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Overview

Introduction

Full-time and part-time salaried employees choose from among several different healthcare programs. State agencies and employees each pay a portion of health insurance coverage costs. Agencies administer healthcare benefits for their employees and collect and pay premiums to cover the cost of healthcare through CIPPS payroll deductions. An employee's premium may be reduced slightly by participating in health incentive activities. The reduction is a "Premium Reward" and is funded by the Health Insurance Fund (HIF). Employees are enrolled in a premium conversion plan for "pre-tax" deductions of healthcare premiums in which premiums are exempt from federal, state, and OASDI and HI taxes.

Healthcare coverage is provided on a calendar month basis. One-half of the monthly premium for the coverage month is collected on the paydays of the 16th (of the coverage month) and 1st (of the month following the coverage month). Example: Premiums for June coverage are collected on the June 16th and July 1st paydays. Healthcare rate schedules are located in the Payroll Fiscal Year-End Bulletin on the DOA website.

HIPAA

Beginning April 14, 2003, Health Plans, including medical, prescription drug, dental and vision benefits are subject to the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA requires health plans to notify plan participants and beneficiaries about its policies and practices to protect the confidentiality of their health information. For more information, visit the website of the Department of Human Resources Management (www.dhrm.virginia.gov).

Central Benefits Administration

The Office of Health Benefits in the Department of Human Resource Management (DHRM):

- Administers statewide health benefits and premium conversion plans,
- Manages the Health Insurance Fund (HIF) to which premiums are deposited and from which claims and other bills are paid, and
- Operates the automated Benefits Eligibility System (BES), which serves as the official healthcare enrollment record of the Commonwealth.
- Annually distributes Employer Provided Health Insurance reports (1094 and 1095) as required by the Internal Revenue Service.

Overview, Continued

Agency Benefits Administration

Agency benefits administrators are responsible for processing new enrollments and enrollment changes, validating employee eligibility, and maintaining BES. When notified of new hires or qualifying status changes, benefits administrators advise payroll administrators immediately to ensure the correct premium rates are applied in payroll processing.

Detailed administrative guidelines governing healthcare plans and BES are available from DHRM.

Central Payroll Administration

State Payroll Operations in the Department of Accounts:
- Runs CIPPS, in which payroll deductions for healthcare plans are processed,
- Runs the interface between BES and CIPPS, which automates the establishment and maintenance of CIPPS healthcare data based on BES updates,
- Runs the automated healthcare reconciliation, which compares BES enrollment records and CIPPS payroll records to identify differences, and
- Reviews monthly certification of healthcare reconciliation forms and Agency to Agency journals (ATAs) submitted by agencies and reports status in the Comptroller's Quarterly Report on Statewide Financial Management and Compliance.

Agency Payroll and Fiscal Administration

Agency payroll administrators ensure CIPPS payroll deductions are established for employees based on the healthcare plan, and effective dates provided by agency benefits administrators in BES. The employee, premium reward and agency portions are computed in CIPPS during payroll processing. The employee portion is deducted from pay, the agency portion is charged to agency expenditures, and the combined total is transferred to the HIF. The premium reward is funded by existing balances in the HIF.

Whenever overrides are required to collect additional/refund employee or employer health care amounts (e.g., mid-month termination) an override will also be required for the premium reward amount accordingly.

Agencies must review the reconciliation reports, verify exceptions and submit ATA's (if applicable) to ensure the correct amount of premiums are collected for each employee.

Premium Refund Policy

Retroactive Healthcare Changes

Agencies can make retroactive healthcare changes in BES and applicable premium refunds resulting from administrative error or employee status change up to 59 days following the effective date of the change. After 59 days, agencies must contact DHRM for approval and assistance in updating BES.

Premium refunds should not be processed in CIPPS until BES has been updated.

Tax Consequences of Premium Conversion Refunds

State employees enjoy the tax savings of the premium conversion (pre-tax premium) program authorized by section 125 of the Internal Revenue Code. Under IRS rules, the premium actually constitutes a salary reduction, with the state providing the healthcare benefit. Consequently, when employees participating in premium conversion receive refunds in a calendar year subsequent to the year the premium was originally deducted, a corrected W-2 (Form W2-C) may be required.

