2016 Participation

Washington Health Benefit Exchange
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GUIDANCE FOR PARTICIPATION IN THE WASHINGTON HEALTH BENEFIT EXCHANGE

March 2015

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SECTION 1: INTRODUCTION

This Guidance for Participation specifies how a health insurance issuer can participate in Washington Healthplanfinder (HPF), Washington's State Health Benefit Exchange (WAHBE). An issuer may participate in the individual Exchange by offering qualified health plans (QHPs) through the open enrollment period, November 1, 2015—January 31, 2016, for coverage in plan year 2016. An issuer may also offer QHPs through the Small Business Health Options Program (SHOP) that covers small-employer groups in Washington State. A separate section in this document provides guidance to issuers who want to participate in SHOP.

The Guidance will provide information on the following:

- Certifying and recertifying a health plan to become a QHP;
- Monitoring and compliance of QHPs;
- Decertifying a QHP;
- Special guidance for coverage of American Indian/Alaska Natives.

The Patient Protection and Affordable Care Act of 2010 (ACA) authorized the creation of State-based Marketplaces also known as Exchanges. The Washington State Legislature established WAHBE by enacting Substitute Senate Bill 5445. WAHBE is governed by an eleven member Board consisting of nine voting Board members and two non-voting, ex-officio members, the Washington State Insurance Commissioner and the Director of the Washington State Health Care Authority. The WAHBE Board is authorized by the Legislature to certify QHPs offered through HPF using 19 certification criteria.

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

1.1 Glossary

WAHBE applied the standard definitions found within the Affordable Care Act and subsequent guidance whenever possible.

"ACTUARIAL VALUE"

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

"AFFORDABLE CARE ACT"

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

"APPEAL"

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

"ENROLL"

The point at which an individual is covered for benefits under a QHP, without regard to when the individual may have completed or filed any forms that are required to become covered by the health plan.

"ENROLLEE"

Qualified individual or qualified employee enrolled in a QHP.

"EXPIRE"

The point at whcih a QHP issuer does not elect to seek recertification of a QHP offered through Healthplanfinder. This act by the QHP issuer will constitute "non-renewal of recertification" (45 CFR §156.290).

"HEALTH BENEFIT EXCHANGE BOARD"

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

"HEALTH INSURANCE ISSUER" OR "ISSUER"

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

(In this document, Issuer refers to a health insurance company, **Product** to a suite of plans that share, for example, a common set of health benefits, and Health Plan refers to the actual insurance coverage purchased by a consumer. The document does not refer to health insurance companies as "the plans" or "the health plans.")

"HEALTH PLAN"

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

"NAVIGATOR"

An organization that has been awarded a grant by the Exchange to carry out activities and meet the standards described in 45 CFR §155.210. Navigator representatives are qualified, trained, and certified to engage in education, outreach and facilitation of selection of a QHP by a consumer for Healthplanfinder.

"OPEN ENROLLMENT"

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

As of publication of this Guidance, proposed federal rules provide that Open Enrollment for 2015 coverage is an extended period from October 1, 2015 through December 15, 2015.

SHOP open enrollment begins 90 days prior to the group's renewal date for the employer and 60 days prior to the group's renewal date for the employees.

1.1 Glossary
(Continued)

"PLAN YEAR"
The consecutive 12-month period during which a health plan provides coverage for health benefits. For individuals, it is the calendar year, and for SHOP it is the 12-month period beginning with the qualified employer's effective date of coverage.

"PRODUCER"
A person licensed by the OIC as an agent or solicitor to sell or service insurance policies.

"QUALIFIED HEALTH PLAN OR QHP"
A health plan that is certified by an Exchange.

"QUALIFIED HEALTH PLAN ISSUER OR QHP ISSUER"
A health insurance issuer that provides coverage through a qualified health plan offered through Healthplanfinder.

"SHOP"
The Small Business Health Options Program operated by an Exchange through which a qualified employer can provide its employees and their dependents with access to one or more QHPs.

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

"WASHINGTON HEALTHPLANFINDER" OR "HEALTHPLANFINDER"
The marketplace in Washington State where qualified individuals and small employers can shop for and purchase Qualified Health Plans (QHP).

1.2 Overview of Guidance

1.2.1 Objective

The purpose of this Guidance is to provide health insurance issuers the foundational information needed to offer individual and/or SHOP QHPs through Healthplanfinder. The certification criteria set forth within this document do not supersede a QHP issuer's responsibility to provide coverage based upon state and federal laws and rules. While the Guidance specifies some, but not all, federal and state laws or regulations that apply to offering health insurance coverage through Healthplanfinder, this document does not release a QHP issuer from complying with all relevant state and federal laws. Please see Appendix I for a directory of Federal rules issued under the ACA.

The Guidance will also specify how WAHBE will apply the certification criteria to a health plan. To be certified, a QHP must:

- Be approved by the OIC;
- Satisfy the certification criteria specified by the Washington State Legislature; and
- Satisfy the minimum federal requirements of a QHP as outlined in 45 CFR parts §155 and §156.

To participate in the Exchange, a QHP issuer must meet the legal requirements of offering health insurance in Washington State. A QHP issuer must also sign a Participation Agreement with WAHBE to participate in Healthplanfinder.

1.2.2 Term of Engagement

An Individual or SHOP health insurance plan certified or recertified as a QHP will be offered through Healthplanfinder. New and renewed individual plans will be available beginning November 1, 2015 with an initial effective date of coverage beginning no sooner than January 1, 2016. The date when SHOP plans will be made available for plan year 2016 will be announced in a separate communication.

Health insurance issuers, responding to this Guidance, will offer certified or recertified individual QHPs for a term of one year beginning January 1, 2016 and ending December 31, 2016. Only OIC approved health plans certified by the Board may be offered as QHPs through Healthplanfinder during this period.

1.2.3 Contact

Your contact at WAHBE for this document is Susanne Towill, Senior Plan Manager, Operations Division. Please direct all questions regarding plan management and this document to Susanne Towill at (360) 688-7789 or QHP@WAHBExchange.org.

