# Centers for Medicare & Medicaid Services (CMS)

## Standard Companion Guide Transaction Information

## Instructions related to the ASC X12 Benefit Enrollment and Maintenance (834) transaction, based on the 005010X220 Implementation Guide and its associated 005010X220A1 addenda for the Federally facilitated Exchange (FFE)

**Companion Guide Version Number: 1.5**

**March 22, 2013**

This page intentionally left blank.

# PREFACE

This Companion Guide to the v5010 Accredited Standards Committee (ASC) X12N Implementation Guides and associated errata adopted under Health Insurance Portability and Accountability Act (HIPAA) clarifies and specifies the data content when exchanging electronically with the Federally facilitated Health Insurance Exchange via the Data Services Hub. Transmissions based on this companion guide, used in tandem with the v5010 ASC X12N Implementation Guides, are compliant with both ASC X12 syntax and those guides. This Companion Guide is intended to convey information that is within the framework of the ASC X12N Implementation Guides adopted for use under HIPAA. The Companion Guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the Implementation Guides.

This Companion Guide is based on, and must be used in conjunction with, the ASC X12 X12N/005010X220 Type 3 Technical Report (TR3) and its associated A1 addenda. The Companion Guide clarifies and specifies specific transmission requirements for exchanging data with the Federally facilitated Health Insurance Exchange via the Data Services Hub. The instructions in this companion guide conform to the requirements of the TR3, ASC X12 syntax and semantic rules and the ASC X12 Fair Use Requirements. In case of any conflict between this Companion Guide and the instructions in the TR3, the TR3 takes precedence.

# TABLE OF CONTENTS

# LIST OF FIGURES



# LIST OF TABLES

# 1. INTRODUCTION

## 1.1. Background

On March 23, 2010, the President signed into law the Patient Protection and Affordable Care Act (P.L. 111-148). On March 30, 2010, the President signed into law the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152). The two laws are collectively referred to as the Affordable Care Act (ACA). The ACA creates new competitive private health insurance markets – called Health Insurance Exchanges (Exchanges) – that provide millions of Americans and small businesses access to affordable coverage and the same insurance choices as members of Congress. Exchanges help individuals and small employers shop for, select, and enroll in high quality, affordable private health plans that fit their needs at competitive prices.

The Act and subsequent Rule outline the standards to be used between the Exchange and covered entities. The Exchange is required to use the standards, implementation specifications, operating rules, and code sets adopted by the Secretary in 45 CFR parts 160 and 162. Further, the Exchange is required to incorporate interoperable and secure standards and protocols developed by the Secretary in accordance with section 3021 of the Public Health Service (PHS) Act.

This companion guide contains detailed information about how the Federally facilitated Exchanges (FFE) will use the ASC X12 Benefit Enrollment and Maintenance (834) transaction, based on the 005010X220 Implementation Guide and its associated 005010X220A1 addenda.

## 1.2. Companion Guides

Companion guides (CG) are documents created to supplement ASC X12 Type 3 Technical Reports (TR3). TR3s, commonly known as Implementation Guides (IG), define the data content and format for specific business purposes. This CG was created for distribution to health care issuers, clearinghouses, and software vendors. The instructions in this CG are not intended to be stand-alone requirements, the CG must be used in conjunction with the ASC X12/005010X220 Benefit Enrollment and Maintenance (834) TR3 and its associated A1 Addenda. ASC X12 TR3s are copyrighted documents and may be purchased at http://store.x12.org.

## 1.3. Other Resources

The Websites provided in Table 1 contain additional information and documentation for adopted Electronic Data Interchange (EDI) transactions and code sets.

**Table 1: FFE Enrollment Other Resources**

| Resource | Web Address |
|---|---|
| ASC X12 TR3 Implementation Guides | http://store.x12.org |
| Washington Publishing Company Health Care Code Sets | http://www.wpc-edi.com/content/view/711/401/ |
| To request changes to HIPAA adopted standards | http://www.hipaa-dsmo.org/ |
| CMS Implementation Guide for the Federally-facilitated Exchange and Data Services Hub | **TBD** |

# 2. GETTING STARTED

In order to send and/or receive transactions from the FFE, Trading Partners (clearinghouses, qualified health plan issuers (QHP issuers) and State-Based Exchanges (SBEs)) must complete a trading partner agreement, exchange profile information and establish connectivity. The following sections outline the steps.

## 2.1. Trading Partner Profile

Establishing a Trading Partner Profile is a simple process, the Trading Partner completes and signs a Trading Partner Agreement form and submits it to the Hub team for processing. Electronic Data Interchange (EDI) interface should be set up and tested with the Trading Partner. The first step that the Hub team will take is to establish Trading Partner Profile(s).

The Hub team will configure a test profile for one or more EDI interfaces with the Trading Partner. A Trading Partner with multiple data centers must acquire multiple Trading Partner Profiles. Once the EDI interface(s) have been successfully tested, the Hub team will notify the FFE to open the Trading Partner's Qualified Health Plan (QHP) for enrollment and will switch the Trading Partner Profile to a production status.

# 3. TESTING

Syntax Integrity and Syntax Requirement specifications must be met in order for 834 transactions to be processed in a production mode. The Hub team will work with Trading Partners (clearinghouses, QHP Issuers and SBEs) throughout the testing process.

## 3.1. Testing Overview

Testing is conducted to ensure compliance with HIPAA guidelines as related to:

- Syntactical integrity: EDI files must pass verification checks related to valid segment use, segment order, element attributes, proper transmission of numeric values, validation of ASC X12 syntax, and compliance with ASC X12 rules.
- Syntactical requirements: EDI files must be validated for compliance with HIPAA Implementation Guide-specific syntax requirements, such as limits on repeat counts and the use of qualifiers, codes, elements and segments. Testing will also verify intra-segment situational data elements, non-medical code sets and that values and codes are used according to the Implementation Guide instructions.

It's important to know additional testing may be required when the system is upgraded, when business requirements change, or when new versions of the ASC X12 834 implementation guide are implemented.

## 3.2. Testing Process

Trading Partners may call the eXchange Operational Support Center (XOC) in Contact Information Section below for help at any point in the testing process outlined below.

1. The Trading Partner downloads the 834 Companion Guides and Trading Partner Enrollment package from URL.
2. The Trading Partner completes and signs the Trading Partner Agreement and submits the signed agreement to Hub team.

3. The Hub team coordinates the linkage between the Trading Partner Submitter Identifier, User Logon Identifier and password and notifies the Trading Partner.
4. The Hub team provides a limited number of initial test files to the Trading Partner for processing. The Trading Partner downloads the files via Secure File Transfer Protocol (SFTP).
5. The Trading Partner processes the files through their validation process and reports any failure via acknowledgement transaction.
6. If all the test files pass cleanly through the validation process, the Trading Partner submits a confirmation 834 to the Hub via SFTP.
7. The FFE validates the confirmation 834 and reports any issues via an acknowledgement transaction.
8. If the confirmation 834 is successfully validated, the test is considered successful and the trading partner is approved to begin processing in the production environment.
9. If issues or errors are identified in steps 4, 5, 6 or 7, the test is not considered successful and the Hub team and Trading Partner work together until the issues are resolved and a successful test is completed.

# 4. CONNECTIVITY

Trading Partners will connect to the Hub for exchange of EDI transactions (enrollment, acknowledgement, payment, etc.) via the CMS Enterprise File Transfer (EFT) system which is a batch system. Real-time transmissions are not available at this time.

Each Trading Partner is assigned a Submitter Identifier in the EFT system which allows access to a mailbox. The Trading Partner and the Hub will use this mailbox to pick up and drop off data files.

The Enterprise File Transfer (EFT) Supplement, available at CMS Technical Reference Architecture, defines the enterprise-wide standard architecture for transferring files between CMS data centers as well as between CMS data centers and external partners.

## 4.1. Transmission Specifics

**Delimiters:**

The Exchange is not establishing a requirement or preference for delimiters on inbound transactions. See Table B.5 in Appendix B.1.1.2.5 of the TR3 for ASC X12's requirements related to delimiters.

**Control Numbers:**

The Exchange is not establishing specific requirements for the ISA, GS and ST control numbers, other than a rule that at least one of the control numbers must increment from one day to the next. However, since the ASC X12C 005010X231 Implementation Acknowledgement for Health Care Insurance (999) transaction does not reflect the ISA control number, we strongly recommend that one or both of the GS and ST control numbers increment from day to day.

**Hub Processing Capabilities:**

The Hub can accept multiple:

- Physical files in multiple submissions in one day.
- ISA-IEA envelopes within a single physical file.

- GS-GE envelopes within a single ISA-IEA interchange.
- ST-SE envelopes within a single GS-GE functional group.
- Members (2000 loop) within a single ST-SE transaction.

**File Rejection Reasons:**

The entire logical structure contained within a physical submission will be rejected in the following situations:

- Submission of data that is not valid based on the TR3.
- Submission of a segment or data element specified in the TR3 as "Not Used".
- Submission of non-unique values in the ST02 or GS06 Control Number elements.

# 5. CONTACT INFORMATION

Trading Partners that need to interact with the Level One Help Desk shall be able to contact the eXchange Operational Support Center (XOC) at the following number and email address:

Telephone: 1-855-CMS-1515
Email: CMS_FEPS@cms.hhs.gov

Hours of Operation: 9:00 am – 5:00 pm Eastern
Any correspondence received during off hours at the email address above is addressed the next business morning.

# 6. FFE Enrollment (834) Transaction Flows

## 6.1. Overview of Eligibility and Enrollment Activities

The Affordable Care Act (P.L. 111-148 and 111-152) allows each State the opportunity to establish an Affordable Insurance Exchange ("Exchange") to help individuals and small employers purchase affordable health insurance coverage. Coverage through the Exchange will begin in every State on January 1, 2014, with enrollment beginning October 1, 2013. Recognizing that not all States may elect to establish a State-based Exchange by this statutory deadline, the Affordable Care Act directs the Secretary of HHS to establish and operate an FFE in any State that does not elect to do so, or will not have an operable Exchange for the 2014 coverage year.

