Carrier Enrollment and Payment Process Guide

Individual Market

Plan Year 2025

Version 2.2
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1. INTRODUCTION

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

2. AFFORDABLE CARE ACT

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

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

1.2 WASHINGTON HEALTH BENEFIT EXCHANGE

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

1.3 DOCUMENT PURPOSE

The Exchange has authority to establish operational requirements and guidelines for carrier partners operating on the Exchange.[1] The Exchange's operational requirements are communicated to carriers through this Enrollment and Payment Process Guide, as well as the 834 Companion Guide, QHP and/or QDP Guidance for Participation, and the EDI Trading Partner Agreement. Meeting these operational requirements is a condition of participation in the Exchange, which carriers agree to when they sign the QHP and/or QDP Guidance for Participation and EDI Trading Partner Agreement. The requirements contained in this guide apply to the following organizations and entities:

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

At a high level, these operational requirements include but are not limited to:

- Complying with WAHBE policies, standards, and processes established for the individual market for transfer of EDI transactions, enrollment, reconciliation, and reporting. This includes participating in carrier testing and process improvement initiatives with WAHBE (e.g., the FitGap process and enhancements to the monthly reconciliation process).

[1] See 45 CFR 156.200(d), stating that a QHP issuer certified by an Exchange must adhere to the certification standards AND any provisions imposed by the Exchange, or a State in connection with its Exchange, that are conditions of participation or certification with respect to each of its QHPs; see also 45 CFR 156.200(h), stating that as a condition of certification of a QHP, an issuer must attest that it will comply with all QHP operational requirements.

- Ensuring carrier vendors conform to the same policies, standards and processes.
- Curing errors or deficiencies in EDI transactions or related processes identified by the Exchange.

1.4 VERSION HISTORY

DATE	VERSION NUMBER	REVISION DESCRIPTION
7/22/2022 (draft) 8/16/2022 (final)	1.0	- To support Cascade Care Savings, updates to 3.1, 4, 5.3, 6.0, 6.4, 8.2 - Update to 5.6 to support NBPP guidance changes regarding repayment of past due premiums - Update to 5.11 to align with WAHBE Sponsorship Policy - Clarifying guidance added to 7.1.1 - Addition of 10.2 to support renewal processing - Expansion of 11.2 to aggregate and clarify guidance on transaction processing and correction
11/18/2022 (draft) 12/29/2022 (final)	1.1	- Addition of 4.4.3 - Update to 11.3 and Full Carrier Audit Guide - Updated Reinstatements graphic in 13.1
4/14/2023 (draft) 5/25/2023 (final)	1.4	- Minor modifications to support clarifying language to 4.3, 8.1.2, 9.1, 11.1, 11.2.3, 11.3.4 - Additional language added to clarify guidance to 4.3, 8.1.2, 9.1, 11.1, 11.2.3, 11.3.4
8/1/2023	1.0	- Addition of ACP, IHC - Updates o 26-year-old age out - 155.505 Regulation reference added - Clarification added under 5.6, 11.0 - Updated language throughout/updated screenshots - Combined FCA into EPPG
10/2/2024	2.0	- Restarting version numbering to clean up the previous confusion. - Updated Document Purpose - Policy language updates made to 4.3.9, 4.3.12 - Updated 4.3.12 to be consistent with 4.3.9 - Clarified language 8.0 - Updates to 8.1.1 - Updated scenario examples in 8.1.5 - Added clarifying language to 10.1.3 - Added clarifying language to 11.3.1 - Revised requirements in 11.3.2 - Expanded 11.3.5 - Updated graphics in 13.0
10/10/2024	2.1	Section 13.4 • Updated Contacts
12/10/2024	2.2	Updated language related to 15th Rule change 4.3.10 Coverage Start Date 4.3.13 Third-Party Sponsor

1.5 AMENDMENTS TO DOCUMENT

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

Once the final version of the guide is published, clarifications or updates to the guide are issued via major or minor versions of the guide and may be accompanied by a supplemental bulletin. HBE formally publishes updated versions of the guide on the HBE corporate website at least 30 days prior to the change effective date.

1.6 RELATIONSHIP TO 834 AND 820 COMPANION GUIDES

For rules related to format and content of Electronic Data Interchange (EDI) transactions and managing the exchange of EDI transactions between HBE and QHP/QDP carriers, please refer to the 834 Companion Guide and 820 Companion Guide. These guides address the 834 and 820 EDI requirements for the Individual Market.

1.7 COMPLIANCE WITH STATE AND FEDERAL LAWS

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

1.8 HBE CONTACT INFORMATION

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

2.0 ACRONYMS AND DESCRIPTIONS

ACRONYM/TERM	DESCRIPTION
ACA	Collective reference for the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010
ACP	Address Confidentiality Program
AI/AN	American Indian or Alaska Native
APTC	Advanced Premium Tax Credit
BAR	Batch Annual Renewal
CCS	Cascade Care Savings
CCIIO	Center for Consumer Information and Insurance Oversight
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
CSR	Cost-Sharing Reduction
DEP	Dependent-only coverage
ECDM	CMS Enterprise Canonical Data Model
EDI	Electronic Data Interchange
Edifecs	Validation engine for incoming and outgoing EDI transactions
EDS	Enrollment Data Store
EID	Enrollment Identifier
EFT	Enterprise File Transfer
EHB	Essential Health Benefits
EITA	Exchange Information Technology Architecture
Exchange	Washington Health Benefit Exchange
FAM	Family coverage
FCA	Full Carrier Audit
FFM	Federally Facilitated Marketplace
FMP	Full Monthly Premium
FPL	Federal Poverty Level
HBE	Washington Health Benefit Exchange
IHC	Immigrant Health Care

Washington Healthplanfinder	Washington Health Benefit Exchange’s consumer facing online marketplace
HHS	U.S. Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act of 1996
Hub	Federal Data Services Hub
HIPTC	Health Insurance Premium Tax Credit
MEC	Minimum Essential Coverage
OEP	Open Enrollment Period
PA	Primary Applicant
QDP	Qualified Dental Plan
QHP	Qualified Health Plan
QLE	Qualifying Life Event
SBE	State Based Exchange
SBMI	State Based Market Interchange
SEP	Special Enrollment Period
SFTP	Secure File Transfer Protocol
WAH	Washington Apple Health
WAHBE	Washington Health Benefit Exchange

3.0 WASHINGTON HEALTHPLANFINDER INDIVIDUAL MARKET

3.1 ELIGIBILITY

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

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

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

The 2021 Washington State Legislature enacted Engrossed Second Substitute Senate Bill 5377 which, among other provisions, directed the Exchange to establish a state premium assistance program for Washington residents. This program is branded and known to consumers as Cascade Care Savings. These individuals must meet program criteria, including having income up to 250% of the FPL[3] and must enroll in a Cascade Care Silver or Gold plan.[4]

- *Multiple-Enrollment Eligibility.* For households with individuals enrolled in multiple enrollment groups, only those eligible individuals within the household enrolled in a premium assistance eligible plan will be able to have state premium assistance applied to their health plan premium.
- *Insurance Affordability Programs.* To be eligible for state premium assistance, individuals must receive an eligibility determination for insurance affordability programs, including Washington Apple Health, Advanced Premium Tax Credits, and Cost Sharing Reduction Subsidies.

Washington Healthplanfinder does not permit applicants to apply APTC or CCS to QDPs. Cost sharing reductions are not applicable to QDPs under federal law.

Enrollment transactions sent to carriers include conditionally eligible customers, though HBE does not report

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

[3] Exchange State Premium Assistance Policy Section 4

[4] AI/AN individuals are not required to select a gold or silver Cascade Care plan in order to be eligible for state premium assistance

The CMS Administrator has the ability to review Exchange eligibility appeals decisions prior to judicial review in accordance with (§ 155.505) conditional eligibility status. Enrollment changes or terminations at the end of the 95-day conditional eligibility period are reported to carriers. Coverage is not retroactively terminated for customers determined ineligible at the end of the 95-day period. Rather, enrollment changes or termination dates follow standard monthly enrollment deadlines.

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

3.2 MEDICARE

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

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

New QHP Enrollments

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

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

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

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

Existing QHP Enrollees Transitioning to Medicare Coverage

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

CMS guidance prohibits carriers from terminating enrollees whom they subsequently find to be eligible for or enrolled in Medicare, unless the enrollee requests the termination or another legal basis for carrier termination applies.[5] If a customer contacts a carrier wishing to terminate their coverage due to gaining Medicare, they should be directed to report changes in their *Washington Healthplanfinder* account or contact the Customer Support Center.

Carriers must communicate to HBE via the reconciliation process instances when dual Medicare and QHP enrollment is known. HBE conducts outreach to the customer to provide the option to: 1) remain enrolled in QHP without APTC/CSR; or 2) disenroll from the QHP.

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

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

Consistent with guaranteed renewability provisions, Medicare eligibility or enrollment is not a basis to not renew an individual's health insurance coverage in the individual market.[6] The 2018 Notice of Benefit and Payment finalized an interpretation of the anti-duplication provision that prohibits carriers with knowledge that an enrollee in individual market coverage is entitled to Medicare Part A or enrolled in Medicare Part B from renewing the individual market coverage if it duplicates benefits to which the enrollee is entitled, unless the renewal is effectuated under the same policy or contract of insurance. HBE renewal processes for enrollees have not changed. Throughout the coverage year and during renewals, HBE and carriers coordinate to identify dual enrolled populations that may not be eligible for renewal consistent with the 2018 notice. HBE conducts outreach to each enrollee known to be dually enrolled to provide the applicable 95-day verification period to determine Medicare status.

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

[5] 45 CFR § 147.106
[6] 45 CFR § 147.106

3.3 FORM 1095-A HEALTH INSURANCE MARKETPLACE STATEMENT

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

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

Corrections: When a customer believes their 1095-A document is incorrect, they can request a correction review via HBE's 1095-A webpage: https://www.wahbexchange.org/resources/tax-resources/

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

3.4 EXEMPTIONS TO THE SHARED RESPONSIBILITY PAYMENT

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

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

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

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

3.5 APPEALS

Customers who apply through *Washington Healthplanfinder* may appeal the eligibility determination they receive. The CMS Administrator can review Exchange eligibility appeals decisions prior to judicial review in accordance with (§ 155.505). All appeals must be filed within 90-days of the date on the customer's eligibility notification:

- Online: www.wahbexchange.org/appeals
- Email: Appeals@wahbexchange.org
- Fax: 360-841-7653
- Phone: 1-855-859-2512 (360-688-7814)

- Mail: PO Box 1757, Olympia, WA 98507-1757

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

- Eligibility for a health insurance plan through *Washington Healthplanfinder*
- Eligibility to enroll in a *Washington Healthplanfinder* plan outside the regular open enrollment period
- Eligibility for lower monthly premiums based on their income
- The amount of savings the customer is eligible for when they use services through a QHP
- Eligibility for benefits as an American Indian or Alaska Native (AI/AN)

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

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

4.0 WASHINGTON HEALTHPLANFINDER SYSTEM OF RECORD

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

4.1 APPLICATION DATA

Application data is created at initial intake. Updates are made by the customer reporting changes in their *Washington Healthplanfinder* account. HBE does not accept change of application data from carriers. An update to application data requires a new eligibility determination[7] which may impact eligibility or enrollment and can only be accepted by updating the *Washington Healthplanfinder* application.

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

4.1.1 American Indian/Alaska Native Designation

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

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

- AI/AN new and current enrollees are eligible for a SEP once per month to change QHP/QDP plans in accordance with 45 CFR 155.420 (d)
- Ability to receive tribal premium sponsorship payments in accordance with 45 CFR 155.240 (b)
- $0 cost sharing for AI/AN customers with incomes under 300% of the FPL, so long as the AI/AN customer is APTC eligible
- $0 cost sharing for item or service furnished through Indian Health Care Providers (regardless of income or receipt of APTC).
  NOTE: Health programs operated by Indian Health Care Providers are the payer of last resort for services provided by such programs, notwithstanding any federal, state, or local law to the contrary
- Compliance with Indian Health Care Improvement Act, Sections 206 and 408
- All other applicable state and federal laws

4.2 CHANGE REPORTING

All customers are required to report changes within 30 days that may impact their eligibility for QHP enrollment. Customers who have requested to be considered for subsidized coverage are required to report changes that may impact program eligibility.[8] Change reporting may result in potential churn between Medicaid eligibility and subsidized or non-subsidized QHP coverage. HBE supports reenrollment of QHP/QDP coverage during the annual

[7] 45 CFR § 156.335
[8] 45 CFR § 155.330 (b)

open enrollment period or upon eligibility for a special enrollment period (SEP).[9]

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

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

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

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

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

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

4.3 Enrollment data

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

Carriers accept initial and ongoing payments. HBE accepts carrier updates to enrollment data for effectuation status and coverage end dates via nonpayment termination or reinstatement 834 transactions.

[9] 45 CFR § 155.420 (d)

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

4.3.1 Multiple Enrollments

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

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

4.3.2 Location and Plan Options

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

- If the primary applicant is seeking coverage, the winning address is the primary applicant’s home address.
- If the primary applicant is not seeking coverage and all dependent members seeking coverage live in the same county, the winning address is the dependents’ physical address.
- If the dependent members seeking coverage live in different counties, the winning address will default back to the primary applicant’s physical address.
- Customers listed as “homeless” in the Washington Healthplanfinder application must enter in the city and zip code for the city they are located in to gain access to their plan options.

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

If a dependent child under age 26 is living in a different state from the primary applicant (parent), the dependent may be enrolled on their parent’s plan.

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

4.3.3 Address Confidentiality Program (ACP)

The Address Confidentiality Program (ACP) is a records protection and mail forwarding service used as part of an overall safety plan to prevent perpetrators from locating participants through public records. Passed into Legislation in 1991 ACP, Washington’s program was the first of its kind in the nation.

To comply with Washington law, Washington Healthplanfinder has the functionality to recognize when **P.O. Box**

257 in Olympia for address confidentiality is entered into the mailing address field. Once entered, the system will generate a modal asking for the PMB or Post Mail Box to be entered.

Our system must have the customers physical zip code to provide plans during the shopping experience. The customer is asked to enter in their zip code for the county they physically reside in upon eSigning the application. This guarantees that we are not only providing the customer with the correct plans, but the correct rates as well.

4.3.4 Enrollment Status

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

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

4.3.5 Premium Rating Factors

HBE applies the application data for age, location, and tobacco factor (if applicable) to plan selection in order to create the premium enrollment data. Premiums are rated individually, but for family members enrolled in the same policy under the age of 21, the premiums for the three oldest covered children are taken into account in determining the total family premium.[10]

Enrollees maintain the same rate during the coverage year when:

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

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

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

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

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

[10] 45 CFR § 147.102

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

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

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

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

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

4.3.6 APTC Amount

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

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

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

4.3.7 Cost-Sharing Reduction (CSR) Tier and Amounts

Cost-sharing reduction (CSR) is a discount that lowers the amount a customer pays for deductibles, co-insurance, co-payments, and other out-of-pocket expenses (like lab tests and prescriptions). APTC eligibility is a requirement for CSR, except for American Indian/Alaska Natives.[11] A customer who is eligible for APTC can select a monthly applied APTC of $0 and remain eligible for CSRs.

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

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

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

There is a special rule for family policies.[12] When there is an enrollment in a QHP under a single policy that covers two or more individuals who could be eligible for different cost sharing if enrolled in separate, individual policies, HBE determines the individuals under such policy to be collectively eligible for the category of eligibility last listed in which all the individuals covered would be eligible. The order of CSR tier under this scenario is as follows: Tier 1, then Tier 3, then Tier 4, then Tier 5, then Tier 6, then Tier 2.

4.3.7 Cascade Care Savings

Customers determined eligible for CCS will only have it applied to their enrollment if they:

1. Apply for and accept all APTC; AND
2. Enroll in a state premium assistance eligible plan.

CCS only begins on the first of the month and is paid at the subscriber level for an enrollment group. HBE notifies customers of the maximum CCS amount for which they are eligible during the shopping experience prior to selecting a health insurance plan. HBE reports the CCS amount to the carrier to facilitate the payment from HBE directly to the carrier.

Fixed-dollar maximum Cascade Care Savings amounts are calculated annually, and the maximum Cascade Care Savings available will not exceed the lesser of either the household’s net premiums after applying all eligible tax credits or, the net premium of all eligible enrollees that they would pay if each were enrolled in the lowest cost Cascade Care Silver plan available in their county. All tax credits the individual is eligible for must be applied to the household’s premiums before any state premium assistance amount is applied. The household premium assistance amount can be applied to the entire net premium including portions not attributed to essential health benefits.

Opt-out. Eligible enrollees who are awarded state premium assistance may contact *Washington Healthplanfinder* Customer Support Center to disenroll from the state premium assistance program.

[11] 45 CFR § 156.315 (e)
[12] 45 CFR § 155.305 (g) (3)

4.3.8 IHC (Immigrant Health Care)

Pursuant to Section 1332 of the Patient Protection and Affordable Care Act (ACA), Washington submitted and received a waiver of ACA Section 1312(f)(3), which bars persons considered “not lawfully present” from purchasing QHP coverage, including QDP coverage, through Washington Healthplanfinder, beginning in 2024. This waiver allows applicants newly eligible to purchase coverage on the Exchange to have the same plan shopping and enrollment experience as those currently eligible. This includes accessing the online application, utilizing decision support tools that help customers compare and select plans, viewing and enrolling in available QHP plan options, and applying available Cascade Care Savings. This policy, governing the administration of the Immigrant Health Coverage Program (IHC), is effective beginning for coverage effective in plan year 2024. The Exchange may update this policy annually or more frequently as needed.

In guidance the Exchange issues in writing and verbally to carriers, the following HBE and OIC requirements should be reinforced:

- Issuers offering plans on the Exchange must comply with the Exchange’s QHP and QDP Guidance’s for Participation and Cascade Care Savings Policy. This includes additional reporting and rate filing expectations as required by CMS for the continued implementation of the Section 1332 waiver.
- This means these newly eligible customers will have the same plan shopping and enrollment experience as those who are currently eligible. This includes accessing the online application, utilizing decision support tools that help customers compare and select plans, viewing and enrolling in available QHP and QDP options, and applying available Cascade Care Savings.

