



# Carrier Enrollment and Payment Process Guide

## Individual Market

Plan Year 2022

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## 1.0 INTRODUCTION

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The following sections outline the legislative basis for the establishment of state-based exchanges (SBEs), as well as the intended use and intended audience for the Enrollment and Payment Process Guide.

### 1.1 AFFORDABLE CARE ACT

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (P.L. 111-148). On March 30, 2010, the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152) was signed into law. The two laws are collectively referred to as the Affordable Care Act (ACA).

The ACA creates competitive private health insurance marketplaces that provide millions of Americans and small businesses access to affordable healthcare coverage. SBEs help individuals select and enroll in high quality, affordable private health plans that fit their needs at competitive prices.

### 1.2 WASHINGTON HEALTH BENEFIT EXCHANGE

The ACA gave states the option of establishing an SBE or participating in the Federally Facilitated Marketplace (FFM). The Washington State Legislature made the decision to establish an SBE, called the Washington Health Benefit Exchange (HBE) in RCW 43.71.020.

### 1.3 DOCUMENT PURPOSE

This guide provides operational and policy guidance on eligibility, enrollment, payment, and reconciliation activities within HBE. The information contained in this guide applies to the following organizations and entities:

- Qualified Health Plan (QHP) carriers and Qualified Dental Plan (QDP) carriers (collectively referred to as “Carriers”)
- Third-Party Administrators (TPAs) of QHP or QDP carriers
- Trading Partners of QHP and QDP carriers

### 1.4 REVISION HISTORY

DATE	REVISION NUMBER	REVISION DESCRIPTION
7/1/2021	1.0	Updates to section 11.1 – 11.3: daily reconciliation, transaction maintenance, and monthly reconciliation
12/27/2021	1.1	Updates to section 11.3: monthly reconciliation Updates to Appendix A
6/10/2022	1.2	Updates to section 6.3.1, addition of section 7.1.1, updates to Appendix A

### 1.5 AMENDMENTS TO DOCUMENT

Amendments to this guide are made at a minimum of an annual basis. HBE communicates any amendments to carriers prior to their incorporation into the guide. Any amendments made to the guide are effective as of the next Open Enrollment Period, or as defined in the update. HBE formally publishes the guide annually on the

HBE website each year on August 1st, or the next business day.

Once the final version of the guide is published, clarifications or updates to the guide are issued via supplemental bulletins or minor versions of the guide (e.g., 3.0.1) to coincide with point releases. HBE formally publishes supplemental bulletins or minor versions of the guide on the HBE corporate website at least 30 days prior to the effectuation of any changes.

## 1.6 RELATIONSHIP TO 834 COMPANION GUIDE

For rules related to format and content of Electronic Data Interchange (EDI) transactions and managing the exchange of EDI transactions between HBE and QHP/QDP carriers, please refer to the 834 Companion Guide. The 834 Companion Guide addresses the 834 EDI requirements for the Individual Market.

## 1.7 COMPLIANCE WITH STATE AND FEDERAL LAWS

HBE expects carriers to comply with all state and federal laws and regulations, including but not limited to the ACA and Title 48 of the Revised Code of Washington (RCW).

## 1.8 HBE CONTACT INFORMATION

For questions about the content of this guide, please contact your assigned Enrollment Analyst directly by phone or email.

## 2.0 ACRONYMS AND DESCRIPTIONS

ACRONYM/TERM	DESCRIPTION
ACA	Collective reference for the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010
AI/AN	American Indian or Alaska Native
APTC	Advanced Premium Tax Credit
BAR	Batch Annual Renewal
CCIIO	Center for Consumer Information and Insurance Oversight
CHIP	Children’s Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
CSR	Cost-Sharing Reduction
DEP	Dependent-only coverage
ECDM	CMS Enterprise Canonical Data Model
EDI	Electronic Data Interchange
Edifecs	Validation engine for incoming and outgoing EDI transactions
EDS	Enrollment Data Store
EFT	Enterprise File Transfer
EHB	Essential Health Benefits
EITA	Exchange Information Technology Architecture
Exchange	Washington Health Benefit Exchange
FAM	Family coverage
FCA	Full Carrier Audit
FFM	Federally Facilitated Marketplace
FMP	Full Monthly Premium
FPL	Federal Poverty Level
HBE	Washington Health Benefit Exchange
Washington Healthplanfinder	Washington Health Benefit Exchange’s consumer facing online marketplace
HHS	U.S. Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act of 1996

Hub	Federal Data Services Hub
HIPTC	Health Insurance Premium Tax Credit
MEC	Minimum Essential Coverage
OEP	Open Enrollment Period
PA	Primary Applicant
QDP	Qualified Dental Plan
QHP	Qualified Health Plan
QLE	Qualifying Life Event
SBE	State Based Exchange
SBMI	State Based Market Interchange
SEP	Special Enrollment Period
SFTP	Secure File Transfer Protocol
WAH	Washington Apple Health
WAHBE	Washington Health Benefit Exchange



## 3.0 WASHINGTON HEALTHPLANFINDER INDIVIDUAL MARKET

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### 3.1 ELIGIBILITY

HBE provides *Washington Healthplanfinder*, a single portal to determine eligibility for customers to purchase a QHP and QDP. Customers can request an eligibility determination for insurance affordability programs: advanced premium tax credits (APTC), cost-sharing reductions (CSRs), Washington Apple Health (WAH), and the Children’s Health Insurance Program (CHIP).

Customers are determined eligible, conditionally eligible, or denied for purchase of a QHP/QDP and to receive premium tax credits and cost-sharing reductions for QHP enrollment. Those determined conditionally eligible have 95 days to provide additional documentation to verify the self-attested information included in their application. Conditionally eligible customers must supply additional documentation to HBE for possible verification of social security number, income, citizenship status, lawful presence, incarceration status, access to minimum essential coverage (MEC), and/or tribal membership.

Customers with incomes between 100% and 400% of the federal poverty level (FPL) may be eligible for APTC.<sup>1</sup> Individuals and families between 100% and 250% of the FPL are also eligible for CSRs if they enroll in a silver plan.<sup>2</sup> HBE reports the applied APTC and CSR eligibility to the carrier and the Centers for Medicare & Medicaid Services (CMS) to facilitate payment from CMS to the carrier.

*Washington Healthplanfinder* does not permit applicants to apply APTC to QDPs and cost sharing reductions are not applicable to QDPs under federal law.

Enrollment transactions sent to carriers include conditionally eligible customers, though HBE does not report conditional eligibility status. Enrollment changes or terminations at the end of the 95-day conditional eligibility period are reported to carriers. Coverage is not retroactively terminated for customers determined ineligible at the end of the 95-day period. Rather, enrollment changes or termination dates follow standard monthly enrollment deadlines.

If a customer is determined eligible for APTC or CSRs, or if program eligibility changes, HBE notifies the carrier and transmits the information necessary for carriers to implement, discontinue, or modify the APTC and/or CSRs, including the dollar amount of the APTC and the CSR eligibility category. Carriers are responsible for timely processing of any changes in APTC and/or CSRs and notifying customers of any changes to benefits.

### 3.2 MEDICARE

Section 1882(d) of the Social Security Act prohibits the sale or issuance of an individual health insurance policy to a Medicare beneficiary with the knowledge that it duplicates Medicare benefits. *Washington Healthplanfinder* denies eligibility for QHP enrollment when an applicant indicates they have Medicare. The customer is still eligible to enroll in a QDP, provided they meet other eligibility criteria.

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<sup>1</sup> Non-citizens who are lawfully present and who are ineligible for Medicaid due to immigration status may be eligible for APTC if their income is less than 100% of the FPL. For 2021 and 2022, the American Rescue Plan act removed the 400% FPL “cliff” and capped premium contributions at 8.5% of household income based on the benchmark plan.

<sup>2</sup> Non-citizens who are lawfully present and who are ineligible for Medicaid due to immigration status may be eligible for CSRs if their income is less than 100% of the FPL.

Carriers should not assume that everyone 65 or older is Medicare-entitled for new or active enrollees. Individuals that are not entitled to premium-free Part A but are eligible to enroll in Part A with a premium and has either not yet signed up, or no longer has active Part A coverage at the time of applying, can enroll in QHP coverage without violating the anti-duplication provision.

### New QHP Enrollments

Medicare status:	Able to enroll in new coverage?
Covered under Part A-only	No
Covered under Part B-only	No
Eligible for Medicare, but not yet signed up	Yes*
Covered under Medicare and would like to drop coverage to enroll in Healthplanfinder	Yes, after Medicare is dropped**

\* Individuals who do not enroll in Medicare when first eligible (during their initial enrollment period) may have to pay late enrollment penalties if they later apply for both Premium Part A and Part B.

\*\* Individuals who get free Part A cannot drop it without dropping their retiree benefits (social security or railroad retirement) and paying back all retirement benefits received and costs incurred by the Medicare program

If a customer becomes eligible for benefits under Medicare after enrolling in coverage through HBE, the customer may maintain coverage in the QHP but in most instances is no longer eligible for APTC or CSRs. Medicare Part A and Part C are considered MEC. Some forms of Medicare coverage (e.g. Medicare Part B only and Part D only) are not considered MEC.

### Existing QHP Enrollees Transitioning to Medicare Coverage

Medicare status:	Able to keep QHP coverage in Healthplanfinder?	Eligible to continue receiving tax credits?
Become eligible for free Part A	<b>Yes</b>	<b>No</b> , individuals are no longer eligible for tax credits once Part A begins
Become eligible to buy Premium Part A	<b>Yes</b>	<b>Yes</b> , if only enrolled in Part B as Part B does not constitute Minimum Essential Coverage

CMS guidance prohibits carriers from terminating enrollees whom they subsequently find to be eligible for or enrolled in Medicare, unless the enrollee requests the termination or another legal basis for carrier termination applies.<sup>3</sup> If a customer contacts a carrier wishing to terminate their coverage due to gaining Medicare, they should be directed to report changes in their *Washington Healthplanfinder* account, or contact the Customer Support Center.

Carriers must communicate to HBE via the reconciliation process instances when dual Medicare and QHP enrollment is known. HBE conducts outreach to the customer to provide the option to: 1) remain enrolled in

<sup>3</sup> 45 CFR § 147.106

QHP without APTC/CSR; or 2) disenroll from the QHP.

HBE has found limited instances when it is beneficial for Medicare enrollees to maintain duplicative QHP coverage. Generally, customers do not intend to continue dual enrollment and assume HBE automatically discontinues QHP coverage. Once informed that Medicare recipients are no longer eligible for subsidies, most customers elect to terminate their QHP.

HBE refers customers to the State Health Insurance Benefit Advisors (SHIBA), a division of the Office of the Insurance Commissioner (OIC), for information about Medicare supplemental/Medigap coverage options and other information about Medicare. SHIBA contact information: Phone: 800-562-6900 or URL: <http://www.insurance.wa.gov/SHIBA> .

Consistent with guaranteed renewability provisions, Medicare eligibility or enrollment is not a basis to not renew an individual's health insurance coverage in the individual market.<sup>4</sup> The 2018 Notice of Benefit and Payment finalized an interpretation of the anti-duplication provision that prohibits carriers with knowledge that an enrollee in individual market coverage is entitled to Medicare Part A or enrolled in Medicare Part B from renewing the individual market coverage if it duplicates benefits to which the enrollee is entitled, unless the renewal is effectuated under the same policy or contract of insurance. HBE renewal processes for enrollees have not changed. Throughout the coverage year and during renewals, HBE and carriers coordinate to identify dual enrolled populations that may not be eligible for renewal consistent with the 2018 notice. HBE conducts outreach to each enrollee known to be dually enrolled to provide the applicable 95-day verification period to determine Medicare status.

Medicare recipients may continue their QDP coverage, and HBE continues this enrollment as a QDP-only renewal.

### 3.3 FORM 1095-A HEALTH INSURANCE MARKETPLACE STATEMENT

HBE generates Internal Revenue Service (IRS) Form 1095-A as the covered individual's record for QHP and QDP coverage. Customers use Form 1095-A to complete IRS Form 8962 Premium Tax Credit and reconcile advance payments of the premium tax credit, or claim the premium tax credit on annual, federal tax filings.

**Issue Date and Access:** Each year HBE generates 1095-A documents by January 31. Each issued document is sent according to the customer's notification preferences. The document can also be accessed by directing the customer to log in to their *Washington Healthplanfinder* individual account through <http://www.wahealthplanfinder.org/> .

**Corrections:** When a customer believes their 1095-A document is incorrect, they can request a correction review via HBE's 1095-A webpage: <https://www.wahbexchange.org/current-customers/your-1095-a-statement/>

For other questions regarding 1095-A forms, customers can be referred to the *Washington Healthplanfinder* Customer Support Center at 1-855-WAFINDER (1-822-923-4633).

### 3.4 EXEMPTIONS TO THE SHARED RESPONSIBILITY PAYMENT

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<sup>4</sup> 45 CFR § 147.106

The ACA requires most individuals to have health insurance (individual mandate) or pay a penalty (shared responsibility payment). With passage of the new tax reform law in 2017, the penalty for 2019 and beyond is assessed as a zero-dollar tax. Customers who want to request an exemption from this penalty must make their request with either the Internal Revenue Service (IRS) or the Federal Marketplace. Customers *should not* upload an exemption request through *Washington Healthplanfinder* or send their exemption request to HBE or Customer Support Staff.

HBE does not have authority to grant exemptions. HBE may provide letters of support for customers that wish to seek hardship exemptions because they were without qualifying coverage for some period during the year due to an error caused by HBE. HBE error does *not* include:

- Failure by insurance carrier to process the 834 transactions, including changes to the enrollment after the initial enrollment
- Failure by insurance carrier to invoice the customer, resulting in termination or cancellation for nonpayment.

If failure on the part of the carrier is determined to be the reason for the gap in coverage, the customer may request a letter of support from the carrier.

### 3.5 APPEALS

Customers who apply through *Washington Healthplanfinder* may appeal the eligibility determination they receive. All appeals must be filed within 90 days of the date on the customer's eligibility notification:

- Online: [www.wahbexchange.org/appeals](http://www.wahbexchange.org/appeals)
- Email: [Appeals@wahbexchange.org](mailto:Appeals@wahbexchange.org)
- Fax: 360-841-7653
- Phone: 1-855-859-2512 (360-688-7814)
- Mail: PO Box 1757, Olympia, WA 98507-1757

The HBE Presiding Officers have authority to rule on the following:

- Whether the customer can buy a health insurance plan through *Washington Healthplanfinder*
- Whether the customer can enroll in a *Washington Healthplanfinder* plan outside the regular open enrollment period
- Whether the customer is eligible for lower monthly premiums based on their income
- The amount of savings the customer is eligible for when they use services through a QHP
- Whether the customer should receive benefits as an American Indian or Alaska Native

The HBE Presiding Officers do not have authority to decide the following:

- Correcting the 1095A IRS form
- Health insurance coverage start date and end dates
- Termination of coverage
- Requests for reinstatement
- The HBE Board policy requiring all children to enroll in a dental plan through *Washington Healthplanfinder*
- Billing disputes and refund requests
- The carrier's decision to deny a special enrollment period

- Claims the insurance company denied to pay

## 4.0 WASHINGTON HEALTHPLANFINDER SYSTEM OF RECORD

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*Washington Healthplanfinder* is the system of record for application and enrollment. Application data is provided by the customer during the initial application intake and by reporting a change. HBE uses application data to determine eligibility and create enrollment data after plan selection. Application and enrollment data are used to generate annual 1095-A documents for customers, to reconcile with carriers, and to report APTC and CSR amounts to CMS.