1.2 Overview of Guidance
(Continued)

1.2.4 Plan Management Timeline and Letter of Intent

An issuer is recommended to inform WAHBE of its intent to participate in Healthplanfinder. Submitting a letter of intent is nonmandatory and nonbinding, but will help the WAHBE prepare for the certification process and Open Enrollment. WAHBE is not requesting that an issuer indicate the specific health plans it intends to offer through Healthplanfinder. Please, however, inform WAHBE of the markets (Individual and/or SHOP) in which your organization intends to offer QHPs. WAHBE also requests that issuers include a list of counties that they intend to serve in their Letter of Intent. An issuer may submit a letter of intent to WAHBE at QHP@WAHBExchange.org.

Plan Management Timeline

Please click on the following link to access WAHBE plan management materials where you will find the most recent plan management timeline:

http://wahbexchange.org/partners/insurance-carriers/plan-management-workgroup/

1.3 Participating in Healthplanfinder

A QHP issuer may participate in WAHBE's Individual market, SHOP market, or both. An issuer is not required to participate in the same markets inside and outside of Healthplanfinder.

1.3.1 Initial Certification of Qualified Health Plans

WAHBE intends to certify QHPs annually and only those health plans certified or recertified by WAHBE may be offered as QHPs through Healthplanfinder.

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

An issuer will need to enter into a Participation Agreement with WAHBE before offering QHPs through Healthplanfinder. The terms of the Participation Agreement will incorporate the health plan certification criteria described in this Guidance. WAHBE, in addition to the Legislature, reserves discretion to modify and amend the terms and conditions of current QHP certification criteria and how they may be applied in the certification or decertification process, consistent with current laws and rules, at any time up to and including the execution of issuer Participation Agreements.

Prior to publishing plan offerings, an issuer will need to enter into an Electronic Data Interchange (EDI) Trading Partner Agreement and one or more EDI interfaces will need to be tested between the issuer and WAHBE. These steps will ensure that the issuer and WAHBE will be able to communicate enrollment data to and from each other. Two hardcopies of the EDI Trading Partner Agreements should be sent to WAHBE; WAHBE will sign both and return one to the issuer. EDI Trading Partner Agreements need to be submitted only by issuers new to WAHBE and have not previously offered plans through Healthplanfinder.

1.3.2 Recertification of Qualified Health Plans

WAHBE intends to recertify a QHP annually and must complete the recertification process by the ACA deadline of September 15 of the applicable calendar year (45 CFR §155.1075(b)). The recertification process will involve a review of the certification criteria reflected in this document.

1.3.3 Submitting Health Plans to Become Certified as a QHP

The WAHBE certification process begins when an issuer submits a rate and form filing to the OIC for regulatory review and approval of a health plan. Please refer to the OIC for information on how and where to submit the rate and form filing for a health plan.

SECTION 2: SPECIFICATIONS FOR PARTICIPATION

2.1 Summary of Initial Certification and Recertification Criteria

To participate in WAHBE's QHP certification process, an issuer will need to submit plans and supporting documentation as specified for each criterion. The following chart summarizes the nineteen criteria to be applied in the certification process of a QHP. Each criterion is reviewed and approved by either the OIC or WAHBE.

Table 1

Summary of Initial Certification and Recertification Criteria

No.	Criteria Level	Criteria	Reviewed by OIC or WAHBE?	Initial Certification Criteria	Recertification Criteria?
1.	Issuer	Issuer must be in good standing	OIC	Yes	Yes
2.	Issuer	Issuer must pay user fees, if QHPs assessed	WAHBE	Yes	Yes
3.	Issuer	Issuer must comply with the risk management programs	WAHBE	Yes	Yes
4.	Issuer	Issuer must comply with market rules on offering plans	OIC	Yes	Yes
5.	Issuer	Issuer must comply with non-discrimination rules	OIC	Yes	Yes
6.	Issuer	Issuer must be accredited by an entity that the federal Department of Health and Human Services recognizes for accreditation of health plans within the specified timeframe	WAHBE	Yes	Yes
7.	Product	QHP must meet marketing requirements	WAHBE	Yes	Yes
8.	Product	QHP must meet network adequacy requirements which will include essential community providers	OIC	Yes	Yes
9.	Product	Issuer must submit health care provider directory data	WAHBE	Yes	Yes
10.	Product	Issuer must implement a quality improvement strategy	WAHBE	Yes	Yes
11.	Product	Issuer must submit health plan data to be used in a standard format for presenting health benefit plan options	WAHBE	Yes	No
12.	Product	Issuer must report quality and health performance	WAHBE	Yes	Yes
13.	Product	Issuer must use a standard enrollment form	OIC	Yes	Yes
14.	Product	Issuer may only contract with a hospital with more than 50 beds if the hospital utilizes a patient safety evaluation system	OIC	Yes	Yes
15.	Product	Services provided under a QHP through a Direct Primary Care Medical Home must be integrated with the QHP issuer	OIC	Yes	Yes
16.	Plan	A QHP must comply with benefits design standards (e.g., cost sharing limits, "metal level" (Platinum, Gold, Silver, or Bronze), essential health benefits)	OIC	Yes	Yes
17.	Plan	Issuer must submit to the WAHBE a QHP's service area and rates for a plan year	OIC	Yes	Yes
18.	Plan	Issuer must post justifications for QHP premium increases	WAHBE	No	Yes
19.	Plan	Issuer must submit to the WAHBE QHP benefit and rate data for public disclosure	WAHBE	Yes	Yes

2.2 QHP Specifications

An issuer's health plan must satisfy the following criteria to become certified as a QHP offered through Healthplanfinder.

2.2.1 Licensed and Good Standing

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

The OIC determines if an issuer is in good standing. Please direct requests for a certificate of good standing to companysupervisionfilings@oic.wa.gov.
OIC determinations of good standing will be based on authority granted to the OIC by Title 48 RCW and Title 284 WAC. Such authority may include restricting an issuer's ability to issue new or renew existing coverage for an enrollee.

