

**HEALTH CARE REFORM ACT – PUBLIC GOODS POOL**  
**DOH-4399 INSTRUCTIONS**

A payor voluntarily electing to make public goods payments directly to the Office of Pool Administration must complete forms DOH-4399 (Payor Election Application) and DOH-4264 (Electronic Filing User ID Application).

Instructions for pages 1 and 2:

**Effective Date:** Enter effective date of election. Note: An election application received from any payor or organization shall begin on the first day of the month following the date it was received by the Office of Pool Administration unless a future date is specified.

**Federal Employer Identification # (FEIN):** Enter federal employer identification number (FEIN) of the payor. Please note that Section 2807-j(5)(a)(iii)(D) of the Public Health Law requires the New York State Department of Health to publish the FEIN of all electing payors on a secure website.

**Payor Name:** Enter name of payor. The payor name is that of the incorporated entity, local government, self-insured fund.

**D/B/As:** Enter any assumed name(s) ("d/b/a") under which the entity is doing business.

**Address:** Enter address of payor.

**Contact Person:** Enter name of contact person that will be responsible for providing the Department with the information regarding the payor's election, lines of business and claims processing.

**Phone #:** Enter phone number of the contact person.

**E-Mail Address:** Enter the e-mail address of the contact person.

If the election submission is for a payor that is utilizing a third-party administrator (TPA)/administrative services only (ASO) for claims processing, the following information must also be provided. If more than one TPA/ASO is utilized, attach a list of additional TPAs/ASOs.

**TPA/ASO Name:** Prefilled to ConnectiCare Insurance Company, Inc.

**TPA/ASO FEIN:** Prefilled to 06-1618303

The Signature of the chief financial officer or other duly authorized individual binds the payor to make direct pool payments for all its public goods funding obligations, file reports and remit funds in conformance with the Health Care Reform Act (HCRA) provisions and Department requirements, and represents an agreement as to the jurisdiction of the State for purposes of enforcing payments required under Public Health Law sections 2807-j and 2807-t. This does not, in any way, preclude a payor from litigating other issues in Federal court such as ERISA based challenges, etc.

Instructions for page 3:

This form must be completed by all payors making an election and represents a payor's attestation of the coverage it provides. A payor electing to pay the Department's Office of Pool Administration directly is making an election for all its coverages for which it assumes risk for the payment of medical claims. Payors utilizing multiple third-party administrators (TPA)/administrative services only (ASO) organizations must complete a Coverage Information form for each TPA/ASO.

- In each payor category which applies, the payor should mark an "X" in each column to indicate that the payor provides such coverage. Each box marked with an "X" represents the coverages that it assumes risk for. As stated before, a payor is required to elect for all coverages for which it assumes risk for the payment of medical claims. Shaded areas should not be checked.
- If an Article 43 NYS Insurance Law corporation or licensed commercial insurer has a separate incorporation for its Article 44 NYS Public Health Law business, that corporation must check the appropriate boxes on a single election form. Otherwise, the Article 44 NYS Public Health Law business is considered to be a product line of the Article 43 or commercial payor and the payor is required to make a single election for this and all other types of coverage provided by the corporation. A payor, who does not fall into any of the categories listed, should check "Other" in the payor identification section and explain their payor type in the space provided.

**HEALTH CARE REFORM ACT – PUBLIC GOODS POOL**

**Effective Date:** \_\_\_\_\_

**FEDERAL EMPLOYER  
IDENTIFICATION # (FEIN):** \_\_\_\_\_

**PAYOR NAME:** \_\_\_\_\_

**D/B/As (IF APPLICABLE):** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**CONTACT PERSON:** \_\_\_\_\_

**PHONE #:** \_\_\_\_\_

**E-MAIL ADDRESS:** \_\_\_\_\_

If the above referenced entity is a payor that utilizes a third-party administrator (TPA)/administrative services only (ASO) for claims processing, please provide the following information:

