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Reinsurance Fees—Examples of Counting Methods

The Affordable Care Act (ACA) created a transitional reinsurance program to help stabilize premiums in the individual market for the first three years of Exchange operation (2014-2016), when individuals with higher-cost medical needs gain insurance coverage. The program imposes a fee on health insurance issuers and self-funded group health plans (contributing entities).

Each year, contributing entities are required to submit their annual enrollment count to the Department of Health and Human Services (HHS). 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.

On Aug. 18, 2015, CMS published a bulletin that provides operational guidance and examples for contributing entities on how to calculate their annual enrollment counts for purposes of the reinsurance fees. For the 2015 benefit year, contributing entities are required to submit their annual enrollment count no later than **Nov. 16, 2015**.

OVERVIEW OF THE REINSURANCE FEES

The ACA requires "contributing entities" to pay fees to support the reinsurance program. A contributing entity is defined as a health insurance issuer or a third-party administrator (TPA) on behalf of 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).

As described below, certain types of coverage are excluded from paying fees to the reinsurance program.

- ***Fully-insured Group Health Plans***: For insured health plans, the **issuer of the health insurance policy** is required to pay reinsurance fees. Although sponsors of fully-insured plans are not responsible for paying the reinsurance fees, issuers will likely shift the cost of the fees to sponsors through premium increases.
- ***Self-insured Group Health Plans***: For self-insured plans, the **plan sponsor** is liable for paying reinsurance fees, although a TPA or administrative-services-only (ASO) contractor may pay the fee at the plan's direction. For a plan maintained by a single employer, the employer is the plan sponsor. The Department of Labor (DOL) has advised that **paying reinsurance fees constitutes a permissible expense of the plan under ERISA** because the payment is required by the plan under the ACA.

For 2015 and 2016, the term "contributing entity" excludes self-insured group health plans that do not use a TPA in connection with the core administrative functions of claims processing or adjudication (including the management of internal appeals) or plan enrollment for services other than for pharmacy benefits or excepted benefits. 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.

ANNUAL ENROLLMENT COUNT SUBMISSIONS

For the 2015 benefit year, contributing entities are required to submit their annual enrollment count through Pay.gov no later than **Nov. 16, 2015** (as Nov. 15, 2015, is a Sunday). The annual enrollment count must identify the number

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of covered lives of reinsurance contribution enrollees during the 2015 benefit year for all of the contributing entity's "major medical coverage," unless an exception applies to the coverage.

Contributing entities will use the "2015 ACA Transitional Reinsurance Program Annual Enrollment and Contributions Submission Form" to submit their annual enrollment counts, which is expected to become available on www.Pay.gov on **Oct. 2, 2015**. This form will auto-calculate the contribution amount owed based on the 2015 uniform contribution rate of **$44 per reinsurance covered life**.

COUNTING METHODS FOR DETERMINING THE NUMBER OF REINSURANCE COVERED LIVES

CMS has provided the following five permitted counting methods that contributing entities may use to calculate the number of covered lives of reinsurance contribution enrollees for a benefit year:

1	The Actual Count Method
2	The Snapshot Count Method
3	The Snapshot Factor Method
4	The Member Months or State Form Method
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:

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

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. In addition, 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.

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In either case, a group health plan does not need to treat the following as providing major medical coverage:

- Any coverage option or group health plan that **consists solely of excepted benefits**;
- Any coverage option or group health plan that only **provides benefits related to prescription drugs**; or
- Any coverage option or group health plan that is a **health reimbursement arrangement** (HRA), **health savings account** (HSA) or **health flexible spending arrangement** (FSA).