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

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

2.2.2 User Fee Adherence

In ESHB 1947, the Washington State Legislature designated a portion of premium tax receipts and a fee assessed on QHPs as sustainable funding for WAHBE's administrative expenses beginning in 2015.

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

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

2.2.3 Risk Management Programs

A QHP issuer must comply with the requirements of the reinsurance, risk corridors, and risk adjustment programs as specified in the ACA, standards set in federal rules 45 CFR part 153, state rules adopted by the OIC, and the annual Notice of Benefit and Payment Parameters published by the Department of Health and Human Services (HHS) or the OIC.

The OIC will monitor a QHP issuer's compliance with the risk management programs. If the OIC determines that a QHP issuer is no longer complying with the requirements of the risk management programs, and further determines that the QHP issuer will not resume full compliance with the requirements of the risk management programs, then WAHBE will decertify all of the QHP issuer's QHPs.

2.2.4 Market Rules for Offering QHPs

An issuer must comply with the market rules for offering Individual or SHOP QHPs set forth by the ACA or Washington State law, including the four metal levels of coverage designated in §1302 of the ACA.

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

Only a QHP issuer that satisfies the following market rules may offer QHPs through either market in Healthplanfinder:

- A QHP issuer must offer at least one QHP at the silver level and at least one QHP at the gold level.

- An issuer must offer a child-only plan at the same level of coverage as any QHP (which does not include catastrophic plans) offered through Healthplanfinder (45 CFR §156.200(c)(2)) to individuals who, at the start of the plan year, have not reached the age of 21.

- A health plan meeting the definition of a catastrophic plan in RCW 48.43.005 may only be sold through Healthplanfinder.

If the OIC determines that a QHP issuer is not complying with the market rules in either market within Healthplanfinder, and the OIC further determines that the QHP issuer will not resume compliance with the market rules, then WAHBE will decertify all of the issuer's QHPs in that market.

2.2.5 Non-discrimination

A QHP issuer must comply with federal and Washington State non-discrimination requirements. A QHP issuer may not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation (45 CFR §156.200(e)). An issuer may not provide essential health benefits if its benefit design also discriminates based on an individual's degree of medical dependency or quality of life (45 CFR §156.215).

The OIC will enforce non-discrimination requirements and monitor for noncompliance. If the OIC determines that a QHP issuer is not complying with the non-discrimination requirements, and the OIC further determines that the QHP issuer will not resume compliance with the non-discrimination requirements, then WAHBE will decertify all of the issuer's QHPs affected by that noncompliance.

2.2.6 Accreditation

For a plan to become certified as a QHP, the QHP issuer must meet a minimum level of accreditation by an accrediting entity recognized by HHS. WAHBE will verify an issuer's accreditation status for certification or recertification.

A QHP issuer must achieve the AAAHC, URAC or NCQA Exchange accreditation by the first accreditation renewal date after the QHP issuer's third certification process. If a QHP issuer does not maintain accreditation of a QHP as defined by WAHBE, then WAHBE must decertify that QHP.

WAHBE may offer a QHP prior to that health plan becoming Exchange-accredited in these two circumstances:

1. Offering a health plan as an accredited QHP

WAHBE will certify a health plan as accredited if one of the following statuses is held by an issuer for commercial insurance or Medicaid products:

- NCQA: excellent, commendable, accredited, provisional, or interim (interim is a new 18-month Exchange accreditation offered by NCQA). WAHBE will not recognize these NCQA statuses: denied, appealed by issuer, in process, revoked, scheduled, suspended, or expired.

- URAC: full, conditional, provisional, or corrective action. WAHBE will not recognize this URAC status: denial.

- AAAHC: Certificate of Accreditation. WAHBE will not recognize: denial.

2. Offering a health plan as an unaccredited QHP

During a new issuer's initial and next two certification processes, WAHBE may certify a health plan as an unaccredited QHP if the issuer satisfies the following:

- When submitting a health plan for certification, an issuer must attest that it will schedule the "Exchange accreditation" in the plan types (HMO, MCO, POS, or PPO) used in offering its QHPs.

- A QHP issuer must achieve "Exchange accreditation" and make provide proof of that accreditation before the beginning of the QHP issuer's third certification process. For example, if an unaccredited issuer began offering QHP coverage in the 2014 plan year, then it would need to achieve and document "Exchange accreditation" by the beginning of the certification process to be performed by WAHBE in 2016 for offering QHP coverage in the 2017 plan year.

2.2.7 Marketing

A QHP issuer will be encouraged to actively market products available through Healthplanfinder and to participate in joint marketing efforts with WAHBE, as applicable. WAHBE has created its own logo and logo mark (or "bug") that designates the certification of a QHP. An issuer can use the Healthplanfinder bug to co-brand QHP marketing materials or web pages in accordance with guidelines developed by WAHBE Communications. The logo or bug cannot be modified, and no other logo can be used to represent Healthplanfinder or QHP certification. WAHBE will review and approve the use of the logo or bug on an issuer's marketing materials. The QHP issuer will be able to review any WAHBE marketing materials that use the QHP issuer's logo.

A QHP issuer must submit for WAHBE approval one marketing document to post on Healthplanfinder for each QHP. In these marketing materials the QHP issuer may inform consumers that the plan is certified by WAHBE as a QHP. The QHP issuer cannot inform consumers that the certification of a QHP implies any form of further endorsement or support of the QHP. A QHP issuer and its officials, employees, agents and representatives must not employ marketing practices or benefit designs that may discourage the enrollment of individuals with preexisting conditions or significant health needs in QHPs (45 CFR §156.225(b)). A QHP issuer must submit marketing materials in both English and Spanish in PDF form.

QHP issuers will be expected to create marketing and enrollment materials in advance of the validation of plans to be offered in production. Marketing materials will not be displayed on Healthplanfinder if they do not conform to the standards set through this criterion.

