

**CORE Benefit Enrollment & Maintenance (834) Data
Content Rule
Version BEM.1.0
August 2023**

**CAQH Committee on Operating Rules for Information Exchange (CORE)
Benefit Enrollment & Maintenance (834) Data Content Rule vBEM.1.0**

Revision History for CORE Benefit Enrollment & Maintenance (834) Data Content Rule

Version	Revision	Description	Date
BEM.1.0	Major	DRAFT requirements approved for inclusion by the CORE Value-based Payments Subgroup	August 2023

DRAFT

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1. Background Summary

1.1. CORE Overview

CAQH CORE is an industry-wide facilitator committed to the creation and adoption of healthcare operating rules that support standards, accelerate interoperability, and align administrative and clinical activities among providers, health plans and patients. Guided by over 100 participating organizations – including healthcare providers, health plans, government entities, vendors, associations, and standards development organizations – CORE Operating Rules drive a trusted, simple, and sustainable healthcare information exchange that evolves and aligns with market needs.¹

To date, this cross-industry commitment has resulted in operating rules addressing many pain points of healthcare business transactions, including eligibility and benefits verification, claims and claims status, claim payment and remittance, health plan premium payment, enrollment and disenrollment, prior authorization, and aspects of value-based healthcare such as patient attribution and social determinants of health (SDOH).

1.2. Industry Interest in Value-based Payment Focused Operating Rules

Value-based Payment models (VBP) are transformative to the healthcare landscape. Shifting reliance away from fee-for-service, volume-driven payment, VBP incentivizes good outcomes and the thoughtful utilization of services. Doing so drives efficiency – measured by both time and dollars – and increases the quality of care provided to attributed patient populations.

The move to value-driven models is accelerating, but continued reliance on a fee-for-service infrastructure paired with the need for stakeholders to accommodate new, innovative methodologies leads to administrative barriers that are often solved using manual workarounds. CORE participating organizations and other key industry leaders recognize the need for standardization and uniformity to further support value-based payment programs and their aim to create more efficient and effective patient care.

CORE is an active contributor to the evolution, adoption, and simplification of VBP models. In 2018, CORE released the foundational report [All Together Now: Applying the Lessons of Fee-for-Service to Streamline Adoption of Value-based Payments](#), informed by industry partners who identified common barriers to VBP adoption, including, but not limited to.

- A lack of data uniformity
- Challenges with patient attribution
- Nascent technical interoperability

This pioneering work led to the consensus-based development of a set of CORE Operating Rules addressing patient attribution. These are:

- CORE Eligibility & Benefits (270/271) Single Patient Attribution Data Content Rule vEB.1.0
- CORE Attributed Patient Roster (X12 005010X318) Data Content Rule
- CORE Attributed Patient Roster (X12 005010X318) Infrastructure Rule

The National Committee for Vital and Health Statistics (NCVHS), a public advisory committee to the Department of Health and Human Services (HHS), sent a letter to the Secretary of HHS recommending several CORE Operating Rules for federal adoption, including the CORE Single Patient Attribution Operating Rule.² This marks the first time an operating rule directly addressing value-based payments was recommended for federal adoption by NCVHS. The Single Patient Attribution Rule is the foundation of which this rule builds upon.

¹ In 2012, CORE was designated by the Secretary of the Department of Health and Human Services (HHS) as the author for [federally mandated operating rules](#) under Section 1104 of the Patient Protection and Affordable Care Act (ACA). See Appendix §5.1 for more information.

² Letter submitted by NCVHS to HHS on June 30, 2023: https://ncvhs.hhs.gov/wp-content/uploads/2023/07/Recommendation-Letter-Updated-and-New-CAQH-CORE-Operating-Rules-June-30-2023_Redacted-508.pdf.

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1 In 2022, in recognition of the changing contexts in which VBP is implemented, CORE conducted an
2 extensive environmental scan to understand how known barriers to the adoption of VBP have evolved
3 and what new areas have emerged since the foundational work completed in 2018. These findings,
4 detailed in the report [Unifying Value: Industry Opportunities to Streamline Value-based Payment Data
5 Exchange](#), confirmed the relevance and influence of the operational areas identified in the 2018, and
6 highlighted new challenges, including:

- 7 • Incorporation of methodologies to promote health equity and
- 8 • Growing administrative complexity of value-based payment models.

9 In 2023, CORE convened a Value-based Payment Subgroup to evaluate these opportunities further and
10 assess the need for new or updated operating rules to de-burden and streamline the administration of
11 VBP.