### 6.1.1. The Data Services Hub (Hub) and Eligibility and Enrollment Transactions

The Hub is a single interface for the States and federal partners (e.g., Social Security Administration, Department of Homeland Security, Internal Revenue Service, et al) which facilitates the information exchange and business functionality in support of Health Insurance Exchange operations. The Hub ensures adherence to federal and industry standards regarding security, data transport, and information safeguards management. The Hub streamlines and simplifies the information flows between States and federal agencies. The Hub will facilitate the exchange of 834 transactions between the parties as described in this companion guide. Specifically, the hub will serve as the gateway for enrollment transactions between the FFE and QHP issuers that offer coverage through the FFE, and will also accept copies of enrollment transactions sent by SBEs to QHP issuers that offer coverage through SBEs, for the purposes of enabling Federal payments of advance payments of the premium tax credit (APTC) and cost-sharing reductions (CSR), preventing duplicate APTC across multiple Exchanges, and

performance measurement. The Hub will facilitate the exchange of 834 transactions between the parties as described in this companion guide.

### 6.1.2. Centers for Medicare and Medicaid Services (CMS) Enterprise File Transfer (EFT) System

QHP Issuers will connect to the Hub (for enrollment EDI transactions) via the CMS Enterprise File Transfer (EFT) system which is a batch system. Each QHP Issuer is assigned a Submitter Identifier in the EFT system which allows access to a mailbox. The QHP Issuer and the Hub use this mailbox to pick up and drop off data files.

## 6.2. FFE to QHP Issuer 834 Transaction Flow

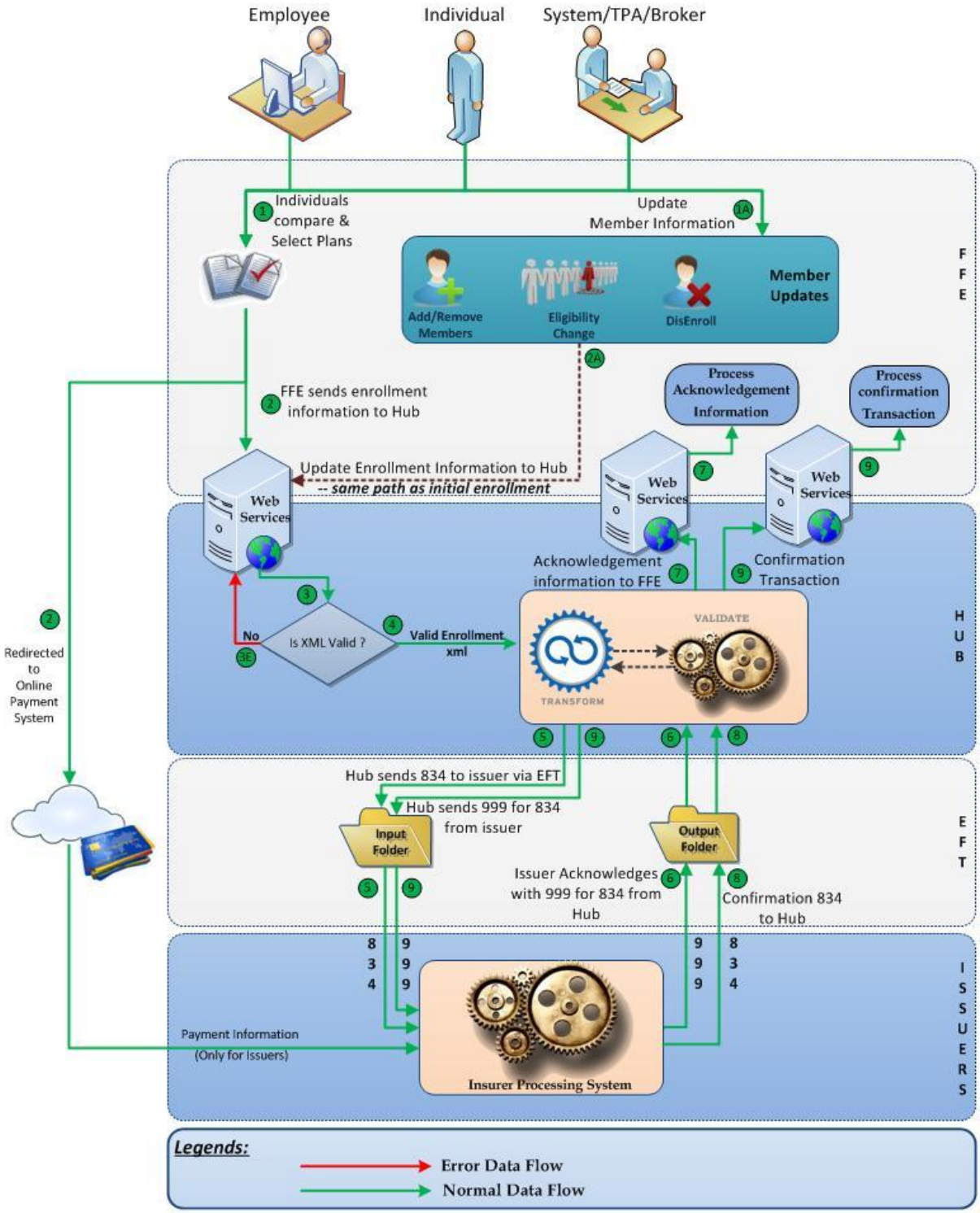
The FFE will send the first 834 transaction to a QHP Issuer(s) with enrollment information; this exchange contains the Initial Enrollment Notification transaction(s). This transaction is created after an application has been determined eligible and a Qualified Health Plan (QHP) selected.

The Trading Partner will return an Enrollment Effectuation Confirmation 834. This effectuation confirmation transaction will contain information assigned by the QHP Issuer and be stored within the FFE data store.

Other 834 uses detailed in this companion guide include cancellations, terminations, reinstatements and changes to existing health coverage enrollments.

Figure 1 outlines the high level steps and interactions between the FFE, Hub, and QHP Issuers.

**Figure 1: FFE Enrollment Context Diagram**



## 6.3. SBE to the Department of Health and Human Services (HHS) 834 Transaction Flow

The SBE will send the first 834 transaction to the HHS with enrollment information; this exchange contains the Initial Enrollment Notification transaction(s). This transaction is created after an application has been determined eligible and a Qualified Health Plan (QHP) selected. The SBE enrollment data sent to HHS will be stored in the Federal Exchange Program System (FEPS) Enrollment Data Store (EDS).

Once enrollment has been effectuated the SBE will send an Enrollment Effectuation Confirmation 834. This effectuation confirmation transaction will contain information assigned by the QHP Issuer.

# 7. CONTROL SEGMENTS/ENVELOPES

This section identifies the qualifiers the FFE will send in the outer envelopes.

## 7.1. The ISA Segment

The transmission envelope must be created according to the instructions in the 005010X220 TR3. In accordance with those instructions, FFE will send, and prefers to receive, the qualifiers outlined in Table 2 below.

**Table 2: The ISA Segment Instructions**

| Segment | Reference | Name | Code | Exchange Instruction |
|---|---|---|---|---|
| ISA | | Interchange Control Header | | |
| | ISA01 | Authorization Information Qualifier | 00 | |
| | ISA04 | Security Information Qualifier | 00 | |
| | ISA05 | Interchange ID Qualifier | ZZ | |
| | ISA07 | Interchange ID Qualifier | ZZ | |
| | ISA14 | Acknowledgment Requested | 1 | |

# 8. ACKNOWLEDGEMENTS

The Hub expects to receive a TA1 acknowledgement for every outbound interchange in which an ASC X12 005010 834 transaction set is sent.

The Hub expects to receive a 999 acknowledgement for every functional group in every outbound 834 file sent.

The Hub will send a TA1 acknowledgement for every inbound interchange received.

The Hub will send a 999 acknowledgement for every inbound functional group in every inbound 834 file received.

# 9. FFE SPECIFIC BUSINESS RULES AND LIMITATIONS

This section contains design rules and other helpful information used as transaction requirements were developed.

## 9.1. Identifying the Member in 834 Transmissions

An Exchange enrollee, also referred to as a qualified individual, has a number of different identifiers within the Exchange. These enrollee identifiers are transmitted in loop 2000 REF segments in 834 transmissions, with a specific Reference Identification Qualifier associated with each use. Table 3 describes the various enrollee identifiers and their associated qualifier. In addition, the enrollee's SSN, if available, is transmitted in the NM1 segment on the initial enrollment transactions but is not included in maintenance transactions between the FFE and QHP Issuer.

**Table 3: All Other FFE Outbound Transaction Identifiers**

| Member Identifier | Ref ID Qualifier | Notes |
|---|---|---|
| Exchange Assigned ID | 0F | When transmitted in the Subscriber Identifier REF<br><br>**Note:** 10 numeric characters placed in the Alphanumeric field. No check digits, no intelligence is found in the characters |
| Issuer Assigned Subscriber ID | ZZ | When transmitted in the Member Supplemental Identifier REF |
| Exchange Assigned Member ID | 17 | Transmitted in the Member Supplemental Identifier REF<br><br>**Note:** See the Exchange Assigned ID describing formatting |
| Issuer Assigned Member ID | 23 | Transmitted in the Member Supplemental Identifier REF |

## 9.2. General Business Rules

- The FFE shall create explicit transactions identified by the Maintenance Type and Maintenance Reason Codes for the Add, Change, Cancellation or Termination purpose.
- Dates must be explicitly transmitted, they cannot be assumed.
- An inconsistency period starts on the date of determination, not the date of enrollment
- An enrollment group consists of all individuals enrolled and linked by the policy exchange identifier. ***Note:*** Other individuals may be linked by the policy exchange identifier such as custodial parent, but may not be considered part of the enrollment group. The policy exchange identifier is a number that links together the individuals within an enrollment group that are enrolled in a qualified health plan under a subscriber.
- When there is a change in circumstance, eligibility re-determination must be completed for every member of the enrollment group before the enrollment group can be terminated.
- A Cancellation Transaction is generated when the enrollment is to be ended with no actual coverage. A cancellation can happen any time prior to the effective date of the initial coverage.
- A Termination Transaction is generated when the enrollment is to be terminated after the effective date. The enrollee was covered by the QHP Issuer for some period of time.

