2016 Participation

Washington Health Benefit Exchange
810 Jefferson St. SE
Olympia, Washington 98501

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

April 2015

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SECTION 1: INTRODUCTION

This Guidance for Participation specifies how an issuer of a stand-alone dental plan can participate in the Healthplanfinder, Washington's State Health Benefit Exchange (WAHBE).

This Guidance for Participation specifies how an issuer of a stand-alone dental plan can participate in the Washington Healthplanfinder, Washington's State Health Benefit Exchange (WAHBE). An issuer may participate in the Individual Exchange by offering qualified dental plans (QDPs) that provide pediatric-only benefits during the open enrollment period, November 1, 2015 – January 31, 2016, for coverage in plan year 2016. Family QDPs for 2016 that include pediatric and adult benefits may be made available to Individual Exchange customers with special enrollment qualifying events sometime during the 2016 plan year, contingent upon the identification of a funding source for costs attributable to offering family QDPs. Under current state law, a Legislative change is needed in order for the Exchange to receive funds from family QDPs at a level that would assure the sustainability of the family dental program in the Exchange.

The Guidance will provide information on the following:

- Certifying and recertifying a dental plan to become a Qualified Dental Plan (QDP) offered through the Exchange;
- Monitoring and compliance of QDPs;
- Decertifying a QDP; and
- 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 the Washington Health Benefit Exchange (WAHBE or Exchange) 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 Washington State Office of the Insurance Commissioner (OIC) regulates health and dental insurance issuers and health and dental plans. This document does not provide a health or dental issuer with 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 plan of the total allowed costs of benefits. Unless otherwise permitted or required by law a stand-alone dental plan offered in Healthplanfinder must provide a low level of coverage with an actuarial value of 70% with respect to coverage of the pediatric dental essential health benefits (EHB) or a high level of coverage with an actuarial value of 85% with respect to coverage of the pediatric dental EHB. A dental issuer may offer stand-alone plans in both actuarial value levels. A plan will be considered to meet these requirements if the actuarial value applicable to its pediatric dental EHB falls within two percentage points of 70% or 85% (45 CFR § 156.150(b)). Adult dental benefits included in family QDPs are not subject to these actuarial value requirements under the Affordable Care Act.

In addition to designating a plan as a low or high actuarial value plan, a dental issuer must limit cost sharing for pediatric dental coverage to $350 for one covered child and $700 for two or more covered children (45 CFR Sec. 155.1065). Adult dental coverage included in family QDPs is not subject to these cost-sharing limitations under the Affordable Care Act.

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 or dental insurance issuer that WAHBE reconsider a decision to decertify a QDP, deny recertification of a QDP, or not certify a health plan as a QDP.

DENTAL PLAN: Dental plan means coverage for pediatric-only or family dental services as defined in the ACA and state law, and rules promulgated thereunder. A dental plan refers to the specific stand-alone policy, contract, or agreement purchased by a primary subscriber. Each dental plan has a defined set of covered benefits and cost-sharing, and multiple dental plans can be associated with a single product.

ENROLL: The point at which an individual is covered for benefits under a QDP, 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 QDP.

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

HEALTH BENEFIT EXCHANGE BOARD: The governing board of 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 dental insurance company, Product to a suite of plans that share, for example, a common set of dental benefits, and Dental Plan refers to the actual insurance coverage purchased by a consumer. The document never refers to dental insurance companies as "the plans" or "the dental 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

1.1 Glossary
(Continued)

area. Multiple health plans can be associated with a single product. A health plan that is certified by and offered on Healthplanfinder is a Qualified Health Plan (QHP). QHPs offered on the Individual Exchange will not include embedded dental benefits.

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 during each year during which consumers may enroll or change coverage in a QDP through Healthplanfinder. The open enrollment period for the 2016 plan year is from November 1, 2015 through January 31, 2016.

