Carrier Enrollment & Payment Process Guide

Individual Market

August 2016

Version 3.0

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1 INTRODUCTION

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

1.1 AFFORDABLE CARE ACT

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

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

1.2 WASHINGTON HEALTH BENEFIT EXCHANGE

The ACA gave states the option of establishing an SBE or participating in the Federally Facilitated Marketplace (FFM). The Washington State Legislature made the decision to establish an SBE, called the Washington Health Benefit Exchange, or the HBE.[1]

1.3 DOCUMENT PURPOSE

This guide provides operational and policy guidance on eligibility, enrollment, payment and reconciliation activities within the HBE. The information contained in this guide applies to the following organizations and entities:

- Qualified Health Plan Issuers (QHPs) and Qualified Dental Plan Issuers (QDPs) (collectively referred to as "Carriers")
- Third-party administrators (TPAs) of QHPs or QDPs
- Trading Partners of QHP and QDP issuers

1.4 Revision History

DATE	REVISION NUMBER	REVISION DESCRIPTION
9/14/2016	3.0 – Final	Incorporated carrier feedback; added "Aging Out" section and additional detail for section 4.4.7 "Grace Periods for Initial Binder Payment"
8/17/2016	3.0 – Draft	Entire document reorganized and revised

1 RCW 43.71.020

07/07/2015	2.0	Revised draft to include carrier feedback, added 1095 correspondence, dental grace periods, renewal timeline, updates to SEP and exemption process
06/02/2015	2.0 – Draft	Consolidated Carrier Enrollment and Payment Process Guide with Reconciliation Process Guide and updated for Premium Aggregation Removal (PAR)
04/01/2014	1.2	Updated special enrollment events and dates for upcoming Open Enrollment
11/25/2013	1.1	Updated file naming convention, contact information, and general clarification
11/05/2012	1.0	Initial version
09/10/2012	Draft	Draft version for Carrier Review

1.5 Amendments to Document

Amendments to this guide are made on an annual basis. The HBE will communicate any amendments to carriers prior to their incorporation into the guide. Any amendments made to the guide will be effective as of the next Open Enrollment period. The HBE will formally publish the guide on the HBE website on August 1st, or the next following business day, of each year.

Once the final version of the guide is published any clarifications or updates to the guide will be issued via supplemental bulletins. The HBE will formally publish supplemental bulletins on the HBE corporate website at least 30 days prior to the effectuation of any changes.

1.6 Relationship to 834 Companion Guide

For rules related to format and content of EDI transactions, and managing the exchange of EDI transactions between the HBE and QHP/QDP carriers, please refer to the 834 Companion Guide. The 834 Companion Guide addresses the 834 EDI requirements for the Individual Market. A separate 834 Companion Guide exists for the SHOP Market.

1.7 Compliance with State and Federal Laws

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

1.8 HBE Contact Information

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

2 ACRONYMS AND DESCRIPTIONS

ACRONYM/TERM	DESCRIPTION
ACA	Patient Protection and Affordable Care Act
AI/AN	American Indian and Alaska Native
APTC	Advanced Premium Tax Credit
CCIIO	Center for Consumer Information and Insurance Oversight
CHIP	Children's Health Insurance Plan
CMS	Centers for Medicare & Medicaid Services
CSR	Cost-Sharing Reduction
Advance CSR	Advance Cost-sharing Reduction Payment
DEP	Dependent-Only coverage
ECDM	CMS Enterprise Canonical Data Model
EDI	Electronic Data Interchange
Edifecs	Validation Engine for incoming and outgoing EDI transactions.
EDS	Enrollment Data Store
EFT	Enterprise File Transfer
EHB	Essential Health Benefits
EITA	Exchange Information Technology Architecture
Exchange	Washington Health Benefit Exchange
FAM	Family coverage
FFM	Federally Funded Marketplace
FPL	Federal Poverty Level
FTI	Federal Tax Information

ACRONYM/TERM	DESCRIPTION
HBE	Washington Health Benefit Exchange
Healthplanfinder or HPF	Washington Health Benefit Exchange's consumer facing online marketplace
HHS	U.S. Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIPTC	Health Insurance Premium Tax Credit
Hub	Federal Data Services Hub
OEP	Open Enrollment Period
PA	Primary Applicant
PAR	Premium Aggregation Removal
PROD	Production Environment
QDP	Qualified Dental Plan
QHP	Qualified Health Plan
SBE	State Based Exchange
SBM	State Based Marketplace
SEP	Special Enrollment Period
SFTP	Secure File Transfer Protocol
SHOP	Small Business Health Option Program
WAH	Washington Apple Health
WAHBE	Washington Health Benefit Exchange

3 ENROLLMENT IN THE INDIVIDUAL MARKET

3.1 ELIGIBILITY

The HBE provides a single portal via its Healthplanfinder system to determine eligibility to purchase a QHP and QDP through the HBE and, if the consumer selects to apply for affordability programs, the consumer's eligibility for health insurance premium tax credits (HIPTC), cost-sharing reductions (CSRs), and Washington Apple Health (WAH), including Children's Health Insurance Program (CHIP).