### 4.1 APPLICATION DATA

Application data is created at initial intake. Updates are made by the customer reporting changes in their *Washington Healthplanfinder* account. HBE does not accept change of application data from carriers. An update to application data requires a new eligibility determination<sup>5</sup> which may impact eligibility or enrollment and can only be accepted by updating the *Washington Healthplanfinder* application.

Application data includes but is not limited to First and Last Name, Social Security Number, Date of Birth, Gender, Marital Status, Physical Address, Mailing Address, and Applicant-Initiated Voluntary Disenrollment.

#### 4.1.1 American Indian/Alaska Native Designation

*Washington Healthplanfinder* collects race information for all applicants as a non-required field. For customers that pursue eligibility for American Indian/Alaska Native (AI/AN) coverage provisions, they must indicate membership to an American Indian tribe or as a shareholder in an Alaska Native corporation. The term *Indian* means an individual as defined in section 4(d) of the Indian Self-Determination and Education Assistance Act (Pub. L. 93-638).

AI/AN status is included in 834 transactions files for both the subscriber and/or dependents. The AI/AN indicator is included to facilitate carrier compliance with the following AI/AN provisions:

- AI/AN new and current enrollees are eligible for a SEP once per month to change QHP/QDP plans in accordance with 45 CFR 155.420 (d)
- Ability to receive tribal premium sponsorship payments in accordance with 45 CFR 155.240 (b)
- \$0 cost sharing for AI/AN customers with incomes under 300% of the FPL, so long as the AI/AN customer is APTC eligible
- \$0 cost sharing for item or service furnished through Indian Health Care Providers (regardless of income or receipt of APTC).

*NOTE: Health programs operated by Indian Health Care Providers are the payer of last resort for services provided by such programs, notwithstanding any federal, state, or local law to the contrary*

- Compliance with Indian Health Care Improvement Act, Sections 206 and 408
- All other applicable state and federal laws

### 4.2 CHANGE REPORTING

All customers are required to report changes within 30 days that may impact their eligibility for QHP enrollment. Customers who have requested to be considered for subsidized coverage are required to report changes that may impact program eligibility.<sup>6</sup> Change reporting may result in potential churn between Medicaid eligibility and subsidized or non-subsidized QHP coverage. HBE supports reenrollment of QHP/QDP coverage during the annual

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<sup>5</sup> 45 CFR § 156.335

<sup>6</sup> 45 CFR § 155.330 (b)

open enrollment period or upon eligibility for a special enrollment period (SEP).<sup>7</sup>

If a customer is determined eligible for APTC or CSRs, or if eligibility for those programs changes, HBE notifies the carrier and transmits the information necessary via 834 Change transaction files for carriers to implement, discontinue, or modify the APTC and/or CSRs, including the dollar amount of the APTC and the CSR eligibility category. Carriers are responsible for timely processing of any changes in APTC and/or CSRs and notifying customers of any changes to benefits.

Examples of changes that must be reported through *Washington Healthplanfinder* are listed in the table below.

Change Type
Increase or decrease in projected annual household income or change to current month's household income
Add or remove applicant or non-applicant household member listed on application
Relocation/change of address to a new ZIP Code or county
Gain or loss of other health coverage
Pregnancy that could affect eligibility for Washington Apple Health
Change in tax filing status (e.g., will or will not file, joint or separate filer) or change in tax dependents that will be claimed
Newly incarcerated or released from incarceration
Change in immigration status or citizenship
Change in status as member of federally recognized tribe
Became disabled or in need of long term care (or is no longer in need of long term care)
Change to available employer coverage
Correct/update the relationships between family members

Some updates can trigger eligibility for a Special Enrollment Period (SEP) allowing the customer to create new enrollments or make a change to existing plan selection (see sections 6.2 and 6.3 for more information on SEPs).

When a carrier is contacted by a customer to update their application data, the customer should be:

- Instructed to report changes to *Washington Healthplanfinder* by logging into their individual account at: <http://www.wahealthplanfinder.org/>; or
- Referred to *Washington Healthplanfinder* Customer Support Center at 1-855-WAFINDER (1-822-923-4633).

### 4.3 ENROLLMENT DATA

Enrollment data is created by *Washington Healthplanfinder* using information returned in the eligibility determination and plan selection. This information is populated by HBE in the enrollment transactions.

Carriers accept initial and ongoing payments. HBE accepts carrier updates to enrollment data for effectuation status and end date updates by nonpayment termination or reinstatement. These updates are communicated by the carrier to HBE via 834 transactions.

<sup>7</sup> 45 CFR § 155.420 (d)



Updates to enrollment data as a result of application updates are sent by HBE to carriers via 834 transactions. As the system of record, all discrepancies or updates to enrollment data are directed to an HBE Enrollment Analyst. Most enrollment discrepancies are resolved by carriers processing an 834-transaction file from HBE or carriers sending (or re-sending) an 834 transaction to HBE. This is the compliant method to communicate enrollment intent and make updates to the HBE systems during an enrollment transaction plan year.

### 4.3.1 Multiple Enrollments

*Washington Healthplanfinder* facilitates customer choice across health plans for individuals to make an informed decision during the shopping experience. Expected utilization, member-level eligibility differences, and continuity of on-going care (among other factors) can drive consumer decision to make separate enrollment choices among household members and create multiple enrollments for the same or multiple insurance companies.

Carriers must accept multiple enrollments for a single household if the coverage does not overlap to create dual member-level coverage. These enrollments are conveyed with a single Primary Subscriber but a unique Enrollment Identifier, different member-level covered individuals, and appropriate coverage code designation.

### 4.3.2 Location and Plan Options

*Washington Healthplanfinder* accepts customer attestation for physical address. Plan availability and rates are displayed for rating areas in accordance with the following “winning address” logic:

- If the primary applicant is seeking coverage, the winning address is the primary applicant’s home address.
- If the primary applicant is not seeking coverage and all dependent members seeking coverage live in the same county, the winning address is the dependents’ physical address.
- If the dependent members seeking coverage live in different counties, the winning address will default back to the primary applicant’s physical address.

If a customer would like to shop for a plan for dependent that is available in the dependent’s county, but is not displayed in the shopping flow due to the winning address logic described above, they can contact the *Washington Healthplanfinder* Customer Support Center to have a separate shopping flow facilitated.

If a carrier believes a customer is no longer eligible for coverage due to residing outside of a service area, the customer should be directed to contact *Washington Healthplanfinder* to report their address change. If the customer indicates they are not willing to contact *Washington Healthplanfinder*, insurance carriers can notify their designated Enrollment Analyst, who will conduct outreach and/or escalate internally as needed.

### 4.3.3 Status

Enrollment status is not conveyed on enrollment transactions, but status is updated by the HBE EDI System as transactions are sent and received. Status includes the following:

- **Initial:** Enrollment created during an Open Enrollment Period or Special Enrollment Period
- **Active:** An effectuated enrollment
- **Terminated:** A previously active enrollment (for at least 1 day or more) that is end-dated
- **Cancelled:** A previously initial enrollment that has been cancelled as never effective

### 4.3.4 Premium Rating Factors

HBE applies the application data for age, location, and tobacco factor (if applicable) to plan selection in order to create the premium enrollment data. Premiums are rated individually, but for family members enrolled in the same policy under the age of 21, the premiums for the three oldest covered children are taken into account in



determining the total family premium.<sup>8</sup>

Enrollees maintain the same rate during the coverage year when:

- Continuous coverage occurs; in
- The same plan; for
- The same individual

Enrollments created during the OEP or by annual renewals, re-rate the January 1 enrollment when application updates are made between November 1 and December 15. Re-rating does not occur outside of the OEP unless a new plan is selected by a SEP or a gap in coverage occurs. HBE re-rates on passive (batch) and active (manual) renewal transactions for the new calendar year rate.

**Premium Example 1:** Primary Applicant selects a plan during the OEP on November 5 for a January 1 start date. On December 8, the customer updates the application tobacco designation from “No” to “Yes”. The customer is re-rated using their latest tobacco factor due to change reported prior to the monthly 15<sup>th</sup> cut-off.

**Premium Example 2:** Primary Applicant selects a plan during the OEP on November 5 for a January 1 start date. On December 26, the customer updates the application tobacco designation from “No” to “Yes”. The customer is not re-rated for the January 1 start date using the latest tobacco factor due to change reported after the monthly 15<sup>th</sup> cut-off.

Customers are rated based on the latest factors for plans effective in a new calendar year and when they change plans (identified by a new Enrollment Identifier) mid-year during as a result of a SEP. This is true whether they stay with the same carrier or switch to a new carrier.

**Premium Example 3:** Customer enrolls in Plan A during the OEP for a plan to start January 1. The customer’s date of birth is April 21. On July 5, the customer reports a change resulting in a SEP. On the same day, they enroll in Plan B (with a different Enrollment Identifier) with the same carrier for an August 1 start date. The customer is re-rated due to the plan change based on their latest rating factors, including their increased age.

Customers are rated based on the latest factors when a new plan is selected by a SEP or a gap in coverage occurs.

**Premium Example 4:** Customer enrolls in Plan A during the OEP for a plan to start January 1. On March 9, the customer reports a change resulting in Medicaid eligibility. The QHP ends March 31. The customer’s date of birth is April 21. On July 5, the customer reports a change ending Medicaid eligibility, resulting in a SEP. On the same day, they re-enroll into the prior QHP product with an August 1 start date. The customer is re-rated using their latest rating factors, including their increased age because they are starting new coverage – even though they are re-enrolling in Plan A.

Customers are rated based on the age at the coverage effective date. Age is the only rating factor that is impacted by start date adjustments. All other rating factors are rated at the time of plan selection. Earlier or later start date adjustments across an enrollee date of birth will change the appropriate rate. Retroactive event SEPs or manual adjustment of start dates by HBE are re-rated to the age factor of the new effective date.

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<sup>8</sup> 45 CFR § 147.102

**Premium Example 5:** On March 9, the customer applies for coverage due to birth of a child. The date of the birth event is February 2. On the same day (March 9), the customer enrolls in a QHP/QDP product with a February 2 start date. The customer's birth date is February 20; they turned 36. The customer is rated using the rating factors as of March 9 except for age due to the retroactive start date that crosses a date of birth. They are rated with the March 9 factors for location and tobacco, but re-rated to age 35 for age.

#### 4.3.5 APTC Amount

Customers determined eligible for APTC only receive the tax credit if they enroll in a QHP through HBE. The APTC can be applied to Gold, Silver, and Bronze QHP plans. Catastrophic plan enrollments are not eligible for APTC. *Washington Healthplanfinder* does not permit APTC to be applied to QDP plan premiums.

APTC only begins on the first of the month. APTC is paid at the subscriber level for an enrollment group. HBE notifies customers of the maximum APTC amount for which they are eligible during the shopping experience prior to selecting a health insurance plan. The customer can apply the maximum APTC amount monthly or apply less and receive the remaining credit with their federal tax filing. The tax credit applied monthly cannot exceed the cost of the essential health benefit (EHB) portion of the plan premium. Customers eligible for APTC that elect to receive \$0 on an advanced basis are not eligible for the 3-month grace period that is applied to customers using the advanced tax credits.

HBE reports the APTC amount to the carrier and to CMS to facilitate the payment from CMS directly to the carrier.

#### 4.3.6 Cost-Sharing Reduction (CSR) Tier and Amounts

Cost-sharing reduction (CSR) is a discount that lowers the amount a customer pays for deductibles, co-insurance, co-payments and other out-of-pocket expenses (like lab tests and drugs). APTC eligibility is a requirement for CSR, except for Native Americans.<sup>9</sup> A customer who is eligible for APTC can select a monthly applied APTC of \$0 and remain eligible for CSRs.

There are six cost-sharing tiers. One tier designates no cost-sharing reductions. There are three silver metal level CSR tiers and two CSR tiers specific to AI/AN enrollees.

- Tier 1 (T1) – Not eligible for Cost Sharing Reductions (default tier for all plans, unless the conditions are met for eligibility into another tier)
- Tier 2 (T2) – Zero Cost-Sharing: American Indian/Alaska Native
- Tier 3 (T3) – Limited Cost-Sharing: American Indian/Alaska Native
- Tier 4 (T4) – 73% AV Variant: Silver Plan
- Tier 5 (T5) – 87% AV Variant: Silver Plan
- Tier 6 (T6) – 94% AV Variant: Silver Plan

CSR is paid at the subscriber level for an enrollment group. This is the amount the carrier can expect to receive as the advance CSR payment. The CSR amount should be rounded using the “Half Up” methodology. If the value is .005 or above, round up to the nearest penny and only provide two (2) decimal places.

There is a special rule for family policies.<sup>10</sup> When there is an enrollment in a QHP under a single policy that covers two or more individuals who could be eligible for different cost sharing if enrolled in separate, individual policies, HBE determines the individuals under such policy to be collectively eligible for the category of eligibility

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<sup>9</sup> 45 CFR § 156.315 (e)

<sup>10</sup> 45 CFR § 155.305 (g) (3)

last listed in which all the individuals covered would be eligible. The order of CSR tier under this scenario is as follows: Tier 1, then Tier 3, then Tier 4, then Tier 5, then Tier 6, then Tier 2.

#### **4.3.7 Monthly Premiums and Proration**

The full monthly premium is included in all enrollment transactions. HBE does not prorate the enrollment premium, APTC/CSR, and customer responsibility amount in enrollment transactions and reporting. In the event of mid-month coverage start or termination at a policy or member level, carriers calculate the applicant's updated responsibility amount based on a proration of the premium that corresponds to the number of days covered during the month and then invoice accordingly.

Certain SEP-initial enrollments and SEP member-level additions have a start date other than the first day of the month. Retroactive start date qualifying life events begin on the date of the event.<sup>11</sup> Terminations for a deceased enrollee are effective the date of death.<sup>12</sup>

#### **4.3.8 Coverage Start Date**

In general, coverage start dates are based on an applicant's plan selection date. A plan selected from the 1<sup>st</sup> through the 15<sup>th</sup> of a month is effective the 1<sup>st</sup> of the following month. Plans selected from the 16<sup>th</sup> through 31<sup>st</sup> (or last day) of a month are effective the 1<sup>st</sup> of the second following month. Certain SEP events (e.g. birth, adoption, placement for adoption, placement in foster care, or child support or other court order) allow or require an earlier or later start date based on the date of event rather than the plan selected date.

HBE does not accept start date changes from carriers by 834 transactions. When carriers approve changes to an enrollee coverage start date, the process is to first effectuate the initial enrollment by 834 Confirm, then work directly with their assigned HBE Enrollment Analyst for system of record updates. The carrier needs to include the reason for approving the change in start date (e.g. invoicing error, SEP verification delay, etc.).