During open enrollment, a qualified individual may enroll in a new QHP and a new QDP. Pediatric-only QDPs will be available to consumers during the open enrollment period for 2016 coverage. Family QDPs for 2016 that include pediatric and adult benefits may be made available to Individual Exchange customers with special enrollment qualifying events sometime during the 2016 plan year, contingent upon identification of a funding source for costs attributable to offering family QDPs

PLAN YEAR: The consecutive 12-month period during which a health plan provides coverage for dental 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 DENTAL PLAN OR QDP: A stand-alone dental plan (as required under RCW 43.71.065(2)) that is certified by the Exchange after being determined to meet the criteria described in Section II below, and is a commitment to insure at a minimum the essential health benefit of pediatric oral services (established as an essential health benefit under ACA § 1302(b) and defined under WAC 284-43-879) under specific cost-sharing (deductibles, copayments, and out-of-pocket maximum amounts) and other regulatory and contractual requirements.

A QDP may offer pediatric-only dental benefits or may offer family dental benefits. Family QDPs include benefits for individuals over the age of 18 as well as the pediatric dental EHB for individuals aged 18 and younger.

QUALIFIED DENTAL PLAN ISSUER OR QDP ISSUER: A dental insurance issuer that provides stand-alone dental coverage through a qualified dental plan certified by and offered through Washington 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 QDP 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 (QHPs) and Qualified Dental Plans (QDPs). QDPs will not be available in the SHOP Exchange in 2016; all QHPs offered in SHOP during 2016 will include embedded pediatric dental benefits.

1.2 Overview of Guidance

1.2.1 Objective

The purpose of this Guidance is to provide issuers of stand-alone dental insurance plans the foundational information needed to offer individual QDPs through Healthplanfinder. The certification criteria set forth within this document do not supersede a QDP 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 stand-alone dental insurance coverage through Healthplanfinder, this document does not release a QDP issuer from complying with all relevant state and federal laws. Please see the Appendix for a directory of Federal rules issued under the ACA.

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

- Be approved by the OIC;
- Satisfy the certification criteria adopted by the Board;
- Provide the essential health benefit of pediatric oral services as required under ACA § 1301(b) and defined under WAC 284-43-879; and
- Meet the requirements of a stand-alone dental plan offered in an Exchange as set forth in 45 CFR Parts 155 and 156, 45 CFR § 156.150, and RCW 43.71.065(2).

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

1.2.2 Term of Engagement

An Individual stand-alone pediatric-only dental insurance plan certified as a QDP will be offered through Healthplanfinder beginning November 1, 2015 with an initial effective date of coverage beginning no sooner than January 1, 2016. A family dental insurance plan certified as a QDP for 2016 may be offered through Healthplanfinder to those with special enrollment qualifying events beginning sometime during 2016, contingent on the legislative and regulatory identification of a funding source for costs attributable to offering family QDPs.

Dental insurance issuers, responding to this Guidance, will offer certified QDPs for a term of one year beginning January 1, 2016 and ending December 31, 2016. Only OIC-approved stand-alone pediatric or family dental plans certified by the Board may be offered as QDPs through Washington Healthplanfinder during this period. Certified family QDPs will be available in the outside-Exchange market as of January 1, 2016, and will be available inside the Exchange sometime during 2016 to customers with special enrollment qualifying events, contingent on the legislative and regulatory identification of a funding source for the Exchange family dental program.

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. This 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 dental plans it intends to offer through Healthplanfinder. Issuers should, however, include a list of counties that they intend to serve in their Letter of Intent.

Please submit your letter of intent via e-mail to WAHBE at QHP@WAHBExchange.org by the date shown on the Plan Management Timeline Calendar found on the Plan Management Workgroup section on the WAHBE website.

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 QDP issuer may participate in Healthplanfinder's Individual market. Engrossed Second Substitute House Bill 2319 specifies that Healthplanfinder will offer stand-alone dental plans. The bill further specifies that dental benefits must be offered and priced separately to assure transparency for consumers. WAHBE, consequently, must offer all dental benefits through individual stand-alone dental plans. For 2016, no stand-alone dental plans will be offered in the SHOP market; all SHOP QHPs will include pediatric dental as an embedded benefit in 2016. An issuer is not required to participate in the same markets inside and outside of Healthplanfinder.

1.3.1 Initial Certification of Qualified Dental Plans

WAHBE intends to certify QDPs annually. Only those plans certified or recertified by WAHBE may be offered as QDPs through Healthplanfinder.