- United States addresses sent shall conform to the guidelines established by the United States Postal Service (USPS).
- Table 4 outlines the situation when a member obtains coverage for multiple products. The situation depicts two separate Member Detail Loops repeating at the 2000 Member Level.

Table 4: Sample for Multiple Policy (Medical & Dental) information in an 834 Transaction

| **Example of One Qualified Individual – 2 types of coverage: One coverage for Medical Coverage and one coverage for Dental Coverage** | |
|---|---|
| ST<br>Table 1 – Header Information<br>Table 2 – Detail<br>**Subscriber – John Anyman**<br>2000 – Member Level Detail<br>INS – Member Level Detail<br>REF – Subscriber Identifier<br>REF – Member Supplemental Identifier<br>DTP – Member Level Dates<br>2100A – Member Name<br>NM1 – Member Name<br>PER – Member Communication Numbers<br>N3 – Member Residence, Street Address<br>N4 – Member City, State, ZIP code<br>DMG – Member Demographics<br>HLH – Member Health Information<br>LUI – Member Language (if applicable)<br>2100C – Member Mailing Address (If applicable)<br>**2300 – Health Coverage**<br>**HD – Health Coverage - Medical**<br>DTP – Health Coverage Dates<br>REF – Health Coverage Policy Number<br>LS<br>2700 – Member Reporting Categories<br>LX – Member Reporting Categories<br>2750 – Reporting Category<br>N1 – Reporting Category<br>REF – Reporting Category Reference<br>DTP – Reporting Category Date<br>LE<br>2000 – Member Level Detail<br>INS – Member Level Detail | 2000 – Member Level Detail<br>INS – Member Level Detail<br>REF – Subscriber Identifier<br>REF – Member Supplemental Identifier<br>DTP – Member Level Dates<br>2100A – Member Name<br>NM1 – Member Name<br>PER – Member Communication Numbers<br>N3 – Member Residence, Street Address<br>N4 – Member City, State, ZIP code<br>DMG – Member Demographics<br>HLH – Member Health Information<br>LUI – Member Language (if applicable)<br>2100C – Member Mailing Address (If applicable)<br>**2300 – Health Coverage**<br>**HD – Health Coverage - Dental**<br>DTP – Health Coverage Dates<br>REF – Health Coverage Policy Number<br>LS<br>2700 – Member Reporting Categories<br>LX – Member Reporting Categories<br>2750 – Reporting Category<br>N1 – Reporting Category<br>REF – Reporting Category Reference<br>DTP – Reporting Category Date<br>LE<br>ST |

## 9.3. Enrollment Business Rules

- Enrollment periods are considered "open ended" until a triggering event results in an end to the individual's enrollment with a QHP.
- An **Enrollment Period End Date** is not sent on initial enrollment transactions.
- An **Enrollment Period End Date** is sent when cancelling or terminating an enrollment period.
- Except for initial enrollments, the old enrollment must always be terminated with an end date before a new enrollment can be processed.
- **Communication Contacts**. The implementation guide limits the number of member communication contacts that can be sent to 3. Communication contacts will be sent in the following order:
    - Primary Phone (TE)

        - Secondary Phone (AP)
        - Preferred Communication Method (EM for email or BN for text message), either an email address or phone number for receiving text messages. If no preferred communication method chosen, the 3rd communication contact will not be sent.
    - Member Health Information, Health Related Code. Information about tobacco use will be sent on every enrollment transaction. The three valid responses a QHP Issuer may receive are:
        - "N" No Tobacco Use, if indicated with QHP selection
        - "T" Tobacco Use, if indicated with QHP selection
        - "U" Unknown Tobacco Use, if not "N" or "T"

## 9.4. Premium Business Rules

- APTC is paid at the subscriber level for an enrollment group.
    - In general, will only begin on the first of the month but can be terminated mid-month.
    - APTC eligibility is a requirement for CSR, EXCEPT for Native Americans. So, it may be rare to see CSR without APTC although an individual who is eligible for APTC can select an actual APTC of $0 in which case he or she can still be eligible for CSR.
- CSR is paid at the subscriber level for an enrollment group

## 9.5. Individual and SHOP Market Rate Calculations

The following subsections outline the Market Rate Calculations within ASC X12 834 used in the Individual and SHOP markets. Specifically, the premium payment elements, their definitions and the calculations used to derive their values within the FFE created 834 transactions.

### 9.5.1. Individual Market Rate Calculations within the 834

For the Individual Market Table 4 contains premium payments elements, their definitions and the calculations used to derive their values within the FFE 834 created transactions.

**Table 5: Individual Market, Individually Rated Definitions and Calculations**

| Premium Payment | 834 - 2750 Member Reporting Category Name |
|---|---|
| Rating Area. The rating area used to determine the premium amounts. | RATING AREA<br>Subscriber Only |
| Premium Amount<br>Individual member rated portion of the premium if the plan is individually rated.<br><br>The total of all individual premiums should equal the premium amount total. If the plan is family rated, this qualifier will not be sent. | PRE AMT 1<br>Every member (i.e., every enrollment record) |
| Premium Amount Total. The Exchange derives the total premium amount by adding all individual member premium amounts (PRE AMT 1). This is also the amount the QHP Issuer can expect to receive from all payment sources for the enrollment group.<br>*PRE AMT TOT =*<br>+ Sum of all PRE AMT 1 for the enrollment group | PRE AMT TOT<br>Subscriber Only |
| Other Payer Amounts. The amount the QHP Issuer can expect to receive from other payment sources to pay a portion of the total premium amount. Examples could be Tribal premium payments or a State Mandated Benefit portion of the premium. | OTH PAY AMT 1<br>Subscriber Only |
| Advance Payment of the Premium Tax Credit (APTC) Amount. The amount the QHP Issuer can expect to receive as the amount of actual APTC toward the total premium amount. | APTC<br>Subscriber Only |
| Total Amount owed by the enrollment group (the amount the covered individuals owe toward the total premium amount)<br>*TOT RES AMT =*<br>+ PRE AMT TOT<br>- APTC<br>- OTH PAY AMT 1 | TOT RES AMT<br>Subscriber Only |

Table 6 contains premium payments elements, their definitions and the calculations used to derive their values within the FFE 834 created transactions.

**Table 6: Individual Market, Family Rated Definitions and Calculations**

| Premium Payment | 834 - 2750 Member Reporting Category Name |
|---|---|
| Rating Area. The rating area used to determine the premium amounts. | RATING AREA<br>Subscriber Only |

| | |
|---|---|
| Premium Amt Total. This is the family rated total premium amount as determined by the Exchange. It is also the amount the QHP Issuer can expect to receive from all payment sources for the enrollment group. | PRE AMT TOT<br>Subscriber Only |
| Other payer amounts. The amount the QHP Issuer can expect to receive from other payment sources to pay a portion of the total premium amount. Examples could be Tribal premium payments or a State Mandated Benefit portion of the premium. | OTH PAY AMT 1<br>Subscriber Only |
| Advance Payment of the Premium Tax Credit (APTC) Amount. The amount the QHP Issuer can expect to receive as the actual APTC toward the total premium amount. | APTC<br>Subscriber Only |
| Total Amt owed by the enrollment group (the amount the covered individuals owe toward the total payment amount)<br>*TOT RES AMT =*<br>+ PRE AMT TOT<br>- APTC<br>- OTH PAY AMT 1 | TOT RES AMT<br>Subscriber Only |

### 9.5.2. SHOP Market Rate Calculations within the 834

For the SHOP Market Table 7 contains premium payments elements, their definitions and the calculations used to derive their values within the FFE 834 created transactions.

**Table 8: SHOP Market, Individually Rated Definitions and Calculations**

| Premium Payment | 834 - 2750 Member Reporting Category Name |
|---|---|
| Rating Area. The rating area used to determine the premium amounts. | RATING AREA<br>Subscriber Only |
| Premium Amount<br>Individual member rated portion of the premium if the plan is individually rated.<br><br>The total of all individual premiums should equal the premium amount total. If the plan is family rated, this qualifier will not be sent. | PRE AMT 1<br>Every member (i.e., every enrollment record) |
| Premium Amount Total. The Exchange derives the total premium amount by adding all individual member premium amounts (PRE AMT 1). This is also the amount the QHP Issuer can expect to receive from all payment sources for the enrollment group.<br>*PRE AMT TOT =*<br>+ Sum of all PRE AMT 1 for the enrollment group | PRE AMT TOT<br>Subscriber Only |
| Total Employer Responsibility Amount. The Amount the employer will pay against the total premium amount. | TOT EMP RES AMT<br>Subscriber Only |
| Total Amount owed by the enrollment group (the amount the covered individuals owe toward the total premium amount)<br>*TOT RES AMT =* | TOT RES AMT<br>Subscriber Only |

| | |
|---|---|
| + PRE AMT TOT<br>- TOT EMP RES AMT | |

Table 9 contains premium payments elements, their definitions and the calculations used to derive their values within the FFE 834 created transactions.

**Table 10: SHOP Market, Family Rated Definitions and Calculations**

| Premium Payment | 834 - 2750 Member Reporting Category Name |
|---|---|
| Rating Area. The rating area used to determine the premium amounts. | RATING AREA<br>Subscriber Only |
| Premium Amt Total. This is the family rated total premium amount as determined by the Exchange. It is also the amount the QHP Issuer can expect to receive from all payment sources for the enrollment group. | PRE AMT TOT<br>Subscriber Only |
| Total Employer Responsibility Amount. The Amount the employer will pay against the total premium amount. | TOT EMP RES AMT<br>Subscriber Only |
| Total Amt owed by the enrollment group (the amount the covered individuals owe toward the total payment amount)<br>*TOT RES AMT* =<br>+ PRE AMT TOT<br>- TOT EMP RES AMT | TOT RES AMT<br>Subscriber Only |

## 9.6. 2700 Member Reporting Categories Loop

The FFE has defined a number of Member Reporting Categories, and associated information, that must be transmitted in various 834 transmissions. For easy reference, the next two subsections describe the Individual Marketplace and the SHOP Marketplace. When there is no information to be sent, for example, the individual does not qualify for APTC, then the segment(s) are not to be transmitted.