Premium Refund Guidelines

When healthcare deductions (premiums) are withheld in error, the CIPPS deduction refund process should be used to refund the employee deduction, premium reward and the agency expenditures associated with the premium. The refund must be processed along with the employee's regular payment. Process the refund on HTODA, "Employee Deduction Refund/Adjustment." Reference CAPP – Cardinal Topic 50605, *Tax and Deduction Adjustments,* for instructions.

Special Considerations

Special care should be taken when processing premium conversion deduction refunds. You may need to collect any appropriate taxes due directly from the employee when premium conversion deduction refunds are processed for employees who are no longer receiving regular pay. Upon receipt of the delinquent taxes, the employee's masterfile will have to be updated and taxes deposited. Refer to CAPP – Cardinal Topics 50605, *Tax and Deduction Overrides*, and 20319, *Electronic Federal Tax Payments System (EFTPS)*, for procedures.

BES/CIPPS Processing Features

Benefits Eligibility System

BES is the official healthcare enrollment system of the Commonwealth and the "driver" of health insurance transactions created in CIPPS. To emphasize the importance of this point, the employee benefits screen in CIPPS (HMCU1) displays the message, "Enter Health Transactions in BES." This informational message remains on the screen as a reminder and does not clear after the Enter key is depressed.

BES/CIPPS Interface

Based on BES updates, a nightly interface automatically establishes and maintains CIPPS healthcare deduction data on the HMCU1 screen, eliminating to a significant degree duplicate manual data entry in CIPPS. The interface changes the CIPPS healthcare plan and provider, and establishes the employee, premium reward and employer payroll deductions on the H0ZDC screen. Agencies still receive BES/Agency Transaction Turnaround Documents for all BES updates. Agencies must validate the proper coverage was set up in CIPPS by the interface. The interface also establishes flexible reimbursement account deductions. Refer to CAPP – Cardinal Topic No. 50435, *Flexible Reimbursement.*

Timing Considerations

The timing of transactions entered into BES and CIPPS affects the interface:

- An employee must first be hired in CIPPS, through the daily PMIS to CIPPS automated update process or using the Menu/Link functions or individual screen access (H0BNE), to be automatically updated through the interface. Refer to CAPP – Cardinal Topic No. 50305, *New Employee Add,* to establish the employee's record in CIPPS.
- If no match on agency and employee number is made between BES and CIPPS, the transaction is rejected and listed on Report U130, BES/CIPPS Transaction Error Listing. These rejected transactions will not recycle and must be manually entered in CIPPS, as described later in this topic.
- The effective date of the BES transaction dictates when the entry will update CIPPS. Those transactions which do not contain a future effective date will show on the morning of the second day after entry in BES.

BES/CIPPS Processing Features, continued

Valid Transactions

Valid transactions will update CIPPS. These transactions are listed on Report U131, BES/CIPPS Update Listing. This update listing shows old/new values for the two medical insurance CIPPS codes: provider and plan. Retroactive transactions should be evaluated manually to determine if additional action is required (i.e., retroactive collections or refunds). Note: The U131 also reflects old and new values for the flexible reimbursement accounts.

Transfers Between Agencies Other Than at the Beginning of the Month

DHRM policy requires that when an employee transfers from their current agency to a new agency after the first day of a month, the entire healthcare premium for that month should be collected by the current agency, with the new agency collecting premiums for the month following the transfer. Accordingly, agencies should carefully monitor employee transfer transactions in CIPPS. Employee transfers are reflected on the receiving agency's U131 with a code of 'TR' under the 'CHG IND' column.

Transactions That Require Direct Data Entry in CIPPS

BES is the initial point of entry for most health care transactions. However, the transactions rejected during the BES/CIPPS interface process and listed on Report U130 require direct entry in CIPPS.

Establishing Healthcare Deductions in CIPPS

Online Data Entry In CIPPS

While deduction activity for Health Care should be largely controlled by the automated BES to CIPPS daily update, there may be times when manual data entry will be required. Transaction entry on the Employee Benefits screen (HMCU1) automatically establishes or disables the applicable deductions on the Employee Deductions screen (H0ZDC). However, data entry on HMCU1 will not automatically establish the applicable premium reward amount in deduction 025. After entering the correct values on HMCU1, reduce deduction 024 on H0ZDC by the reward amount and establish deduction 025 for the reward amount. Access and change the Employee Deductions screen (H0ZDC) as instructed in CAPP – Cardinal Topic No. 50110, *CIPPS Navigation*.