12 **2. Issues to Be Addressed and Business Requirement Justification**

13 **2.1. Problem Space**

14 Value-based payment models began principally as a tool to control healthcare expenditures. The theory
15 being that the incentivization of better outcomes leads to the judicious use of appropriate treatments,
16 services, and care settings. Though these goals have been achieved for some models, the continued
17 allure of and reliance on fee-for-service payments paired with operational difficulties in implementing and
18 administering the programs has led to mixed results with costs and quality often remaining stable despite
19 the novel interventions and methodologies included in the payment models.

20 Despite modest results, the penetration and perceived favorability of VBP continues to grow across the
21 industry. Part of this is attributable to methodology refinements applied to existing and new models that
22 may result in cost-savings or quality improvements. It is also driven by an increased realization among
23 stakeholders that the reach of VBP models coupled with their ability to pilot novel interventions on a large-
24 scale make them a valuable tool to address health inequities.

25 This emerging and laudable use of VBP models is limited by the non-uniform collection, exchange, and
26 processing of socio-demographic data, which is necessary to identify population-level disparities and
27 design generalizable interventions. CORE Operating Rules support the standard exchange of this
28 information by identifying distinct data content requirements that trading partners must adhere to when
29 exchanging this sensitive and valuable information.

30 **2.1.1. Process in Identifying the Problem Space and Barriers to Automating the 31 Exchange of Socio-demographic Information**

32 CORE performed extensive environmental scanning to identify opportunities for operating rule
33 development that would address automation and other operational difficulties in the administration of
34 value-based payment models. This process involved a literature review of industry resources and in-
35 depth one-on-one interviews with provider, health plan, vendor, and standard development organization
36 stakeholders that highlighted directions CORE could take to standardize VBP data exchange and
37 infrastructure requirements.

38 From here, CORE tested these findings and assumptions by convening a VBP Focus Group comprised of
39 industry representatives. This group was essential in refining and finalizing the VBP-related topics to
40 present to a CORE VBP Subgroup for rule development. These recommendations included:

- 41 • Data alignment for the exchange of socio-demographic information.
- 42 • Infrastructure updates to improve the administration of VBP.
- 43 • Streamlining the claim submission process to support VBP methodologies.
- 44 • Simplification of contracting concepts and terminology to align industry language.

45 The opportunities presented to the Subgroup span multiple transactions. This operating rule focuses on
46 standardizing the exchange of socio-demographic information to support the growth and continued

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1 implementation of VBP interventions that directly address health inequity. There are several key
2 contributors to variation of socio-demographic information:

- 3 1. **Unaligned data sets:** Concepts, such as race and ethnicity, are exchanged using different
4 vocabulary standards. These are sometimes incompatible and limit translation and
5 generalizability between stakeholders.
6
- 7 2. **Industry interpretation:** Standards, both those that are widely implemented and those that are
8 emerging, can be subject to interpretative implementations based on the varying understandings
9 and needs of implementers.
10
- 11 3. **Evolving vocabulary:** Some concepts, such as gender identity or the documented sex of an
12 individual, are still being defined by industry groups as the need for standard data exchange is
13 balanced with inclusivity of new concepts.
14
- 15 4. **Security of Protected Health Information:** Socio-demographic information is sensitive and, if
16 misused or exchanged without appropriate acknowledgment of this fact, can result in harm
17 through discriminatory actions.

18 CORE plays a central role in standardization of data exchange and each of these issues is addressed in
19 the operating rule requirements.

20 **2.2. Focus of the CORE Benefit Enrollment & Maintenance (834) Data Content Rule**

21 The purpose of this operating rule is to identify and standardize the data used for collecting and
22 exchanging key socio-demographic data at the point of member enrollment or renewal to a health plan
23 using the HIPAA-mandated X12N 005010X220 Benefit and Enrollment Maintenance (834) transaction
24 (hereafter referenced as X12 v5010X220 834).

25 The following requirements included in the rule address data content of benefit enrollment related to key
26 socio-demographic data:

- 27 • Standardize the collection, exchange, and processing of self-reported race and ethnicity at the
28 point of member enrollment or renewal to a health plan using the unique identifiers contained in
29 the CDC Race and Ethnicity Code Set exchanged in the DMG segment of the X12 v5010X220
30 834.
- 31 • Enhance the availability of member-facing information about the exchange, use, and benefit of
32 collecting sensitive information, supporting a type of informed consent for sensitive data
33 exchange.
- 34 • Streamline the collection, exchange, and processing of member language at the point of
35 enrollment or renewal using ISO 639-3 language codes and use codes available in the LUI
36 segment of the X12 v5010X220 834.
- 37 • Align reporting of gender identity in the X12 v5010X220 834 with the most recent **regulated**
38 version of the United States Core Data for Interoperability (USCDI) to expand and enrich the
39 concepts currently included in the TR3.
- 40 • Elevate the importance of privacy by requiring an option be available to members at the point of
41 enrollment or renewal to not disclose sensitive information for any of the indicated socio-
42 demographic concepts included in this rule.

