

State Planning and Establishment Grants for the Affordable Care Act's Exchanges

Quarterly Project Report

Date: April 15, 2011

State: Kentucky

Project Title: Kentucky State Planning and Establishment Grant for the Affordable Care Act's Exchange

Project Quarter Reporting Period: Quarter 2 (2/1/2011-4/15/2011)

**Grant Contact Information**

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Award Number: HBE100037-01-00

Date submitted: September 1, 2010

**Project Summary**

The following provides a summary by core area of the Kentucky Exchange Planning Grant for the second reporting period.

**Background Research-** Kentucky has secured a contract with the University of Kentucky (UK) to conduct background research. The University has designated a team of two (2) principal investigators and five (5) investigators who will research and analyze the insured and un-insured populations in Kentucky as well as conduct economic and actuarial modeling for new policy options under the Affordable Care Act (ACA). We expect to meet with a principal investigator on the first set of deliverables in late April and report additional information during quarters three (3) and four (4). See attachment.

**Stakeholder Involvement-** In late April, Kentucky will launch a health care reform website that allows for comments and interested parties to sign-up for e-alert messages. In the near future Stakeholders will also receive a mailed letter requesting comments identifying, issues and concerns on various provisions

of the ACA relating to the Exchange. A complete report on stakeholder input will be compiled in a written document.

**Program Integration-** Information technology (IT), Medicaid Eligibility, and the Office of Health Policy (OHP) staff have participated in five(5) vendor presentations (Msat, Deloitte, CGI, HP, and ACS) regarding systems development, integration and business operations of an Exchange. Cabinet for Health and Family Services (CHFS) program representatives, including the Department for Aging and Independent Living, Office of the Inspector General, Department for Medicaid Services, Department for Community Based Services, Office of Ombudsman, and Department for Behavioral Health, Developmental and Intellectual Disabilities ) meet with the OHP monthly to update other departments of program development. OHP also meets weekly with the Kentucky Department of Insurance, Department for Medicaid Services and IT staff to discuss Exchange issues and concerns.

**Resources and Capabilities-**The OHP hired two (2) additional staff on February 16, 2011 to assist with Exchange planning. Both staff members have extensive background experience in healthcare, Medicaid and private health insurance.

**Governance-** OHP staff is completing an analysis of governance options for establishing an Exchange Governing Board. This analysis will potentially be shared with interested parties. Additionally, staff continues to review enacted and pending legislation of other states for 2011, particularly as it relates to defining a Governing structure. Our partners at the Kentucky Department of Insurance also analyzed and reviewed options for developing a regional Exchange and have had discussions with other states on feasibility of a multi-state operation.

**Finance-** CHFS budget staff has begun the process of developing an Exchange budget. The OHP is pursuing the possibility of issuing a Request for Proposal (RFP) through Level One Establishment grant funds to develop a financial model that will ensure a fully sustainable Exchange and meet all federal requirements.

**Technical Infrastructure-** CHFS IT staff are currently reviewing systems needs and capability options. Kentucky would like to have an outside vendor review our IT Gap analysis with the possibility of that vendor supplying an off-the-shelf solution that can be modified to meet the specific needs of Kentucky in relation to assessing premium tax credits, cost-sharing and Medicaid eligibility.

**Business Operations-** At this time, the OHP plans to apply for a *Level One Establishment* grant in the near future to assist Kentucky with defining and developing the required business operations of an Exchange.

**Regulatory or Policy Actions-** As indicated earlier, the OHP has been reviewing, and will continue to review, enabling legislation and proposed legislation from other states.

**Barriers, Lessons Learned, and Recommendations to the Program**

None identified at this time.

**Technical Assistance**

Additional assistance is needed to educate States on the ACA premium tax credit and cost sharing requirements. It would be beneficial to states if CCIIO could offer assistance in this area through conference calls, webinars or meetings.

**Draft Exchange Budget:** Kentucky is currently in the process of developing an Exchange budget. A complete budget for FFY 2011 through FFY 2014 will be submitted in the third quarter report.

**Work Plan:** See attachment.

**Background Research****Milestone 1**

- Finalized a contract with the University of Kentucky (UK) to conduct background research of Kentucky's current insured and uninsured populations and insurance market.
- Timing: Signed and finalized in March 2011 with the first set of deliverables due in April.
- Description: Background research will include research and analysis on the insurance market and insured/un-insured populations; compilation of a dataset; economic and actuarial modeling to evaluate new policy options; and publish a written report(s) of UK's findings.

**Milestone2**

- First deliverables were reported to the CHFS on UK's initial findings of the insured and uninsured populations and insured market
- Timing: Reported to the CHFS in April 2011
- Description: The UK has provided the CHFS with initial data on: income and poverty rates by county; health insurance coverage of the nonelderly by county and by Medicaid Managed Care region; and a brief summary of health insurance coverage in the private sector findings.

**Milestone 3**

- Request for information (RFI) was mailed to Third Party Administrators (TPA) registered with the Kentucky Department of Insurance (DOI)
- Timing: March 2011
- Description: The purpose of the RFI was to obtain more information on employer sponsored, self funded health plans in Kentucky. The DOI expects to receive all input by May 1, 2011. All information will be reviewed and analyzed by DOI staff and shared with OHP staff and UK investigators. See attachment.

#### Milestone 4

- Begin actuarial and economic modeling based on findings provided by the UK and existing datasets
- Timing: April –August 2011
- Description: In coordination with UK, OHP will coordinate efforts with the Department of Insurance (DOI) to utilize current contracted actuaries to assist in the development of an actuarial and economic model that meets the specific needs of a Kentucky Health Benefit Exchange.

#### **Stakeholder Involvement**

##### Milestone 1

- Exchange round table meetings
- Timing: August and September 2010
- Description: Informal meetings were held with health insurers, agents, healthcare providers, employers and consumer advocacy groups regarding governance; organization; number and type of Exchanges; and participation within an Exchange.

##### Milestone 2

- Exchange stakeholder input
- Timing: April 2011
- Description: A letter has been prepared and will be mailed to health insurers, agents, healthcare providers, employers, consumer advocacy groups and associations soliciting input on several different aspects of operating an Exchange. A copy of the Stakeholder letter will be included in our third quarter report.

##### Milestone3

- Health Care Reform Website
- Timing: April 2011
- Description: The OHP in collaboration with IT staff developed and will launch a new website relating to health care reform in late April. The website allows for individuals who visit the site to be updated on health care reform in Kentucky and to sign up for additional information using the "govdelivery" system and submit comments to a specific email address monitored by OHP staff.