#### **4.3.9 Coverage End Date**

The coverage end date for every active enrollment is December 31<sup>st</sup> of the plan year. Certain HBE and carrier activities can end coverage before the end of the year. Mid-year coverage end date updates are communicated by 834 transactions between HBE and carriers. Premium nonpayment termination and reinstatement of nonpayment are the only end date changes accepted from carriers. HBE sends outbound 834 transactions for terminations due to voluntary requests, cancellations, death, and eligibility denials.

#### **4.3.10 Broker Partnership**

HBE communicates enrollments with partnered brokers via 834 transactions. If a broker partners with a customer when the initial enrollment is confirmed, HBE sends the broker information in the 834 Add transaction. If a broker is removed, HBE sends an 834 Change transaction. The effective date for the partnership is the start of coverage based on the timestamp in the transaction. If it is between the 1<sup>st</sup> and 15<sup>th</sup> of the month, start date is the first of the following month. If it is after the 15<sup>th</sup> of the month, start date is the first of the second following month. In some cases, a broker partnership ends at the same time as a termination (see the 834 Companion Guide for transaction details). Reconciliation of broker issues is addressed via an HBE Enrollment Analyst.

#### **4.3.11 Third-Party Sponsor**

Carriers offering individual market QHPs and QDPs must accept premium and cost-sharing payments on behalf

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<sup>11</sup> 45 CFR § 155.420 (c)

<sup>12</sup> 45 CFR § 155.430 (d) (7)

of plan enrollees from third-party sponsors.<sup>13</sup> Sponsors through the HBE may include:

- Ryan White HIV/AIDS Program under Title XXVI of the Public Health Service Act
- An American Indian or Alaska Native tribe, tribal organization, or urban American Indian organization
- A local, state, or federal government program, including a grantee directed by a government program to make payments on its behalf

Entities that provide premium and cost-sharing support to enrollees must participate in the HBE Sponsor program. Sponsorship of premiums is at the policy-level for a given enrollment. *Washington Healthplanfinder* allows an HBE Sponsor administrator to create new sponsorship entities and maintain sponsorship entity rosters by adding/removing enrollees.

If the sponsorship link is present at the time of plan selection, the initial enrollment 834 Add transaction generates with the sponsor entity as payer. The effective date of the sponsor is the start of coverage. If the link is created after enrollment initiation, the updated information is sent in an 834 Change transaction, and the effective date of the sponsor is based on the timestamp in the transaction. If it is between the 1<sup>st</sup> and 15<sup>th</sup> of the month, start date is the first of the following month. If it is after the 15<sup>th</sup> of the month, start date is the first of the second following month.

Sponsorship discontinuation on an enrollment is based on the timestamp in the 834 Change transaction similar to adding a sponsor after initial enrollment (see the 834 Companion Guide for more details).

#### **4.3.12 Data Fix Indicator**

A data fix is a manual fix completed by an account worker or by HBE's system integrator after manual review and approval. The resulting 834 transaction generated to the carrier will include a data fix indicator (see the 834 Companion Guide for more details).

## **4.4 ENROLLMENT TRANSACTIONS**

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 includes provisions for administrative simplification through the implementation of standardized Electronic Data Interchange (EDI) transactions between authorized covered entities, also referred to as "trading partners". These EDI standards are extended to the exchange of enrollment data between HBE and carriers offering products through the HBE. The 834 Companion Guide addresses the 834 EDI requirements for the individual market.

*Washington Healthplanfinder* accumulates transactions and sends them once each day (seven days a week, except during pre-scheduled maintenance windows). HBE accepts enrollment transactions from carriers seven days a week. Pre-scheduled maintenance windows do not impact a carrier's ability to send enrollment transactions, but may delay file processing.

### **4.4.1 Enrollment Transactions for a Plan Year**

Enrollment transactions for a plan year begin November 1 and remains in effect for a 17-month duration, ending March 31. The start of an OEP and the corresponding passive (batch) renewal cycle begins the plan year at November 1. Conversely, the 60-day SEP reporting window for a prior year retroactive event lapses on March 1. A subsidized customer with a 3-month grace period that begins December 1, ends on the last day of February. After receiving the final prior year nonpayment termination files during the month of March, enrollment transactions end on March 31.

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<sup>13</sup> 45 CFR § 157.1250

#### **4.4.2 Updates after March 31**

It is important for carriers to review prior year transactions before delivery. Automation of outbound 834 transactions to HBE should stop for a given plan year on March 31 to avoid negative impacts to customers and operations. There are specific requirements for prior year reconciliation after the plan year ends (see section 12 for more information).

## 5.0 PAYMENTS AND GRACE PERIODS

At a minimum, carriers must accept paper checks, cashier's checks, money orders, Electronic Fund Transfer (EFT), and all general purpose prepaid debit cards (including state agency issued debit cards) for the purpose of payment for benefits.<sup>14</sup> For the binder payment, carriers may accept a method that is exclusive to the initial premium. For example, the "Pay Now" function on *Washington Healthplanfinder* that redirects to a carrier site, may accept binder payment by credit card, even though the carrier does not accept credit cards as a method of payment for regular monthly premiums.

Application of premium payment methods must not discriminate against any individual or group. Carriers may not offer a discount on premiums to customers who elect a specific type of premium payment method (e.g. EFT). Additionally, carriers may not apply additional fees based on their choice of valid payment method. For example, a carrier may not pass on administrative fees for processing a premium payment via credit card.

### 5.1 BINDER PAYMENTS

Initial enrollments created during the OEP or by SEP require a binder payment to become effectuated (see section 6.0 for more detail on both scenarios). The binder payment is the first month's premium. The due date for the binder payment must be no earlier than the coverage effective date, but no later than 30 calendar days from the coverage effective date. With retroactive or special effective dates, the binder payment due date must be no later than 30 calendar days from the date the carrier receives the enrollment transaction. The due date for the binder payment must also allow 15 business days from the time the customer receives the invoice to make the payment.

For retroactive coverage effective dates, the carrier must bill the customer for all premiums, including premiums for both retroactive and prospective coverage, in accordance with the effectuation rules.<sup>15</sup> When the enrollee makes a payment to satisfy at least a single month's premiums, but the payment is insufficient to pay the entire total monthly premium due, the carrier must still effectuate the coverage. The enrollee enters the applicable grace period and is required to pay all outstanding premiums due before the expiration of the grace period to avoid termination for nonpayment according to applicable grace period requirements.

### 5.2 PAY NOW

For initial enrollments selected during the OEP, *Washington Healthplanfinder* enables a "Pay Now" feature. When a customer selects the "Pay Now" option, they are redirected to the carrier's payment site (available until the plan effective date). If the customer selects plans from more than one carrier, *Washington Healthplanfinder* enables multiple "Pay Now" links with each redirect occurring in a separate window.

The "Pay Now" feature is not available for initial enrollments generated by SEPs outside of the OEP, or for regular monthly premium payments on an effectuated enrollment outside of the OEP.

Payments made via "Pay Now" typically occur before *Washington Healthplanfinder* generates the 834-enrollment transaction to the carrier. Therefore, at the time of payment redirect, the carrier often does not have any information on file regarding the initial enrollee's plan selection or the APTC amounts (if eligible). The "Pay Now" feature securely transfers basic information in the redirect to the carrier's payment portal so that an accepted payment can be linked to a corresponding 834 transaction.

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<sup>14</sup> 45 CFR § 157.1240 (a)(2)

<sup>15</sup> 45 CFR § 156.400(e)(1)(iii)

Orphaned payments are funds received by carriers via the “Pay Now” feature that do not have a corresponding 834 transaction. This may occur if a customer re-shops during the OEP and selects a different plan with a different carrier on the same day as their initial selection. When this happens, HBE does not send an 834 Add transactions for the customer’s initial selection. If an orphaned payment occurs, the carrier should issue a refund back to the customer according to the method of payment received.

### 5.3 GRACE PERIODS

Once a binder payment is received and the enrollment is effectuated, the enrollee begins a regular monthly payment cycle with carrier invoices. A grace period is initiated on an effectuated enrollment when a regular monthly payment has not been received, beginning on the first day of the month following the first missed payment. Carriers must allow a one-month grace period for QDP and non-subsidized QHP enrollments and a 3-month grace period for all QHP enrollments with any amount of APTC applied monthly.

Customers eligible for APTC that elect to receive \$0 on an advanced basis are not eligible for the 3-month grace period that is applied to customers using the advanced tax credits (see section 4.3.5).

The length of grace period does not change during an active grace period. For example, customers receiving APTC who enter a grace period for failing to pay premiums and lose APTC eligibility during the grace period, are able to complete the remaining grace period as though the loss of eligibility for APTC did not occur.<sup>16</sup>

Due to change reporting, a household may transition from FAM to DEP enrollment or vice versa. Provided the household maintains the same plan and subsidized status, the 3-month grace period should carry over to new enrollments as applicable.

### 5.4 DELINQUENCY NOTICE REQUIREMENTS

Carriers must include information in delinquency notices that concisely explains the impact of nonpayment of premiums on access to coverage and health care services and encourages the customer to contact the carrier regarding coverage options that may be available. Carriers must also include information for subsidized customers on reporting changes of income or circumstances to *Washington Healthplanfinder* including the 30-day deadline<sup>17</sup>, along with an explanation that it may result in a change in eligibility.<sup>18</sup>

### 5.5 RENEWALS

Renewal enrollments (active or passive) into the same product do not require a binder payment. Carriers continue to bill the customer via their existing enrollment billing cycle. Nonpayment of the January premium by the due date, triggers the applicable grace period.

If a policy was not included in passive renewals and the customer has not completed an active renewal by December 15, the carrier should discontinue January auto-draft payments. Carriers must promptly refund payments drawn by the carrier or mistakenly provided by the customer for January coverage when the customer has cancelled coverage prior to the effective date or has completed an active renewal into new coverage plan with a new carrier prior to the end of OEP.

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<sup>16</sup> RCW 49.43.039 (3)

<sup>17</sup> 45 CFR § 156.330

<sup>18</sup> 45 CFR § 156.430 and 45 CFR § 157.270



## 5.6 PAST DUE PREMIUMS

Carriers may condition effectuation of new coverage (OEP or SEP) on past due premiums owed by the customer contractually responsible for past-due premiums on prior coverage with the same carrier in the preceding 12-month period.<sup>19</sup> Payments can be attributed to the past due amount. This is referred to as the “look-back” policy. This does not include premiums for months in which the customer was not enrolled in coverage. Generally, a customer will not owe more than three months of their net subsidy premium to effectuate new coverage.

In instances where the customer’s grace period ends December 31, carriers may choose to effectuate or refuse to effectuate the new enrollment as long as they apply a consistent policy across all enrollments.

Carriers adopting this “look-back” policy must describe consequences of nonpayment on future enrollment in enrollment application materials and notices regarding premium nonpayments. The binder payment invoice for past due premiums must clearly indicate the enrollment details related to the past due premium, the amount due, and consequences for nonpayment on future enrollment.

### **Scenario 1: Past due premiums, termed enrollment, binder and one month billed**

A prior enrollment was termed for nonpayment within the prior 12-month period, terminating coverage June 30. June’s premium remains unpaid and the coverage end date is the last day of the first month of the grace period. The prior year enrollment premium payment less subsidy = \$120. Binder payment due for new enrollment less subsidy = \$130. The carrier may condition effectuation of new enrollment on two months premium payment: a binder payment for the new enrollment of \$130 and the past due premium of \$120.

### **Scenario 2: Past due premiums, active grace period, binder and two months billed**

A prior enrollment is in an active grace period that ends January 31. The prior year enrollment premium payment less subsidy = \$120. Binder payment due for new enrollment less subsidy = \$130. The carrier may condition effectuation of the new enrollment on three months premium payments: a binder payment for the new enrollment of \$130 and two months past due premium of \$120.

### **Scenario 3: Past due premiums, grace period ending December 31**

A prior enrollment is in an active grace period that ends December 31. The prior year enrollment premium payment less subsidy = \$120. Binder payment due for new enrollment less subsidy = \$130. The carrier may choose to effectuate or refuse to effectuate new enrollment in a policy that is consistent across all enrollments in this scenario.

### **Scenario 4: Past due premiums, grace period does not exist, 1-month premium paid**

There is a binder payment due for a new enrollment = \$130. An initial enrollment from a SEP is created during the OEP with binder payment amount = \$120. The customer makes a premium payment in the amount of \$130. The carrier may *not* attribute that payment towards past due premiums. The SEP initiated enrollment was never effectuated, so the grace period to create past due premiums does not exist. The carrier must effectuate the OEP enrollment when the one-month premium payment is made.

## 5.7 NONPAYMENT TO VOLUNTARY UPDATE

A nonpayment of a one-month subsidized enrollment is reported by HBE to CMS and on the 1095-A, which has implications for the tax-filer. Carriers must inform HBE when a past due payment is accepted as the tax-filer is due a corrected 1095-A. Carriers can contact the HBE Enrollment Analyst to update a prior year disposition

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<sup>19</sup> 45 CFR § 147.104



from nonpayment to voluntary, and HBE will issue a corrected 1095-A to the customer.

## 5.8 OVER PAYMENTS

When carriers discover an over-payment, a credit to the customer account and/or a refund should be issued for the over-billed amount within a reasonable time of the discovery. Any resulting 834 transaction sync issues and APTC discrepancies are addressed during enrollment reconciliation.

## 5.9 UNDER-BILLED PREMIUMS

The term “under-billed premium” refers to a circumstance where a carrier erroneously bills an enrollee too little or not at all. If this occurs, carriers are highly encouraged to allow customers a reasonable amount of time to pay the premium amount considering the customers regularly billed monthly premium amounts. QHP and QDP carriers are permitted to allow customers to pay under-billed premiums in equal installments.

## 5.10 HBE RETROACTIVE UPDATES

Retroactive updates initiated by HBE that create under-billed or overbilled premiums are infrequent and are handled in a timely manner. If an appeal, a data fix (manual fix completed by an account worker or by HBE’s system integrator), or a HBE review results in a change to an enrollee’s coverage that causes an overbilled premium, a data fix indicator is included in the 834 transaction (see the 834 Companion Guide for details).

Customer-initiated changes are always prospective (except through SEPs that grant retroactive effective dates). If the carrier receives an 834 Change transaction without a data fix indicator that creates an under-billed or overbilled premium, carriers should flag the transaction and contact the HBE Enrollment Analyst for review. This result is unexpected and warrants individual review by HBE.

## 5.11 SPONSOR PAYMENTS

Carriers should allow sufficient time for receipt of premium payment by a third-party Sponsor in order to prevent termination of enrollments for nonpayment.