43 **3. X12 v5010X220 834 Benefit Enrollment & Maintenance Data Content Rule: Requirements**
44 **Scope**

45 **3.1. What the Rule Applies To**

46 This CORE Operating Rule conforms with and builds upon the X12 v5010X220 834 implementation guide
47 and specifies the minimum socio-demographic data content that a health plan and its agent is required to
48 collect at the point of member enrollment or renewal. The operating rule further specifies minimum data
49 content requirements for how a health plan and its agents must process collected socio-demographic

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1 information using the X12 834 transaction.

2 The collection and use of socio-demographic information necessitates the maintenance of privacy and retention
3 of enrollee choice of whether to share sensitive information. This operating rule requires health plans and their
4 agents to disclose exchange and use of socio-demographic information allowing enrollees to make an informed
5 choice of whether to share their personal information. Consistent with this requirement, health plans and their
6 agents are required to provide an option for enrollees to not disclose specified socio-demographic information at
7 the point of enrollment and renewal.

8 **3.2. When the Rule Applies**

9 This rule applies when:

- 10 • A health plan or its agent enrolls or renews an individual into a health plan.

11 **And**

- 12 • A health plan or its agent successfully collects required and recommend socio-demographic
13 information.

14 **And**

- 15 • A health plan or its agent receives socio-demographic information collected at the point of
16 member enrollment or renewal and processes the information into enrollment and membership
17 databases using the X12 v5010X220 834 transaction.

18 **3.3. What this Rule Does Not Address**

- 19 • Requirements for the use of the X12 v5010 834 transaction by the Affordable Care Act or State
20 Health Information Exchanges (HIX).
21
22 • Infrastructure requirements applicable to the X12 v5010X220 834.

23 **3.4. What the Rule Does Not Require**

- 24 • This rule does not require any HIPAA-covered entity to modify its use and content of other loops
25 and data elements that may be submitted in the X12 v5010X220 834 that are not addressed in
26 this rule.

27 **3.5. Applicable Loops, Data Elements & Code Sources**

28 This rule covers the following specified loops, segments, and data elements in the X12 v5010X220 834
29 Benefit Enrollment & Maintenance transactions:

Applicable Loops & Segments in X12 v5010X220 834 Benefit Enrollment and Maintenance		
Loop ID	Segment	Element
Exchange of Race and Ethnicity		
Loop ID 2100A Member Name	DMG Member Demographics	DMG05-01 Race or Ethnicity Code
		DMG05-02 Code List Qualifier Code
		DMG05-03 Industry Code
		DMG10 Code List Qualifier Code
		DMG11 Industry Code
Exchange of Member Language		
Loop ID 2100A Member Name	LUI Member Language	LUI01 Identification Code Qualifier
		LUI02 Identification Code
		LUI04 Use of Language Indicator

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Applicable Loops & Segments in X12 v5010X220 834 Benefit Enrollment and Maintenance		
Exchange of Gender Identity		
Loop ID 2700 Member Reporting Categories	LX Member Reporting Categories	LX01 Assigned Number
Loop ID 2750 Reporting Category	N1 Reporting Category	N101 Entity Identifier Code N102 Name
	REF Reporting Category Reference	REF01 Reference Identification Qualifier
		REF02 Reference Identification

1

2 **3.6. Data Classes, Code Sources, and Value Sets Addressed**

3 This rule addresses the following data classes, code sources, and value sets:

- 4 • X12 External Code Source 859 Classification of Race or Ethnicity, which communicates the race
5 and/or ethnicity of an enrolling or renewing member using the CDC Race and Ethnicity Code
6 Set.³
- 7 • X12 External Code Source 860 Race or Ethnicity Collection Code, which communicates how an
8 enrolling members race and/or ethnicity was recorded based on values in the CDC Race or
9 Ethnicity Collection Code Set.⁴
- 10 • X12 External Code Source 102 ISO-639, which communicates a member language using the
11 ISO-639-3 standard where three characters represent macro and individual languages.⁵
- 12 • Codes from SNOMED International, Systematized Nomenclature of Medicine Clinical Terms
13 (SNOMED CT®) U.S. Edition, aligned with most current regulated USCDI version.⁶
- 14 • Codes from the HL7 Null Flavor data set to standardize reporting of unknown gender identity
15 values.⁷

16 **3.7. Maintenance of This Rule**

17 Any substantive updates to the rule (i.e., change to rule requirements) are determined based on
18 industry need as supported by the CORE Participants per the CORE Change and Maintenance
19 Process.