##### Milestone 4

- Kentucky Stakeholder Report
- Timing: June 2011
- Description: Begin drafting a written report, including all stakeholder involvement and comments.

## **Program Integration**

### Milestone 1

- Exchange IT coordination
- Timing: November 2010 and ongoing
- Description: IT staff worked with the Department for Medicaid Services and the Department for Community Based Services (DCBS) to document existing Medicaid Eligibility system capabilities and discuss modifications to comply with ACA. DMS contracts with DCBS to determine Medicaid eligibility in Kentucky's 120 counties. This collaboration with IT staff, DMS and DCBS will be ongoing.

### Milestone2

- Exchange web portal
- Timing: November 2010 and ongoing
- Description: Kentucky is planning for a web portal and has conducted reviews of other states with existing web portals to determine data needs for a Kentucky specific web portal.

### Milestone 3

- Vendor Presentations
- Timing: March 2011 and ongoing
- Description: IT staff, Medicaid Eligibility staff and OHP Exchange staff participated in five (5) vendor presentations from Msat Mahindra Satyam (March 2, 2011), Deloitte (March 2, 2011), CGI (March 14, 2011), HP (March 17, 2011) and ACS (April 6, 2011).

### Milestone 4

- Health Care Reform and Exchange collaborative meetings.
- Timing: December 2010 and ongoing
- Description: All CHFS representatives and contractors involved in implementation of the ACA meet monthly to update all on program timelines and coordinate any possible collaborative efforts on existing programs.

## **Resources & Capabilities**

### Milestone 1

- Exchange staff
- Timing: February 2011
- Description: Two (2) additional OHP staff members were hired in February to assist existing staff with Exchange planning and operation development.

Milestone 2

- Medicaid funding opportunity
- Timing: January 2011
- Description: Review and consider pursuing enhanced 90/10 funding to develop a new stand alone Medicaid eligibility system. Research necessary Cabinet administrative and budgetary procedures to obtain funds for the state match.

Milestone 3

- Add additional IT staff
- Timing: March 2011
- Description: Designate two (2) additional IT staff positions for work on specific issues and needs assessment for an Exchange. Staff will also collaborate with Medicaid eligibility systems and other public program staff operating within its current system.

Milestone 4

- Research and assess feasibility for releasing an RFP
- Timing: June 30, 2011
- Description: Begin development of an RFP for additional technology systems needs and the development of financial/administrative operations systems.

**Governance**Milestone 1

- Exchange governance structure
- Timing: December 2010
- Description: Conducted research on existing governance Exchange structures from other states and proposed governance Exchange structure for Kentucky based upon other states seeking enabling legislation.

Milestone 2

- Regional Exchange
- Timing: March 2011
- Description: Research and consider Regional Exchange option. The OHP with assistance from DOI are analyzing the commonalities in demographics, insurers and consumer protections between Kentucky and bordering states to determine the feasibility of a multi-state Exchange operation.

Milestone 3

- Governance analysis

- Timing: March 2011
- Description: The OHP is completing an analysis of options for establishing an Exchange Governing Board. This analysis will potentially be shared with interested parties to identify Kentucky's specific issues and needs.

#### Milestone 4

- Attending Utah Conference
- Timing: May 12 & 13, 2011
- Description: Collaboration with the state of Utah and meet with other state representatives on Exchange issues and governance. Preliminary Agenda topics include:

The Utah Approach to Health System Reform

Underlying Insurance Market Updates:

- Solutions for Small Business: Creating a Defined Contribution Market
- Solutions for the Utah Individual Market

Understanding the Utah Health Exchange

- Meet with Our Private Partners
- Participation of Insurance Carriers
- Technological Considerations
- Governance Issues
- Plans for Future Development

Exploring Multi-State Partnerships & Cooperation

#### **Finance**

##### Milestone 1

- Exchange budget
- Timing: March 2011 and ongoing
- Description: Develop a preliminary Exchange budget for FFY 2011 thru FFY 2014.

##### Milestone 2

- Exchange Finance
- Timing: March 2011 and ongoing
- Description: Identify accounting and financial resources necessary to operate an Exchange.

Milestone 3

- IT Gap Analysis and systems assessment
- Timing: March 2011 and ongoing
- Description: Review IT Gap Analysis report and determine systems costs for the development and maintenance for both the Medicaid eligibility system and Exchange. Identify the cost allocation for both systems.

Milestone 4

- Develop Exchange operation plan
- Timing: March to December 2011
- Description: Develop an operation plan to ensure adequate resources are available to support required accounting and financial reporting systems. Review system needs and costs of utilizing an outside vendor to address system interfaces, development and maintenance.

**Technical Infrastructure**Milestone 1

- Exchange IT gap analysis
- Timing: October through December 2010
- Description: Initiated analysis and IT gap assessment of the Kentucky Automated Management and Eligibility System (KAMES), Supplemental Nutrition Assistance Program (SNAP) and Income Maintenance Programs integration readiness for exchange functionalities.

Milestone 2

- Exchange IT gap analysis report
- Timing: March 31, 2011
- Description: Completed IT gap analysis and draft written report identifying IT modifications, technical architecture, systems standards, and integration framework required to conform to CMS and CCIIO guidance of 2010 concerning, "Exchange and Medicaid Information Technology Systems".

Milestone 3

- Medicaid Eligibility and Exchange System integration
- Timing: March and ongoing
- Description: Review desired operating system of both systems that meets the federal requirements of the "no wrong door" approach, which provides the user with a seamless "front door" experience regardless of whether they are Medicaid eligible or provided the choice of a qualified health plan.

Milestone 4

- Assess the feasibility of using an approach under development by an Early Innovator State Grantee
- Timing: March 2011 and ongoing
- Description: Research and study the different strategies being used by the Early Innovator grantees to arrive at a technology solution to support Medicaid eligibility and enrollment and/or enrollment in State Exchange services; assess feasibility for use in Kentucky.

**Business Operations**Milestone 1

- Exchange operational functions
- Timing: April 2011
- Description: Identify the operational functions of an Exchange.

Milestone 2

- Exchange administrative functions
- Timing: April 2011
- Description: Begin plans for identifying the administrative functions.

Milestone 3

- Determine preliminary business requirements and develop an IT architectural and integration framework
- Timing: April 2011-June 30, 2011 (Preliminary requirements & high-level IT framework)
- Description: Identify business requirements and the high-level technical infrastructure required to support business processes as the 2<sup>nd</sup> stage of the IT gap analysis and in preparation for future release of an APD for Medicaid 90/10 funding and RFP for a systems development vendor and for preparation of a Systems Development Life Cycle implementation plan and budget for a Stage 1 CCIIO Establishment Grant for submission to CMS in June 2011.