**TPA/ASO NAME:** \_\_\_\_\_ ConnectiCare Insurance Company Inc.

**TPA/ASO FEIN:** \_\_\_\_\_ 06-1618303

**By signature below, the above entity elects to make all public goods surcharge payments directly to the Office of Pool Administration for all its coverages for which it assumes risk for the payment of medical claims and agrees to:**

1. remit to the Department's Office of Pool Administration required surcharge payments for all applicable services on a monthly basis on or before the 30th day following the calendar month for which monies have been paid to designated providers of service;
2. provide the Department's Office of Pool Administration monthly certified reports on or before the 30th day following the calendar month for which monies have been paid which separately report patient service expenditures for services provided by designated provider type(s) (i.e., hospital inpatient, hospital outpatient, diagnostic & treatment center, laboratory<sup>1</sup>, or ambulatory surgery center) by product line;
3. provide the Department with certification of data and access to allowance expenditure data upon request for audit verification purposes; and

<sup>1</sup>For services provided on or after October 1, 2000, freestanding clinical laboratories with Article 5 Title V permits are exempt from HCRA surcharges.

4. the jurisdiction of the state to maintain an action in the courts of the State of New York to enforce any provision of section 2807-j of the Public Health Law (see note below).
5. the Department's website posting of the above entity's FEIN in accordance with Public Health Law Section 2807-j(5)(a)(iii)(D).

**By signature below, the above entity also agrees to make public goods covered lives payments directly to the Department's Office of Pool Administration in instances where it provides inpatient coverage as a corporation organized and operating in accordance with Article 43 of the Insurance Law, an organization operating in accordance with Article 44 of the Public Health Law, a self-insured fund, or an HMO or insurer licensed outside New York State and authorized to write accident and health insurance and whose policy provides inpatient coverage on an expense incurred basis. In such instances the above entity agrees to:**

1. remit to the Department's Office of Pool Administration within 30 days after the end of each month one-twelfth of both the individual and family unit annual assessment amounts for each of the individuals and family units residing in the state which were included on the payor's membership rolls for all or a portion of the prior month and for which the payor covered general hospital inpatient care, including retroactive additions and deletions;
2. provide the Department with data certification and access to individual and family unit data, upon request, for audit verification purposes; and
3. the jurisdiction of the state to maintain an action in the courts of the State of New York to enforce any provision of section 2807-t of the Public Health Law (see note below).

**By signature below, the Chief Financial Officer or other duly authorized individual of the above entity certifies that the data submitted on all applicable attachments have been carefully prepared in accordance with instructions provided, and to the best of his/her knowledge, the information presented is accurate and correct.**

**Signature** \_\_\_\_\_ **Title** \_\_\_\_\_  
Chief Financial Officer or Duly Authorized Individual

**Date** \_\_\_\_\_

**Note:** Payors making an election are only agreeing to the jurisdiction of NYS courts for purposes of enforcing payments required under 2807-j and 2807-t. This does not, in any way, preclude a payor from litigating other issues in Federal court such as ERISA based challenges, etc.

COVERAGE INFORMATION (See Attached For Further Explanation)

PAYOR NAME: \_\_\_\_\_ FEDERAL ID#: \_\_\_\_\_

TPA/ASO NAME: ConnectiCare Insurance Company Inc. TPA/ASO FEDERAL ID#: 06-1618303

MARK AN "X" IN EACH COLUMN TO INDICATE TYPE OF COVERAGE BY PAYOR TYPE (Prefilled)