	Group Health Plans with both Self-insured and Insured Coverage Options	Multiple Group Health Plans Maintained by the Same Plan Sponsor
Aggregate Reporting	The plan must use either the **Actual Count Method** or **Snapshot Count Method** if it chooses aggregate reporting of enrollment under its coverage options.	The plan sponsor must use the **Actual Count Method** or **Snapshot Count Method** if it chooses to aggregate the multiple plans and at least one of the plans is insured. The plan sponsor must use the **Actual Count Method**, **Snapshot Count Method** or **Snapshot Factor Method** if it chooses to aggregate the multiple group health plans and none of the plans are insured.
Separate Reporting	The 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.	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 plan as if the separate plan provided major medical coverage (that is, as its own plan for which reinsurance contributions are required).
Special Rules	A group health plan with both self-insured and insured coverage options that chooses to aggregate its reporting **cannot claim the self-insured, self-administered exemption** in light of the insured coverage option. However, if the group health plan chooses to report each coverage option separately, then the group health plan could claim the self-insured, self-administered exemption for any self-insured coverage option that is deemed self-administered.	When calculating the average number of covered lives across two or more group health plans maintained by the same plan sponsor, the same counting method must be used across all of the plans, because they would be treated as a single plan for reinsurance contribution counting purposes. A plan sponsor that chooses aggregate reporting and that maintains multiple group health plans, none of which are insured, that collectively provide major medical coverage for the same covered lives simultaneously can only claim the self-insured, self-administered exemption if all of its self-insured coverage options meet the criteria for being self-administered.

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

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EXAMPLES

To assist contributing entities in determining the number of covered lives of reinsurance contribution enrollees during a benefit year, CMS' bulletin provides a discussion of each counting method, including a list of the types of contributing entities that may use each counting method, a description of each counting method and an example of each counting method. Throughout the examples, "A" represents the total number of covered lives of reinsurance contribution enrollees.

Actual Count Method

The Actual Count Method may be used by **all contributing entities**.

The Actual Count Method may be used by **all contributing entities**. This 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.

Example: 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 (that is, the sum of lives covered for each day of the month for 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.

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

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Snapshot Count Method

The Snapshot Count Method may be used by **all contributing entities**.

This 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 (for example, 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.

Example: An issuer elects to count the number of covered lives on March 1, 2015, June 1, 2015, and Sept. 1, 2015. The issuer has the following covered lives on each date:

March 1, 2015:	June 1, 2015:	Sept. 1, 2015:
1,600 covered lives	1,650 covered lives	1,650 covered lives

The issuer adds 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**.

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		
Sept. 1, 2015	1,650		
Total:	4,900		

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Snapshot Factor Method

The Snapshot Factor Method may only be used by:

- **Self-insured group health plans;** and
- **Multiple group health plans maintained by the same plan sponsor that do not include an insured plan**.

This 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
- 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. In addition, the same months must be used for each quarter (for example, March, June and September).

Under this method, the number of lives covered on a date is calculated by adding:

- The number of participants with self-only coverage on the date; and
- The product of the number of participants with coverage other than self-only coverage on the date and a factor of 2.35.

The 2.35 dependency factor was developed by the IRS to reflect that all participants with coverage other than self-only have coverage for themselves and some number of dependents. The IRS developed the factor (and other similar factors used in the regulations) in consultation with Treasury Department economists as well as with plan sponsors regarding the procedures they currently use for estimating the number of covered individuals.

In the 2013 Instructions for Form 5500, the DOL clarified that, for this purpose, a "participant" does not include covered dependents. Also:

- A **self-only policy** is major medical coverage offered by a self-insured group health plan that only covers an individual (for example, a participant) but not his or her spouse, dependents or family members.
- An **other-than-self-only policy** is major medical coverage offered by a self-insured group health plan for an individual (for example, a participant) plus one or more family members.

See the following page for an example of the Snapshot Factor Method.

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Example: 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 Sept. 1, 2015. The group health plan has the following coverage options that provide major medical coverage in place on each date:

	March 1, 2015:	June 1, 2015:	Sept. 1, 2015:
Self-only	1,000 participants	1,100 participants	1,175 participants
Other than self-only	800 participants	895 participants	950 participants

The group health plan adds 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 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 adds 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.

Date for quarter	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 x 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 x 895)		
Sept. 1, 2015	1,175	2,232.50 (2.35 x 950)		
Total:	**3,275**	**6,215.75**		

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Member Months or State Form Method

The Member Months or State Form Method may only be used by **a health insurance issuer**.

This 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).

Example: An issuer has **39,550 policies** from their previous year's NAIC Supplemental Health Care Exhibit Part 1 and **98,875 covered lives**.