Milestone 4

- Navigator White paper for NAIC
- Timing: March 2011
- Description: Our collaborative partners at the DOI worked with Utah and Pennsylvania to draft a white paper regarding Navigators for the NAIC. Currently, the draft document is being circulated for review and comments. See attachment.

## Regulatory or Policy Actions

### Milestone 1

- Enabling legislation from other states
- Timing: February 2011 and ongoing
- Description: Review and analyze enabling legislation (proposed and enacted) from other states.

### Milestone 2

- Statutory and Administrative Actions
- Timing: February 2011
- Description: Identify key provisions for enabling legislation and/or other administrative methods to establish an Exchange.

### Milestone 3

- Identify state flexibility and future policy decisions
- Timing: June 2011
- Description: Kentucky is awaiting additional guidance and future policy decisions in the following areas:
  - Governance/Funding
  - Adverse Selection/Risk Adjustment
  - Other State Programs Impacted
  - SHOP Exchange
  - Exchange health plan certification
  - Consumer Assistance
  - Marketing and Outreach

### Milestone 4

- Apply for Level One Establishment Grant
- Timing: June 30, 2011
- Description: Kentucky filed a Letter of Intent on February 22, 2011, with HHS, indicating that Kentucky plans to pursue a Level One Establishment grant to continue the planning and feasibility of establishing a state operated Exchange.

## Collaborations/Partnerships

**Name of Partner:** Kentucky Department of Insurance

**Organization Type of Partner:** The DOI is a division of the Kentucky Public Protection Cabinet with regulatory authority over Kentucky's insurance market, licensed agents, and other insurance professionals. The DOI also monitors the financial condition of companies, educates consumers to make wise choices and ensures that Kentuckians are treated fairly in the marketplace

**Role of Partnership in Establishing Insurance Exchange:** Collaboration on background research and stakeholder input in addition to identifying key issues in the areas of: defining policy goals; reviewing governance; operation of one Exchange or two separate Exchanges for individual and small employer groups; development of a Basic Health Benefits Plan.

**Accomplishments of Partnerships:** Identification of key issues and processes, weekly meetings are held with DOI to discuss Exchange planning and progress.

**Barriers/Challenges of Partnership:** None identified at this time.

**Name of Partner:** University of Kentucky College of Public Health, Department of Health Services Management

**Organization Type of Partner:** State University

**Role of Partner in Establishing Insurance Exchange:** The CHFS has entered into a Memorandum of Agreement with the UK to conduct background research on the insured market and un-insured, and complete economic modeling on policy options.

**Accomplishments of Partnership:** OHP and DOI expect to meet with primary investigators on initial findings at the end of this month.

**Barriers/Challenges of Partnership:** None identified at this time.

**Name of Partner:** Kentucky Department for Medicaid Services (DMS)

**Organization Type of Partner:** The Department for Medicaid Services (DMS) is a program agency of the CHFS, which purchases quality healthcare and related services that produce positive outcomes for persons eligible for programs administered by the department. The DMS also administers the Child Health Insurance Program in this state, will administer/oversee expansion of Medicaid eligibility in January 2014, and is in the process of implementing the KY Health Information Exchange project.

**Role of Partner in Establishing Insurance Exchange:** Collaboration on expansion of Medicaid eligibility issues, interface with information technology (IT) systems, and development of a "no wrong door" approach to the purchasing of health insurance in Kentucky.

**Accomplishments of Partnership:** Identification of key issues and eligibility interface processes, weekly meetings are held with DMS to discuss Exchange planning and progress.

**Barriers/Challenges of Partnership:** None identified at this time.

**Work Plan:**

<b>Work plan by Key Objectives and Milestones to Implement ACA in Kentucky</b>
<b>2011</b>
<b>Key Objectives</b>
Begin planning process and identify issues associated with an exchange
Solicit stakeholder input on governance, business operations, organization and functions
Collect background research on current Kentucky insurance market and un-insured
Review summary of benefits and coverage explanations from HHS
Assess operational relationship and interface between Medicaid and Exchange
Determine impact of an Exchange on the current insurance market
Determine operational Structure of Exchange
Assess operating one Exchange for individual and small group markets or separate Exchanges both
Assess eligibility determination issues under the ACA for exchange, KCHIP, Medicaid and other existing state programs
<b>Milestones</b>
<p><b>Background Research:</b> Procurement of background research contract.  <b>January – June 30, 2011</b>  <b>Description:</b> The University of Kentucky College of Public Health, Department of Health Services Management will conduct background research on the insured market and un-insured, and complete economic modeling for policy options.</p>
<p><b>Stakeholder Input:</b>  <b>January, February, March &amp; April 2011</b>  <b>Description:</b> Solicit additional stakeholder input on exchange issues such as: governance, operations, systems interface, and transitioning of existing programs.</p>
<p><b>Program Integration:</b> Exchange IT Systems  <b>November 2010 – February 2011</b>  <b>Description:</b> Agency Collaboration (DMS and DCBS) with IT in documenting Medicaid eligibility system capabilities and determination of future modifications for ACA. Planning for web portal.</p>
<p><b>Resources &amp; Capabilities:</b>  <b>2/1/11 to 9/30/2011</b>  <b>Description:</b> Provide staff support to existing staff with hiring two (2) additional positions. A candidate has been recommended for both positions and we are awaiting final approval from our Personnel Cabinet with a proposed start date of February 16, 2011.</p>
<p><b>Governance</b>  <b>4/1/2011 to 9/30/2011</b>  <b>Description:</b> Review options to organize a state-based exchange, join a multi-state or regional exchange, or cede functions to Federal exchange.</p>
<p><b>Finance</b>  <b>3/1/2011 to 9/30/2011</b>  <b>Description:</b> Kentucky will begin to identify the necessary accounting and financial resources to operate an exchange.</p>
<p><b>Technical Infrastructure:</b>  <b>10/1/2011 to 9/30/2011</b>  <b>Description:</b> Initiate IT gap analysis to critically evaluate the state of readiness to implement Exchange IT functionalities. The analysis includes an assessment of the “as is” environment of the Kentucky Automated Management and Eligibility System (KAMES), an integrated system that supports eligibility and enrollment processes for the Medicaid and CHIP programs as well as the SNAP and Income Maintenance Programs. The analysis and written summary will be completed by March 15, 2010.</p>