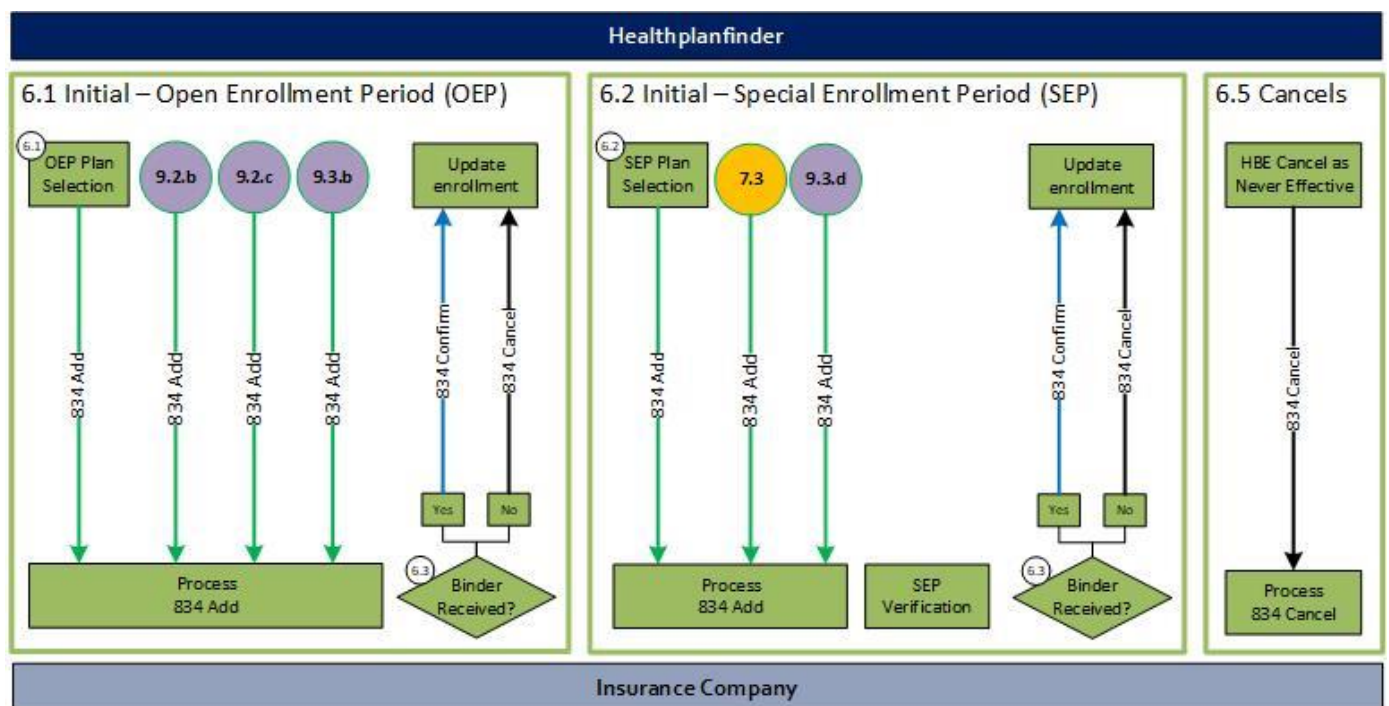
## 6.0 INITIAL ENROLLMENTS

Washington Healthplanfinder allows customers to create initial enrollments during the OEP or by SEP<sup>20</sup>.

Business rules that apply to initial enrollments include:

- 834 Add transactions are sent to create an initial enrollment and during renewals. Subsequent updates to the enrollment are conveyed by 834 Change and Term transactions.
- Potential enrollees have the option to create separate initial coverage for individual household members across the same or multiple carriers.
- Carrier response to HBE is expected within 10 business days of either receipt of binder payment or the binder payment due date has passed; whichever is sooner.

The table below provides an overview of the initial enrollment process.



### 6.1 INITIAL – OPEN ENROLLMENT PERIOD (OEP)

An initial QHP/QDP enrollment is created after QHP and QDP plan selections are finalized by the customer in *Washington Healthplanfinder*. HBE sends an 834 Add transaction to transmit the coverage details to the carrier. Each initial enrollment requires a binder payment to become effectuated.

The OEP for the 2021 coverage year is November 1 to January 15. Plans selected between November 1 and December 15 will have a January 1 start date. Plans selected between December 16 and January 15 will have a February 1 start date.

### 6.2 SPECIAL ENROLLMENT PERIOD DURING OEP

Customers may become eligible for a SEP during the OEP and initiate both an OEP-initial and SEP-initial

<sup>20</sup> 45 CFR § 156.530

enrollment. Carriers must accept the OEP enrollment under guaranteed availability<sup>21</sup>. Carriers should promptly invoice the customer and not wait for SEP verification on the December enrollment or condition effectuation on receiving the SEP-initial binder payment.

Enrollments created between November 1 and December 15 for a January 1 start date are initiated based on OEP and are invoiced using the binder payment guidelines noted in section 5.0 Payments and Grace Periods. Disposition of the SEP coverage (beginning earlier than January 1) does not impact the availability of customer to effectuate January 1 coverage.

**Scenario 1: Future OEP Enrollment with No Current Year SEP**

Initiated during OE	Current Year SEP Enrollment	Next Year OE Enrollment
Yes	N/A	Normal OE invoice

**Current Year SEP Disposition:** N/A

**Future Year OE Disposition:** Normal Open Enrollment invoicing to receive customer’s binder payment.

**Scenario 2: Future OEP Enrollment with Current Year SEP; SEP approved by Carrier**

Initiated during OE	Current Year SEP Enrollment	Next Year OE Enrollment
Yes	SEP approved, no binder received	Normal OE invoice

**Current Year SEP Disposition:** SEP approved and the customer was invoiced but did not make their binder payment. Carrier sends HBE an 834 Cancel file.

**Future Year OE Disposition:** Normal Open Enrollment invoicing to receive customer’s binder payment. The coverage is not automatically cancelled.

**Scenario 3: Future OEP Enrollment with Current Year SEP; SEP denied by Carrier**

Initiated during OE	Current Year SEP Enrollment	Next Year OE Enrollment
Yes	SEP denied, not invoiced for binder	Normal OE invoice

**Current Year SEP Disposition:** SEP denied, and the applicant was not invoiced. Carrier informs HBE of the SEP denial via SEP denial process.

**Future Year OE Disposition:** Normal Open Enrollment invoicing to receive customer’s binder payment. The coverage is not automatically cancelled.

**6.3 INITIAL – SPECIAL ENROLLMENT PERIOD (SEP)**

SEPs constitute periods outside of the OEP when a customer can shop to create an initial QHP/QDP enrollment, or an active enrollee may elect to change a QHP/QDP selection<sup>22</sup>. Most qualifying life events are available in *Washington Healthplanfinder* and will automatically open a shopping window based on self-attestation. Other qualifying life events are only available by contacting the *Washington Healthplanfinder* Customer Support Center for escalation and HBE review.

HBE indicates the SEP reason on the 834 add transaction sent to the carrier. For HBE-confirmed SEPs, carriers shall accept the applicable SEP code provided in the 834 file as verification, and should not require documentation for verify the SEP. For SEPs not confirmed by HBE, the decision to require customers provide proof of their qualifying life event and/or prior coverage is at the option of the carrier.

<sup>21</sup> 45 CFR § 147.104

<sup>22</sup> 45 CFR § 155.420

If a customer reports changes that open a SEP and elect to remain in the same plan, a SEP code may be sent on the 834 change file. Carriers should not request documentation when the 834 transaction is a change. Documentation for SEPs not validated by HBE should only be requested for new enrollments (834 add) or the addition of dependents (834 change-add).

### 6.3.1 HBE-Confirmed SEPs

**Exceptional Circumstance (EX):** Exceptional Circumstance SEPs are not available in *Washington Healthplanfinder*. They are a result of an HBE review. The SEP reason code on the 834 transaction is “EX” and is an HBE confirmed SEP.

**WAH to QHP/APTC Program Change (PC):** This qualifying life event occurs when Washington Apple Health (WAH) eligible customers report an application update and are determined newly eligible for QHP/APTC. The underlying qualifying life event is loss of Minimum Essential Coverage (MEC) and HBE-system automation confirmed the WAH to QHP/APTC program change. The SEP reason code on the 834 transaction is “PC” and is an HBE confirmed SEP.

**Financial Change (FC):** This qualifying life event occurs when customers submit an application and are determined newly eligible or ineligible for APTC or experience a change in CSR tier. The SEP reason code on the 834 transaction is “FC” and is an HBE-confirmed SEP. Carriers should not request documentation to verify this qualifying life event. If a customer is currently enrolled with a carrier and uses this SEP to change plans within the same carrier, the carrier should not request proof of prior coverage. If a customer is new to a carrier, the carrier can request proof of prior coverage.

**Error of the Exchange (ER):** Error of the Exchange SEPs are not available in *Washington Healthplanfinder* and are reviewed on an individual basis by HBE. The SEP reason code on the 834 transaction is “ER” and is an HBE confirmed SEP.

**Domestic Violence (07):** Domestic violence is defined as an Exceptional Circumstance by HBE. This SEP is available in the *Washington Healthplanfinder* application flow. The SEP reason code on the 834 transaction is “07.” Due to the sensitivity of this situation, carriers should not request documents to prove the qualifying life event when an initial enrollee indicates they are a victim under this circumstance, but can request proof of prior coverage.

**Member of a federally recognized tribe or a shareholder in an Alaska Native Corporation (NE):** A customer or their dependent who is enrolling in the same coverage, who is an enrolled member of a federally-recognized tribe, may enroll in a QHP or change from one QHP to another one time per month. The SEP reason code is “NE”, and race/ethnicity indicator for American Indian or Alaska Native (“I”) will be sent in the 834 transaction.

**Cascade Care Savings (PC):** Pursuant to the Exchange’s Exceptional Circumstances Special Enrollment Period (SEP) Policy and authority granted to the Exchange<sup>23</sup>, individuals up to 250% FPL that are not enrolled in a Silver or Gold Cascade Care plan will be eligible for a monthly SEP to enroll in a Silver or Gold Cascade Care Plan. HBE verifies eligibility for this SEP. The SEP reason code on the 834 transaction is “PC” and is an HBE confirmed SEP.

See full table of SEPs with descriptions, applicable regulations, coverage effective dates, and SEP reason codes in [Appendix A](#).

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<sup>23</sup> 45 CFR § 155.420(d)(9) and (16)

### 6.3.2 SEP Denial Process

For SEPs not confirmed by HBE, a carrier may deny the enrollment or addition of a household member if the customer fails to provide valid documentation or does not provide documentation timely to prove their qualifying life event and/or prior coverage.

Carriers should report denied special enrollment periods to HBE weekly, utilizing existing ticketing processes or by sending a weekly report. The report should be sent as an Excel file and at a minimum contain the enrollment ID, subscriber ID, SEP denial reason, and applicable dependent PIDs, if the denial is for a member-level add.

If a carrier elects to overturn a SEP denial, they should reach out to their designated HBE Enrollment Analyst to reinstate the enrollment or household member.

## 6.4 CARRIER EFFECTUATION PROCESS

Upon receiving an 834 Add transaction, carriers seek a binder payment from the customer. A binder payment equal to a one-month premium is required to effectuate the initial enrollment. Carriers provide effectuation by sending HBE an 834 Confirm transaction. Effectuation disposition is due 10 business days after receipt of payment.

If carrier does not receive the binder payment, an 834 Cancel transaction response is due to HBE within 10 business days after the binder payment due date.

## 6.5 HBE INITIATED CANCELLATIONS

A cancellation is a specific type of termination action that ends a qualified individual's enrollment through HBE on the date such enrollment became effective, resulting in enrollment never having been effective.<sup>24</sup>

### 6.5.1 Voluntary Cancellations

When a customer requests voluntary cancellation prior to the coverage effective date, HBE sends an 834 Cancel transaction file.

### 6.6.1 10-Day Free Look

Under state insurance regulations, an applicant who purchases a health or dental plan has a contractual right to return the policy to the carrier for any reason within 10 days of delivery of the policy (or contract) to the customer<sup>25</sup>. This 10-day period begins on the date the carrier provides the actual insurance policy to the customer, not on the date the customer selects a plan in *Washington Healthplanfinder*. Therefore, this date may differ from the coverage effective date. If the customer returns the policy within 10 days of the delivery date, it is void from the effective date and any payment must be refunded to the customer. If this situation occurs, the following business rules apply:

- Washington Healthplanfinder does not facilitate delivery of the policy and is unaware of when delivery occurs and the 10-day period begins. The customer must contact the carrier directly and reach an agreement that the "10-day free look" policy applies.
- The carrier contacts HBE to request cancellation of the policy through the reconciliation process.
- HBE contacts the customer to confirm that they wish to cancel their coverage. Once confirmed, HBE sends an 834 Cancel transaction to the carrier.
- If this situation occurs outside of OEP, the customer is not able to purchase another plan until the next

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<sup>24</sup> 45 CFR § 156.330 (e)(2)

<sup>25</sup> RCW 48.44.230

enrollment period. HBE will not reinstate the plan or provide a SEP by request of the customer.

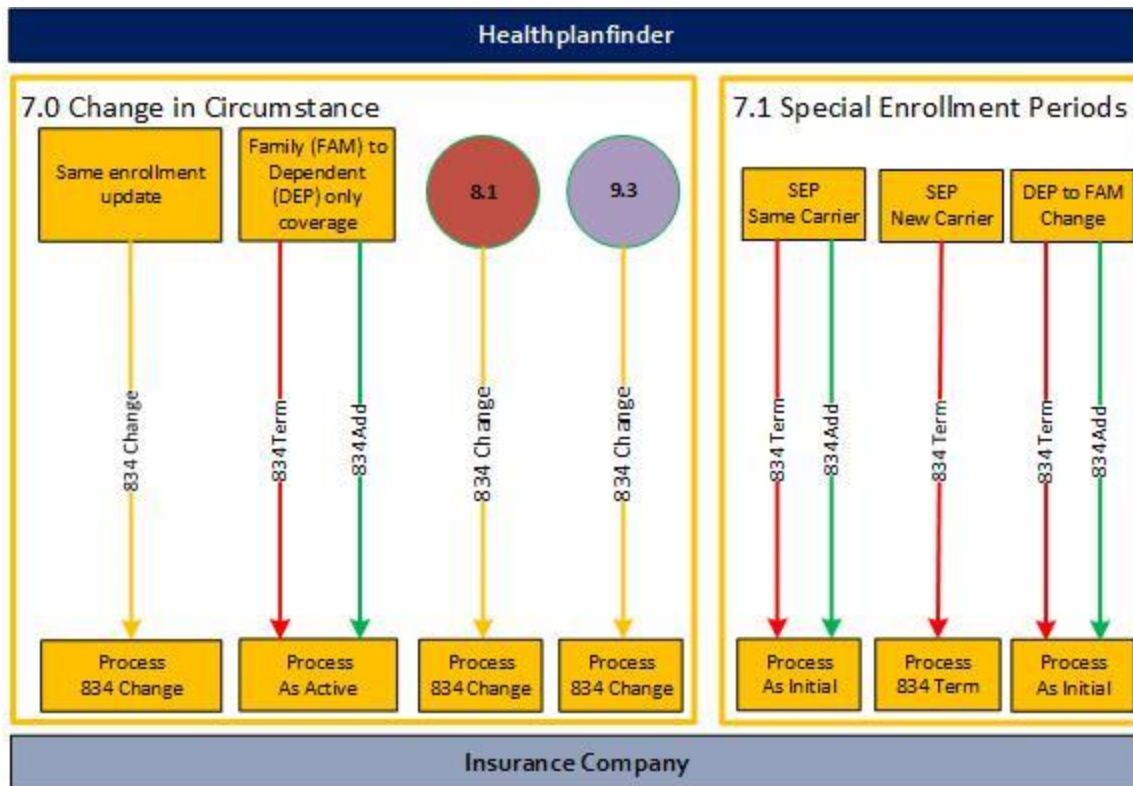
## 7.0 APPLICATION UPDATES DURING THE BENEFIT YEAR

After initial enrollments, updates are communicated by 834 Change transactions. In general, HBE maintains the same Enrollment-ID when the enrollee continues the same plan. Exceptions may occur when the Primary Applicant makes an update to newly seeking or newly not seeking on an application with active enrollment. This initiates an 834 Term transaction and an 834 Add transaction with a new Enrollment-ID.