Establishing Healthcare Deductions in CIPPS, Continued

Enter the provider code for the health benefits plan selected.

Provider Name	Active Provider Code	Involuntary Separation Provider Code	Project Code
Kaiser Permanente HMO	006	056	93003
COVA Care Basic	042	092	93002
COVA Care Out-of-Network	043	093	93002
COVA Care Expanded Dental	044	094	93002
COVA Care Out-of-Network and Expanded Dental	045	095	93002
COVA Care Vision, Hearing and Expanded Dental	046	096	93002
COVA Care Full	047	097	93002
COVA Care High Deductible	050	090	93005
TRICARE Voluntary Supplement	110	160	93038
COVA HealthAware Basic	101	151	93033
COVA HealthAware Expanded Dental and Vision	102	152	93033
COVA HealthAware Expanded Dental	103	153	93033
COVA Care High Deductible Expanded Dental	105	155	93005

Enter the membership type code.

Status	Membership Type
Active/ LWOP	S – Single
	O – Single – Part time
	F – Family
	M – Family – Part time
	D – Employee plus one dependent
	T – Employee plus one dependent – Part time
	W – Employee waived coverage
Ineligible/Terminated	E – Employee not eligible for coverage

Leave Without Pay (LWOP)

LWOP Premium Payment

DHRM Policy requires employees on LWOP due to medical leave, agency convenience, or layoffs to continue to pay the employee share. The agency must pay the agency share of the healthcare premium.

For other reasons (e.g., personal, education) the employee must pay the entire healthcare premium.

Coverage Code

Effective December 1, 2011, codes used on HMCU1 to indicate employees in a LWOP status are no longer allowed in CIPPS. Previously, these codes established the employee-paid deduction for health insurance premiums at a rate of zero ($0) and the employer-paid deduction at the full premium amount. In lieu of LWOP health care codes the automated reconciliation between BES and CIPPS ensures that the Health Insurance Fund (HIF) receives all the funds due. The automated recon provides a clear audit trail for audit/fiscal staff to identify employees whose entire health insurance premium is paid by the agency due to LWOP or insufficient pay situations. It is the agency's responsibility to collect the funds from the identified employee in accordance with DHRM's guidelines.

Medicare Carve-Out

Overview
DHRM policy permits employees who are eligible for Medicare because they are diagnosed with end state renal disease (ESRD) to retain healthcare coverage. The State plan pays primary to Medicare for the first 30 months of treatment. After 30 months Medicare becomes the primary payer and the state plan coordinates with Medicare and pays secondary on claims.

Reimbursement Procedure
Employees with ESRD who pay Medicare premiums are eligible for premium reimbursement on a quarterly basis. Agencies should:

- Obtain a copy of employee's Medicare bill or other appropriate documentation.
- Verify Medicare Carveout status in BES.
- Reimburse the employee through the Expenses module in Cardinal using the "Other Employee Reimbursements" Expense Type (interfacing agencies will use the "Interfacing" Expense Type). Update the Account to 5011150 on the Accounting Detail Page. This will charge the agency expenditures and generate a payment to the employee. See CAPP – Cardinal Topic No. 20310, *Expenditures.*
- Process an ATA by submitting a General Ledger Journal Spreadsheet Upload Excel Template to Payroll Operations at HealthRecons@doa.virginia.gov. The spreadsheet journal should have the coding in the table below to recover expenditures from the HIF (Health Insurance Fund). The agency distribution may include agency level chartfields as necessary (i.e, project, task).
- The text file should be named with the following convention: HC, Business Unit, Month, Year (Example HC26100Feb2016).
- Include "**Medicare Carve Out – Employee name, employee #"** in the subject line of the e-mail to Payroll Operations. DOA will then forward the information to DHRM after processing.