20 **3.8. Assumptions**

21 A goal of this rule is to adhere to the principles of electronic data interchange (EDI) in assuring
22 that transactions sent are accurately received and to facilitate the electronic exchange of data
23 content benefiting the use of socio-demographic data to combat health disparities.

24 The following assumptions apply to this rule:

- 25 • A successful communication connection has been established.
- 26 • This rule is a component of the larger set of CORE Benefit Enrollment & Maintenance
27 (834) Operating Rules.
- 28 • The CORE Guiding Principles apply to this rule and all other rules.
- 29 • This rule is not a comprehensive companion document addressing any content
30 requirements of the X12 v5010 834 Benefit Enrollment & Maintenance transaction.

³ PHINVADS CDC Race and Ethnicity Code Set: <https://phinivads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.876>
⁴ PHINVADS CDC Race and Ethnicity Collection Code: <https://phinivads.cdc.gov/vads/ViewValueSet.action?id=256BFE72-CB04-E011-9273-00188B39829B>
⁵ ISO 639-3 source: https://iso639-3.sil.org/code_tables/639/data
⁶ UMLS Licensees may download here: https://www.nlm.nih.gov/research/umls/rxnorm/sourcereleasedocs/snomedct_us.html
⁷ <https://terminology.hl7.org/3.1.0/CodeSystem-v3-NullFlavor.html>

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- Compliance with all CORE Operating Rules is a minimum requirement; any entity is free to offer more than what is required in the rule.

3.9. Value-based Payment Terminology

To understand concepts, terms, and methodologies used to navigate and administer value-based payment program CORE developed the CORE Framework for Semantic Interoperability in Value-based Payments.⁸

4. X12 v5010X220 834 Benefit Enrollment & Maintenance: Technical Requirements

4.1. Requirements for Receivers of a X12 v5010X220 834

The receiver of an X12 v5010X220 834 is required to detect and extract all data elements to which this rule applies. The receiver must display or otherwise make the data appropriately available to the end user without altering the semantic meaning of the X12 v5010X220 834 data content.

4.2. Disclosure of the Collection, Exchange, and Use of Socio-demographic Information.

When socio-demographic data is indicated for required or recommended collection in this rule, a health plan and its agent must develop language disclosing the purpose of data collection, detailing its exchange and potential uses. This information, required to be included in the transaction-specific companion guide per the CORE Benefit Enrollment and Maintenance Infrastructure Rule, must be presented to members at the point of enrollment or renewal.

4.3. Collection, Exchange, and Processing of Race and Ethnicity Information

When operationalizing rule requirements and recommendations, the order in which they are encountered should be followed to standardize the collection, exchange, and use of race and ethnicity data. The following subsections outline the requirements and recommendations for collecting race and ethnicity information.

4.3.1. Parameters for the Collection and Exchange of Race and Ethnicity Information

At a **minimum**, a health plan and its agent is required to collect and exchange race and ethnicity concepts consistent with those contained in the most current [Office of Management and Budget Statistical Directive 15](#) required under regulation for the collection of race and ethnicity for federal programs.⁹

In addition to these concepts, a health plan and its agent:

- Must provide members with the option **to not disclose their race and/or ethnicity** and collect and exchange this information when it is indicated.
- Must require the collection and exchange how race and ethnicity information was collected, at a minimum indicating whether the information was either **Self-identified** or **Observer-identified**.
- At their discretion, provide members with the option to choose the **Middle Eastern or North African** racial concept and collect and exchange this information when it is indicated.

⁸ Once approved, a link to The Framework will be provided here.

