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Cascade Care Savings: State Premium Assistance Policy
Public Comment and Exchange Responses

May 10, 2022

In 2021, the Washington State Legislature passed legislation directing the Exchange, operating within Legislatively appropriated funds, to implement a state premium assistance program. The Exchange developed a draft policy to establish criteria for implementation of the program, which was published for public comment on April 5, 2022. The Exchange held a public comment period on the Draft State Premium Assistance Policy from April 5, 2022 – April 29, 2022, with a public hearing taking place on April 27, 2022. The Exchange received written comments from stakeholders on various aspects of the policy, as described below. Throughout this document, the state premium assistance program governed by the policy is referred to as "Cascade Care Savings," which is the name that the state premium assistance program is known and marketed. The Exchange welcomes this important addition to its tools to improve affordability, access, equity, and quality of health care on the individual market and agrees with common feedback supporting the increased public investment in reducing costs of premiums for Washington residents.

Coverage of Non-EHB Premiums

One commenter provided written feedback requesting transparency regarding the application of state premium assistance to premium amounts attributable to non-essential health benefit (EHB) services.

Comment: Each previously published policy draft has indicated that premium assistance may be applied to premium amounts attributable to non-EHB services by describing $0 member premiums. In the interest of transparency, we ask that WAHBE clarify in this policy whether state subsidies do or do not include the required $1 per member per month premium amount for coverage of non-Hyde abortion services.

Exchange Response: State premium assistance can be applied to any net premium owed by an eligible enrollee (e.g., remaining premium following application of any applicable federal advanced premium tax credits). The Exchange has added language to Section 5.2 of the policy to provide examples of non-EHB services, including non-Hyde abortion services, that could be included in a net plan premium to which a Cascade Care Savings amount available to a particular household will be applied in *Washington Healthplanfinder*.

Three-Month Grace Period

The Exchange received written feedback from three commenters regarding the three-month grace period for state premium assistance recipients.

Comment: We are particularly supportive of the following elements of the Savings Program Rules: Grace period policy in Section 8(6). The proposal to align the state Savings program grace period with the federal grace period will prevent unnecessary uninsurance and churn by giving enrollees a reasonable opportunity to catch up on premium payments, while fairly splitting any financial risk from payment delinquency among providers, carriers, and enrollees. As we noted in our previous

comments, this approach will minimize operational complexity for consumers, WAHBE, carriers, and providers— particularly given the limited number of individuals who will be eligible for Cascade Care Savings without federal advance premium tax credits (APTCs). Also, as WAHBE presented at the April 12th Cascade Care Workgroup meeting, the most recent Exchange report on grace periods showed that at least 77% of consumers were able to make a catch-up payment and fewer than 14% were terminated for nonpayment.

Comment: Kaiser Permanente continues to strongly object to state-subsidy-only members having the ability to receive a three-month grace period for non-payment of premiums. While we understand the intent to mirror the requirements in the federal APTC policy, its applicability is not the same and could have the following financial consequences and risks should it be implemented:

- The federal government reimburses carriers the full APTC amount for the first month of unpaid premium by a member; the WAHBE state subsidy policy would reimburse the much smaller state subsidy.
- The burden of covering the financial liability related to medical services rendered for a lesser state subsidy amount is not equivalent to the federal APTC payment for the same month, regardless of the anticipated low volume of state-subsidy-only members.
- It is indicated that carriers can terminate a state-subsidy-only member's coverage on the last day of the first month of the grace period ***only if*** claims were pended in the second and third months of the grace period. Given Kaiser's model of care and current system limitations, this provision create enormous financial consequences for services provided by our internal Kaiser providers and facilities.
- Finally, under existing regulation, WAC 284-170-431 , carriers are required to pay clean claims on a timely basis, which is defined as being within thirty days. Carriers who fail to do so may be subject to financial penalties and/or corrective action. WAHBE's proposed policy requiring carriers to pend claims for non-APTC eligible consumers during a state 90-day grace period would place issuers in conflict with this OIC requirement.

Comment: Our second concern is related to the 90-day grace period. We appreciate your desire to align state subsidy grace period with the federal grace period requirements to reduce and recognize the relatively small population who will have a state-only subsidy, but this is a significant undertaking from an administrative burden perspective. Additionally, a significant difference between your 90-day grace period and the federal grace period is your required repayment of the subsidy for the period after the first 30-days. The federal program recognizes that health plans are taking the risk and bearing the burden of reimbursement for individuals who have not paid their premium for the first thirty days, and allows the plans to keep the subsidy payments for the second and third months. We would ask that if you proceed with these planned program changes, you mirror to the federal grace period and allow plans to retain those dollars from months two and three.