### 9.6.1. Individual Market: 2750 Reporting Categories Loop

Table 11: summarizes all the categories defined for transmission in the Individual Market of any 2750 Reporting Category Loop. The required categories are also included in the instruction section for each applicable business use. Please note that these Member Reporting Categories MAY be sent in some and MUST be sent in others. For example, if a new enrollee was not eligible for APTC, the APTC amount will not be included on the outbound initial enrollment transaction, but is listed here as a "Y" because it *could* be sent on an initial enrollment. A second example is; Confirmation Transactions MUST include the Member Reporting Category loop, "ADDL MAINT REASON" with the code value of "CONFIRM."

**Table 12: The Individual Member Reporting Category Loop**

| To transmit this information | Send | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | N102 Value | REF01 Value | REF02 Data | DTP Y/N | Init Enroll | Confirm Enroll | CAN | TERM | CHG |
| Additional Maintenance Reason (reason category) | | 17 | The specific reason code, see below | | | | | | |
| Cancellation (cancellation category) | "ADDL MAINT REASON" | 17 | "CANCEL" | Y | | | Y | | |
| Confirmation (confirmation category) | "ADDL MAINT REASON" | 17 | "CONFIRM" | Y | | Y | | | |
| Termination (termination category) | "ADDL MAINT REASON" | 17 | "TERM" | Y | | | | Y | |
| Change (change category) | "ADDL MAINT REASON" | 17 | ***[1] | Y | | | | | Y |

[1] Analysis continues on the use of additional maintenance reason codes. A definitive list is not available at this time. Examples of Change reason codes are "FINANCIAL CHANGE", "OTHER GOVT PGMS" and "PREMIUM CHANGE".

| To transmit this information | Send | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | **N102 Value** | **REF01 Value** | **REF02 Data** | **DTP Y/N** | **Init Enroll** | **Confirm Enroll** | **CAN** | **TERM** | **CHG** |
| Another payment amount (payment category) | "OTH PAY AMT 1" | 9V | NNNNNNN N.NN The amount is the total other payment amount the QHP Issuer can expect to receive for this health coverage | Y | Y | Y | | | Y |
| APTC amount (APTC category)<br><br>**NOTE:** Sent when the member qualifies for APTC. If the member has elected no APTC amount, then zero shall be transmitted. | "APTC AMT" | 9V | NNNNNNN N.NN This is the amount the QHP Issuer can expect to receive as the amount of actual APTC toward the total premium amount. | Y | Y | Y | | | Y |
| CSR amount (CSR amount category)<br><br>**NOTE:** Sent when the member qualifies for CSR. If the member does not qualify then no CSR amount shall be sent. | "CSR AMT" | 9V | NNNNNNN N.NN This is the advance CSR payment amount. | Y | Y | Y | | | Y |
| Premium amount (premium category) | "PRE AMT 1" | 9X | NNNNNNN N.NN For individual rated coverage, this is the individual premium rate. For family rated coverage, this is the family | Y | Y | Y | | | Y |

| To transmit this information | Send | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | N102 Value | REF01 Value | REF02 Data | DTP Y/N | Init Enroll | Confirm Enroll | CAN | TERM | CHG |
| | | | premium rate. | | | | | | |
| Rating area used to determine premium amounts.<br>(premium category) | "RATING AREA" | 9X | R-NNNNNNN<br>This is the rating area used in determining the individual or family premium amounts. | Y | Y | Y | | | Y |
| Source Exchange ID<br>(source category) | "SOURCE EXCHANGE ID" | 17 | This is the Source Exchange ID. | Y | Y | Y | | | Y |
| Special Enrollment Period Reason<br>(SEP category) | "SEP REASON" | 17 | This is the reason for the Special Enrollment Period | Y | Y | Y | | | Y |
| Total individual responsibility amount<br>(payment category) | "TOT RES AMT" | 9V | NNNNNNN N.NN<br>This is the Total Amt owed by the enrollment group (the amount the covered individuals owe toward the total premium amount). | Y | Y | Y | | | Y |
| Total premium for the health coverage sent at the subscriber level.<br><br>(premium category) | "PRE AMT TOTAL" | 9X | NNNNNNN N.NN<br>This is the total amount the QHP Issuer can expect to receive from all payment. | Y | Y | Y | | | Y |

### 9.6.2. SHOP Market: 2750 Member Reporting Categories Loop

Table 13 summarizes all the categories defined in the SHOP Market of any 2750 Reporting Category Loop. The required categories are also included in the instruction section for each applicable business use. Please note that these Member Reporting Categories MAY be sent in some and MUST be sent in others. The SHOP example required a Confirmation Transactions MUST include the Member Reporting Category loop, "ADDL MAINT REASON" with the code value of "CONFIRM."

**Table 14: The SHOP Member Reporting Category Loop**

| To transmit this information | Send | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | N102 Value | REF01 Value | REF02 Data | DTP Y/N | Init Enroll | Confirm Enroll | CAN | TERM | CHG |
| Additional Maintenance Reason (reason category) | | 17 | The specific reason code, see below | | | | | | |
| Cancellation (cancellation category) | "ADDL MAINT REASON" | 17 | "CANCEL" | Y | | | Y | | |
| Confirmation (confirmation category) | "ADDL MAINT REASON" | 17 | "CONFIRM" | Y | | Y | | | |
| Termination (termination category) | "ADDL MAINT REASON" | 17 | "TERM" | Y | | | | Y | |
| Change (change category) | "ADDL MAINT REASON" | 17 | ***[2] | Y | | | | | Y |
| Premium amount (premium category) | "PRE AMT 1" | 9X | NNNNNNN N.NN For individual rated coverage, this is the individual premium rate. For family rated coverage, this is the family premium | Y | Y | Y | | | Y |

[2] Analysis continues on the use of additional maintenance reason codes. A definitive list is not available at this time. Examples of Change reason codes are "FINANCIAL CHANGE", "OTHER GOVT PGMS" and "PREMIUM CHANGE".

| To transmit this information | Send | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | N102 Value | REF01 Value | REF02 Data | DTP Y/N | Init Enroll | Confirm Enroll | CAN | TERM | CHG |
| | | | rate. | | | | | | |
| Rating area used to determine premium amounts. (premium category) | "RATING AREA" | 9X | R-NNNNNN This is the rating area used in determining the individual or family premium amounts. | Y | Y | Y | | | Y |
| Source Exchange ID (source category) | "SOURCE EXCHANGE ID" | 17 | This is the Source Exchange ID. | Y | Y | Y | | | Y |
| Special Enrollment Period Reason (SEP category) | "SEP REASON" | 17 | This is the reason for the Special Enrollment Period | Y | Y | Y | | | Y |
| Total individual responsibility amount (payment category) | "TOT RES AMT" | 9V | NNNNNNN N.NN This is the Total Amt owed by the enrollment group (the amount the covered individuals owe toward the total premium amount). | Y | Y | Y | | | Y |
| Total employer responsibility amount (payment category) | "TOT EMP RES AMT" | 9V | NNNNNNN N.NN This is the Total Employer Responsibility Amount. | Y | Y | Y | | | Y |

| To transmit this information | Send | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | **N102 Value** | **REF01 Value** | **REF02 Data** | **DTP Y/N** | **Init Enroll** | **Confirm Enroll** | **CAN** | **TERM** | **CHG** |
| Total premium for the health coverage sent at the subscriber level.<br><br>(premium category) | "PRE AMT TOTAL" | 9X | NNNNNNN N.NN<br>This is the total amount the QHP Issuer can expect to receive from all payment. | Y | Y | Y | | | Y |

# 10. DETAILED 834 INFORMATION BY BUSINESS USE

The information in this section applies to both individual and SHOP segment markets, except where noted.

## 10.1. Initial Enrollment Instructions - FFE to QHP Issuer

An Initial Enrollment transmission is created by the Exchange and sent to the QHP Issuer after an application has been determined eligible and a QHP has been selected.

Transmissions will be created according to the instructions in the 005010X220 TR3, please refer to that TR3 for a complete understanding of 834 transmission requirements, additional information specific to the FFE implementation is outlined in Table 15 below.

**Table 15: 834 Supplemental Instructions for Initial Enrollment**

| Loop | Reference | Name | Code | Exchange Instruction |
|---|---|---|---|---|
| HEADER | BGN | Beginning Segment | | |
| | BGN08 | Action Code | 2 | |
| | DTP | File Effective Date | | Will transmit to indicate the date the information was gathered if that date is not the same as the ISA09/GS04 date. |
| | DTP01 | Date Time Qualifier | 303 | |
| | QTY | Transaction Set Control Totals | | |
| | QTY01 | Quantity Qualifier | TO | Will transmit to indicate that the value conveyed in QTY02 represents the total number of INS segments in this ST/SE set |
| | | | DT | Will transmit to indicate that the value conveyed in QTY02 represents the total number of INS segments in this ST/SE set with INS01 = N |
| | | | ET | Will transmit to indicate that the value conveyed in QTY02 represents the total number of INS segments in this ST/SE set with INS01 = Y |
| 1000A | N1 | Sponsor Name | | Individual market: identifies the subscriber from the enrollment group, unless the subscriber is under-aged. If the subscriber is under-aged, identifies the responsible person.<br>SHOP market: identifies the employer group |
| | N103 | Identification Code Qualifier | FI | Individual market |
| | | | 24 | SHOP market |