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

An issuer will need to enter into a Participation Agreement with WAHBE before offering QDPs through Healthplanfinder. The terms of the Participation Agreement will incorporate the stand-alone dental plan certification criteria described in this Guidance. WAHBE, in addition to the Legislature, reserves the discretion to establish, modify, and amend QDP certification and decertification criteria, terms, and conditions 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 then 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 Agreement 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 that have not previously offered plans through Healthplanfinder.

1.3.2 Recertification of Qualified Dental Plans

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

1.3.3 Submitting a Dental Plan to Become Certified as a QDP

The WAHBE certification process begins when an issuer submits a rate and form filing to the OIC for regulatory review and approval of a stand-alone dental plan. **All stand-alone plans submitted for certification by WAHBE must include the pediatric dental EHB. All stand-alone dental plans submitted for certification by WAHBE to be offered in the Exchange must apply a rating structure based on age bands.** Please refer to the OIC for information on how and where to submit the rate and form filing for a stand-alone dental plan.

SECTION 2: SPECIFICATIONS FOR HEALTHPLANFINDER PARTICIPATION

2.1 Summary of Initial Certification and Recertification Criteria

To participate in WAHBE's QDP certification process, an issuer will need to submit plans and supporting documentation as specified for each criterion. The following chart summarizes the 10 criteria to be applied in the certification process of a QDP. 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 QDPs assessed	WAHBE	Yes	Yes
3	Issuer	Issuer must comply with non-discrimination rules	OIC	Yes	Yes
4	Product	QDP must meet marketing requirements	WAHBE	Yes	Yes
5	Product	QDP must meet network adequacy requirements which will include essential community providers	OIC	Yes	Yes
6	Product	Issuer must display dental provider directory data	WAHBE	Yes	Yes
7	Product	Issuer must submit dental plan data to be used in a standard format for presenting dental benefit plan options	WAHBE	Yes	No
8	Plan	A QDP must comply with benefit design standards (e.g., cost sharing limits, actuarial value requirements, essential health benefits designated for stand-alone dental plans)	OIC	Yes	Yes
9	Plan	Issuer must submit to the WAHBE a QDP's service area and rates for a plan year	OIC	Yes	Yes
10	Plan	Issuer must provide to WAHBE (directly or by way of the OIC, as applicable) QDP benefit and rate data for public disclosure	WAHBE	Yes	Yes

2.2 QDP Specifications

An issuer's stand-alone dental plan must satisfy the following criteria to become certified as a QDP offered through Healthplanfinder.

2.2.1 Licensed and Good Standing

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

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 or dental plans, then WAHBE will determine, consistent with OIC restrictions, if the issuer can submit a stand-alone dental plan for certification or recertification as a QDP.

Restrictions on an issuer's ability to underwrite current or new dental plans may result in QDP 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 and QDPs as sustainable funding for WAHBE's administrative expenses beginning in 2015. As of publication of this document, a separate funding source to fund the costs attributable to offering family dental plans in the Exchange has not been identified. Family QDPs are not expected to be offered in the Exchange until a dedicated funding mechanism is determined.

If a QDP issuer's payment of the QDP 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 the payment is overdue. To avoid penalties for late payment, a QDP issuer is encouraged to pay any and all assessed amounts while contesting a fee.

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

2.2.3 Non-discrimination

A QDP issuer must comply with federal and Washington State non-discrimination requirements. A QDP 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 will not be considered to provide essential health benefits if its benefit design discriminates based on an individual's degree of medical dependency or quality of life (45 CFR § 156.125).

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

2.2.4 Marketing

A QDP 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 QDP. An issuer can use the Healthplanfinder bug to co-brand QDP 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 QDP

2.2 QDP Specifications
(Continued)

certification. WAHBE will review and approve the use of the logo or bug on an issuer's marketing materials. The QDP issuer will be able to review any WAHBE marketing materials that use the QDP issuer's logo.

A QDP issuer may submit for approval one marketing document as a part of the same electronic file that contains all other plan documents. These documents will be posted on Healthplanfinder for each QDP. In these marketing materials the QDP issuer may inform consumers that the plan is certified by WAHBE as a QDP. The QDP issuer cannot inform consumers that the certification of a QDP implies any form of further endorsement or support of the QDP. A QDP 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 QDPs (45 CFR §156.225(b)). Marketing materials should be in the same file as all plan documents and submitted in both English and Spanish in PDF form.