4.3.9 Monthly Premiums and Proration

The Exchange will prorate member premiums in the case of mid-month terminations due to death. HBE will prorate the enrollment premium, APTC, CSR, and cap CCS, or customer responsible amount in enrollment transactions and reporting. In the event of mid-month termination at a policy or member level, Carriers should not prorate APTC, CSR, or CCS.

The Exchange does not currently prorate for life events that result in a mid-month member add.

Certain SEP-initial enrollments and SEP member-level additions have a start date other than the first day of the month. Retroactive start date qualifying life events begin on the date of the event.[13] Terminations for a deceased enrollee are effective the date of death.[14]

4.3.10 Coverage Start Date

Coverage start date is the 1st of the following month after plan selection. . Certain SEP events (e.g. birth, adoption, placement for adoption, placement in foster care, or child support or other court order) allow or require an earlier or later start date based on the date of event rather than the plan selected date.

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

[13] 45 CFR § 155.420 (c)
[14] 45 CFR § 155.430 (d) (7)

4.3.11 Coverage End Date

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

If a carrier receives a termination request or cancellation request from a customer, the customer should be referred to *Washington Healthplanfinder* Customer Support Center.

4.3.12 Broker Partnership

HBE communicates enrollments with partnered brokers via 834 transactions. If a broker partners with a customer when the initial enrollment is confirmed, HBE sends the broker information in the 834 Add transaction. If a broker is removed, HBE sends an 834 Change transaction. The effective date for the partnership is based on the timestamp in the transaction. In some cases, a broker partnership ends at the same time as a termination (see the 834 Companion Guide for transaction details). Reconciliation of broker issues is addressed via an HBE Enrollment Analyst.

If a carrier is made aware of changes that a broker needs to make to their broker record, they should direct the broker to the WAHBE Producer Support team to facilitate the change.

4.3.13 Third-Party Sponsor

Carriers offering individual market QHPs and QDPs must accept premium and cost-sharing payments on behalf of plan enrollees from third-party sponsors.[15] Sponsors through HBE may include:

(a) Ryan White HIV/AIDS Program under Title XXVI of the Public Health Service Act;
(b) Indian tribes, tribal organizations, or urban American Indian organizations; and
(c) State and Federal Government programs

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

If the sponsorship link is present at the time of plan selection, the initial enrollment 834 Add transaction generates with the sponsor entity as payer. The effective date of the sponsor is the start of coverage. If the link is created after enrollment initiation, the updated information is sent in an 834 Change transaction, and the effective date of the sponsor is based on the timestamp in the transaction. Coverage start date is the first of the following month following plan selection.

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

[15] 45 CFR § 156.1250

4.3.14 Data Fix Indicator

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

4.4 Enrollment Transactions

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 includes provisions for administrative simplification through the implementation of standardized Electronic Data Interchange (EDI) transactions between authorized covered entities, also referred to as "trading partners". These EDI standards are extended to the exchange of enrollment data between HBE and carriers offering products through the HBE. The 834 and 820 Companion Guides address the 834 and 820 EDI requirements for the individual market.

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

4.4.1 Enrollment Transactions for a Plan Year

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

4.4.2 Updates after March 31

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

4.4.3 Daily 834 Transaction Quality

Quality in 834 daily transactions is essential to ensure alignment in carrier and HBE systems, reducing manual work and improving the customer enrollment experience. While some number of timing issues are expected, in general carrier inbound transactions in a given month should be accepted and processed at a rate of 98% or higher. Daily file health that is of concerning quality and below will be tracked as an active Fitgap item.

Legend			
Healthy	97%	-	100%
Concerning	93%	-	96%
Severely Concerning	88%	-	92%
Critical	0%	-	87%

- Daily file quality of 97% or higher indicates healthy EDI processes.
- Daily file quality between 93%-96% is cause for concern, as it results in significant manual work and review for both HBE and carrier teams. At this threshold, it can also have significant impact on

customers because of misaligned enrollment data.

- Daily file quality between 88%-92% is severely concerning.
- Daily file quality below 87% is critical. Carriers should endeavor to correct any underlying system or process issues within 30 days.

5.0 PAYMENTS AND GRACE PERIODS

At a minimum, carriers must accept paper checks, cashier's checks, money orders, Electronic Fund Transfer (EFT), and all general-purpose prepaid debit cards (including state agency issued debit cards) for the purpose of payment for benefits.[16] For the binder payment, carriers may accept a method that is exclusive to the initial premium. For example, the "Pay Now" function on *Washington Healthplanfinder* that redirects to a carrier site, may accept binder payment by credit card, even though the carrier does not accept credit cards as a method of payment for regular monthly premiums.

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

5.1 Binder Payments

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

For retroactive coverage effective dates, the carrier must bill the customer for all premiums, including premiums for both retroactive and prospective coverage, in accordance with the effectuation rules.[17] When the enrollee makes a payment to satisfy at least a single month's premiums, but the payment is insufficient to pay the entire total monthly premium due, the carrier must still effectuate the coverage. The enrollee enters the applicable grace period and is required to pay all outstanding premiums due before the expiration of the grace period to avoid termination for nonpayment according to applicable grace period requirements.

5.2 Pay Now

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

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

Payments made via "Pay Now" typically occur before *Washington Healthplanfinder* generates the 834-

[16] 45 CFR § 156.1240 (a)(2)
[17] 45 CFR § 155.400(e)(1)(iii)

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

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

5.3 Grace Periods

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

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

The length of grace period does not change during an active grace period. For example, customers receiving APTC who enter a grace period for failing to pay premiums and lose APTC or CCS eligibility during the grace period, are able to complete the remaining grace period as though the loss of eligibility for APTC or CCS did not occur.[18]

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

5.4 Delinquency Notice Requirements

Carriers must include information in delinquency notices that concisely explains the impact of nonpayment of premiums on access to coverage and health care services and encourages the customer to contact the carrier regarding coverage options that may be available. Carriers must also include information for subsidized customers on reporting changes of income or circumstances to *Washington Healthplanfinder* including the 30-day deadline[19], along with an explanation that it may result in a change in eligibility.[20]

5.5 Renewals

Renewal enrollments (active or passive) into the same product do not require a binder payment (see Section 10 for additional details). Carriers continue to bill the customer via their existing enrollment billing cycle. Nonpayment of the January premium by the due date triggers the applicable grace period.

If a policy was not included in passive renewals and the customer has not completed an active renewal by

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18 RCW 48.43.039 (3) and
19 45 CFR § 156.330
20 45 CFR § 156.430 and 45 CFR § 157.270

December 15, the carrier should discontinue January auto-draft payments. Carriers must promptly refund payments drawn by the carrier or mistakenly provided by the customer for January coverage when the customer has cancelled coverage prior to the effective date or has completed an active renewal into new coverage plan with a new carrier prior to the end of OEP.

5.6 Past Due Premiums

QHP carriers must accept individuals who apply for coverage without requiring them to pay past due premiums, even when the individual owes past-due premiums for coverage from the same carrier or another carrier in the same controlled group[21]. QHP carriers may not condition effectuation of new coverage (OEP or SEP) on payment of past due premiums owed by the customer.[22]

QHP carriers may not attribute payment intended for new coverage to a past due amount and thereby not allow an individual to enroll in new coverage. QHP carriers may not bill for the new coverage in such a way that it would require a greater amount due than the premium for the new coverage. QHP carriers are required to bill for the new coverage separately from past premiums due. Nothing in this section prevents a QHP carrier from pursuing past due premiums using other available mechanisms.

Dental carriers must accept individuals who apply for coverage even when the individual owes past-due premiums for coverage from the same carrier or another carrier in the same controlled group. Dental carriers may continue to attribute payments to past due amounts and may condition effectuation of new coverage (OE or SEP) on payment of past due premiums owed by the customer. In instances where the customer's grace period ends December 31, dental carriers may choose to effectuate or refuse to effectuate the new enrollment if they apply a consistent policy across all enrollments. If a dental carrier elects to refuse to effectuate the new enrollment, a nonpayment cancellation must be sent by the dental carrier for the new enrollment.

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

5.7 Nonpayment To Voluntary Update

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

5.8 Over Payments

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

[21] 45 CFR § 147.106(d)(4) For purposes of this section, the term-controlled group means a group of two or more persons that is treated as a single employer under sections 52(a), 52(b), 414(m), or 414(o) of the Internal Revenue Code of 1986, as amended, or a narrower group may be provided by applicable state law

[22] 45 CFR § 147.104

5.9 Under-Billed Premiums

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

5.10 HBE Retroactive Updates

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

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

5.11 Sponsor Invoicing and Payments

Carriers are required to clearly communicate full and/or partial premium assistance amounts to sponsored enrollees as part of the invoicing and payment process, so enrollees understand what net premium payment amount is owed by them to the carrier (if any).

Carriers should allow sufficient time for receipt of premium payment by a third-party Sponsor to prevent enrollment termination for nonpayment. Payments will be delivered no later than the 22nd of each month and carriers shall apply payments made by Sponsors to the sponsored enrollment only (see the WAHBE Sponsorship Policy for additional details).

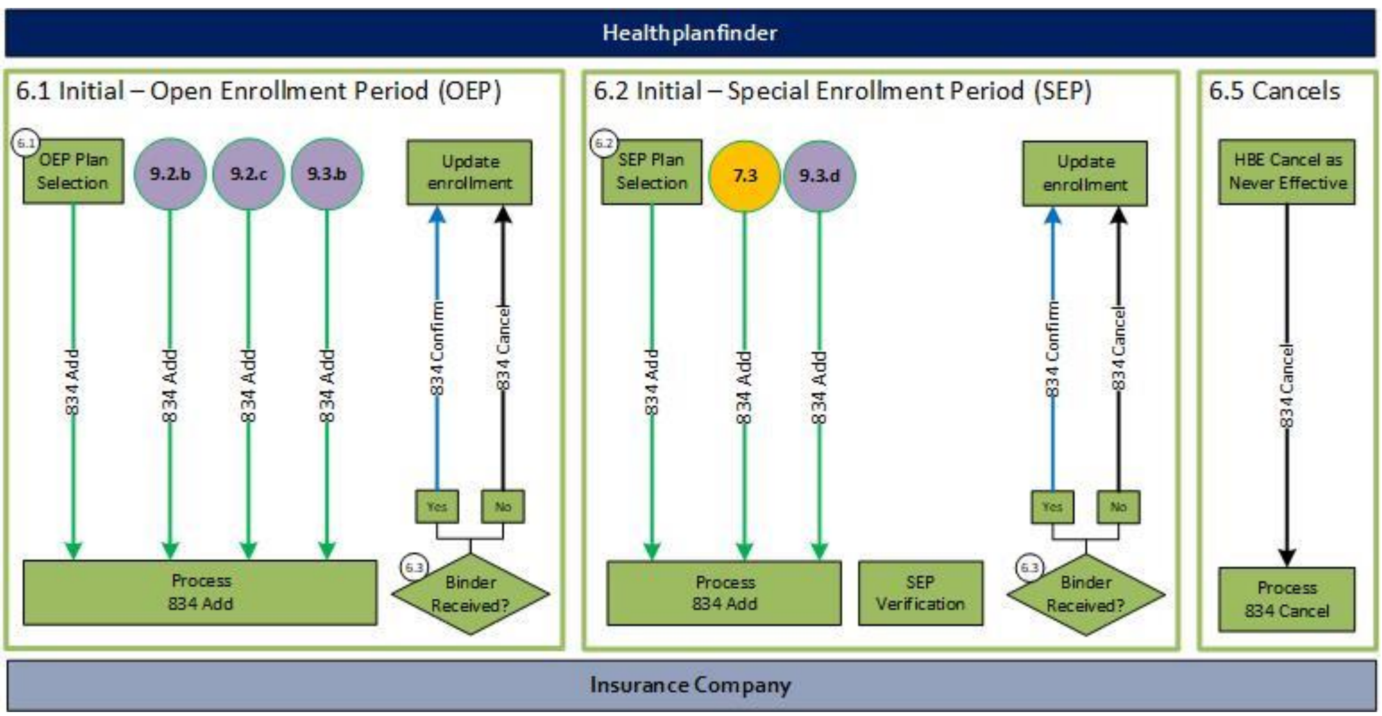
6.0 INITIAL ENROLLMENTS

Washington Healthplanfinder allows customers to create initial enrollments during the OEP or by SEP[23].

Business rules that apply to initial enrollments include:

- 834 Add transactions are sent to create an initial enrollment and during renewals. Subsequent updates to the enrollment are conveyed by 834 Change and Term transactions.
- Potential enrollees can create separate initial coverage for individual household members across the same or multiple carriers.
- Carrier response (effectuation or nonpayment cancellation) to HBE is expected within 10 business days of either receipt of binder payment or the binder payment due date has passed; whichever is sooner.
- In the circumstance of an eligible enrollee or household with a zero-dollar monthly remaining responsibility, an effectuation to HBE is expected within 10 business days of the date binder payment would have been due if the binder payment were greater than $0.

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



6.1 Initial– Open Enrollment Period (OEP)

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

The OEP for the 2023 coverage year is November 1 to January 15. Plans selected between November 1 and December 15 will have a January 1 start date. Plans selected between December 16 and January 15 will have a February 1 start date.

[23] 45 CFR § 156.260

6.2 Special Enrollment Period during OEP

Customers may become eligible for a SEP during the OEP and initiate both an OEP-initial and SEP-initial enrollment. Carriers must accept the OEP enrollment under guaranteed availability[24]. Carriers must promptly invoice the customer for the OEP enrollment and not wait for SEP verification on the December enrollment or condition effectuation on receiving the SEP-initial binder payment.

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

Scenario 1: Future OEP Enrollment with No Current Year SEP

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

Current Year SEP Disposition: N/A
Future Year OE Disposition: Normal Open Enrollment invoicing to receive customer's binder payment.

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

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

Current Year SEP Disposition: SEP approved and the customer was invoiced but did not make their binder payment. Carrier sends HBE an 834 Cancel file.
Future Year OE Disposition: Normal Open Enrollment invoicing to receive customer's binder payment. The coverage is not automatically cancelled.

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

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

Current Year SEP Disposition: SEP denied, and the applicant was not invoiced. Carrier informs HBE of the SEP denial via SEP denial process.
Future Year OE Disposition: Normal Open Enrollment invoicing to receive customer's binder payment. The coverage is not automatically cancelled.

6.3 Initial – Special Enrollment Periods (SEP)

SEPs constitute periods outside of the OEP when a customer can shop to create an initial QHP/QDP enrollment, or an active enrollee may elect to change a QHP/QDP selection[25]. Most qualifying life events are available in *Washington Healthplanfinder* and will automatically open a shopping window based on self-attestation. Other qualifying life events are only available by contacting the *Washington Healthplanfinder* Customer Support Center for escalation and HBE review.

HBE indicates the SEP reason on the 834 add transaction sent to the carrier. For HBE-confirmed SEPs, carriers shall accept the applicable SEP code provided in the 834 files as verification, and should not require

[24] 45 CFR § 147.104
[25] 45 CFR § 155.420

documentation to verify the SEP. For SEPs not confirmed by HBE, the decision to require customers provide proof of their qualifying life event and/or prior coverage is at the option of the carrier.

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

6.3.1 HBE-Confirmed SEPs

Exceptional Circumstance (EX): Exceptional Circumstance SEPs are not available in *Washington Healthplanfinder*. They are the result of an HBE review. The SEP reason code on the 834 transaction is “EX” and is an HBE confirmed SEP. Carriers should not request documentation to verify this qualifying life event.

WAH to QHP/APTC Program Change (PC): This qualifying life event occurs when Washington Apple Health (WAH) eligible customers report an application update and are determined newly eligible for QHP/APTC. The underlying qualifying life event is loss of Minimum Essential Coverage (MEC) and HBE-system automation-confirmed WAH to QHP/APTC program change. The SEP reason code on the 834 transaction is “PC” and is an HBE confirmed SEP. Carriers should not request documentation to verify this qualifying life event.

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

Error of the Exchange (ER): Error of the Exchange SEPs are not available in Washington Healthplanfinder and are reviewed individually by HBE. The SEP reason code on the 834 transaction is “ER” and is an HBE confirmed SEP. Carriers should not request documentation to verify this qualifying life event.

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

Member of a federally recognized tribe or a shareholder in an Alaska Native Corporation (NE): A customer or their dependent who is enrolling in the same coverage, who is an enrolled member of a federally recognized tribe, may enroll in a QHP or change from one QHP to another one time per month. The SEP reason code is “NE”, and race/ethnicity indicator for American Indian or Alaska Native (“I”) will be sent in the 834 transactions. Carriers should not request documentation to verify this qualifying life event.

Cascade Care Savings (PC): Pursuant to the Exchange’s Exceptional Circumstances Special Enrollment Period (SEP) Policy and authority granted to the Exchange[26], individuals up to 250% FPL that are not enrolled in a Silver or Gold Cascade Care plan will be eligible for a monthly SEP to enroll in a Silver or Gold Cascade Care Plan. HBE verifies eligibility for this SEP. The SEP reason code on the 834 transaction is “PC” and is an HBE

[26] 45 CFR § 155.420(d)(9) and (16)

confirmed SEP. Carriers should not request documentation to verify this qualifying life event.

See full table of SEPs with descriptions, applicable regulations, effective coverage dates, and SEP reason codes in **Appendix A**.

6.3.2 SEP Denial Process

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

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

If a carrier elects to overturn a SEP denial, they should reach out to their designated HBE Enrollment Analyst to reinstate the enrollment or household member. They may utilize existing communication channels or send a weekly report.

6.4 Carrier Effectuation Process

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

If carrier does not receive the binder payment, an 834 Cancel transaction response is due to HBE within 10 business days after the binder payment due date. In the instance that the carrier grants reinstatement following a binder nonpayment cancellation, the carrier should send an 834 Reinstatement transaction, followed by an 834 Confirm transaction.

For details regarding effectuation requirements for renewals, see Section 10.

