

GUIDANCE FOR PARTICIPATION OF HEALTH PLANS IN THE WASHINGTON HEALTH BENEFIT EXCHANGE

Section 1: Introduction

This Guidance for Participation specifies requirements for a health insurance issuer to participate in the Washington State Health Benefit Exchange (the Exchange). An issuer may participate in the individual Exchange by offering qualified health plans (QHPs) from November 1, 202~~4~~³ through January 15, 202~~5~~⁴ for coverage in plan year 202~~5~~⁴.

The Guidance will provide information on the following:

- Certifying a health plan to become a QHP
- Monitoring and compliance of a QHP
- Decertifying a QHP
- Standards for issuers offering QHPs through the Exchange
- Requirements for the standard plan offering
- Administering the State Premium Assistance Program
- Expectations for issuer coordination with the Exchange
- Special guidance for coverage of American Indian/Alaska Natives

This Guidance is in accordance with the Patient Protection and Affordable Care Act of 2010 (ACA) and Chapters 43.71 RCW and 48.43 RCW. This Guidance applies to issuers offering plans that meet public option requirements as described in RCW 41.05.410 and RCW 43.71.095 for 202~~5~~⁴ coverage. Any product intended to be offered under those public option plan requirements will be required to be certified as a QHP under this Guidance before it may be offered as a public option plan.

The Washington State Office of the Insurance Commissioner (OIC) regulates health insurance issuers and health plans. This document does not provide guidance on achieving regulatory approval by the OIC. Throughout this document, however, the Exchange may refer issuers to OIC as the source of regulatory information.

1.1 Glossary

The Exchange applies the standard definitions found within the Affordable Care Act and subsequent guidance whenever possible.

ACTUARIAL VALUE

The percentage paid by a health plan of the total allowed costs of benefits.

AFFORDABLE CARE ACT

The comprehensive health care reform law enacted in March 2010. The law was enacted in two parts: The Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name AffordableCare Act (ACA) is used to refer to the final, amended version of the law.

APPEAL

An official request from a health insurance issuer that the Exchange reconsider a decision to not certify a health plan as a QHP, deny recertification of a QHP, or decertify a QHP.

CASCADE CARE

Collectively, the Washington state health care laws passed in May 2019 (Engrossed Substitute Senate Bill (ESSB) 5526) and March 2021 (ESSB 5377), directing the Exchange to offer “standard plans.” The law also grants the Health Care Authority the authority to procure qualified health plans that are standard plans and also meet certain affordability and quality standards as defined in the legislation (“public option” plans). ESSB 5377 established the funding and directed the Exchange to provide guidance for and administer the State Premium Assistance Program in partnership with carriers. The term “Cascade Care” as used in this document may refer to both standard plans and public option plans.

CASCADE CARE SAVINGS

Cascade Care Savings is the branded name for the State Premium Assistance Program, implemented for coverage beginning in plan year 2023.

ENROLL

The point at which coverage is effective under a QHP.

ENROLLEE

Qualified individual enrolled in a QHP.

EXPIRE

The end of a plan year in which a QHP issuer elects not to seek recertification of a QHP offered through the Exchange for the following year. This act by the QHP issuer will constitute voluntary expiration of certification and result in non-certification for a subsequent consecutive certification cycle (45 CFR §156.290).

GRACE PERIOD

A period – either one month or three months – after an enrollee’s monthly health insurance payment is due. The grace period for health insurance is three months if an enrollee is subsidized by at least one of the following: 1) advance payments of the premium tax credit; or 2) state premium assistance. The grace period for health insurance is one month for unsubsidized enrollments.

HEALTH BENEFIT EXCHANGE BOARD

The governing board of the Exchange as established in Chapter 43.71 RCW.

HEALTH INSURANCE ISSUER OR ISSUER

An issuer, which includes a disability insurer, health care service contractor, or health maintenance organization, as defined in RCW 48.43.005 and defined in the Employee Retirement Income Security Act and used in the ACA.

In this document, “issuer” refers to a health insurance company; “product” refers to a suite of plans that share, for example, a common set of health benefits; and “health plan” refers to the actual insurance coverage purchased by a consumer. The document does not refer to health insurance companies as the “plans” or “the health plans.”

HEALTH PLAN

Health plan means any policy, contract, or agreement as defined in RCW 48.43.005 and offered by an issuer and used in accordance with section 1301(b)(1) of the ACA. A health plan is the specific health benefit plan purchased by a subscriber, employer, or employee. Each health plan is the pairing of a product's benefits with a particular cost-sharing structure, provider network, and service area. Multiple health plans can be associated with a single product.

IMMIGRANT HEALTH COVERAGE PROGRAM

In 2021, the Washington State Legislature directed the Exchange to explore access pathways for Washington residents who do not currently qualify for state or federal coverage options. The Legislature authorized the Exchange to seek a federal Section 1332 waiver for this purpose and required a state-based solution to be implemented by no later than plan year 2024. In December 2022, CMS approved Washington’s 1332 waiver that allows all Washington residents, regardless of immigration status, to enroll in health and dental coverage through *Washington Healthplanfinder* beginning in plan year 2024. Washington residents, regardless of immigration status, may receive Cascade Care Savings if they meet the eligibility requirements for that program.

NON-SUBSIDIZED ENROLLMENT

Enrollment that does not receive APTC or state premium assistance.

NAVIGATOR

An organization that has been awarded a contract by the Exchange to carry out activities and meet the standards described in 45 CFR §155.210. Navigator representatives are qualified, trained, and certified to engage in education, outreach and facilitation of selection of a QHP or Washington Apple Health (Medicaid) by a consumer in *Washington Healthplanfinder*.

OPEN ENROLLMENT PERIOD

The period each year during which consumers may enroll or change coverage in a QHP and QDP through *Washington Healthplanfinder*.

The open enrollment period for 2025⁴ coverage is from November 1, 2024³ through January 15, 2025⁴, unless otherwise published by the Exchange as an amendment to the 2025⁴ QHP Guidance for Participation.

PLAN YEAR

The consecutive 12-month period during which a health plan provides coverage for health benefits. For individuals, it is the calendar year.

PRODUCER

A person licensed by OIC as an agent to sell or service insurance policies.

PUBLIC OPTION PLAN

A Cascade Care qualified health plan procured by the Health Care Authority and offered on the Health Benefit Exchange as described in RCW 41.05.410 that meets the standard plan design and additional affordability and quality metrics included in the Health Care Authority procurement.

QUALIFIED DENTAL PLAN OR QDP

A stand-alone dental plan that is certified by an exchange and is a commitment to insure at a minimum the essential health benefit of pediatric oral services (established as an essential health benefit under ACA § 1302(b) and defined under WAC 284-43-5700) under specific cost-sharing (deductibles, copayments, and out-of-pocket maximum amounts) and other regulatory and contractual requirements.

QUALIFIED HEALTH PLAN OR QHP

A health plan that is certified by an exchange. To be certified in Washington, a health plan must be approved by OIC, satisfy the certification criteria specified in RCW 43.71.065, satisfy the minimum federal requirements of a QHP as outlined in 45 CFR parts §155 and §156, and be certified by the Exchange Board.

SPECIAL ENROLLMENT PERIOD

A period during which a qualified individual or enrollee who experiences certain qualifying events may enroll in, or change enrollment in, a QHP through *Washington Healthplanfinder* outside of the annual open enrollment period.

STANDARD OR STANDARDIZED PLAN

A Cascade Care qualified health plan that meets specific benefit design and cost-sharing requirements published annually by the Washington Health Benefit Exchange, pursuant to RCW 43.71.095.

STATE PREMIUM ASSISTANCE PROGRAM

The program, established by the 2021 Washington State Legislature in Engrossed Second Substitute Senate Bill 5377 and funded in the Operating Budget, provides premium assistance to Washington residents up to 250% of the federal poverty level, who meet specified eligibility requirements and enroll in a silver or gold Cascade Care plan through the Exchange. This program is branded and known to consumers as Cascade Care Savings.

SUBSIDIZED ENROLLMENT

Enrollment that receives APTC and/or state premium assistance.

WASHINGTON HEALTHPLANFINDER OR HEALTHPLANFINDER

The marketplace in Washington State operated by the Washington Health Benefit Exchange where qualified individuals can shop for and purchase qualified health plans (QHPs) and qualified dental plans(QDPs).

1.2 Overview of Guidance

1.2.1 Objective

The purpose of this Guidance is to provide health insurance issuers the foundational information needed to offer individual QHPs through the Exchange. The certification criteria set forth within this document do not supersede a QHP issuer's responsibility to provide coverage based upon state and federal laws and rules. While the Guidance specifies some federal and state laws or regulations that apply to offering health insurance coverage through the Exchange, a QHP issuer is required to comply with all relevant state and federal laws in order to offer coverage through the Exchange.

The Guidance also specifies the certification criteria that apply to a participating health plan. To be certified a QHP must:

- Be approved by OIC;
- Satisfy the certification criteria specified in RCW 43.71.065;
- Satisfy the minimum federal requirements of a QHP as outlined in 45 CFR parts §155 and §156; and
- Be certified by the Exchange Board.

To participate in the Exchange, a QHP issuer must meet the legal requirements of offering health insurance in Washington State, including the offering of standard plans as required under RCW 43.71.095 and compliance with the Exchange's guidance for the State Premium Assistance Program and Immigrant Health Coverage Program. A QHP issuer must also sign a Participation Agreement with the Exchange to participate in the Exchange.

1.2.2 Term of Engagement

An individual health insurance plan certified or recertified as a QHP will be offered through the Exchange. New and renewed individual plans will be available for preview prior to the start of open enrollment for a period as determined by the Exchange. New and renewed individual plans will be available for selection beginning November 1, 2024³ with an initial effective date of coverage beginning no earlier than January 1, 2025⁴.

Health insurance issuers responding to this Guidance may offer certified or recertified individual QHPs for a term of one year beginning January 1, 2025⁴ and ending December 31, 2025⁴. Only OIC-approved health plans certified by the Board may be offered as QHPs through the Exchange during this period.

The Guidance shall be amended as required to incorporate changes to federal and state law.

1.2.3 Contact

Your contact at the Exchange for this document is Christine Gibert, Policy Director. Please direct all questions regarding plan certification and this document to Christine Gibert at (360) 688-7773 or the QHP inbox (QHP@wahbexchange.org).