	TYPE OF PAYOR:	IDENTIFICATION OF TYPE OF COVERAGE:									
		<u>INDEMNITY COVERAGE</u>	HMO NON- MEDICAID OR NON- NYS MEDICAID COVERAGE	SELF- INSURED COVERAGE	NEW YORK STATE HMO/PHSP MEDICAID COVERAGE	NEW YORK STATE GOVT PROGRAM W/INPATIENT COMPONENT & NYS LOCAL GOVT CORRECTIONS	NEW YORK STATE WORKERS COMPENSATION <u>LAW COVERAGE</u>	NEW YORK STATE MOTOR VEHICLE REPAIRATIONS ACT COVERAGE	NEW YORK STATE VOLUNTEER AMBULANCE WORKER'S BENEFIT LAW COVERAGE	NEW YORK STATE VOLUNTEER FIREFIGHTERS' BENEFIT LAW COVERAGE	OTHER COVERAGE
1	Corporations Organized & Operating in accordance with Article 43 of the NYS Insurance Law										
2	Corporations that are Commercial Insurers licensed in New York State										
3	Corporations Organized & Operating in accordance with Article 44 of the NYS Public Health Law, not incorporated as Commercial Insurers or under Article 43 of the NYS Insurance Law										
4	Self-Insured Fund with No Third Party Administrator/Administrative Svcs Only Organization for Claims Processing										
5	Self-Insured Fund with a Third Party Administrator/Administrative Svcs Only Organization for Claims Processing			X							
6	New York State Governmental Agency/ New York State Local Government										
7	Other (please explain below): Includes: State/Local Governments outside New York for Medical Assistance Programs; insurers licensed outside New York State, authorized to write OTHER than Accident and Health										
8	HMOs and insurers licensed outside New York State, authorized to write Accident and Health										

Explanation of "Other" Payor Identification

**HEALTH CARE REFORM ACT – PUBLIC GOODS POOL  
COVERAGE INFORMATION****Payor Type 1: Corporation organized and operating in accordance with Article 43 of the New York State Insurance Law offering:**

- Indemnity Coverage with an expense incurred inpatient hospital component, thus requiring a surcharge obligation on affected services plus regional GME covered lives assessments for NYS resident insureds
- Indemnity Coverage without an expense incurred inpatient hospital component, thus requiring a surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident insureds
- HMO non-Medicaid managed care coverage, thus requiring a surcharge obligation on affected services plus regional GME covered lives assessments for NYS resident non-Medicaid insureds
- HMO Medicaid managed care coverage, thus requiring a surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident Medicaid managed care enrollees

**Payor Type 2: Commercial Insurance Corporation licensed by New York State offering:**

- Indemnity Coverage with an expense incurred inpatient hospital component, thus requiring a surcharge obligation on affected services plus regional GME covered lives assessments for NYS resident insureds
- Indemnity Coverage without an expense incurred inpatient hospital component, thus requiring a surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident insureds
- HMO non-Medicaid managed care coverage, thus requiring a surcharge obligation on affected services plus regional GME covered lives assessments for NYS resident non-Medicaid insureds
- HMO Medicaid managed care coverage, thus requiring a surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident Medicaid insureds
- New York State Workers Compensation Law coverage, thus requiring a surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident insureds
- New York State Motor Vehicles Reparations Act coverage, thus requiring a surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident insureds
- New York State Volunteer Ambulance Workers Benefit Law coverage, thus requiring a surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident insureds
- New York State Volunteer Firefighters Benefit Law coverage, thus requiring a surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident insureds

**Payor Type 3: Corporation organized and operating in accordance with Article 44 of the New York State Public Health Law not incorporated as a NYS licensed commercial insurer or under Article 43 of the New York State Insurance Law offering:**

- HMO non-Medicaid managed care coverage, thus requiring a surcharge obligation on affected services plus regional GME covered lives assessments for NYS resident non-Medicaid managed care enrollees
- HMO Medicaid managed care coverage, thus requiring a surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident Medicaid managed care enrollees