| Loop | Reference | Name | Code | Exchange Instruction |
|---|---|---|---|---|
| 1000B | N1 | Payer | | Identifies the Issuer of the qualified health plan. |
| | N103 | Identification Code Qualifier | 94<br><br>XV | Will transmit “94” until the HPID is required.<br><br>Will transmit “XV” after the HPID is required. |
| 1000C | N1 | TPA/Broker | | Identifies the TPA/Broker associated with the enrollment. |
| | N103 | | 94 | Will transmit the TPA/Broker ID. |
| 2000 | INS | Member Level Detail | | |
| | INS03 | Maintenance Type Code | 021 | |
| | INS04 | Maintenance Reason Code | EC | Will transmit when the member has selected a QHP. |
| | INS08 | Employment Status Code | AC | |
| 2000 | REF | Subscriber Identifier | | |
| | REF02 | | | Will transmit the Exchange Assigned ID of the primary coverage person. |
| 2000 | REF | Member Supplemental Identifier | | |
| | REF01 | Reference Identification Qualifier | 17<br><br>6O | Will transmit when the Exchange Assigned Member ID will be conveyed in REF02.<br><br>Will transmit when a Payment Transaction ID was created because the individual was redirected from the FFE to the QHP Issuer’s portal and will be conveyed in REF02. |
| 2100A | NM1 | Member Name | | |
| | NM109 | Member Identifier | | The SSN is allowed for this Federally administered program based on confidentiality regulations.<br><br>Will transmit the member’s SSN, when known. |
| 2100A | PER | Member Communications Numbers | | Will transmit three communication contacts, when the information is available. Refer to **Section 9.3.** |
| 2100A | N4 | Member City, State, ZIP Code | | Will transmit FIPS HUB 6-4 Counties: |

| Loop | Reference | Name | Code | Exchange Instruction |
|---|---|---|---|---|
| | N406 | Location Identifier | | Will transmit County of Residence. See http://www.itl.nist.gov/fipspubs/fip6-4.htm<br><br>**FIPS PUB 6-4**<br>Supersedes FIPS PUB 6-3<br>1979 December 15<br><br>For further detail.<br><br>**Examples:**<br>New York City is 36061<br><br>Baltimore City is 24510<br><br>Maricopa county is 04013 |
| 2100A | EC | Employment Class | | Additional employment class information will never be transmitted. |
| 2100A | ICM | Member Income | | Member income information will never be transmitted. |
| 2100A | AMT | Member Policy Amount | | Member Policy Amount information will never be transmitted. |
| 2100A | HLH | Member Health Information | | Only information about tobacco use will be transmitted. |
| 2100A | LUI | Member Language | | Transmission of this information is required when known and allowed so member language information will be transmitted when known. |
| 2100B | | Incorrect Member Name Loop | | This loop does not apply to initial enrollments. |
| 2100D | | Member Employer Loop | | This loop will never be transmitted. |
| 2100E | | Member School Loop | | This loop will never be transmitted. |
| 2100F | | Custodial Parent Loop | | Since minors are subscribers in their own right, custodial parent information will always be sent for minor subscribers when known. |
| 2100G | | Responsible Person Loop | | The Custodial Parent loop and the Responsible Person loop may both be transmitted for an enrollment. |
| 2100G | NM1 | Responsible Person | | |
| | NM101 | Entity Identifier Code | | Will transmit “QD” or “S1” as appropriate. |
| 2100G | PER | Responsible Person Communication Numbers | | Will transmit three communication contacts, home phone, cell phone and work phone or email address, when the information is available. Refer to **Section 9.3**. |
| 2100H | NM1 | Drop-Off Location | | This loop will never be transmitted. |
| 2200 | | Disability Information | | This loop will never be transmitted. |
| 2300 | HD | Health Coverage | | |

| Loop | Reference | Name | Code | Exchange Instruction |
|---|---|---|---|---|
| | HD03 | Insurance Line Code | HLT<br>DEN | Will transmit coverage information for the qualifiers shown, as applicable. |
| 2300 | REF | Health Coverage Policy Number | | |
| | REF01 | Reference Identification Qualifier | CE | QHP ID Purchased is the Assigned Plan Identifier (standard component identifier) plus the Variation Component.<br><br>See Assigned Qualified Health Plan Identifier (QHP) in 11 Acronyms/Glossary For detailed information. |
| | REF01 | Reference Identification Qualifier | E8 | SHOP market: Will transmit when the Employer Group Number will be conveyed in the associated REF02 element.<br>Will transmit when the Exchange Assigned Policy Identifier will be conveyed in the associated REF02 element. |
| | REF01 | Reference Identification Qualifier | IL | Will transmit when the Exchange Assigned Policy Identifier will be conveyed in the associated REF02 element. |
| 2300 | REF | Prior Coverage Months | | Prior Coverage Months information will never be transmitted. |
| 2300 | REF | Identification Card | | Identification Card information will never be transmitted. |
| 2310 | | Provider Information Loop | | This loop will never be transmitted. |
| 2320 | | Coordination of Benefits Loop | | This loop will be transmitted when other insurance coverage has been identified. |
| 2330 | | Coordination of Benefits Related Entity | | This loop will be transmitted when another insurance company responsible for providing benefits has been identified. |
| 2700 | | Member Reporting Categories | | This loop will be transmitted when additional premium category reporting is appropriate.<br>See **Section 9.6** for a complete list of Reporting Categories. (Note: The use of the 2700 LS, 2700 LX & LE follows the base TR3.) |
| 2750 | N1 | Reporting Category | | See **Section 9.6.1 and Section 9.6.2** for a complete list of Reporting Categories. |

## 10.2. Enrollment Confirmation/Effectuation Instructions – QHP Issuer to FFE

An Enrollment Effectuation/Confirmation transmission is created by the QHP Issuer and sent to the Hub when the Initial Enrollment transaction is successfully processed. Except where overruled by the usage requirements of the 005010X220 TR3, QHP Issuers must return all the information transmitted on the Initial Enrollment Transaction in addition to the information detailed below. An example of a TR3 usage rule superseding the instruction to return information as received is BGN03, which must reflect the creation date of the Enrollment Effectuation Confirmation transaction and not the Initial Enrollment's creation date.

Transmissions must be created according to the instructions in the 005010X220 TR3, please refer to that TR3 for a complete understanding of 834 transmission requirements. Additional information specific to the FFE implementation is outlined in Table 16 below.

**Table 16: 834 Supplemental Instructions for Confirmation/Effectuation**

| Loop | Reference | Name | Code | Exchange Instruction |
|---|---|---|---|---|
| HEADER | QTY | Transaction Set Control Totals | | If the transaction set control totals sent with the Initial Enrollment transaction are not accurate for this confirmation/effectuation, transmit accurate totals instead of the values received in the Initial Enrollment file. |
| | QTY01 | Quantity Qualifier | TO<br><br>DT<br><br>ET | The total is required for all transactions.<br><br>Dependent total is required for all transactions.<br><br>Employee total is required for SHOP transactions |
| 2000 | INS | Member Level Detail | | |
| | INS04 | Maintenance Reason Code | 28 | Transmit when the QHP Issuer has effectuated member coverage |
| 2000 | REF | Member Supplemental Identifier | | |
| | REF01 | Reference Identification Qualifier | 23<br><br>ZZ | Transmit with the QHP Issuer Assigned Member ID conveyed in REF02.<br><br>Transmit with the QHP Issuer Assigned Subscriber ID conveyed in REF02. |
| 2100B | | Incorrect Member Name Loop | | Member information may not be corrected in an effectuation/confirmation transmission. Do not transmit this loop. |
| 2300 | DTP | Health Coverage Dates | | Two iterations are required. |
| | DTP03 | Coverage Period | 348 | The actual enrollment begin date must be transmitted.<br>Enrollment into the QHP is not effectuated until the initial premium has been paid. |
| | DTP03 | Coverage Period | 543 | The Last Premium Paid Date must be transmitted. |

| Loop | Reference | Name | Code | Exchange Instruction |
|---|---|---|---|---|
| 2300 | REF | Health Coverage Policy Number | | |
| | REF01 | Reference Identification Qualifier | X9 | Transmit with the QHP Issuer assigned Health Coverage Purchased Policy Number conveyed in REF02. |
| 2700 | | Member Reporting Categories | | This loop will be transmitted when additional premium category reporting is appropriate.<br>See **Section 9.6** for a complete list of Reporting Categories. (Note: The use of the 2700 LS, 2700 LX & LE follows the base TR3.) |
| 2750 | N1 | Reporting Categories | | See **Section 9.6.1 and Section 9.6.2** for a complete list of Reporting Categories. |
| | N102 | Member Reporting Category Name | | "ADDL MAINT REASON" |
| | REF | Reporting Category Reference | | |
| | REF01 | Reference Identification Qualifier | 17 | |
| | REF02 | Member Reporting Category Reference ID | | "CONFIRM" |

## 10.3. Individual Market Cancellation Instructions – QHP Issuer to FFE, FFE to QHP Issuer

Unlike the preceding transactions, the Cancellation transaction may be initiated by either the FFE or the QHP Issuer. Cancellation transactions are not required to include all information transmitted in the Initial Enrollment and Confirmation/Effectuation transactions.

As indicated in Section 9.2 above, a Cancellation transaction is generated when the enrollment is to be ended with no actual coverage. A cancellation can happen any time prior to the effective date of the initial coverage.

The FFE will send a Cancellation transaction to the QHP Issuer when a specific individual market coverage is cancelled prior to the effective date of enrollment. A cancellation should result in no coverage for any period of time. One example for the usage of a Cancellation transaction from the FFE to the QHP Issuer would be a result of an enrollee gaining Minimum Essential Coverage (MEC) through an employer and then notifying the FFE that he or she want to terminate his or her enrollment in a QHP.

QHP Issuers will send a Cancellation transaction to the FFE when the initial premium payment was not timely for individual market coverage. A Cancellation transaction from the QHP Issuer to the FFE will result in the health coverage being cancelled for the entire enrollment group.

Transmissions must be created according to the instructions in the 005010X220 TR3, please refer to that TR3 for a complete understanding of 834 transmission requirements. Additional information specific to the FFE

implementation is outlined in Table 17 below. These instructions apply to 834 transactions regardless of who initiates the transaction.

