

Enrollment & Transaction Frequently Asked Questions

Selected Responses

Release Date: July 2, 2013



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Frequently Asked Questions (FAQ) # 2

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Policy and Technical Information

Q1: What time of day will the ASC X12 834 transaction files be transmitted to Issuers?

A1: The Federally-facilitated Marketplace has not finalized the decision about daily transmission times yet.

Q2: The 834 Enrollment Companion Guide has only one field for Agent ID, but it looks like an agent can log into the Federally-facilitated Marketplace (FFM) with both the Marketplace Assigned ID and/or the National Producer Number (NPN). We need to confirm that this is the case if Issuers are to receive both identifiers on the 834 transaction?

A2: The Federally-facilitated Marketplace will send only one identifying number for the Broker or Agent on the ASC X12 834 Enrollment transaction, using the number that the individual has used to log in to the system. That number could be either the Marketplace Assigned ID or the National Producer Number (NPN). Within the information model CMS has designed, the enrollment transaction will only provide the one number. It is possible for an issuer to receive both the Broker and an Agent on one transaction, each with one NPN or one Marketplace ID as the identifier.



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Q3: Are there values/definitions for the Special Enrollment Period (SEP) Reason Codes?

A3: Within the ASC X12 834 enrollment transaction, every effort is being made to use existing Maintenance Reason Codes (INS04) where applicable. In those instance where there is not an existing maintenance reason code that describes the Special Enrollment Reason, the FFM will include a loop in the 2750 “SEP REASON” and add a proprietary code.

The SEP Reason codes are as follows:

- (1) Qualified Individual (QI) or dependent loss of Minimum Essential Coverage (MEC); 07-Termination of Benefits, located in the INS04-Maintenance Reason Code.
- (2) QI gains or becomes a dependent due to marriage, birth, adoption or placement of adoption; 32-Marriage, 02-Birth, 05-Adoption, located in the INS04 – Maintenance Reason Code.
- (3) An individual, who was not previously a citizen, national or lawfully present individual gain such status; NEWLY ELIGIBLE, located in the 2750 as SEP REASON.
- (4) A QI enrollment or non-enrollment in a QHP is the result of an Exchange ERROR; EXCHANGE ERROR, located in the 2750 as SEP REASON.
- (5) Qualified Health Plan (QHP) is in violation of material provision of its contract with the enrollee; AB/Dissatisfied with medical care/service rendered, located in the INS04-Maintenance Reason Code.
- (6) Newly eligible for Advance Premium Tax Credit (APTC) or change in Cost Sharing Reduction (CSR); FINANCIAL CHANGE, located in the 2750 as SEP REASON.
- (7) New QHPs available due to a permanent move; 43-Change of Location, located in the INS04-Maintenance Reason Code.
- (8) Indian; NEWLY ELIGIBLE, located in the 2750 as SEP REASON.
- (9) Exceptional Circumstances; EXCEPTIONAL CIRCUMSTANCES, located in the 2750 as SEP REASON.

Q4: In the ASC X12 834 Enrollment Transaction, is the ISA06 Sender ID the same as the Source Exchange ID in Loop 2750 REF02?

A4: Yes, both identifiers will be the source exchange ID (identifier).

Q5: In the Enrollment Transaction, is the 1000A N101 Plan Sponsor the alternate payer?

A5: In the Federally-facilitated Marketplace, the subscriber is listed in 1000A. In the FF-SHOP, the Plan Sponsor is the employer group. We do not use the term alternate payer in the FFM.



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Q6: In the Enrollment Transaction, in the field for 1000B N102 Payer, what information is published as the name?

A6: The Federally-facilitated Marketplace will insert the name of the issuer that was provided in HIOS for the Qualified Health Plan (QHP) application.

Q7: Does the 2320 Coordination of Benefits need to be included on the Issuer to Federally-facilitated Marketplace (FFM) 834 file?

A7: No, the Federally-facilitated Marketplace is not sending Coordination of Benefits information to the Issuers, so there is no expectation for this information to be returned by the issuer to the FFM.

Q8: Are the 2100G, 2100F Loops for Responsible Person and Custodial Parent required on the Issuer to FFM ASC X12 834 Enrollment file?

A8: On daily files, the Federally-facilitated Marketplace (FFM) is requesting that Issuers return all of the data the FFM sent in the initial enrollment transaction, along with the new issuer assigned member identifier, issuer policy number etc. This does not apply to the monthly audit files for which separate instructions will be provided.

Q9: What is the format/definition of rating areas to be used on the ASC X12 834?

A9: The ASC X12 834 enrollment transaction will include the address for the enrollee and a location identifier for that address within its county. The format of the location identifier is 5 digits, alphanumeric. The first two characters are the state abbreviation followed by 3 digits which identify the county based on the FIPS data base. For example, a county in Arizona would appear as: AZ123. Additional information is provided in the Companion Guide, which is available at: <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/companion-guide-for-ffe-enrollment-transaction-v15.pdf>.

