Centers for Medicare & Medicaid Services (CMS)
Transitional Adjustment Reporting Form
Filing Instructions for the 2014 Benefit Year

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Instructions for the 2014 Transitional Adjustment Reporting Form

On November 14, 2013, the Centers for Medicare & Medicaid Services (CMS) sent a letter to the insurance commissioners of the 50 States and the District of Columbia announcing a policy under which CMS will not consider certain health insurance coverage in the individual or small group markets that is renewed for a policy year starting after January 1, 2014, under certain conditions to be out of compliance with specified 2014 market rules (CMS transitional policy), and requested that states adopt a similar non-enforcement policy.[1] To help mitigate the CMS transitional policy's effect on the risk pool for qualified health plan (QHP) issuers in the 2014 benefit year, CMS amended the risk corridors program provisions at 45 CFR Part 153 to provide for a state-level adjustment to profits and administrative expenses in the risk corridors formula.

These are the filing instructions for the data submission required under 45 CFR §153.530(e). The data included in the Transitional Adjustment Reporting Form (Reporting Form) will be used to calculate the risk corridors adjustment percentage for 2014 as defined in 45 CFR 153.500. The implementing regulations can be found at: http://www.cms.gov/cciio/resources/regulations-and-guidance/index.html#Premium Stabilization Programs.

These Transitional Adjustment Form Filing Instructions (Filing Instructions) apply only for the reporting requirements relating to the 2014 benefit year. Filing will require issuers to obtain valid company and issuer identification from the Health Insurance Oversight System (HIOS) through the secured CMS Enterprise Portal. The CMS Enterprise Portal can be accessed at https://portal.cms.gov/wps/portal/unauthportal/home/.

These Filing Instructions are to be used in completing the Reporting Form by all health insurance issuers (issuers) that offered health insurance coverage in the individual or small group market in 2014 in a state that adopted the CMS transitional policy (transitional state).[2] Issuers offering non-grandfathered individual or small group coverage in a transitional state should complete this reporting form for all states in which they operate. All terms used in these Filing Instructions that are not defined here have the meanings given them in 45 CFR Part 153, the Patient Protection and Affordable Care Act (PPACA), and the Public Health Service Act (PHSA).

The term "health insurance coverage" means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise, including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer. The definition includes any insurance product, such as drug, chiropractic, or mental health coverage, whether sold as a stand-alone product or in conjunction with any other health insurance coverage, unless specifically identified as "excepted benefits" under section 2791 of the PHSA.

[1] http://www.cms.gov/CCIIO/Resources/Letters/Downloads/commissioner-letter-11-14-2013.pdf

[2] The transitional states in 2014 are: Alabama, Alaska, Arizona, Arkansas, California, Colorado, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Michigan, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, West Virginia, Wisconsin, and Wyoming.

Submission Instructions

- **Only one Reporting Form should be submitted per company. Companies with multiple issuers in a market and State must combine member months for all issuers in each State.**
- **Issuers may submit their completed Reporting Forms from February 9, 2015-February 13, 2015.**
- **Completed forms should be emailed to RCadjustment@cms.hhs.gov.**

General Instructions

Aggregation of Member Months

An issuer's member months, aggregated by individual and small group markets within each state must be included on the report submitted with respect to the state where the policy was issued, except as specified below.

If an issuer does not participate in a market (individual or small group) in a state, "N/A" should be entered in the respective columns for that market.

If an issuer participates in the individual or small group market but has zero enrollment in either "Transitional Policies" (Columns 1, 3) or "All Other Non-grandfathered Policies" (2, 4) then "0" should be entered in the respective column.

Group Coverage in Multiple States:
Group coverage that covers employees in multiple States must be reported for the state where the contract has its situs. The situs of a contract is the jurisdiction in which the contract is issued or delivered, as stated in the contract.

Individual Coverage through an Association:
For individual business sold through an association, the issuer report the member months for the state in which the certificate of coverage was issued.