**Table 17: 834 Supplemental Instructions for Individual Market Cancellation**

| Loop | Reference | Name | Code | Exchange Instruction |
|---|---|---|---|---|
| 2000 | INS | Member Level Detail | | |
| | INS04 | Maintenance Reason Code | 59<br><br>**<br> | QHP Issuer to the FFE: This qualifier must be used because the only valid reason for cancellation is non- payment of premium.<br><br>**FFE to the QHP Issuer: May include any valid Maintenance Reason Code. (mapping is still underway) |
| 2000 | REF | Subscriber Identifier | | |
| | REF02 | | | The Exchange Assigned ID of the primary coverage person. |
| 2000 | REF | Member Supplemental Identifier | | Transmit the IDs shown below when they were present on the initial enrollment. |
| | REF01 | Reference Identification Qualifier | 17<br><br>23<br><br>ZZ | When the Exchange Assigned Member ID will be conveyed in REF02.<br><br>When the QHP Issuer Assigned Member ID will be conveyed in REF02.<br><br>When the QHP Issuer Assigned Subscriber ID will be conveyed in REF02. |
| 2000 | DTP | Member Level Dates | | |
| | DTP03 | Status Information Effective Date | | The eligibility end date of the cancellation must match the benefit begin date sent on the initial enrollment. |
| 2700 | | Member Reporting Categories | | This loop will be transmitted when additional premium category reporting is appropriate.<br>See **Section 9.6** for a complete list of Reporting Categories. (Note: The use of the 2700 LS, 2700 LX & LE follows the base TR3.) |
| 2750 | N1 | Reporting Categories | | See **Section 9.6.1 and Section 9.6.2** for a complete list of Reporting Categories. |
| | N102 | Member Reporting Category Name | | “ADDL MAINT REASON” |
| | REF | Reporting Category Reference | | |
| | REF01 | Reference Identification Qualifier | 17 | |
| | REF02 | Member Reporting Category Reference ID | | “CANCEL” |

## 10.4. Individual Market Termination Instructions – QHP Issuer to FFE, FFE to QHP Issuer (Entire Enrollment Group)

Like the cancellation transactions, the Termination transaction may be initiated by either the FFE or the QHP Issuer. Termination transactions are not required to include all information transmitted in the Initial Enrollment and Confirmation/Effectuation transactions.

As indicated in Section 9.2 above, a Termination Transaction is generated when the enrollment is to be terminated after the effective date. The enrollee was covered by the QHP Issuer for some period of time.

The FFE will send a Termination transaction to the QHP Issuer for a variety of reasons. An enrollee has coverage for a period of time before the termination ends the coverage. For example, an enrollee may choose to be terminated for moving out of the QHP service area.

QHP Issuers will send a Termination transaction to the FFE when a premium payment was not timely for individual market coverage, based on QHP Issuer grace period policies. This transaction will result in the health coverage being terminated for the entire enrollment group. QHP Issuer grace period policies must meet applicable state and federal requirements for grace periods.

Transmissions must be created according to the instructions in the 005010X220 TR3, please refer to that TR3 for a complete understanding of 834 transmission requirements. Additional information specific to the FFE implementation is outlined in Table 18 below. These instructions apply to 834 transactions regardless of who initiates the transaction.

**Table 18: 834 Supplemental Instructions for Individual Market Termination**

| Loop | Reference | Name | Code | Exchange Instruction |
|---|---|---|---|---|
| 2000 | INS | Member Level Detail | | |
| | INS04 | Maintenance Reason Code | 59 | QHP Issuer to FFE: This qualifier must be used because the only valid reason for termination is non- payment of premium.<br><br>FFE to QHP Issuer: The appropriate Maintenance Reason Code will be sent for the transaction being created. |
| 2000 | REF | Subscriber Identifier | | |
| | REF02 | | | The Exchange Assigned ID of the subscriber. |
| 2000 | REF | Member Supplemental Identifier | | Transmit the IDs shown below when they were present on the initial enrollment. |
| | REF01 | Reference Identification Qualifier | 17<br><br>23<br><br>ZZ | When the Exchange Assigned Member ID will be conveyed in REF02.<br><br>When the QHP Issuer Assigned Member ID will be conveyed in REF02.<br><br>When the QHP Issuer Assigned Subscriber ID will be conveyed in REF02. |
| 2000 | DTP | Member Level Dates | | |
| | DTP03 | Status Information Effective Date | | The eligibility end date of the termination must be transmitted. |

| Loop | Reference | Name | Code | Exchange Instruction |
|---|---|---|---|---|
| 2700 | | Member Reporting Categories | | One iteration is required for all Terminations.<br><br>See **Section 9.6** for a complete list of Reporting Categories. (Note: The use of the 2700 LS, 2700 LX & LE follows the base TR3.) |
| 2750 | N1 | Reporting Categories | | See **Section 9.6.1 and Section 9.6.2** for a complete list of Reporting Categories. |
| | N102 | Member Reporting Category Name | | "ADDL MAINT REASON" |
| | REF | Reporting Category Reference | | |
| | REF01 | Reference Identification Qualifier | 17 | |
| | REF02 | Member Reporting Category Reference ID | | "TERM" |

## 10.5. Individual and SHOP Market Termination Instructions – FFE to QHP Issuer Individual(s) from an Enrollment Group

Termination transactions for one or more individuals for an Enrollment Group shall only be initiated by the FFE.

As indicated in Section 9.2 above, a Termination Transaction is generated when the enrollment is to be terminated after the effective date. The enrollee was covered by the QHP Issuer for some period of time.

The FFE will send a Termination transaction to the QHP Issuer for a variety of reasons. An enrollee has coverage for a period of time before the termination ends the coverage. For example, an enrollee that has moved out of the QHP Service area may choose to be terminated. The individuals being Terminated shall be included at the 2300 Health Coverage Loop when this situation occurs

Transmissions must be created according to the instructions in the 005010X220A1 TR3, please refer to that TR3 for a complete understanding of 834 transmission requirements. Additional information specific to the FFE implementation is outlined in Table 18 below. These instructions apply to 834 transactions regardless of who initiates the transaction.

**Table 19: 834 Supplemental Instructions for Individual and SHOP Market Termination**

| Loop | Reference | Name | Code | Exchange Instruction |
|---|---|---|---|---|
| 2000 | INS | Member Level Detail | | |
| | INS03 | Maintenance Type Code | 024 | |
| | INS04 | Maintenance Reason Code | | The appropriate Maintenance Reason Code will be sent for the transaction being created. |
| 2000 | REF | Subscriber Identifier | | |

| Loop | Reference | Name | Code | Exchange Instruction |
|---|---|---|---|---|
| | REF02 | | | The Exchange Assigned ID of the subscriber. |
| 2000 | REF | Member Supplemental Identifier | | Transmit the IDs shown below when they were present on the initial enrollment. |
| | REF01 | Reference Identification Qualifier | 17<br><br>23<br><br>ZZ | When the Exchange Assigned Member ID will be conveyed in REF02.<br><br>When the QHP Issuer Assigned Member ID will be conveyed in REF02.<br><br>When the QHP Issuer Assigned Subscriber ID will be conveyed in REF02. |
| | | | | |
| 2300 | HD | Health Coverage | | |
| | HD01 | Maintenance Type Code | 024 | |
| 2300 | DTP | Health Coverage Dates | | |
| | DTP03 | Status Information Effective Date | 349 | The benefit end. |
| 2300 | REF | Health Coverage Policy Number | | |
| | REF01 | Reference Identification Qualifier | CE | QHP ID Purchased is the Assigned Plan Identifier (standard component identifier) plus the Variation Component.<br><br>See Assigned Qualified Health Plan Identifier (QHP) in 11 Acronyms/Glossary For detailed information. |
| | REF01 | Reference Identification Qualifier | E8 | SHOP market: Will transmit when the Employer Group Number will be conveyed in the associated REF02 element.<br>Will transmit when the Exchange Assigned Policy Identifier will be conveyed in the associated REF02 element. |
| | REF01 | Reference Identification Qualifier | IL | Will transmit when the Exchange Assigned Policy Identifier will be conveyed in the associated REF02 element. |
| | REF01 | Reference Identification Qualifier | X9 | Will transmit when the Issuer Assigned Policy Identifier will be conveyed in the associated REF02 element. |
| 2700 | | Member Reporting Categories | | One iteration is required for all Terminations.<br><br>See **Section 9.6** for a complete list of Reporting Categories. (Note: The use of the 2700 LS, 2700 LX & LE follows the base TR3.) |

| Loop | Reference | Name | Code | Exchange Instruction |
|---|---|---|---|---|
| 2750 | N1 | Reporting Categories | | See **Section 9.6.1 and Section 9.6.2** for a complete list of Reporting Categories. |
| | N102 | Member Reporting Category Name | | "ADDL MAINT REASON" |
| | REF | Reporting Category Reference | | |
| | REF01 | Reference Identification Qualifier | 17 | |
| | REF02 | Member Reporting Category Reference ID | | "TERM" |

## 10.6. Other Transaction Instructions - FFE to QHP Issuer

This section describes a number of enrollment transactions that are patterned after the Initial Enrollment.

### 10.6.1. Individual Market – Re-enrollment, FFE to QHP Issuer

A Re-enrollment transaction is generated when an enrollee who has been terminated needs to be re-enrolled. A potential reason for this transaction would be when the subscriber is no longer eligible and the remaining members of the enrollment group need to be re-enrolled under a new subscriber. In this situation, the previous QHP Issuer assigned subscriber identifier will be conveyed as a member supplemental identifier.

Except as noted in the table below, the Reinstatement transaction will contain all the information transmitted on the Initial Enrollment Transaction.

Transmissions must be created according to the instructions in the 005010X220 TR3, please refer to that TR3 for a complete understanding of 834 transmission requirements. Additional information specific to the FFE implementation is outlined in Table 20 below. These instructions apply to 834 transactions regardless of who initiates the transaction.