Q10: On the 834 audit file, how will historical data be structured in comparison to current data? Should the records be sent in a particular order?

A10: Details about the requirements and structure of the monthly reconciliation audit file and how the records should be sent will be finalized by the end of July.



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Q11: Where will adjustment reason codes be found on the HIX 820 premium payment report transaction?

A11: The HIX 820 premium payment report transaction does not have a data field for adjustment reason codes. The Centers for Medicare & Medicaid Services (CMS) plans to issue a monthly payment letter that will outline key adjustments made during the monthly payment cycle. The 2300 Loop REF03 “Exchange-Related Report Type” element will provide report reference numbers. These referenced documents will provide additional information on manual adjustments. The format and method of distribution for these documents are still being evaluated and will be provided later in 2013.

Q12: The Exchange Final Rule requires that a QHP issuer provide notice to an enrollee if coverage is terminated at least 30 days prior to the last day of coverage and notify the Exchange of the effective date of termination and reason. We have not yet received written clarification on who will be responsible for rolling the over-age dependent off the policy, and who will provide notice to the individual. Please confirm the following for the FFM:

- a. Health plans will complete the termination and provide notice to the aged-off dependent and primary subscriber in a manner consistent with the Exchange Regulations and applicable state laws. CMS will be providing additional guidance on these processes in the near future.
- b. Following the FFM’s receipt of the termination from the Issuer, an exchange eligibility determination will be triggered by the FFM to examine impact on premium, ATPC amount and CSR eligibility as a result of the enrollment change.
- c. The FFM is developing additional eligibility support and outreach approaches to ensure the consumer’s eligibility and enrollment information remain update date.
- d. For initial enrollments, the FFM is currently not programming to state specific rules like full-time student or veteran’s status).

A12: The process for handling aging-off dependents is still under development. We are currently engaged in dialog with Issuers and we anticipate finalizing the policy and process by the end of July.

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Q13: Enrollment File Indicator: States that permit coverage of dependents over age 26 may do so only for certain adult children, including veterans, full-time students, or persons with disabilities. The Federally-facilitated Marketplace does not obtain or provide this information as part of the eligibility determination process. However, health plans need a way to provide the reason for termination to the Marketplace. For example, in Iowa (a State Partnership Exchange), Issuers must allow dependents to maintain their parent's coverage if the child is a full-time student or has a disability. Will CMS be updating a list of termination reason codes to account for terminations other than non-payment of premium? If so, when?

Currently the companion guide indicates that the disability indicator will not be sent on the 834? Will CMS consider revising the companion guide as this impacts whether individuals can remain on the policy after the maximum dependent age?

A13: The Federally-facilitated Marketplace will add several codes to the list of maintenance reason codes for communicating termination reasons to the Issuers, including codes for fraud, non-payment of premium and minimum essential coverage. These codes will be listed in the next version of the Enrollment Companion Guide, expected to be published by mid-August.

In addition, the testing process, which begins July 15th, is expected to generate additional information that will result in another version of the Companion Guide before October 1, 2013.

CMS is discussing methods for providing disability status to Issuers based on relationship codes used on the application forms.

Q14: Aging off Pediatric Coverage: What will occur when an individual is enrolled in pediatric dental and they reach the age when Dental Pediatric coverage will end? Will the FFM manage the eligibility and send the issuer a termination 834 Transaction at the end of the plan year after the individual meets the age limit for pediatric dental coverage (e.g. 19 years)? If the FFM does not send a termination transaction, then the individual will still be enrolled in the issuer's system because the issuer cannot terminate individuals.

The policies for "dependent age out" on a family plan vary by State. If the family does not take any action during open enrollment (i.e., wants to maintain current coverage), will the FFM be able to determine that the dependent is no longer eligible based on the age? If the FFM does not enroll an over age dependent, will it send a termination transaction, or just send an updated enrollment transaction for the entire family/enrollment group?

A15: CMS is developing a process to address the topic of "dependent age out," issuer options for action, and roles for the FFM and the Issuers. Information should be available by the end of July.



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Q15: Policy Number: Issuers are to send the issuer's assigned enrollee's policy number back to the Federally-facilitated Marketplace (FFM) in the confirmation transaction. Specifically, this is referring to loop 2300, REF02 Member Group or Policy Number - Issuer assigned health coverage purchased policy number. How will the FFM use this policy number (an identifier, customer service, etc.) which is different than loop 2000 REF02 Member Supplemental Identifier (the issuer assigned subscriber ID)?

A16: The Federally-facilitated Marketplace (FFM) will use the issuer's assigned enrollee's policy number as one of multiple data elements to ensure an accurate enrollee match during reconciliation processing. There are also IRS reporting requirements for Issuers, and the FFM is considering sending the issuer's assigned identifiers to the IRS.