2.2.8 Network Adequacy

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

- The network is sufficient in number and type of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay;

- Includes essential community providers in accordance with 45 CFR §156.235 or meets the alternate standard; and

- Is consistent with the network adequacy provisions of section 2702(c) of the PHS Act (45 CFR §156.230(a)) and WAC 284-43-200, *et. seq.,* and any subsequent rules issued by the OIC.

A QHP issuer may only contract with a hospital with more than 50 beds if the hospital utilizes a patient safety evaluation system. Hospital contracts must comply with this provision by January 1, 2015. The OIC will enforce network adequacy requirements and monitor for noncompliance. If the OIC determines that a QHP issuer is not complying with the network adequacy requirements, and the OIC further determines that the QHP issuer will not resume compliance with the network adequacy requirements, then the WAHBE will decertify all of the issuer's QHPs affected by that noncompliance. Please refer to the OIC for additional regulatory guidance on network adequacy.

2.2.9 Provider Directory

A QHP issuer must contribute data on the health care providers that participate in networks associated with

a QHP. Please make sure to include your issuer name in the name of your network when submitting provider directory data to eHealth.

2.2.10 Quality Improvement Strategy

Issuers are required to submit their quality improvement strategy in both PDF and Word Formats. The PDF format will be viewed by consumers and should include the issuer's logo and be formatted for direct upload to Healthplanfinder. WAHBE will provide issuers with a form to submit your quality improvement strategy in Word.

2.2.11 Standard Format for Presenting Health Benefit Plan Options

Issuers are required to provide WAHBE with a Summary of Benefits and Coverage (SBC) for each plan variant of a QHP, in English and Spanish, for display on Healthplanfinder. Issuers will need to use the new standard SBC form developed by the Department of Health and Human Services (HHS) effective for plan year 2016.

The naming convention for SBCs is:

- Plan year
- Carrier name
- Full plan name
- Metal level (if not included in plan name)
- Any cost share variant detail (73/87/94)
- AI/AN version, if so
- English or Spanish
- Draft or Final version
- Plan ID number

A QHP that provides coverage for abortion services must provide notice of that coverage on the SBC in the "other covered services" section (45 CFR 156.280(f)). If the QHP does not include abortion services, it should be listed under the "excluded services" section.

Issuers will include direct links to a plan's drug formulary in each SBC that must be accessible to consumers as defined by HHS in the 2016 Notice of Benefit and Payment Parameters.

Issuers will submit final SBCs in English and Spanish in a PDF document with English and Spanish versions of each plan variant.

Cross Mapping Form

WAHBE will implement plan cross-mapping in order to facilitate eligibility redeterminations and coverage renewals (including automatic renewals) in the individual market for both QHPs and QDPs. This includes circumstances where an issuer non-renews coverage under a particular plan (a "plan non-renewal") or discontinues coverage under a product (a "product discontinuation").

Issuers must perform cross-mapping in accordance with applicable state law and federal requirements. WAHBE will review for compliance with federal requirements set forth in 45 CFR 155.335.

Issuers will need to use WAHBE's Plan Cross-Mapping Submission Form to provide plan cross-mapping information; WAHBE is not using the CMS Plan Crosswalk Template.

2.2.12 Quality Measures

To satisfy this criterion, a QHP issuer will need to participate in the implementation of this rating system, including the disclosure and reporting of information on health care quality and outcomes described in §1311(c)(1)(H) and §1311(c)(1)(I) of the ACA, and the

2.2 QHP Specifications
(Continued)

implementation of appropriate enrollee satisfaction surveys consistent with §1311(c)(4) of the ACA (45 CFR §156.200(b)(5)). During 2015, QHP issuers are required to report quality measures specified by CMS as part of the 2015 Quality Rating System beta test. WAHBE will provide more information as it becomes available.

A QHP issuer will be required to participate in any additional quality reporting requirements that may be authorized by federal regulation and specified by WAHBE.

2.2.13 Standard Enrollment Form

The standard enrollment form for Washington State is based on the HHS standard enrollment form and is housed on the Health Care Authority's website. This form and the electronic enrollment application process within Healthplanfinder satisfy this criteria for QHP Issuers.

2.2.14 Hospital Patient Safety Contracts

A QHP issuer will satisfy this criterion by establishing an adequate health care provider network as specified in section 2.2.8 and further directions provided by the OIC.

2.2.15 Direct Primary Care Medical Homes

The ACA directs that a QHP may provide coverage through a qualified direct primary care medical home plan so long as the services covered by the medical home plan are coordinated with the QHP issuer. The federal rules further establish a coordination criterion to be used if a direct primary care medical home is submitted with a QHP.

State law, Chapter 48.150 RCW, however, specifies that a direct primary care medical home must be integrated with an issuer's QHP. If a QHP filing contains a direct primary care medical home, then WAHBE will recognize the OIC's approval of the plan to confirm that the medical home is integrated with the QHP.

2.2.16 Benefit Design Standards

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

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

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

2.2.17 Service Areas and Rating Requirements

The QHP service area must be established without regard to racial, ethnic, language, or health-status related factors specified under section 2705(a) of the Public Health Service Act, or other factors that exclude specific high utilization, high cost, or medically-underserved populations (45 CFR §155.1055(b)). A QHP service area will be set by county or counties; however, an issuer demonstrating good cause, as specified in WAC 284-43-130, may set a QHP service area by zip codes. Good cause includes geographic barriers within a service area, or other conditions that make offering coverage throughout an entire county unreasonable. Consumers will be able to identify a service area by providing a zip code or county in Healthplanfinder.

WAHBE will display the rates on the Healthplanfinder web pages. The OIC will approve a QHP issuer's health plan rates for an entire benefit or plan year. Approval of a plan by the OIC will confirm that a QHP has met the service area standards.

2.2 QHP Specifications
(Continued)

2.2.18 Posting Justifications for Premium Increases

QHP issuers must provide premium increase justifications as part of the regulatory rate filing procedure. The OIC posts this justification, along with its own summary of the premium increase justification for the public. The submission of the justification to the OIC will satisfy this criterion for an issuer submitting a plan to become a certified QHP.