Other business rules for application updates during the benefit year include:

- Latest eligibility is auto-applied to the enrollment when a change in circumstance is reported and no plan shopping occurs.
- 834 Change transactions are the only transactions with the intent to make a financial update on the enrollment, including terminated enrollments.
- Only prospective changes are conveyed on 834 Change transactions unless a data fix indicator is present.

The table below provides a graphic overview of application updates during the benefit year.



### 7.1 EXISTING ENROLLEE SEP

Existing QHP enrollees who have a qualifying life event and become eligible for a SEP outside of the OEP are limited to selecting coverage in the same metal level if they choose to change plans. They may choose another carrier's plan in the same metal level. If there are no other available plans at the same metal level, the customer and any dependents may enroll in a plan one metal level higher or lower. This applies to all qualifying life events except the following:

- QHP enrolled customers with a qualifying life event that involves adding a dependent (marriage, birth, adoption, placement for adoption, placement in foster care, or court order) must either add the dependent to the existing enrollment or enroll the dependent separately in a different QHP. If the new



dependent cannot be added to the customer's existing plan, another plan at the same metal level can be added to the existing plan. If there are no other available plans at the same metal level for which all enrollees are eligible, the customer can choose a plan one metal higher or lower.

- QHP enrolled customers and their dependent(s) who become newly eligible for CSRs and are not currently enrolled in a silver metal plan, are allowed to change metal levels to silver plan with the same carrier or a new carrier.
- AI/AN enrolled customers and their dependent(s) have the option to select any plan during the SEP.
- QHP enrolled customers and their dependent(s) who become eligible for a SEP as a result of Error of the Exchange have the option to select any plan during the SEP.
- QHP enrolled customers and their dependent(s) who become eligible for a SEP due to a domestic violence qualifying life event have the option to select any plan during the SEP.
- QHP enrolled customers and their dependent(s) who become eligible for a SEP due to an Exceptional Circumstance have the option to select any plan during the SEP.
- QHP enrolled customers and their dependent(s) who are not enrolled in a Silver or Gold Cascade Care plan and have a projected annual income at or below 250% of the Federal poverty level have the option to select any Silver or Gold Cascade Care plan during the SEP.

### 7.1.1 Accumulator Carryover

Accumulator carryover should be consistent with the most current Guidance for Participation, State Premium Assistance Policy, and Sponsorship Policy, which define expectations for carriers to manage enrollee cost accumulators.

- In the event that disenrollment of the primary subscriber, for any reason, and remaining enrollees' continuing enrollment results in the issuance of a new policy (FAM to DEP), the issuer is expected to apply any amounts previously paid toward the enrollee's deductible and out of pocket maximum in the first policy toward the enrollee's deductible and out-of-pocket maximum in the second policy.
- In the event that enrollment of the primary subscriber through a confirmed SEP, and remaining enrollees' continuing enrollment results in the issuance of a new policy (DEP to FAM), the issuer is expected to apply any amounts previously paid toward the enrollee's deductible and out-of-pocket maximum in the second policy.
- Payments made on behalf of consumers by a sponsor must accumulate toward the deductible if they would have accumulated toward the deductible had a consumer made the payment directly.
- An individual granted a Cascade Care Savings SEP that changes plans and remains enrolled with the same carrier will not lose any cost accumulators accrued while in the previous plan.<sup>26</sup>
- Accumulator carryover should be performed in an automated fashion, without the need for a customer or HBE to initiate the carryover request.

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<sup>26</sup> State Premium Assistance Policy Section 9.1(d)



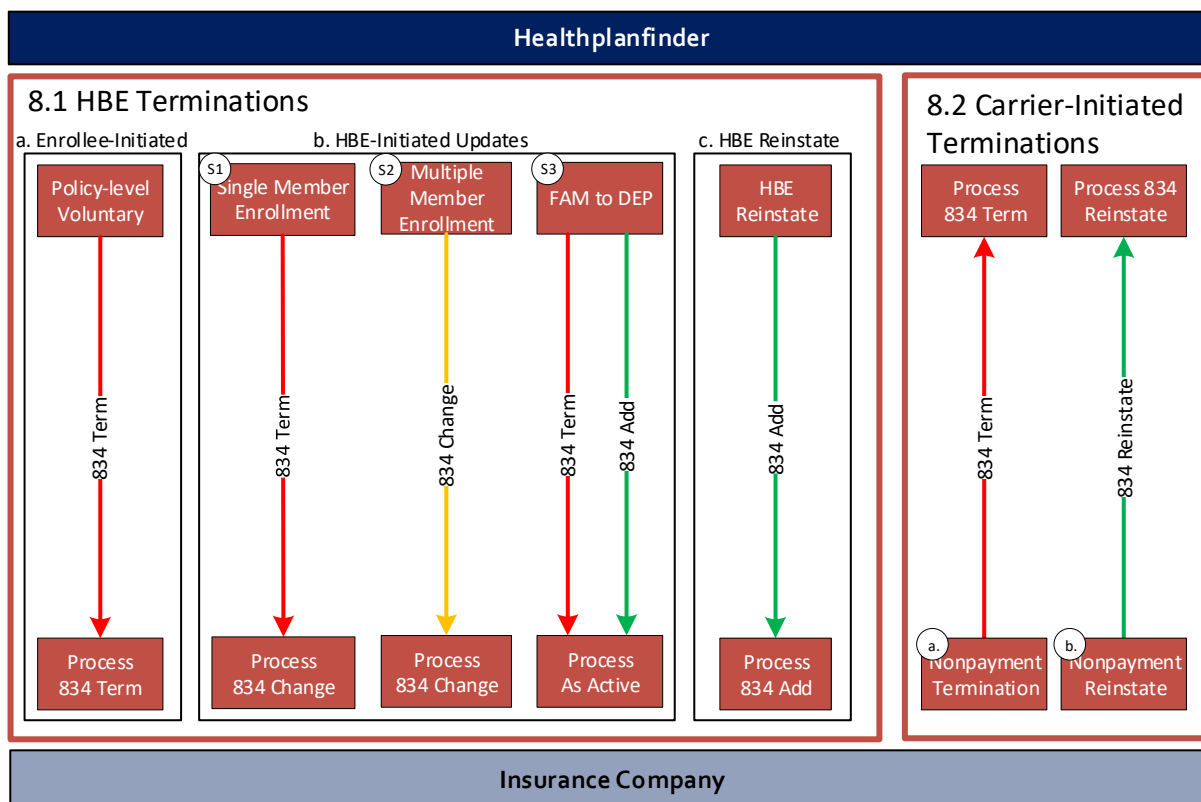
## 8.0 TERMINATIONS

A termination is an action taken after a coverage effective date that ends an enrollee’s active enrollment through the HBE for a date after the original coverage effective date.

Business rules for terminations include:

- 834 Term transactions discontinue enrollment at the policy level.
- Nonpayment (2000 loop, INS04=59) is the only reason expected in carrier to HBE termination transactions (see 834 Companion Guide for more information).
- Termination transactions do not make updates to financial information.

The table below provides a graphic overview of the termination processes.



### 8.1 HBE INITIATED TERMINATIONS

Customer requests for termination (voluntary termination) ends coverage on the last day of the month that termination occurs. HBE sends an 834 Term transaction with the end date of coverage. If the voluntary end date does not match the carrier’s paid through date on the enrollment and it is in an active grace period in which the customer has not made payment for past due premiums before the last due date, carriers terminate coverage based on the grace period and end date determined by their APTC status (see section 5.0 for more information).

#### 8.1.1 Requests for Earlier End Date

After a customer voluntarily terminates coverage, they may contact the *Washington Healthplanfinder* Customer Support Center to request an earlier end date within a grace period. Upon HBE review, the following

scenarios result in a second 834 Term transaction with an earlier end date:

- If customer gains MEC (other than Medicare) and reports this within 10 business days of coverage beginning, they may be termed back to last day of month before new coverage begins.
- If customer reports Medicare coverage during the first month of coverage, they may be termed back to last day of month before Medicare coverage begins.
- If customer experienced an Error of the Exchange that was out of their control which is clearly documented.
- Based on review, HBE may approve the later of the paid through date (confirmed with carrier) and the applicant requested date (as voluntary termination) if requested during the grace period. HBE will not override nonpayment termination dispositions once a grace period has lapsed.

### **8.1.2 26-Year Old QHP Age Out**

Dependents are eligible to continue enrollment on their parent's coverage through the calendar year during which they turn 26 years old<sup>27</sup>. If a customer reports a change after a dependent has turned 26, the 26-year-old may be automatically disenrolled. These customers are directed to contact HBE for reinstatement until system updates can be implemented to prevent automatic disenrollment.

### **8.1.3 19-Year Old Pediatric Dental Age Out**

Dependents are eligible to continue enrollment in a pediatric-only dental coverage plan through the calendar year during which they turn 19 years old. If a customer reports a change after a dependent has turned 19, the 19-year-old may be automatically disenrolled. These customers are directed to contact HBE for reinstatement until system updates can be implemented to prevent automatic disenrollment.

### **8.1.4 Conditional Eligibility Determination**

HBE terminates customers who have been determined ineligible for QHP enrollment as a result of an eligibility review and who do not successfully appeal that determination. HBE sends an 834 Term transaction with termination code "26."

### **8.1.5 Member Death**

When an enrolled household member passes away, the coverage end date is the date of death<sup>28</sup>. This often results in mid-month end dates. If the member death is the Primary Applicant on the application, manual processing and outreach by HBE is required to assist surviving members of the household to:

- Create an application with the new Primary Applicant
- Transition to covered status and complete updates to make the enrollment continuous across the prior and current application
- Review and ensure the monthly coverage terms in the new enrollment produce the enrollment transactions expected

The new Primary Applicant's (previously a dependent on the application) Person-ID from prior coverage becomes the new Primary Subscriber in the new application enrollment. The 14-digit CMS Plan ID remains the same if the same plan is selected on the new enrollment application. Carriers should apply deductible and out-of-pocket accruals in the current period towards the new coverage.

Death of a household member must be reported within 60 days of the date of death for SEP eligibility and to allow new plan selection for surviving household members. If the customer chooses to change plans, plan

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<sup>27</sup> 45 CFR § 147.120

<sup>28</sup> 45 CFR § 155.430 (d)(7)

selection must occur within 60 days of the qualifying life event. New coverage begins the first of the following month from when the change is reported.

If death is reported more than 60 days from the date of the death, the eligibility and enrollment is updated accordingly and surviving (enrolled) household members remain in the same plan.

### 8.1.6 Scenario Based Terminations

HBE may terminate coverage via a batch process or based on HBE review. Three household scenarios are depicted below.

**Scenario 1:** Single member enrollment; HBE sends an 834 Term transaction to end the policy level coverage

Single Member - FAM Coverage		Single Member - DEP Coverage	
Enrollment Transaction	834 Term	Enrollment Transaction	834 Term
Primary Applicant	Termed	Primary Applicant	Not Covered
Dependent 1	n/a	Dependent 1	Termed
Coverage code	FAM	Coverage code	DEP

**Scenario 2:** Multiple member enrollment and HBE terming non-Primary Applicant; HBE sends an 834 Change transaction to discontinue coverage for the individual and continue existing policy under the same Enrollment-ID.

Multiple Member Enrollment - 834 Change			
		Before	After
	Plan Name	Quality Silver	Quality Silver
Primary Applicant		300	300
Dependent 1		300	Termed
Enrollment ID		123	123
Coverage code		FAM	FAM
Premium		600	300
APTC		400	100
Resp Amount		200	200

**Scenario 3:** Multiple member enrollment and HBE terminating Primary Applicant; HBE sends an 834 Term transaction and an 834 Add transaction to discontinue coverage for the Primary Applicant and continue existing policy for remaining enrollees under a new Enrollment-ID.

FAM to DEP - 834 Term/Add			
		Before	After
	Plan Name	Quality Silver	Quality Silver
Primary Applicant		300	Termed
Dependent 1		300	300
Enrollment ID		123	456
Coverage code		FAM	DEP
Premium		600	300
APTC		400	100
Resp Amount		200	200

## 8.2 CARRIER INITIATED TERMINATIONS

Carriers may terminate enrollments for nonpayment after the customer has exhausted their applicable grace

period (1 month for non-subsidized and 3 months for subsidized). The applicable coverage end dates are depicted in the charts below.

If an enrollee receiving APTC exhausts the 3-month grace period, carriers terminate on the last day of the first month of the grace period<sup>29</sup>.

Subsidized Three Month Grace Period			
Paid Thru Month	Grace Period Begins	Grace Period Ends	Coverage End Date
January	1-Feb	30-Apr	28-Feb
February	1-Mar	31-May	31-Mar
March	1-Apr	30-Jun	30-Apr
April	1-May	31-Jul	31-May
May	1-Jun	31-Aug	30-Jun
June	1-Jul	30-Sep	31-Jul
July	1-Aug	31-Oct	31-Aug
August	1-Sep	30-Nov	30-Sep
September	1-Oct	31-Dec	31-Oct
October	1-Nov	31-Jan	30-Nov
November	1-Dec	29-Feb	31-Dec
December	1-Jan	31-Mar	31-Jan

If an enrollee not receiving APTC exhausts the 1-month grace period, carriers terminate on the last day of the month prior to the grace period start date.

Unsubsidized One Month Grace Period			
Paid Thru Month	Grace Period Begins	Grace Period Ends	Coverage End Date
January	1-Feb	28-Feb	31-Jan
February	1-Mar	31-Mar	28-Feb
March	1-Apr	30-Apr	31-Mar
April	1-May	31-May	30-Apr
May	1-Jun	30-Jun	31-May
June	1-Jul	31-Jul	30-Jun
July	1-Aug	31-Aug	31-Jul
August	1-Sep	30-Sep	31-Aug
September	1-Oct	31-Oct	30-Sep
October	1-Nov	30-Nov	31-Oct
November	1-Dec	31-Dec	30-Nov
December	1-Jan	31-Jan	31-Dec

<sup>29</sup> 45 CFR § 156.270 (g)

## 9.0 REINSTATEMENTS

A reinstatement is a correction of an erroneous termination or cancellation action and results in restoration of an enrollment with no break in coverage. Reinstatement and effectuation are different. An effectuation follows receipt of a binder payment and communicates to HBE that an enrollment is in active, paid status. A reinstatement occurs when a previously sent 834 Term or Cancel transaction needs to be restored to an active coverage state with no gap in coverage.

