple coverage options as separate group health plans and determine the number of covered lives of reinsurance contribution enrollees under each separate coverage option as if the coverage option provided major medical coverage (that is, as its own plan for which reinsurance contributions are required), then the group health plan could claim the self-insured, self-administered exemption for any self-insured coverage option that is deemed self-administered pursuant to the definition of contributing entity under 45 CFR 153.20.

[5] Pursuant to 45 CFR 153.405(g)(3), a plan sponsor that maintains multiple group health plans is not required to include as part of a single group health plan as determined under 45 CFR 153.405(g)(1) any group health plan that consists solely of excepted benefits as defined by section 2791(c) of the PHS Act, that only provides benefits related to prescription drugs, or that is an HRA, HSA, or health flexible spending arrangement.

[6] When calculating the average number of covered lives across two or more group health plans maintained by the same plan sponsor under 45 CFR 153.405(g), the same counting method must be used across all of the multiple plans, because they would be treated as a single plan for reinsurance contribution counting purposes.

[7] If the plan sponsor treats each group health plan as its own plan for reinsurance contribution purposes, for any fully insured plans, the plan sponsor may use the following counting methods: actual count, snapshot count or Member Months or State Form Method. For any self-insured plans, the plan sponsor may use the following counting methods: actual count, snapshot count, snapshot factor, or Form 5500 Method.

[8] If a plan sponsor that maintains multiple group health plans that collectively provide major medical coverage for the same covered lives simultaneously and the multiple group health plans do ***not*** include an insured plan and the plan sponsor chooses aggregate reporting under 45 CFR 153.405(g)(1), the plan sponsor can only claim the self-insured, self-administered exemption if all of its self-insured coverage options meet the criteria for being self-administered as outlined in the definition of contributing entity under 45 CFR 153.20.

If a plan sponsor that maintains multiple group health plans that collectively provide major medical coverage for the same covered lives simultaneously and the multiple group health plans ***includes*** an insured plan and the plan sponsor chooses aggregate reporting under 45 CFR 153.405(g)(1), the plan sponsor cannot claim the self-insured, self-administered exemption in light of the insured plan. However, if a plan sponsor chooses to report each coverage option separately under 45 CFR 153.405(g)(1), that is, the plan sponsor chooses to treat the multiple plans as separate group health plans and determines the number of covered lives of reinsurance contribution enrollees under each separate group health plan as if the separate group health plan provided major medical coverage (that is, as its own plan for which reinsurance contributions are required), then the plan sponsor could claim the self-insured, self-administered exemption for any self-

To assist contributing entities in determining the number of covered lives of reinsurance contribution enrollees during a benefit year, below is a discussion of each counting method, including: (A) a list of the types of contributing entities that may use each counting method; (B) a description of each counting method; and (C) an example of each counting method.

Rounding: When calculating the annual enrollment count, contributing entities should round the number of covered lives of reinsurance contribution enrollees to the **nearest hundredth**.

NOTE: Throughout this document, the Variable "A" represents the total number of covered lives of reinsurance contribution enrollees.

1. Actual Count Method

(A) Type of Contributing Entity Allowed for this Counting Method: The **Actual Count Method** may be used by all contributing entities [see 45 CFR 153.405(d)(1), (e)(1), (f)(1), (g)(4)(i) and (g)(4)(ii)].

(B) Description: The **Actual Count Method** requires a contributing entity to add the total number of lives (enrollees) covered for each day of the first nine months of the benefit year and divide that total by the number of days in those nine months [see 45 CFR 153.405(d)(1))].

(C) Example 1: An issuer adds the number of covered lives of reinsurance contribution enrollees for each day of the month for the first nine months of the benefit year, i.e. the sum of lives covered for each day of the month of the first nine months of the benefit year. For this issuer, that amount equals 8,195,000 covered lives over the nine months. There are 273 days in the first nine months of the 2015 benefit year. The issuer then divides 8,195,000 covered lives by 273 days to obtain 30,018.32, which is the total number of covered lives of reinsurance contribution enrollees for the 2015 benefit year.

Table 2: Calculation of Covered Lives using Actual Count Method

Month	Sum of lives covered for each day in the month	Sum of days in the month	Calculation
January	905,000	31	
February	910,000	28	
March	905,000	31	
April	910,000	30	A = 8,195,000 ÷ 273
May	910,000	31	A = 30,018.315
June	915,000	30	**A = 30,018.32 covered**
July	900,000	31	
August	925,000	31	
September	915,000	30	
Total	8,195,000	273	

insured coverage option that is deemed self-administered pursuant to the definition of contributing entity under 45 CFR 153.20.