2.2.19 Reporting Data

As part of the OIC regulatory filing process, a QHP issuer must use the federally supplied data templates during the SERFF filing process. The OIC will forward the data for approved plans to WAHBE after plan regulatory approval has been completed.

WAHBE will use these templates to populate Healthplanfinder with rates, benefits, service area, and provider network names. WAHBE will not alter the data within these templates without written direction from the OIC.

The discontinuation of premium aggregation through Healthplanfinder will necessitate changing the reporting between WAHBE and issuers. Issuers offering QHPs through the Exchange will provide enrollment, payment, and disenrollment data in a manner and frequency specified by the Exchange as necessary to support Exchange operations including but not limited to:

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

WAHBE will provide more information to carriers as it becomes available.

2.3 Pediatric Dental Essential Health Benefit

RCW 43.71.065 specifies that Healthplanfinder will offer stand-alone pediatric dental plans. The bill further specifies that dental benefits must be offered and priced separately to assure transparency for consumers through Healthplanfinder. Stand-alone Pediatric Dental Plans will not be offered in SHOP in 2016. Instead pediatric dental benefits are embedded in SHOP QHPs. Please refer to the OIC for further guidance on setting the rate for pediatric dental. A separate Guidance for Participation for Qualified Dental Plans offered through Healthplanfinder can be found on the WAHBE website.

2.4 Monitoring and Compliance of Qualified Health Plans

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

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

No.	Criteria Level	Criteria	Monitoring Entity	Penalty?	Descertification?
1	Issuer	Issuer must be in good standing	OIC	Per OIC	Yes
2	Issuer	Issuer must pay user fees, if QHPs assessed	WAHBE	Yes (see Section 2.2.2)	Yes
3	Issuer	Issuer must comply with the risk management programs	OIC	Per OIC	Yes
4	Issuer	Issuer must comply with market rules on offering plans	OIC	Per OIC	Yes
5	Issuer	Issuer must comply with non-discrimination rules	OIC	Per OIC	Yes
6	Issuer	Issuer must be accredited by an entity that federal HHS recognizes for accreditation of health plans within specified timeframe	WAHBE	No	Yes
7	Product	QHP must meet marketing requirements	WAHBE	Yes (see section 2.2.7)	No
8	Product	QHP must meet network adequacy requirements which will include essential community provider	OIC	Per OIC	Yes
9	Product	Issuers must submit health care provider directory data	WAHBE	No	No
10	Product	Issuers must implement a quality improvement strategy	WAHBE	No	No

2.4 Monitoring and Compliance of Qualified Health Plans
(Continued)

No.	Criteria Level	Criteria	Monitoring Entity	Penalty?	Descertification?
11	Product	Issuers must submit health plan data to be used in a standard format for presenting health benefit plan options	WAHBE	No	No
12	Product	Issuers must implement quality and health performance measures made available to Healthplanfinder consumers	WAHBE	No	Not yet applicable
13	Product	Issuer must use a standard enrollment form	OIC	Per OIC	No
14	Product	Issuer may only contract with a hospital with more than 50 beds if the hospital utilizes a patient safety evaluation system	OIC	Per OIC	Yes
15	Product	Services provided under a QHP through a Direct Primary Care Medical Home must be integrated with the QHP issuer	OIC	Per OIC	Yes
16	Plan	A QHP must comply with benefits design standards (e.g., cost sharing limits, "metal level" (Platinum, Gold, Silver, or Bronze), essential health benefits)	OIC	Per OIC	Yes
17	Plan	Issuer must submit to WAHBE a QHP's service area and rates for a plan year	OIC	Per OIC	Yes
18	Plan	Issuer must post justifications for QHP premium increases	OIC	Per OIC	No
19	Plan	Issuer must submit to WAHBE QHP benefit and rate data for public disclosure	WAHBE	No	No

2.4 Monitoring and Compliance of Qualified Health Plans
(Continued)

2.4.2 Summary Table 3: Key Decisions That Alter the Offering of Enrollment in a QHP

WAHBE has identified key decisions by issuers, the OIC, or WAHBE that may close QHP enrollment or result in a QHP no longer being offered through Healthplanfinder. The key decisions are summarized in the table below:

No.	Decision	Notice or Request	Open to New Enrollments?	Participate in Special Enrollments throughout Plan Year?	Decertification?	Terminate Coverage and Provide Opportunity to Enroll in Other QHPs?	Is Recertification Performed?
1	QHP Issuer discontinues a QHP from the entire individual or small group market	Annual OIC filing and WAHBE Certification process (cannot be done outside of annual event) QHP issuer provides 90-day notice to enrollees of plan discontinuation.	N/A	N/A	N/A	Yes, Coverage in Healthplanfinder will expire at end of plan year and enrollees must select another certified QHP to continue coverage through Healthplanfinder and receive tax credits.	N/A
2	A QHP Issuer Discontinues All QHPs in an Individual or SHOP Market Mid-year and Exits that Market entirely	Notification to OIC and WAHBE QHP issuer provides 180-day notice to enrollees if discontinuing all plans and withdrawing from the mark	N/A	N/A	N/A	Yes. Issuers must notify enrollees that Enrollees must select a certified QHP to continue coverage through Healthplanfinder and receive tax credits.	N/A