Exchange Response: The Exchange appreciates stakeholder feedback received on the proposed three-month grace period. We agree that alignment with federal policy will prevent unnecessary uninsurance and churn and reduce administrative complexity, and that this will result in similar high proportions of enrollees catching up on premium payments and staying covered. Section 8.6 of the final policy has been updated to more clearly describe the Exchange's intent to align the grace period for Cascade Care Savings recipients with the federal grace period for APTC recipients. The Exchange understands concerns expressed by carriers regarding financial risk associated with the requirement to provide a three-month grace period to the very small number (approximately 4%) of Cascade Care Savings enrollees who do not also receive federal tax credits and are already entitled to the grace period. Carriers' ability to pend claims in the second and third months of the grace period

(as is the normal course of business for customers in second and third months of a federal grace period) and ability to retain the state premium assistance amount for the first month of grace period coverage offset the potential financial risk to carriers.

As stewards of the state investment in lower premiums for Washingtonians, the Exchange adopts this requirement regarding eligibility and facilitation of premium payments to improve customer retention, ensure consistency with federal standards, and minimize confusion for all customers who receive premium subsidies through the Exchange.

The Exchange therefore finalizes the three-month grace period in the final policy as proposed.

Special Enrollment Period (SEP)

The Exchange received written feedback from four commenters regarding the Special Enrollment Period (SEP) for individuals with incomes at or below 250% of the federal poverty level (FPL) who are not enrolled in a Cascade Care silver or gold plan to enroll in a Cascade Care silver or gold plan.

Comment: We are particularly supportive of the following elements of the Savings Program Rules: Special enrollment period policy in Section 9. We also strongly support WAHBE in proposing an ongoing special enrollment opportunity (SEP) for individuals with incomes under 250% FPL who are not yet enrolled in a silver or gold Cascade Care plan. This proposal will promote coverage and with careful monitoring, can be introduced without posing an undue adverse selection risk. As we have previously noted, available data suggests that broad SEPs for low-income enrollees promote coverage without introducing undue risk. This proposal also aligns with federal policy and would offer a critical safety net at the end of the public health emergency. We particularly appreciate that currently-enrolled individuals who switch plans under this SEP would not lose any cost accumulators if enrolled with the same carrier.

Comment: We believe the proposed SEP for this population is overly broad. There is a federal 60-day SEP trigger for someone newly eligible for APTC or CSR, due to a change in income. We do not recommend providing longer election periods for the State subsidy. Allowing unresponsive individuals and individuals who do not file their household tax information being afforded the ability to enroll at any point during the year is not good public policy. Consumer protections and ease in the enrollment are important, but so is consumer accountability and precedent-setting policy.

Comment: With regards to the special enrollment period (SEP), we thank HBE for clarifying that the SEP is only available to new enrollees and current enrollees not enrolled in Cascade Care silver or gold plans. We also appreciate the clarification that accumulator transfers will apply when enrollees stay with the same carrier. After careful review of draft three, LifeWise has significant concerns that a monthly SEP open to anybody who meets the income criteria will cause consumer confusion and weaken the financial efficacy of the market. The Affordable Care Act (ACA) established the fundamental market rule that, outside of open enrollment, only certain qualifying events trigger an SEP. An income level up to 250% FPL is not one of those triggers. Therefore, the proposed SEP is inconsistent with the ACA. We believe that such an inconsistency will confuse consumers and inevitably drive-up inquiries, complaints, administrative costs, and contribute to a poor member experience. We know that affordability is the number one factor for Washingtonians when considering which health plan to purchase. LifeWise reiterates the concerns raised from other carriers about adverse selection. The proposed SEP is open to the point where we should expect uncontrolled, frequent, jumping from plan to plan. This will negatively impact our ability to keeps costs low and potentially push people away from the market altogether. For all the reasons above, we urge HBE to reconsider the proposed SEP. Thank you.

Comment: First, we are very concerned about the Special Enrollment Period (SEP) language. Our data shows that SEP members are more expensive than regular members, and we are concerned about the broad SEP language you are considering. Given that the Medicaid population will have their own Qualifying Life Event (QLE) to allow them to enroll in a subsidized plan when redeterminations begin on that population, and loss of coverage is already a coverage QLE, we do not feel that an ongoing SEP is necessary for this population and would strongly urge you instead to plan on a more traditional Open Enrollment Period. We have included data below to show the cost of SEP members versus regular members for Molina over the last few years. In particular, please note that in 2019 the MLR for the SEP members was 10% worse than OEP members. And as you know, the impact of the additional cost and burden on the single risk pool, puts upward pressure of premium rates for all members.