Q16: 834 Confirmations for Enrollment Changes. This requirement is not in the ASC X12 834 Companion Guide but was mentioned in the annual letter to Issuers: chapter 5, SECTION 4. TRANSMISSION OF ENROLLMENT INFORMATION BETWEEN THE FFE AND QUALIFIED HEALTH PLANS, subsection ii: The letter also states that "in response to the exchange sending a file to an issuer containing changes for multiple enrollees, once the issuer has made those changes or effectuated an enrollment, the issuer will send the exchange a full ASC X12 834 "confirmation" record for each individual affected". This requirement is not in the ASC X12 834 companion guide and does not have an "issuer to FFE" transaction for "changes". We do not recommend confirmations for enrollment changes because it would create an unnecessary amount of files.

A17: The Federally-facilitated Marketplace does not require Issuers to send a confirmation transaction for changes. We will clarify this in the next version of the Enrollment Companion Guide as well as any future versions of the Issuer Letter/Annual Letter.

Q17: Will CMS provide a machine-readable EDI implementation guideline for their particular implementation (SEF, for example), and if so, what standards / format(s) will be available?

A18: CMS is not planning to provide a machine-readable EDI implementation guideline for the implementation of any programming for the Federally-facilitated Marketplace.

Q18: In one of the enrollment scenarios (#8), it talks about multiple tax filers who both qualify for APTC and CSR, and each of them have a child. The life partner has one child and is listed as the responsible person for that child. Will the APTC and CSR amounts be combined and placed under the subscriber in this scenario?

A19: Yes. If both partners are eligible for APTC, the amounts will be combined and placed under the subscriber in this scenario.



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Q19: Will the Federally-facilitated Marketplace Assigned ID for brokers be sent on the ASC X12 834 enrollment transaction along with the broker's National Producer Number (NPN)? If yes, is the FFM ID going to be sent when the broker is using the FFM (sitting side by side with consumer) and they enter their NPN?

A20: The Federally-facilitated Marketplace will send one identifier for the broker, either the Marketplace Assigned ID or the National Producer Number, depending on which identifier the broker used to log in to the system. When the broker provides side by side assistance to the enrollee, the identifier they use to log in to the system will be the identifier sent on the enrollment transaction.

Q20: When would a program level manual adjustment (APTC MADJ) be made? Is this only during reconciliation? Shouldn't adjustments always be tied to a subscriber?

A21: During the monthly payment approval process, CMS will perform a series of analytical checks to help identify any payment issues. These issues may be the result of improper system programming, bad data transfers from one system to another, rounding errors, file integrity issues, etc. A manual adjustment may take place when CMS has identified a payment issue through these reviews. For example, an APTC Manual Adjustment (APTCMADJ) may occur when CMS is aware of an error in enrollment group data that has not yet been resolved. Due to a system error, an issuer cannot provide enrollment-related data to CMS. While the error is being resolved, CMS may choose to issue an APTC Manual Adjustment similar to a previous month's APTC payment amount. This results in a manual adjustment amount being sent to the payee because enrollment group information is not yet available. When accurate enrollment group data becomes available, CMS can then correct the payment made using the updated information.

Q21: For the member, will the 2100C loop or other address loops be sent to indicate the member's mailing address or will you send only 2100A loop for address?

A22: We will send the member mailing address in the 2100C loop if applicable. The ASC X12 834 Implementation Guide (TR3) requires that the mailing address be sent if it is different from the residential address (in 2100A) or when the dependent's address is different from the Subscriber's address. The FFM will send the mailing address when these situations apply.



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Q22: The ASC X12 834 Enrollment Companion Guide indicates that Issuers need to provide back to the FFM the same information on the effectuation file as was passed to them on the ASC X12 834 enrollment inbound. However, Issuers may not necessarily store information sent on the file. Furthermore, there will be some codes that we would not be able to map back to the code that came in on the file. Will CMS expect to receive the exact codes that came in on the enrollment file in the effectuation and reconciliation files?

Can CMS provide a policy on which relationship codes are irreversible (meaning, they need the same code that they sent in the 834 enrollment to the carrier)? One example: Relationship codes have many possible values based on the TR3 that may be mapped to a shortened list on the carrier side. "Sister-in-law", "Adopted Child" and many others may all be mapped to "Dependent" in carrier system. Will CMS require Issuers to reverse map back "Dependent" into "Sister-in-law" and "Adopted Child" and all others possible?

A23: Yes, CMS expects the same codes that came in on the enrollment file to be returned on the effectuation and reconciliation files. With respect to a policy codes that are irreversible – Adopted child mapped to Dependent and back to Adopted Child – CMS will have further discussions with Issuers about this topic to determine this best options.