2. Snapshot Count Method

(A) Type of Contributing Entity Allowed for this Counting Method: The **Snapshot Count Method** may be used by all contributing entities [see 45 CFR 153.405(d)(2), (e)(1), (f)(1), (g)(4)(i) and (g)(4)(ii)].

(B) Description: The **Snapshot Count Method** requires a contributing entity to add the total number of covered lives of reinsurance contribution enrollees on any date (or more dates, if an equal number of dates are used for each quarter) during the same corresponding month in each of the first three quarters (e.g., March, June and September) of the benefit year, and divide that total by the number of dates on which a count was made. The date(s) used for the second and third quarters must fall within the same week of the quarter as the corresponding date(s) used for the first quarter [see 45 CFR 153.405(d)(2)].

(C) Example 2: An issuer elects to count the number of covered lives on March 1, 2015, June 1, 2015, and September 1, 2015. The issuer has the following covered lives on each date: 1,600 covered lives on March 1, 2015, 1,650 covered lives on June 1, 2015, and 1,650 covered lives on September 1, 2015. The issuer sums the lives for each date, which equals 4,900. The issuer then divides 4,900 by 3 (the number of dates on which a count was made). Therefore, using the snapshot count method, the issuer's number of covered lives of reinsurance contribution enrollees for the 2015 benefit year equals 1,633.33.

Table 3: Calculation of Covered Lives using Snapshot Count Method

Date for quarter	Total number of covered lives for the date	Number of dates	Calculation
March 1, 2015	1,600	3	A = 4,900 ÷ 3 A = 1,633.333 **A = 1,633.33 covered lives**
June 1, 2015	1,650		
September 1, 2015	1,650		
Total	4,900		

3. Snapshot Factor Method

(A) Type of Contributing Entity Allowed for this Counting Method: The **Snapshot Factor Method** may only be used by: (a) self-insured group health plans, and (b) multiple group health plans maintained by the same plan sponsor that do not include an insured plan [see 45 CFR 153.405(e)(2) and (g)(4)(ii)].

(B) Description: The **Snapshot Factor Method** requires a contributing entity to add the total number of covered lives of reinsurance contribution enrollees on any date (or more dates, if an equal number of dates are used for each quarter) during the same corresponding month in each of the first three quarters of the benefit year, and dividing that total by the number of dates on which a count was made. The date(s) used for the second and third quarters must fall within the same week of the quarter as the corresponding date(s) used for the first quarter. In addition, the same months must be used for each quarter (i.e., March, June, and

September). Under this method, the number of lives covered on a date is calculated by adding: (1) the number of participants[9] with self-only coverage[10] on the date, and (2) the product of the number of participants with coverage other than self-only coverage[11] on the date and a factor of 2.35 [see 45 CFR 153.405(e)(2)].

(C) Example 3: A self-insured group health plan that elects to use the **Snapshot Factor Method** counts the number of covered lives of reinsurance contribution enrollees on March 1, 2015, June 1, 2015, and September 1, 2015. The group health plan has the following coverage options that provide major medical coverage in place on each date: 1,000 participants with self-only coverage and 800 participants with other than self-only coverage on March 1, 2015; 1,100 participants with self-only coverage and 895 participants with other than self-only coverage on June 1, 2015; and 1,175 participants with self-only coverage and 950 participants with other than self-only coverage on September 1, 2015. The group health plan sums the lives for each date which equals 3,275 participants with self-only coverage and 2,645 participants with other than self-only coverage. The group health plan then applies the constant multiplier of 2.35[12] to the 2,645 participants with other than self-only coverage, resulting in 6,215.75 covered lives through other than self-only coverage across the dates for the three quarters. Next, the group health plan sums the 3,275 covered lives with self-only coverage and 6,215.75 covered lives with other than self-only coverage, resulting in 9,490.75 covered lives across the dates for the three quarters. Then, the group health plan divides 9,490.75 covered lives by 3 (the number of dates on which a count was made), resulting in 3,163.58 covered lives of reinsurance contribution enrollees for the 2015 benefit year.