6.5 HBE Initiated Cancellations

A cancellation is a specific type of termination action that ends a qualified individual's enrollment through HBE on the date such enrollment became effective, resulting in enrollment never having been effective.[27]

6.5.1 Voluntary Cancellations

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

6.6.1 10-Day Free Look

Under state insurance regulations, an applicant who purchases a health or dental plan has a contractual right to return the policy to the carrier for any reason within 10 calendar days of delivery of the policy (or contract) to the customer[28]. This 10-day period begins on the date the carrier provides the actual insurance policy to the customer, not on the date the customer selects a plan in *Washington Healthplanfinder*. Therefore, this date

[27] 45 CFR § 156.430 (e)(2)
[28] RCW 48.44.230

may differ from the coverage effective date. If the customer returns the policy within 10 calendar days of the delivery date, it is void from the effective date and any payment must be refunded to the customer. If this situation occurs, the following business rules apply:

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

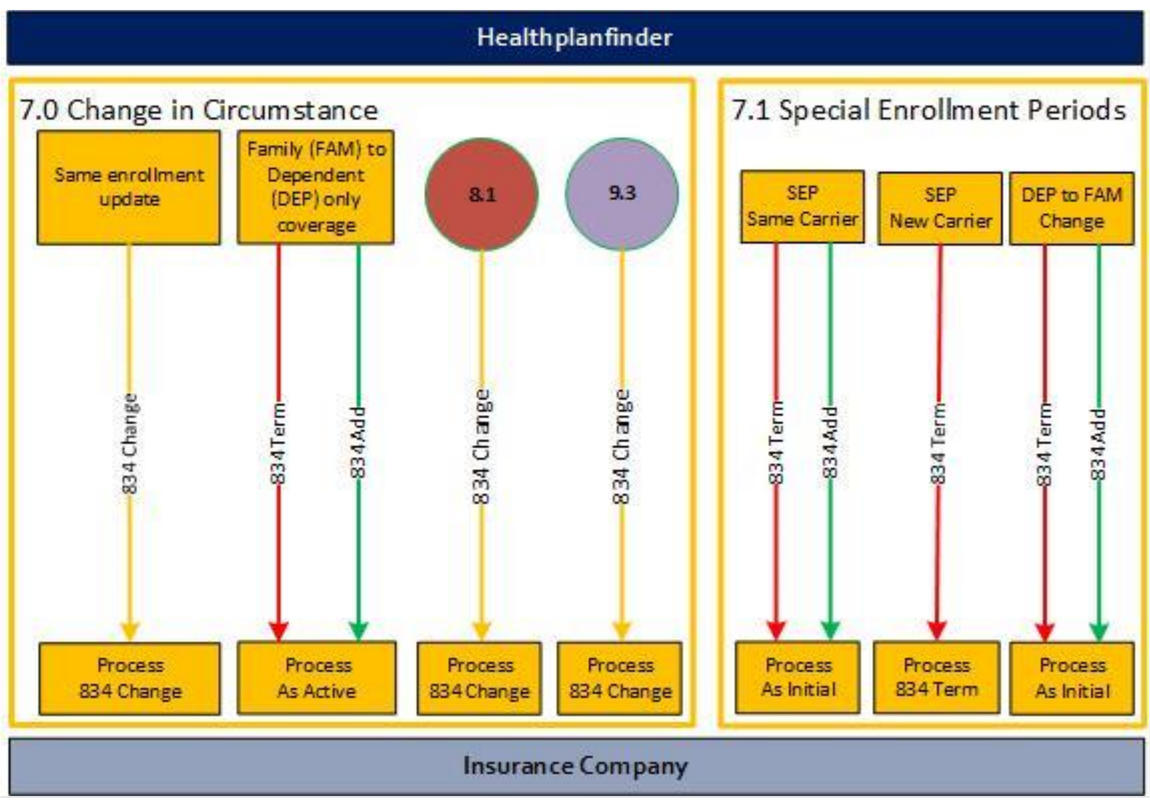
7.0 APPLICATION UPDATES DURING THE BENEFIT YEAR

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

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

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

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



7.1 Existing enrollee SEP

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

- QHP enrolled customers with a qualifying life event that involves adding a dependent (marriage, birth, adoption, placement for adoption, placement in foster care, or court order) must either add the dependent to the existing enrollment or enroll the dependent separately in a different QHP. If the new dependent cannot be added to the customer's existing plan, another plan at the same metal level can be added to the existing plan. If there are no other available plans at the same metal level for which all enrollees are eligible, the customer can choose a plan one metal level higher or lower.

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

7.1.1 Accumulator Carryover

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

- In the event that disenrollment of the primary subscriber, for any reason, and remaining enrollees' continuing enrollment results in the issuance of a new policy (FAM to DEP), the carrier is expected to apply any amounts previously paid toward the individual enrollee's deductible and out-of-pocket maximum in the first policy toward the individual enrollee's deductible and out-of-pocket maximum in the second policy.
    - This includes if the primary subscriber dies, and remaining enrollees' continuing enrollment results in a new policy under a new subscriber.
- If enrollment of the primary subscriber through a confirmed SEP, and remaining enrollees' continuing enrollment results in the issuance of a new policy (DEP to FAM), the carrier is expected to apply any amounts previously paid toward the individual enrollee's deductible and out-of-pocket maximum toward the individual enrollee's deductible and out-of-pocket maximum in the second policy.
- If enrollment of a dependent through a confirmed SEP after a gap in coverage results in the issuance of a new policy (FAM to FAM), the carrier is expected to apply any amounts previously paid toward the individual enrollee's deductible and out-of-pocket maximum toward the individual enrollee's deductible and out-of-pocket maximum in the second policy.
- Payments made on behalf of an individual enrollee by a sponsor must accumulate toward the individual enrollee deductible if they would have accumulated toward the deductible had an individual enrollee made the payment directly.
- A person who has granted a Cascade Care Savings SEP that changes plans and remains registered with the same carrier will not lose any accumulators accrued while in the previous year.
- Accumulator carryover should be performed in an automated fashion, without the need for a customer or HBE to initiate the carryover request.

8.0 TERMINATIONS

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

Business rules for terminations include:

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

8.1 HBE Initiated Terminations

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

8.1.1 Requests for Earlier End Date

After a customer voluntarily terminates coverage, they may contact the *Washington Healthplanfinder* Customer Support Center to request an earlier end date within a grace period. Upon HBE review, the following scenarios result in a second 834 Term transaction with an earlier end date:

- If a customer gains MEC (other than Medicare) and reports this within 10 business days of coverage beginning, they may be termed back to last day of month before new coverage begins.
- If a customer reports Medicare or Medicare Advantage up to 6 months after gaining Medicare eligibility, termination is approved back to their Medicare start date, rRegardless of payment status.
- If a customer reports Medicare more than 6 months after gaining Medicare eligibility, they may be terminated up to 3 months back from their pay-through date.
- If a customer experienced an Error of the Exchange that was out of their control which is clearly documented.
- Based on review, HBE may approve the later of the paid through date (confirmed with carrier) and the applicant requested date (as voluntary termination) if requested during the grace period. HBE will not override nonpayment termination dispositions once a grace period has lapsed.

8.1.2 26-Year-Old QHP and QDP Age Out

Dependents are eligible to continue enrollment on their parents or legal guardian(s) QHP and/or QDP plan through the calendar year in which they turn 26 years old[29]. HBE will not auto-renew the 26-year-old into the parent's or legal guardian(s) QHP or QDP for the plan year following the year they turn 26.

8.1.3 19-Year-Old Pediatric Dental Age Out

Dependents are eligible to continue enrollment in a pediatric-only dental coverage plan through the calendar year during which they turn 19 years old[30]. HBE will not auto-renew the 19-year-old into a pediatric QDP for the plan year following the year they turn 19.

[29] 45 CFR § 147.120
[30] 45 CFR § 156.115(a)(6)

8.1.4 Conditional Eligibility Determination

HBE terminates customers determined ineligible for QHP enrollment due to an eligibility review and who do not appeal that determination. HBE sends an 834 Term transaction with termination code “26.”

8.1.5 Member Death

When an enrolled household member passes away, the coverage end date is the date of death[31]. This often results in mid-month end dates. If the member death is the Primary Applicant on the application, manual processing, and outreach by HBE is required to assist surviving members of the household to:

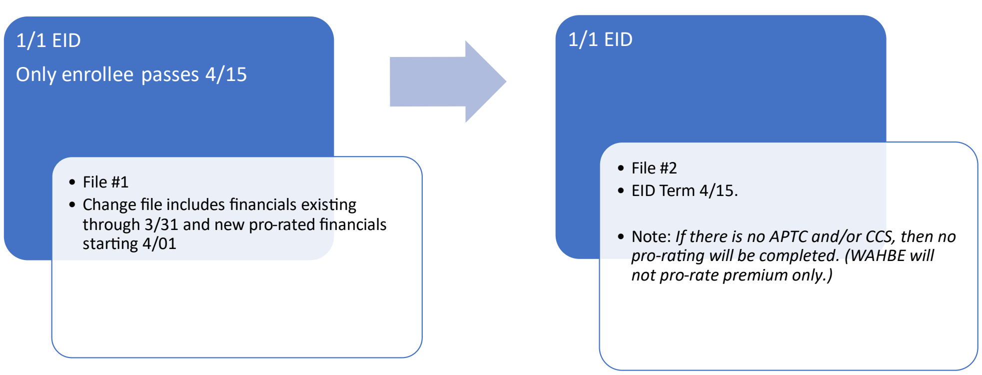
- Create an application with the new Primary Applicant
- Transition to covered status and complete updates to make the enrollment continuous across the prior and current application
- Review and ensure the monthly coverage in the new enrollment produces the enrollment transactions expected

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

Death of a household member must be reported within 60 days of the date of death for SEP eligibility and to allow new plan selection for surviving household members. If the customer chooses to change plans, plan selection must occur within 60 days of the qualifying life event. New coverage begins the first of the following month from when the change is reported.

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

Subscriber only or Single Dep enrolled: Enrollee passing 4/15



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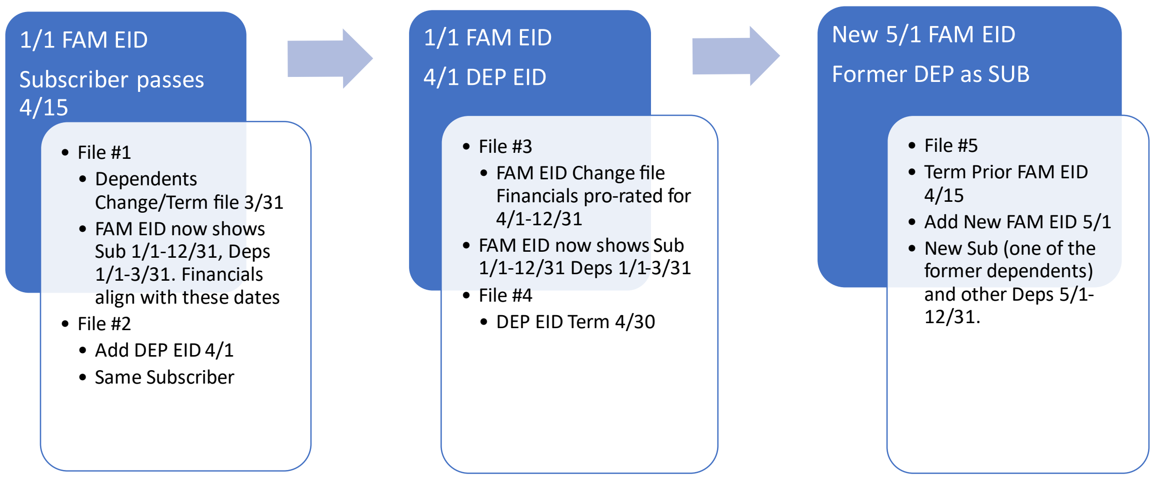
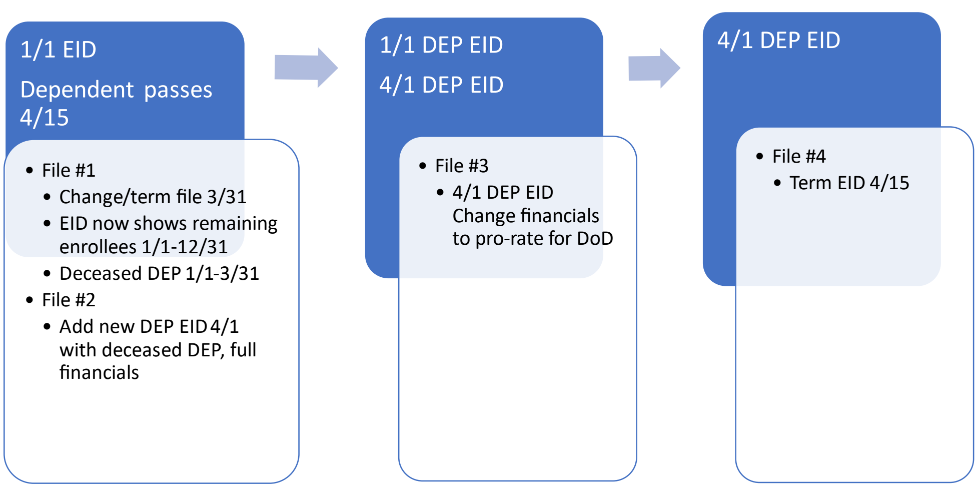
Subscriber and dependent(s) enrolled in FAM: Subscriber passing 4/15



Multiple dependents enrolled: DEP passing 4/15



8.2 Carrier initiated terminations

Carriers may terminate enrollments for nonpayment after the customer has exhausted their applicable grace period (1 month for non-subsidized and 3 months for subsidized). An 834 Termination transaction is due to the Exchange within 15 business days of expiration of the grace period.

If an enrollee receiving APTC and/or CCS exhausts the 3-month grace period, carriers terminate on the last day of the first month of the grace period[32]. The applicable coverage end dates are depicted in the charts below.

In instances where the carrier end date aligns with a customer's loss in APTC, the carrier should communicate this to the designated HBE Enrollment Analyst, who will update the enrollment to reflect a voluntary termination with a date that corresponds to the carrier end date, to ensure the customer is issued an accurate 1095-A tax form.

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

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

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

[32] 45 CFR § 156.270 (g)

9.0 REINSTATEMENTS

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

9.1 Carrier Initiated Reinstatements

Carriers may revoke a previously sent 834 Term transaction (for nonpayment) and restore the enrollment to active coverage. This occurs by sending HBE an 834 Reinstate transaction. An 834 Reinstate transaction is due to the Exchange within 10 business days of the reinstatement.

Business rules for carrier reinstatements are as follows:

- Enrollments may only be reinstated in the current plan year
    - Prior year reinstatements must be handled through prior year reconciliation processes
- Reinstatement action occurs at the household level only and should only be used when the reinstate action is required for all members on an enrollment
    - If HBE has termed or cancelled coverage for one or more members, carriers should submit reinstatement requests to their designated Enrollment Analyst
- Reinstatement actions do not create a gap in coverage
- Reinstatements may not be used in lieu of effectuations
- Carrier reinstatements update enrollment end date to 12/31
- Nonpayment is the only termination type carriers can reinstate
- If an enrollment is cancelled due to no binding payment and is subsequently reinstated, the carrier must follow the 834 Reinstate transaction with an 834 Confirm transaction.
- We understand that each carrier may have certain operational processes in place for reinstatement if a customer is terminated for non-payment.
    - If the Carrier reinstatement process will impact the Full Carrier Audit comparison by showing an enrollment as active, an 834-reinstatement transaction is due to the Exchange within 10 business days of the reinstatement regardless of payment status. If payment is not remitted through the carrier reinstatement process, an updated 834 termination transaction is due to the Exchange within 15 business days of the payment due date.

If the Carrier reinstatement process does not impact the Full Carrier Audit comparison until the reinstatement is complete, an 834-reinstatement transaction is due to the Exchange within 10 business days of the completed reinstatement

If a carrier receives a reinstatement request from a customer after an HBE initiated termination or cancellation, the customer should be referred to the *Washington Healthplanfinder* Customer Support Center.

9.1.1 Reinstatement Limitations

The following limitations apply to carrier generated 834 Reinstatement transactions:

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

9.1.2 Reinstatement Scenarios

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

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

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

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

1. Carrier sends 834 Cancel transaction to HBE
2. Carrier determines that 834 Cancel transaction was sent to HBE in error
3. Carrier sends 834 Reinstatement transaction to HBE
4. Carrier sends 834 Confirm Transaction to HBE if no prior 834 Confirm was sent

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

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

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

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

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

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

9.2 HBE Initiated Reinstatements

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

10.0 RENEWALS

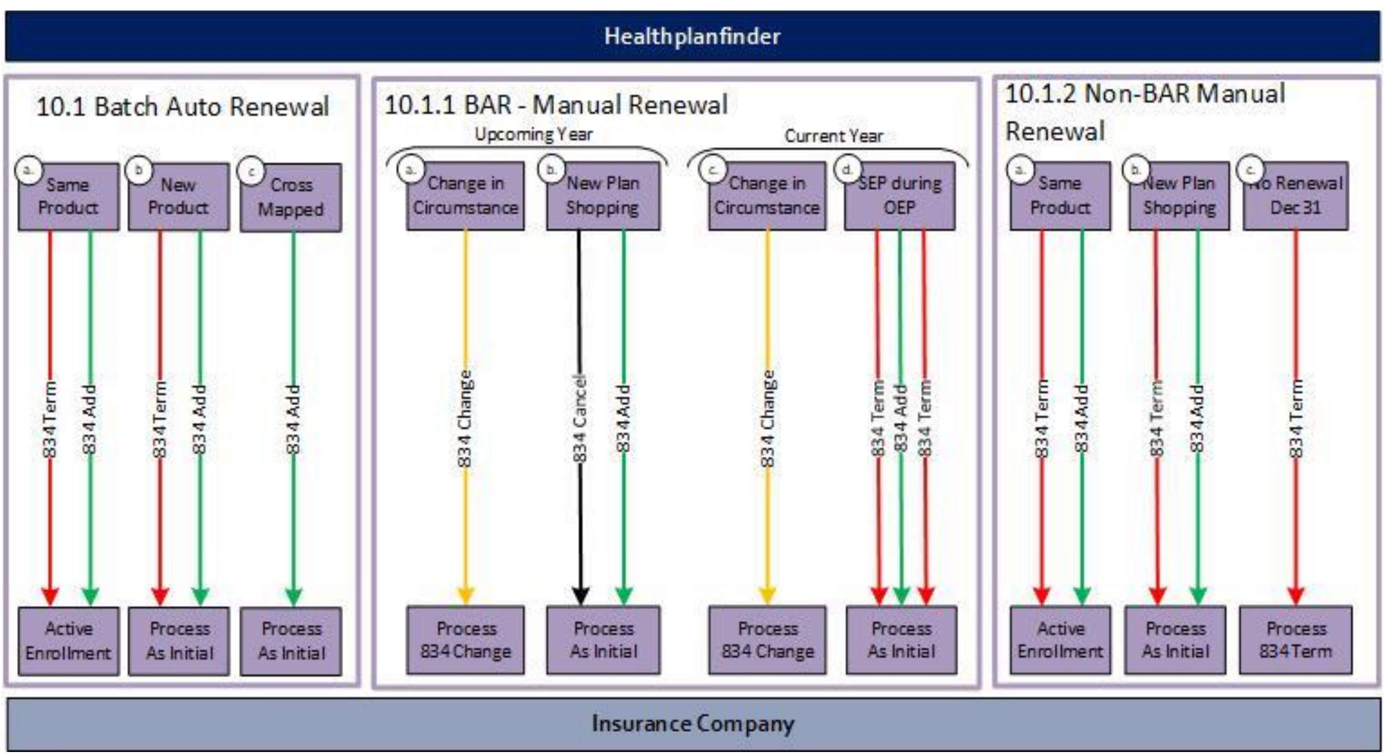
HBE coordinates with the federal hub to complete the annual passive (batch) renewal process in October. The effective date for renewals is January 1. During the passive renewal process, the most recent application data is used to:

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

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

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

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



10.1 Renewal Information for Carriers

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

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

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

10.1.1 Active Renewals Included in BAR Report

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

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

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

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

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

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

(SEP-Initial), an 834 Term (SEP end of year), an 834 Cancel (end BAR enrollment), and an 834 Add (OEP re-shop).