**Table 20: 834 Supplemental Instructions for Individual Market – Re-enrollment**

| Loop | Reference | Name | Code | Exchange Instruction |
|---|---|---|---|---|
| 2000 | INS | Member Level Detail | | |
| | INS04 | Maintenance Reason Code | 41 | |
| 2000 | REF | Member Supplemental Identifier | | Transmit the IDs shown below when they were present on the initial enrollment. |
| | REF01 | Reference Identification Qualifier | Q4 | When the Previous QHP Issuer Assigned Subscriber ID will be conveyed in REF02. |

### 10.6.2. SHOP Market – Reinstatements, FFE-SHOP to QHP Issuer

A Reinstatement transaction is generated when an enrollee who has been cancelled or terminated needs to be reinstated. A potential reason for this transaction would be when an employer group falls behind in payment and then makes full payment within policy timeframes. All employees would have been terminated for non-payment of premium. They are being added back using the reinstatement maintenance type code.

Except as noted in the table below, the Reinstatement transaction will contain all the information transmitted on the Initial Enrollment Transaction.

Transmissions must be created according to the instructions in the 005010X220 TR3, please refer to that TR3 for a complete understanding of 834 transmission requirements. Additional information specific to the FFE implementation is outlined in Table 21 below. These instructions apply to 834 transactions regardless of who initiates the transaction.

**Table 21: 834 Supplemental Instructions for FFE-SHOP Market Reinstatement**

| Loop | Reference | Name | Code | Exchange Instruction |
|---|---|---|---|---|
| 2000 | INS | Member Level Detail | | |
| | INS04 | Maintenance Reason Code | 41 | Reinstatement is the FFE-SHOP equivalent to the ASC X12 term Re-enrollment. |

### 10.6.3. Change in Health Coverage Levels

The FFE will send two Coverage Level Change transactions to the QHP Issuer when an enrollee's health coverage level changes. The first Coverage Level Change transaction will convey a health coverage termination for the old coverage level and a second Coverage Change transaction will convey a health coverage level addition (new coverage).

Transmissions must be created according to the instructions in the 005010X220 TR3, please refer to that TR3 for a complete understanding of 834 transmission requirements

### 10.6.4. Change in Circumstance – FF-SHOP only

The FFE will send three transactions to the QHP Issuer when a change in circumstance results in a new enrollment during the month. One example would be an enrollment for a newborn. This enrollment results in a change in premium transaction, a Pro-rated premium transaction (for a period) and a new premium transaction.

In the first transaction (end dating the old premium amount), INS03 will contain "001", INS04 will be blank, and the 2750 REF02 Member Reporting Category Reference ID will contain "PREMIUM CHANGE."

In the second transaction (adds the prorated premium amount with the prorated effective date and end date), INS01 will contain "001", INS04 will be blank, and the 2750 REF02 Member Reporting Category Reference ID will contain "PREMIUM CHANGE."

In the third transaction (adds the 'new' premium amount with just an effective date), INS01 will contain "001", INS04 will be blank, and the 2750 REF02 Member Reporting Category Reference ID will contain "PREMIUM CHANGE."

Additional transactions, depending on the reason for the change in circumstance may follow, examples are:

- Change/add for the coverage code as a separate transaction
- Add for the newborn

### 10.6.5. Address Change

The FFE will send two transactions to the QHP Issuer when a change of address results in a QHP termination. Two transactions will be created and sent, the first transaction will be the change of address and the second the termination.

## 10.7. Monthly Reconciliation File Processes

The exchange rule requires that a QHP Issuer reconcile enrollment files with the exchange no less than once a month and that the exchange reconcile enrollment information with QHP Issuers and HHS no less than on a monthly basis. These separate processes are discussed below in the following sections.

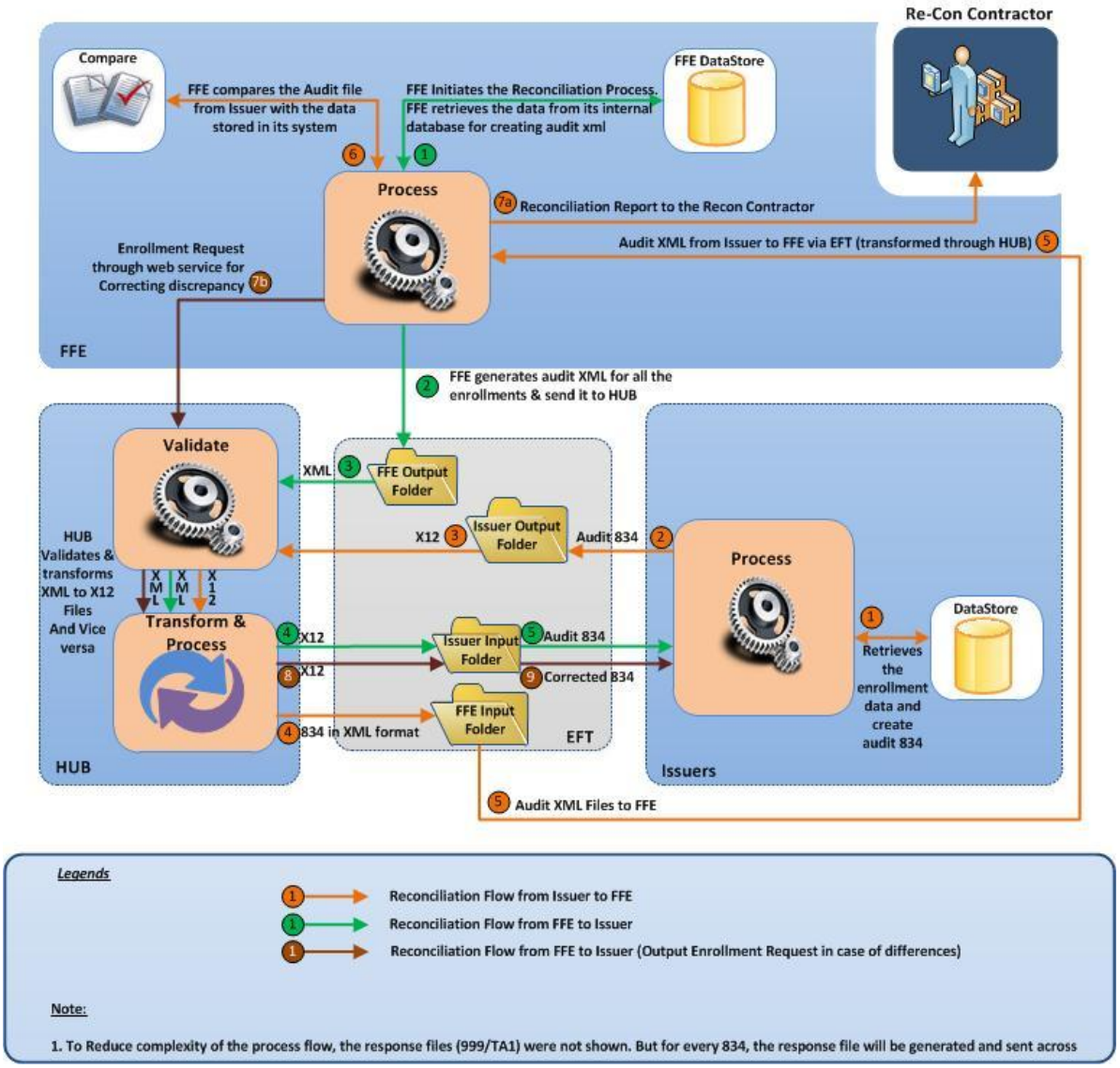
### 10.7.1. Reconciliation File - FFE to QHP Issuer

The FFE will have completed all daily operational activities related to enrollment before initiating monthly reconciliation with QHP Issuers. Next the FFE will extract the membership information to be transmitted to the QHP issuer from the Enrollment Data Store (EDS) and format the outbound 834 Monthly enrollment transaction set to be sent to the QHP Issuer, based upon the same selection criteria the QHP Issuer will create the 834 file to be sent to the FFE for comparison purposes. The information from the two files will then be compared. The comparison process will produce a list of discrepancies (aka delta information, or differences). This information will then be made available to the FFE Reconciliation Contractor for follow-up.

The has the ability to perform the same function within their own operating environment by comparing the data received from the FFE via the monthly 834 and their own extracted data. The differences or delta can then be confirmed with the FFE Reconciliation Contractor.

Figure 2 outlines the high level steps and interactions for the reconciliation process that takes place between the FFE, Hub, and QHP Issuers.

**Figure 2: FFE – QHP Issuer Reconciliation Process Flow**




### 10.7.2. Transaction Element Specific Requirements, SBE to the Department of Health and Human Services (HHS)

At this time there is no supplemental instruction information for transactions from a SBE to the Department of Health and Human Services (HHS). The SBE enrollment data sent to HHS will be stored in the Federal Exchange Program System (FEPS) Enrollment Data Store (EDS). There are no differences between the 834 transactions shared between the FFE and QHP Issuers and those of the SBE and FEPS.