Table 4: Calculation of Covered Lives using Snapshot Factor Method

Dates for the quarters	Total number of self only covered lives for the date	Total number of other than self only covered lives for the date	Number of dates	Calculation
March 1, 2015	1,000	1,880 (2.35*800)	3	A = (3,275+6,215.75) ÷ 3 A = 3,163.583 **A = 3,163.58 covered lives**
June 1, 2015	1,100	2,103.25 (2.35*895)		
September 1, 2015	1,175	2,232.50 (2.35*950)		
Total	3,275	6,215.75		

[9] As discussed in the "2013 Instructions for Form 5500, Annual Return/Report of Employee Benefit Plan" a "participant" does not include covered dependents. See: http://www.dol.gov/ebsa/pdf/2013-5500inst.pdf.
[10] A self-only policy is major medical coverage offered by a self-insured group health plan that only covers an individual (e.g., participant) but not his or her spouse, dependents or family members.
[11] An other than self-only policy is major medical coverage offered by a self-insured group health plan for an individual (e.g., participant) plus one or more family members.
[12] The preamble to the Patient-Centered Outcomes Research Trust Proposed Rule published on April 17, 2012 (77 FR 22691) explains that "the 2.35 dependency factor reflects that all participants with coverage other than self-only have coverage for themselves and some number of dependents. The Treasury Department and the IRS developed the factor, and other similar factors used in the regulations, in consultation with Treasury Department economists and in consultation with plan sponsors regarding the procedures they currently use for estimating the number of covered individuals."

4. Member Months or State Form Method

(A) Type of Entity Allowed for this Counting Method: The **Member Months or State Form Method** may only be used by a health insurance issuer [see 45 CFR 153.405(d)(3)].

(B) Description: The **Member Months or State Form Method** requires an issuer to multiply the average number of policies in effect for the first nine months of the benefit year by the ratio of covered lives per policy in effect, calculated using the prior year's National Association of Insurance Commissioners (NAIC) Supplemental Health Care Exhibit or a form filed with the issuer's State of domicile for the most recent time period [see 45 CFR 153.405(d)(3)].

(C) Example 4: An issuer has 39,550 policies from their previous year's NAIC Supplemental Health Care Exhibit Part 1 and 98,875 covered lives. In **Step 1**, the issuer calculates the average number of policies in effect for the first nine months – January through September – of the applicable benefit year. The issuer sums each month's number of policies, resulting in 42,750 policies, and divides by 9. The average number of policies in this example is 4,750. In **Step 2**, the issuer divides the 98,875 number of covered lives by the 39,550 number of policies, resulting in a ratio of 2.5. In **Step 3**, the issuer multiplies the 4,750 average number of policies (from step 1) by the 2.5 ratio of covered lives per policy (from step 2). The result is 11,875 covered lives of reinsurance contribution enrollees for the 2015 benefit year.

Table 5.1: Calculation of Covered Lives using Member Months or State Form Method
Step 1

Month	Number of policies in effect each month	Number of months	Calculation of average number of policies
January	5,000	9	B= 42,750 ÷ 9 **C = 4,750 average number of policies**
February	5,000		
March	4,500		
April	4,500		
May	4,500		
June	4,500		
July	4,750		
August	5,000		
September	5,000		
Total	42,750		

Table 5.2: Calculation of Covered Lives using Member Months or State Form Method **Step 2**

	Number of policies	Number of covered lives	Calculation of ratio
Previous Year's NAIC Supplemental Health Care Exhibit Part 1[13]	39,550	98,875	C = 98,875 ÷ 39,550 **D = 2.5 ratio of covered lives per policy in effect**

Table 5.3: Calculation of Covered Lives using Member Months or State Form Method - **Step 3**

Description	Value	Variable	Calculation of Covered Lives
Average Number of Policies in Effect	4,750	C	A = C * D A = 4,750 * 2.5
Ratio of Covered Lives Per Policy	2.5	D	**A = 11,875 covered lives**