For questions about OIC regulatory requirements referenced throughout this document, please contact the OIC Rates, Forms, and Provider Networks Help Desk at (360) 725-7111.

1.2.4 Plan Certification Timeline and Letter of Intent

An issuer is recommended to inform the Exchange of its intent to participate in the Exchange by submitting a letter of intent. Submitting a [non-binding](#) letter of intent, ~~though is not mandatory for certification, and is nonbinding, but will~~ help the Exchange ~~communicate with and~~ potential participating issuers ~~and~~ prepare for [a smooth and successful plan review and the certification process and improves efficacy of communication between issuers, the Exchange, and OIC](#). The letter of intent should be in letter format on official letterhead and be signed by the issuer's Chief Executive Officer or their designee. The due date for the letter of intent is specified in the plan certification timeline. Issuers should include a list of counties in which they intend to offer coverage, and include information about service area changes anticipated by plan type (e.g., expanding or contracting service areas of public option, standard, or non-standard plans). The letter of intent is for internal Exchange use only and will not be shared publicly. An issuer may submit a letter of intent ~~to at~~ QHP@wahbexchange.org.

PLAN CERTIFICATION TIMELINE

The Exchange expects issuers to adhere to the plan certification timeline. Please click on the following link to find the [2025⁴ plan certification timeline](#). ~~If an issuer anticipates that it may not meet a plan certification deadline, the issuer is required to provide advance written notice to the Exchange. If a deadline is missed, the issuer will be required to submit a written remediation plan that describes why it was missed, when the deliverable will be provided, and how the issuer will ensure the deliverable will be submitted on time in the future. Information about missed plan certification deadlines may be considered by the Board as part of their plan certification deliberations.~~

~~Approaching the Board meeting for which Plan Certification is scheduled, an issuer is required to notify the Exchange of:~~

- ~~• [Any outstanding objection against the issuer's Exchange plans existing as of the date that is ten business days prior to the OIC approval deadline \(August 21, 2024 for 2025 coverage\), or,](#)~~
- ~~• [Any new objection received on or after August 21, 2024, within one business day of receiving the objection.](#)~~

1.3 Participating in the Exchange

A QHP issuer participating in the Exchange's individual market is not required to participate in the individual market outside of the Exchange.

1.3.1 Initial Certification of Qualified Health Plans

The Exchange certifies QHPs annually and only those health plans certified or recertified by the Exchange may be offered as QHPs through the Exchange.

An issuer must comply with OIC regulatory requirements, and OIC will provide regulatory review of health insurance issuers and health plans. The Exchange will determine if the issuer satisfies the Exchange-based certification criteria. Once the Board issues QHP certifications, the Exchange will inform an issuer of the decision.

An issuer must enter into a Participation Agreement with the Exchange before offering QHPs through the Exchange. The Participation Agreement requires issuers to adhere to all health plan certification criteria described in this Guidance. The Exchange, in addition to the Legislature and OIC, reserves discretion to modify and amend the terms and conditions of current QHP certification criteria and how they may be applied in the certification or decertification process, consistent with current laws and rules, at any time, including after the execution of issuer Participation Agreements.

Prior to publishing plan offerings, an issuer must also enter into an Electronic Data Interchange (EDI) Trading Partner Agreement and one or more EDI interfaces are required will need to be tested between the issuer and the Exchange. Successful testing will be required in advance of Open Enrollment following a schedule determined by the Exchange. These steps ensure that the issuer and the Exchange will be able to communicate enrollment and payment data.

Issuers who rely primarily on third-party vendors for communication of enrollment or payment data are required to coordinate with the Exchange when there is a change in vendors. Issuers are responsible for ensuring their vendors conform to the EDI Trading Partner Agreement, along with all other Exchange Guidance, including but not limited to the Enrollment and Payment Process Guide.

1.3.2 Recertification of Qualified Health Plans

The Exchange will consider renewing QHPs for recertification annually. The recertification process will involve a review of the certification criteria reflected in this document.

1.3.3 Submitting Health Plans to Become Certified as a QHP

The Exchange certification process begins when an issuer submits rate, form, SERFF Binder, and network filings to OIC for regulatory review. Please contact OIC for information on when, how, and where to submit the filing documents for a health plan. Issuers shall submit to the Exchange the QHP submission form provided by the Exchange at the time of filing.

~~The Exchange intends to complete the certification or recertification process for 2024 plans by September 14, 2023.~~ Issuers ~~should have~~must received OIC approval of any plans for which they are seeking Exchange certification by September ~~57, 2024~~3 to be presented to the Board for certification on September 12, to guarantee consideration for certification for 2024. The Exchange Board will meet on September 12, 2024 to certify plans for 2025 coverage.

Plans certified by September 12, 2024, will be included in the Exchange’s plan preview period and auto-renewal process for the 2025 plan year, and will be available through the Exchange in open enrollment for 2025 coverage. Any plans not certified on or after September 12, 2024, may be considered for inclusion certification at the Board’s discretion on a case-by-case basis, based on staff recommendation. Board certification after the September 12 Exchange Plan Certification meeting may necessitate additional coordination with an issuer, including, e.g., a requirement that the issuer’s CEO participate in any additional Board meetings to discuss the reason for the late certification request and an assessment payable by the issuer of costs of holding additional Board meetings and costs attributable to Exchange re-work for late certification.

If an issuer wishes to withdraw a plan from consideration for QHP certification after plan approval by OIC, the issuer must submit a plan withdrawal form to the Exchange.

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Section 2: Specifications for Participation

2.1.1 Summary Table 1: Initial Certification and Recertification Criteria

To participate in the Exchange’s QHP certification process, an issuer must submit plans and supporting documentation as specified for each criterion. The following chart summarizes the nineteen criteria applied in the certification process of a QHP. Each criterion is reviewed and approved by OIC, the Exchange, or both.

NUMBER	CRITERIA LEVEL	CRITERIA	OIC OR EXCHANGE REVIEW	INITIAL CERTIFICATION CRITERIA	RECERTIFICATION CRITERIA
1	Issuer	Issuer must be in good standing	OIC	Yes	Yes
2	Issuer	Issuer must pay user fees, if QHPs assessed	Exchange	Yes	Yes
3	Issuer	Issuer must comply with the risk adjustment program	OIC	Yes	Yes
4	Issuer	Issuer must comply with market rules on offering plans, including participation in State Premium Assistance Program*	OIC/Exchange*	Yes	Yes
5	Issuer	Issuer must comply with non-discrimination rules	OIC	Yes	Yes
6	Issuer	Issuer must be accredited by an entity that HHS recognizes for accreditation of health plans	Exchange	Yes	Yes
7	Product	QHP must meet marketing requirements	Exchange	Yes	Yes
8	Product	QHP must meet network access requirements, including ECPs	OIC	Yes	Yes

9	Product	Issuer must submit provider directory data	Exchange	Yes	Yes
10	Product	Issuer must implement a quality improvement strategy	Exchange	Yes	Yes
11	Product	Issuer must submit health plan data to be used in standard format for presenting health benefit plan options	Exchange	Yes	Yes
12	Product	Issuer must report quality and health performance data	Exchange	No	Yes
13	Product	Issuer must use the Exchange enrollment application	Exchange	Yes	Yes
14	Product	Issuer may only contract with a hospital with more than 50 beds if the hospital utilizes a patient safety evaluation system	OIC	Yes	Yes
15	Product	Services provided under a QHP through a direct primary care medical home must be integrated with the QHP issuer	OIC	Yes	Yes
16	Plan	A QHP must comply with benefit design standards (e.g., cost-sharing limits, "metal level," EHB, standard plan design*)	OIC/Exchange*	Yes	Yes
17	Plan	Issuer must submit a QHP's service area and rates for a plan year	OIC	Yes	Yes
18	Plan	Issuer must post justifications for QHP premium increases	OIC	No	Yes
19	Plan	Issuer must submit QHP benefit and rate data for public disclosure	Exchange/OIC	Yes	Yes

2.2 QHP Specifications

An issuer's health plan must satisfy the following criteria [by the deadlines specified in the plan certification timeline](#) to become certified as a QHP offered through the Exchange.

2.2.1 Licensed and Good Standing

An issuer must have unrestricted authority to write its authorized lines of business in Washington in order to be considered "in good standing" and to offer a QHP through the Exchange.

OIC determines if an issuer is in good standing. Please direct requests for a certificate of good standing to companysupervisionfilings@oic.wa.gov.

OIC determinations of good standing will be based on authority granted to OIC by Title 48 RCW and Title 284 WAC. Such authority may include restricting an issuer's ability to issue new or renew existing coverage for an enrollee.

An issuer should inform the Exchange immediately, but in any case, within two business days, if OIC has restricted in any way the issuer's authority to write any of its authorized lines of business. If OIC has restricted the issuer's ability to underwrite current or new health plans, the Exchange will determine, consistent with OIC restrictions, if the issuer can submit a health plan for certification or recertification as a QHP.

Restrictions on an issuer's ability to underwrite current or new health plans may result in QHP decertification by the Exchange.

2.2.2 User Fee Adherence

RCW 43.71.060 designates a portion of premium tax receipts and a fee assessed on QHPs as funding for the Exchange's operating expenses.

If a QHP issuer's payment of the QHP assessment is delinquent, the Exchange will assess a penalty equal to 1%, rounded up to the nearest whole dollar, of the issuer's delinquent amount for each 15-day period that an issuer's payment is overdue. To avoid penalties for late payment, a QHP issuer is encouraged to pay any and all assessed amounts while contesting a fee.

If the Exchange determines that a QHP issuer is not making timely and full payment of the QHP assessment, and the Exchange determines that the QHP issuer will not resume making timely and full payments, the Exchange will decertify all the issuer's QHPs.

2.2.3 Risk Adjustment Program

A QHP issuer must comply with the requirements of the risk adjustment program as specified in the ACA standards set in federal rules 45 CFR part 153, Washington State statute, rules adopted by OIC, the annual Notice of Benefit and Payment Parameters published by the Department of Health and Human Services (HHS), and other applicable law.

OIC will monitor a QHP issuer's compliance with the risk adjustment program. If OIC determines that a QHP issuer is no longer complying with the requirements of the risk adjustment program, and determines that the QHP issuer will not resume full compliance with the requirements of the risk adjustment program, the Exchange will decertify all the issuer's QHPs.