To…	Business Unit/PC Business Unit	Department	Fund	Cardinal Account	Project**	Task
Credit Agency	XXXXX	XXXXX	XXXXX	5011150		
Charge HIF	14900	60000	06200	4005100	Determined by Provider Code:	
COVA Care	14900	60000	06200	4005100	AHI100	10
COVA Health Aware	14900	60000	06200	4005100	AHI200	10
COVA High Deductible	14900	60000	06200	4005100	AHI300	10
Kaiser	14900	60000	06200	4005100	AHI810	40
TriCare Supplement	14900	60000	06200	4005100	AHI820	40

With Project must include PC Business Unit (see second column).

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Automated Healthcare Reconciliation

Overview   The Automated Healthcare Reconciliation:
- Runs monthly identifying differences between the premium due according to the BES healthcare plan enrollment and the premium collected through the combined employee, premium reward and agency-paid payroll deductions in CIPPS.
- Generates reports that list each difference identified.
- Charges agencies by an Automated Healthcare General Ledger Journal in Cardinal for differences in which the amount collected through CIPPS payroll is **less than** the amount due in BES.
- Identifies possible "credit due agency." Agencies must complete the GL Journal Spreadsheet Upload Excel Template with the coding for both their agency and the HIF and submit the GL Spreadsheet Journal text file to Payroll Operations at HealthRecons@doa.virginia.gov to receive credit. **See procedures for this process later in this topic.**

Automated ATA   The Automated Healthcare ATA transactions can be identified in Cardinal by using the Other Agency Transaction Report. The Journal will have a Source of 'CIP' and the Journal ID format will be 'HLTHYYYYMM'.

The automated ATA is not charged to each employee's unique programmatic data. Default coding for the automated ATA is provided by the agency and maintained on a separate table by DOA Payroll/Benefits Accounting.

Agency ATA   Agencies must prepare and submit the GL Journal Spreadsheet Upload Excel Template for any differences in which the amount collected through CIPPS payroll is more than the amount due in BES. This GL Journal Spreadsheet must also include any differences incorrectly charged through the automated Healthcare ATA and/or additional charges discovered by the agency that were omitted from the automated ATA. Additional procedures governing agency healthcare ATA processing are provided later in this CAPP – Cardinal topic.

Reconciliation Reports

The U107, U108, U110, and U111 reports are produced by the automated reconciliation. In each report, BES premium amounts are taken from CIPPS healthcare tables based upon the BES plan-provider code. The following table applies to all reconciliation reports.

If…	Then…
The employee's CIPPS plan code changes within the same provider during the month,	The last plan code is used for comparison purposes.
The employee's CIPPS provider code changes during the month,	Multiple exception reports (one for each provider) are generated.

Automated Healthcare Reconciliation, Continued

U107, Healthcare Exception Report

Identifies CIPPS and/or BES records that have a variance in the agency number, provider code, plan code, or amount fields. A separate report is generated for each agency-provider-group number combination. Summarizes the BES Total, Payroll Total, Credit Due Agency, and Charge to Agency (Automated ATA). U107 report logic follows:

If …	Then…
A difference is detected,	An error code identifies the type of exception: • 1 – Same plan code, collections $\neq$ bill amount. • 2 – Different plan code, collections = bill amount. • 3 – Different plan code, collections $\neq$ bill amount. • 4 – On BES, not on CIPPS. • 5 – On CIPPS, not on BES.
A payroll record is identified for which there is not a matching BES record within the same provider code,	The exception will print on the U107 with a group number of 'blank'.

U108, Monthly Healthcare Reconciliation Summary

Summarizes the total healthcare costs in BES, the premiums collected in CIPPS, the Credit Due Agency, and the Charge to Agency (Automated Healthcare ATA). A separate report is generated for each agency-provider-group number combination. Premiums Due are itemized by plan code.

U110, BES Premium Listing

Lists the eligibility information in BES by provider and group number. This report is a BES bill that supports the BES premiums due amount on the U108 Summary. It may be used to determine an employee's coverage in BES. Do not submit the U110 to DOA with the Healthcare Reconciliation unless it is required to document an exception.

U111, Invalid Healthcare Plan/Provider Codes

Lists all employees with invalid plan or provider codes in BES or CIPPS. Transactions on this report have not been included in the automated reconciliation. Therefore, agencies must review each exception listed and take corrective action.