**Payor Type 4/5: Self insured fund offering:**

- self insured employee health coverage with an expense incurred inpatient hospital component, thus requiring a surcharge obligation on affected services and regional GME covered lives assessments for NYS resident plan participants
- self insured employee health coverage without an expense incurred inpatient hospital component, thus requiring a surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident plan participants
- self insured New York State Workers Compensation Law coverage, thus requiring a surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident plan participants
- self insured **non-New York State** Workers Compensation Law coverage, thus requiring a surcharge obligation on affected services and a regional GME covered lives assessments (if coverage includes expense incurred inpatient hospital care) for NYS resident plan participants
- self insured New York State Motor Vehicles Reparation Act coverage, thus requiring a surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident plan participants
- self insured **non-New York State** Motor Vehicles Reparations Act coverage, thus requiring a surcharge obligation on affected services and a regional GME covered lives assessments (if coverage includes expense incurred inpatient hospital care) for NYS resident plan participants

**Payor Type 6: New York State Governmental Agency/ New York State Local Government:**

- New York State political subdivision for New York State county corrections, New York City corrections, and, New York State governmental agencies for New York State administered payments that reimburse hospitals for rendered inpatient services to eligible patients. (e.g. Office of Mental Health payments for services provided to individuals residing in New York State operated developmental centers), thus requiring a surcharge obligation on affected services but no regional GME covered lives assessment

**Payor Type 7: Other**

- Insurers **licensed outside New York State, authorized to write OTHER than Accident and Health** thus requiring a surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident insureds
- States **other than New York State** and localities **other than New York State political subdivisions** for medical assistance program expenses (i.e. Medicaid Programs in states OTHER than New York State), thus requiring a surcharge obligation on affected services but no regional GME covered lives assessment
- NYS licensed fraternal benefit societies offering coverage with or without an expense incurred inpatient hospital component, requiring a surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident insureds

**Payor Type 8: HMOs and insurers licensed outside New York State, authorized to write Accident and Health:**

- Indemnity Coverage with an expense incurred inpatient hospital component, thus requiring a surcharge obligation on affected services plus regional GME covered lives assessments for NYS resident insureds
- Indemnity Coverage without an expense incurred inpatient hospital component, thus requiring a surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident insureds
- HMOs **organized and operating outside New York State Insurance and Public Health Laws**, thus requiring a surcharge obligation on affected services plus regional GME covered lives assessments for NYS resident insureds

**HEALTH CARE REFORM ACT – PUBLIC GOODS POOL**  
**DOH-4264 INSTRUCTIONS**

All electing payors/third party administrators (TPA)/administrative services only (ASO) organizations and designated providers are required to file Public Goods Pool reports electronically. This also applies to the 1% Statewide Assessment report filed by hospitals. A website has been established at [www.hcrapools.org](http://www.hcrapools.org) to facilitate this process.

**New Request/Revision to Existing Account:** Check the appropriate box. An entity requesting an initial account/password should check the *New Request* box; an entity that has an existing account and is advising the Department of a change to that account should check the *Revision to Existing Account* box.

**Payor/TPA/ASO/Provider Name:** Enter company name.

**Federal Employer Identification Number (FEIN):** Enter FEIN assigned to the entity named above.

**Operating Certificate #: (For providers only):** Enter Operating Certificate number assigned by the Department of Health to the entity named above. - Leave Blank

**Report(s) being filed electronically (check ALL applicable types):** Check all applicable types of reports that your entity will be filing electronically – Public Goods Pool (prefilled)

**Signature:** Must be signed by the Chief Executive/Financial Officer and/or Administrator of the entity named above.

**Name/Title/Phone Number (Please Print):** Enter name, title and phone number of the person signing above.

**Address/City/State/Zip Code:** Enter address of the person signing above.

**E-mail Address:** Enter e-mail address of the person signing above. This email address will be used to communicate Health Care Reform Act information, including delinquency reporting notifications and periodic legislative updates.