2.4 Monitoring and Compliance of Qualified Health Plans (Continued)

3	QHP Issuer elects to not seek recertification of a QHP	Annual OIC filing and WAHBE Certification process (cannot be done outside of annual event)	N/A	N/A	N/A	No. However, enrollment ends at the end of the plan year. To remain covered through Healthplanfinder, an enrollee must select a different QHP for the next plan year during open enrollment.	No. The QHP status will expire at renewal.
4	WAHBE denies recertification of a QHP	WAHBE Certification process (cannot be done outside of annual event)	N/A	N/A	Yes	Yes. Coverage terminated only after WAHBE offers special or open enrollment.	No. The QHP status will expire at renewal.
5	OIC withdraws regulatory approval of a QHP	WAHBE follows the notification requirements for Decertification of QHPs (See 45 CFR §155.1080(e)).*	No	No	Yes. The Board will decertify the QHP status.	Yes. Coverage terminated only after WAHBE offers special or open enrollment.	N/A
6	WAHBE withdraws Certification of a QHP	WAHBE follows the notification requirements for Decertification of QHPs (See 45 CFR §155.1080(e)).**	No	No	Yes. The Board will decertify the QHP status.	Yes. Coverage terminated only after WAHBE offers special or open enrollment.	N/A
7	QHP Issuer petitions the OIC to Suspend new sales for the risk pool	QHP Issuer notifies WAHBE of OIC Petition and subsequent approval of suspension.	No. New enrollees may not select the suspended QHPs for a minimum of six months. However, the current enrollees may select to retain the suspended QHPs.	Suspended QHPs will be available for specific special enrollments (such as adding a dependent) to the existing plan for current enrollees to retain the coverage as an option.	No	Yes	Yes, during the annual certification process. The QHPs must be certified to continue offering coverage to current enrollees through Healthplanfinder, whether the suspension is lifted for new sales or not.

*The issuer must terminate coverage for enrollees only after the Exchange has made notification and enrollees have an opportunity to enroll in other coverage.

**The issuer must terminate coverage for enrollees only after the Exchange has made notification and enrollees have an opportunity to enroll in other coverage.

2.5 Description of Key Decisions

2.5.1 A QHP Issuer Discontinues a QHP and Removes the QHP from the entire Individual or SHOP Market

A QHP issuer may only discontinue a plan during their annual regulatory filing event. WAHBE certification of the QHP will expire at the end of the plan year as set forth in 45 CFR §156.290 and 45 CFR §155.1080, and the QHP issuer must terminate coverage for the enrollees as set forth in 45 CFR §155.430. Termination of coverage may only occur after WAHBE has notified the enrollees within the same 90-day timeframe specified in RCW 48.43.035 and RCW 48.43.038 and the enrollees have had an opportunity to participate in open enrollment as set forth in §156.290. A QHP issuer may never again offer the discontinued QHP through Healthplanfinder, except as required by state or federal law or deemed necessary by WAHBE.

2.5.2 A QHP Issuer Discontinues All QHPs in an Individual or SHOP Market and Exits that Market entirely

A QHP issuer must provide formal notice to the OIC and WAHBE that all of the issuer's QHPs in a market (Individual or SHOP) will be discontinued. The QHP issuer must provide the formal notice 15 calendar days before enrollees receive the "180-day" notice required in RCW 48.43.035 for SHOP QHPs and RCW 48.43.038 for Individual market QHPs.

WAHBE must decertify the QHPs as set forth in 45 CFR §156.290 and 45 CFR §155.1080, and the QHP issuer must terminate coverage for the enrollees as set forth in 45 CFR §155.430. Termination of coverage may only occur after WAHBE has notified the enrollees within the same 180-day timeframe specified in RCW 48.43.035 and RCW 48.43.038 and the enrollees have had an opportunity to participate in special or open enrollment as set forth in 45 CFR §156.290. A QHP issuer may never again offer a discontinued QHP through Healthplanfinder, except as required by state or federal law or deemed necessary by WAHBE.

2.5.3 A QHP Issuer Elects Not to Seek Recertification and the QHP's Certification Expires

A QHP issuer must notify WAHBE of any QHPs for which it will not seek recertification. The QHP issuer's designated QHP or QHPs will expire at the end of the plan year and will no longer provide coverage in the next plan year through Healthplanfinder.

A QHP issuer must notify WAHBE before the beginning of the recertification process of the intent to let a QHP certification expire. The expiring QHP will not be offered in the next open enrollment period and the current enrollees may select a different QHP during open enrollment for coverage in the next plan year to continue coverage through Healthplanfinder. A QHP set to expire must fulfill the obligations set forth in 45 CFR §156.290 which include providing coverage until the end of the plan year and notice to enrollees of the non-renewal. The QHP set to expire must also be made available outside of Healthplanfinder to any current enrollees who exercise their guaranteed renewal rights as set forth in 45 CFR §147.106.

Once expired, the QHP issuer may never again offer that QHP through Healthplanfinder, except as required by state or federal law or deemed necessary by WAHBE.

2.5.4 WAHBE Denies Recertification of a QHP

WAHBE will inform a QHP issuer before the beginning of the next open enrollment period that a QHP has been denied recertification. A QHP with denied recertification must fulfill the obligations set forth in 45 CFR §156.290 which include providing coverage until the end of the plan year.

The denied QHP will not be offered in the next open enrollment period and the current enrollees may select a different QHP during open enrollment for coverage in the next plan year through Healthplanfinder. The QHP

with denied certification must also be made available outside of Healthplanfinder to any current enrollees who exercise their guaranteed renewal rights as set forth in 45 CFR §147.106. A QHP issuer may never again offer that denied QHP through Healthplanfinder, except as required by state or federal law or deemed necessary by WAHBE.

2.5.5 OIC Withdraws Regulatory Approval

The OIC will inform WAHBE that it must withdraw a QHP from the market.

WAHBE must decertify the QHPs as set forth in 45 CFR §156.290 and 45 CFR §155.1080, and the QHP issuer must terminate coverage for the enrollees as set forth in 45 CFR §155.430. Termination of coverage may only occur after WAHBE has notified the enrollees and the enrollees have had an opportunity to participate in special or open enrollment. A QHP issuer may never again offer a withdrawn QHP through Healthplanfinder, except as required by state or federal law or deemed necessary by WAHBE.

The direction provided in this section does not alter the OIC authority in RCW 48.18.110, RCW 48.44.020, and RCW 48.46.060 to withdraw approval of a plan.

2.5.6 WAHBE Decertifies a QHP

WAHBE may determine that a QHP no longer satisfies the certification criteria of a QHP and decertify the plan. WAHBE must notify a QHP issuer when a QHP is decertified as set forth in 45 CFR §156.290 and 45 CFR §155.1080.