2.2.4 Market Rules for Offering QHPs

An issuer must comply with the market rules for offering individual QHPs set forth by the ACA and Washington State law, including the four metal levels of coverage (bronze, silver, gold, and platinum) designated in §1302 of the ACA and the standardized plans as required in RCW 43.71.095. Issuers must comply with requirements to administer the State Premium Assistance Program and Immigrant Health Coverage Program pursuant to E2SSB 5377 and in accordance with program guidance published by the Exchange including, but not limited to, the State Premium Assistance Policy.

Please refer to OIC regulatory specifications for information on the calculation of the actuarial value for each metal level.

Only a QHP issuer that satisfies the following market rules may offer QHPs through the Exchange:

- A QHP issuer must offer at least one QHP at the silver level and at least one QHP at the gold in all counties in which it offers coverage through the Exchange.
- An issuer must offer a standard plan at least at the gold and silver level in any county in which it participates, and if offering bronze, a bronze standard plan.
- A QHP issuer may not offer more than two non-standard bronze, one non-standard silver, and two non-standard gold plans on the Exchange in any county in which the issuer offers a QHP.
- An issuer must offer a child-only plan at the same metal level as any QHP offered through the exchange (not including catastrophic plans) (45 CFR §156.200(c)(2)) to individuals who, at the start of the plan year, have not reached the age of 21.

If OIC (or the Exchange, to the extent an aspect of this certification criterion is reviewed by the Exchange) determines that a QHP issuer is not complying with the market rules, and OIC (or the Exchange, as applicable, in consultation with OIC) further determines that the QHP issuer will not resume compliance with the market rules, the Exchange will decertify all the issuer's QHPs [in that market](#).

2.2.5 Non-Discrimination

A QHP issuer must comply with federal and Washington State nondiscrimination requirements. A QHP issuer may not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation (45 CFR §156.125, §156.200(e), RCW 48.43.0128, and WAC 284-43-5940-5950), or on the basis of an individual's degree of medical dependency, health status or condition, quality of life, or expected length of life (ACA Sec. 1302(b)(4)(D), RCW 48.43.0128, and WAC 284-43- 5940).

OIC will enforce nondiscrimination requirements and monitor for noncompliance. If OIC determines that a QHP issuer is not complying with the nondiscrimination requirements, and OIC determines that the QHP issuer will not resume compliance with the nondiscrimination requirements, the Exchange will decertify all the issuer's QHPs affected by that noncompliance.

2.2.6 Accreditation

The QHP issuer must meet a minimum level of accreditation by an accrediting entity recognized by HHS. The Exchange will verify an issuer's accreditation status for certification or recertification.

A QHP issuer must achieve AAAHC, NCQA, or URAC exchange accreditation at least 90 days before the first day of the annual open enrollment period that follows the QHP issuer's fourth certification process. QHP issuers must maintain current accreditation every subsequent year of participation. [If an issuer's accreditation is](#)

expiring during the next plan year, the issuer must and provide proof of ongoing accreditation at least 90 days prior to the annual open enrollment period. The issuer must present a copy of each accreditation certificate (one per accredited product type (e.g., HMO, EPO, PPO)) to the Exchange.

A QHP issuer shall notify the Exchange of any accreditation review scheduled for the current plan year through the QHP inbox (QHP@wahbexchange.org) by January 31st. The issuer shall notify the Exchange within five business days if there is a change in accreditation status or if there is a failure to maintain up-to-date accreditation.

The Exchange reserves the right to decertify a QHP if accreditation is terminated or not achieved by the relevant deadline.

The Exchange will certify a health plan as accredited if one of the following statuses is held by the QHP issuer:

- NCQA: accredited with a star rating, if applicable, provisional with a star rating, if applicable, or interim with a star rating, if applicable (interim status requires a second review within 18 months)
 - The Exchange will not recognize NCQA status: denied with a star rating, if applicable
- URAC: full, provisional, or conditional (conditional status requires a second review within three to six months)
 - The Exchange will not recognize URAC status: denial
- AAAHC: Certificate of Accreditation
 - The Exchange will not recognize AAAHC status: denial

The Exchange may certify a QHP prior to that health plan becoming exchange-accredited as described below. During a new issuer's initial and next two certification processes, the Exchange may certify a health plan as a QHP that is unaccredited if the issuer satisfies the following:

- When submitting a health plan for certification, an issuer must attest that it will schedule the "exchange accreditation" (in accordance with 45 CFR §§156.275 and 156.1045) in the product types (HMO, EPO, MCO, POS, or PPO) used in offering its QHPs.
- A QHP issuer must achieve Exchange accreditation and provide proof of that accreditation at least 90 days before the first day of the annual enrollment period that follows the QHP issuer's fourth certification process. For example, if an unaccredited issuer began offering QHP coverage in the 202~~3~~ plan year, it would need to achieve and document Exchange accreditation by August 202~~5~~⁴ for offering QHP coverage in the 202~~6~~⁵ plan year.

2.2.7 Marketing

A QHP issuer is encouraged to actively market products available through *Washington Healthplanfinder* and to participate in joint marketing efforts with the Exchange, as applicable. The Exchange has created its own logos that designate the certification of a QHP. Issuers that offer products certified as QHPs give the Exchange the right to use their logos in the Exchange application and acknowledge that Exchange designated logos are included in QHP displays sold through the Exchange. The QHP issuer will be provided any Exchange marketing materials, for review, that use the QHP issuer's logo. Issuers are required to provide the Exchange information about their communication and advertising plans directed toward Exchange customers in advance of implementation to support the ability of the Exchange and carriers to align in messaging when we have common initiatives to address. Expectations for this requirement will be discussed through the Carrier Communications Workgroup and deliverables will be provided to the Exchange Chief

[CommunicationsMarketing](#) Officer and Associate Director of Marketing [and Communications](#) using the method

and with the timing directed through the Workgroup.

Cascade Care (including variants thereof, e.g., Cascade, Cascade Select, Cascade Care Savings) is a Washington Health Benefit Exchange Certification Mark brand and logo that represents a product or plan only offered on *Washington Healthplanfinder*. The Exchange will utilize the Cascade Care brand, names, website domains, and logo in advertising materials of these health plans.

An issuer can use the *Washington Healthplanfinder* or Cascade Care logos, if applicable, to co-brand on-Exchange QHP marketing materials or web pages in accordance with guidelines developed by the Exchange [Communications](#). The Exchange *Style Guide*, linked [here](#), can be found on the corporate website (wahbexchange.org) under *Partner Toolkit*. The logos cannot be modified, and no other logos can be used to represent *Washington Healthplanfinder*, Cascade Care, or QHP certification. The Exchange must review and approve any use of Exchange brands and logos on an issuer's marketing materials. Approval should be requested by sending an email to QHP@wahbexchange.org. Only plans offered on the Exchange and meeting the requirements to be classified as Cascade Care may use any logos or verbiage that indicates the plan meets such requirements, and issuers that use the Cascade Care logos must do so consistently across their line of Cascade Care products consistent with the Exchange [Communications](#) guidance. Plans not meeting this requirement may not use "Cascade," "Cascade Select," "Cascade Care," "Cascade Care Savings" or any logos for such brand in marketing materials, marketing name, or network name.

Issuers are not permitted to use "Cascade," "Cascade Care," "Cascade Select" or "Cascade Care Savings" in a web domain unless the following criteria are met: (1) the domain must only promote plans that are approved exchange plans; (2) the domain must include an indicator that identifies the issuer; and (3) the Exchange must be given advanced opportunity to review and have given approval for usage of the domain. Approval of a new domain name must be requested the carrier by sending an email to QHP@wahbexchange.org prior to the domain name going live for use. If a domain name is rejected, the carrier cannot use the rejected domain name.

Issuers must use a standard naming convention for Cascade Care standard plans and public option plans in their plan filings and when marketing the plans.

For standard plans that are not public option plans, issuers are required to use the following naming convention:

[Issuer Name] + Cascade + [Metal Level]

Example: IssuerXYZ Cascade Silver

For public option plans, issuers are required to use the following naming convention: [Issuer Name] + Cascade

Select + [Metal Level]

Example: IssuerXYZ Cascade Select Silver

The above naming conventions should be used for all cost-sharing reduction versions of the standard plans, including cost-sharing reduction silver plan variants for consumers up to 250% of the federal poverty level and zero cost-share and limited cost-share plan variants for AI/AN consumers.

Issuers generally may not add additional elements to the name of a Cascade Care plan. When following the above naming convention for Cascade Care plans would result in the same plan name being applied to multiple plan offerings, an issuer must contact the Exchange to discuss this and receive approval from the Exchange for the addition of any additional identifying element in the name of a Cascade Care plan.

If an issuer uses a plan marketing name instead of an issuer name for its Exchange products generally, the issuer may request to use the same plan marketing name for its Cascade Care products in place of the “Issuer Name” in the naming convention above. Issuers that wish to use a plan marketing name that is different than their issuer name for this purpose must contact the Exchange to receive approval.

Issuers should provide the Exchange with a marketing brochure for each QHP in English and in Spanish for display on *Washington Healthplanfinder*. Issuers are encouraged to have unique marketing materials for each product offered. The Exchange intends to display the marketing brochure through a direct link to a PDF hosted on the issuer’s website. The Exchange will obtain these links from the Exchange’s URL Template, and issuers will be expected to update content to reflect accurate information for open enrollment. If an issuer cannot provide an updated marketing brochure via a direct link, it may submit the marketing brochure to the Exchange via email. The due date for providing marketing materials is specified in the plan certification timeline.

The QHP issuer cannot inform consumers that the certification of a QHP implies any form of further endorsement or support of the QHP. A QHP issuer and its officials, employees, agents and representatives must not employ marketing practices or benefit designs that may discourage the enrollment of individuals with preexisting conditions or significant health needs in QHPs (45 CFR §156.225(b)).

Issuers will be expected to confirm the accuracy of the display of their marketing and enrollment materials during issuer ratification (the validation of plan data in *Washington Healthplanfinder*).

Marketing materials will not be displayed on *Washington Healthplanfinder* if they do not conform to the standards set through this criterion.

2.2.8 Network Access

An issuer must ensure that a QHP's network satisfies at least the following standards:

- Is sufficient in number and type of providers, including providers that specialize in mental health and substance use disorder services, to assure that all services will be accessible without unreasonable delay;
- Includes essential community providers in accordance with 45 CFR §156.235 or meets the alternate standard; and
- Is consistent with the network access provisions of section 2702(c) of the PHS Act (45 CFR §156.230(a)) and WAC 284-170-200, et. seq., and any subsequent federal or state rules.