**Date:** Enter date this form is signed.



**HEALTH CARE REFORM ACT – PUBLIC GOODS POOL**

☐ **New Request**

☐ **Revision to Existing Account**

**Payor/Third Party Administrator/Administrative Services Only Organization/Provider Name:**

\_\_\_\_\_

**Federal Employer Identification # (FEIN):** \_\_\_\_\_

**Operating Certificate # (FOR PROVIDERS ONLY):** \_\_\_\_\_

**Report(s) being filed electronically (check ALL that apply):**

☒ Public Goods Pool

☐ 1% Statewide Assessment (for hospitals only)

By signature below, the Chief Financial Officer or other duly authorized individual of the above named entity authorizes the Office of Pool Administration to assign a secure electronic filing user ID and password to the entity. This information will be mailed directly to the attention of the signer and must remain secured. If an email address is provided, this information will be sent electronically to the email address listed. It is the responsibility of the above named entity to ensure that this information is released only to those individuals requiring knowledge thereof.

**Signature** \_\_\_\_\_

**Name (Please Print)** \_\_\_\_\_

**Title** \_\_\_\_\_

**Phone Number** \_\_\_\_\_

**Address** \_\_\_\_\_

\_\_\_\_\_

**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip Code** \_\_\_\_\_

**E-mail Address** \_\_\_\_\_

**Date** \_\_\_\_\_

**HEALTH CARE REFORM ACT – PUBLIC GOODS POOL**  
**DOH-4403 INSTRUCTIONS**

This form is to be completed by a payor whose status has changed from the original election as it relates to whether a TPA/ASO is utilized for claim processing.

**Effective Date:** Enter the effective date of the status change.

**Payor Information:** Enter the payor (group/entity) name, EIN, contact and phone #.

**Type of Status Change:** prefilled to changing TPA/ASO.

**Section I:** Previous TPA/ASO: Enter the name, EIN of the previous TPA/ASO on file with the Pool.

If the group/entity did not have a previous level funded plan, mark this section NA.

**Section II:** Prefilled to ConnectiCare Insurance Company., Inc.

**Section III: Most common selections are option 1 or 3**

**Check option 1** if this is a change from a preexisting TPA on file.

**Check option 2** if any claims incurred under the previous TPA have been adjudicated and the effective date.

**Check option 3** if this is a new TPA/ASO election and there was no level funded plan previously in place.

**HEALTH CARE REFORM ACT – PUBLIC GOODS POOL**

This form must be completed if an electing payor is adding or changing their TPA/ASO.

**Effective Date:** \_\_\_\_\_

**PAYOR INFORMATION:**

Payor Name: \_\_\_\_\_ Payor FEIN: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Type of Status Change** (check appropriate box):

- ☐ **Additional TPA/ASO** (complete Section II only)
- ☒ **Changing TPA/ASO** (complete Sections I, II & III)

**I. PREVIOUS TPA/ASO INFORMATION:**

TPA/ASO Name: \_\_\_\_\_ TPA/ASO FEIN: \_\_\_\_\_

**II. NEW or ADDITIONAL TPA/ASO INFORMATION:**

TPA/ASO Name: ConnectiCare Insurance Company, Inc. TPA/ASO FEIN: 06-1618303

Address: 175 Scott Swamp Road  
Farmington, CT 06032

TPA/ASO Contact Person: Stephanie Chaparro TPA/ASO Phone #: 860-214-2615

**III. CHECK ONE OF THE FOLLOWING:**

- ☐ Previous TPA/ASO will continue to process claims and file reports for all dates of service prior to the change for a period of one year following the end of the year in which the change in TPA occurred or until all such claims have been adjudicated, at which time a final monthly report with a copy of this form indicating same will be filed.
- ☐ All self-insured claims that previous TPA/ASO was responsible for have been adjudicated effective \_\_\_\_\_.
- ☐ New TPA/ASO is assuming responsibility for all pending claims and HCRA reporting requirements.

**Signature of Payor:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Please mail completed form to:**  
Mr. Jerome Alaimo, Pool Administrator  
Office of Pool Administration  
Excellus BlueCross BlueShield, Central New York Region  
P.O. Box 4757  
Syracuse, New York 13221-4757