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

10.1.2 Active Renewals Not Included in BAR Report

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

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

10.1.3 Nonpayment Terminations After BAR Report

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

If payment is received, carriers process the BAR enrollment as Initial and send an 834 Confirm transaction to HBE. All active enrollments processed during this period must be processed under 147.104 consistent with guaranteed availability provisions under the ACA.

Subsidized enrollments with a 3-month grace period beginning August 1 and September 1 are terminated after the BAR report is sent with grace period end dates of October 31 and November 30, respectively. Non-subsidized enrollees with grace periods beginning October 1 and November 1 are terminated after the BAR report is sent with grace period end dates of October 31 and November 30, respectively. The nonpayment termination transaction updates the coverage end date to an earlier date than what was sent in the BAR 834 Term transaction. Carriers cannot bill past due premiums in accordance with the guidelines specified in Section 5.6.

10.2 Carrier invoicing and effectuation process for renewals

Renewal enrollments (active or passive) into the same product do not require a binder payment, and carriers continue to bill the customer via their existing enrollment billing cycle:

Renewal Type	Next Year Carrier	Next Year Product (10-digit CMS Plan ID)	Next Year Plan (14-digit CMS Plan ID)	January Binder or Regularly Billed payment
Included in TE (Auto renewal) (Passive Renewal)	Same Carrier	Same Product	Same Plan	Regularly Billed
	Same Carrier	Same Product	New Plan	Regularly Billed
	Same Carrier	New Product	New Plan	Regularly Billed
	New Carrier	New Product	New Plan	Binder Payment
Manual Renewal (Active Renewal)	Same Carrier	Same Product	Same Plan	Regularly Billed
	Same Carrier	Same Product	New Plan	Regularly Billed

	Same Carrier	New Product	New Plan	Binder Payment
	New Carrier	New Product	New Plan	Binder Payment

Passive renewal enrollments into the same carrier do not require an 834 Confirm transaction be sent to HBE. Passive renewal enrollments into a new carrier and all active renewal enrollments require an 834 Confirm transaction be sent to HBE:

Renewal Type	**Next Year Carrier**	**Next Year Product (10-digit CMS Plan ID)**	**Next Year Plan (14-digit CMS Plan ID)**	**Confirm Required**	**2000, INS03**	**2000, INS04**	**2700/2750 Passive Renewal Indicator**
Included in TE (Auto renewal) (Passive Renewal)	Same Carrier	Same Product	Same Plan	No	21	41	Yes
	Same Carrier	Same Product	New Plan	No	21	41	Yes
	Same Carrier	New Product	New Plan	No	21	41	Yes
	New Carrier	New Product	New Plan	Yes	21	EC	Yes
Manual Renewal (Active Renewal)	Same Carrier	Same Product	Same Plan	Yes	21	41	No
	Same Carrier	Same Product	New Plan	Yes	21	EC	No
	Same Carrier	New Product	New Plan	Yes	21	EC	No
	New Carrier	New Product	New Plan	Yes	21	EC	No

11.0 CURRENT YEAR RECONCILIATION

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

11.1 Direct Reconciliation

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

Urgent Enrollment inquiry: An initial or active enrollee reports an enrollment discrepancy to HBE or the carrier. The HBE Enrollment Team uses the following criteria to define urgent enrollment inquiries:

- The customer has an immediate need to access services but is prevented from doing so due to the discrepancy; or
- The customer has an emergent need to schedule future urgent services, but is prevented from doing so because the facility or provider requires proof of active coverage; or
- The customer is in imminent danger of being terminated for nonpayment, has an immediate need to access or schedule services, and a nonpayment termination will prevent them from accessing or scheduling urgent services
- OIC, Legislative or other inquiry.[33]General inquiries for which a response or a response deemed insufficient have to be escalated due to customer impact or continued customer outreach without resolution; or
- Other factors considered on a case-by-case basis.

These cases are considered high severity. Steps towards resolution and response to incidents are expected within 1 business day of receiving the request. When access to care is impacted, the Carrier is expected to resolve access to care barriers within 1 business day.
1095-A Correction: An enrollee reports a discrepancy between the 1095-A document issued by HBE and their coverage with a carrier. This error may be delaying their annual tax filing or impacting their IRS payment/refund calculation. Resolution is expected within 2-3 business days of receiving the request.

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

For general inquiries from the Customer Support CARE team:

Resolution is expected within 8 business days of receiving the request January through March. In instances where the request is received at the close of a business day, the 8-days will begin on the next business day. Resolution is expected within 5 business days of receiving the request April through December. In instances where the request is received at the close of a business day, the 5-days will begin on the next business day.

[33] Issues of this nature are explicit to complaints or inquiries generated from an external state or consumer agency directly to the Exchange.

For general inquiries from the HBE Enrollment team:

- Resolution is expected within 5 business days of receiving the request from January through March. In instances where the request is received at the close of a business day, the 5-days will begin on the next business day.
- Resolution is expected within 3 business days of receiving the request April through December. In instances where the request is received at the close of a business day, the 3-days will begin on the next business day.

11.2 Transaction Maintenance

Misaligned enrollment data can impact enrollees in a variety of ways, including but not limited to: access to care, inaccurate claims processing, incorrect billing statements, exclusion from autorenewal or incorrect inclusion in autorenewal, etc. To support aligned enrollment data and minimize manual intervention and reconciliation efforts, the Exchange and carriers mutually partner and adhere to a set of expectations for sending, processing, and correcting enrollment transactions.

11.2.1 Sending Enrollment Transactions

Expectations for sending enrollment transactions are as follows:

Carrier-Generated Transactions

- Carrier-generated effectuation or cancellation transactions are 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
- Carrier-generated nonpayment termination transactions are due to the Exchange within 15 business days of the expiration of the one-month (non-subsidized) or three-month (subsidized) grace period.
- Carrier-generated reinstatement transactions are due to the Exchange within 10 business days of reinstatement
- Carrier-generated transactions for a prior year should cease on March 31 of the year immediately following
    - If a carrier grants reinstatement of a prior year enrollment after March 31, they should reach out to the designated enrollment analyst, who will process the reinstatement and issue or correct the customer's 1095-A tax form

Exchange-Generated Transactions

- Exchange-generated add and change/add transactions are sent to the carrier within 5 business days of the customer's plan selection or member addition
- Exchange-generated change transactions are sent to the carrier within 5 business days of the reported change
- Exchange-generated termination and cancel transactions are sent to the carrier within 5 business days of the termination action
- Exchange-generated reinstatement transactions are sent to the carrier within 5 business days of the reinstatement action

11.2.2 Processing Enrollment Transactions

In general, carrier-generated transactions are processed by the HBE EDI system on a daily basis, and it is expected that carriers process files from HBE on a daily basis. Pre-planned maintenance windows, system activities, or unplanned downtime may in rare instances delay processing. At the latest, daily carrier- or Exchange-generated transactions are expected to be processed within 5 business days of receipt.

11.2.3 Enrollment Transaction Corrections

Enrollment files and individual transactions contained within those files sent by *Washington Healthplanfinder* or a carrier to the HBE EDI System are validated against HBE-defined business rules to safeguard enrollment data from erroneous files and to proactively address EDI issues upstream in the process flow.

Enrollment File Correction

If an enrollment file fails, this information will be relayed through transaction acknowledgments (see section 4.1 and 4.2 of the 834 Companion Guide for more details).

- If a file is rejected on the TA1, the carrier should copy down the TA1 from the SFTP folder, correct the file, and resubmit with a different file name within five business days.
- If a file is rejected on the 999, the carrier should copy down the 999 from the SFTP folder, correct the enrollment transaction, and resubmit in a file with a different file name within five business days.

Enrollment Transaction Correction ("Exceptions")

If data within an individual enrollment transaction within an enrollment file does not match expected values, a daily exception is generated which requires manual review by an HBE Enrollment Analyst.

- If an exception requires carrier correction, the Enrollment Analyst will notify the carrier via e-mail. The carrier should correct the enrollment transaction and resubmit in a file with a different file name within five business days.
- If an exception does not require carrier correction, the Enrollment Analyst will release the transaction back into the processing flow to update all *Washington Healthplanfinder* systems
- Transactions sent by HBE to a carrier which fail or generate an exception due to carrier business validations are expected to be resolved by the carrier within five business days.

For carriers with healthy daily file quality, 97% of transactions (or higher) should process successfully, without generating an exception in HBE systems (see Section 4.4 for additional details). Each Carrier is assigned a designated Enrollment Analyst as their primary point of contact. Carriers work directly with their assigned Enrollment Analyst to focus on unresolved errors, urgent discrepancies, and other issues that need to be addressed. The designated Enrollment Analyst conducts regularly scheduled meetings with their Carrier, responds to emails and phone calls, and coordinates resolution of escalated/urgent issues.

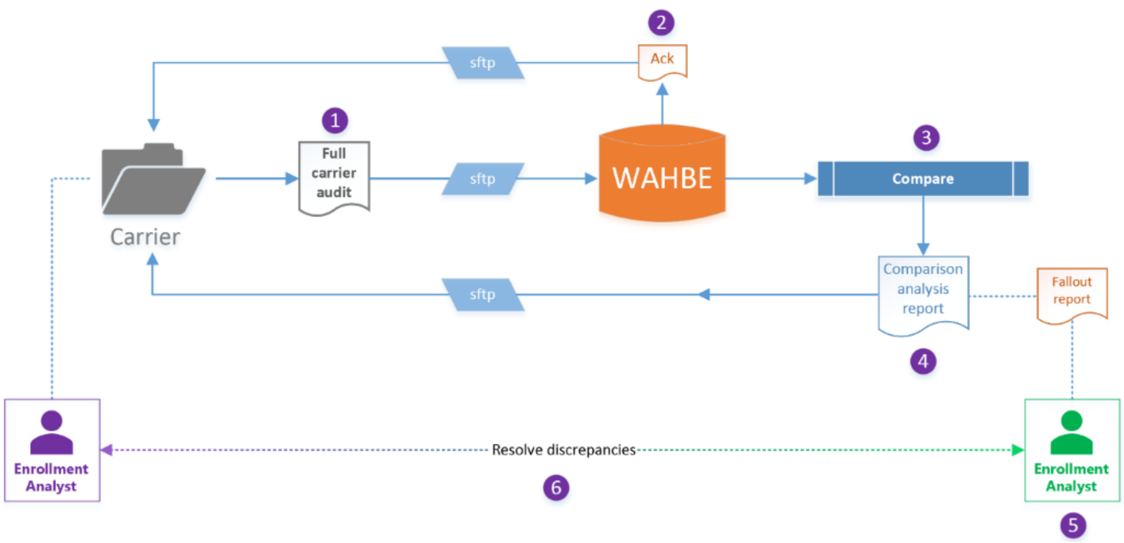
11.3 Monthly Reconciliation

HBE and carriers are required to reconcile enrollments no less than once per month[34]. Carriers are the system of record for payments and effectuations, while HBE is the system of record for CCS payments and for reporting to CMS, which informs APTC/CSR payments to carriers. It is critical that HBE and carrier systems are in sync. The Full Carrier Audit (FCA) allows for rapid comparison of a complete plan year roster using a modernized audit format.

11.3.1 Process Overview

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

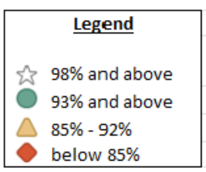
[34] 45 CFR § 156.400 (d)



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

11.3.2 FCA Summary and Audit Metrics

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



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

- Audit quality of 98% or higher indicates exceptional health of enrollment and EDI processes. Discrepancies should mainly be attributed to timing errors. For PY 2025, carriers should reach audit quality of 98% or higher by the September audit cycle to ensure customers experience a smooth and accurate autorenewal period and subsequent Open Enrollment. Unexpected or emerging trends or issues will be discussed during Carrier 1:1 calls, regularly scheduled reconciliation calls, or via e-mail.
- Audit quality of 93% or higher indicates healthy enrollment and EDI processes. For PY 2025, carriers should reach audit quality of 93% or higher by the April audit cycle to ensure customers experience accurate enrollment throughout the year. Unexpected or emerging trends or issues will be discussed during Carrier 1:1 calls, regularly scheduled reconciliation calls, or via e-mail.
- An audit quality between 85%-92% is cause for concern. Carriers with audit quality between 85%-92% should update WAHBE weekly regarding known or newly identified issues, and the status and timeline of anticipated resolution. This update will take place during Carrier 1:1 calls through FitGap, regularly scheduled reconciliation calls, or via e-mail.
- An audit quality below 85% is severely concerning. Carriers with audit quality below 85% must meet

with WAHBE weekly to discuss the status and timeline of anticipated enhancements and resolution of defects. This meeting will take place during carrier 1:1 calls through FitGap, regularly scheduled reconciliation calls, or a through a standalone meeting.

11.3.3 Discrepancy Resolution and Carrier Audit Guide

For detailed guidance regarding discrepancy scenarios, error definitions, dispute submission, and expectations for resolving audit discrepancies and disputes, refer to Appendix B (Carrier FCA Guide), which is included in this document.

11.3.4 Off-Cycle FCA

Except for pre-defined windows, carrier requests for an off-cycle FCA are considered on a case-by-case basis. Carriers should contact enrollmentleads@wahbexchange.org to request an off-cycle FCA. The request should include business justification and desired timing.

In general, an off-cycle FCA will not include HBE-calculated quality metrics or the analyst audit summary.

11.3.5 EDI trading partner agreements and Audit quality

T The EDI trading partner agreement requires that Carriers cure errors or deficiencies in transactions identified by the Exchange.

Audit quality Metrics described in 11.3.2 are guidelines used to ensure high quality data between HBE and carrier systems. EDI trading partner agreements require Issuer compliance with these guidelines. Nothing within the EPPG or FCA including audit quality metric permits an Issuer to disregard discrepancies, especially if they result in impacts to coverage access or availability.

12.0 PRIOR YEAR RECONCILIATION

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

12.1 Timeframes and mechanisms

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

12.1.1 Updates via 834 Transactions

Carriers may initiate updates to enrollments for the prior benefit year via 834 transactions from January 1 through March 31 of the year immediately following. For example, corrections to enrollments for plan year 202 may be made from January 1, 2023, through March 31, 2023. Carriers may not submit 834 transactions for prior plan years that fall outside of this threshold. All transactions submitted should follow the guidelines in the 834 Companion Guide and in the 834 Standards section of this document.

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

12.2 Acceptable 834 transactions

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

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

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

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

*Several business validation rules apply to scenarios where an adjustment to an enrollment's end date is required. Certain desired outcomes are not feasible with an 834 transaction and will require the initiation of a prior year reconciliation project. Examples are shown in the table below.

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

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

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

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

12.3 Prior year reconciliations

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

12.3.1 Justification

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

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

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

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

12.3.2 Planning

Following project justification, the project planning phase begins. Tasks are identified, and resources are assigned. It is recommended that each party designate a project lead. A project schedule is collaboratively developed and should contain adequate detail regarding the tasks and deliverables required for the comparison phase. Project leads consult with technical stakeholders involved in the project to ensure requirements are clearly communicated.

12.3.3 Comparison

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

12.3.4 Finalization

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

Once root-cause analysis is complete and shared with project stakeholders, corrective action is taken. Often, this involves the implementation of data fixes and/or code changes. When the scope includes fixes to HBE data, please see section 12.3.5 HBE Data Fix Standards

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

12.3.5 HBE Data Fix Standards

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

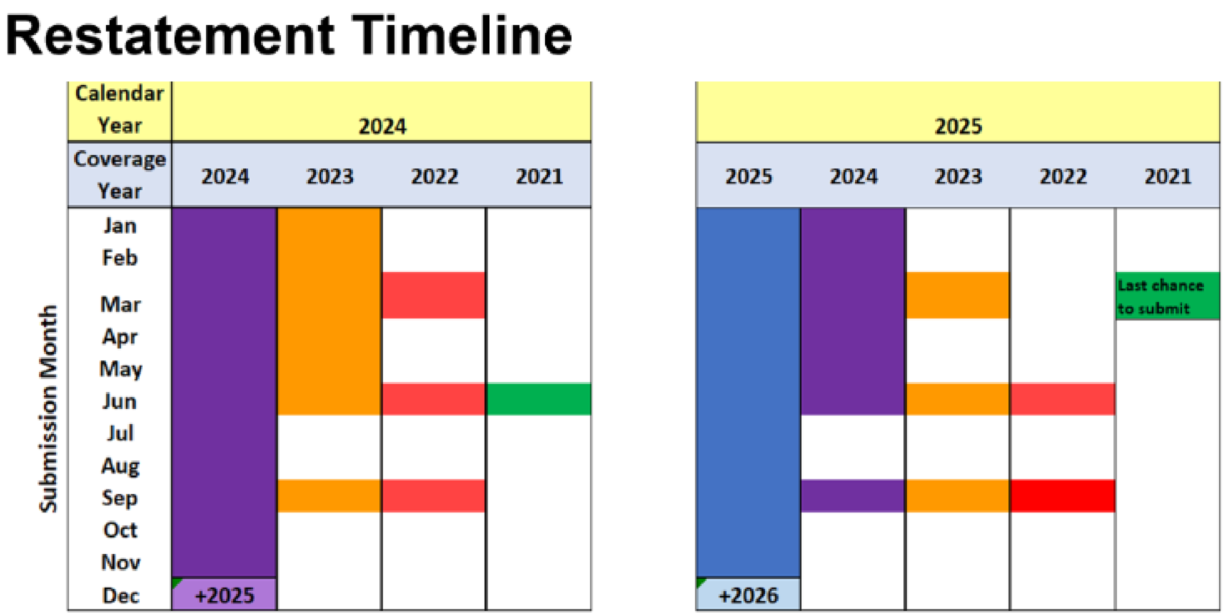
1. No enrollments may be updated by HBE from a cancelled to a non-cancelled status unless:
    a. Member made premium payments; or
    b. Carrier paid claims
2. Coverage periods may be extended, provided:
    a. Extension aligns with customer's paid through date; and
    b. Is consistent with #1 above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

13.0 Prior Year Reporting

For prior plan year reinstatements, the original method of reporting to CMS determines the reinstatement method. After the CMS transition to policy-based payments, the 1A workbook reinstatements phase into State Based Market Interchange (SBMI) reinstatements.