The QHP issuer must terminate coverage for the enrollees as set forth in 45 CFR §155.430. Termination of coverage may only occur after WAHBE has notified the enrollees and the enrollees have had an opportunity to participate in special or open enrollment. The decertified QHP must also be made available outside of Healthplanfinder to any current enrollees who exercise their guaranteed renewal rights as set forth in 45 CFR §147.106. A QHP issuer may never again offer a decertified QHP through Healthplanfinder, except as required by state or federal law or deemed necessary by WAHBE.

2.5.7 A QHP Issuer Petitions the OIC to Suspend New Sales for the Risk Pool

A QHP issuer must notify WAHBE of the OIC Petition and subsequent OIC approval of suspension. The QHP issuer must enroll any new enrollees “in the pipeline” with effective dates after the date of closure. WAHBE will no longer offer a suspended QHP during open enrollment and current enrollees may enroll in any other QHP during open enrollment.

A suspended QHP must continue to provide special enrollment to enrollees with qualifying events. A suspended QHP, however, will no longer participate in the special enrollment activities when enrollees of other QHPs or new enrollees experience qualifying events. To be offered through Healthplanfinder, a suspended QHP must continue to achieve annual recertification.

SECTION 3: SPECIAL GUIDANCE FOR COVERAGE OF AMERICAN INDIAN/ ALASKA NATIVES

An issuer will need to comply with all federally required laws and regulations specific to American Indians and Alaska Natives (AI/AN) in the Affordable Care Act (ACA) and other federal regulations, including but not limited to:

- Monthly enrollment periods for AI/AN people to enroll through Healthplanfinder;
- AI/AN enrollee able to change from qualified heath plan to another plan one time per month;
- No cost sharing for AI/AN enrollees with incomes under three hundred (300) percent of federal poverty level;
- No cost sharing for any item or service furnished through Indian Health Care Providers, or any other health care providers, as defined in the ACA;
- Health programs operated by Indian Health Care Providers will be the payer of last resort for services provided by such programs, notwithstanding any federal, state, or local law to the contrary; and,
- Compliance with Indian Health Care Improvement Act § 206 and § 408.

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

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

A premium sponsorship service, provided through Healthplanfinder, will assist the enrollment of tribal members in QHPs.

SECTION 4: SHOP SPECIFICATIONS

WAHBE operates the Small Business Health Options Program (SHOP). WAHBE will certify QHPs to be offered through SHOP and determine employer eligibility, support employee open enrollment and special enrollment, and perform premium aggregation through the billing and collection of employer premium payments. To be offered through SHOP, a plan must be submitted as both an employee only and an employee plus dependent(s) plan. Beginning with plan year 2016, a SHOP plan may be offered to an employer with 100 or fewer full-time equivalent employees as defined by the ACA and federal rules.

Key elements of the Washington State SHOP include, but are not limited to, the following:

- An employer may offer a single health plan or a choice of health plans at a single metal level.
- Employer premium contribution of at least 50% for employees.
- Employee participation requirement of 100% for employer groups with three or fewer employees or 75% for employer groups with more than three employees as consistent with Title 48 RCW.

Based on federal requirements, the SHOP must:

- Offer an employee choice option (for the Washington State SHOP this will be a metal level consisting of multiple plan choices).
- Offer a way for employers to compute an estimated premium.
- Prohibit carriers from varying rates during the plan year.
- Provide electronic data to the Internal Revenue Service (IRS) for tax administration purposes.

SECTION 5: ISSUER CERTIFICATION APPEAL PROCESS

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

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

An issuer's appeal must:

1. Identify the specific criterion or criteria appealed;

2. Provide information that clarifies the issuer's position on each unsatisfactory criterion; and

3. Succinctly state the outcome sought by the issuer.

WAHBE must send notice to the issuer in writing within seven calendar days that the appeal was received. WAHBE will offer the issuer the opportunity to address the Board about the appeal prior to a Board decision regarding the appeal. The Board will have up to 20 calendar days from receipt of the appeal to send a final written decision that upholds or denies the issuer's appeal. The Board's written response to such an appeal will be a final decision and all appeals with respect to that health plan will be exhausted. This appeal process represents the sole remedy for an issuer with respect to a Board decision regarding initial certification of a health plan or recertification or decertification of a QHP offered through Healthplanfinder.

SECTION 6: CUSTOMER SUPPORT

The WAHBE will provide a Customer Support Center to provide assistance to consumers. The WAHBE Customer Support Center will receive inquiries and answer questions about health insurance eligibility, application and enrollment, including the availability of tax credits and cost sharing reductions. The Customer Support Center will serve customers with a simple streamlined approach to ensure ease of use and customer satisfaction. The Customer Support Center will provide a toll-free phone number to respond to inquiries regarding coverage offered through WAHBE. The Customer Support Center will facilitate the application and enrollment process by offering assistance in Web-based and paper-based applications processing. The Customer Support Center will help consumers navigate eligibility for Washington Apple Health or Advanced Premium Tax Credits (APTC) and QHPs. The Customer Support Center will also triage calls concerning eligibility for other health benefit programs available to Washington State consumers, and for more complex questions, route accordingly. The WAHBE Customer Support Center will be the first point of contact for many customers with questions about applying for and enrolling in health insurance through Healthplanfinder.

An issuer must notify WAHBE of any grievances received from enrollees with respect to the operation of the Healthplanfinder marketplace. WAHBE will work with the issuer to resolve any such grievances where the issuer is responsible for resolution.

SECTION 7: ENROLLMENT IN A QHP

7.1 Individual Enrollment Processes and Timelines

Issuers will be expected to comply with the enrollment and payment processes outlined in the WAHBE Enrollment and Payment Process Guide. The Enrollment and Payment Process Guide can be obtained on the WAHBE website.

7.2 Premium Aggregation

WAHBE is in the process of ceasing the practice of premium aggregation for individual plans.