OIC will enforce network access requirements and monitor for noncompliance. If OIC determines that a QHP issuer is not complying with the network access requirements, and OIC determines that the QHP issuer will not resume compliance with the network access requirements, the Exchange will decertify all the issuer's QHPs affected by that noncompliance. Please refer to OIC for additional regulatory guidance on network access.

An issuer shall notify the Exchange in writing, in addition to OIC, when notification of network changes is required under WAC 284-170-230. Issuers should notify the Exchange of network changes described in WAC 284-170-230 that will be occurring from one plan year to the next by September 15 (or, if later, as soon as possible after the issuer becomes aware of the anticipated change).

2.2.9 Provider Directory

Issuers are required to provide data on providers that participate in networks associated with their QHPs sold

on the Exchange. Issuers are required to update their provider directory data with the Exchange, and any vendor utilized by the Exchange to support the provider directory, on or by the 15th of each month, unless otherwise instructed. If the 15th falls on a weekend or holiday, provider directory data is due by midnight the business day prior. On-time submissions are processed and published to *Washington Healthplanfinder* the following month.

Issuers must provide data in the format established by the Exchange and the provider directory vendor. Issuers must ensure that the network name for each provider associated to a network in a submission matches the exact network name as approved by OIC.

For the provider directory data to be used for the start of open enrollment, issuers must include providers for the current and upcoming plan years. Provider rosters for the 202~~5~~4 plan year should be submitted to the Exchange for the first time in a stand-alone submission in the month of September, or as otherwise established by the Exchange.

Issuers shall submit [a](#) request to send additional submissions to the Exchange for evaluation if there are provider contract changes. The Exchange will evaluate the request with the provider directory vendor and publish updated provider information as soon as operationally possible.

Issuers are responsible for conducting quality assurance of provider directory data prior to submission and are required to participate in ongoing provider directory testing and coordination activities.

~~The Exchange's provider directory vendor conducts ongoing provider outreach to validate provider data with the goal of improving provider directory data for the Exchange. Error reports are generated by the provider directory vendor and based on provider attestation and any other established mechanisms to validate provider directory accuracy. In addition, t~~The Exchange identifies potential provider errors during testing, from OIC, from consumers, from providers, and through the Provider Directory Comment Form, available on the Exchange website. Issuers shall review reports provided by the provider directory vendor and errors escalated by the Exchange to correct erroneous data in their systems in a timely manner. Issuers shall submit a corrected provider roster the following month to resolve any discrepancies.

If a discrepancy is not pertinent to the issuer, or the issuer does not agree with the findings, the issuer should address the discrepancy with the Exchange, depending on who identifies the discrepancy, and discrepancies should be resolved between the parties. ~~During 202~~4~~3, the Exchange will continue efforts to improve provider directory data.~~ Issuers will be consulted to establish next steps regarding reducing data discrepancies.

In addition to requirements outlined in this Guidance related to provider directory, issuers are required to adhere to requirements provided in the Exchange's Provider Directory Guide.

2.2.10 Quality Improvement Strategy

Participation Criteria

Any eligible QHP issuer participating in the Exchange must implement and report on a quality improvement strategy (QIS) in accordance with ACA § 1311(g) and Exchange guidance. Issuers applying for QHP certification on the Exchange for the 20254 plan year are expected to submit a QIS form in calendar year 20243 to either implement a new QIS beginning no later than January 20254 or provide a progress update on an existing QIS. This state requirement differs from the federal participation criterion that issuers offer coverage for two or more consecutive years prior to participating in a QIS, 45 CFR 156.1130.

An eligible issuer for the 20254 plan year is any QHP issuer that provides medical coverage and intends to offer coverage on Exchange for plan year 20254. There will be no minimum enrollment threshold for participation in the QIS program. The QIS requirements apply to all eligible issuers offering QHPs, including QHPs compatible with health savings accounts (HSAs). For plan year 20254, QIS requirements will not apply to child-only plans or stand-alone dental plans.

QIS Requirements

General QIS Requirements

A QIS is required to incentivize quality by tying payments to performance measures when providers meet specific quality indicators or enrollees make certain choices or exhibit behaviors associated with improved health.

All eligible issuers must comply with the following QIS requirements for the 20254 plan year:

- Implement a QIS, which is a payment structure that provides increased reimbursement or other market-based incentives for improving health outcomes of plan enrollees.
- Implement a QIS that has a topic area of “Activities to reduce health and health care disparities” and at least one of the following:
 - Activities for improving health outcomes;
 - Activities to prevent hospital readmissions;
 - Activities to improve patient safety and reduce medical errors; and
 - Activities for wellness and health promotion; and/or
 - ~~Activities to reduce health and health care disparities;~~
- Implement a QIS that monitors QIS progress by using, at minimum, the following National Quality Forum(NQF)-endorsed clinical measures:
 - Cervical Cancer Screening (NQF ID: 0032); and
 - Antidepressant Medication Management (NQF ID: 0105) Address health and health disparities by choosing “activities to reduce health and health care disparities” as a topic area.
- Adhere to federal QIS requirements.
- Adhere to Exchange guidelines, including the QIS User Guide for 20254.
- Report on progress implementing the QIS to the Exchange in accordance with guidelines established by the Exchange.

Issuers may implement one QIS that applies to all eligible QHPs in the Exchange, or may implement more than one QIS, tailored to the needs of different QHPs. A QIS does not have to address the needs of all enrollees in a

given QHP but may address needs of specified sub-populations. All QIS are required to monitor the two NQF-endorsed measures that are outlined above: Cervical Cancer Screening and Antidepressant Medication Management. Issuers are encouraged to adopt Breast Cancer Screening (NQF ID: 2372) into their QIS but this measure will not be required for the 2025~~4~~ plan year. Additionally, issuers will be expected to achieve the NCQA Measure Year 2022 66th Percentile Commercial Benchmark All LOBs performance on the Cervical Cancer Screening and Antidepressant Medication Management measures on their QIS form submitted in 2025 (reporting on 2024 measurement year). Issuers may monitor and track progress on additional quantitative measures to analyze progress towards the goals of the QIS. The Board may consider achievement of performance expectations as part of their plan certification decisions, and the Exchange may use issuer quality performance as a consideration for plan display in Healthplanfinder.

Issuers must use the Exchange Quality Improvement Strategy form, unique to Washington, to report QIS to the Exchange. Every QHP offered in the Exchange must have an associated QIS.

Eligible issuers for the 2025~~4~~ plan year must submit the following documents and receive confirmation of completion from the Exchange in order to meet this certification criterion:

- ~~• A 2025~~4~~ the Exchange Quality Improvement Strategy form for each QIS applicable to any QHP to be offered in the Exchange.~~

Issuers that operated a QIS during the 2024~~3~~ plan year are required to complete the progress portion of the 2025~~4~~ the Exchange Quality Improvement Strategy form as part of their 2025~~4~~ QIS submission. This progress portion of the form should include a description of activities conducted to implement the QIS and results of the QIS.

Issuers should refer to the Exchange Quality Improvement Strategy User Guide for additional guidance on how to complete the Quality Improvement Strategy form.

Addressing Health and Health Care Disparities

The Exchange seeks to reduce health and health care disparities that exist in the QHP population. Race and ethnicity enrollee data is essential to addressing health equity and disparities. Because efforts by issuers and the Exchange to identify health disparities and effectively monitor activities to reduce disparities in the Exchange population have been limited by a lack of consistent and comprehensive population data, the Exchange ~~has intends to~~ set a benchmark for demographic data collection.

In alignment with NCQA standards, fFor measurement year 2024~~3~~ (and reported on ~~their the~~ QIS form submitted to the Exchange in 2025~~4~~), issuers must achieve ~~eightyseventy~~ percent (870%) self-identification of race and ethnicity data for *Washington Healthplanfinder (HPF)* enrollees. ~~The expectation is that issuers will reach NCQA's data completeness threshold of 80% directly reported enrollee race and ethnicity data for Measurement Year 2024 data reported in 2025. In alignment with NCQA standards, R~~race and ethnicity data completeness are measured separately. The Exchange will support this reporting by passing race and ethnicity information collected in *HealthplanfinderHPF* to QHP issuers through enrollment files (834). Issuers are encouraged to support collection of race and ethnicity data by collecting enrollee data after enrollment. Issuers will report race and ethnicity data to the Exchange through the QISQuality Improvement Strategy form and will be required to report the following measures stratified by race and ethnicity using directly reported data: Cervical Cancer Screening and Antidepressant Medication Management (acute and continuation rates). In the 2025 QIS form (submitted in July 2024), carriers will report on activities to work with Producers to increase collection of this information.

Incentivizing Primary Care

The Exchange believes that investing in primary care and care coordination is an important component of improving health care delivery and delivering high value care to Exchange enrollees. QHP issuers should promote and encourage use of primary care and explore innovative programs to provide whole person care that integrates behavioral health into primary care in their Exchange line of business. ~~Exchange issuers are required to participate in one of the following primary care strategies identified by the Bree Collaborative Primary Care workgroup:~~

~~Enrollees should receive information about the value of primary care and how to access primary care within the available plan options, and are asked or otherwise encouraged to select a primary care provider/team at enrollment.~~

~~Members select or are paneled to a primary care provider/team through a claims-based attribution process or other assignment mechanism.~~

~~A payment mechanism supports primary care features that are not reimbursed through traditional fee-for-service payments. These mechanisms include value-based reimbursement such as fee-for-service enhancements or prospective payments made in the form of per member per month (PMPM) payments that could include incentives for transformation, performance-based incentives, or more expansive forms of capitation.~~

~~Issuers will identify the strategy or strategies they will be employing in 2025⁴ through the Quality Improvement Strategy form. For 2025⁴, the Exchange encourages issuers to continue the strategy for their QHP line of business established in 2024³. If an issuer selects a strategy that they are already implementing, they will work with the Exchange to identify an appropriate improvement benchmark. Issuers agree to work with the Exchange on these focus areas and report their progress to the Exchange. The Exchange and issuers will agree on timelines for accomplishing the strategy based on the strategy selected. The Exchange may set targets for the issuers in future requirements.~~

~~For 2025, QHP issuers are required to participate in the following primary care strategy identified by the Bree Collaborative: Members select or are paneled to a primary care provider/team through a claims-based attribution process or other assignment mechanism. Issuers will report the number and proportion of enrollees who selected or were assigned a primary care clinician during the prior calendar year in the 2025 QIS form, submitted in 2024. Participation in other Bree Collaborative primary care initiatives is encouraged, but not required.~~

The Exchange seeks to have QHP enrollees benefit from advanced primary care models. Issuers will report on their participation and Exchange enrollee inclusion in HCA's Primary Care Transformation Model (PCTM) and other advanced primary care work in the 2025⁴ [Quality Improvement Strategy QIS](#) form.