### 9.1 CARRIER INITIATED REINSTATEMENTS

Carriers may revoke a previously sent 834 Term transaction (for nonpayment) and restore the enrollment to active coverage. This occurs by sending HBE an 834 Reinstatement transaction. This supersedes all previous guidance that asked carriers to re-send an 834 Confirm to indicate reinstatement intent.

Business rules for carrier reinstatements are as follows:

- Enrollments may only be reinstated in the current plan year
  - Prior year reinstatements must be handled through prior year reconciliation processes
- Reinstatement action occurs at the household level only and should only be used when the reinstatement action is required for all members on an enrollment
  - If HBE has termed or cancelled coverage for one or more members, carriers should submit reinstatement requests to their designated Enrollment Analyst
- Reinstatement actions do not create a gap in coverage
- Reinstatements may not be used in lieu of effectuations
- Carrier reinstatements update enrollment end date to 12/31
- Nonpayment is the only termination type carriers can reinstate

#### 9.1.1 Reinstatement Limitations

The following limitations apply to carrier generated 834 Reinstatement transactions:

- Enrollments may only be reinstated in the current benefit year
- Reinstatement actions occurs at the household level only
- Reinstatement actions do not include gaps in coverage
- Reinstatement actions may not be used in lieu of effectuations
- Carriers may only send Reinstatement transactions to update an enrollment end date to 12/31

#### 9.1.2 Reinstatement Scenarios

The following scenarios provide additional details regarding when an 834 Reinstatement transaction can be sent to HBE.

**Scenario 1:** An effectuated enrollment is terminated by the carrier and then reinstated

1. Following binder payment, carrier sends 834 Confirm transaction file to HBE
2. Customer grace period expires, resulting in 834 Term transaction file sent to HBE for nonpayment
3. Carrier grants exception to customer to allow reinstatement of coverage
4. 834 Reinstatement transaction is sent to HBE

**Scenario 2:** An enrollment is mistakenly cancelled by the carrier and is reinstated

1. Carrier sends 834 Cancel transaction to HBE
2. Carrier determines that 834 Cancel transaction was sent to HBE in error
3. Carrier sends 834 Reinstatement transaction to HBE

**Scenario 3:** Carrier needs to reinstate coverage for a prior year enrollment

1. During plan year, carrier sends 834 Term transaction to HBE following customer's expiration of grace period
2. Following plan year, carrier determines the enrollment should have remained active through 12/31
3. Carrier may not send 834 Reinstatement (see section 12.0 Prior Year Reconciliation)

**Scenario 4:** Enrollment is voluntarily terminated by customer and then reinstated

1. Following binder payment, carrier sends 834 Confirm transaction file to HBE
2. Customer takes action and voluntarily dis-enrolls using *Washington Healthplanfinder*
3. Customer asks carrier for reinstatement because they accidentally dis-enrolled
4. Carrier may not send 834 Reinstatement (see section 9.2 HBE Initiated Reinstatements)

**Scenario 5:** HBE terms a dependent on an effectuated enrollment. The enrollment is later terminated for nonpayment, then reinstated.

1. Following binder payment, carrier sends 834 Confirm transaction file to HBE
2. HBE sends 834 Change transaction file terminating a dependent
3. Enrollment is terminated for nonpayment
4. Carrier grants exception to customer to allow reinstatement of coverage
5. Carrier reaches out to designated Enrollment Analyst, who processes the reinstatement in order to keep the dependent appropriately terminated

## 9.2 HBE INITIATED REINSTATEMENTS

HBE supports reinstatements for timely, accidental disenrollment when the customer contacts HBE within the month disenrollment occurs.

## 10.0 RENEWALS

HBE coordinates with the federal hub to complete the annual passive (batch) renewal process in October. The effective date for renewals is January 1. During the passive renewal process, the most recent application data is used to:

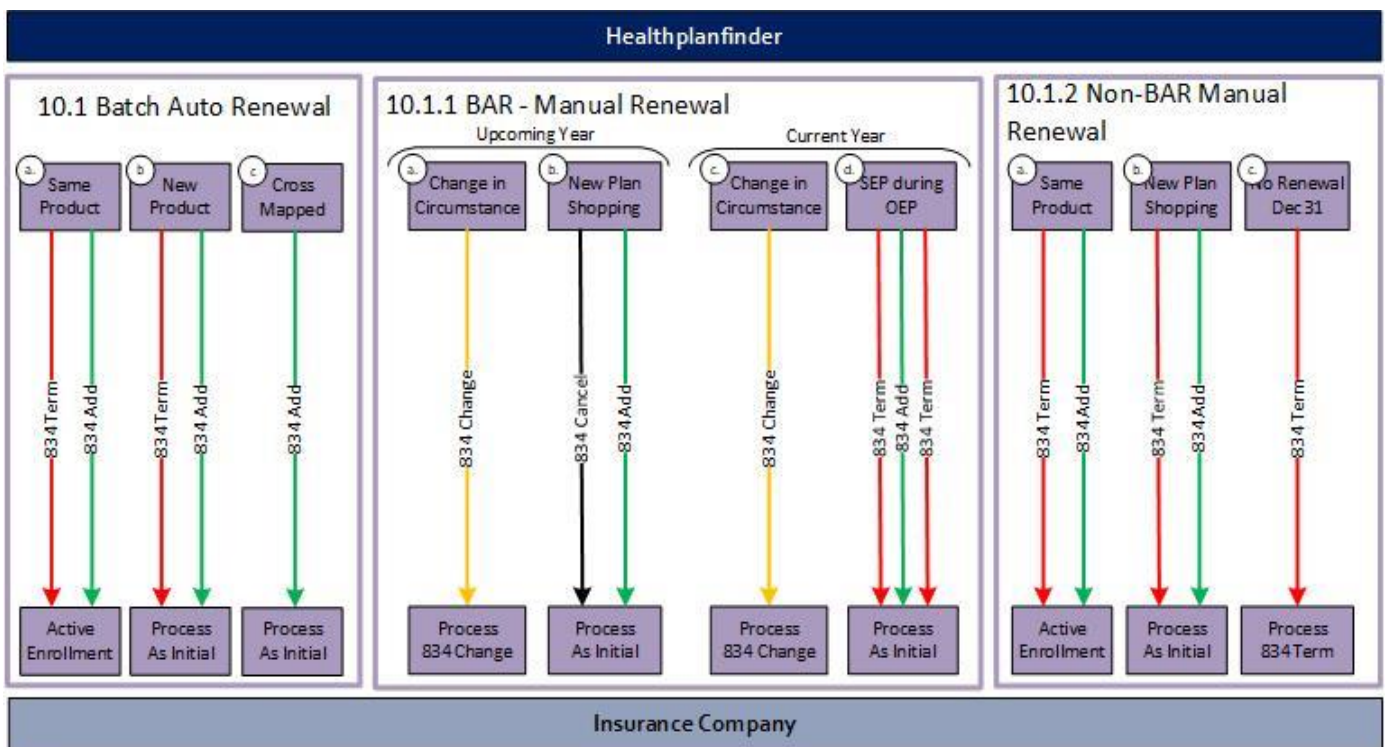
- Determine eligibility for enrollment
- Obtain updated income information from federal tax data (if customer consent is provided)
- Determine eligibility for subsidized coverage
- Utilize the upcoming year FPL data and benchmark plan premium information to recalculate APTC and determine eligibility for CSRs

Coverage that remains continuous by renewal into the same product does not require a binder payment and is effectuated under the initial binder payment. The enrollment retains active status and does not require an 834 Confirm response from the carrier. Renewal into the same product is identified as the same first 10-digits of the 14-digit CMS Plan ID.



HBE sends an open enrollment notice to customers that includes the results of the annual eligibility renewal/redetermination as well as general information about the OEP.

The diagram below is an illustration of the renewal processes described in the following sections.





## 10.1 RENEWAL INFORMATION FOR CARRIERS

HBE sends the Batch Annual Renewal (BAR) report to each carrier on November 2 or November 3 via 834 transactions. This batch process includes termination transactions for the current year enrollment and creates new enrollment records for the upcoming plan year. New Enrollment Identifiers are issued for the upcoming plan year.

In the BAR report, carriers receive renewals from current enrollees into the same product, renewals into new products (when previous product is no longer available), and renewals for new customers that have been cross-mapped due previous carrier not providing previous product or not providing products for the same service area.

As part of the passive renewal process, daily enrollment transactions are discontinued on October 31. HBE begins generating the renewal transactions on November 2 (or November 3, if needed). Daily transactions begin the following day and include active (manual) renewals (i.e. customer selected) since November 1. The period between the time HBE sends the BAR report and the close of the OEP presents an operational challenge. The passive batch renewal includes a current year term and next year renewal. An active renewal can impact just the next year or may include changes to current year. The following sections define active renewal scenarios for existing enrollees included and not included in the BAR report.

### 10.1.1 Active Renewals Included in BAR Report

Enrolled customers are encouraged to complete an active renewal to ensure their application has the most up-to-date information and eligibility and reflects their current circumstances and needs. Disposition of multiple enrollments can occur during this time. Carriers must rely on the 834 transaction timestamp and the enrollment segments to capture each file and update enrollments accordingly (see the 834 Companion Guide for more information).

Application updates during the OEP impact next year's enrollment. When an active renewal occurs between November 1 and January 15 and changes are made, carriers receive an 834 Change transaction.

*Washington Healthplanfinder* allows open access to re-shop for plans until January 15. When an enrollee included in the BAR report makes a new plan selection, carriers receive an 834 Cancel to end the BAR enrollment. If the new plan selection is with the same carrier, HBE sends an 834 Cancel transaction (to end BAR enrollment) and an 834 Add Transaction (to reflect OEP re-shop selection).

Application updates that result in a change in circumstance reported between November 1 and November 15, may include enrollments included in the BAR report and may be eligible for the change to take effect the first of the next month in accordance with change reporting effective dates. HBE sends carriers an 834 Change transaction to update the current year enrollment. If the change impacts the next year enrollment, an 834 Change is sent to update the BAR enrollment.

Some application updates are a qualifying life event and may result in a change of plans in the current year as a result of a SEP with accelerated, retroactive, or special effective dates. HBE sends an 834 Term transaction to update the current year enrollment from December 31 to an earlier date, a SEP 834 Add transaction (SEP-Initial), and an 834 Term transaction (SEP end of year).

Most updates that impact current year also impact the next year. Carriers receive the current year update and the next year update. When the current year SEP is with the same carrier and an OEP re-shop for the next year occurs, the carrier receives: an 834 Term transaction (update to current year), an 834 Add transaction (SEP-Initial), an 834 Term (SEP end of year), an 834 Cancel (end BAR enrollment), and an 834 Add (OEP re-shop).



The shopping experience is separate for OEP and SEP plan selection. There could be rare instances in which the update makes a change to current year enrollment but continues the BAR enrollment year.

### **10.1.2 Active Renewals Not Included in BAR Report**

Customers not included in the BAR report that complete an active renewal into a new product are processed as initial enrollments.

Customers not included in the BAR report that do not complete an active renewal before the close of OEP are terminated by HBE on December 31.

### **10.1.3 Nonpayment Terminations After BAR Report**

The BAR report is generated in mid-October and includes enrollees in an active 3-month grace period. When an enrollee is terminated for nonpayment for the current year enrollment, the next year enrollment is processed as an initial enrollment. The BAR report is used for HBE and carrier outreach to encourage customers to renew and enroll. Since carriers are the system of record for payments, HBE does not automatically cancel or carry forward the renewed enrollment. If payment is received, carriers process the BAR enrollment as Initial and send an 834 Confirm transaction to HBE.

Subsidized enrollments with a 3-month grace period beginning August 1 and September 1 are terminated after the BAR report is sent with grace period end dates of October 31 and November 30 respectively. Non-subsidized enrollees with grace periods beginning October 1 and November 1 are terminated after the BAR report is sent with grace period end dates of October 31 and November 30 respectively. The nonpayment termination transaction updates the coverage end date to an earlier date than what was sent in the BAR 834 Term transaction. Carriers can bill past due premiums in accordance with the guidelines specified in Section 5.6.

## 11.0 CURRENT YEAR RECONCILIATION

There are three general types of reconciliation that occur for current plan year records. These include direct reconciliation, transaction maintenance, and monthly reconciliation.

### 11.1 DIRECT RECONCILIATION

Direct reconciliation is primarily driven by customer requests to the *Washington Healthplanfinder* Customer Support Center or to carriers, but may also arise from external stakeholder referrals (e.g. Office of Insurance Commissioner, state legislators, etc.). Direct reconciliation may take place between the carrier and the Customer Support Center's specialized CARE team, or between the carrier and the HBE Enrollment Team. There are specific service response requirements based on the type of request as noted below.

**Medically Urgent:** An initial or active enrollee reports an enrollment discrepancy to HBE or the carrier. The HBE Enrollment Team defines medically urgent as follows:

- The customer has an immediate need to access services but is prevented from doing so due to the discrepancy; or
- The customer has an emergent need to schedule future urgent services, but is prevented from doing so because the facility or provider requires proof of active coverage; or
- The customer is in imminent danger of being terminated for nonpayment, has an immediate need to access or schedule services, and a nonpayment termination will prevent them from accessing or scheduling urgent services.

Medically Urgent cases, also known as "Code Red", are a high severity incident and resolution is expected within 1 business day of receiving the request.

**1095-A Correction:** An enrollee reports a discrepancy between the 1095-A document issued by HBE and their coverage with a carrier. This error may be delaying their annual tax filing or impacting their IRS payment/refund calculation. Resolution is expected within 2-3 business days of receiving the request.

**General Inquiry:** General inquiries require some research and information gathering to facilitate resolution of enrollment discrepancies. Requests may range from payment or coverage discrepancies to confirming status of coverage with the carrier. Service response requirements are as follows:

For general inquiries from the Customer Support CARE team:

- Resolution is expected within 8 business days of receiving the request January through March
- Resolution is expected within 5 business days of receiving the request April through December

For general inquiries from the HBE Enrollment team:

- Resolution is expected within 5 business days of receiving the request from January through March
- Resolution is expected within 3 business days of receiving the request April through December

### 11.2 TRANSACTION MAINTENANCE

Transactions sent by *Washington Healthplanfinder* or a carrier to the HBE EDI System are validated against HBE-defined business rules. If data in the file does not match expected values, a daily exception is generated which requires manual review by an HBE Enrollment Analyst.

Enrollment Analyst review of an enrollment transaction exception has two options. Within five business days,

the file is either released back into the processing flow or it is stopped for a manual correction. The daily exception process allows HBE to safeguard enrollment data from erroneous files and to proactively address EDI issues upstream in the process flow.