13.1 Restatements by SBMI

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



To align with the expectation that SBEs will resolve any inaccuracies within 60 days of receipt, the restatement timeline has been adjusted to allow SBEs to submit a final 2021 SBMI in March 2025.

Restatement Submission Schedule:
Current Plan Year: Submit monthly
Current Plan Year – 1: Submit monthly through June, and then once in September
Current Plan Year – 2: Submit March, June, September
Current Plan Year – 3: Submit March, June, December

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

13.2 Restatements by 1A Workbook

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

13.3 Restatements by CMS exceptions process

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

13.3.1 Legally Acceptable Reason

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

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

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

13.3.2 CMS Exception Submittal

Exception requests are submitted via e-mail as follows:

To: marketplacepayments@cms.hhs.gov
Subject: Request for Exceptions Process
Attach: Completed request form worksheet (shown below)

Part 1: Contact Information

Entity Name/Legal Business Name of Issuer	
Health Insurance Oversight System (HIOS) ID	
Payee Group ID	
Submitter (SBE or Issuer)	
Primary Contact Name of Submitter	
Primary Contact Phone Number	
Mailing Address (Street address, City, ST, Zip Code)	
Email Address	
Date	

Part 2: Reason for Request

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

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

Section 2: Additional Information, Documentation, and Support

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

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

Part 3: APTC Adjustment Calculation Worksheet

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

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

Section A	Section B
(Complete for FFE and SBE issuer reasons 1-3 and SBE reasons 1-3.)	(Complete for FFE and SBE issuer reasons 1-3 and SBE reasons 1-3.)

QHP ID	Total Previous APTC payment from CMS for that QHP for the 2014 and 2015 benefit year (as submitted in final manual workbook)	Corrected APTC fee for that QHP for the 2014 and 2015 benefit year	Total requested adjustment to APTC requested (i.e. Column D – Column C). Positive amount = payment to the issuer

13.3.3 Exception Process Timing and Schedule

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

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

13.4 Carrier audit support

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

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

James Brackett, Compliance Manager E-mail: James.Brackett@WAHBExchange.org Phone: 360-688-7724	Brittney Ross, Compliance Analyst E-mail: Brittney.Ross@WAHBExchange.org Phone: 360-688-7891

Appendix A: Special Enrollment Events and Coverage Dates

SEP Category	Regulatory provision (unless otherwise noted, under 45 CFR §155.420)	Triggering event description	SEP Code	Accessed through
1. Loss of qualifying health coverage	(d)(1)(i-iv) – Loss of minimum essential coverage	A SEP-Initial enrollee or dependent loses minimum essential coverage, including but not limited to Medicaid, CHIP, or qualifying employer sponsored coverage. For purposes of qualifying for this SEP, this includes: • The end of the plan year for any non-calendar year group health plan or individual health insurance coverage; • Losing pregnancy-related coverage described under section 1902(a)(10)(A)(i)(IV) and (a)(10)(A)(ii)(IX) of the Social Security Act; and/or • Losing medically needy coverage described under section 1902(a)(10)(C) of the Social Security Act only once per calendar year. • Termination of COBRA benefits that coincide with an employer newly no longer contributing to monthly premiums. Note: This does not include loss of coverage due to nonpayment of premiums. **Coverage Effective Dates:** Plan selection after Loss of MEC: Accelerated start date Advanced availability: 1st of the month following the loss of MEC	07	Application

SEP Category	Regulatory provision (unless otherwise noted, under 45 CFR §155.420)	Triggering event description	SEP Code	Accessed through
1. Loss of qualifying health coverage (continued)	(d)(6)(iii) – Become newly eligible for APTC due to changes to current employer –sponsored coverage	A qualified individual or their dependent who is enrolled in an eligible employer-sponsored plan is determined newly eligible for APTC based in part on a finding that such consumer is ineligible for qualifying coverage in an eligible-employer sponsored plan in accordance with 26 CFR §1.36B2I(3). **Coverage Effective Dates:** Plan selection after Loss of MEC: Accelerated start date Advanced availability: 1st of the month following the loss of MEC	FC	Application
1. Loss of qualifying health coverage (continued)	(d)(10)(i-ii) – Victim of domestic violence or spousal abandonment	A QI or enrollee or their dependent is a victim of domestic abuse or spousal abandonment as defined by 26 CFR 1.36B-2 or a dependent or unmarried victim within a household, is enrolled in minimum essential coverage, and sought to enroll in coverage separate from the perpetrator of the abuse or abandonment Note: Carriers should be sensitive to each instance and work with initial enrollees that enrolled under this triggering event with potential difficulties in obtaining documentation for SEP verification. **Coverage Effective Dates:** Accelerated effective date	07	Application

SEP Category	Regulatory provision (unless otherwise noted, under 45 CFR §155.420)	Triggering event description	SEP Code	Accessed through
2.Change in primary place of living	(d)(7) – Gain access to new QHPs due to a permanent move	A QI or enrollee, or their dependent, gains access to new QHPs as a result of a permanent move.[35] Note: Temporary moves or vacation would not be considered a permanent move for purposes of qualifying for this SEP. **Coverage Effective Dates:** Regular prospective coverage effective dates.	43	Application
3. Change in eligibility for coverage or help paying for coverage	(d)(3) – Become newly eligible for QHP coverage	A QI or their dependent becomes newly eligible for enrollment in a QHP due to gaining status as a citizen, national, or lawfully present individual or being released from incarceration. **Coverage Effective Dates:** Regular prospective coverage effective dates.	NE	Application
	(d)(6)(i-ii) – Become newly eligible or ineligible for APTC, or experience a change in eligibility for CSR	An enrollee or their dependent is determined newly eligible or newly ineligible for APTC or has a change in eligibility for cost-sharing reductions (CSR). **Coverage Effective Dates:** For becoming newly eligible for APTC, accelerated effective date. Otherwise, regular prospective coverage effective dates.	FC	Application

[35] 45 CFR 155.420 (a)(5): Prior Coverage Requirement

SEP Category	Regulatory provision (unless otherwise noted, under 45 CFR §155.420)	Triggering event description	SEP Code	Accessed through
4. Change in eligibility for coverage or help paying for coverage (continued)	(d)(8) – Member of a federally recognized tribe or a shareholder in an Alaska Native Corporation	A QI, or their dependent enrolling in the same coverage, who is an Indian, as defined by Section 4 of the Indian Health Care Improvement Act, gains or maintains such status and may enroll in a QHP or change from one QHP to another one time per month. **Coverage Effective Dates:** Regular prospective coverage effective dates.	NE	Application
	(d)(15) – Loss of COBRA subsidies by an employer or government entity	A QI, or their dependent is enrolled in COBRA continuation coverage for which an employer is paying all or part of the premiums, or for which a government entity is providing subsidies, and the employer or government entity's contributions/subsidies completely cease. **Coverage Effective Dates:** Accelerated effective date	07	Application

SEP Category	Regulatory provision (unless otherwise noted, under 45 CFR §155.420)	Triggering event description	SEP Code	Accessed through
5. Enrollment or plan error	(d)(4) – Experience an error of the Exchange	A QI or their dependent enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, misconduct, or inaction of an officer, employee, or agent of the Exchange, its instrumentalities, or a non-Exchange entity providing enrollment assistance or conducting enrollment activities. A QI or their dependent enrollment or non-enrollment in a QHP or inaccurate eligibility determination is a result of a technical error or Exchange-related enrollment delay. A QI or their dependent enrollment in a QHP is impacted by a plan or benefit display error. A QI's or their dependent's non-enrollment in a QHP is the result of being determined ineligible for Medicaid or CHIP by the State Medicaid or CHIP agency. Note: This includes Unresolved casework and technical errors **Coverage Effective Dates:** Retroactive back to the coverage effective date the QI would have gotten absent the error or regular prospective or accelerated coverage effective date, at the option of the consumer.	ER	HBE Review
	(d)(5) – Experience a plan contract violation	An enrollee, their dependent, or other interested parties can adequately demonstrate to the Exchange that a material plan error influenced the qualified individual's, enrollee's, or their dependents' enrollment decision to purchase a QHP through the Exchange. **Coverage Effective Dates:** Retroactive back to the coverage effective date the QI would have gotten absent the error or regular prospective or accelerated coverage effective date, at the option of the consumer.	EX	HBE Review

SEP Category	Regulatory provision (unless otherwise noted, under 45 CFR §155.420)	Triggering event description	SEP Code	Accessed through
	(d)(12) – Error in plan benefit	The qualified individual or enrollee, their dependent, or other interested parties adequately demonstrates to the Exchange that a material error related to plan benefits, service area, or premium influenced the qualified individual or enrollees' decision to purchase a QHP through the Exchange	EX	HBE Review
6. Other qualifying changes	(d)(9) – Experience an exceptional circumstance	A qualified individual, enrollee, or dependent, enrollment or non-enrollment in a QHP is the result of an exceptional circumstance, as determined by the Exchange, including being incapacitated or experiencing a natural disaster. **Coverage Effective Dates:** Vary based on circumstances.	EX	HBE Review
	(d)(11) – Denied Washington Apple Health or non-MAGI Medicaid	A qualified individual is determined ineligible for Medicaid or CHIP	07	Application
7. Cascade Care Savings	(d)(9) - Experience an exceptional circumstance State Premium Assistance Policy Section 9.1(d)	A qualified individual or enrollee, or their dependent, whose household income is expected to be no greater than 250 percent of the Federal poverty level, and who is not currently enrolled in a Cascade Care Silver or Gold plan, may enroll in or switch to a Cascade Care Silver or Gold plan monthly. **Coverage Effective Dates:** Accelerated effective date	PC	Application

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Appendix B: Full Carrier Audit (FCA) Guide

Version 4.0
Last Update: XX/XX/2

1.0 Full Carrier Audit Process

1.1 Purpose

The Washington Health Benefit Exchange (WAHBE) provides process and formatting guidance for the monthly audit in the Enrollment Payment and Process Guide, 834 Companion Guide, and Full Carrier Audit (FCA) ICD. This guide is an appendix of the Enrollment Payment and Process Guide. It covers discrepancy scenarios, error definitions, and expectations for resolving and disputing audit discrepancies.

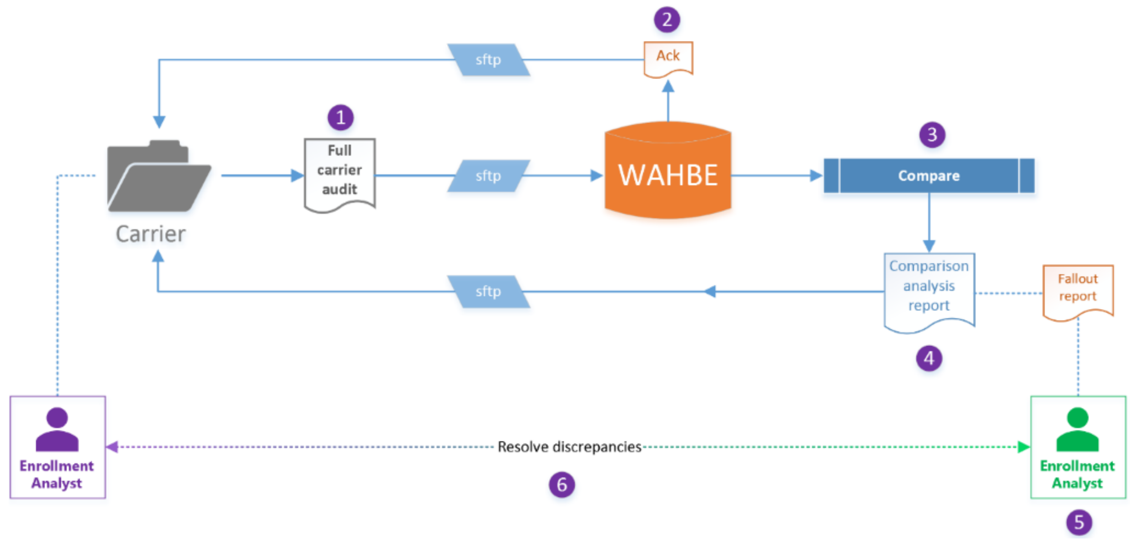
1.2 Version History

Version	Date	Details
1.0	12/2/20	Initial version of guide
2.0	6/25/21	Business error comparison logic updates and updates to several comparison error codes, addition of financial disputes
3.0	11/18/22	- Addition of business and comparison error codes to support Cascade Care Savings - Updated guidance for address and broker comparison error resolution
Carrier Bulletin	2/24/2024	Added FCA Guide as "Appendix B" to EPPG
4.0	4/26/2024	Annual Review: 11.3.2 – Added 1.4 – Added bullet 1.6 Updated and added additional details 2.1 Updated Business Validation Error Code table 3.1 Updated Comparison Report Error Codes table 3.2.2 Updated table 3.2.3 Removed 3.2.34 Updated 3.2.4 DEP-027 clarified scenarios

1.3 1.2 Process Overview

Currently, the monthly audit process begins with the carrier submission of Full Carrier Audit (FCA) transactions for each active plan for the given plan year. Submission is to contain the full roster of enrollments for the plan year, including enrollments that are not yet effectuated or have been terminated or cancelled. Further, all subscribers and dependent members are to be included regardless of current status. These files should be submitted between the 16th and 18th of each month. Once received, acknowledgements are returned. If one or more files is rejected due to validation errors, carriers should notify their designated Exchange enrollment analyst and correct and resubmit the files within 24 hours.

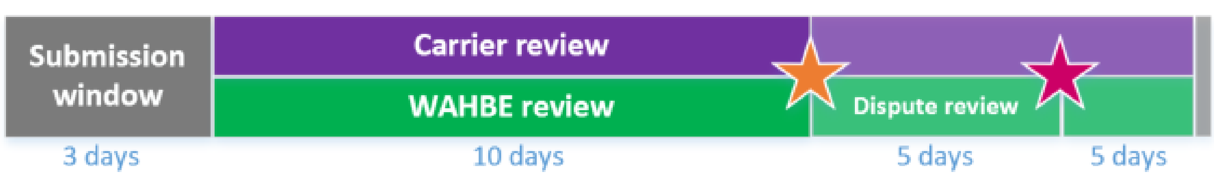
Provided the FCA files pass validation and are processed, two comparison artifacts are produced. A comparison analysis report is returned to the carrier with carrier-assigned errors, and a fallout report is made available to the Exchange enrollment analyst. Once these artifacts have been produced, the initial 10-business-day review period will begin.



1.3 Review Period and Error Resolution

Upon receiving their respective artifacts, carriers and Exchange enrollment analysts have 10 business days to review and provide initial findings.

The Exchange enrollment analyst will provide a summary with high-level findings within this review period to assist with error resolution prioritization and identify trends.
Carrier corrections are expected to be completed within the initial 10-business-day review period but may continue to be submitted until 2 business days prior to the start of the next audit submission window.
Carrier disputes regarding findings from the comparison analysis report are due no later than the last day of the review period (see Dispute section for additional details). The Exchange enrollment analyst will subsequently review disputes and report on initial findings within an additional five business days. Further review may continue until 2 business days prior to the start of the next audit submission window.



★	Any carrier disputes regarding findings from the comparison report are due within the 10-business day review period
★	The WAHBE enrollment team will review disputes and report on initial findings within 5 business days
	WAHBE and carrier corrections identified during the audit cycle are due no later than 2 business days prior to the start of the next audit submission window

1.4 Timing and Enrollment Transaction Expectations

Some number of timing issues are generally expected whenever an audit comparison is performed. In accordance with Carrier Enrollment Payment Process Guide section 11.2 Transaction Maintenance, the following Service Level Agreements (SLA) exist around sending, processing, and correcting enrollment transactions:

- An effectuation or cancellation transaction is due to the Exchange within 10 business days of binder payment due date or, if applicable, the expiration of a carrier's binder grace period

    - For a $0 binder payment, an effectuation is due to the Exchange within 10 business days of the date binder payment would have been due if it were greater than $0
- A termination for nonpayment transaction is due to the Exchange within 15 business days of expiration of the grace period.
- Carrier-generated nonpayment reinstatement transactions are due to the Exchange within 10 business days of reinstatement.
- Exchange-generated transactions must be processed by the carrier within 5 business days.
- Carrier files that are rejected on the TA1 or 999 are corrected and resubmitted by the carrier with a new file name within 5 business days of receiving the negative acknowledgement.
- Carrier individual enrollment transaction errors (exceptions) that the Exchange is unable to consume due to business validations are corrected and resubmitted by the carrier with a new file name within 5 business days of receiving notification from the designated Enrollment Analyst.

For the purposes of the monthly audit and this document, additional SLAs apply:
- Any carrier corrections or disputes regarding findings from the comparison report are due within the 10-business day review period.
- The Exchange enrollment team will review submitted disputes and report on initial findings within 5 business days.
- Carriers and the Exchange are required to finalize any corrections no later than 2 days prior to the start of the next audit cycle.
- FCA errors that carry over from the previous month are of particular concern. All carryover errors should be prioritized by carrier teams and corrected within the 10-business day review period.