**Work Plan:**

<p><b>Technical Infrastructure Continued:</b>  <b>10/1/2011 to 9/30/2011</b>                  It will identify the desired “to be” environment, including the technical architecture, systems standards, and integration framework required to conform to the framework and approach specified in the OCIO and CMS November 2010 joint guidance for exchange and Medicaid information technology systems.</p>
<p><b>Business Operations</b>  <b>3/1/2011 to 9/30/2011</b>  <b>Description:</b> Kentucky will begin reviewing necessary administrative, operation, and financial functions to operate an exchange.</p>
<p><b>Regulatory or Policy Actions</b>  <b>9/30/2010 to 9/30/2011</b>  <b>Description:</b> Kentucky is currently reviewing options regarding enabling legislation or other administrative methods to establish an Exchange, and is researching proposed legislation in other states.</p>
<b>2012</b>
<b>Key Objectives</b>
Continue implementation efforts through Implementation Planning grant
Develop sustainability model for an Exchange
Continue assessing the insurance market
Continue to assess the IT systems for the creation of seamless system
Continue efforts to determine how Medicaid and the Exchange will coordinate on eligibility, complying with the “no wrong door” approach
Develop system for a call center or hot line
Define role of agents
Research funding options for navigator program
Develop Risk Adjustment process
Develop financial systems
Continued consideration for implementation activities provided by CCIIO/CMS
<b>Milestones</b>
Complete IT systems analysis and report for the State Planning and Implementation grant which will identify necessary systems changes and determine the need of a vendor or development of a new system in-house.
<b>2013</b>
<b>Key Objectives</b>
Conduct ongoing financial analysis of impact of current state program expansion
Monitor market trends to assure that proposed model will meet potential needs
Develop prototype
Continued consideration for implementation activities provided by OCIO/CMS
Monitor business operation to ensure fully sustainable by 2015
Obtain funding for navigator program
Assess adequacy of accounting and financial reporting system

**Work Plan:**

<b>2013</b>
<b>Key Objectives</b>
Determine adequacy of data security and back-up systems
Develop detailed testing plan
Outreach and marketing plan for exchange
Secure electronic interface between all state programs
Ensure enrollment systems meet federal specifications
<b>Milestones</b>
In late 2013 begin extensive testing of prototype
Web portal fully functional
Call center fully functional
<b>2014</b>
<b>Key Objectives</b>
Fully operational and self sustaining Health Benefit Exchange
<b>Milestones</b>
Seamless system that determines Medicaid eligibility and Exchange functions

STEVEN L. BESHEAR  
GOVERNOR



ROBERT D. VANCE  
SECRETARY

SHARON P. CLARK  
COMMISSIONER

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«LtrDate»

«ContactName»  
«AddrName»  
«AddrLine1»  
«AddrLine2»  
«AddrLine3»  
«AddrCity», «AddrState» «AddrZip»

Re: Request for Data

Dear «ContactName»:

This letter is being sent to all third party administrators licensed to do business in the state of Kentucky in order to collect data regarding the self insured market as required by KRS 304.32-320. This important information about group health plans providing self insured hospital or surgical benefits is needed in order for the Kentucky Department of Insurance (department) to more fully understand the existing insured/self insured marketplace in Kentucky.

For reference, according to 45 CFR 146.145(a) a Group health plan is "an employee welfare benefit plan to the extent that the plan provides medical care to employees or their dependents." Do not include information relating to workers compensation.

Visit the department's website at [www.doi.com](http://www.doi.com) to download a template of the spreadsheet for your response. Instructions for completing the spreadsheet are attached for your reference.

Responses must be sent electronically in a Microsoft Excel spreadsheet, either via electronic mail to [voin.barker@ky.gov](mailto:voin.barker@ky.gov) or by a CD mailed to the Kentucky Department of Insurance, Attn: Voin Barker II, 215 West Main Street, Frankfort, KY 40601. Your completed response is due to the department by March 31, 2011.

Should you have any questions relating to this request, please contact Jill Mitchell or myself by calling 502-564-6088.

Sincerely,

A handwritten signature in black ink, appearing to read "W. J. Nold". The signature is fluid and cursive, with the first letters of the first and last names being capitalized and prominent.

William J. Nold,  
Director  
Health and Life Division  
Kentucky Department of Insurance

## Instructions for the Submission of the TPA Report

The Third Party Administrator Report consists of two Excel spreadsheets. A downloadable template of the report is located on the Kentucky Department of Insurance's website at the following link -----(add Link)----- . The completed reports must be sent electronically in a Microsoft Excel spreadsheet. This can either be email to [Voin.Barker@ky.gov](mailto:Voin.Barker@ky.gov), or it can be copied to a CD and mailed to the Kentucky Department of Insurance, Attn: Voin Barker II, 215 W. Main Street, Frankfort, KY 40601.

The report must include both:

1. Sheet One labeled - TPA Identification Information- This sheet collects general information on the TPA. Please see below for valid values.

	Column A		Column B
Row/ Column	Field Description	Row/ Column	Valid Values
1/A	Name of TPA	1/B	Alpha-numeric
2/A	Reporting Year	2/B	Must be Numeric,
3/A	First Line of mailing address	3/B	Alpha-numeric
4/A	Second Line of mailing address	4/B	Alpha-numeric
5/A	City	5/B	Alpha-numeric
6/A	State	6/B	Must be 2 digits alphabetic
7/A	Zip Code	7/B	Must be 5 or 9 digits numeric (do not include dashes, etc.)
8/A	State of Domicile	8/B	Must be 2 digits alphabetic
9/A	Contact Name	9/B	Alpha-numeric
10/A	Contact Phone	10/B	Must be Numeric (do not include dashes, etc.)
11/A	Contact E-mail	11/B	Alpha-numeric
12/A	Does this TPA administer a Group health plan that provides hospital or surgical benefits (Do not include workers compensation plans)	12/B	Must be expressed using a Y=Yes or N=No

2. Sheet Two labeled - Contracted Employers- This sheet collects information pertaining to each employer contracted with the reporting TPA. The department is looking for a snapshot of covered employees as of December 31, 2010. Please see below for valid values.