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 adds 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**.

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**		

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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**.

	Number of policies	Number of covered lives	Calculation of ratio
Previous Year's NAIC Supplemental Health Care Exhibit Part I (or a form filed with the issuer's state of domicile for the most recent time period)	39,550	98,875	C = 98,875 ÷ 39,550 **D = 2.5 ratio of covered lives per policy in effect**

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.

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

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Form 5500 Method

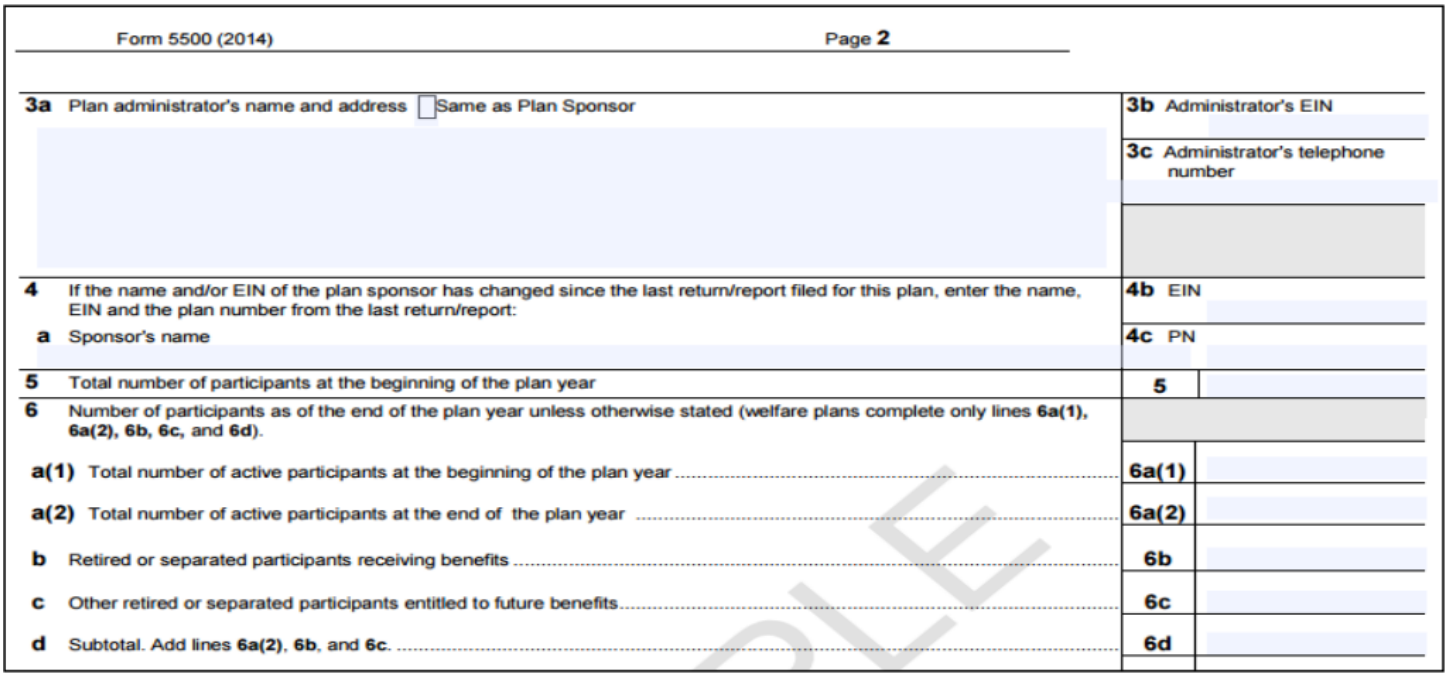
The Form 5500 Method may only be used by **self-insured group health plans**.

This 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 on the "Annual Return/Report of Employee Benefit Plan" filed with the DOL (Form 5500) for the last applicable time period.

The IRS understands 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.

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.



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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**

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Example 1—A self-insured group health plan offering only self-only coverage: The total number of covered lives 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 Aug. 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.

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

Example 2—A self-insured group health plan offering self-only coverage and other-than-self-only coverage: The total number of covered lives 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 Aug. 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.