1.5 Assumptions

The following assumptions apply to all discrepancy scenarios:
1) Carrier audits are received within the expected timeframe (16th – 18th of each month) and contain the full roster of enrollments and members regardless of effectuation, coverage dates, or other status.
2) In scenarios where the last action was the Exchange's, more than 5 business days have elapsed.
3) Transactions are not impacted by HIPAA or business validation errors, unless otherwise specified.

1.6 File Acknowledgments

For each carrier audit file submitted to the Exchange, a positive or negative acknowledgement will be returned. If one or more files are rejected due to validation errors, carriers should notify the Exchange that they received the rejection notice and are working to make corrections, by emailing enrollmentleads@wahbexchange.org and cc: the designated Exchange enrollment analyst. Correction Resubmission should occur within 24 hours.

Example: Rejected due to XSD Validation Error
Assigned To: Carrier
Scenario
• Audit file submitted fails schema validation • Negative acknowledgment is returned to Carrier • Carrier File Status is Rejected
Error

• XML Parser error: The element type "CarrierEnrollments" must be terminated by the matching end-tag
Expected outcome: Carrier corrects and resubmits with new file name and new, unique FileId.

Example: Accepted with Errors
Assigned To: Carrier
Scenario
• Audit file submitted contains one or more nodes with data issues • Negative acknowledgement is returned to Carrier • Carrier File Status is AcceptedWithErrors • Technical errors are provided on acknowledgment and comparison analysis report is produced for remaining policies
Error
• Parsing error at line 9; please correct and resubmit
Expected outcome: Carrier reviews technical errors and corrects prior to next audit submission.

2.0 Business Validation Errors

The Exchange validates all policies against a set of business rules which can be found in the Full Carrier Audit ICD. If a policy fails due to a business validation error, no further comparison will be completed. The file will be accepted with errors.

2.1 Business Validation Error Codes

Error Code	Error Type	Error Description
BIZ-002	Identifier	Policy node contains more than MemberInformation node where SubscriberIndicator = Y
BIZ-003	Identifier	ExchangeAssignedSubscriberId and ExchangeAssignedMemberId should match when SubscriberIndicator = Y
BIZ-004	Demographic	AddressInformation node where AddressType = Physical must be present 1
BIZ-006	Dates	MemberStartDate and/or MemberEndDate are missing from MemberInformation node
BIZ-007	Dates	MemberStartDate is earlier than PolicyStartDate
BIZ-008	Dates	MemberEndDate is later than PolicyEndDate
BIZ-009	Dates	FinancialEffectiveStartDate is earlier than PolicyStartDate
BIZ-010	Dates	FinancialEffectiveStartDate is later than PolicyEndDate
BIZ-011	Financials	MonthlyAPTCAmount is greater than MonthlyTotalPremiumAmount
BIZ-012	Financials	MonthlyTotalResponsibilityAmount is greater than MonthlyTotalPremiumAmount
BIZ-014	Financials	MonthlyCSRTier is greater than 01 but MonthlyCSRAmount is 0.00
BIZ-015	Dates	One or more FinancialInformation nodes have overlapping start or end

		dates
BIZ-020	Identifier	Multiple members with Edifecs MemberID =
BIZ-022*	Demographic	ZipCode for physical address should match WA zip code list
BIZ-030	Financials	Balancing error in one or more FinancialInformation nodes
BIZ-032	Financials	MonthlyTotalResponsibilityAmount is greater than MonthlyTotalPremiumAmount
BIZ-033	Financials	MonthlyTotalPremium and/or MonthlyTotalResponsibilityAmount contains a null value
BIZ-035	Financials	State subsidy amount is greater than premium amount

*The BIZ-022 error has been identified as requiring comparison logic updates and will be removed in a future FCA release. It is not included in the calculation of carrier FCA metrics.

2.2 Business Validation Error Resolution

Carrier technical and EDI teams should work to correct business validation errors no later than 2 business days prior to the start of the next audit cycle. Because these errors are technical in nature, enrollment analysts are typically unable to provide guidance or assist with resolution. Questions or requests for assistance with business validation errors should be directed to the Exchange's Carrier Operations Team (carrier@wahbexchange.org).

Business validation errors are a high priority. Because no further comparison is executed on enrollments that experience a business validation error, comparison errors may go undetected until the business error is resolved.

3.0 Comparison Differences

If a policy is successfully compared but contains differences after comparing the carrier and Exchange data, a comparison error is generated. Misaligned enrollment data can impact covered members in a variety of ways:

- Access to care
- Inaccurate and untimely claims processing
- Incorrect billing statements
- Failure to receive billing statements in the mail
- Incorrect or missing 1095-A
- Exclusion from autorenewal or incorrect inclusion in autorenewal

3.1 Comparison Report Error Codes

Error Code	Error Description	Error Location
ADR-001	Difference found in address node	Policy/MemberInformation
ADR-002	${AddressType} Address line 1 does not match WAHBE value	Policy/MemberInformation
ADR-003	${AddressType} Address line 2 does not match WAHBE value	Policy/MemberInformation
ADR-004	${AddressType} Zip code does not match WAHBE value	Policy/MemberInformation
BRK-001	Difference found in broker node	Policy/BrokerInformation
BRK-004	Broker identifier does not match WAHBE value	Policy/BrokerInformation
BRK-005	Difference found in broker agent node	Policy/BrokerInformation
BRK-008	Agent identifier does not match WAHBE value	Policy/BrokerInformation

DEP-001	Dependent ${Member ID} present or missing from intake audit; mismatch with WAHBE roster.	Policy/Dependent
DEP-002	Dependent ${Member ID} missing in intake update but found within Source of Truth with an existing EndDate	Policy/Dependent
DEP-016	Dependent ${Member ID} start date does not match WAHBE value	Policy/MemberInformation
DEP-017	Dependent ${Member ID} end date does not match WAHBE value	Policy/MemberInformation
DEP-021	Dependent date of birth does not match WAHBE value for ${MemberID}	Policy/MemberInformation
DEP-022	Dependent ID ${MemberID} sex assigned at birth does not match WAHBE value	Policy/MemberInformation
DEP-025	Difference found at member/dependent level for [PID]	Policy/MemberInformation
DEP-026	Dependent member identifier does not match WAHBE value	Policy/MemberInformation
DEP-027	Difference found in address node for ${MemberID}	Policy/MemberInformation
ENR-010	Subscriber start date does not match WAHBE value	Policy
ENR-011	Subscriber end date does not match WAHBE value	Policy
ENR-016	Plan ID does not match WAHBE value	Policy
FIN-001	Financial information node missing	Policy/FinancialInformation
FIN-003	CSR tier does not match WAHBE value for YYYY-MM-DD	Policy/FinancialInformation
FIN-008	Responsible amount does not match WAHBE value for YYYY-MM-DD	Policy/FinancialInformation
FIN-013	Premium amount does not match WAHBE value for YYYY-MM-DD	Policy/FinancialInformation
FIN-018	CSR amount does not match WAHBE value for YYYY-MM-DD	Policy/FinancialInformation
FIN-024	APTC amount does not match WAHBE value for YYYY-MM-DD	Policy/FinancialInformation
FIN-025	State subsidy amount does not match WAHBE value for YYYY-MM-DD	Policy/FinancialInformation
MEM-005	Subscriber date of birth does not match WAHBE value	Policy/MemberInformation
MEM-006	Subscriber sex assigned at birth does not match WAHBE value	Policy/MemberInformation
MFI-001	Enrollment found on WAHBE roster not included in carrier audit submission	Policy
MFI-002	Enrollment found on WAHBE roster not included in carrier audit submission	Policy
NEW-001	Enrollment included in carrier audit submission not found on WAHBE roster	Policy
PST-001	Policy Status does not match WAHBE value	PolicyUnit/Subscriber
SPN-003	Sponsor identifier does not match WAHBE value	Policy/SponsorInformation
SPN-006	Sponsor identifier does not match WAHBE value	Policy/SponsorInformation
SPN-007	Sponsor identifier does not match WAHBE value	Policy/SponsorInformation

*Greyed out enrollment errors are currently not included in the calculation of carrier FCA metrics, but are included in carrier compare reports: ADDR-002; ADDR-003; BRK-001; BRK-004; BRK-005; BRK-008; DEP-0273.2 Comparison Error Resolution

3.2.1 Example

Error Code Message Text
Scenario: [brief description of the error scenario]
Assigned to: [party responsible for discrepancy resolution]
• Action 1 • Action 2
Expected outcome: [steps necessary to resolve the discrepancy] **Dispute permitted**

Describes the actions, in chronological order, which caused the discrepancy

Will be present only if the scenario falls into an acceptable dispute category

3.2.2 Address Information

The following address elements are compared. Physical addresses are required, and mailing addresses will be compared if they exist:

- Address Type
- Address Line 1
- Address Line 2
- Zip Code

Per the *Carrier Enrollment Payment and Process Guide (EPPG)* section 4.1, customers must contact the Exchange to update their enrollment information, including physical and/or mailing address.

ADR-001 Difference found in address node
Scenario 1: Mailing address present in carrier roster, not found in WAHBE roster
Assigned to: Carrier
• WAHBE Add sent with physical address only, no mailing address present • Audit received from carrier includes mailing address
Expected Outcome: Carrier does not submit mailing address on next audit submission
Scenario 2: Mailing address not found in carrier roster, present in WAHBE roster
Assigned to: Carrier
• WAHBE Add sent with physical and mailing address • Audit received from carrier does not include mailing address
Expected Outcome: Carrier includes mailing address on next audit submission
Scenario 3: Mailing address not found in carrier roster, present in WAHBE roster
Assigned to: Carrier
• WAHBE Add sent with physical address only • WAHBE Change sent with mailing address • Audit received from carrier does not include mailing address
Expected Outcome: Carrier includes mailing address on next audit submission per WAHBE Change

ADR-002 [Physical/Mailing] Address line 1 does not match WAHBE value
Assigned to: Carrier

• Because of the high number of “false positives” in this category due to formatting or abbreviation, WAHBE does not include this error category when calculating audit quality metrics.
Expected Outcome: Carrier updates address to match WAHBE value.

ADR-003 [Physical/Mailing] Address line 2 does not match WAHBE value
Assigned to: Carrier
• Because of the high number of “false positives” in this category due to formatting or abbreviation, WAHBE does not include this error category when calculating audit quality metrics.
Expected Outcome: Carrier updates address to match WAHBE value.

ADR-004 [Physical/Mailing] Zip code does not match WAHBE value
Scenario 1: Physical address zip code submitted in carrier roster does not match WAHBE value
Assigned to: Carrier
• WAHBE Add sent with physical address zip code 90001 • WAHBE Change file sent with physical address zip code 90002 • Audit received from carrier contains physical address zip code 90001
Expected Outcome: Carrier updates physical address zip code to 90002 per WAHBE Change
Scenario 2: Mailing address zip code submitted in carrier roster does not match WAHBE value
Assigned to: Carrier
• WAHBE Add sent with mailing address zip code 90001 • WAHBE Change file sent with mailing address zip code 90002 • Audit received from carrier contains mailing address zip code 90001
Expected Outcome: Carrier updates mailing address zip code to 90002 per WAHBE Change

3.2.3 Broker Information

The following elements are compared when a broker exists:

- Broker Agent Name
- Broker Identifier

Broker errors are not included in the calculation of audit quality metrics due to the significant differences in WAHBE and carrier relationships with producers and the inability to pass explicit date information associated with broker partnerships in the 834 file.

BRK-001 Difference found in broker node
Scenario 1: Broker organization present in carrier roster, not found in WAHBE roster
Assigned to: Carrier
• WAHBE does not include this error category when calculating audit quality metrics.

Expected Outcome: Carrier removes broker organization per WAHBE Change and does not include in next audit submission
Scenario 2: Broker organization not found in carrier roster, present in WAHBE roster
Assigned to: Carrier
• WAHBE does not include this error category when calculating audit quality metrics.
Expected Outcome: Carrier updates broker organization per WAHBE Change and includes in next audit submission

BRK-004 Broker identifier does not match WAHBE value
Scenario 1: Broker organization submitted in carrier roster does not match WAHBE roster
Assigned to: Carrier
• WAHBE does not include this error category when calculating audit quality metrics.
Expected Outcome: Carrier updates broker organization to organization B per WAHBE Change

BRK-005 Difference found in broker agent node
Scenario 1: Broker agent present in carrier roster, not found in WAHBE roster
Assigned to: Carrier
• WAHBE does not include this error category when calculating audit quality metrics.
Expected Outcome: Carrier removes broker agent per WAHBE Change and does not include in next audit submission
Scenario 2: Broker agent not found in carrier roster, present in WAHBE roster
~~Assigned to: Carrier~~
~~• WAHBE does not include this error category when calculating audit quality metrics.~~
~~Expected Outcome: Carrier updates broker agent per WAHBE Change and includes in next audit submission~~

BRK-008 Agent identifier does not match WAHBE value
Scenario 1: Broker agent submitted in carrier roster does not match WAHBE roster
Assigned to: Carrier
• WAHBE does not include this error category when calculating audit quality metrics.
Expected Outcome: Carrier updates broker agent to Belinda per WAHBE Change

3.2.4 Dependent Information

All dependents are to be included in the FCA submission, regardless of the dependent's current status. The following member elements are compared when a dependent is present:

- Birth Date
- Gender
- Disability Code
- Member Start Date

- Member End Date
- Dependent physical/mailing address

Per the *Carrier Enrollment Payment and Process Guide (EPPG)* section 4.1, customers must contact the Exchange to update their enrollment information, including dependent birth date, sex assigned at birth, disability status, or unique dependent physical/mailing address.

DEP-001 Dependent [PID] present or missing from intake audit; mismatch with WAHBE roster
Scenario 1: Dependent is present in carrier roster, not found in WAHBE roster
Assigned to: Carrier
• WAHBE Add sent for 2020 policy including DEP PID 234 effective 1/1 • WAHBE Term sent for 2020 policy ending coverage effective 12/31 • WAHBE Add sent for 2021 policy subscriber coverage only effective 1/1. Dependent does not renew. • 2021 Audit received from carrier contains DEP PID 234 1/1-12/31
Expected Outcome: Carrier terminates DEP PID 234 12/30/20 and does not include in 2021 audit submission.
Scenario 2: Dependent is not found in carrier roster, present in WAHBE roster, SEP denial
Assigned to: Carrier
• WAHBE Add sent for HH with coverage effective 1/1 • WAHBE Change/Add sent to add DEP PID 345 effective 3/1 • Audit received from carrier does not include DEP PID 345 • PID 345 is undergoing or has undergone SEP verification by carrier
Expected Outcome: Once SEP verification period has ended, carrier communicates SEP denial to WAHBE or processes addition of DEP PID 345 per WAHBE Change/Add and includes in next audit submission **Dispute Permitted* - ONLY if SEP verification has been completed and at least 10 business days have elapsed since the SEP denial was communicated to WAHBE*

DEP-002 Dependent [name] missing in intake update but found within Source of Truth with an existing EndDate
Scenario 1: Dependent is not found in carrier roster, present in WAHBE roster
Assigned to: Carrier
• WAHBE Add sent for HH with coverage effective 1/1 • WAHBE Change/Add sent to add DEP PID 234 effective 3/1 • Audit received from carrier does not include DEP PID 234
Expected Outcome: Carrier includes DEP PID 234 in next audit submission per WAHBE Change/Add
Scenario 2: Dependent with end date prior to 12/31 is not found in carrier roster, present in WAHBE roster
Assigned to: Carrier
• WAHBE Add sent for subscriber and DEP PID 456 with coverage effective 1/1 • WAHBE Change/Term sent to terminate DEP PID 456 effective 3/31

• Audit received from carrier does not include DEP PID 234
Expected Outcome: Carrier includes DEP PID 456 in next audit submission
DEP-016 Dependent [Member PID] start date does not match WAHBE value
Scenario 1: Carrier start date is earlier than WAHBE start date
Assigned to: Carrier
• WAHBE Add sent with enrollment start date of 3/1 for DEP PID 456 • WAHBE Change is sent with new enrollment start date of 4/1 for DEP PID 456 • Audit received from reflects enrollment start date of 3/1 for DEP PID 456
Expected Outcome: Carrier updates DEP PID 456 start date to 4/1 per WAHBE Change
Scenario 2: Carrier start date is later than WAHBE start date
Assigned to: Carrier
• WAHBE Add sent with enrollment start date of 3/1 for DEP PID 567 • WAHBE Change is sent with new enrollment start date of 2/1 for DEP PID 567 • Audit received from carrier reflects enrollment start date of 3/1 for DEP PID 567
Expected Outcome: Carrier updates DEP PID 567 start date to 2/1 per WAHBE Change
Scenario 3: Carrier incorrectly submits multiple MemberInformation nodes for dependent
Assigned to: Carrier
• WAHBE Add sent with enrollment start date of 3/1 for DEP PID 678 • WAHBE Change is sent updating tax credit amount effective 5/1 • Audit received from carrier contains two MemberInformation nodes for DEP PID 678. One with coverage dates 3/1-4/30 and a second with coverage dates 5/1-12/31
Expected Outcome: Carrier submits a single MemberInformation node for DEP PID 678 reflecting coverage dates 3/1-12/31
Scenario 4: Carrier correctly submits multiple MemberInformation nodes for a dependent due to gap in coverage
Assigned to: Carrier
• WAHBE Add with enrollment start date of 1/1 for DEP PID 789 • WAHBE Change/Term sent to terminate DEP PID 789 effective 3/31 • WAHBE Change/Add sent to add DEP PID 789 effective 7/1 • Audit received from carrier includes member node for DEP PID 678 from 1/1-3/31 and 7/1-12/31, WAHBE reflects DEP PID 678 from 7/1-12/31
Expected Outcome: Carrier notifies WAHBE Enrollment Analyst, who processes correction. **Dispute Permitted**

DEP-017 Dependent [Member PID] end date does not match WAHBE value
Scenario 1: Carrier end date is later than WAHBE end date, last action WAHBE Change/Term
Assigned to: Carrier
• WAHBE Add sent with enrollment start date of 3/1 for DEP PID 345 • WAHBE Change/Term is sent with DEP PID 345 enrollment end date of 6/30 • Audit received from carrier reflects DEP PID 345 with enrollment end date of 12/31
Expected Outcome: Carrier updates DEP PID 345 end date to 6/30 per WAHBE Change/Term

Scenario 2: Carrier end date is earlier than WAHBE end date, last action WAHBE Reinstate
Assigned to: Carrier
• WAHBE Add sent with enrollment start date of 3/1 for DEP PID 456 • WAHBE Change/Term is sent with DEP PID 456 enrollment end date of 6/30 • WAHBE Change/Add or Reinstate is sent for DEP PID 456 • Audit received from carrier reflects DEP PID 456 with enrollment end date of 6/30
Expected Outcome: Carrier updates DEP PID 456 end date to 12/31 per WAHBE Reinstate

Scenario 3: Carrier end date is later than WAHBE end date, last action carrier reinstate
Assigned to: Carrier
• WAHBE Add sent with enrollment start date of 3/1 for DEP PID 567 • WAHBE Change/Term sent with DEP PID 567 end date of 6/30 • Carrier terminates enrollment 5/31 for NP • Carrier subsequently reinstates enrollment • Carrier audit reflects DEP PID 567 with end date of 12/31, WAHBE roster continues to reflect 6/30 termination date for PID 567
Expected Outcome: Carrier should update DEP 567 end date to 6/30 per WAHBE Change/Term. See EPPG section 9.1.2 Scenario 5 for correct process.

