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(xiii) A self-insured group health plan or health insurance coverage that consists solely of benefits for prescription drugs.

(b) *Data requirements.* Each contributing entity must submit to HHS data required to substantiate the contribution amounts for the contributing entity, in the manner and timeframe specified by HHS.

[78 FR 15528, Mar. 11, 2013]

§ 153.405 Calculation of reinsurance contributions.

(a) *In general.* The reinsurance contribution required from a contributing entity for its reinsurance contribution enrollees during a benefit year is calculated by multiplying:

(1) The number of covered lives of reinsurance contribution enrollees during the applicable benefit year for all plans and coverage described in § 153.400(a)(1) of the contributing entity; by

(2) The contribution rate for the applicable benefit year.

(b) *Annual enrollment count.* No later than November 15 of benefit year 2014, 2015, or 2016, as applicable, a contributing entity must submit an annual enrollment count of the number of covered lives of reinsurance contribution enrollees for the applicable benefit year to HHS. The count must be determined as specified in paragraphs (d) or (e) of this section, as applicable.

(c) *Notification and payment.* (1) Within 30 days of the submission of the annual enrollment count described in paragraph (b) of this section or by December 15 of the applicable benefit year, whichever is later, HHS will notify the contributing entity of the reinsurance contribution amount to be paid for the applicable benefit year.

(2) A contributing entity must remit reinsurance contributions to HHS within 30 days after the date of the notification.

(d) *Procedures for counting covered lives for health insurance issuers.* To determine the number of covered lives of reinsurance contribution enrollees under a health insurance plan for a benefit year, a health insurance issuer must use one of the following methods:

(1) Adding the total number of lives covered for each day of the first nine

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months of the benefit year and dividing that total by the number of days in the first nine months;

(2) 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 dividing that total by the number of dates on which a count was made. For this purpose, the same months must be used for each quarter (for example January, April and July) and the date used for the second and third quarter must fall within the same week of the quarter as the corresponding date used for the first quarter; or

(3) Multiplying 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).

(e) *Procedures for counting covered lives for self-insured group health plans.* To determine the number of covered lives of reinsurance contribution enrollees under a self-insured group health plan for a benefit year, a plan must use one of the following methods:

(1) One of the methods specified in either paragraph (d)(1) or paragraph (d)(2) of this section;

(2) 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 (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); or

(3) Using the number of lives covered for the benefit 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 paragraph (e)(3), the number of lives covered for the benefit year for a plan offering only self-only coverage equals the sum of the total participants covered at the beginning and end of the benefit year, as reported on the Form 5500, divided by 2, and the number of lives covered for the benefit 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 benefit year, as reported on the Form 5500.

(f) *Procedures for counting covered lives for group health plans with a self-insured coverage option and an insured coverage option.*

(1) To determine the number of covered lives of reinsurance contribution enrollees under a group health plan with a self-insured coverage option and an insured coverage option for a benefit year, a plan must use one of the methods specified in either paragraph (d)(1) or paragraph (d)(2) of this section.

(2) Notwithstanding paragraph (f)(1), a plan with multiple coverage options may use any of the counting methods specified for self-insured coverage or insured coverage, as applicable to each option, if it determines the number of covered lives under each option separately as if each coverage option provided major medical coverage (not including 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, health savings account, or health flexible spending arrangement).

(g) *Multiple group health plans maintained by the same plan sponsor.*

(1) *General rule.* If a plan sponsor maintains two or more group health plans (including one or more group health plans that provide health insurance coverage) that collectively pro-

vide major medical coverage for the same covered lives simultaneously, then those multiple plans must be treated as a single group health plan for purposes of calculating any reinsurance contribution amount due under this section. However, a plan sponsor may treat the multiple plans as separate group health plans for purposes of calculating any reinsurance contribution due under this section if it determines the number of covered lives under each separate group health plan as if the separate group health plan provided major medical coverage.