### 11.2.1 File Corrections

There are a number of reasons that a file sent from a carrier may fail (see section 4.2.1 of the 834 Companion Guide for details). Expectations for file corrections is as follows:

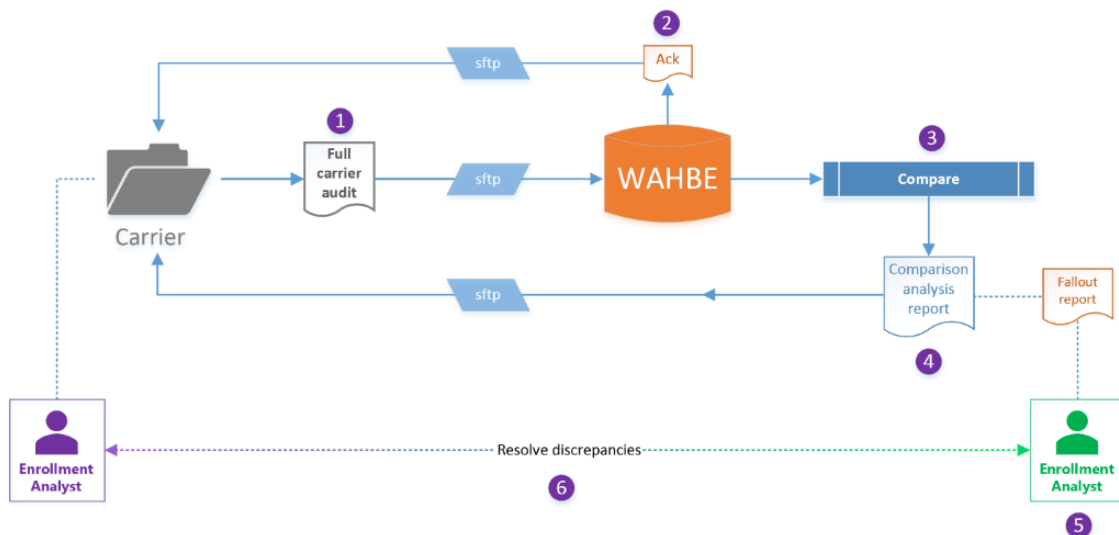
- If a file is rejected on the TA1, the carrier should copy down the TA1 from the SFTP folder, correct the file, and resubmit with a different file name within five business days.
- If a file is rejected on the 999, the carrier should copy down the 999 from the SFTP folder, correct the enrollment transaction, and resubmit in a file with a different file name within five business days.
- If an individual enrollment transaction within a carrier file fails due to business validation errors, the Enrollment Analyst will notify the carrier via e-mail. The carrier should correct the enrollment transaction and resubmit in a file with a different file name within five business days.
- Transactions sent by *Washington Healthplanfinder* to a carrier EDI system which fail or generate an exception due to carrier business validations are expected to be resolved within five business days.

## 11.3 MONTHLY RECONCILIATION

HBE and carriers are required to reconcile enrollments no less than once per month<sup>30</sup>. Carriers are the system of record for payments and effectuations, while HBE is the system of record for reporting to CMS which informs APTC/CSR payments to carriers. Misaligned enrollment data can negatively impact customers in a variety of ways. Therefore, it is critical that HBE and carrier systems are in sync. The Full Carrier Audit allows for rapid comparison of a complete plan year roster using a modernized audit format.

### 11.3.1 Process Overview

Carriers are required to submit Full Carrier Audit files between the 16<sup>th</sup> and 18<sup>th</sup> of each month. Once received, acknowledgements are returned. Files that pass the readability check will be processed through the comparison engine, and two comparison artifacts are produced: the comparison analysis, which is typically generated and sent to carriers within 12 hours, and the fallout report, which is sent to the WAHBE enrollment analyst for manual review.






<sup>30</sup> 45 CFR § 156.400 (d)

During the review period, carriers and WAHBE enrollment analysts will review and resolve errors. During this review, the WAHBE enrollment analyst will share analysis and the running FCA Summary report with the carrier.

### 11.3.2 FCA Summary and Audit Metrics

The FCA Summary report contains current and historical error counts for the plan year, metrics, and a current-month comparison of audit quality across all carriers. Audit quality is measured as the percentage of in-sync enrollments out of the total enrollments compared:

-  85% and above
-  70% - 84%
-  below 70%

Some discrepancies may be a result of the way data is extracted, submitted, or compared and are not reflective of a true underlying discrepancy. However, “false positive” noise may prevent the carrier and WAHBE from identifying true errors. Carriers and HBE partner to identify and resolve FCA gaps and defects to drive towards an accurate comparison.

- Audit quality of 95% or higher indicates exceptional health of enrollment and EDI processes. Discrepancies may be largely attributed to timing errors.
- Audit quality of 85% or higher indicates healthy enrollment and EDI processes. For PY 2022, carriers should target audit quality of 85% or higher by the September audit cycle to ensure customers experience a smooth and accurate autorenewal period and subsequent Open Enrollment.
- An audit quality between 70%-84% is some cause for concern. Carriers with audit quality between 70-84% should update WAHBE no less than monthly regarding known or newly-identified issues, and the status and timeline of anticipated resolution. This update can take place during regularly-scheduled reconciliation calls, carrier 1:1 calls, or via e-mail.
- An audit quality below 70% is moderately to severely concerning. Carriers with audit quality below 70% must meet with WAHBE no less than monthly to discuss the status and timeline of anticipated enhancements and resolution of defects. This meeting can take place during regularly-scheduled reconciliation calls, carrier 1:1 calls, or a through standalone meeting.

### 11.3.3 Discrepancy Resolution and Carrier Audit Guide

For detailed guidance regarding discrepancy scenarios, error definitions, dispute submission, and expectations for resolving audit discrepancies and disputes, refer to the Carrier Audit Guide:



Carrier FCA Guide

## 12.0 PRIOR YEAR RECONCILIATION

HBE is the system of record for data submitted to CMS that informs APTC and CSR payments to carriers. Carriers are the system of record for payments and effectuations. The alignment of these systems and data sets is critically important. HBE recognizes the need may arise to perform reconciliation for prior plan years. This section provides guidance concerning the standards and processes that inform these efforts.

### 12.1 TIMEFRAMES AND MECHANISMS

Prior year enrollment changes that impact effectuation status, coverage dates, or subsidy amounts can have an impact on an enrollee’s 1095-A. In order to mitigate this and other downstream impacts, changes to prior year enrollment data must follow prescribed timeframes use the appropriate mechanism.

#### 12.1.1 Updates via 834 Transactions

Carriers may initiate updates to enrollments for the prior benefit year via 834 transactions from January 1 through March 31 of the year immediately following. For example, corrections to enrollments for plan year 2021 may be made from January 1, 2022 through March 31, 2022. Carriers may not submit 834 transactions for prior plan years that fall outside of this threshold. All transactions submitted should follow the guidelines in the 834 Companion Guide and in the 834 Standards section of this document.

If the prior year 834 transaction submission window has passed or if reconciliation cannot occur via 834 transactions, a prior year reconciliation project may be initiated upon request by a carrier and review/approval by HBE. When a prior year reconciliation project request is submitted, HBE evaluates and determines which CMS mechanism is applicable, restatements or the exceptions process (see Section 13.0).

### 12.2 ACCEPTABLE 834 TRANSACTIONS

Carriers may take the following actions on prior year enrollments as defined below:

- **Reinstatement:** Carrier wishes to revoke a previously sent Term or Cancel and restore coverage
- **Cancel for Nonpayment:** Carrier wishes to move an enrollment previously in an active or initial status to a cancelled state.
- **Term for Nonpayment:** Carrier wishes to move an enrollment previously in an active status to a terminated status.
- **Adjust End Date:** Carrier wishes to modify the coverage end date of a previously termed or cancelled policy, with the policy remaining in a termed or cancelled status.
- **Effectuate:** Carrier wishes to update an enrollment’s effectuation indicator to a value of “Yes.”

The table below details actions carriers may perform (as noted above) and the corresponding 834 transactions. This list is considered comprehensive of all acceptable uses for prior year 834 transactions.

	Confirm	Inbound (carrier generated) Cancel	Inbound (carrier generated) Term
Cancel for nonpayment		✓	
Term for nonpayment			✓
Adjust end date*		✓	✓
Effectuate	✓		

\*Several business validation rules apply to scenarios where an adjustment to an enrollment’s end date is

required. Certain desired outcomes are not feasible with an 834 transaction and will require the initiation of a prior year reconciliation project. Examples are shown in the table below.

Current State	Desired State	Transaction/Action
Termed	Cancelled	834 Cancel
Termed	Termed; reduce end date	834 Term
Termed	Termed; extend end date	Requires project
Cancelled	Termed	Requires project

As noted above, no 834 transaction exists to communicate a reinstatement action for prior year enrollments. If this outcome is required, carriers will need to request a prior year reconciliation project (see section 12.3).

Similarly, the following actions are unacceptable uses for carrier-generated 834 transactions for prior year enrollments:

- Termination or cancellation for reasons other than nonpayment
- Adjustments to premium, APTC, or other financial elements
- Adjustments to household composition
- Changes to any demographic data elements, including address
- Changes to coverage start dates

## 12.3 PRIOR YEAR RECONCILIATION PROJECTS

If a carrier and HBE agree that a prior year reconciliation project is needed, a project is initiated. The project phases are outlined in this section.

### 12.3.1 Justification

HBE and carrier stakeholders conduct an in-depth discussion regarding why a project is warranted and the goals and expected outcomes upon completion. In past projects, some typical goals are as follows:

- Understand root causes for discrepancies
- Identify correction(s) needed
- Assign roles and responsibilities
- Identify impact on CMS reporting and policy-based payments
- Identify potential process and system enhancements

HBE and carrier teams clarify, restate, and document the project justification and goals to ensure all parties have a shared understanding.

Additionally, tools and terms are defined. Tools may encompass file formats, data sources, or other components necessary to complete the project. Terms likely include definitions of data elements, status descriptors, or scenarios. HBE recommends adopting term definitions as described in this document and the 834 Companion Guide.

### 12.3.2 Planning

Following project justification, the project planning phase begins. Tasks are identified, and resources are assigned. It is recommended that each party designate a project lead. A project schedule is collaboratively developed and should contain adequate detail regarding the tasks and deliverables required for the

comparison phase. Project leads consult with technical stakeholders involved in the project to ensure requirements are clearly communicated.

### **12.3.3 Comparison**

Working in accordance with the schedule and data set requirements outlined in the project documents, a comparison of HBE and carrier data is performed. In general, this step is completed by HBE, and several safeguards are in place to ensure accuracy and completeness. The results of the comparison should be categorized in preparation for the final project phase. The comparison includes identification of the impacted population and estimate of project scope.

### **12.3.4 Finalization**

With the comparison complete and categorized, the HBE project lead produces a summary in business-friendly language. If available, root cause information should be incorporated into this document. The summary is shared with project stakeholders. Detailed comparison results are distributed to the appropriate technical stakeholders. Depending on the nature and origin of the discrepancies, additional action may be required to determine HBE and/or carrier root causes.

Once root-cause analysis is complete and shared with project stakeholders, corrective action is taken. Often, this involves the implementation of data fixes and/or code changes. When the scope includes fixes to HBE data, the standards described in the next two sections apply.

If a code change is needed and cannot be implemented immediately, an interim workaround is identified, and the workaround and permanent fix are tracked through a Carrier Fitgap Project. Carrier Fitgap Projects include process improvement and/or technical system correction efforts conducted by carriers in coordination with HBE's Carrier Operations Team and their assigned Enrollment Analyst.

### **12.3.5 HBE Data Fix Standards**

Edits to prior year enrollment data can have tax implications for enrollees. HBE has developed a framework of standards that informs which enrollments are eligible for a data fix in HBE's systems. The data fix standards include:

1. No enrollments may be updated by HBE from a cancelled to a non-cancelled status unless:
  - a. Member made premium payments; or
  - b. Carrier paid claims
2. Coverage periods may be extended, provided:
  - a. Extension aligns with customer's paid through date; and
  - b. Is consistent with #1 above
3. Enrollments with the following conditions are not eligible for a data fix:
  - a. Fix would result in overlapping QHP or more than one month of WAH coverage between time issue occurred and data fix is run; or
  - b. Changes to the household composition occurred

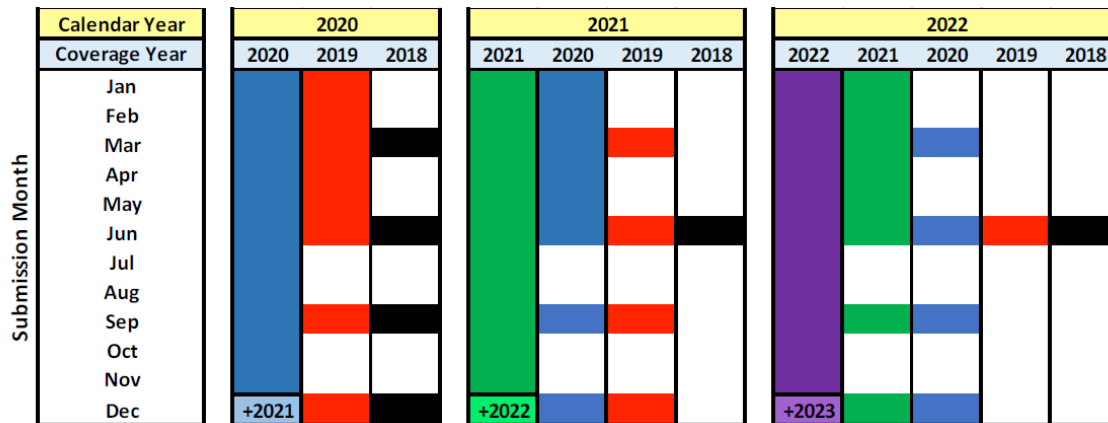
## 13.0 Prior Year Reporting

For prior plan year restatements, the original method of reporting to CMS determines the restatement method. After the CMS transition to policy-based payments, the 1A workbook restatements phase into State Based Market Interchange (SBMI) restatements. The table below depicts the restatement method by coverage year and reporting method.

Coverage Year	Policy-based payments	1A Workbook	CMS Exceptions
2020	January 2020 – December 2020	n/a	no
2019	January 2019 - December 2019	n/a	no
2018	Final monthly by: November 10 CMS Restatements	Final July 2018	n/a for August onward
2017	Final submitted July 2018	CMS Restatements	Not at this time, expected going forward
2016	n/a	Final submitted: October 2018	Yes, with legally acceptable reason
2015	n/a	Final submitted: October 2017	Yes, with legally acceptable reason

### 13.1 RESTATEMENTS BY SBMI

HBE continues to submit SBMI's to CMS for a prior plan year until the June payment cycle submission into the next year as depicted in the chart below. Each color in the chart below depicts data for a distinct plan year and the allowable data submission windows for restatements according to CMS rules.



#### Restatement Submission Schedule:

Current Plan Year: Submit monthly

Current Plan Year - 1: Submit monthly through June, and then quarterly beginning September

Current Plan Year - 2: Submit quarterly

Current Plan Year - 3: Submit yearly



Current Plan Year - 4: Submit yearly

This timeline is subject to change as CMS continues to perform analysis and consult with the SBEs to determine if adjustments are needed.

### 13.2 RESTATEMENTS BY 1A WORKBOOK

CMS accepts restatements on the previous year enrollments by 1A workbook (Excel file). After the transition to policy-based payments, future years are submitted via the SBMI. Only those plan years that were originally reported by 1A workbook are stated via the same method. HBE can still restate via 1A workbook until CMS announces the final opportunity to restate for that plan year. At that point, restatement falls into the CMS exceptions process described in section 13.3.