Reconciliation Procedures

Healthcare Adjustments Worksheet

Use this worksheet to document any adjustments required to change the amounts identified in the automated reconciliation. Examples include retroactive adjustments (which require an additional premium due or a reduction in premiums due) and coverage termination (which require a reduction in premiums due). Obtain copies and/or Excel spreadsheets of the Adjustments Worksheet from the DOA website (www.doa.virginia.gov).

Reviewing Differences on the U107

Review every employee listed on the U107 to determine if the differences identified through the automated reconciliation are correct. Use source documents such as enrollment forms and BES Turnaround Documents in your review. Agencies may also identify additional differences that were not identified by the automated reconciliation.

Listing Differences on Adjustments Worksheet

Generally, each employee with an adjustment, whether resulting in a credit or additional charge to the agency, must be listed on the worksheet as specified below. However, as a general rule, do not list employees who are already identified on the U107 under the column Credit Due Agency.

If…	Then…
the total of the Credit Due Agency column on the U107 is correct,	use the U107 as documentation in place of the worksheet.
employees are listed under the Credit Due Agency column for which agency research indicates the credit is not due,	line through the employee amount on the U107, reduce the total under the Credit Due Agency column, list the employee on the adjustments worksheet, provide an explanation and the BES (PSB305 or PSB309 detail) screen print.
employees are listed under the Charge To Agency column for which agency research indicates a charge should not have been made,	line through the employee amount on the U107, increase the total under the Credit Due Agency column, list the employee on the adjustments worksheet, provide an explanation and the BES (PSB305 or PSB309 detail) screen print.
employees are not listed on the U107 for which agency research indicates an additional charge or credit is due,	list the employee on the adjustments worksheet, provide an explanation and the BES (PSB305 or PSB309 detail) screen print for a credit.
the BES Total column is incorrect due to changes made after the generation of the healthcare bill,	list the employee on the adjustments worksheet, provide an explanation and the BES (PSB305 or PSB309 detail) screen print.

Reconciliation Procedures, Continued

Compiling and Totaling Adjustments

Bring forward the (adjusted) total Credit Due Agency from the U107 to the adjustment worksheet. Add this total to the other adjustment amounts listed on the Adjustments worksheet, deducting charges and adding credits. If the total is positive, the agency is due a refund from the HIF (agency credit). If the total is negative, the agency owes the HIF (agency charge).

BES Screen Prints

All requests for credit amounts must be supported by a screen print of the PSB305 (Participant Data) for active employees or the PSB309 (Participant History detail) for terminates. The date of the transaction and the transaction type must validate the refund request.

NO REFUNDS (with the exception of those listed on the U107 as "Credit Due Agency") are allowed without the applicable BES screen print.

Agency ATA

Agencies may need to request refunds for credits due the agency or pay additional charges due to the Health Insurance Fund (HIF). These transactions will be processed as ATAs in Cardinal. Agencies will be required to complete the GL Journal Spreadsheet Upload Excel Template with the coding for both their agency and the HIF and submit the GL Journal Spreadsheet text file to Payroll Operations at HealthRecons@doa.virginia.gov.

The file should be named with the following convention: HC, Business Unit, Month, Year (Example HC26100Feb2016).

Payroll Operations will review the transactions, upload, and post them to Cardinal. These transactions will then interface to CARS until it is decommissioned.

The following table summarizes Cardinal transaction coding for processing agency healthcare ATA's:

Used when…	To…	Business Unit	Cardinal Account *	Fund	Program	Dept	PC Business Unit (PCBU)	Project
Payroll deductions exceed BES	Credit agency (-)	XXXXX	5011150	XXXXX	XXXXX	XXXXX	See note #	See note #
	Charge HIF	14900	4005100	06200	N/A	60000	14900	Determined by Provider Code**
Payroll deductions are less than BES.	Charge agency	XXXXX	5011150	XXXXX	XXXXX	XXXXX	See note #	See note #
	Credit HIF (-)	14900	4005100	06200	N/A	60000	14900	Determined by Provider Code**

#Note: Must include PC Business Unit with Project.