### 10.7.3. Reconciliation File - SBE to the HHS

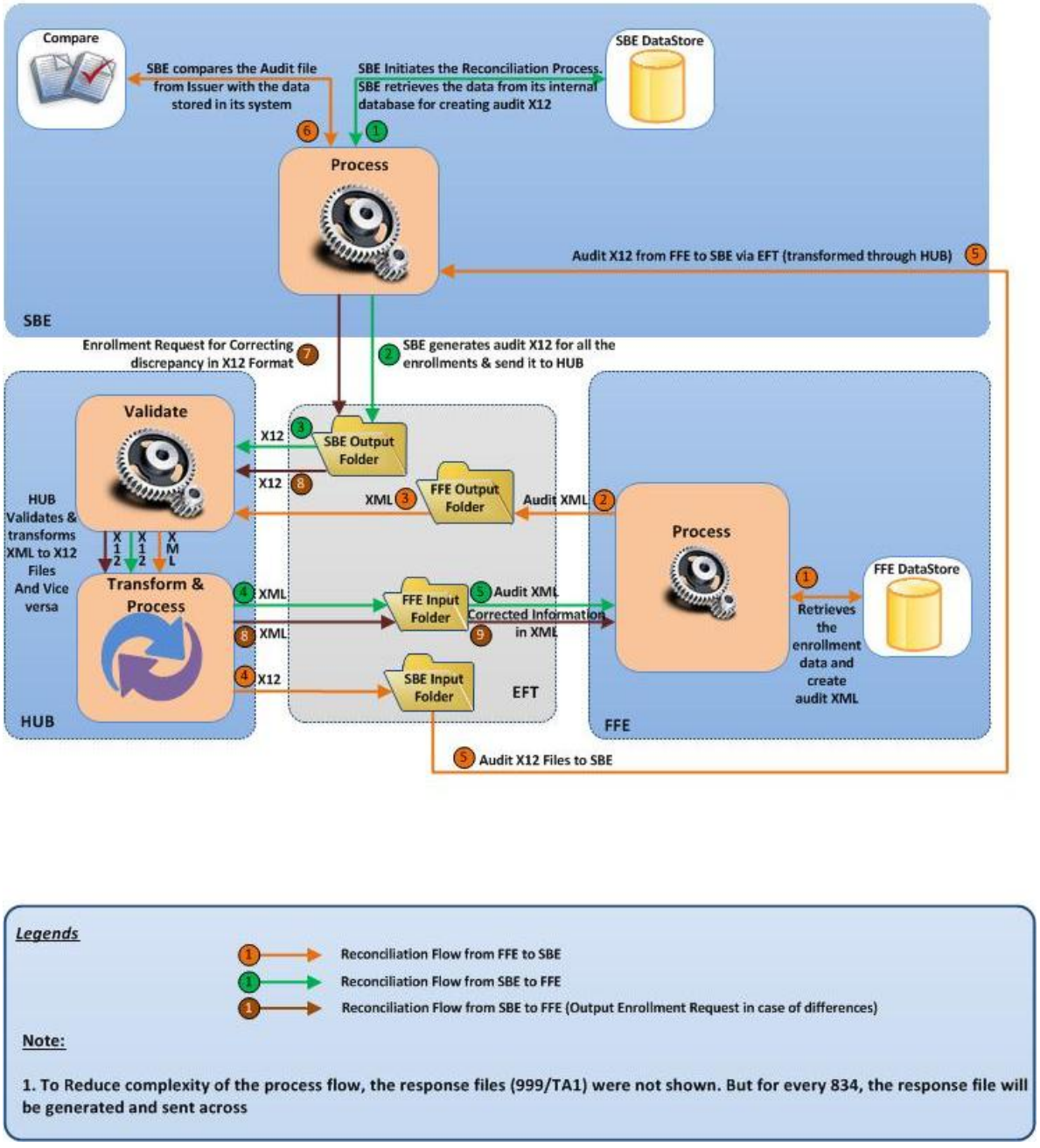
The exchange rule requires that a QHP Issuer reconcile enrollment files with the Exchange no less than once a month and that the exchange reconcile enrollment information with QHP Issuers and HHS no less than on a monthly basis. The SBE will complete the monthly enrollment reconciliation process with QHP Issuers before initiating monthly enrollment reconciliation processes with HHS. The SBE will have completed all daily operational activities related to enrollment before initiating monthly reconciliation with HHS.

Next membership information will be extracted from FEPS and formatted into the appropriate internal XML schema in order to compare the translated inbound 834 monthly enrollment transaction file received from the SBE. Both files must contain enrollment information based upon the same selection criteria. The information from the two files will then be compared. The comparison process will produce a list of discrepancies (aka delta information, or differences). This information will then be made available to the FFE Reconciliation Contractor for follow-up.

The SBE has the ability to perform the same function within their own operating environment by comparing the data received from the HHS and their own extracted data. The differences or delta can then be confirmed with the FFE Reconciliation Contractor.

Figure 3 outlines the overall flow for the SBE and the HHS Monthly Reconciliation process.

**Figure 3: SBE – HHS Reconciliation Process Flow**



# 11. Acronyms/Glossary

**Table 22: Acronyms/Glossary**

| Acronym/Term | Description |
|---|---|
| ACA | Affordable Care Act |
| APTC | Advance Payments of the Premium Tax Credit |
| ASC | Accredited Standards Committee |
| Assigned Qualified Health Plan Identifier (QHP) | The Assigned Qualified Health Plan Identifier is the Standard Component Identifier plus the Variation Component.<br><br>The Standard Component ID generated by CMS is a 14 characters(alphanumeric):<br><br>• A five digit Issuer ID<br>• Two character State ID<br>• Three digit Product Number<br>• Four digit Standard Component Number<br><br>An example is as follows: 12345VA0020021<br><br>The Variant Component ID is 2 characters (Numeric) with the following values and description<br>• 00 - Non-Exchange variant<br>• 01 - Exchange variant (no CSR)<br>• 02 - Open to Indians below 300%FPL<br>• 03 - Open to Indians above 300%FPL<br>• 04 - 73% AV Level Silver Plan CSR<br>• 05 - 87% AV Level Silver Plan CSR<br>• 06 - 94% AV Level Silver Plan CSR<br><br>Assigned Qualified Health Plan Identifier is a concatenation of the 2.<br><br>An example of both the Plan Id and Variant Component ID is as follows: 12345VA002002104 |
| Cancellation of Health Coverage | Termination of health coverage PRIOR to the effective date of the health coverage. The enrollee requests that the health coverage they previously selected is cancelled prior to the first possible effective date.<br>(Cancellation = Prior to effective date of coverage<br>Termination = After effective date of coverage) |
| CCIIO | Center for Consumer Information and Insurance Oversight |
| CG | Companion Guide |
| CMS | Centers for Medicare & Medicaid Services |
| CSR | Cost-Sharing Reduction |
| Advance CSR | Advance Cost-sharing Reduction Payment |
| DHHS | Department of Health and Human Services |
| EDI | Electronic Data Interchange |
| EDS | Enrollment Data Store |
| EFT | Enterprise File Transfer |
| FEPS | Federal Exchange Program System |
| FF-SHOP | Federally Facilitated Small Business Health Option Program |

| Acronym/Term | Description |
|---|---|
| FFE | Federally Facilitated Exchange<br>HHS operates |
| HHS | Department of Health and Human Services |
| HIPAA | Health Insurance Portability and Accountability Act of 1996 |
| Hub | Data Services Hub<br>Referred to as the Hub |
| IG | Implementation Guide |
| PHS | Public Health Service |
| QHP | Qualified Health Plan |
| MEC | Minimum Essential Coverage |
| SBE | State Based Exchange<br>State operates all Exchange activities |
| SFTP | Secure File Transfer Protocol |
| SHOP | Small Business Health Option Program |
| Termination of Health Coverage | Terminate (end-date) health coverage after the health coverage effective date.<br>(Cancellation = Prior to effective date of coverage<br>Termination = After effective date of coverage) |
| Companion Guide Technical Information (TI) | The Technical Information (TI) section of the ASC X12 Template format for a Companion Guide which supplements an ASC X12 Technical Report Type 3 (TR3) |
| TR3 | Type 3 Technical Report |
| XOC | eXchange Operational Support Center |

# 12. Change Summary

**Table 23: Change Summary**

| Date | Version | By | Description of Changes |
|---|---|---|---|
| 3/22/2013 | 1.5 | MJC | Review changes applied Version 1.0 to 1.5 |
| 3/22/2013 | 1.5 | MJC | Minor non-substantive changes applied from Industry review<br>• Change “Insurer” to “Issuer” throughout the guide<br>• Adds the definition of Technical Information (TI)<br>• Update bullet items in Section 4.1:<br>  • Hub Processing Capabilities<br>  • File Rejection Recon<br>• Updated XOC hours of Operation for post April 1st, 2013 start-up<br>• Update to ISA04 in Table 2<br>• Updated references to TA1 in third sentence<br>• Updated notes in Table 3 and corrected the word to be “issuer” replacing “insurer” |
| 3/22/2013 | 1.5 | MJC | • Updates to Section 9.2 General Business Rules<br>• Added Table – Sample for Multiple Policy Information<br>• Updated bullets under Communications Contacts<br>• Separated Section 9.5 into two subsections which describe Individual and SHOP<br>• Added Section 9.5.2 SHOP Market Rate Calculation within 834<br>• Separated Section 9.6 into two subsections which describe Individual and SHOP |

| Date | Version | By | Description of Changes |
|---|---|---|---|
| 3/22/2013 | 1.5 | MJC | • Updated Table 11 – 834 Supplemental Instructions for Initial Enrollment<br>  • REF – transaction set policy number<br>  • 1000C N1 and N3 segments were added<br>  • REF01 code value “6O” instruction added<br>  • 2100A NM1, N4 and N406 instructions updated<br>  • 2300 REF01 code value “CE’, “E8” “IL” instructions updated<br>  • 2700 Member Reporting Categories instructions updated<br>  • 2750 N1 Reporting Categories instructions updated<br>  • 2750 N1 Reporting Categories instructions updated<br>• Correction to the following references to 2700:<br>  • Pgs 19 & 21 added note to refer to 2700 LS, LX segments related to 2700 Loop usage. |
| 3/22/2013 | 1.5 | MJC | • Section 10.2 updated Table 12 and Table 13<br>  • BGN segment reference updated<br>  • NS04 Maintenance Reason Code instructions updated<br>  • 2700 Member Reporting Categories instructions updated<br>• Section 10.4 title updated to: Individual Market Termination Instruction – QHP Issuer to FFE, FFE to QHP Issuer (Entire Enrollment Group)<br>• Table 14 8334 Supplemental Instructions for Individual Market Termination updated:<br>  • 2700 Member Reporting Categories instructions updated<br>  • 2750 N1 Reporting Categories instructions updated |

| Date | Version | By | Description of Changes |
|---|---|---|---|
| 3/22/2013 | 1.5 | MJC | • Added Section 10.5 Individual and SHOP Market Termination Instructions – FFE to QHP Issuer Individual(s) from Enrollment Group<br>• Section 10.6.1 third paragraph revised slightly<br>• Section 10.6.2 third paragraph revised slightly<br>• Section 11 Acronyms/Glossary updated:<br>  • Assigned Qualified Health Plan Identifier (QHP)<br>  • Companion Guide Technical Information (TI)<br>• Updated Section 12 Change Summary |
| | | | |
| | | | |