Investment in primary care is essential to a healthy population and efficient use of health care spending. Beginning with 2023 claims data, Issuers will be required to report on primary care spend in their 2025 QIS form (submitted July 2024) for their Exchange population using [HCA's Primary Care Expenditure Template](#).

2.2.11 Standard Format for Presenting Health Benefit Plan Options

Summary of Benefits and Coverage

Issuers are required to provide the Exchange with a Summary of Benefits and Coverage (SBC) for each plan variant of a QHP, in English and Spanish, for display on *Washington Healthplanfinder*. Issuers should use the standard SBC template form developed by the Department of Health and Human Services (HHS) for all plans. The Exchange will publish a completed SBC template for Cascade (standard) plans that issuers are required to use for PY 2025. Issuers are required to ensure that the information included in all SBCs, including Cascade SBCs, reflects the benefit information included in the plan and benefits template. Issuers should use the following file naming convention in their SBC submission to the Exchange: issuer, plan name, metal level, CSR tier. The Exchange will consider exceptions for carriers that request Exchange approval for a file name following an alternative convention.

Name convention for SBC file example:

[Issuer Name] + [Plan Name] + [Metal Level (if not included in plan name)] + [CSR tier]

Example: IssuerXYZCascadeSilverTier01

The Exchange intends to display the SBC through a direct link to a PDF hosted on the issuer's website. The Exchange will obtain SBC links from the Exchange's URL Template, and issuers will be expected to update content to reflect accurate information for open enrollment. The due date for providing SBCs is specified in the plan certification timeline. All links to and web pages displaying issuer marketing brochures and SBCs must be tested and verified as working and accurate by both issuers and the Exchange prior to the end of carrier ratification. Non-working or incorrect URLs and/or documents accessible via URLs identified afterpost the end of carrier ratification will incur a per URL error fee, charged to the issuer, if data correction is necessary in the *Washington Healthplanfinder* system.

~~The Exchange will work with issuers to improve certain inconsistencies that we have identified in the SBCs which are a particular pain point to ensure clarity for Exchange consumers when they compare plans between different issuers.~~ The Exchange will review submitted draft SBCs ~~for completeness~~ and provide feedback to issuers. Issuers should respond to requested changes feedback by incorporating feedback changes or providing a response as to why feedback changes cannot be incorporated. Issuers must submit revised SBCs (Word or PDF file format) to the Exchange via email with any changes incorporated by the due date in the plan certification timeline. Issuers may choose to wait for feedback prior to submitting Spanish language SBCs.

HHS resources on SBCs, including a standard SBC form, may be found here:

<https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/SBC-Template-Accessible-Format-01-2020.pdf>

A QHP must provide notice of covered abortion services in the SBC in the "other covered services" section (45 CFR 156.280(f)). If an issuer does not include one or more state required benefits as a covered service, this must be clearly indicated in the "Excluded Services" section of the SBC, in addition to any other state or federal requirements.

Issuers will include direct links to a plan's drug formulary in each SBC that must be accessible to consumers. This link must take a client directly to a webpage that displays the formulary for the benefit package reflected on the SBC. A direct link is a link that does not require logging on to a website, entering a policy number, clicking through web pages, or creating user accounts, memberships, or registrations. A direct link is not a link to a search tool or webpage that requires additional navigation by the client to get to the formulary.

All SBCs are required to include underlined terms that are included in CMS's Uniform Glossary. The Exchange encourages issuers to hyperlink all underlined terms included in the Uniform Glossary, so that consumers are directed to the term's definition when they click on the term.

Formulary

The Exchange will upload an issuer's formulary filings to display prescription drug coverage information to consumers through *Smart_Planfinder*, the Exchange's consumer decision support tool. The Exchange will receive an issuer's first quarter formulary information from the CMS QHP Prescription Drug Template in the binder after OIC completes its review. Subsequent quarterly formulary filings (the second, third, and fourth quarters) will be transmitted to the Exchange from OIC after they complete their review. The Exchange cannot guarantee issuers who submit their quarterly updates after the deadlines set by OIC will have their information uploaded into *Smart_Planfinder*. The Exchange reserves the right to charge issuers for incurred costs for late submissions to be reflected in the tool. Before charging for incurred costs, the Exchange will take into consideration the circumstances of the late filing.

2.2.12 Quality Measures

CMS Participation Criteria

Qualifying issuers are required to participate in the federal Quality Rating System (QRS) provided under ACA Section 1311(c)(3), including the disclosure and reporting of information on health care quality and outcomes described in ACA Sections 1311(c)(1)(H) and 1311(c)(1)(I), and the implementation of appropriate enrollee satisfaction surveys consistent with ACA Section 1311(c)(4) (and 45 CFR §156.200(b)(5)). Issuers must also comply with additional federal guidance regarding the QRS and enrollee satisfaction surveys, including requirements described in the Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 202~~43~~ and the 202~~43~~ Quality Rating System Measure Technical Specification, published by CMS, and any subsequent updates to that guidance.

All qualifying issuers offering a QHP of any metal level through the Exchange must comply with QRS requirements and report on all quality measures defined by CMS. For data reporting to CMS during 202~~43~~ (to be displayed during the open enrollment period for the 202~~54~~ plan year), a qualifying issuer is an issuer that offered through the Exchange in the prior year (202~~32~~ calendar year), ~~and~~ offered through ~~the~~ Exchange in the ratings year (202~~43~~ calendar year), and offers a product type in the Exchange that meets the minimum enrollment threshold (more than 500 enrollees in that product type as of both July 1, 202~~32~~ and January 1, 202~~43~~).

Washington Participation Criteria

QHP issuers are required to collect and submit validated QRS clinical measure data directly to the Exchange at the time of submission to CMS via NCQA's Interactive Data Submission System (IDSS). Issuers should export this data from IDSS and transmit via email to the Exchange QHP inbox at QHP@wahbexchange.org. This submission is due on June 1~~45~~, 202~~4,3~~ for the 202~~43~~ QRS. The Exchange will not require submission of QHP Enrollee Survey response data to the Exchange.

If an issuer does not meet the federal requirements for participation due to a lower enrollment count than the federal threshold, the Exchange will still require issuers to report their data to the Exchange. Issuers should forgo submitting to CMS and may use the same IDSS format or another format approved by the Exchange for reporting to the Exchange via the QHP inbox. The Exchange will utilize its flexibility as a state-based exchange to

explore display options for star ratings when issuers are not required to report to CMS. This is in an effort to increase the availability of quality information for consumers shopping on the Exchange.

An issuer that meets the minimum enrollment threshold but is offering a different product type for 2024 coverage will have their QRS rating displayed in *Washington Healthplanfinder* for plans of the different product type if one is available from CMS.

Issuers must administer the QHP Enrollee Survey to eligible enrollees if they meet the requirements of participation outlined above. Issuers eligible to field the QHP Enrollee Survey should use the maximum oversampling of 1,690 surveys for the QRS member survey to increase response rates. If a QHP issuer has a sample of eligible enrollees that is less than 1,690, they should use all eligible enrollees. [All submissions should be directed to CMS.](#)

CMS will work with issuers to collect data and calculate the quality performance ratings for QHPs offered through the Exchange. During 202~~43~~, qualifying issuers will report data from the 202~~32~~ plan year to CMS, and that data will be analyzed by CMS and be the basis for the quality performance ratings that will be displayed in the Exchange during open enrollment for 202~~54~~ coverage. ~~The Exchange will not require submission of QHP Enrollee Survey data to the Exchange directly. All submissions should be directed to CMS.~~

For the 202~~54~~ plan year, the Exchange expects to display the overall plan rating and three summary indicator ratings for each eligible QHP. In future years, additional quality ratings may be displayed.

~~Beginning in pPlan yYear 2024, Issuers must include and identify Exchange enrollees in claims data submitted to the Washington Health Alliance (WHA) so that WHA can produce Exchange population specific quality reports, including by carrier analysis for the Exchange. Issuers submitting data to WHA ~~are will be~~ required to authorize WHA to produce carrier specific reports and provide such reports to the Exchange. ~~The Exchange will work with carriers not currently submitting claims data to WHA to develop an approved timeline. This data will be used to inform future quality program requirements, and potentially may be considered by the Exchange Board as part of plan certification and included in the customer shopping experience.~~~~

In addition to the requirements described above, a QHP issuer will also be required to participate in any other quality reporting requirements that may be authorized by federal regulation or specified by the Exchange. The Exchange intends to identify opportunities to align to HCA quality and value reporting. In their QIS forms, issuers reporting to HCA must either authorize HCA to share their report with the Exchange or must share their HCA report with the Exchange. [If the reporting the carrier provides to HCA is not specific to the HIOS issuer ID for each Exchange issuer, the carrier cannot use the submission to HCA and must report directly to the Exchange with information specific to an issuer's Exchange line of business by HIOS issuer ID.](#) Additional standards to be discussed for future years will be discussed with issuer's quality teams, and could include:

1. Value-based purchasing
2. High value networks
3. Primary care
4. Health disparities
5. Population health

2.2.13 Exchange Enrollment Application

The electronic enrollment application process within *Washington Healthplanfinder* is the single streamlined application for determination of eligibility and enrollment in Washington State as required under 45 CFR §155.405 and satisfies this criterion for issuers.

2.2.14 Hospital Patient Safety Contracts

A QHP issuer may only contract with a hospital with more than 50 beds if the hospital meets certain patient safety standards, including use of a patient safety evaluation system and a comprehensive hospital discharge program. These contractual requirements are monitored by OIC. In addition, a QHP issuer must provide the CMS Certification Number (CCN) to the Exchange upon request for each hospital subject to these requirements with which it is contracted.