Scenario 4: Carrier incorrectly submits multiple MemberInformation nodes for a dependent
Assigned to: Carrier
• WAHBE Add sent with enrollment start date of 3/1 for DEP PID 678 • WAHBE Change is sent updating tax credit amount effective 5/1 • Audit received from carrier includes a member node for DEP PID 678 from 3/1-4/30 and 5/1-12/31
Expected Outcome: Carrier submits a single member node reflecting DEP PID 678 covered from 3/1-4/30

Scenario 5: Carrier correctly submits multiple MemberInformation nodes for a dependent due to dependent gap in coverage
Assigned to: Carrier
• WAHBE Add with enrollment start date of 1/1 for DEP PID 789 • WAHBE Change/Term sent to terminate DEP PID 789 effective 3/31 • WAHBE Change/Add sent to add DEP PID 789 effective 7/1 • Audit received from carrier includes member node for DEP PID 678 from 1/1-3/31 and 7/1-12/31
Expected Outcome: Carrier notifies WAHBE Enrollment Analyst, who processes correction. **Dispute Permitted**

DEP-021 Dependent date of birth does not match WAHBE value for [Member PID]
Scenario 1: Dependent date of birth submitted in carrier roster does not match WAHBE roster
Assigned to: Carrier
• WAHBE Add sent with date of birth 2/22/1982 for DEP PID 123 • Audit received from carrier reflects date of birth 2/24/1982 for DEP PID 123

Expected Outcome: Carrier updates enrollment record to correct birth date to 2/22/1982 for DEP PID 123
Scenario 2: Dependent date of birth submitted in carrier roster does not match WAHBE roster
Assigned to: Carrier
• WAHBE Add sent with date of birth 3/22/1972 for DEP PID 156 • WAHBE Change sent with date of birth 3/21/1972 for DEP PID 156 • Audit received from carrier reflects date of birth 3/22/1972 for DEP PID 156
Expected Outcome: Carrier updates enrollment record to correct birth date to 3/21/1972 for DEP PID 156 per WAHBE Change

DEP-022 Dependent ID [Member PID] gender does not match WAHBE value
Scenario 1: Dependent gender submitted in carrier roster does not match WAHBE roster
Assigned to: Carrier
• WAHBE Add sent with sex assigned at birth code = M for DEP PID 225 • Audit received from carrier reflects sex assigned at birth code = F for DEP PID 225
Expected Outcome: Carrier updates enrollment record to correct sex assigned at birth code = M for DEP PID 225
Scenario 2: Dependent sex assigned at birthsex assigned at birth submitted in carrier roster does not match WAHBE roster
Assigned to: Carrier
• WAHBE Add sent with sex assigned at birth code = F for DEP PID 133 • WAHBE Change sent with sex assigned at birth code = M for DEP PID 133 • Audit received from carrier reflects sex assigned at birth code = F for DEP PID 133
Expected Outcome: Carrier updates enrollment record to correct sex assigned at birth code = F for DEP PID 133 per WAHBE Change

DEP-026 Dependent member identifier does not match WAHBE value
Scenario 1: Dependent member identifier submitted in carrier roster does not match WAHBE roster; carrier submitted internal member ID
Assigned to: Carrier
• WAHBE Add sent with DEP PID 326 • Audit received from carrier reflects DEP PID WA65576F
Expected Outcome: Carrier corrects audit logic to pull WAHBE member ID by next audit submission
Scenario 2: Dependent member identifier submitted in carrier roster does not match WAHBE roster; carrier submitted Subscriber member ID
Assigned to: Carrier
• WAHBE Add sent with DEP PID 276 • Audit received from carrier reflects DEP PID 726, which is the subscriber PID
Expected Outcome: Carrier corrects audit logic to pull correct DEP PID
Scenario 3: Dependent member identifier submitted in carrier roster does not match WAHBE roster

Assigned to: Carrier
• WAHBE Add sent with DEP PID 589 • Audit received from carrier reflects DEP PID 775
Expected Outcome: Carrier corrects enrollment record to reflect DEP PID 589 or corrects audit logic as needed

DEP-027 Difference found in address node for [Member PID]
Scenario 1: Dependent physical or mailing address present in carrier roster, not found in WAHBE roster
Assigned to: Carrier
• ~~WAHBE Add does not include unique dependent mailing or physical address~~ • ~~Audit received from carrier includes unique dependent mailing or physical address~~ Because of the high number of "false positives" in this category, WAHBE does not include this error category when calculating audit quality metrics.
Expected Outcome: ~~Carrier does not include unique dependent mailing or physical address in next audit submission~~
Scenario 2: Dependent physical or mailing present in carrier roster, not found in WAHBE roster, last action WAHBE Change
~~Assigned to: Carrier~~
• ~~WAHBE Add includes unique dependent mailing or physical address~~ • ~~WAHBE Change removes unique dependent mailing or physical address~~ • ~~Audit received from carrier includes unique dependent mailing or physical address~~
~~Expected Outcome: Carrier corrects enrollment to remove unique dependent mailing or physical address, and does not include in next audit submission~~
~~**Scenario 3:** Dependent physical or mailing address not found in carrier roster, present in WAHBE roster~~
~~Assigned to: Carrier~~
• ~~WAHBE Add includes unique dependent mailing or physical address~~ • ~~Audit received from carrier does not include unique dependent mailing or physical address~~
~~Expected Outcome: Carrier corrects enrollment record and includes unique dependent mailing or physical address in next audit submission~~
~~**Scenario 4:** Dependent physical or mailing address not found in carrier roster, present in WAHBE roster, last action WAHBE Change~~
~~Assigned to: Carrier~~
• ~~WAHBE Add does not includes unique dependent mailing or physical address~~ • ~~WAHBE Change includes unique dependent mailing or physical address~~ • ~~Audit received from carrier does not include unique dependent mailing or physical address~~
~~Expected Outcome: Carrier includes unique dependent mailing or physical address in next audit submission~~
~~**Scenario 5:** Dependent physical or mailing address submitted in carrier roster does not match WAHBE roster~~
~~Assigned to: Carrier~~

• ~~WAHBE Add includes unique dependent mailing address of PO Box 555~~ • ~~WAHBE Change updates unique dependent mailing address to PO Box 571~~ • ~~Audit received from carrier reflects PO Box 555~~
~~Expected Outcome: Carrier corrects enrollment to reflect dependent mailing address of PO Box 571~~

3.2.5 Enrollment Information

The following elements are compared for each enrollment:

- Enrollment start date
- Enrollment end date
- Plan ID

If a customer contacts a carrier to request a change in enrollment start or end date and the carrier agrees to grant the request, the carrier should contact the designated Exchange enrollment analyst. The carrier should not make any changes to the enrollment until a file is received from WAHBE to update the start or end date.

ENR-010 Subscriber start date does not match WAHBE value
Scenario 1: Carrier start date is earlier than WAHBE start date
Assigned to: Carrier
• WAHBE Add sent with enrollment start date of 3/1 • WAHBE Change is sent with new enrollment start date of 4/1 • Audit received from reflects enrollment start date of 3/1
Expected Outcome: Carrier corrects enrollment start date to 2/1 per WAHBE Change
Scenario 2: Carrier start date is later than WAHBE start date
Assigned to: Carrier
• WAHBE Add sent with enrollment start date of 3/1 • WAHBE Change is sent with new enrollment start date of 2/1 • Audit received from carrier reflects enrollment start date of 3/1
Expected Outcome: Carrier corrects enrollment start date to 2/1 per WAHBE Change
Scenario 3: Carrier incorrectly submits multiple PolicyNodes
Assigned to: Carrier
• WAHBE Add sent with enrollment start date of 2/1 • WAHBE Change is sent updating tax credit amount effective 4/1 • Audit received from carrier includes a policy node from 2/1-3/31 and 4/1-12/31
Expected Outcome: Carrier submits a single policy node for coverage from 2/1-12/31

ENR-011 Subscriber end date does not match WAHBE value
Scenario 1: Carrier end date is later than WAHBE end date, last action WAHBE Term
Assigned to: Carrier
• WAHBE Add sent with enrollment start date of 1/1 • WAHBE Term is sent with policy end date 3/31

• Audit received from carrier reflects enrollment end date of 12/31
Expected Outcome: Carrier corrects enrollment record to reflect 3/31 end date per WAHBE Term
Scenario 2: Carrier end date is later than WAHBE end date, last action carrier reinstate
Assigned to: Carrier
• WAHBE Add sent with enrollment start date of 1/1 • Carrier terminates enrollment 5/31 for NP • Carrier subsequently reinstates enrollment • Carrier audit reflects enrollment end date 12/31, WAHBE reflects 5/31
Expected Outcome: Carrier sends 834 Reinstate to WAHBE **Dispute Permitted**
Scenario 3: Carrier end date is later than WAHBE end date, last action carrier term
Assigned to: Carrier
• WAHBE Add sent with enrollment start date of 1/1 • Carrier terminates enrollment 5/31 for NP • Carrier reinstates enrollment • Carrier terminates enrollment 7/31 for NP • Carrier audit reflects enrollment end date 7/31, WAHBE reflects 5/31
Expected Outcome: Carrier first sends 834 Reinstate to WAHBE. Once positive acknowledgement is received, carrier sends 834 Term to WAHBE. **Dispute Permitted**
Scenario 4: Carrier end date is earlier than WAHBE end date, last action Carrier Term
Assigned to: Carrier
• WAHBE Add sent with enrollment start date of 1/1 • WAHBE Term sent with enrollment end date 5/31 • Carrier terminates enrollment 3/31 for NP • Carrier audit reflects enrollment end date 3/31, WAHBE reflects 5/31
Expected Outcome: Carrier sends 834 Termination to WAHBE **Dispute Permitted**
Scenario 5: Carrier end date is earlier than WAHBE end date, last action WAHBE Reinstate
Assigned to: Carrier
• WAHBE Add sent with enrollment start date of 1/1 • WAHBE Term is sent with enrollment end date 4/30 • WAHBE Reinstate is sent • Audit received from carrier reflects enrollment end date 4/30, WAHBE reflects 12/31
Expected Outcome: Carrier processes reinstatement per WAHE Reinstate
Scenario 6: Carrier incorrectly submits multiple PolicyNodes
Assigned to: Carrier
• WAHBE Add sent with enrollment start date of 2/1 • WAHBE Change is sent updating tax credit amount effective 4/1 • Audit received from carrier includes a policy node from 2/1-3/31 and 4/1-12/31
Expected Outcome: Carrier submits a single policy node for coverage from 2/1-12/31
Scenario 7: Carrier end date is earlier than WAHBE end date, SEP denial

Assigned to: Carrier
• WAHBE Add sent with enrollment start date of 2/1 • Subscriber is undergoing or has undergone SEP verification by carrier • Carrier audit reflects enrollment end date 2/1, WAHBE reflects 12/31
Expected Outcome: Once SEP verification period has ended, carrier communicates SEP denial to WAHBE *Dispute Permitted*
Scenario 8: Carrier end date is later than WAHBE end date, SEP reinstatement
Assigned to: Carrier
• WAHBE Add sent with enrollment start date of 3/1 • Carrier submits SEP denial to WAHBE • WAHBE Term sent cancelling enrollment 3/1-3/1 • Carrier overturns SEP denial • Carrier audit reflects enrollment end date 12/31, WAHBE reflects 3/1
Expected Outcome: Carrier communicates SEP reinstatement to WAHBE *Dispute Permitted*

ENR-016 Plan ID does not match WAHBE value
Scenario 1: Plan ID submitted in carrier roster does not match WAHBE roster
Assigned to: Carrier
• WAHBE Add sent with Plan ID 1234 for Enrollment 5552241 • Audit received from carrier reflects Plan 8721 for Enrollment 5552241
Expected Outcome: Carrier should ensure correct CMS Plan ID is mapped to the 834 Add received from WAHBE

3.2.6 Financial Information

The current values for each of the elements below will be compared for all financial periods within the policy dates.

- Financial Effective Start Date
- Financial Effective End Date
- Monthly Total Premium Amount
- Monthly APTC Amount
- Monthly State Subsidy Amount
- Monthly Total Responsibility Amount
- Monthly CSR Amount

Monthly CSR Tier**FIN-001** Financial information node missing
Scenario 1: Financial node not found in carrier roster, present in WAHBE roster
Assigned to: Carrier
• WAHBE Add sent with enrollment start date of 1/1 • WAHBE Change sent with updated financials effective 4/1

• Audit received from carrier does not include a FinancialInformation node
Expected Outcome: Carrier submits financial node for 1/1-3/31 and 4/1-12/31 on next audit submission

FIN-003 CSR tier does not match WAHBE value for YYYY-MM-DD
Scenario 1: CSR tier submitted in carrier audit does not match WAHBE roster
Assigned to: Carrier
• WAHBE Add sent with enrollment start date of 1/1 and CSR T1 • WAHBE Change sent with monthly CSR T4 effective 3/1 • WAHBE Change sent with monthly CSR T5 effective 5/1 • Audit received from carrier reflects monthly CSR T1 effective 1/1-2/28 and monthly CSR T4 effective 3/1-12/31
Expected Outcome: Carrier corrects enrollment record to reflect monthly CSR T1 effective 1/1-2/28, monthly CSR T4 effective 3/1-4/30, and monthly CSR T5 effective 5/1-12/31 per WAHBE Change **Dispute Permitted**

FIN-008 Responsible amount does not match WAHBE value for YYYY-MM-DD
Scenario 1: Responsible amount submitted in carrier audit does not match WAHBE roster
Assigned to: Carrier
• WAHBE Add sent with $50 monthly responsible amount effective 1/1 • WAHBE Change sent with $100 monthly responsible amount effective 4/1 • Audit received from carrier reflects $50 responsible amount effective 1/1-12/31
Expected Outcome: Carrier corrects enrollment record to reflect $50 responsible amount effective 1/1-3/31 and $100 responsible amount effective 4/1-12/31 per WAHBE Change **Dispute Permitted**

FIN-013 Premium amount does not match WAHBE value for YYYY-MM-DD
Scenario 1: Premium amount submitted in carrier audit does not match WAHBE roster
Assigned to: Carrier
• WAHBE Add sent with $975 monthly premium effective 1/1 • WAHBE Change sent with $1072 monthly premium effective 4/1 • Audit received from carrier reflects $975 monthly premium effective 1/1-12/31
Expected Outcome: Carrier corrects enrollment record to reflect $975 monthly premium effective 1/1-3/31 and $1072 monthly premium effective 4/1-12/31 per WAHBE Change **Dispute Permitted**

FIN-018 CSR amount does not match WAHBE value for YYYY-MM-DD
Scenario 1: CSR amount submitted in carrier audit does not match WAHBE roster
Assigned to: Carrier

• WAHBE Add sent with $105 monthly CSR amount effective 1/1 • WAHBE Change sent with $160 monthly CSR amount effective 5/1 • Audit received from carrier reflects $50 responsible amount effective 1/1-12/31
Expected Outcome: Carrier corrects enrollment record to reflect $105 monthly CSR amount effective 1/1-4/30 and $160 monthly CSR amount effective 5/1-12/31 per WAHBE Change **Dispute Permitted**

FIN-024 APTC amount does not match WAHBE value for YYYY-MM-DD
Scenario 1: APTC amount submitted in carrier audit does not match WAHBE roster
Assigned to: Carrier
• WAHBE Add sent with $200 monthly APTC effective 1/1 • WAHBE Change sent with $330 monthly APTC effective 4/1 • Audit received from carrier reflects $200 monthly APTC effective 1/1-12/31
Expected Outcome: Carrier corrects enrollment record to reflect $200 monthly APTC effective 1/1-3/31 and $330 monthly APTC effective 4/1-12/31 per WAHBE Change **Dispute Permitted**

FIN-025 State Subsidy amount does not match WAHBE value for YYYY-MM-DD
Scenario 1: State Subsidy amount submitted in carrier audit does not match WAHBE roster
Assigned to: Carrier
• WAHBE Add sent with $100 monthly State Subsidy effective 1/1 • WAHBE Change sent with $155 monthly State Subsidy effective 4/1 • Audit received from carrier reflects $100 monthly State Subsidy effective 1/1-12/31
Expected Outcome: Carrier corrects enrollment record to reflect $100 monthly State Subsidy effective 1/1-3/31 and $155 monthly State subsidy effective 4/1-12/31 per WAHBE Change **Dispute Permitted**

3.2.7 Member Information

The following member elements are compared:

- Birth Date
- Sex assigned at birth code
- Disability Code

Per the *Carrier Enrollment Payment and Process Guide (EPPG)* section 4.1, customers must contact the Exchange to update their enrollment information, including birth date, sex assigned at birth, and disability status.