<b>Row/ Column</b>	<b>Field Description</b>	<b>Valid Values</b>
<b>2-11/B</b>	<b>Name of Contracted Employer</b>	Alpha-numeric
<b>2-11/C</b>	<b>Plan type (Employer, Union, Governmental, or Church)</b>	Must be expressed using the examples given: Employer, Union, Governmental, or Church
<b>2-11/D</b>	<b>First Line of Employer's mailing address</b>	Alpha-numeric
<b>2-11/E</b>	<b>Second Line of Employer's mailing address</b>	Alpha-numeric
<b>2-11/F</b>	<b>City</b>	Alpha-numeric
<b>2-11/G</b>	<b>State</b>	Must be 2 digits alphabetic
<b>2-11/H</b>	<b>Zip Code</b>	Must be 5 or 9 digits numeric (do not include dashes, etc.)
<b>2-11/I</b>	<b>Total Number of Employees (Including Part-time employees)</b>	Must be Numeric.
<b>2-11/J</b>	<b>Total Number of Eligible Employees</b>	Must be Numeric.
<b>2-11/K</b>	<b>Total Number of Enrolled Employees</b>	Must be Numeric.
<b>2-11/L</b>	<b>Total Covered Lives (Enrollees &amp; Dependents)</b>	Must be Numeric. Total covered lives includes enrollees and dependents

# **The Comparative Roles of Navigators and Producers In an Exchange What are the Issues?**

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*The purpose of this document is to identify and discuss issues surrounding the traditional role of Producers<sup>1</sup> in the solicitation, sale, negotiation and servicing of health insurance in the individual and small group markets as compared to the expected role of Navigators<sup>2</sup> established by the Affordable Care Act (ACA)<sup>3</sup> to perform certain duties within these markets for Qualified Health Plans<sup>4</sup> offered through an Exchange<sup>5</sup>.*

## **Introduction and Background Regarding**

### **Navigators and Producers**

In order to appreciate the comparative roles of these distinct entities and how they must cooperate in the successful implementation of the Exchange, some independent background information will be presented describing the current role of Producers in the health insurance marketplace and the expected role of Navigators. While the ACA provides some information about Navigators, additional insight is expected from regulations to be promulgated by the Secretary of the U.S. Department of Health and Human Services (“Secretary”). Note the following regarding Navigators and Producers and the important role each must play in the success of the Exchange:

#### **Navigators**

In accordance with the ACA, an Exchange must establish a program under which it awards grants to entities called Navigators to perform the following duties:

1. Conduct public education activities to raise awareness of the availability of Qualified Health Plans;
2. Distribute fair and impartial information concerning enrollment in Qualified Health Plans, and the availability of premium tax credits and cost-sharing reductions in accordance with federal tax laws;

3. Facilitate enrollment in Qualified Health Plans;
4. Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman, or any other appropriate state agency or agencies, for any enrollee with a grievance, complaint, or question regarding their health plan, coverage, or a determination under such plan or coverage; and
5. Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange.

Navigators may include trade, industry, and professional associations, commercial fishing industry organizations, ranching and farming organizations, community and consumer-focused nonprofit groups, chambers of commerce, unions, resource partners of the Small Business Administration (SBA)<sup>6</sup>, other licensed insurance agents and brokers, and other entities that are capable of carrying out the required duties<sup>7</sup>, meet the standards established by the Secretary and provide information that is fair, accurate, and impartial.

To be eligible to receive a grant from the Exchange, an entity must demonstrate to the Exchange involved that the entity has existing relationships, or could readily establish relationships, with employers and employees, consumers (including uninsured and underinsured consumers), or self-employed individuals likely to be qualified to enroll in a Qualified Health Plan. Grants must be made from the operational funds of the Exchange and not federal funds received by the state to establish the Exchange.

The Secretary must establish standards for Navigators including provisions to ensure that any private or public entity that is selected as a Navigator is qualified, and licensed, if appropriate, to engage in the Navigator activities described and to avoid conflicts of interest. Under these standards, a Navigator shall not be a health insurance issuer<sup>8</sup> or receive any consideration directly or indirectly from any health insurance issuer in connection with the enrollment of any qualified individuals or employees of a qualified employer in a Qualified Health Plan.

The Secretary, in collaboration with states, must also develop standards to ensure that information made available by Navigators is fair, accurate, and impartial. (See ACA §1311(i)(5), 42 USCS §18031(i)(5))

Furthermore, in accordance with the ACA a Qualified Health Plan means, among other things, a plan offered by a health insurance issuer that agrees to charge the same premium rate for each Qualified Health Plan it offers without regard to whether the plan is offered through an Exchange or whether the plan is offered directly from the issuer or through an agent. (See ACA § 1301(a)(1)(C)(iii), 42 USC §18021(a)(1)(C)(iii))

## **Producers**

States have been regulating the activities of Producers for decades. Thus, substantial background information is available to describe the importance of the role Producers play in the procurement of health insurance. However, a full discussion is beyond the scope of this document. In summary, Producers are universally regulated by the various states and territories. Typically, a Producer is an individual or business entity appointed by a health insurance issuer to sell, solicit, or negotiate insurance contracts on its behalf. The term “producer” is used in many states to include both agents and brokers. A broker negotiates the purchase of insurance on behalf of the consumer (individual or business entity) rather than the health insurance issuer.

Producers are representatives of the health insurance issuer and are subject to terms of the contract or written agreement between themselves and the health insurance issuers they represent. In the conduct of their business as an agent, the Producer essentially stands in the shoes of the health insurance issuer and regulators may hold their health insurance issuer liable for the errors or misconduct of the appointed Producer. Producers are subject to strict rules in the state in which they operate. Producers must be licensed, must meet various educational requirements, including continuing education requirements, are accountable for their actions, and must demonstrate financial responsibility. These state requirements function to assure competency and professionalism, and also serve to provide a mechanism protecting consumers by license suspensions and revocations where violations of the law are found.

## **Producers Will Play a Crucial Role in the Success or Failure of an Exchange**

In looking at the historical background of Producers in the health insurance marketplace and issues surrounding the establishment of a Navigator program under the ACA, it is clear that

determining the future role of Producers is a vital part of the implementation process for the Exchanges. States must consider not only what role Producers will play in the start-up and day to day operations of an Exchange but how Producers will interact with the Navigators. There are many issues in this regard, but experience has shown that all issues must be considered with the firm belief that Producers are crucial players in the success or failure of an Exchange. Producers have a significant relationship of trust with the individuals covered by the small employer insurance market. There are also segments of the individual market that are better reached and represented by Producers rather than consumer and industry groups. Producers who are accountable and trained on the functions of the Exchange and the products and services available can increase public awareness of the Exchange and increase consumer traffic to the Exchange websites. Also, consumers who are directed to the Exchanges will need education and assistance to determine which products best suit their needs and affordability standards. Producers can assist with these matters. Lastly, an Exchange that uses the already established system of Producers to market, advertise and assist with the Exchanges can save on costly overhead and administrative expenses.