5. Form 5500 Method

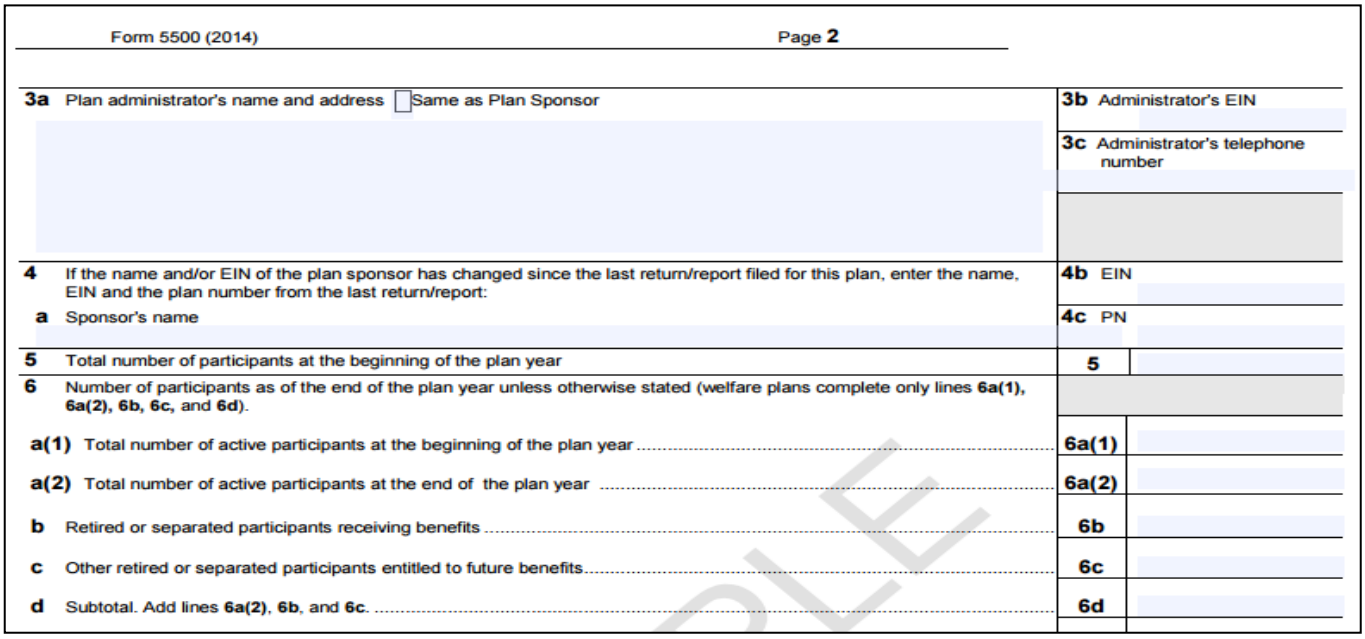
(A) Type of Entity Allowed for this Counting Method: The **Form 5500 Method** may only be used by self-insured group health plans [see 45 CFR 153.405(e)(3)].

(B) Description: The **Form 5500 Method** requires a self-insured group health plan to use the number of covered lives of reinsurance contribution enrollees for the most current plan year calculated based upon the "Annual Return/Report of Employee Benefit Plan" filed with the Department of Labor (Form 5500) for the last applicable time period.[14] For purposes of this counting method, the number of lives covered for the plan year for a plan offering only self-only coverage equals the sum of the total participants covered at the beginning and end of the plan year, as reported on lines 5 and 6(d) of the Form 5500, divided by 2. The number of lives covered for the plan year for a plan offering self-only coverage and other than self-only coverage equals the sum of the total participants covered at the beginning and the end of the plan year, as reported on lines 5 and 6(d) of the Form 5500 [see 45 CFR 153.405(e)(3)].

[13] As detailed at 45 CFR 153.405(d)(3), the issuer may use either the previous year's NAIC Supplemental Health Care Exhibit or a form filed with the issuer's State of domicile for the most recent time period for determining the ratio of covered lives per policy in effect (for **Step 2**).

[14] We understand that for the 2015 benefit year, self-insured group health plans would use the Form 5500 for 2014 in light of the Form 5500 reporting deadlines.

Figure 1: Form 550 (2014)



Form 5500 (2014) Page **2**

3a Plan administrator's name and address ☐ Same as Plan Sponsor		**3b** Administrator's EIN
		3c Administrator's telephone number
4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report:		**4b** EIN
a Sponsor's name		**4c** PN
5 Total number of participants at the beginning of the plan year		**5**
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines **6a(1)**, **6a(2)**, **6b**, **6c**, and **6d**).		
a(1) Total number of active participants at the beginning of the plan year		**6a(1)**
a(2) Total number of active participants at the end of the plan year		**6a(2)**
b Retired or separated participants receiving benefits		**6b**
c Other retired or separated participants entitled to future benefits		**6c**
d Subtotal. Add lines **6a(2)**, **6b**, and **6c**.		**6d**

C) Example 5(a): *A self-insured group health plan offering only self-only coverage* covered lives total will equal the sum of the total participants covered at the beginning and end of the plan year, as reported on the Form 5500, divided by 2. Therefore, if the plan, as reported on its Form 5500, covers 5,000 participants on August 1, 2014 and 8,000 participants on July 30, 2015, for reinsurance purposes, the result is 6,500 (average) total covered lives of reinsurance contribution enrollees for the 2015 benefit year.