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

PARTIAL YEAR COVERAGE

A health plan or coverage may be established or terminated, or may change funding mechanisms during the first nine months of a benefit year. This is referred to 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 Jan. 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 that the plan changed to fully insured through Sept. 30, 2015**.

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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, 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 may change funding mechanisms (that is, 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. If this occurs, a contributing entity could, due to its selection of dates, be required to pay an amount significantly greater or less 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 to ensure that contributions are required to be paid only once with respect to the same covered life, CMS has provided a special rule in this case. 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, it must choose a set of counting dates for the nine-month counting period so that the plan or coverage has enrollees on each of the dates, if possible.

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

Example: An issuer that is a contributing entity that has coverage that terminates on Aug. 31 (that is, 62 days into the third quarter) would not be permitted to use Sept. 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, and, for self-insured group health plans, the Snapshot Factor Method, as all of the other permitted counting methods automatically account for partial year enrollment.

Date for Quarter	Total number of covered lives for the date	Number of Quarters/Dates	Calculation
Feb. 1, 2015	90	3	A = 90 + 90 + (90 – (90 (30 ÷ 92))) ÷ 3 **A = 80.22**
May 1, 2015	90		
Aug. 1, 2015	90 - (90 (30 ÷ 92))		
Total:	**240.65**		

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Example: A contributing entity that is a health insurance issuer has new coverage that was established on Sept. 1, 2015, (that is, 62 days into the third quarter) would not be permitted to use a date on July 1, 2015, or Aug. 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).

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		
Sept. 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. For purposes of the reinsurance program, the benefit year 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, the same counting method must be used across all of the 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.

Uniformity Requirement

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**. 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). This uniformity requirement does not extend to self-insured group health plans that are contributing entities.

Coordination with PCORI Fee Counting Methods

Consistency in counting methods between the count calculated under the Patient-Centered Outcome Research (PCORI) Fee final rule 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 for PCORI fees.

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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. 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 counting methods by that percentage; or
- 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 counting methods.

If a plan has enrollees who should not be included in the enrollee count due to an exemption, a reasonable method of estimating the number of exempted lives could include subtracting the exempted lives as follows:

- **Actual Count Method**: 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 months of the benefit year, and then divide that total by the number of days in the first nine months.
- **Snapshot Count Method**: Subtract 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 quarters of the benefit year, and then divide that total by the number of dates on which a count was made.
- **Snapshot Factor Method**: 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 falls within the same week of the quarter as the corresponding date used for the first quarter), and divide 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. ***Following this determination, subtract the number of exempted covered lives from the total number of covered lives***.
- **State Form or Member Months Method**: Determine the average number of policies for the first nine months of the calendar year and multiply 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 the number of exempted covered lives from the total number of lives covered***.
- **Form 5500 Method**: Determine the number of lives covered for the most current plan year, calculated based on the Form 5500 filed with the DOL 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 2; and
  - 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 the Form 5500).

  Following this determination, subtract the number of exempted covered lives from the total number of lives covered.

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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. A contributing entity is not required to make reinsurance contributions for certain types of coverage.

Secondary Coverage

Reinsurance contributions are not required, in the case of employer-provided group health coverage if:

- The coverage applies to individuals with individual market health insurance coverage for which reinsurance contributions are required; or
- The coverage is supplemental or secondary to group health coverage for which reinsurance contributions must be made for the same covered lives.

Medicare Secondary Payer (MSP) Rules

Reinsurance contributions are not required, in the case of employer-provided health coverage, to the extent that the coverage applies to individuals with respect to which Medicare benefits are primary under the MSP rules.

Enrollees Residing in Territories

Reinsurance contributions are not required to the extent that the plan or coverage applies to individuals with primary residence in a territory that does not operate the transitional reinsurance program. As of August 2015, no territories have elected to operate a transitional reinsurance program.

Compliance Standards

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 for purposes of verification, investigation, audit or other review of reinsurance contribution amounts. Additionally, HHS or its designee may audit a contributing entity to assess its compliance with the requirements of the transitional reinsurance program.

Source: U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services

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