⁹ https://obamawhitehouse.archives.gov/omb/fedreg_1997standards

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4.3.2. Parameters to Process Race and Ethnicity Information Using the X12 005010X220
834

When the information indicated in §4.3.1 is collected and shared with a health plan or its agent, the following loops, segments, and data elements must be used to process the information in the X12 v5010X220 834:¹⁰

- **When a Member Chooses NOT to Disclose Their Race or Ethnicity**

- Loop 2100A – Member Name
DMG – Member Demographics
DMG05-01 = '7' (Not Provided)

- **When a Member Chooses to Disclose Race or Ethnicity**

- Loop 2100A – Member Name
DMG – Member Demographics
DMG05-02 = 'RET'
DMG05-03 = <Unique Identifier from CDC Race and Ethnicity Code Set>¹¹

- **Processing of How Race and Ethnicity was Collected**

- Loop 2100A – Member Name
DMG – Member Demographics
DMG05-10 = 'REC'
DMG05-11 = '100-8' (Self-identified) or '128-9' (Observer-identified)¹²

4.3.3. Discretionary Data Processing Requirements Using the X12 005010X220 834

When operating rule requirements are designated as discretionary for the X12 v5010X220 834, it is at the discretion of the health plan or its agent whether to process the data in accordance with the indicated requirements. When a health plan exercises this discretion to process the data, any included loop, segment, or data elements designated as required must be collected.

- **Processing Using the CDC Race and Ethnicity Hierarchical Code**

The DMG05 segments can be repeated up to 10 times. When a health plan and its agent meet the requirement to process race and ethnicity using the CDC Race and Ethnicity Code Set unique identifier in fewer than 10 repeats of the DMG05 segments, a health plan and its agent may additionally process the CDC Race and Ethnicity Hierarchical Code¹³ for informational purposes using the following:

- Loop 2100A – Member Name
DMG – Member Demographics
DMG05-02 = 'RET'
DMG05-03 = <CDC Race and Ethnicity Hierarchical Code>

¹⁰ Note that if more than one concept is shared, they must be processed in separate repeats of the data segment up to 10 times, in line with the X12 v5010X220 834 requirements.

¹¹ The CDC Race and Ethnicity Code Set is maintained by the PHIN Vocabulary Access and Distribution System (PHINVADS) and contains unique identifiers and hierarchical categorization for a comprehensive – but not exhaustive – list of racial and ethnic concepts. Extensions to these code sets are in the external code set reference '859 – Classification of Race or Ethnicity' in the X12 v5010 TR3.

¹² The CDC Race and Ethnicity Code Set is maintained by the PHIN Vocabulary Access and Distribution System (PHINVADS) and contains unique codes for how a race and ethnicity was collected. Extensions to these code sets are in the external code set reference '860 – Race or Ethnicity Collection Code' in the X12 v5010 TR3.

¹³ Note that exchange using the hierarchical code cannot be standardized as it may change over time as additional race and ethnicity concepts are introduced into the CDC Race and Ethnicity Code Set. The hierarchical code should only be included for informational purposes.

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4.4. Collection, Exchange, and Processing of Member Language

Standardized collection of member language assists in promoting equitable access to healthcare and assures that, when care is sought, it is delivered in a way that is culturally appropriate and meaningful to a patient.

4.4.1. Requirement to Collect Member Language at Enrollment or Renewal

A health plan and its agent are required to collect member language at the point of enrollment or renewal.

4.4.2. Processing of Member Language

For the language(s) collected in §4.4.1, a health plan and its agent must process that information consistent with the ISO 639-3 standard using the following loops, segments, and data elements. The ISO 639-3 standard provides a granular view of member language, identifying parent language concepts, as well as dialects.

Loop 2100A – Member Name
LUI – Member Language
LUI01 = 'LE' (ISO 639 Language Codes)
LUI02 = <applicable ISO 639-3 code>

4.4.3. Requirement to Collect Use of Member Language for Each Recorded Language

For each language collected in in §4.4.1, a health plan or its agent must collect at least one and a maximum of four member language uses for each recorded language at the point of enrollment or renewal.¹⁴ The four valid indicators of use, defined in the X12 v5010X220 834 are:

- Reading
- Writing
- Speaking
- Native Language

4.4.4. Processing of Use of Member Language

For each use of language collected in §4.4.3., a health plan and its agent must process the information consistent with the loops, segments, and data elements indicated below:¹⁵

Loop 2100A – Member Name
LUI – Member Language
LUI04 = <applicable X12 use code>
- Reading = 5
- Writing = 6
- Speaking = 7
- Native Language = 8

If use of member language is not collected, LUI04 should not be populated.

¹⁴ the X12 v5010X220 834 TR3 defines four values for use of member language. CORE requires the collection, exchange, and processing of this information, the four values are an X12 TR3 requirement.