2.2.15 Direct Primary Care Medical Homes

The ACA directs that a QHP may provide coverage through a qualified direct primary care medical homeplan so long as the services covered by the medical home plan are coordinated with the QHP issuer. State law, Chapter 48.150 RCW, specifies that a direct primary care medical home must be integrated with an issuer's QHP. If a QHP filing contains a direct primary care medical home, the Exchange will recognize OIC's approval of the plan to confirm that the medical home is integrated with the QHP.

2.2.16 Benefit Design Standards

A QHP issuer must ensure that each QHP complies with the benefit design standards specified in the ACA, including the cost-sharing limits, actuarial value requirements for metal levels, and the essential health benefits (45 CFR §156.200(3)).

The ACA, §1302(d), requires non-grandfathered individual health insurance plans, except for catastrophic plans, to be offered through one of four metal level categories (platinum, gold, silver, or bronze) in an Exchange. The actuarial value calculator, provided by HHS, can be used to produce computations of a QHP's metal level based upon benefit design features.

Please refer to OIC for further regulatory guidance on benefit design standards.

Standard Plan Designs

Washington State law RCW.43.71.095 requires issuers participating in the Exchange to offer standardized health plans designed by the Health Benefit Exchange in consultation with the Office of the Insurance Commissioner and the Health Care Authority and approved by the Exchange Board. Issuers must offer, at minimum, the following in each county in which it offers coverage:

- 1 standard gold plan;
- 1 standard silver plan;
- Standard cost-sharing reduction (CSR) variants for the standard silver plan to be made available to households with attested income up to 250% of the Federal Poverty Level; and
- Cost-sharing alternatives for each standard plan that conform to requirements as defined in 45CFR § 156.420 and 45 CFR § 155.350 to be made available to members of federally recognized American Indian tribes or Alaskan Natives.

If an issuer offers a bronze plan in a county, it must at minimum offer the bronze standard plan in that county.

Nothing shall prohibit an issuer from offering only a standard plan at any metal level and discontinuing its non-standard plans, as long as it complies with applicable state and federal renewability requirements.

The Exchange is authorized to make necessary changes to the approved plans to remain in compliance with federal and state regulation. The Exchange will notify issuers if changes are made to the plans after approval by

the Exchange Board.

The standard plans can be found at: https://www.wahbexchange.org/content/dam/wahbe-assets/plan-certification-workgroup/WAHBE_2024_Standard_Plan_Designs_2023.04.19.

Non-standard Plan Designs

In addition to the required standard plans, participating Exchange issuers may continue to offer plans that do not use the standard benefit design. A health carrier offering a standard health plan under this section may also offer up to two non-standard gold health plans, two non-standard bronze health plans, one non-standard silver health plan, one non-standard platinum health plan, and one non-standard catastrophic health plan on the Exchange in each county where the carrier offers a qualified health plan. In accordance with RCW 43.171.095, a non-standard silver plan may not have an actuarial value less than that of the standard silver plan finalized by the Exchange for 2025⁴. An issuer that offers a non-standard bronze plan in a county must also offer a standard bronze plan in that county.

2.2.17 Services Areas and Rating Requirements

The QHP service area must be established without regard to racial, ethnic, language, or health status related factors specified under section 2705(a) of the Public Health Service Act, or other factors that exclude specific high utilization, high cost, or medically underserved populations (45 CFR §155.1055(b)). A QHP service area will be generally defined by county or counties; however, an issuer demonstrating good cause, as specified in WAC 284-43-0160(29), may request that OIC approve a QHP service area defined by zip codes. Good cause includes geographic barriers within a service area, or other conditions that make offering coverage throughout an entire county unreasonable. Consumers will be able to identify a service area by providing a zip code and county in *Washington Healthplanfinder*. Please refer to OIC for further regulatory guidance on service area requirements.

The Exchange will display plan rates on the *Washington Healthplanfinder* web pages. A QHP issuer's [health plan](#) rates are for an entire plan year. Approval of a plan by OIC will confirm that a QHP has met the service area and rating requirements.

Tobacco surcharges, if utilized by an issuer, will apply only when the definition of tobacco use is met. Section 2701(a)(4) of the ACA defines tobacco use as:

- Using any tobacco product other than for religious or ceremonial use on average four or more times per week within the last six months.

Tobacco use does not include the use of e-cigarettes or other vaping products and therefore the tobacco surcharge will not apply in those instances.

2.2.18 Posting Justifications for Premium Increases

Issuers must provide premium increase justifications as part of the regulatory rate filing procedure. OIC posts this justification, along with its own summary of the premium increase justification, for the public. The Board may engage with issuers in discussions regarding justifications for premium increases from one year to the next and between initial rate filing and finalization of rates.

2.2.19 Reporting Data

As part of the OIC regulatory filing process, a QHP issuer must use the federally supplied data templates during

the SERFF filing process. OIC will forward the data for approved plans to the Exchange whenever plan regulatory approval has been completed.

The Exchange will use these templates to populate *Washington Healthplanfinder* with rates, benefits, service area, and provider network names. The Exchange will not alter the data within these templates without written direction from OIC. Issuers are required to review this data during the annual ratification process (the validation of plan data in *Washington Healthplanfinder*) to ensure the accuracy of the information. The Exchange reserves the right to charge an issuer for incurred costs if the issuer requests changes to plan data after the issuer has reviewed and ratified that plan data. Before charging for incurred costs, the Exchange will take into consideration the circumstances of the request to make changes to plan data.

Issuers offering QHPs through the Exchange must provide data in a manner and frequency specified by the Exchange as necessary to support Exchange operations, including but not limited to:

- Eligibility, enrollment, or disenrollment processes.
- Reports or provision of information required by the U.S. Department of Health and Human Services, Internal Revenue Service, or the Washington State Legislature.
- Estimation or collection of assessments or fees specified in RCW 43.71.080.
- Administration of the State Premium Assistance and Immigration Health Coverage programs.

The Exchange will make enrollment and payment data available to issuers to support issuers in complying with this certification criterion:

2.3 Pediatric Dental Essential Health Benefit

RCW 43.71.065 specifies that *Washington Healthplanfinder* will offer stand-alone dental plans, required under Section 1311(d)(2) of the ACA to include the pediatric dental essential health benefit (described in ACA Section 1302). Washington law further specifies that dental benefits must be offered and priced separately to assure transparency for consumers through *Washington Healthplanfinder*.

A separate Guidance for Participation for Qualified Dental Plans offered through *Washington Healthplanfinder* can be found on the Exchange's website. Please refer to the Guidance for Participation for Qualified Dental Plans and OIC for further guidance on setting the rate for stand-alone dental plans.

Stand-alone dental plans in the individual market that offer the pediatric dental essential health benefit must be Qualified Dental Plans and must be certified by the Exchange Board, even if they are offered only outside the Exchange. Any issuer filing a plan for OIC review that is seeking the designation of Qualified Dental Plan in 2025⁴ outside the Exchange must notify the Exchange of the plan filing when it is submitted to OIC, so that the Exchange Board may prepare to consider the plan for certification.

2.4 Monitoring and Compliance of Qualified Health Plans

2.4.1 Summary Table 2: Monitoring and Compliance of Qualified Health Plans

The following chart summarizes the monitoring and compliance activities associated with the 19 certification criteria. Monitoring activities are conducted by OIC, the Exchange, or both. Any penalties associated with criteria #2 or #7 were described in section 2.2. See sections 2.1 and 2.2 for further detail on the certification criteria.

NUMBER	CRITERIA LEVEL	CRITERIA	MONITORING ENTITY	EXCHANGE PENALTY	DECERTIFICATION CRITERIA
1	Issuer	Issuer must be in good standing	OIC	N/A	Yes
2	Issuer	Issuer must pay user fees, if QHPs assessed	Exchange	Yes (see Section 2.2)	Yes
3	Issuer	Issuer must comply with the risk adjustment program	OIC	N/A	Yes
4	Issuer	Issuer must comply with market rules on offering Plans (including participation in State Premium Assistance program*)	OIC/Exchange*	No WAHBE penalty	Yes
5	Issuer	Issuer must comply with non-discrimination rules	OIC	N/A	Yes
6	Issuer	Issuer must be accredited by an entity that HHS recognizes for accreditation of health plans within specified timeframe	Exchange	No	Yes
7	Product	QHP must meet marketing requirements	Exchange	Yes (see Section 2.2.7)	No
8	Product	QHP must meet network access requirements, including ECPs	OIC	N/A	Yes
9	Product	Issuer must submit provider directory data	Exchange	No	Yes
10	Product	Issuer must implement a quality improvement strategy	Exchange	No	No

11	Product	Issuer must submit health plan data to be used in standard format for presenting health benefit plan options	Exchange	Yes (see Section 2.2.11)	No
12	Product	Issuer must report quality and health performance measures	Exchange	No	No
13	Product	Issuer must use the Exchange enrollment application	Exchange	No	Yes
14	Product	Issuer may only contract with a hospital with more than 50 beds if the hospital utilizes a patient safety evaluation system	OIC	N/A	Yes
15	Product	Services provided under a QHP through a direct primary care medical home must be integrated with the QHP issuer	OIC	N/A	Yes
16	Plan	A QHP must comply with benefit design standards (e.g. cost sharing limits, "metal level," EHB, standard plan design*)	Exchange*/OIC	No WAHBE penalty	Yes
17	Plan	Issuer must submit a QHP's service area and rates for a plan year	OIC	N/A	No
18	Plan	Issuer must post justifications for QHP premium increases	OIC	N/A	No
19	Plan	Issuer must submit QHP benefit and rate data for public disclosure	Exchange/OIC	No	No

2.5 QHP Status Changes

2.5.1 Changes to Plans as Part of the Annual Certification Process

The Exchange certification of a QHP lasts for one plan year and must be renewed for each future plan year in which the issuer seeks to offer the QHP in the Exchange, as set forth in 45 CFR §156.290 and 45 CFR §155.1080. During the annual plan filing and certification process, a QHP issuer may elect not to seek Exchange recertification of a QHP and may discontinue the plan at the end of the year. A QHP issuer must notify the Exchange of any QHPs for which it intends to seek certification or recertification upon filing the plan with OIC. An issuer must fulfill the obligations set forth in 45 CFR §156.290 with respect to any QHP that will be discontinued at the end of a plan year, including providing coverage until the end of the plan year and providing the required 90-day discontinuation notice to enrollees. During the Exchange's automated renewal process in open enrollment, the Exchange will cross-map enrollees, in accordance with 45 CFR §155.335 and other applicable regulations.