MEM-005 Subscriber date of birth does not match WAHBE value
Scenario 1: Subscriber date of birth submitted in carrier roster does not match WAHBE roster
Assigned to: Carrier
• WAHBE Add sent with date of birth 2/22/1982 for Subscriber • Audit received from carrier reflects date of birth 2/24/1982 for Subscriber

Expected Outcome: Carrier updates enrollment record to correct birth date to 2/22/1982 for Subscriber
Scenario 2: Subscriber date of birth submitted in carrier roster does not match WAHBE roster
Assigned to: Carrier
• WAHBE Add sent with date of birth 3/22/1972 for Subscriber • WAHBE Change sent with date of birth 3/21/1972 for Subscriber • Audit received from carrier reflects date of birth 3/22/1972 for Subscriber
Expected Outcome: Carrier updates enrollment record to correct birth date to 3/21/1972 for Subscriber per WAHBE Change

MEM-006 Subscriber sex assigned at birth does not match WAHBE value
Scenario 1: Subscriber sex assigned at birth submitted in carrier roster does not match WAHBE roster
Assigned to: Carrier
• WAHBE Add sent with sex assigned at birth code = M for Subscriber • Audit received from carrier reflects sex assigned at birth code = F for Subscriber
Expected Outcome: Carrier updates enrollment record to correct sex assigned at birth code = M for Subscriber
Scenario 2: Subscriber sex assigned at birth submitted in carrier roster does not match WAHBE roster
Assigned to: Carrier
• WAHBE Add sent with sex assigned at birth code = F for Subscriber • WAHBE Change sent with sex assigned at birth code = M for Subscriber • Audit received from carrier reflects sex assigned at birth code = F for Subscriber
Expected Outcome: Carrier updates enrollment record to correct sex assigned at birth code = F for Subscriber per WAHBE Change

3.2.8 Missing

The missing from intake discrepancy type is the result of an enrollment found in WAHBE's full roster but missing from the carrier full roster submission.

MFI-001 or MFI-002 Enrollment found on WAHBE roster not included in carrier audit submission
Scenario 1: Last action WAHBE Add
Assigned to: Carrier
• WAHBE Add sent • Audit received from carrier does not contain enrollment
Expected Outcome: Carrier processes WAHBE Add and includes enrollment in next audit submission
Scenario 2: Last action carrier SEP denial
Assigned to: Carrier
• WAHBE Add sent • Subscriber is undergoing or has undergone SEP verification by carrier and was denied

• Audit received from carrier does not contain enrollment
Expected Outcome: Carrier communicates SEP denial to WAHBE. Carrier should include all policies, including cancelled, in next full roster audit submission.
Scenario 3: Cancelled enrollment
Assigned to: Carrier
• WAHBE Add sent for HH with coverage effective 1/1 • Enrollment cancelled by WAHBE or carrier • Audit received from carrier does not contain enrollment
Expected Outcome: Carrier should include all policies, including cancelled, in next full roster audit submission

3.2.9 New in Intake

The new in intake discrepancy type is the result of a policy included in the carrier full roster submission but not found in the WAHBE full roster. This may be the result of an incorrect combination of subscriber and enrollment identifiers, or due to an enrollment being sent in with the incorrect CMS plan ID or plan year.**NEW-001** Enrollment included in carrier audit submission not found on WAHBE roster
Scenario 1: Enrollment not found on WAHBE roster
Assigned to: Carrier
• Add from WAHBE does not exist for the specified subscriber/policy combination • Subscriber/policy combination included in carrier submission • WAHBE is unable to match the given combination to a policy in the database
Expected Outcome: Carrier should ensure subscriber/enrollment identifiers and CMS Plan ID map to an 834 Add received from WAHBE
Scenario 2: Enrollment sent with prior year Plan ID
Assigned to: Carrier
• Member completes active renewal, changing from Plan A in 20X1 to Plan B in 20X2 with the same carrier • Add is sent for Plan B with new Exchange-Assigned Policy ID for 20X2 • Carrier audit includes CMS Plan ID for Plan A for 20X2 enrollment
Expected Outcome: Carrier should ensure subscriber/enrollment identifiers and CMS Plan ID map to an 834 Add received from WAHBE

3.2.10 Policy Status

Effectuation status is compared for each policy.

PST-001 Policy Status does not match WAHBE value
Scenario 1: Carrier uneffectuated, WAHBE effectuated
Assigned to: Carrier
• WAHBE Add sent with 1/1 start date • Enrollment is auto-effectuated by WAHBE

- Audit received from carrier has effectuation indicator = N and WAHBE has effectuation indicator = Y

Expected Outcome: Carrier updates enrollment record to reflect effectuated status

Scenario 2: Carrier effectuated, WAHBE uneffectuated

Assigned to: Carrier

- WAHBE Add sent with 1/1 start date
- Carrier receives binding payment from customer
- Audit received from carrier has effectuation indicator = Y and WAHBE has effectuation indicator = N

Expected Outcome: Carrier to send 834 Confirm file to WAHBE
Dispute Permitted

Scenario 3: Carrier effectuated, WAHBE uneffectuated

Assigned to: Carrier

- WAHBE Add sent with 1/1 start date
- Carrier does not receive binding payment from customer and cancels for nonpayment
- Carrier subsequently reinstates enrollment
- Audit received from carrier has effectuation indicator = Y and WAHBE has effectuation indicator = N

Expected Outcome: Carrier to send 834 Confirm file to WAHBE after reinstating coverage; the reinstate transaction does not automatically include a confirm action
Dispute Permitted

3.2.11 Sponsor Information

The current value for this element will be compared only when a third-party sponsor exists:

- Third-Party Sponsor Name

SPN-003
Sponsor identifier does not match WAHBE value

Scenario 1: Third-party sponsor not found in carrier roster, present in WAHBE roster

Assigned to: Carrier

- WAHBE Add sent with third-party sponsor
- Audit received from carrier does not include third-party sponsor

Expected Outcome: Carrier corrects enrollment record to reflect third-party sponsor per WAHBE Add

Scenario 2: Third-party sponsor not found in carrier roster, present in WAHBE roster

Assigned to: Carrier

- WAHBE Add sent without third-party sponsor
- WAHBE Change sent including third-party sponsor
- Audit received from carrier does not include third-party sponsor

Expected Outcome: Carrier corrects enrollment record to reflect third-party sponsor per WAHBE Change

SPN-006

Sponsor identifier does not match WAHBE value
Scenario 1: Third-party sponsor found in carrier roster, but does not match WAHBE roster
Assigned to: Carrier
• WAHBE Add sent with third-party sponsor • WAHBE Change sent updating to new third-party sponsor • Audit received from carrier includes original third-party sponsor
Expected Outcome: Carrier corrects enrollment record to remove third-party sponsor per WAHBE Change

SPN-007 Sponsor identifier does not match WAHBE value
Scenario 1: Third-party sponsor present in carrier roster, not found in WAHBE roster
Assigned to: Carrier
• WAHBE Add sent with third-party sponsor • WAHBE Change sent removing third-party sponsor • Audit received from carrier includes third-party sponsor
Expected Outcome: Carrier corrects enrollment record to remove third-party sponsor per WAHBE Change

4.0 Dispute Process

4.1 Assumptions

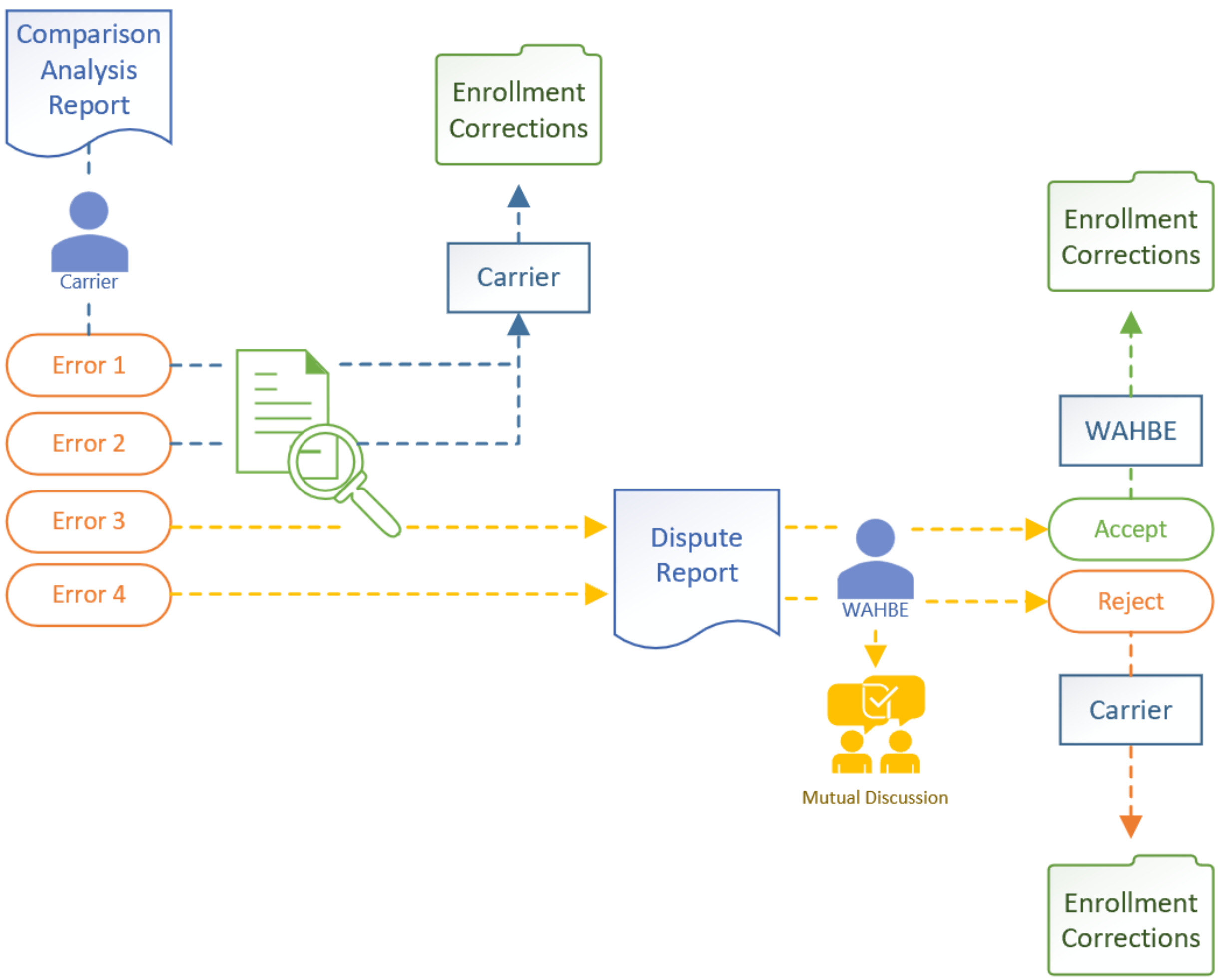
The following assumptions apply to all dispute scenarios:

- In scenarios where the last action prior to the audit submission was by the carrier:
  - More than 5 business days have elapsed between the last transaction file submission and the audit comparison
  - The carrier received positive TA1 and 999 acknowledgements for the file and transaction in question
  - The carrier has corrected all individual enrollment transaction errors that fail due to business validation
  - More than 10 business days have elapsed following communication of a household or member SEP denial
- In scenarios where the last action prior to the audit submission was by WAHBE:
  - More than 5 business days have elapsed between the last transaction file submission and the audit comparison
  - The carrier has processed all WAHBE files correctly and timely
  - The carrier has corrected all individual enrollment transaction errors that fail due to business validation

4.2 Dispute Process Overview

- Carrier disputes regarding findings from the comparison analysis report are due no later than the last day of the initial 10-business-day review period.
- Disputes must be submitted using the Carrier Dispute Template and should follow the naming convention “[Carrier Name or TIN] Comparison Disputes MM.YYYY”, where the month corresponds to the month of audit submission.
- Disputes must be emailed to the designated enrollment analyst and cc: enrollmentleads@wahbexchange.com

The Exchange enrollment analyst will review disputes and report on initial findings within an additional five business days. Further review may continue until 2 business days prior to the start of the next audit submission window. Rejected disputes will be returned to the carrier for correction, while accepted disputes will be processed by the Exchange.



4.4 Permissible Disputes

Carriers may only dispute specific scenarios for select error codes. To promote efficient analysis, the carrier should use the exact text provided for a dispute reason. When submitting a dispute, the carrier must provide file names, dates, or other data in the “Carrier Notes” column of the dispute report as described for each dispute scenario.

4.3.1 Dependent Disputes

- DEP-001: Dependent [Member PID] present or missing from intake audit; mismatch with WAHBE roster
        - Scenario 2: If a dependent has undergone SEP verification and the SEP was denied, the carrier may dispute this error provided at least 10 business days have elapsed since the SEP denial was communicated to WAHBE*Dispute Reason:* SEP denial
        - *Carrier Notes*: provide the date of the SEP denial report/notification and list the applicable dependent member ID
- DEP-016: Dependent [Member PID] start date does not match WAHBE value
    - Scenario 4: If a dependent has a gap in coverage on a single enrollment ID and the carrier correctly reflects two spans of coverage, but WAHBE only reflects a single span of coverage, the carrier may dispute the error
        - *Dispute Reason:* Dependent gap in coverage
        - *Carrier Notes*: list the applicable dependent member ID
- DEP-017: Dependent [PID] end date does not match WAHBE value
    - Scenario 5: If a dependent has a gap in coverage on a single enrollment ID and the carrier correctly reflects two spans of coverage, but WAHBE only reflects a single span of coverage, the carrier may dispute the error
        - *Dispute Reason*: Dependent gap in coverage
        - *Carrier Notes*: list the applicable dependent member ID

4.3.2 Enrollment Disputes

- ENR-011: Subscriber end date does not match WAHBE value
    - Scenario 2: Carrier end date is later than WAHBE end date, last action carrier reinstate. The carrier may dispute this error, provided more than 5 business days have elapsed since the file containing the reinstate was submitted and the carrier received positive acknowledgements for the file and transaction.
        - *Dispute Reason:* Enrollment reinstated
        - *Carrier Notes:* Name of the file containing the enrollment reinstatement
    - Scenario 3: Carrier end date is later than WAHBE end date, last action carrier term. The carrier may dispute this error, provided more than 5 business days have elapsed since the file containing the termination was submitted and the carrier received positive acknowledgements for the file and transaction
        - *Dispute Reason:* Enrollment terminated for nonpayment
        - *Carrier Notes:* Names of the files containing the original termination date, the subsequent reinstatement, and the new termination date.
    - Scenario 4: Carrier end date is earlier than WAHBE end date, last action carrier term. The carrier may dispute this error, provided more than 5 business days have elapsed since the file containing the termination was submitted and the carrier received positive acknowledgements for the file and transaction.
        - *Dispute Reason:* Enrollment terminated for nonpayment
        - *Carrier Notes*: Name of the file containing the enrollment termination

- Scenario 7: Carrier end date is earlier than WAHBE end date, SEP denial. If a subscriber has undergone SEP verification and the SEP was denied, the carrier may dispute this error provided at least 10 business days have elapsed since the SEP denial was communicated to WAHBE
  - *Dispute Reason*: SEP denial
  - *Carrier Notes:* provide the date of the SEP denial report/notification
- Scenario 8: Carrier end date is later than WAHBE end date, SEP reinstatement. If a SEP was denied and then subsequently overturned, the carrier may dispute this error provided at least 10 business days have elapsed since the SEP reinstatement was communicated to WAHBE
  - *Dispute Reason*: SEP reinstatement
  - *Carrier Notes*: provide the date of the SEP reinstatement report/notification

4.3.3 Financial Disputes

- FIN-003: CSR tier does not match WAHBE value for YYYY-MM-DD
  - Scenario 1: CSR tier submitted in carrier audit does not match WAHBE roster. The carrier may dispute this error, provided the carrier's information matches the latest WAHBE file received and that all carrier exceptions or errors for WAHBE files or policies have been resolved.
    - *Dispute Reason:* Carrier CSR tier matches latest WAHBE file
    - *Carrier Notes:* Name of the last WAHBE file received which updated the enrollment
- FIN-008: Responsible amount does not match WAHBE value for YYYY-MM-DD
  - Scenario 1: Responsible amount submitted in carrier audit does not match WAHBE roster. The carrier may dispute this error, provided the carrier's information matches the latest WAHBE file received and that all carrier exceptions or errors for WAHBE files or policies have been resolved.
    - *Dispute Reason:* Carrier responsible amount matches latest WAHBE file
    - *Carrier Notes:* Name of the last WAHBE file received which updated the enrollment
- FIN-013: Premium amount does not match WAHBE value for YYYY-MM-DD
  - Scenario 1: Premium amount submitted in carrier audit does not match WAHBE roster. The carrier may dispute this error, provided the carrier's information matches the latest WAHBE file received and that all carrier exceptions or errors for WAHBE files or policies have been resolved.
    - *Dispute Reason:* Carrier premium amount matches latest WAHBE file
    - *Carrier Notes:* Name of the last WAHBE file received which updated the enrollment
- FIN-018: CSR amount does not match WAHBE value for YYYY-MM-DD
  - Scenario 1: CSR amount submitted in carrier audit does not match WAHBE roster. The carrier may dispute this error, provided the carrier's information matches the latest WAHBE file received and that all carrier exceptions or errors for WAHBE files or policies have been resolved.
    - *Dispute Reason:* Carrier CSR amount matches latest WAHBE file
    - *Carrier Notes:* Name of the last WAHBE file received which updated the enrollment
- FIN-024: APTC amount does not match WAHBE value for YYYY-MM-DD
  - Scenario 1: APTC amount submitted in carrier audit does not match WAHBE roster. The carrier may dispute this error, provided the carrier's information matches the latest WAHBE file

received and that all carrier exceptions or errors for WAHBE files or policies have been resolved.
    - *Dispute Reason:* Carrier APTC amount matches latest WAHBE file
    - *Carrier Notes:* Name of the last WAHBE file received which updated the enrollment

- FIN-025: State subsidy amount does not match WAHBE value for YYYY-MM-DD
  - Scenario 1: State Subsidy amount submitted in carrier audit does not match WAHBE roster. The carrier may dispute this error, provided the carrier's information matches the latest WAHBE file received and that all carrier exceptions or errors for WAHBE files or policies have been resolved.
    - *Dispute Reason:* Carrier State Subsidy amount matches latest WAHBE file

***Carrier Notes:* Name of the last WAHBE file received which updated the enrollment**

4.3.4 Policy Disputes

- PST-001: Policy status does not match WAHBE value
  - Scenario 2 and Scenario 3: Carrier effectuated, WAHBE uneffectuated. The carrier may dispute this error, provided more than 5 business days have elapsed since the file containing the confirm was submitted, and the carrier received positive acknowledgements for the file and transaction
    - *Dispute Reason*: Enrollment confirmed
    - *Carrier Notes*: Name of the file containing the enrollment confirmation