Table 6.1: Calculation of Covered Lives for a Plan Offering Only Self-Only Coverage Using Form 5500 Method

	Number of covered lives	Number of dates	Calculation
Beginning of the plan year	5,000	2	A = 13,000 ÷ 2
End of the plan year	8,000		**A = 6,500 covered lives**
Total	13,000		

Example 5(b): *A self-insured group health plan offering self-only coverage and other than self-only coverage* covered lives total will equal the sum of the total participants covered at the beginning and the end of the plan year, as reported on the Form 5500. Therefore, if the plan offering both self-only coverage and other than self-only coverage, as reported on its Form 5500, covers 6,000 participants on August 1, 2014 and 9,000 participants on July 30, 2015, for reinsurance purposes, the result is 15,000 total covered lives of reinsurance contribution enrollees for the 2015 benefit year.

Table 6.2: Calculation of Covered Lives for a Plan Offering Self-Only and Coverage Other than Self Only Coverage Using Form 5500 Method

	Number of covered lives for the date	Calculation
Beginning of the plan year	6,000	A = 6,000 + 9,000
End of the plan year	9,000	**A = 15,000 covered lives**
Total	15,000	

Partial Year Coverage

A health plan or coverage may be established or terminated, or change funding mechanisms during the first nine months of a benefit year, we refer to this as partial year coverage. When a group health plan that offers only one coverage option changes from self-insured to fully insured during the calendar year, the self-insured group health plan would be responsible for paying the reinsurance contribution for those reinsurance contribution enrollees from January 1, 2015, through the date on which the plan changed to fully insured. The issuer of the fully insured plan would be responsible for paying the reinsurance contribution for those reinsurance contribution enrollees starting on the date the plan changed to fully insured through September 30, 2015. Therefore, both plans would be responsible for paying a portion of the contribution for the year in which the change was made on behalf of the covered lives of reinsurance contribution enrollees in those plans using one of the permitted counting methods in 45 CFR 153.405(d) and 45 CFR 153.405(e), as applicable. This approach would also apply if a plan changes from fully insured to self-insured status during the calendar year.

A health plan or insurance coverage may also be established or terminated, or change funding mechanisms (i.e. from fully insured to self-insured or self-insured to fully insured) in the middle of a quarter. In these circumstances, the new plan or coverage would not have covered lives enrolled in the plan or coverage for the entire quarter. We note that if this occurs, a contributing entity could, due to its selection of dates, be required to pay an amount significantly greater or lesser than the amount that would be due based on its average count of covered lives under the plan or coverage over the course of the ordinarily applicable nine-month counting period. To avoid this result and ensure that contributions are required to be paid only once with respect to the same covered life, if the plan or coverage in question had enrollees on any day during a quarter and if the contributing entity elects to and is permitted to use either the snapshot count method or snapshot factor method set forth in 45 CFR 153.405(d)(2) and (e)(2), respectively, it must choose a set of counting dates for the nine-month counting period such that the plan or coverage has enrollees on each of the dates, if possible.[15]

However, the enrollment count for a date during a quarter in which the plan or coverage was not in existence during the entire quarter can be reduced by a factor reflecting the amount of time during the quarter for which the plan or coverage did not have enrollment. This approach is intended to accurately capture the amount of time during the quarter for which major medical coverage was

[15] See the HHS Notice of Benefit and Payment Parameters for 2016 Final Rule (80 FR 10774), and FAQ #6438 available on https://www.regtap.info/.

provided to reinsurance contribution enrollees, while not requiring contributions to be paid more than once with respect to the same covered life.

