DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
200 Independence Avenue SW
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Subject: **The Transitional Reinsurance Program Operational Guidance: Counting Method Examples for Contributing Entities**

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 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. "Contributing entities" include health insurance issuers and certain self-insured group health plans offering major medical coverage.[1] Third party administrators (TPAs) and administrative services-only (ASO) contractors may submit data and funds on behalf of contributing entities.

The purpose of this document is to provide contributing entities with operational guidance on how to calculate annual enrollment counts for the transitional reinsurance program. The Centers for Medicare & Medicaid Services (CMS) uses 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.

Contributing entities are required to submit to CMS an annual enrollment count no later than November 15 of each benefit year of the reinsurance program.[2] This submission will permit CMS to calculate and notify the entity of the annual contribution amount owed. The annual enrollment count must identify the number of covered lives of reinsurance contribution enrollees during the benefit year for all of the contributing entity's "major medical coverage," 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 153.405, the permitted counting method(s) varies depending on the type of contributing entity. Contributing entities generally include:

- A health insurance issuer (45 CFR 153.405(d));

[1] The criteria for self-insured group health plans to be considered contributing entities under 45 CFR 153.20 changes for the 2015 and 2016 benefit years.
[2] A contributing entity is required to submit an annual enrollment count only once for each benefit year under 45 CFR 153.405(b), by no later than November 15 of the benefit year 2014, 2015, or 2016 (78 FR 13776).

- A self-insured group health plan (45 CFR 153.405(e));
- Group health plans 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 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 plans with a self-insured coverage option and an insured coverage option:[3] Pursuant to 45 CFR 153.405(f), a group health plan with a self-insured option and an insured option may choose to report its annual enrollment count on either a separate or aggregate basis.

[3] 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 Public Health Service (PHS) Act, that only provides benefits related to prescription drugs, or that is a health reimbursement arrangement, health savings account, or health flexible spending arrangement.

- 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. [4]

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

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 group health plans that provide health insurance coverage) 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 a separate or aggregate basis.

- 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).[6]

- Aggregate Reporting: The plan sponsor must use the actual count or snapshot count counting method if it chooses to aggregate the multiple group health plans and at least one is an insured plan. The plan sponsor must use the actual count, snapshot count, or snapshot factor counting method if it chooses to aggregate the multiple group health plans and none of the plans are an insured plan.[7]

When calculating annual covered lives for reporting to HHS, contributing entities should round the number of lives to the **nearest hundredth**.

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.

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

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[4] If the group health plan treats each coverage option as its own plan for reinsurance contribution purposes, for any fully insured coverage option, the group health 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.

[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 a health reimbursement arrangement, health savings account, or health flexible spending arrangement.

[6] 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. For any self-insured plans, the plan sponsor may use the following counting methods: actual count, snapshot count, snapshot factor or Form 5500.

[7] 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.

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 2014 benefit year. The issuer 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 2014 benefit year.

Table 2: Calculation of Covered Lives using Actual Count Method

Month	Sum of lives covered for each day of 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 = 30,0182.32
June	915,000	30	**A = 30,0182.32 covered lives**
July	900,000	31	
August	925,000	31	
September	915,000	30	
Total	8,195,000	273	

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 5, 2014, June 5, 2014, and September 5, 2014. The issuer has the following covered lives on each date: 1,600 covered lives on March 5, 2014, 1,650 covered lives on June 5, 2014, and 1,650 covered lives on

September 5, 2014. 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 2014 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 5, 2014	1,600	3	A = 4,900 ÷ 3 A = 1,633.333 **A = 1,633.33 covered lives**
June 5, 2014	1,650		
September 5, 2014	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[8] with self-only coverage[9] on the date, and (2) the product of the number of participants with coverage other than self-only coverage[10] on the date and a factor of 2.35 [see 45 CFR 153.405(e)(2)].

(C) Example 3: A group health plan eligible to use the **Snapshot Factor Method** counts the number of covered lives of reinsurance contribution enrollees on March 5, 2014, June 5, 2014, and September 5, 2014. The group health plan has the following policies that provide major medical coverage in place on each date: 1,000 self-only policies and 800 other than self-only policies on March 5, 2014; 1,100 self-only policies and 895 other than self-only policies on June 5, 2014; and 1,175 self-only policies and 950 other than self-only policies on September 5, 2014. The group health plan sums the lives for each date which equals 3,275 self-only policies and 2,645 other than self-only policies. The group health plan then applies the constant multiplier of 2.35 to the 2,645 other than self-only policies, resulting in 6,215.75 covered lives through other than self-only policies across the dates for the three quarters. Next, the group health plan sums the 3,275 covered lives through self-only policies and 6,215.75 covered lives through other than self-only

[8] 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

[9] 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.