In 2019 the medical loss ratio (MLR) for the SEP members was 10% worse than OEP members.

In 2020 the MLR for SEP members was 1% worse than OEP members.

2019			
PMPM Measures	**OPEN**	**SEP**	**Total**
Member Months	233,347	16,330	**249,677**
Average Members	21,213	1,485	**22,698**
Gross Premium	595	521	**591**
Risk Adj	139	186	**143**
MLR Rebate	-	-	-
Other Revenue	2	2	2
Net Revenue	**737**	**710**	**735**
Medical	387	459	**392**
Pharmacy	114	93	**113**
Capitation	0	0	**0**
Other Claims	(0)	(0)	**(0)**
Net Claims	**501**	**552**	**505**
Admin	78	69	**77**
Taxes and Fees	16	14	**16**
Net Expenses	**94**	**83**	**93**
Net Income	**142**	**75**	**137**
Federal MLR	**62%**	**72%**	**63%**

2020			
PMPM Measures	**OPEN**	**SEP**	**Total**
Member Months	386,141	52,837	**438,978**
Average Members	35,104	4,803	**39,907**
Gross Premium	482	453	**478**
Risk Adj	23	(45)	**15**
MLR Rebate	(26)	(26)	**(26)**
Other Revenue	(0)	(0)	**(0)**
Net Revenue	**479**	**383**	**467**
Medical	290	245	**284**
Pharmacy	87	48	**82**
Capitation	2	2	**2**
Other Claims	(0)	(0)	**(0)**
Net Claims	**379**	**295**	**368**
Admin	68	63	**67**
Taxes and Fees	22	20	**21**
Net Expenses	**89**	**84**	**89**
Net Income	**11**	**4**	**10**
Federal MLR	**77%**	**78%**	**77%**

Exchange Response: The Exchange appreciates the feedback provided regarding the proposed SEP for individuals with incomes at or below 250% FPL to enroll in a Cascade Care silver or gold plan. The Exchange is finalizing the SEP as proposed. A special enrollment opportunity for individuals eligible for this new state benefit to enroll into qualifying plans is a critical programmatic support in the first year of the new program. Because state premium assistance is not automatically applied to all who meet income requirements, and selection of a particular plan (a Cascade Care silver or gold plan) is required, it is essential to support eligible customers with the ability to enroll in plans that allow them to access this new benefit.

Additionally, this new SEP aligns with a similar SEP that has been implemented in the federally facilitated marketplace (FFM) and several state-based exchanges, which allows low income individuals to enroll in or change QHPs monthly. In explaining the reasoning for this SEP, CMS has explained that, with enhanced subsidies available under the American Rescue Plan, APTC-eligible enrollees up to 150% FPL are eligible for a $0 silver plan premium. CMS has noted that this SEP is in alignment with those enhanced subsidies for the population that can enroll in a silver plan with no

premium. In Washington, Cascade Care Savings premium assistance sits on top of the federal APTC (for those who are eligible) and results in individuals with incomes up to 250% FPL who receive APTC being eligible for a $0 premium silver plan (the lowest cost Cascade Care silver plan). The reasoning supporting implementation of the 150% FPL SEP in the federal marketplace and other states can be extended to support an SEP for the population up to 250% FPL in Washington because of Cascade Care Savings.

With the unwinding of the federal Public Health Emergency expected to begin sometime later in 2022 and the resulting disenrollment from Washington Apple Health that will likely follow throughout 2023, the Exchange sees this new SEP, available to consumers up to 250% FPL, as critical to help Washingtonians navigate the transition from WAH to qualified health plan coverage. This will be a confusing time for individuals who may be losing coverage they have had for years, and the availability of this SEP is essential to ease customers through this challenging time and ensure that they have access to all available premium assistance for which they might qualify.

One commenter expressed concern that the proposed SEP is open to the point where uncontrolled, frequent, jumping from plan to plan could be expected, which would negatively impact carriers' ability to keeps costs low and potentially push people away from the market altogether. The Exchange disagrees that frequent jumping from plan to plan is likely. The SEP is structured to be essentially a one-time opportunity for qualifying customers to enroll in a Cascade Care Savings-eligible plan and take advantage of the new state premium subsidy. Customers attempting to use this SEP may only enroll in Cascade Care silver or gold plans. Once enrolled in a Cascade Care silver or gold plan, the SEP is no longer available. The structure of the SEP balances concerns about plan switching with the need to encourage enrollment in the Cascade Care Savings program and maximize the benefit to Washingtonians, especially in the first year of implementation.