** HIF Project Coding for various Provider Codes:

PCBU	Project	Description	Task
14900	AHI100	COVA Care	10
14900	AHI200	COVA Health Aware	10
14900	AHI300	COVA High Deductible	10
14900	AHI810	Kaiser	40
14900	AHI820	TriCare Supplement	40

* **5011730 is the account used for employees in Involuntary Separation status.**

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Reconciliation Procedures, Continued

Premium Reward Discrepancies

Effective 7/1/2013, and at the beginning of each month, DHRM generates a **Premium Reward Discrepancies** report and places it in each agency's folder in **HurMan**.

This report must be
- reviewed by the Fiscal Officer (FO) or designee (the designee must not have update access in CIPPS),
- evaluated to determine the reason for the discrepancies (if any), and
- used to develop a corrective action plan when appropriate.

The report must then be signed by the approving Officer and submitted along with the health care reconciliation package to DOA.

Reconciliation packages submitted without the signed report are considered incomplete submissions of materials. (See **Compliance Reporting** on the next page.)

Certification Form Submission Requirements

Once all plans are reviewed, the approving Officer certifies the accuracy by signing the Certification form and submitting it to DOA along with all required supporting documentation. Obtain copies of the Certification Form from the DOA website (www.doa.virginia.gov).

Healthcare reconciliation/certifications are due by the end of the month following the coverage month. However, the May reconciliation is due mid-June. The exact due date is documented in the FYE Payroll Bulletin.

Reconciliation Compliance Reporting

Sunset Policy   Agencies forfeit claims to agency healthcare expenditure refunds when healthcare reconciliation/certifications are either not submitted or contain problems that remain unresolved more than two months following the close of the coverage month (one month following the reconciliation/certification due date). Under this policy, late requests for refunds (ATA's) will be deleted and any required charges will be processed centrally. Employee premium refunds are not affected.

Compliance Reporting   Agencies whose healthcare reconciliation/certifications are submitted late, incomplete or with problems requiring additional adjustments are subject to report in the Comptroller's quarterly Report on Statewide Financial Management and Compliance.

Internal Control

Internal Control   Agencies must ensure all employee premium reward and agency premiums due according to BES are calculated and collected timely.

Records Retention

Time Period   All applicable forms affecting employee healthcare plan eligibility and the related payroll deductions must be maintained at the agency for four years or until audited, whichever is later.

Contacts

DOA Contact   Benefits Supervisor
Voice: (804) 371-8912
E-mail: Payroll@doa.virginia.gov

Benefits Accountant
Voice: (804) 225-2246
E-mail: Payroll@doa.virginia.gov

CARS to Cardinal Transition

Cardinal Transition   CIPPS interfaces to both CARS and Cardinal. No additional action needs to be taken by agencies in order to record CIPPS entries. After CARS has been decommissioned, agencies will no longer use NSSA to establish programmatic data in CIPPS. Instructions on how to load this information to CIPPS will be distributed at a later time.

Subject Cross References

References   CAPP – Cardinal Topic No. 20319, *Electronic Federal Tax Payments System*
CAPP – Cardinal Topic No. 20310, *Expenditures*
CAPP – Cardinal Topic No. 50305, *New Hires, Rehires, Transfers*
CAPP – Cardinal Topic No. 50605, *Tax and Deduction Adjustments*
CAPP – Cardinal Topic No. 20410, *Intra-Agency Transactions*
CAPP – Cardinal Topic No. 20405, *Inter-Agency Transactions*

Refer to suggested job aids and training information for data entry and processing on the Cardinal website: http://www.cardinalproject.virginia.gov/

Suggested Forms and Job Aids

The following forms can be found on the Cardinal Website, under Statewide Toolbox – Forms:

Journal Entry

GL Journal Spreadsheet Upload Excel Template

GL Journal Spreadsheet Upload XLA Macro File

The following training aids can be found on the Cardinal Website, under Statewide Toolbox – Job Aids:

Uploading Spreadsheet Journals

Agency to Agency (ATA) Transactions Information Sheet

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Please note: The Cardinal job aids, training materials and forms on the Cardinal website are not policy of the Department of Accounts and are not part of the Commonwealth Accounting Policies and Procedures Manual (CAPP).