[10] 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.

policies, 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 2014 benefit year.

Table 4: Calculation of Covered Lives using Snapshot Factor Method

Date for Quarters	Total number of self-only covered lives for the date	Total number of covered lives other than self-only for the date	Number of Dates	Calculation
March 5, 2014	1,000	1,880 (2.35*800)	3	A = (3,275+6,215.75) ÷ 3
June 5, 2014	1,100	2,103.25 (2.35*895)		A = 3,163.583
September 5, 2014	1,175	2,232.50 (2.35*950)		
Total	3,275	6,215.75		**A = 3,163.58 covered lives**

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 a contributing entity 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 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: 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 from their previous year's NAIC Supplemental Health Care Exhibit Part 1, 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 2014 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	C = 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[11]	39,550	98,875	D = 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 **A = 11,875 covered lives**
Ratio of Covered Lives Per Policy	2.5	D	

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)].

[11] 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**).

(B) Description: The **Form 5500 Method** requires a contributing entity 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. 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(a)-(c) of 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(a)-(c) of the Form 5500 [see 45 CFR 153.405(e)(3)].

Figure 1: Form 5500

Form 5500 (2013) Page **2**

3a Plan administrator's name and address ☐ Same as Plan Sponsor Name ☐ Same as Plan Sponsor Address | **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 (welfare plans complete only lines **6a, 6b, 6c,** and **6d**).

a Active participants | **6a**

b Retired or separated participants receiving benefits | **6b**

c Other retired or separated participants entitled to future benefits | **6c**

(C) Example 5(a): *A 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, 2013 and 8,000 participants on July 30, 2014, for reinsurance purposes, the result is 6,500 (average) total covered lives of reinsurance contribution enrollees for the 2014 benefit year.

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

Date for Form 5500 Reporting	Number of covered lives for the date	Number of Dates	Calculation
August 1, 2013	5,000		
July 30, 2014	8,000	2	A = 13,000 ÷ 2
Total	13,000		**A = 6,500 covered lives**

Example 5(b): *A 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, 2013 and 9,000 participants on July 30, 2014, for reinsurance purposes, the result is 15,000 total covered lives of reinsurance contribution enrollees for the 2014 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

Date for Quarter	Number of covered lives for the date	Calculation
August 1, 2013	6,000	
July 30, 2014	9,000	A = 6,000 + 9,000
Total	15,000	**A = 15,000 covered lives**

Counting Consistency Requirements

A contributing entity must use the same counting method for an entire benefit 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. However, a contributing entity is **not** required to use the same counting method from benefit year to benefit year throughout the transitional reinsurance program.

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 reinsurance purposes is also **not** required. In other words, CMS allows a contributing entity to use a different counting method for reinsurance purposes than it uses for the PCORTF Rule.

Calculating a Contributing Entity's Total Reinsurance Contribution Amount

The reinsurance contribution required from a contributing entity for a benefit year is calculated by multiplying the number of covered lives of reinsurance contribution enrollees during the applicable benefit year for all of the contributing entity's applicable plans and coverage by the applicable contribution rate for the benefit year. See 45 CFR 153.405(a).

Example: A contributing entity reports 10,000 covered lives for which it must make reinsurance contributions for the 2014 benefit year. The annual per capita reinsurance contribution rate for the 2014 benefit year is $63.00. Therefore, the total reinsurance contribution required for this contributing entity for the 2014 benefit year equals $630,000.

Table 7: Example of Calculation of the Total Reinsurance Contribution Amount

Description	Value	Variable	Calculation
Covered Lives	10,000	A	X = A * B
2014 Uniform Contribution Rate ($)	$63.00	B	X = 10,000 * $63
Contribution Amount Owed ($)	?	X	**X = $630,000**

Other Considerations

Coverage for which reinsurance contributions are not required: A contributing entity is not required to make reinsurance contributions for certain types of coverage. Please see 45 CFR 153.400(a) for further information.

Reinsurance contributions 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)).

Secondary Coverage: Reinsurance contributions are generally required for major medical coverage that is part of a commercial book of business, but 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 generally required for major medical coverage that is part of a commercial book of business, but 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 generally required for major medical coverage that is part of a commercial book of business, but 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.