¹⁵ Each repeat of the LUI segment can only contain one language and one use of language. For a language where multiple uses are reported, each repeat must contain the same language in LUI02 with the unique indicated use in LUI04.

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4.5. Discretionary Collection, Exchange, and Processing of Self-reported Member Gender Identity

To align X12 reporting with new and emerging standards, requirements can be met by using alphanumeric reference fields in the X12 v5010X220 834 transactions.

Industry conformance with the requirements in sections 4.5.1. through 4.5.2. and related subsections is **discretionary**. When requirements are designated as discretionary for the X12 v5010X220 834, it is at the discretion of the health plan whether to collect, exchange, and process the data in accordance with the indicated requirements. When a health plan exercises this discretion to collect, exchange, and process the data, any included loop, segment, or data elements designated as required must be collected.

4.5.1. Collection of Member Self-reported Gender Identity

A health and its agent at their discretion can require collection of a member's self-reported gender identity at the point of enrollment or renewal, providing members with the opportunity to not disclose their gender identity. **At a minimum**, if exercising discretion to collect this information, it should be done so consistent with the set of concepts maintained by the HL7 Gender Harmony Project.¹⁶ The current value-set is shown below.

Description	Definition
Male	A person's self-identification as a man, as male, or as a boy.
Female	A person's self-identification as a woman, as female, or as a girl.
Non-binary	Having a specific identity which is nonbinary (not within a binary construct of male or female) or having an identity which falls under the nonbinary umbrella (i.e., any or all gender identities which are not female or male).
Unknown (e.g., was not able to ask; person does not want to answer)	A proper value is applicable but not known.

4.5.2. Processing of Member Self-reported Gender Identity

When the information specified in §4.5.1. is collected and shared a health plan and its agent must process the information using the X12 v5010X220 834 consistent with the indicated loops, segments, and data elements listed below.

- Member Reporting Categories for Gender Identity Processing**

A health plan and its agent must use a sequential non-negative integer consistent with requirements in the X12 v5010X220 834 to indicate the category being reported for the member. This number must not

¹⁶ <https://confluence.hl7.org/display/VOC/Gender+Identity>

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1 conflict with values already in use for other member reporting categories unrelated to this rule
2 requirement.

3 Loop 2700 – Member Reporting Categories
4 LX – Member Reporting Categories
5 **LX01 = <unique sequential, non-negative integer>**

6 • **Reporting Category for Gender Identity Reporting**

7 A health plan and its agent must specify the name of the reporting category consistent with X12
8 v5010X220 834 reporting requirements to indicate the type of information being exchanged.

9 Loop 2750 – Reporting Category
10 N1 – Reporting Category
11 **N101 = '75' (Participant)**
12 **N102 = 'Gender'**

13 • **Gender Identity Reporting Values**

14 Once Member Reporting Categories are specified, a health plan and its agent must process the
15 member's gender identity collected as part of §4.5.1. consistent with USCDI version 3¹⁷ **that is currently**
16 **proposed for federal adoption with anticipated acceptance into the Federal Register.** USCDI v3
17 requires the exchange of gender identity concepts using SNOMED-CT.¹⁸

18 If collection and exchange was consistent with the minimum requirements listed in §4.5.1. and 'Unknown'
19 is reported, REF02 should be populated with the HL7 Null Flavor¹⁹ value of 'UNK'. Unknown may have
20 multiple meanings, but should be shared when a member chooses not to disclose their gender identity.
21

22
23 Loop 2750 – Reporting Category
24 REF – Reporting Category Reference
25 **REF01 = 'ZZ' (Mutually Defined)**
26 **REF02 = <Appropriate SNOMED CT code for**
27 **collected concept or HL7 Null Flavor code for**
28 **Unknown>**
29

30 SNOMED CT codes for the **minimum** requirements indicated in §4.5.1. are shown below.
31

Description	Data Set	Value
Male	SNOMED	446151000124109
Female	SNOMED	446141000124107
Non-binary	SNOMED	33791000087105
Unknown	HL7 Null Flavor	UNK

¹⁷ <https://www.healthit.gov/isa/taxonomy/term/741/uscdi-v2>

¹⁸ UMLS Licensees may download here: https://www.nlm.nih.gov/research/umls/rxnorm/sourcereleasedocs/snomedct_us.html

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1 5. Conformance Requirements

- 2 Conformance with this rule is considered achieved when all the required detailed step-by-step test scripts
- 3 specified in the Eligibility & Benefits CORE Certification Test Suite are successfully passed.

DRAFT