## **Issues**

Having presented independent information about Producers and Navigators and the crucial role they will play in the success of an Exchange, a number of substantial issues have been identified concerning how these entities will interact in an Exchange. Again, this interaction will be further fleshed out in regulations promulgated by the Secretary.

### **1. Will the regulations promulgated by the Secretary establish a ceiling of standards or will states have flexibility with regard to the oversight and role of Producers and Navigators in their Exchange?**

While most states have adopted uniform laws concerning the regulation of Producers, the states currently retain flexibility to adapt to the specifics of their markets. The ACA requires that an Exchange “shall establish a program under which it awards grants to [Navigator entities].” Further, the ACA states that an entity seeking to receive a Navigator grant “shall demonstrate to the Exchange” its relationships or ability to establish relationships needed to perform the duties

of a Navigator. Both of these provisions suggest that the states, through their Exchanges, will also have flexibility vis-à-vis Navigators.

The ACA also directs that the Secretary “shall establish standards for Navigators”, and contemplates that those standards will address such factors as qualifications, licensure, and the avoidance of conflicts of interest. How the Secretary presents these standards may dictate whether they are a floor or a ceiling. However, the nature of the eligibility criteria in ACA §1311(i)(2), 42 USC §18031(i)(2), suggest that eligibility will depend on factors that require qualitative evaluation of “existing relationships.” In addition, the ACA suggests a wide range of entities that might qualify as Navigators. Those entities may differ substantially from state to state, and even within a state. For example, a commercial fishing industry organization in Massachusetts may be far more equipped to perform Navigator activities than one in Kansas, and a professional counseling association may be far more equipped to serve as Navigators than a professional hairdressers’ association. Therefore, it is suggested that the Secretary’s standards should substantially defer to a state’s Exchange to make qualitative evaluations.

Finally, the standard preemption provision of the Public Health Service Act (PHSA) is adopted into the Exchange provisions of the ACA. Accordingly, the state Exchange may not have rules that “prevent the application” of the federal law or regulations, see ACA§1311(k), 42 USC § 18031(k). In the context of the PHSA, this standard approach has been interpreted to mean that the federal law is a floor. In sum, the language of the ACA suggests that the Secretary’s regulations, when drafted, will operate as a floor, rather than a ceiling.

## **2. Should the states license or certify Navigators?**

The Navigator provision in the ACA does not negate or preempt state laws requiring producers to be licensed to sell, solicit, or negotiate insurance. On the other hand, the ACA does state that the “Secretary shall establish standards for Navigators ... including provisions to ensure [that a Navigator] is licensed if appropriate.” Again, how prescriptive the proposed regulations will be shall significantly impact this question. However, since states each have licensing and certification provisions which depend on the particular characterizations of the states, states flexibility is essential so that states may enforce their existing licensure laws.

States may also have a variety of certification or licensure arrangements for community partners or others with a consumer assistance orientation<sup>9</sup>. To assure consistency with those already existing state laws, the states should be permitted to require parallel competency requirements for Navigators that include educational and continuing education requirements.

This may be similar to the flexibility shown in the Long Term Care Partnership provisions of the Deficit Reduction Act of 2005, where the state insurance department is tasked with assuring sufficient training and understanding on the part of individuals selling partnership policies so that the state Medicaid agency may be satisfied of the seller's competence. In the same way, the Secretary will be looking for a certain level of competency in Navigators, and may be anticipated to rely on the state or the state's Exchange to assure that competency.

### **3. Who will establish educational and continuing education requirements for Navigators?**

As noted above, to the extent Navigators are selling, soliciting, or negotiating insurance, they should be subject to the laws of the jurisdiction in which they are operating. To do otherwise would be to allow persons or entities to avoid licensure requirements by using the term "Navigator," thus undercutting the states' regulation of the insurance marketplace for the protection of the consumer.

Moreover, because the Exchanges in the various states will operate differently, and will operate in jurisdictions with different Producer and Navigator roles, it is expected that there will need to be some variation in the education requirements, though perhaps with a set floor (as in the Long Term Care Partnership provisions of the Deficit Reduction Act of 2005).

### **4. How will Navigators be held accountable for errors? Will they be required to have Errors and Omissions coverage as do Producers?**

Producers are required, as licensed professionals, to carry errors and omissions insurance coverage. To provide a safety net for the consumers, the same should hold true for Navigators. If Navigators are not required to be licensed or certified, there will be no mechanism for an errors and omissions coverage requirement. Yet, depending on the scope of a Navigator's role in assisting consumers in getting the coverage that is most appropriate for them, and then assisting

them further in claims resolution matters, a consumer who is harmed by a Navigator's error or omission should have some recourse.

**5. What is meant by “facilitate enrollment”? How will the Navigator be involved with Medicaid and other public programs? What will Navigators need to know?**

Navigators and Producers must have a thorough knowledge of the Exchange marketplace. They should understand the private insurance market and public programs. Similar to the health insurance advisory service program established in 42 USCS 1395b-3 (for Medicare-eligible individuals), Navigators may facilitate enrollment by providing information, counseling, and assistance to individuals with respect to:

- The private insurance market:
  - eligibility;
  - benefits (both covered and non covered);
  - the process of payment for services;
  - rights and process for appeals of determinations; and
- Public programs:
  - eligibility, benefits, and the application process;
  - linkages between the Exchange, tax credits and Medicaid programs; and
  - State and local agencies involved in the Medicaid program.

Navigators can be especially helpful in underserved populations by partnering with community-based organizations that have experience working with the uninsured, populations with language barriers and other under-served communities.

On the other hand, the ACA, in describing the duties of a Navigator, consistently makes reference to Qualified Health Plans to the exclusion of public plans or programs. Therefore, it unclear that Navigators are expected to facilitate enrollment in public plans or programs.

**6. Will HIPAA and GLBA apply to Navigators? How?**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the various privacy regulations promulgated there under generally apply to three “covered entities”: (1)

health care providers, (2) health care clearinghouses, and (3) health plans. Since Producers act on behalf of health insurance issuers and health plans, some health insurance issuers consider Producers to be “Business Associates” and require them to sign confidentially agreements to safeguard protected health information (PHI) and specify how the Producer may use or disclose PHI.