The Exchange appreciates feedback provided by carriers regarding the potential for higher risk individuals to enroll only when care is needed. While we did not see this risk materialize during recent similar SEPs, the Exchange commits to revisit the need to continue this SEP beyond the 2023 initial implementation plan year. The Exchange will assess continuation of all or part of the SEP with review of the State Premium Assistance Policy for plan year 2024. We commit to gather data regarding utilization of this SEP and related market impacts and to reconsider the SEP in light of any new information about the federal landscape, including continued availability of the 150% FPL SEP on the FFM and in other states, continuation of the enhanced subsidies introduced through the American Rescue Plan, and state of the Public Health Emergency.

Contingency for Low Finds

One commenter requested that the Exchange share information about how the waitlist will function in the case of low funds.

Comment: We understand from the April 12th Cascade Care Workgroup meeting that the Program Rules will not include guidance on how the Cascade Care Savings waitlist will function in the case of low program funds, but that HBE is looking into functionality to track requests for Cascade Care Savings made after program enrollment is frozen. *Recommendation*: We would appreciate the opportunity to review and comment on this mechanism once it is further developed, so we can partner to support a well-functioning system for consumers and assist in any legislative advocacy to expand program funding if needed. It will also be important for this waitlist functionality to incorporate privacy protections for individual information, given the new immigrant population anticipated in PY 2024.

Response: The Exchange commits to sharing with stakeholders information about any mechanism

developed to track requests for Cascade Care Savings made in the case that the program is frozen to new enrollment due to low funds.

State Premium Assistance Program Rules and the Immigrant-Related Section 1332 Waiver

One commentor asked for the Exchange to clarify aspects of the Cascade Care Savings program rules that are inconsistent with the immigrant-related Section 1332 waiver.

Comment: We applaud WAHBE for its plans to move forward with a 1332 waiver application to support immigrant coverage. We understand that such coverage will not be available until PY 2024, while the currently proposed Cascade Care subsidy program only governs PY 2023. However, we are concerned that some elements of the draft Savings Program Rules appear to restrict eligibility in a way that would present concerns when the 1332 waiver is approved.

Response: The Exchange commits to revisit the State Premium Assistance Policy in its entirety for plan year 2024 for alignment with changes that would result from approval of the Section 1332 waiver.

Comment: Section 4(3) requires an individual to receive an eligibility determination for federal APTCs and cost-sharing reductions (CSRs) prior to receiving state premium assistance. This will not be appropriate for the new immigrant population, who are by definition ineligible for these federal programs.

Response: In 2024, consistent with current state law and assuming the federal Section 1332 Waiver is approved, newly eligible QHP-enrollees will need to receive an eligibility determination for available affordability programs (including Apple Health for which they may be eligible), to qualify for the new state subsidy. We do not anticipate needing to adjust this language.

Comment: Section 4(4) indicates that the Exchange will verify data matching inconsistencies, including citizenship/lawful presence status. We understand that as an operational matter, WAHBE only conducts this verification if an applicant has attested to citizenship/lawful presence status. For the purposes of clarity with the new population, however, we recommend addressing this issue directly in the Savings Program Rules.

Response: We have amended current language to reflect that verification of status will occur when an individual attests to citizenship or lawfully present status.

Comment: Section 4(1)(b) and Section 6(1) indicate that an applicant will only be considered for state premium assistance eligibility if the person is determined for Qualified Health Plan coverage. While this is incompatible with the new immigrant program, we expect this issue will be resolved by the 1332 waiver, which would make new immigrants eligible for Qualified Health Plans if approved.

Response: Under current state law, Cascade Care Savings is only available to those eligible to purchase a QHP, specifically a Silver or Gold Cascade or Cascade Select plan. The proposed Section 1332 Waiver, if approved, would enable Washington residents without a federally recognized status to purchase a QHP for Plan Year 2024, allowing them to benefit from Cascade Care Savings. Without an approved waiver, those without a federally recognized status would be unable purchase QHP coverage or benefit from Cascade Care Savings, under current state law.

Draft Appeals Procedural Rules

The Exchange received feedback from one commenter on several aspects of the draft Appeals Procedural Rules referenced in the State Premium Assistance Policy.