If a QHP issuer exits the individual market entirely, it must provide written notice to the Exchange that all of the issuer's QHPs in the individual market will be discontinued at least 180 days before the date the coverage will expire. The QHP issuer must also provide formal 180-day notice to enrollees as required in RCW 48.43.038 for individual market QHPs. The QHP issuer must terminate coverage for the enrollees, as set forth in 45 CFR §156.270, only after the enrollees have had an opportunity to participate in open enrollment as set forth in 45 CFR §156.290.

2.5.2 Denial of Recertification

A renewed plan that is approved by OIC may be denied certification as a QHP by the Exchange if the plan does not meet the certification criteria described in this Guidance for Participation. If a QHP is denied recertification by the Exchange, the QHP will not be offered through the Exchange for the next plan year and the issuer must fulfill the obligations set forth in 45 CFR §156.290, which include providing coverage until the end of the plan year.

2.5.3 Changes to Plans After Certification

The Exchange reserves the right to recoup from an issuer costs incurred by the Exchange resulting from the withdrawal of a plan from being offered in the Exchange after the QHP certification process is completed and plan data has been loaded into Exchange systems and ratified by issuers.

This section shall not apply to a plan approved by the OIC and intended to be offered through the procurement process by the Health Care Authority as described in RCW 41.05.410 which is later determined not to be offered as a public option plan for the plan year.

2.5.4 Changes to Plans During a Plan Year

Decertification of a QHP could occur in the middle of a plan year if OIC withdraws regulatory approval or if the Exchange determines that a QHP no longer satisfies certification criteria. The Exchange will decertify QHPs as set forth in 45 CFR §156.290 and 45 CFR §155.1080. Issuers must terminate coverage for the enrollees as set forth in 45 CFR §155.430. Termination of coverage may only occur after the Exchange has notified enrollees and the enrollees have had an opportunity to participate in special or open enrollment as

outlined in 45 CFR §155.1080. If a non-standard plan is decertified by the Exchange but maintains OIC regulatory approval, the plan shall be made available outside of *Washington Healthplanfinder* for any current enrollees. If a Cascade or Cascade Select plan is not certified or is decertified by the Exchange, the plan will not be available outside of the Exchange.

If a QHP issuer petitions OIC to suspend new sales for the individual market, the QHP issuer must notify the Exchange of the petition and subsequent OIC action on the petition for suspension within two business days of OIC's decision. The QHP issuer must enroll any new enrollees who have selected a plan up through the date of suspension, including those with effective dates after the date of suspension.

The Exchange will not offer a suspended QHP to new enrollees for the following year's coverage during open enrollment. A suspended QHP must continue to provide special enrollment to its current enrollees with qualifying events but will not participate in special enrollment when enrollees of other QHPs or new enrollees experience qualifying events. To be offered through *Washington Healthplanfinder*, a suspended QHP must continue to achieve annual recertification.

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Section 3: Enrollment in a QHP

3.1 Individual Enrollment Processes and Timelines

Issuers will be expected to comply with the enrollment and payment processes outlined in the Exchange Enrollment and Payment Process Guide and EDI standards contained in the 834 and 820 Companion Guides, as well as guidelines provided in the Carrier Operations Guide. The Enrollment and Payment Process Guide, 834 and 820 Companion Guides, and Carrier Operations Guide can be obtained on the Exchange website.

A QHP issuer must agree to comply with the Exchange policies, standards, and processes established for the individual market for transfer of EDI transactions, enrollment, reconciliation, and reporting. This includes accepting all required forms of payment, managing grace periods, participating in process improvement initiatives with the Exchange (e.g., the fitgap process and enhancements to the monthly reconciliation process), and adhering to sponsorship program requirements established in RCW 43.71.030 and the Exchange Sponsorship Policy available on the Exchange website (e.g., accepting payments on behalf of individuals from Exchange-registered sponsors; issuing refunds to Exchange-registered sponsors; providing a sponsor with an accounting of the total amount owed to the issuer); and issuing MLR rebates to enrollees and/or sponsors.

As required by 45 CFR 147.120, issuers making dependent coverage of children available, must make coverage available up to age 26. Issuers offering coverage through the Exchange shall not disenroll such individuals from a parent's plan due to attaining age 26 until the end of the plan year in which the individual attains the age of 26. These individuals will not be eligible for renewal into their parent's QHP and the Exchange will not auto-renew them into the parent's QHP for the plan year following the year they turn 26.

The Exchange must reconcile enrollment information with QHP issuers and CMS no less than on a monthly basis. 45 CFR 155.240. Monthly reconciliation is necessary to ensure any discrepancies and needed corrections are timely addressed and communicated to CMS via monthly APTC reporting. If enrollment discrepancies are not resolved within three months from the first occurrence of the error on the monthly Full Carrier Audit (FCA), carriers are not permitted to hold customers financially responsible if correction of the error results in them having been previously under-billed. The Exchange will work with carriers through the fitgap process to ensure implementation of this requirement.

3.1.1 Plan Mapping

The Exchange performs plan mapping to facilitate renewals during the annual open enrollment period, help consumers avoid breaks in coverage, and help customers navigate the complex plan selection process. The Exchange engages in plan mapping pursuant to authority under federal regulations, requirements under federal and state law, and in consultation with the OIC.

All issuers that offer QHP coverage through the Exchange during 2024⁴³ and 2025⁵⁴ must perform mapping for plan year 2025⁵⁴ in accordance with applicable state law and federal requirements. Issuers must map all prior year non-renewing QHPs to another QHP available in the same county for the subsequent year. The Exchange will review each issuer's mapping assignments for compliance with applicable law, including federal requirements set forth in 45 CFR 155.335, state law, and OIC and ~~the~~ Exchange guidance. The Exchange may cross-map enrollees from one issuer to another, and may identify certain enrollees to be mapped in special circumstances as permitted by applicable law and in accordance with OIC guidance.

Issuers must use the Exchange's Plan Mapping Submission Form to provide plan mapping information; the

Exchange will not accept the CMS Plan Crosswalk Template.

3.1.2 File Transfer and Payment Due Dates

For 2024 enrollments, issuers are expected to comply with the following due dates for initial payments and effectuation, cancellation, and termination files:

Effectuation During Open Enrollment

- Binder payment due date must be no earlier than the coverage effective date, but no later than 30 calendar days from the coverage effective date.
- Payment due date must allow a minimum of 15 business days for a consumer to make a binding payment after the consumer receives an invoice.
- An effectuation or cancellation transaction is due to the Exchange within 10 business days of the binder payment due date, or for a \$0 binder payment, within 10 business days of the date the binder payment would be due if the binder payment was greater than \$0. If a carrier offers a binding payment extension, the carrier-generated effectuation or transaction is due to the Exchange within 10 business days of the binder payment extension end date.
- Issuers are prohibited from requiring receipt of premium subsidy payment(s) from the Exchange, and/or a sponsor, to effectuate a subsidized member's coverage.
- Issuers are prohibited from cancelling coverage due to nonpayment of a subsidy by the Exchange and/or a sponsor.

Effectuation During Special Enrollment

Binder payment due date:

- Payment due date must allow a minimum of 15 business days for a consumer to make a binding payment after the consumer receives an invoice.

If issuer does not verify the qualifying event:

- For coverage being effectuated under regular coverage effective dates (i.e., coverage is effective the first of the next month if a plan is selected by the 15th of a month, and effective the second following month if a plan is selected after the 15th of a month), binder payment deadlines must be no earlier than the coverage effective date, but no later than 30 calendar days from the coverage effective date.
- For coverage being effectuated under retroactive or special effective dates, binder payment deadlines must be no later than 30 calendar days from the date the issuer receives the enrollment transaction.
- An effectuation or cancellation transaction is due to the Exchange within 10 business days of the binder payment due date or, for a \$0 binder payment, within 10 business days of the date the binder payment would be due if the binder payment was greater than \$0.
- Issuers are prohibited from requiring receipt of premium subsidy payment(s) from the Exchange, and/or a sponsor, to effectuate a subsidized member's coverage.
- Issuers are prohibited from cancelling coverage due to nonpayment of a subsidy by the Exchange and/or a sponsor.

If issuer does verify the qualifying event:

- For coverage being effectuated under regular coverage effective dates (i.e., coverage is effective the first of the next month if a plan is selected by the 15th of a month, and effective the second following month if a plan is selected after the 15th of a month), binder payment deadlines must be no earlier than the coverage effective date, but no later than 30 calendar days from the date of verification.
- For coverage being effectuated under retroactive or special effective dates, binder payment deadlines

must be no later than 30 calendar days from the date of verification.

- An effectuation or cancellation transaction is due to the Exchange within 10 business days of the binder payment due date or, for a \$0 binder payment, within 10 business days of the date the binder payment would be due if the binder payment was greater than \$0.
- Issuers are prohibited from requiring receipt of premium subsidy payment(s) from the Exchange, and/or a sponsor, to effectuate a subsidized member's coverage.
- Issuers are prohibited from cancelling coverage due to nonpayment of a subsidy by the Exchange and/or a sponsor.

Rescission due to failure to prove special enrollment qualifying event:

- During special enrollment, issuers may rescind an enrollee's coverage if the documentation provided to an issuer does not support the qualifying event. Cancellations of coverage due to failure to provide documentation to support the qualifying event shall be communicated to the Exchange via the manual reconciliation process (i.e., issuers will not transmit an 834 transaction).

Termination for Nonpayment

A termination for nonpayment transaction is due to the Exchange within 10 business days of expiration of the one-month (non-subsidized) or three-month (subsidized) grace period.

The grace period for non-payment of premiums may span two plan years if subsidized enrollees receiving APTC and/or state premium assistance fail to pay premiums for November or December coverage. Consistent with guaranteed renewability of coverage, issuers must accept the renewal of the enrollee since the enrollee is still in a grace period (45CFR §147.106). If the enrollee does not pay all outstanding premiums for November and December by the end of the three-consecutive-month grace period, the issuer should terminate the enrollment retroactively to the last day of November or December, whichever was the first month of the grace period.

[Pursuant to the final 2023 Notice of Benefit and Payment Parameters, carriers-issuers](#) may not condition renewal during an open enrollment period on payment of outstanding premiums owed. Customers in a grace period in November or December 202~~43~~ will be automatically renewed into 202~~43~~⁵⁴ coverage [\(if they otherwise qualify for auto-renewal\)](#), or may actively enroll into 202~~43~~⁵⁴ coverage, regardless of the disposition of their past due premium from 202~~43~~ coverage. (See 45 CFR §156.270 and §155.430.)