Employer Coverage through Group Trust, Association, or MEWA:
For employer group coverage issued through a group trust, the issuer must include the member months in the state report for the state where the employer has its principal place of business. For group coverage issued through a multiple employer welfare association (MEWA), the issuer must include the member months in the state report for the state where the MEWA has its principal place of business (if the MEWA is the policyholder). For group coverage issued through a non-MEWA association, member months with respect to each employer must be reported as large group or small group, based on the size of each employer, and must be reported in each state based upon the aggregation rules for employer based insurance. Large group business should not be reported in this reporting form.

Definitions

Grandfathered Plans
Policies, including dependent policies, that were in effect on March 23, 2010, and that have not been changed in ways that substantially reduce benefits or increase cost-sharing for consumers, pursuant to the regulations at 45 CFR Part 147.140.

Early Renewals
Policies, including dependent policies that renewed between October 1, 2013, and December 31, 2013, where the term of the policy prior to the renewal was less than 12 months.

Small Group

The small group market is defined as the market where health insurance coverage is obtained by a small employer. For the purposes of the risk corridors program and this Reporting Form, the definition of employer size and the employee counting method applicable under state law will determine whether a plan is considered to be offered in the small group market. We note that the State counting method may result in some employers being part of the small group insurance market, even though these employers would be part of the large group insurance market under the MLR counting rules.

Exclusions

For this Reporting Form, do not include health insurance coverage (as defined above on page 1 of these Filing Instructions) in Columns 1 through 8 that is provided through the following: student health plans, expatriate plans, uninsured or self-funded business, Medicare (Title XVIII, including Medicare Advantage), Medicaid (Title XIX), vision only, dental only, coverage limited to excepted benefits as defined in Section 2791(c) of the PHSA, State Children's Health Insurance Program (SCHIP) (Title XXI), the Federal Employees Health Benefits Program or state government sponsored coverage for State employees or retirees, other federal or state government-sponsored coverage, and short-term, limited duration insurance as further defined in the PHSA.

An issuer must report on this Reporting Form only the business issued by the reporting entity. Business that is written by an unaffiliated entity as part of a package provided to the enrollee (e.g., where inpatient coverage is written by the reporting entity, outpatient coverage written by an unaffiliated separate entity should not be included in this Reporting Form).

Column Definitions

Columns 1–2 **Individual Market**

Include: Health insurance policies issued directly to an individual for self-only or dependent coverage.

Columns 3-4 **Small Group Market**

Include: All policies issued in the small group market (including fully insured State and local government policies), based on the definition of small group that applies for the purposes of the risk corridors program, as described above on page 4 of these Filing Instructions.

Columns 1, 3 – **Transitional Policies**

The total number of member months[3] in the relevant state and market for all insured individuals, including dependents, insured during 2014 under policies that were not deemed to be out of compliance with certain market rules in accordance with the CMS transitional policy and that were not reported in columns 3 or 7. Any health insurance policy that became a transitional policy (i.e. a health insurance policy that was not deemed to be out of compliance under the CMS transitional policy) during the course of 2014 (having previously been an Early Renewal, Grandfathered Plan or Other Policy for a portion of 2014) should report the member-month enrollment that is attributable only to the specific months in 2014 that the policy was considered a transitional policy.
Exclude: If an early renewal policy or grandfathered plan (as defined in these Filing Instructions) became a transitional policy at some point in 2014, report the member-month enrollment that is attributable only to the specific months in 2014 that the plan was considered a transitional policy. Do not include member-month enrollment for months that the policy was considered an early renewal or grandfathered policy in this column.

Example: If an individual market policy with 100 covered lives was an early renewal policy until October 1, and was then deemed not to be out of compliance with Affordable Care Act market standards under the CMS transitional policy, the issuer would only report the member-month enrollment from October 1 through December 31st (300 member months) in column 1.

Exclude: Member months for policies reported in other columns.

[3] The sum of the total number of lives insured on a pre-specified day of each month of the reported period. Reasonable approximations are allowed when exact information is not administratively available to the insurer.

Columns 2, 4 – **All other Non-grandfathered Polices**

The total number of member months in the relevant state and market for all insured individuals, including dependents, insured during 2014, for all health insurance policies where the experience was not included in columns 1 or 3. Do not include member month enrollment that is attributable to months in which the policy was considered transitional, early renewal, or grandfathered, as defined in these Filing Instructions.

Exclude: Member months for policies reported in other columns.