WAHBE will aggregate the premium contributions of subscribers enrolled in a QHP in the individual market on Healthplanfinder and transmit those aggregated premium payments to the appropriate QHP issuer. WAHBE must also allow a subscriber enrolled in a QHP in the individual market on Healthplanfinder to pay a premium contribution directly to the QHP issuer.

WAHBE must aggregate premiums for a QHP offered through SHOP.

A QHP issuer must agree to comply with standards and processes established for either market by WAHBE for the collection of premiums, funds transfer, reconciliation, financial accounting, and reporting. This will include compliance with all forms of payment, managing grace periods, and accepting payments on behalf of individuals from Exchange-registered sponsors in accordance with the sponsorship policy established in RCW 43.71.030.

7.3 Producer and Navigator Specifications

7.3.1 Producer

Producers who are authorized to sell Healthplanfinder products will be able to present QHP offerings to individuals and small businesses in Washington State.

7.3.2 Navigator

WAHBE will award grants to Navigator organizations and in-person assisters to carry out activities and meet the standards described in 45 CFR §155.210. Navigator representatives will be qualified, trained, and certified to engage in education, outreach and enrollment for Healthplanfinder. Navigators must meet conflict of interest standards and are prohibited from receiving indirect or direct compensation from a health insurance issuer based on enrollment. Health insurance issuers cannot act as Navigators.

APPENDIX
FEDERAL REQUIREMENTS

This appendix is not an exhaustive list of applicable requirements. Detailed Federal guidance is available on the website of The Center for Consumer Information & Insurance Oversight (CCIIO), http://cciio.cms.gov/resources/regulations/index.html#hie.

REQUIREMENT CATEGORY	FEDERAL REQUIREMENT	**REFERENCE**
Licensing	State Licensure	45 CFR §156.200(b)(4)
Accreditation	General requirement	45 CFR §156.275(a)
Accreditation	Timeframe for Accreditation	45 CFR §156.275(b)
Health care quality requirements	Quality Improvement Initiative	45 CFR §156.200(b)(5), Section 1311(g) of the ACA
Health care quality requirements	Quality and Outcomes Reporting	45 CFR §156.200(b)(5), Section 1311(c)(1)(I) of the ACA
Health care quality requirements	Enrollee Satisfaction Surveys	45 CFR §156.200(b)(5), Section 1311(c)(4) of the ACA
User Fee Adherence	Requirement for Exchange user fees	45 CFR §156.50(b), 155.160
Risk Adjustment	Participation in Risk Adjustment Programs	45 CFR §156.200(b)(7)
Actuarial Value Designation	Actuarial Value Standards	45 CFR §156.140
Offering requirements	Actuarial Value Tiers	45 CFR §156.200(c)(1)
Offering requirements	Child-only plan	45 CFR §156.200(c)(2)
Rating variations	Product Pricing	45 CFR §156.255(b)
Rating variations	Allowable Variability	45 CFR §156.255(a), 147.102
Marketing	Marketing Rule Compliance	45 CFR §156.225(a)
Marketing	Non-discrimination	45 CFR §156.225(b)
Abortion Services	Compliance with State Abortion Laws	45 CFR §156.280(a)
Abortion Services	Abortion Funds Segregation	45 CFR §156.280
Premium Rate and Benefit Information	Rate Plan Year	45 CFR §156.210(a)
Premium Rate and Benefit Information	Rate submission	45 CFR §156.210 (b)

APPENDIX: FEDERAL REQUIREMENTS (Continued)

REQUIREMENT CATEGORY	FEDERAL REQUIREMENT	REFERENCE
Premium Rate and Benefit Information	Rate Increase Justification	45 CFR §156.210(c), 45 CFR §155.1020(a)
Premium Rate and Benefit Information	Rate Increase Consideration	45 CFR §155.1020 (b)
Premium Rate and Benefit Information	Benefit and Rate Information	45 CFR §155.1020(c)
Service Area	Minimum Service Area	45 CFR §155.1055(a)
Service Area	Non-Discriminatory Service Area	45 CFR §155.1055(b)
Network Adequacy	Network Adequacy Standards	45 CFR §156.230 (a)
Network Adequacy	Provider Directory	45 CFR §156.230(b)
Enrollment Processes and Periods	Individual Enrollment Periods	45 CFR §156.260
Enrollment Processes and Periods	SHOP Enrollment periods	small employer: 45 CFR §155.725
Enrollment Processes and Periods	Enrollment through the Exchange for Individuals	45 CFR §156.260(b), 45 CFR §156.260(e), 45 CFR §156.205(e)
Enrollment Processes and Periods	Acceptance of enrollment information	45 CFR §156.265(c)
Enrollment Processes and Periods	Premium Payment	45 CFR §156.265(d)
Enrollment Processes and Periods	Enrollment Reconciliation	45 CFR §156.265(f), 45 CFR §155.400 (d)
Enrollment Processes and Periods	Enrollment Acknowledgement	45 CFR §156.265(g); 45 CFR §155.400(b)(2)
Enrollment Processes and Periods	Enrollment Termination	45 CFR §156.270; 45 CFR §155.430
Enrollment Processes and Periods	Termination Notification	45 CFR §155.430(d)
Enrollment Processes and Periods	Non-payment of Premium	45 CFR §156.270; 45 CFR §155.430(b)
Enrollment Processes and Periods	Notice of Non-payment of Premiums	45 CFR §156.270(f)
Enrollment Processes and Periods	Grace period for tax credit recipients	45 CFR §156.270 (d)
Transparency in Coverage	Required Information Related to Coverage Transparency	45 CFR §156.220(a)
Transparency in Coverage	Reporting Requirement	45 CFR §156.220(b), 45 CFR §156.220(c)
Transparency in Coverage	Enrollee Cost Sharing	45 CFR §156.220(d)
Non-discrimination	Non-Discrimination	45 CFR §156.200(e)
Benefit Design Standards	Minimum Coverage	45 CFR §156.200(b)(3)