Comment: Appeal timeline in Section 4. We applaud WAHBE for aligning the appeal timeline for federal and state programs in the draft Appeals Rules. In a previous version of the rules, WAHBE allowed aggrieved individuals to request an appeal within 90 days for federal programs (as required by federal law), but only allowed 30 days for state premium assistance. We are glad to see that WAHBE is now proposing a unified 90-day standard for all eligibility determinations, with the possibility of a good cause exception for exceptional circumstances requiring a longer timeline. This unified 90-day timeline will be simpler for WAHBE, clearer for consumers, and offer enrollees a greater chance to maintain their coverage. The longer timeline also recognizes the reality of slower mail delivery times given recent changes to U.S. Postal Service delivery standards.1 (Please note: There is a remaining reference to the 30-day timeline in Sec. 5(1)(b) that should be deleted for consistency).

Response: We appreciate this detailed feedback. The Exchange has updated section 5 to remove the reference to the remaining 30-day timeline referenced in (1)(b).

Comment: Address significant concerns about the impartiality of second-level appeals. We appreciate that Section 13 of the draft Appeals Rules attempts to address the issue of “second level” appeals for appellants who disagree with the decision of an Exchange presiding officer related to eligibility for the state Cascade Care Savings or child care worker premium assistance programs. We recognize that the Exchange is unable to leverage the HHS appeals process for this purpose. However, we have serious concerns with the solution WAHBE has proposed for second level appeals related to state programs. In Section 13(2), WAHBE indicates that an individual seeking a second-level appeal of the Exchange’s decision about eligibility for a state program may only make this appeal to the same Exchange entity that made the decision. This is unacceptable. While the rule specifies that another presiding officer must hear the second appeal, WAHBE proposes no solution to the possibility of bias against the appellant on the part of the second presiding officer, given the collegial relationship between the second presiding officer, the first presiding officer, and WAHBE staff/vendors. There is no meaningful protection for the appellant against the reality that these individuals are all paid staff of the same organization, possibly co-located in the same office, and possibly supervised by the same Exchange legal counsel.

We urge WAHBE to reconsider this inappropriate proposal, particularly because it highlights a longstanding concern of legal advocates about the sufficiency of WAHBE’s procedural protections. As we have noted since WAHBE’s inception as a quasi-public entity, it is highly problematic that WAHBE views itself as outside the purview of the state Administrative Procedures Act, Ch. 34.05 RCW, and thus in its view excepted from the standard due process protections that agencies must follow, such as allowing appellants to petition for judicial review following the exhaustion of administrative remedies.

We do not concede WAHBE’s view, particularly as WAHBE assumes additional responsibilities for conferring benefits under the new state premium assistance programs. We have consistently noted this concern in dialogue with WAHBE staff, including during legislative deliberations about E2SSB 5377, the Cascade Care Savings enabling statute. In these recent conversations, we were assured by WAHBE staff that WAHBE would follow an “APA-like” process for rules and appeals. We are disappointed to see that WAHBE has now proposed a lesser standard that does not allow for a meaningful second level review.

It is possible that a court would disagree with WAHBE's position regarding whether the proposed process is sufficient to meet due process. We note that federal regulations indicate that appellants may even seek third-level review of HHS decisions. 45 C.F.R. §155.505(g). We also note that at least one other peer Exchange recognizes judicial review of Exchange appeal decisions, including a state subsidy program similar to Cascade Care Savings – the Massachusetts Health Connector recognizes that appellants may appeal Exchange appeal decisions in state court after exhausting administrative processes.

Recommendation: We seek dialogue with WAHBE about how to better address second-level appeals for state programs. There are a number of different routes WAHBE could explore, such as using the Office of Administrative Hearings as a neutral entity for second-level appeals. We would appreciate the opportunity for a discussion with WAHBE prior to finalizing this ill-advised proposal.

Response: The Exchange appreciates the focus on ensuring appellants receive due process, particularly in the second level review process. The Exchange is finalizing its proposed procedural process as proposed. The Exchange will also continue to engage in discussion and assess its process. In designing the appeals process for Cascade Care Savings, the Exchange modeled its approach after current federal requirements governing appeals of Exchange eligibility determinations. These regulations provide for due process protections regarding advance notice, opportunity to be heard, and impartial hearings that are comparable to protections provided for by the Administrative Procedures Act (APA). See 45 CFR subpart F. The Procedural Rules create an "APA-like process" by applying the same requirements applicable to eligibility determinations for federal programs to appeals of eligibility determinations for Cascade Care Savings. Specifically related to second level review, the Exchange is unable to use the federal/HHS appeals process for review of Exchange determinations of eligibility for state benefits like Cascade Care Savings. Because the Exchange agrees that a second level appeal, while not required by state law, is important and comparable to APA protections, The Exchange has created a second level review process to ensure consumers have access to an additional level of review across all programs.