Notice of Non-Payment of Premiums

[Issuers on the Exchange are required to send enrollees a notice of payment delinquency promptly and without undue delay within 10 business days of the date the issuer identified the delinquency. \(See 45 CFR § 156.270\(f\).\)](#)

Changing from Termination for Nonpayment to Voluntary Termination

If an issuer accepts a payment for a prior year enrollment after an enrollee is terminated for nonpayment, the issuer should change the reason for termination to voluntary termination. This change must be communicated to the Exchange via the reconciliation process within 10 days of the payment being processed. These changes impact 1095-As sent to members and IRS reporting.

Premium Payment Threshold

[Issuers are required to report to the Exchange on their use of a premium payment threshold as described under 45 CFR § 155.400\(g\) with respect For 2025, QHP issuers are required to apply a premium payment threshold of no greater than 95% to Exchange enrollees' premium payments. Issuers must report their anticipated use of a premium payment threshold for plan year 202~~5~~⁴ to the Exchange by October 1, 202~~4~~³, by providing notification](#)

[to QHP@wahbexchange.org](mailto:QHP@wahbexchange.org).

State Premium Assistance Payments from the Exchange

The Exchange will use the Exchange 820 to communicate individual premium assistance payment information to issuers or their trading partner(s). Issuers are required to receive and process 820 transactions and comply with the Exchange's 820 Companion Guide. The Exchange will transmit premium assistance payments to issuers through electronic fund transfer (EFT). Issuers are required to accept and process premium assistance payments from the Exchange. Issuers are required to clearly communicate premium assistance amounts to enrollees as part of the invoicing and payment process and must refer to these payments by the branded name Cascade Care Savings.

3.1.3 Cost-sharing Accumulation Policies

The Exchange intends for consumers to have access to a consistent experience as it relates to information and policies regarding their cost-sharing, regardless of their selection of issuer.

- Issuers with policies that limit the amount of cost-sharing that accumulates toward the deductible and out-of-pocket maximum, are required to provide notice in the Summary of Benefits and Coverage by indicating which benefits are subject to such policies in the "Limitations, Exceptions, and Other Important Information" column.
- In the event that disenrollment of the primary subscriber, for any reason, and remaining members maintaining enrollment results in the issuance of a new plan, the issuer is expected to apply any amounts previously paid toward the enrollees' deductible and out-of-pocket maximum in the first plan toward the enrollees' deductible and out-of-pocket maximum in the second plan.
 - This includes in the event that the primary subscriber passes away, and remaining enrollees' continuing enrollment results in the issuance of a new policy under a new primary subscriber.
- In the event that enrollment of the primary subscriber through a confirmed special enrollment period, and remaining enrollees' continuing enrollment, results in the issuance of a new policy, the issuer is expected to apply any amounts previously paid toward the individual enrollees' deductible and out-of-pocket maximum toward the individual enrollee's deductible and out-of-pocket maximum in the second policy.
- In the event that the addition of a dependent to existing family coverage through a confirmed special enrollment period after the dependent has experienced a gap in coverage results in the issuance of a new policy for the household, the issuer is expected to apply any amounts previously paid toward the individual enrollee's (other than the newly added dependent) deductible and out-of-pocket maximum toward the individual enrollee's deductible and out-of-pocket maximum in the second policy.
- An individual granted a Cascade Care Savings special enrollment period that changes plans and remains enrolled with the same carrier will not lose any cost accumulators accrued while in the previous plan.
- In the event that a customer is disenrolled from a QHP and enrolled in Medicaid, and later reenrolls in a QHP (same issuer, same product) within the same plan year, without experiencing any breaks in

coverage, the issuer is expected to apply any amounts previously paid toward the individual enrollee's deductible and out-of-pocket maximum in the first enrollment toward the individual enrollee's deductible and out-of-pocket maximum in the second enrollment.

- As outlined in the [Exchange](#) Sponsorship Policy, payments made on behalf of consumers by a charitable organization, tribe, government entity, or other sponsor organization under the Exchange's Sponsorship Policy must accumulate toward the consumer's deductible if they would have accumulated toward the deductible had a consumer made the payment directly.

3.2 Producer and Navigator Specifications

3.2.1 Producer

Producers who are authorized to sell *Washington Healthplanfinder* products will be able to present QHP offerings to individuals in Washington State. To become a registered producer with the Exchange, a producer must hold a valid Washington State disability producer license, sign the Exchange User Participation Agreement, and attend a certification or recertification class annually.

Issuers offering plans on the Exchange that are Cascade Care plans are required to pay commission for the sale of those plans at a level at least equivalent to those of other Exchange plans offered by the Issuer. Issuers will honor enrollments completed by an Exchange assister including producers, regardless of commission.

Amendments to section 2746 of the Public Health Service Act require a health insurance issuer offering individual health insurance coverage or short-term, limited-duration insurance to disclose to enrollees in such coverage and to report annually to HHS the direct or indirect compensation provided by the issuer to an agent or broker associated with enrolling individuals in such coverage. Section 2746(d) directs the Department of Health and Human Services (HHS) to finalize, through notice and comment rulemaking, the timing, form, and manner in which issuers must make these disclosures to consumers and submit reports to HHS. These statutory requirements were applicable beginning December 27, 2021.

On September 10, 2021, HHS issued a proposed rule to require issuers to disclose to policyholders, before finalizing plan selection as well as on documentation confirming the individual's enrollment, commission rates and compensation structure for other direct and indirect compensation provided by the issuer to an agent or broker associated with enrolling those individuals. The proposed rules would also require such issuers to report to HHS the actual, total amount of direct and indirect compensation paid by the issuer to the agent and broker for the preceding year. The proposed rule has yet to be finalized. Once final, issuers will be required to inform the Exchange of their timeframe and approach to implement this requirement and provide the Exchange with a sample of their disclosure language when developed. Additionally, issuers will be required to provide a report to the Exchange that contains the information included in the report to HHS (the actual, total amount of direct and indirect compensation paid to agents and brokers for the preceding year).

If an issuer has knowledge of producer noncompliance with the applicable agent and broker conduct standards of 45 CFR 155 Subpart C, issuer shall notify the Exchange as soon as possible.

If an issuer terminates a producer from an issuer appointment agreement, the issuer shall notify the Exchange as soon as possible.

Please refer to OIC for more information on producer licensing requirements.

3.2.2 Navigator

The Exchange will award contracts to organizations to deliver in-person application and enrollment assistance that meets the standards described in 45 CFR §155.210. Certified assisters will be trained to engage in education, outreach, and enrollment related to *Washington Healthplanfinder*, including enrollment in both QHPs and Washington Apple Health (Medicaid). The navigator program primarily focuses on outreach and assistance to populations that experience barriers to enrolling in and accessing health care coverage. Navigators must meet security, confidentiality, and conflict of interest standards, and are prohibited from receiving indirect or direct compensation from a health insurance issuer based on enrollment. Health insurance issuers cannot act as Navigators.

3.3 Complaints

An issuer must notify the Exchange of any complaints received from enrollees with respect to the operation of the *Washington Healthplanfinder* marketplace within seven business days. The Exchange will work with the issuer to resolve any such grievances where the issuer is responsible for resolution.

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Section 4: Special Guidance for Coverage for American Indian/Alaska Natives (AI/AN)

An issuer must comply with all federally required laws and regulations specific to AI/AN individuals in the ACA and other federal regulations, including but not limited to:

- A once-a-month enrollment period to enroll or change plans in *Washington Healthplanfinder* for any AI/AN individual enrolled in a federally recognized tribe or Canadian Indian lawfully present in the US under the Jay Treaty;
- No cost sharing for AI/AN QHP enrollees with incomes under 300% of federal poverty level who are otherwise eligible for tax credits through the Exchange;
- No cost sharing for AI/AN QHP enrollees for any item or service furnished through Indian HealthCare Providers or through referral under contract health services as defined in Section 1402(d)(2) of the ACA;
- Health programs operated by Indian Health Care Providers will be the payer of last resort for services provided by such programs, notwithstanding any federal, state, or local law to the contrary; and,
- Compliance with Indian Health Care Improvement Act §206 and §408.

The Office of the Insurance Commissioner requires issuers to offer contracts to all Indian Health Care Providers in their service area. If an issuer contracts with an Indian Health Care Provider, the issuer will notify the Exchange in a timely fashion of this relationship.

Issuers are strongly recommended to use the Centers for Medicare and Medicaid Services Model QHP Addendum for Indian Health Care Providers when contracting with a specified Indian Health Care Provider.

A QHP issuer must adhere to sponsorship program requirements as referenced in Section 3.1 above, including accepting payments from and issuing refunds (including medical loss ratio rebates) to Exchange-registered tribal sponsors.

In accordance with provisions of the Exchange's State Premium Assistance Policy, issuers shall recognize AI/AN individuals' eligibility for state premium assistance without consideration of which plan they are enrolled in.

Section 5: Issuer Certification Appeal Process

A QHP issuer may appeal a Board decision to deny initial certification of a health plan or recertification of a QHP. A QHP issuer may also appeal a decision by the Exchange Board to decertify a QHP. An issuer is required to fully cooperate with the Exchange during an appeal process to prepare the health plan to be offered during the open enrollment period.

An issuer will have up to 10 calendar days from the date of the notification of a Board decision to deny initial certification of a health plan, deny recertification of a QHP, or decertify a QHP, to submit a written appeal via electronic mail to the General Counsel of the Exchange.

An issuer's appeal must:

- Identify the specific criterion or criteria appealed;
- Provide information that clarifies the issuer's position on each unsatisfactory criterion; and
- Succinctly state the outcome sought by the issuer.

After submitting the appeal:

- The Exchange will send written notice to the issuer within seven calendar days from the date that the appeal was received.
- The issuer will have the opportunity to address the Board about the appeal prior to a Board decision regarding the appeal.
- The Board will have up to 20 calendar days from receipt of the appeal to send a final written decision that upholds or denies the issuer's appeal.

The Board's written response to such an appeal will be a final decision and all appeals with respect to that health plan will be exhausted. This appeal process represents the sole remedy for an issuer with respect to a Board decision regarding initial certification of a health plan or recertification or decertification of a QHP offered through *Washington Healthplanfinder*.