Example 6(a): An issuer that is a contributing entity that has coverage that terminates on August 31 (that is, 62 days into the third quarter) would not be permitted to use September 1 as the date for the third quarter under the snapshot count method because this would not properly reflect the number of covered lives of reinsurance contribution enrollees under the plan in the third quarter of the benefit year. However, it would be entitled to reduce its count of covered lives for the third quarter by 30/92, the proportion of the quarter during which the plan had no enrollment. This reduction factor is only applicable for the snapshot count method set forth in 45 CFR 153.405(d)(2) and for self-insured group health plans, the snapshot factor method set forth in 45 CFR 153.405(e)(2)) as all of the other permitted counting methods automatically account for partial year enrollment. Using this example, Table 7 illustrates how the reduction factor would work when using the snapshot count method set forth in 45 CFR 153.405(d)(2).

Table 7: Calculation of Covered Lives using Snapshot Count Method (with reduction factor)

Date for Quarter	Total number of covered lives for the date	Number of Quarters/Dates	Calculation
February 1, 2015	90	3	A = 90 + 90 + (90 – (90(30/92)))/3 A = 80.22
May 1, 2015	90		
August 1, 2015	90 – (90(30/92))		
Total	240.65		

Example 6(b): A contributing entity that is a health insurance issuer has new coverage that was established on September 1, 2015 (that is, 62 days into the third quarter) would not be permitted to use a date in July 1, 2015 or August 1, 2015 as the date for the third quarter under the snapshot count method because this would not properly reflect the number of covered lives of reinsurance contribution enrollees under the plan in the third quarter of the benefit year. However, it would be entitled to reduce its count of covered lives for that quarter by 62/92, the proportion of the quarter during which the plan had no enrollment. Using this example, Table 8 illustrates how the reduction factor would work when using the snapshot count method set forth in 45 CFR 153.405(d)(2).

Table 8: Calculation of Covered Lives using Snapshot Count Method (with reduction factor)

Date for Quarter	Total number of covered lives for the date	Number of Quarters/Dates	Calculation
March 1, 2015	0	3	A = 0 + 0 + (90 – (90(62/92)))/3 A = 9.78
June 1, 2015	0		
September 1, 2015	90 – (90(62/92))		
Total	29.35		

Consistency Requirements

A contributing entity must use the same counting method for an entire benefit year, which for purposes of the reinsurance program is the calendar year. When calculating the average number of covered lives across two or more group health plans maintained by the same plan sponsor under 45 CFR 153.405(g), the same counting method must be used across all of the multiple plans, because they would be treated as a single plan for counting purposes, unless the plan sponsor determines the number of covered lives of reinsurance contribution enrollees under each separate group health plan as if the separate group health plan provided major medical coverage, as discussed above.

A contributing entity is **not** required to use the same counting method from benefit year to benefit year throughout the transitional reinsurance program.

A contributing entity that is a health insurance issuer must use the same counting method to calculate its annual enrollment count of covered lives of reinsurance contribution enrollees in a state (including both the individual and group markets) for a benefit year even if the fully insured major medical plans for which reinsurance contributions are required enroll different covered lives.[16] If a health insurance issuer has multiple major medical plans covering different lives in different states, the issuer may use different counting methods for all major medical plans in each state (including both the individual and group markets).

Consistency in counting methods between the count calculated under the Patient-Centered Outcome Research Trust Fund final rule (PCORTF Rule, 77 FR 72721) and the count calculated for the transitional reinsurance purposes is **not** required. In other words, CMS allows a contributing entity to use a different counting method for reinsurance purposes than the entity may use pursuant to the PCORTF Rule.

Deducting Exempted Lives from the Annual Enrollment Count

Contributing entities may use any reasonable method of estimating the number or percentage of its enrollees who are exempted from the requirement to make reinsurance contributions, as set forth in 45 CFR 153.400(a). For example, a contributing entity may calculate the percentage of enrollees for which the employer group health coverage is secondary under the Medicare Secondary Payer (MSP) rules on the dates it uses when applying the Snapshot Count Method or Actual Count Method, or on other periodic dates, and reduce the enrollment count calculated using one of the applicable methods in 45 CFR 153.405(d) through (g) by that percentage. A contributing entity may also calculate the total enrollment of individuals for which the employer group health coverage is secondary under the MSP rules on the last day of the third quarter and reduce the enrollment count that was calculated using one of the methods in 45 CFR 153.405. Alternatively, if a plan has enrollees who should not

[16] This uniformity requirement does not extend to self-insured group health plans that are contributing entities. See the HHS Notice of Benefit and Payment Parameters for 2016 Final Rule (80 FR 10774).

be included in the enrollee count pursuant to an exemption in 45 CFR 153.400(a), a reasonable method of estimating the number of exempted lives could include subtracting the exempted lives as follows:

- **Actual Count Method** (45 CFR 153.405(d)(1)): Subtract any exempted covered lives from the total for each day, ***prior*** to adding the total number of lives covered for each day of the first nine (9) months of the benefit year and then divide that total by the number of days in the first nine (9) months.