QDP 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.

2.2.5 Network Adequacy

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

- The network is sufficient in number and type of providers 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.

The OIC will enforce network adequacy requirements and monitor for noncompliance. If the OIC determines that a QDP issuer is not complying with the network adequacy requirements, and the OIC further determines that the QDP issuer will not resume compliance with the network adequacy requirements, then WAHBE will decertify all of the issuer's QDPs affected by that noncompliance.

Please refer to the OIC for additional regulatory guidance on network adequacy.

2.2.6 Dental Provider Directory Data

A QDP issuer must display data on the dental providers that participate in networks associated with the QDP. WAHBE will provide specifications on displaying dental provider data to prospective QDP issuers.

2.2.7 Standard Format for Presenting Dental Benefit Plan Options

A standard Summary of Benefits and Coverage (SBC) form for dental plans can be obtained from WAHBE. Issuers are required to provide WAHBE with completed SBCs for each QDP, in English and Spanish, for display on Healthplanfinder.

The naming convention for SBCs is:

- Plan year
- Carrier name
- Full plan name
- Actuarial value of High or Low (if not included in plan name)
- Pediatric-only or Family indicator (if not included in plan name)
- English or Spanish
- Draft or Final version
- Plan ID number

2.2 QDP Specifications
(Continued)

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 of stand-alone dental plans should conduct cross-mapping in accordance with applicable state law and federal requirements, including following the cross-mapping hierarchy set forth in 45 CFR 155.335(j).

WAHBE will renew compliance with federal requirements set forth in 45 CFR 155.335.

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

2.2.8 Benefit Design Standards

All stand-alone dental plans submitted for certification by WAHBE must include the pediatric dental EHB. A QDP issuer must ensure that each QDP complies with the benefit design standards required under federal and state law, including those related to pediatric dental essential health benefits (as defined under ACA § 1302(b), WAC 284-43-879, and 45 CFR § 155.1065) and cost-sharing limitations and actuarial value requirements for the pediatric EHB provided in stand-alone dental plans (45 CFR § 156.150).

A stand-alone dental plan, the pediatric EHB portion of which provides an actuarial value of 70 percent (±2 percentage points), will be considered a "low" plan (45 CFR § 156.150). A stand-alone dental plan, the pediatric EHB portion of which provides an actuarial value of 85 percent (±2 percentage points), will be considered a "high" plan (45 CFR § 156.150). Only a QDP issuer that satisfies these actuarial value requirements may offer QDPs in Healthplanfinder. Adult dental benefits included in family QDPs are not subject to these actuarial value requirements under the ACA.

In addition to designating a plan as a low or high actuarial value plan, a dental issuer must limit cost sharing for pediatric dental coverage to $350 for one covered child and $700 for two or more covered children (45 CFR Sec. 155.1065). Adult dental coverage included in family QDPs is not subject to these cost-sharing limitations under the ACA.

Please refer to OIC regulatory specifications for information on benefit design standards or the calculation of the actuarial value of stand-alone dental plans.

2.2.9 Service Areas and Rating Requirements

The QDP service area must be established without regard to racial, ethnic, language, or health-status related factors specified under section 2705(a) of the PHS Act, or other factors that exclude specific high utilization, high cost, or medically-underserved populations (45 CFR §155.1055(b)). QDP service areas will be set by county and consumers will be able to identify a service area by providing a zip code and county in Healthplanfinder. WAHBE will display the rates on the Healthplanfinder web pages. The OIC will approve a QDP issuer's dental plan rates for an entire benefit or plan year. Approval of a plan by the OIC will confirm that a QDP has met the service area standards.

All stand-alone dental plans submitted for certification by WAHBE to be offered in the Exchange must apply a rating structure based on age bands.

2.2.10 Reporting Data

As part of the OIC regulatory filing process, a QDP issuer must use the federally supplied data templates during the SERFF filing process. The OIC will forward the data for

2.2 QDP Specifications
(Continued)

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 QDPs 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; and
- Estimation or collection of assessments or fees specified in RCW 43.71.080.