The Gramm-Leach-Bliley Act (GLBA) requires financial institutions, which includes health insurance issuers, to safeguard a customer’s personal information, provide notice to consumers regarding the company’s information-sharing practices, and provide an opportunity for the customer to “opt-out” if the customer does not want personal information to be shared outside of the company (or its affiliates). Additionally, GLBA created a mechanism for federal oversight, the National Association of Registered Agents and Brokers, that preempts state law and will regulate Producer licensing unless a majority of the states implement and maintain uniformity and reciprocity standards for Producer licensing.

In response to these federal laws, the NAIC adopted model laws and regulations related to producer licensing, the privacy of consumer financial and health information, and safeguarding consumer information. The majority of states have enacted these models. Therefore, if Navigators become licensees of the various departments of insurance, Navigators will be required to comply with state laws and regulations designed to implement the various provisions of GLBA and HIPAA. If Navigators are not regulated by state departments of insurance, then these entities may not have the knowledge or tools to safeguard consumer information to the same extent as Producers. The Secretary and the states should consider the information that Navigators may have in their possession and how personal information (including PHI) will be safeguarded.

## **7. How do you identify, reach out, and oversee non-insurance industry partners acting as Navigators?**

The ACA requires that an entity serving as a Navigator demonstrate to the Exchange that they have existing relationships or could readily establish relationships with employees, employers, and consumers that are qualified to enroll in a Qualified Health Plan. Further guidance is needed

to determine what will constitute sufficient representation of the various areas in the community needing representation within an Exchange. Will Exchanges require a certain level of need for representation in specific areas to merit a grant to specialized entities (i.e. fishing industry, ranching industry, etc)? For example, a commercial fishing industry organization in Massachusetts may be far more equipped to perform Navigator activities than one in Kansas, and a professional counseling association may be far more equipped to serve as Navigators than a professional hairdressers association. Also, what type of documentation will be required to demonstrate relationships or ability to form relationships with individuals in the community in order to be qualified as a Navigator?

Exchanges will need to establish a certification program for all Navigators (that does not vary by industry) to assure that each Navigator has sufficient basic knowledge of the Exchange to assist and educate their consumers.

As state departments of insurance will not necessarily have regulatory authority over Navigators, Exchanges should also consider a complaint process for consumers who are dissatisfied with the performance of a Navigator. This process should take into account the varied types of “community partners” that could serve as a Navigator. The process should include consideration whether certification may be withdrawn as needed.

It would appear that, in the absence of oversight by the commissioner of insurance, the Exchange governing board must be given authority under the enabling legislation to promulgate regulations to oversee the functions of Navigators.

## **8. What funding source may Exchanges use for Navigator programs?**

The ACA requires an Exchange to contract with, and finance, Navigators. Additionally, a Navigator may not receive any direct or indirect compensation from a health insurance issuer. An Exchange may charge a separate fee to compensate the Navigator. Regardless of the group size, plan design or health insurance issuer chosen by the consumer, compensation should not vary. A transparent compensation model that provides a market competitive payment to a Producer or Navigator will best serve consumers.

Proper disclosure will also be necessary to address the inherent conflict in the funding of Navigators that exists in the ACA. Specifically, while Navigators are to be funded “out of the operational funds of the Exchange”, ACA §1311(i)(6), 42 U.S.C. §13031(i)(6), the ACA also contemplates that the Exchange will “charge assessments or user fees to participating health insurance issuers, or ... otherwise generate funding, to support its operations.” ACA §1311(d)(5)(A), 42 U.S.C. §13031(d)(5)(A). Thus, it is quite likely that health insurance issuers will be funding the operations of the Exchange, including the operational funds used for funding Navigators.

### **9. May Producers serve as Navigators? How will commissions be paid?**

The ACA provisions relating to Medical Loss Ratio requirements and relating to the role of Navigators in the Exchange demonstrate that one concern behind this legislation is the question of who Producers truly work for and the value that they bring for the consumer. The marketplace is moving towards a structure that would allow compensation of Producers by employers in lieu of carriers. Discussions with the Secretary would indicate that this is a route with which the Secretary would concur. States should anticipate that Producers will continue to serve a vital role in the industry, although it is expected that the nature of their services will evolve.

States will want to look closely at the ways to make allowances for Producers in the future marketplace. Some states have statutory schemes in place that would prevent a Producer from being compensated by an employer. Statutory analysis may be needed to determine if legislation should be pursued to allow new compensation schemes. This may include setting parameters for Producers to place business within an Exchange and receive some kind of compensation for that service. Or it may include allowing Producers that are not receiving compensation from health insurance issuers to function as Navigators.

There are special considerations for Producers in the small group market. Producers form a working relationship with client employer groups, with the employer often utilizing the Producer as an expert. If a Producer is working with a small employer group that decides to send their employees to the Exchange to purchase coverage, how can the Producer continue to assist the

employer and their employees obtain coverage? In this instance, the Producer (as opposed to a Navigator) may be the individual with the best relationship and tie to these individuals.

States should examine the goals of the Navigator program and determine if Producers are suited to this function or if it would be more advisable to limit Producers to a role in enrolling individuals in Qualified Health Plans. Exchanges would have to consider how a Producer might interface with Medicaid or CHIP programs. Also, Producers may not have the necessary knowledge to assist with subsidy issues.

If a state determines that Navigators should “facilitate” enrollment in the Exchange and Producers may be used to complete enrollment within Qualified Health Plans, how will the Exchange ensure that Navigators aren’t using preferential treatment in which Producer they refer people to? What if Producers are paying “commission” to Navigators?

Regardless of the exact role of the Producer within the Exchange (Navigator or Producer), Producers will not have the necessary knowledge to fully utilize the system without additional training. States may want to look to the educational requirements of the Long Term Care Partnership provisions of the Deficit Reduction Act of 2005 for ideas about the design of the required education for Producers with regard to Exchanges. Under the Deficit Reduction Act of 2005, the state insurance department is tasked with assuring sufficient training and understanding on the part of individuals selling partnership policies so that the state Medicaid agency may be satisfied of the seller’s competence. In the same way, the Secretary will be looking for a certain level of competency in Navigators, and it may be anticipated that the Secretary will rely on the state or the state’s Exchange to assure that competency. It is advisable to set a “floor” of core competencies required by Producers who are involved with the Exchange and allow individual states to determine further educational requirements as needed based on the individual needs of their consumers. Notwithstanding the roles to be played by Navigators or Producers, state Medicaid departments and the state agency that oversees public programs will ultimately be responsible to make enrollment/entitlement determinations.