- **Snapshot Count Method** (45 CFR 153.405(d)(2)): Subtract any exempted covered lives from the total for each date(s) on which a count is taken in a quarter, ***prior*** to adding the total number of lives covered on any date (or more dates, if an equal number of dates are used for each quarter) during the same corresponding month in each of the first three (3) quarters of the benefit year, and then divide that total by the number of dates on which a count was made.

- **Snapshot Factor Method** (45 CFR 153.405(e)(2)): Add the total number of lives covered on any date (or more dates, if an equal number of dates are used for each quarter) during the same corresponding month in each of the first three quarters of the benefit year (provided that the date used for the second and third quarters must fall within the same week of the quarter as the corresponding date used for the first quarter), and dividing that total by the number of dates on which a count was made, except that the number of lives covered on a date is calculated by adding the number of participants with self-only coverage on the date to the product of the number of participants with coverage other than self-only coverage on the date and a factor of 2.35. For this purpose, the same months must be used for each quarter (for example, January, April, and July). ***Following this determination, subtract from the total number of lives covered the number of exempted covered lives***.

- **State Form or Member Months Method** (45 CFR 153.405(d)(3)): Determine the average number of policies for the first nine (9) months of the calendar year and multiply that that number of policies by the ratio of covered lives per policy in effect, calculated using the prior NAIC Supplemental Health Care Exhibit (or a form filed with the issuer's State of domicile for the most recent time period). ***Following this determination, subtract from the total number of lives covered the number of exempted covered lives***.

- **Form 5500 Method** (45 CFR 153.405(e)(3)): Determine the number of lives covered for the most current plan year calculated based upon the Form 5500 filed with the Department of Labor for the last applicable time period. For purposes of this method, the number of lives covered for the plan year for a plan offering only self-only coverage equals the sum of the total participants covered at the beginning and end of the plan year, as reported on the Form 5500, divided by two (2), and the number of lives covered for the plan year for a plan offering self-only coverage and coverage other than self-only coverage equals the sum of the total participants covered at the beginning and the end of the plan year, as reported on the Form 5500. ***Following this determination, subtract from the total number of lives covered the number of exempted covered lives***.

Other Considerations

Reinsurance Contribution and Double Counting: Reinsurance contributions are generally required for major medical coverage that is part of a commercial book of business, but are **not** required to be paid more than once with respect to the same covered life. (see 45 CFR 153.400(a)(1)). A contributing entity is not required to make reinsurance contributions for certain types of coverage. (see 45 CFR 153.400(a)).

Secondary Coverage: Reinsurance contributions are **not** required, in the case of employer-provided group health coverage if: (a) such coverage applies to individuals with individual market health insurance coverage for which reinsurance contributions are required; or (b) such coverage is supplemental or secondary to group health coverage for which reinsurance contributions must be made for the same covered lives (see 45 CFR 153.400(a)(1)(vi)).

Medicare Secondary Payor Rules: Reinsurance contributions are **not** required, in the case of employer-provided health coverage, to the extent such coverage applies to individuals with respect to which benefits under Title XVIII of the Act (Medicare) are primary under the Medicare Secondary Payor rules (see 45 CFR 153.400(a)(1)(iv)).

Enrollees Residing in Territories: Reinsurance contributions are **not** required to the extent such plan or coverage applies to individuals with primary residence in a territory that does not operate the transitional reinsurance program (see 45 CFR 153.400(a)(1)(v)). As of the date of this guidance, no territories have elected to operate a transitional reinsurance program.

Compliance Standards: Pursuant to 45 CFR 153.405(h), a contributing entity must maintain documents and records, whether paper, electronic, or in other media, sufficient to substantiate the enrollment count submitted for a period of at least 10 years, and must make those documents and records available upon request from HHS, the Office of the Inspector General, the Comptroller General, or their designees, to any such entity, for purposes of verification, investigation, audit, or other review of reinsurance contribution amounts. Additionally, pursuant to 45 CFR 153.405(i), HHS or its designee may audit a contributing entity to assess its compliance with the requirements of the transitional reinsurance program.