2.3 Monitoring and Compliance of Qualified Dental Plans

2.3.1 Summary Table 2: Monitoring and Compliance of Qualified Dental Plans

The following chart summarizes the monitoring and compliance activities associated with the ten certification criteria. Monitoring activities are applied by either the OIC or WAHBE. Any penalties associated with criteria #2 and #4 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 QDPs assessed	WAHBE	Yes (see Section 2.2.2)	Yes
3	Issuer	Issuer must comply with non-discrimination rules	OIC	Per OIC	Yes
4	Product	QDP must meet marketing requirements	WAHBE	Yes (see Section 2.2.4)	No
5	Product	QDP must meet network adequacy requirements which will include essential community providers	OIC	Per OIC	Yes
6	Product	Issuers must display dental provider directory data	WAHBE	No	No
7	Product	Issuers must submit dental plan data to be used in a standard format for presenting dental plan options	WAHBE	No	No
8	Plan	A QDP must comply with benefit design standards (e.g., cost sharing limits, actuarial value limitations, essential health benefits)	OIC	Per OIC	Yes
9	Plan	Issuer must submit to WAHBE a QDP's service area and rates for a plan year	OIC	Per OIC	Yes
10	Plan	Issuer must provide to WAHBE (directly or by way of the OIC, as applicable) QDP benefit and rate data for public disclosure	WAHBE	No	No

2.3 Monitoring and Compliance of Qualified Dental Plans

2.3.2 Summary Table 3: Key Decisions That Alter the Offering of Enrollment in a QDP

WAHBE has identified key decisions by issuers, the OIC, or WAHBE that may close QDP enrollment or result in a QDP no longer being offered through Washington Healthplanfinder. As part of the discontinuation of premium aggregation through the Exchange, a primary subscriber's enrollment in a QDP will no longer be related to their enrollment in a QHP, so that changes to a customer's health plan enrollment will not affect their dental plan enrollment (and vice versa). Key decisions altering the offering of enrollment in a QDP 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 QDPs?	Is Recertification Performed?
1	QDP Issuer discontinues a QDP from the entire individual market	Annual OIC filing and WAHBE Certification process (cannot be done outside of annual event) QDP 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 QDP to continue coverage through Healthplanfinder	N/A
2	A QDP Issuer Discontinues All QDPs in an Individual Market Mid-year and Exits that Market entirely	Notification to OIC and WAHBE QDP 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 QDP to continue coverage through Healthplanfinder	N/A

2.3.2 Monitoring and Compliance of Qualified Dental Plans (Continued)

3	QDP Issuer elects to not seek recertification of a QDP	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 QDP for the next plan year during open enrollment.	No. The QDP status will expire at renewal.
4	WAHBE denies recertification of a QDP	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 QDP status will expire at renewal.
5	OIC withdraws regulatory approval of a QDP	WAHBE follows the notification requirements for Decertification of QDPs (See 45 CFR §155.1080(e)).*	No	No	Yes. The Board will decertify the QDP status.	Yes. Coverage terminated only after WAHBE offers special or open enrollment.	N/A
6	WAHBE withdraws Certification of a QDP	WAHBE follows the notification requirements for Decertification of QDPs (See 45 CFR §155.1080(e)).**	No	No	Yes. The Board will decertify the QDP status.	Yes. Coverage terminated only after WAHBE offers special or open enrollment.	N/A
7	QDP Issuer petitions the OIC to Suspend new sales for the risk pool	QDP Issuer notifies WAHBE of OIC Petition and subsequent approval of suspension.	No. New enrollees may not select the suspended QDPs for a minimum of six months. However, the current enrollees may select to retain the suspended QHPs.	Suspended QDPs 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 QDPs 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.

2.4 Description of Key Decisions

2.4.1 A QDP Issuer Discontinues a QDP and Removes the QDP from the Entire Individual Market

A QDP issuer may only discontinue a plan during their annual regulatory filing event. WAHBE certification of the QDP will expire at the end of the plan year as set forth in 45 CFR §156.290 and 45 CFR §155.1080, and the QDP 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 QDP issuer may never again offer the discontinued QDP through Healthplanfinder, except as required by state or federal law or deemed necessary by WAHBE.