(2) *Plan sponsor.* For purposes of this paragraph (g), the term “plan sponsor” means:

(i) The employer, in the case of a plan established or maintained by a single employer;

(ii) The employee organization, in the case of a plan established or maintained by an employee organization;

(iii) The joint board of trustees, in the case of a multiemployer plan (as defined in section 414(f) of the Code);

(iv) The committee, in the case of a multiple employer welfare arrangement;

(v) The cooperative or association that establishes or maintains a plan established or maintained by a rural electric cooperative or rural cooperative association (as such terms are defined in section 3(40)(B) of ERISA);

(vi) The trustee, in the case of a plan established or maintained by a voluntary employees’ beneficiary association (meaning that the association is not merely serving as a funding vehicle for a plan that is established or maintained by an employer or other person);

(vii) In the case of a plan, the sponsor of which is not described in paragraph (g)(2)(i) through (g)(2)(vi) of this section, the person identified by the terms of the document under which the plan is operated as the plan sponsor, or the person designated by the terms of the document under which the plan is operated as the plan sponsor, provided that designation is made, and that person has consented to the designation, by no later than the date by which the count of covered lives for that benefit year is required to be provided, after which date that designation for that benefit year may not be changed or revoked,

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and provided further that a person may be designated as the plan sponsor only if the person is one of the persons maintaining the plan (for example, one of the employers that is maintaining the plan with one or more other employers or employee organizations); or

(viii) In the case of a plan, the sponsor of which is not described in paragraph (g)(2)(i) through (g)(2)(vi) of this section, and for which no identification or designation of a plan sponsor has been made under paragraph (g)(2)(i)(vii) of this section, each employer that maintains the plan (with respect to employees of that employer), each employee organization that maintains the plan (with respect to members of that employee organization), and each board of trustees, cooperative or association that maintains the plan.

(3) *Exception.* A plan sponsor is not required to include as part of a single group health plan as determined under paragraph (g)(1) of this section 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.

(4) *Procedures for counting covered lives for multiple group health plans treated as a single group health plan.* The rules in this paragraph (g)(4) govern the determination of the average number of covered lives in a benefit year for any set of multiple self-insured group health plans or health insurance plans (or a combination of one or more self-insured group health plans and one or more health insurance plans) that are treated as a single group health plan under paragraph (g)(1) of this section.

(i) *Multiple group health plans including an insured plan.* If at least one of the multiple plans is an insured plan, the average number of covered lives of reinsurance contribution enrollees must be calculated using one of the methods specified in either paragraph (d)(1) or paragraph (d)(2) of this section, applied across the multiple plans as a whole. The following information must be determined by the plan sponsor and reported to HHS, in a manner and timeframe specified by HHS:

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(A) The average number of covered lives calculated;

(B) The counting method used; and

(C) The names of the multiple plans being treated as a single group health plan as determined by the plan sponsor and reported to HHS.

(ii) *Multiple group health plans not including an insured plan.* If each of the multiple plans is a self-insured group health plan, the average number of covered lives of reinsurance contribution enrollees must be calculated using one of the methods specified either in paragraph (e)(1) or paragraph (e)(2) of this section, applied across the multiple plans as a whole. The following information must be determined by the plan sponsor and reported to HHS, in a manner and timeframe specified by HHS:

(A) The average number of covered lives calculated;

(B) The counting method used; and

(C) The names of the multiple plans being treated as a single group health plan as determined by the plan sponsor.

[78 FR 15528, Mar. 11, 2013]

§ 153.410 Requests for reinsurance payment.

(a) *General requirement.* An issuer of a reinsurance-eligible plan may make a request for payment when that issuer's claims costs for an enrollee of that reinsurance-eligible plan has met the criteria for reinsurance payment set forth in subpart B of this part and the HHS notice of benefit and payment parameters and State notice of benefit and payment parameters for the applicable benefit year, if applicable.

(b) *Manner of request.* An issuer of a reinsurance-eligible plan must make requests for payment in accordance with the requirements of the annual HHS notice of benefit and payment parameters for the applicable benefit year or the State notice of benefit and payment parameters described in subpart B of this part, as applicable.

[77 FR 17248, Mar. 23, 2012, as amended at 78 FR 15530, Mar. 11, 2013]

§ 153.420 Data collection.

(a) *Data requirement.* To be eligible for reinsurance payments, an issuer of