Exchange goals in developing this additional, second level review were to ensure a simple and transparent process that maximizes efficiencies related to overlap of federal and state program eligibility criteria and provides for timely and accurate resolution of appeals. As part of achieving these goals, the Exchange is leveraging its current process for appeals of federal programs as much as possible, including contracts with Presiding Officers that already have expertise in Exchange eligibility criteria.

While appreciative of the suggestion to use the state's Office of Administrative Hearings (OAH), the Exchange's enabling legislation recognizes the benefits of having an entity separate and distinct from the state. The Exchange contracts with Presiding Officers in their individual capacity and not as agents, employees, or partners or associates of one another. The Presiding Officers are not supervised by any Exchange staff or co-located in the same office. They are both contractually and legally required to review disputes and render decisions with impartiality and without bias. In addition, Presiding Officers must review the appeal record de novo, without deferring to prior decisions in the case.

This process protects consumers from the possibility of bias on the part of the second presiding officer and provides the opportunity for a meaningful second level review. Since 2015: 1) 80% of appeals are resolved through informal resolution to the appellant's satisfaction prior to going to a hearing (first level of review); and 2) less than five appeals of an Exchange decision to HHS have been filed (request for second level review). HHS schedules these hearings between fourteen and twenty-four months after the appeals are requested by appellants. Given the overlap in eligibility

criteria across state and federal programs, the Exchange anticipates that the majority of any appeals related to state premium assistance will be resolved to the appellant's satisfaction prior to needing a first level of review. The Exchange will ensure any second-level appeals are resolved timely, consistent with the Exchange's federal requirement that appeals decisions be made within 90 days of the date of the appeal request. 45 CFR 155.545.

The Exchange is committed to continuing to assess the appropriateness of its appeals process and will monitor and report on appeals and their outcomes as well as continuing to engage with other Exchanges to identify best practices.

Comment: Clarify that individuals may appeal eligibility determinations regarding qualified dental plans.

We are concerned that the proposed Appeals Rules do not adequately indicate that eligibility determinations related to qualified dental plans (QDPs) may be appealed.
In Section 2(8), the draft rules define "eligibility determination" as a "...decision made by the Exchange that an applicant or enrollee is eligible or ineligible for enrollment in a qualified health plan and/or financial assistance…" (emphasis added). Section 3(a) and (b) further specify that individuals may only appeal eligibility determinations related to qualified health plans, with no mention of qualified dental plans. We presume this is an oversight rather than intentional omission, given that Section 2(9) defines "enrollee" to include individuals "enrolled in a health and/or dental plan through Washington Healthplanfinder."

Recommendation: WAHBE should clarify that individuals may appeal eligibility determinations related to qualified dental plans. There are at least two drafting options to achieve this goal – WAHBE could define "qualified health plan" to include qualified dental plans, or WAHBE could instead modify Sections 2(8) and Section 3 to clarify that eligibility determinations related to qualified dental plans are appealable.

Response: The Exchange has updated language in Section 2(8) and Section 3(a)(1) to clarify that eligibility for dental plans is appealable.

Comment: Correct internal reference discussing the content of the notice of hearing in Sec. 9.
Section 9(1) of the draft Appeals Rules requires that the notice of hearing must state that if the appellant fails to attend or participate in a pre-hearing/hearing, the appeal will be dismissed as set out in Procedural Rule 16. This reference to Procedural Rule 16 is confusing, as Procedural Rule 16 relates to Accessibility Assistance/Interpreters. In a previous version of the rule, the same section referenced Procedural Rule 5 instead of 16. This prior reference appears to be more consistent with the goal of the sentence, since Procedural Rule 5 governs the circumstances in which the Exchange may dismiss appeals. It is possible the WAHBE intended to modify this section to clarify that the notice of hearing should comply with the accessibility standards set forth in Section 16. If this is the intent of the sentence, we recommend clarifying the sentence structure.
Recommendation: Revise Section 9(1) to clarify whether the sentence is intended to refer to dismissals, language/interpretation assistance, or both.

Response: Procedural rule 5 should have been cited in this instance. The Exchange has updated the reference to reflect this oversight.