2.4.2 A QDP Issuer Discontinues All QDPs in the Individual Market and Exits the Market Entirely

A QDP issuer must provide formal notice to the OIC and WAHBE that all of the issuer's QDPs in the individual market will be discontinued. The QDP issuer must provide the formal notice 15 calendar days before enrollees receive the "180-day" notice required in RCW 48.43.038 for individual market QDPs.

WAHBE must decertify the QDPs as set forth in 45 CFR §156.290 and 45 CFR §155.1080, and the QDP 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 48.43.038 and the enrollees have had an opportunity to participate in special or open enrollment as set forth in 45 CFR §156.290. A QDP issuer may never again offer a discontinued QDP through Healthplanfinder, except as required by state or federal law or deemed necessary by WAHBE.

2.4.3 A QDP Issuer Elects Not to Seek Recertification and the QDP's Certification Expires

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

A QDP issuer must notify WAHBE before the beginning of the recertification process of the intent to let a QDP certification expire. The expiring QDP will not be offered in the next open enrollment period and the current enrollees may select a different QDP during open enrollment for coverage in the next plan year to continue coverage through Healthplanfinder. A QDP 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 QDP 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 QDP issuer may never again offer that QDP through Healthplanfinder, except as required by state or federal law or deemed necessary by WAHBE.

2.4.4 WAHBE Denies Recertification of a QDP

WAHBE will inform a QDP issuer before the beginning of the next open enrollment period that a QDP has been denied recertification. A QDP 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 QDP will not be offered in the next open enrollment period and the current enrollees may select a different QDP during open enrollment for coverage in the next plan year through Healthplanfinder. The QDP

2.4 Description of Key Decisions
(Continued)

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 QDP issuer may never again offer that denied QDP through Healthplanfinder, except as required by state or federal law or deemed necessary by WAHBE.

2.4.5 OIC Withdraws Regulatory Approval

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

WAHBE must decertify the QDPs as set forth in 45 CFR §156.290 and 45 CFR §155.1080, and the QDP 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 QDP issuer may never again offer a withdrawn QDP 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.

2.4.6 WAHBE Decertifies a QDP

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

The QDP 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 QDP 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 QDP issuer may never again offer a decertified QDP through Healthplanfinder, except as required by state or federal law or deemed necessary by WAHBE.

2.4.7 A QDP Issuer Petitions the OIC to Suspend New Sales for the Risk Pool

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

A suspended QDP must continue to provide special enrollment to enrollees with qualifying events. A suspended QDP, however, will no longer participate in the special enrollment activities when enrollees of other QDPs or new enrollees experience qualifying events. To be offered through Healthplanfinder, a suspended QDP 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 a qualified dental plan to another plan one time per month;
- No cost sharing applied to the pediatric dental EHB 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, 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 recommended to adapt the Centers for Medicare and Medicaid Services Model QHP Addendum for Indian Health Centers for use with a stand-alone dental plan and include it when contracting with an Indian Health Center.

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

SECTION 4: ISSUER CERTIFICATION APPEAL PROCESS

A QDP issuer may appeal a decision by the WAHBE Board to decertify a QDP. An issuer may also appeal a Board decision to deny initial certification of a stand-alone dental plan or recertification of a QDP. An issuer is required to fully cooperate with WAHBE during an appeal process to prepare the dental 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 stand-alone dental plan, deny recertification of a QDP, or decertify a QDP, 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 stand-alone dental 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 stand-alone dental plan or recertification or decertification of a QDP offered through Healthplanfinder.

SECTION 5: CUSTOMER SUPPORT

WAHBE shall 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 Credit (APTC), and QHPs and QDPs. 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.

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

SECTION 6: ENROLLMENT IN A QDP

6.1 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.

6.2 Premium Aggregation

WAHBE is in the process of ceasing the practice of premium aggregation for individual plans. WAHBE does not expect to perform premium aggregation for any individual plans during the 2016 plan year. The below guidance applies to the practice of premium aggregation that WAHBE currently performs, until that functionality is removed from the Healthplanfinder system.

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

A QDP issuer must agree to comply with standards and processes established by WAHBE for the collection and aggregation 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.

6.3 Producer and Navigator Specifications

6.3.1 Producer

Producers who are authorized to sell Healthplanfinder products will be able to present QDP offerings to individuals in Washington State.

6.3.2 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)