## **10. Ethical issues for producers who wish to serve as Navigators**

The ACA requires that Navigators avoid conflicts of interest and provide fair and impartial information concerning enrollment in Qualified Health Plans. An Exchange must consider if

there is an inherent conflict of interest if Producers desire to function as Navigators for the Exchange. Exchanges will need to set criteria or must seek guidance from the Secretary as to what level of health insurance issuer related activity constitutes a conflict of interest. For example, does a conflict exist if a producer: Is currently receiving commissions on unrelated blocks of business? (Is this indirect compensation?) Receiving commission with regard to large group products that cannot be offered through the Exchange? Would Producers that had a prior relationship with a carrier but are no longer functioning as a Producer in the fully insured market be considered to have a conflict of interest? What about Producers that work in the self-funded marketplace and therefore are not receiving any commission from a carrier?

### Conclusion

There are many interrelated issues that must be addressed to assure that the professional competencies of Producers, as well as the educational assistance function of Navigators, may benefit the consumers of the Exchange. By presenting the background and information above, this paper may assist states in considering how best to structure their Exchanges with regard to Producers and Navigators.

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<sup>1</sup> States differ in licensure terminology. For purposes of this document, unless otherwise stated, “Producer” shall include Agent, Broker, Consultant, Insurance Producer, and any other term or designation currently used to refer to those individuals or entities that are required to be licensed by the state to be engaged in the solicitation, sale, negotiation and servicing of insurance, regardless of whom they represent.

<sup>2</sup> For the purposes of this document, “Navigators” refers to entities carrying out the program established under ACA §1311(i), 42 USC § 18031(i)

<sup>3</sup> On March 23, 2010, the President signed into law the Patient Protection and Affordable Care Act. Then, on March 30, 2010, the Health Care and Education Reconciliation Act of 2010 was signed into law. The two laws are collectively referred to in this document as the Affordable Care Act (“ACA”)

<sup>4</sup> A “Qualified Health Plan” is defined at ACA §1311(c), 42 USC §18021(a). The Secretary must promulgate regulations to establish the criteria for certification of health plans offered through the Exchange. See 42 USC §18031(c).

<sup>5</sup> For the purposes of this document, “Exchange” refers to the American Health Benefit Exchanges as described in ACA §1311(b), 42 USC § 18031 (b)

<sup>6</sup> The SBA provides small business counseling and training through a variety of programs and resource partners, located strategically around the country. One example is the Office of Small Business Development Centers (SBDC) which provides management assistance to current and prospective small business owners. SBDCs offer one-stop assistance to individuals and small businesses by providing a wide variety of information and guidance in central and easily accessible branch locations. The program is a cooperative effort of the private sector, the

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educational community and federal, state and local governments and is an integral component of Entrepreneurial Development's network of training and counseling services.

- <sup>7</sup> Although not specifically mentioned in the ACA, community partners that assist in the SCHIP programs of various states have been suggested as performing parallel functions to those duties performed by a Navigator.
- <sup>8</sup> ACA uses the term "health insurance issuer" to describe a health insurer or health insurance company. For purposes of this document, health insurance issuer is an entity licensed by the state or territory that is engaged as principal and as indemnitor, surety, or contractor in the business of entering into contracts of health insurance.
- <sup>9</sup> Community partners may be community-based agencies, organizations, coalitions, hospitals, church groups, guidance counselors, school nurses, health care providers, and other groups or individuals that wish to help an interested person learn about or receive some service or benefit. Typically their work focuses on outreach and education, but may also include providing assistance in completing applications for those services or benefits. Community partners are not licensed, and therefore are not permitted to sell, solicit, or negotiate contracts of insurance. While community partners may be subject to some form of state approval, this approval typically functions as a means to access electronic application systems, rather than as regulatory oversight.

## Instructions for the Submission of the TPA Report

The Third Party Administrator Report consists of two Excel spreadsheets. A downloadable template of the report is located on the Kentucky Department of Insurance's website at the following link -----(add Link)----- . The completed reports must be sent electronically in a Microsoft Excel spreadsheet. This can either be email to [Voin.Barker@ky.gov](mailto:Voin.Barker@ky.gov), or it can be copied to a CD and mailed to the Kentucky Department of Insurance, Attn: Voin Barker II, 215 W. Main Street, Frankfort, KY 40601.

The report must include both:

1. Sheet One labeled - TPA Identification Information- This sheet collects general information on the TPA. Please see below for valid values.

	Column A		Column B
Row/ Column	Field Description	Row/ Column	Valid Values
1/A	Name of TPA	1/B	Alpha-numeric
2/A	Reporting Year	2/B	Must be Numeric,
3/A	First Line of mailing address	3/B	Alpha-numeric
4/A	Second Line of mailing address	4/B	Alpha-numeric
5/A	City	5/B	Alpha-numeric
6/A	State	6/B	Must be 2 digits alphabetic
7/A	Zip Code	7/B	Must be 5 or 9 digits numeric (do not include dashes, etc.)
8/A	State of Domicile	8/B	Must be 2 digits alphabetic
9/A	Contact Name	9/B	Alpha-numeric
10/A	Contact Phone	10/B	Must be Numeric (do not include dashes, etc.)
11/A	Contact E-mail	11/B	Alpha-numeric
12/A	Does this TPA administer a Group health plan that provides hospital or surgical benefits (Do not include workers compensation plans)	12/B	Must be expressed using a Y=Yes or N=No

2. Sheet Two labeled - Contracted Employers- This sheet collects information pertaining to each employer contracted with the reporting TPA. The department is looking for a snapshot of covered employees as of December 31, 2010. Please see below for valid values.

Row/ Column	Field Description	Valid Values
2-11/B	Name of Contracted Employer	Alpha-numeric
2-11/C	Plan type (Employer, Union, Governmental, or Church)	Must be expressed using the examples given: Employer, Union, Governmental, or Church
2-11/D	First Line of Employer's mailing address	Alpha-numeric
2-11/E	Second Line of Employer's mailing address	Alpha-numeric
2-11/F	City	Alpha-numeric
2-11/G	State	Must be 2 digits alphabetic
2-11/H	Zip Code	Must be 5 or 9 digits numeric (do not include dashes, etc.)
2-11/I	Total Number of Employees (Including Part-time employees)	Must be Numeric.
2-11/J	Total Number of Eligible Employees	Must be Numeric.
2-11/K	Total Number of Enrolled Employees	Must be Numeric.
2-11/L	Total Covered Lives (Enrollees & Dependents)	Must be Numeric. Total covered lives includes enrollees and dependents