### 13.3 RESTATEMENTS BY CMS EXCEPTIONS PROCESS

Once CMS closes the restatement window for a 1A workbook plan year, all enrollment changes for that plan year must be reported to CMS via an exception process. Payment adjustments are no longer accepted or made unless processed and approved through this process. Under limited circumstances, and as a necessary part of the appeals process, CMS allows payment adjustments after the final 1A workbook submission. A legally acceptable justification is required as part of the process. HBE works with the carrier to initiate the request.

#### 13.3.1 Legally Acceptable Reason

According to guidance from CMS, legally acceptable reasons for HBE to initiate a request for payment adjustment via the exception process include any or all of the following:

1. Cases where a customer won an eligibility and enrollment appeal and received retroactive coverage.
2. HBE error or change, discovered by HBE, when the HBE is the system of record for APTC reporting.
3. Changes to enrollment processed as a result of the Form 1095-A discrepancy process.
4. HBE errors resulting in a carrier owing money to CMS
5. HBE or carrier errors identified through a carrier-initiated audit process resulting in CMS owing money to a carrier. Carriers that identify a workbook submission error with payment impact to the carrier should first work with HBE to submit the exceptions request to CMS. Requests for exceptions under this reason are time-limited and will only be considered for the duration of the SBE audit schedule.

Additional context for the justification is required when the submission reason is 4 and/or 5 via a summary explanation on the cause of the error, the nature of the error, and how it was discovered. The submission process allows inclusion of additional documents as needed to support the adjustment request.

#### 13.3.2 CMS Exception Submittal

Exception requests are submitted via e-mail as follows:

To: [marketplacepayments@cms.hhs.gov](mailto:marketplacepayments@cms.hhs.gov)

Subject: Request for Exceptions Process

Attach: Completed request form worksheet (shown below)

#### Part 1: Contact Information

<b>Entity Name/Legal Business Name of Issuer</b>	
<b>Health Insurance Oversight System (HIOS) ID</b>	
<b>Payee Group ID</b>	

<b>Submitter (SBE or Issuer)</b>	
<b>Primary Contact Name of Submitter</b>	
<b>Primary Contact Phone Number</b>	
<b>Mailing Address (Street address, City, ST, Zip Code)</b>	
<b>Email Address</b>	
<b>Date</b>	

**Part 2: Reason for Request**

Section 1: State-based Exchange (SBE) Issuers and SBEs (Select all that apply):

	1. Eligibility and enrollment appeals - Cases where a consumer won an appeal and received coverage (Complete Excel template form Tab 2, Sections A and B.)
	2. SBE error or change, discovered by the SBE, where SBE provides enrollment updates to the issuer (analogous to the types of changes initiated through FFE HICS cases) (Complete Excel template form Tab 2, Sections A and B.)
	3. Changes processed as a result of the 1095-A discrepancy process (Complete Excel template form Tab 2, Sections A and B.)
	4. SBE or issuer error resulting in an issuer owing money to CMS (Provide additional background and detail in Section 2 below.)
	5. SBE or issuer error identified through an issuer-initiated audit process resulting in CMS owing money to an issuer. Issuers that identify an SBE workbook submission error with payment impact to the issuer should first work with the SBE to submit the exceptions request to CMS. (Provide additional background and details in Section 2 below.) *Requests for exceptions under this reason will be time-limited and will only be considered through the end of the SBE audit schedule. Additional information about the SBE schedule is forthcoming.

Section 2: Additional Information, Documentation, and Support

Instructions: The following information should be completed for each QHP ID for which adjusted payment is requested if the request is due to an Issuer or SBE error (reasons 4 and 5 above). **If the same explanation applies to more than one QHP, list all QHP IDs for which the given explanation applies.** SBE issuer requests based on SBE error should include documentation from the SBE of the nature of the error.

Include and attach in your email any available supporting documentation on the cause of the error and how the error was discovered.

### Part 3: APTC Adjustment Calculation Worksheet

#### Request for 2014 and 2015 Benefit Year Advance Payment of the Premium Tax Credit (APTC) and User Fee Exception Process

Instructions: For each Qualified Health Plan (QHP) in which you are requesting an adjustment from the Centers for Medicare & Medicaid Services (CMS), complete the following information. Submit a Health Insurance Casework System (HICS) case number for every change initiated by a HICS update.

Section A	Section B		
(Complete for FFE and SBE issuer reasons 1-3 and SBE reasons 1-3.)	(Complete for FFE and SBE issuer reasons 1-3 and SBE reasons 1-3.)		
<b>QHP ID</b>	<b>Total Previous APTC payment from CMS for that QHP for the 2014 and 2015 benefit year (as submitted in final manual workbook)</b>	<b>Corrected APTC fee for that QHP for the 2014 and 2015 benefit year</b>	<b>Total requested adjustment to APTC requested (i.e. Column D - Column C). Positive amount = payment to the issuer</b>

### 13.3.3 Exception Process Timing and Schedule

The table below depicts the CMS exceptions process timing and schedule.

Exchange Initiates Change	Exceptions Submission Deadline	Payment Adjustment Month
April 1, 2018 – June 30, 2018	September 30, 2018	November 2018
July 1, 2018 – September 30, 2018	December 31, 2018	February 2019
October 1, 2018 – December 31, 2018	March 31, 2019	May 2019
January 1, 2019 – March 31, 2019	June 30, 2019	August 2019

### 13.4 CARRIER AUDIT SUPPORT

HBE supports carriers during a CMS audit by supplying reports or requested documentation and providing additional context for enrollment records. The purpose of the audit is to determine the accuracy of payments. HBE will work with carriers to make necessary enrollment changes and submit a request to CMS exception process, as needed.

Carrier requests or inquiries related to an audit should be directed to:



washington  
**healthplanfinder**  
powered by the Washington Health Benefit Exchange

Joanna Donbeck, HBE Compliance Officer

E-mail: [Joanna.Donbeck@WAHBExchange.org](mailto:Joanna.Donbeck@WAHBExchange.org)

Phone: 360-688-7801

## Appendix A: Special Enrollment Events and Coverage Dates

SEP Category	Regulatory provision (unless otherwise noted, under 45 CFR §155.420)	Triggering event description	SEP Code	Accessed through
1. Loss of qualifying health coverage	(d)(1)(i-iv) – Loss of minimum essential coverage	<p>A SEP-Initial enrollee or dependent loses minimum essential coverage, including but not limited to Medicaid, CHIP, or qualifying employer sponsored coverage. For purposes of qualifying for this SEP, this includes:</p> <ul style="list-style-type: none"> <li>• The end of the plan year for any non-calendar year group health plan or individual health insurance coverage;</li> <li>• Losing pregnancy-related coverage described under section 1902(a)(10)(A)(i)(IV) and (a)(10)(A)(ii)(IX) of the Social Security Act; and/or</li> <li>• Losing medically needy coverage described under section 1902(a)(10)(C) of the Social Security Act only once per calendar year.</li> <li>• Termination of COBRA benefits that coincide with an employer newly no longer contributing to monthly premiums.</li> </ul> <p>Note: This does not include loss of coverage due to nonpayment of premiums.</p> <p><b>Coverage Effective Dates:</b> Plan selection after Loss of MEC: Accelerated start date Advanced availability: 1st of the month following the loss of MEC</p>	07	Application
	(d)(6)(iii) – Become newly eligible for APTC due to changes to current employer –sponsored coverage	<p>A qualified individual or their dependent who is enrolled in an eligible employer-sponsored plan is determined newly eligible for APTC based in part on a finding that such consumer is ineligible for qualifying coverage in an eligible-employer sponsored plan in accordance with 26 CFR §1.36B2(c)(3).</p> <p><b>Coverage Effective Dates:</b> Plan selection after Loss of MEC: Accelerated start date Advanced availability: 1st of the month following the loss of MEC</p>	FC	Application

SEP Category	Regulatory provision (unless otherwise noted, under 45 CFR §155.420)	Triggering event description	SEP Code	Accessed through
<b>1. Loss of qualifying health coverage (continued)</b>	(d)(10)(i-ii) – Victim of domestic violence or spousal abandonment	<p>A QI or enrollee or their dependent is a victim of domestic abuse or spousal abandonment as defined by 26 CFR 1.36B-2 or a dependent or unmarried victim within a household, is enrolled in minimum essential coverage, and sought to enroll in coverage separate from the perpetrator of the abuse or abandonment</p> <p>Note: Carriers should be sensitive to each instance and work with initial enrollees that enrolled under this triggering event with potential difficulties in obtaining documentation for SEP verification.</p> <p><b>Coverage Effective Dates:</b> Accelerated effective date</p>	07	Application
	(d)(1)(i-iv) – Loss of minimum essential coverage	<p>An existing Washington Apple Health covered individual reports a Change in Circumstance and is determined newly eligible for QHP/QDP and/or APTC.</p> <p><b>Coverage Effective Dates:</b> Special Effective Dates The date of coverage start is first day after the last day of Washington Apple Health.</p> <p>Note: For Special Effective Dates, consumers may alternatively request a coverage effective date of the first day of the month following the date of the event or following regular prospective coverage effective dates by calling the Customer Support Center.</p>	PC	Application

SEP Category	Regulatory provision (unless otherwise noted, under 45 CFR §155.420)	Triggering event description	SEP Code	Accessed through
<b>2. Change in household size</b>	(d)(2)(i) – Gain a dependent or become a dependent	<p>A qualified individual gains a dependent or becomes a dependent through marriage<sup>31</sup>, birth, adoption, placement for adoption, or placement in foster care, or through a child support order or other court order.</p> <p><b>Coverage Effective Dates:</b>            Marriage: Accelerated start date            Birth, adoption, foster care placement, court order: Retroactive back to the date of the event.</p> <p>Note: For birth, adoption, placement for adoption, or placement in foster care, consumers may alternatively request a coverage effective date of the first day of the month following the date of the event or following regular prospective coverage effective dates by calling the Customer Support Center.</p>	Birth: 02 Marriage: 32	Application
<b>3. Change in primary place of living</b>	(d)(7) – Gain access to new QHPs due to a permanent move	<p>A QI or enrollee, or their dependent, gains access to new QHPs as a result of a permanent move.<sup>32</sup></p> <p>Note: Temporary moves or vacation would not be considered a permanent move for purposes of qualifying for this SEP.</p> <p><b>Coverage Effective Dates:</b> Regular prospective coverage effective dates.</p>	43	Application
<b>4. Change in eligibility for coverage or help paying for coverage</b>	(d)(3) – Become newly eligible for QHP coverage	<p>A QI or their dependent becomes newly eligible for enrollment in a QHP due to gaining status as a citizen, national, or lawfully present individual or being released from incarceration.</p> <p><b>Coverage Effective Dates:</b> Regular prospective coverage effective dates.</p>	NE	Application

<sup>31</sup> 45 CFR 155.420 (a)(5): Prior Coverage Requirement

<sup>32</sup> 45 CFR 155.420 (a)(5): Prior Coverage Requirement

SEP Category	Regulatory provision (unless otherwise noted, under 45 CFR §155.420)	Triggering event description	SEP Code	Accessed through
	(d)(6)(i-ii) – Become newly eligible or ineligible for APTC, or experience a change in eligibility for CSR	<p>An enrollee or their dependent is determined newly eligible or newly ineligible for APTC or has a change in eligibility for cost-sharing reductions (CSR).</p> <p><b>Coverage Effective Dates:</b> For becoming newly eligible for APTC, accelerated effective date. Otherwise regular prospective coverage effective dates.</p>	FC	Application
<b>4. Change in eligibility for coverage or help paying for coverage (continued)</b>	(d)(8) – Member of a federally recognized tribe or a shareholder in an Alaska Native Corporation	<p>A QI, or their dependent enrolling in the same coverage, who is an Indian, as defined by Section 4 of the Indian Health Care Improvement Act, gains or maintains such status and may enroll in a QHP or change from one QHP to another one time per month.</p> <p><b>Coverage Effective Dates:</b> Regular prospective coverage effective dates.</p>	NE	Application
	(d)(15) – Loss of COBRA subsidies by an employer or government entity	<p>A QI, or their dependent is enrolled in COBRA continuation coverage for which an employer is paying all or part of the premiums, or for which a government entity is providing subsidies, and the employer or government entity's contributions/subsidies completely cease.</p> <p><b>Coverage Effective Dates:</b> Accelerated effective date</p>	07	Application
<b>5. Enrollment or plan error</b>	(d)(4) – Experience an error of the Exchange	<p>A QI's or their dependent's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, misconduct, or inaction of an officer, employee, or agent of the Exchange, its instrumentalities, or a non-Exchange entity providing enrollment assistance or conducting enrollment activities. A QI's or their dependent's enrollment or non-enrollment in a QHP or inaccurate eligibility determination is a result of a technical error or Exchange-related enrollment delay. A QI's or their dependent's enrollment in a QHP is impacted by a plan or benefit display error.</p> <p>A QI's or their dependent's non-enrollment in a QHP is the result of being determined ineligible for Medicaid or CHIP by the State Medicaid or CHIP agency.</p> <p>Note: This includes Unresolved casework and technical errors</p> <p><b>Coverage Effective Dates:</b> Retroactive back to the coverage effective date the QI would have gotten absent the error or regular prospective or accelerated coverage effective date, at the option of the consumer.</p>	ER	HBE Review



SEP Category	Regulatory provision (unless otherwise noted, under 45 CFR §155.420)	Triggering event description	SEP Code	Accessed through
	(d)(5) – Experience a plan contract violation	<p>An enrollee or their dependent adequately demonstrates to the Exchange that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee.</p> <p><b>Coverage Effective Dates:</b> Retroactive back to the coverage effective date the QI would have gotten absent the error or regular prospective or accelerated coverage effective date, at the option of the consumer.</p>	EX	HBE Review
	(d)(12) – Error in plan benefit	<p>The qualified individual or enrollee, or their dependent, adequately demonstrates to the Exchange that a material error related to plan benefits, service area, or premium influenced the qualified individual's or enrollee's decision to purchase a QHP through the Exchange</p>	EX	HBE Review
<b>6. Other qualifying changes</b>	(d)(9) – Experience an exceptional circumstance	<p>A qualified individual, enrollee, or dependent, enrollment or non-enrollment in a QHP is the result of an exceptional circumstance, as determined by the Exchange, including being incapacitated or experiencing a natural disaster.</p> <p><b>Coverage Effective Dates:</b> Vary based on circumstances.</p>	EX	HBE Review
	(d)(11) – Denied Washington Apple Health or non-MAGI Medicaid	<p>A qualified individual is determined ineligible for Medicaid or CHIP</p>	07	Application
<b>7. Cascade Care Savings</b>	(d)(9) and (16) - Experience an exceptional circumstance and Low Income  State Premium Assistance Policy Section 9.1(d)	<p>A qualified individual or enrollee, or their dependent, whose household income is expected to be no greater than 250 percent of the Federal poverty level, and who is not currently enrolled in a Cascade Care Silver or Gold plan, may enroll in or switch to a Cascade Care Silver or Gold plan monthly.</p> <p><b>Coverage Effective Dates:</b> Accelerated effective date</p>	PC	Application