Consumers will be determined eligible, conditionally eligible, or denied for HIPTC and CSRs and for purchase of a QHP/QDP. Those determined conditionally eligible will have 90 days to provide additional documentation to verify their self-attested information included in their application. These consumers must supply additional documentation to verify their social security number, income, citizenship status, lawful presence, incarceration status, access to minimum essential coverage (MEC), and/or tribal membership.

Consumers determined conditionally eligible will be included in enrollment transactions transmitted to carriers. The HBE does not report conditional eligibility status to QHPs or QDPs, but the status may result in enrollment changes or terminations at the end of the 90-day period. Coverage will not retroactively terminate for individuals determined ineligible at the end of the 90-day period. Rather, effective dates will follow monthly enrollment deadlines (see Section 3.6 Open Enrollment and Coverage Effective Dates).

3.2 MEDICARE

Consistent with Section 1882(d) of the Social Security Act, it is illegal to sell duplicate coverage to Medicare beneficiaries. Therefore, individuals already receiving Medicare are not eligible to purchase coverage through the HBE. However, if an existing QHP enrollee becomes eligible for Medicare the enrollee may maintain coverage in the QHP but will be ineligible for HIPTC and CSRs. A QHP carrier cannot terminate QHP coverage on behalf of an existing QHP enrollee. Carriers should report the enrollee to the HBE through the reconciliation process (see section 8 Reconciliation of Enrollment Data).

3.3 HEALTH INSURANCE PREMIUM TAX CREDIT (HIPTC) AND COST SHARING REDUCTIONS (CSRS)

If a consumer is determined eligible for HIPTC or CSRs, or if eligibility for those programs changes, the HBE will notify the carrier and transmit the information necessary for carriers to implement, discontinue, or modify the HIPTC and/or CSRs, including the dollar amount of the HIPTC and the CSR eligibility category. Carriers are responsible for timely processing of any changes in HIPTC and/or CSRs and notifying consumers of any changes to benefits.

Consumers with incomes between 100% and 400% of the federal poverty level (FPL) may be eligible for HIPTC.[2] Individuals and families determined eligible for HIPTC will only receive the tax credit if they enroll in a QHP through the HBE.

The HBE notifies applicants of the maximum HIPTC amount for which they are eligible during the shopping experience prior to selecting health insurance plans. Following selection of a QHP, the HIPTC eligible amount will

[2] Non-citizens who are lawfully present and who are ineligible for Medicaid due to immigration status may be eligible for HIPTCs if their income is less than 100% of the FPL.

be equal to the premium of the QHP selected, or maximum HIPTC amount for which they are eligible, whichever is less. The consumer may adjust the amount of HIPTC they want to apply to their monthly premium, not to exceed the cost of the essential health benefit (EHB) portion of the plan premium, and may receive the remaining balance when they file their federal taxes. The HBE will report this amount to the carrier and Centers for Medicare and Medicaid Services (CMS) to facilitate the payment of the HIPTC amount from CMS directly to the carrier.

Individuals and families between 100% and 250% of the FPL are also eligible for CSRs if they enroll in a silver plan.[3] The HBE will report the CSR amount to the carrier and CMS to facilitate the payment of the CSR amount from CMS directly to the carrier.

3.4 American Indians and Alaska Natives

Carriers are expected to comply with all laws and regulations specific to American Indians and Alaska Natives (AI/AN) in the ACA and other federal regulations, including but not limited to the following:

- Monthly special enrollment periods for AI/AN consumers to enroll in a QHP/QDP;
- $0 cost sharing for AI/AN consumers with incomes under 300% of the FPL;
- $0 cost sharing for item or service furnished through Indian Health Care Providers;
- 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 Sections 206 and 408.

For monthly SEPs for AI/AN consumers, there is no SEP code present in the EDI transactions. Carriers are expected to use the AI/AN indicator in the EDI transaction to identify whether the household is eligible for a monthly SEP. More information on 834 data elements is available in the 834 Companion Guide.

3.5 Physical Address

In order to comply with regulations related to access to Medicaid programs, the first line of the physical address is not a required field in the Healthplanfinder system for a consumer applying for QHP/QDP coverage. Carriers are expected to update their systems to process EDI transactions missing the first line of a physical address.

Carriers may request the HBE to contact these consumers via the reconciliation process in order to try and obtain a physical address for the consumer (see Section 8: Reconciliation of Enrollment Data). The HBE Reconciliation Analysts will attempt to contact the consumer using available contact information and request a physical address. Once the update to the consumer's application is made, carriers will receive the update via an EDI change transaction.

3.6 Aging Out (26 and 19 year olds)

When a dependent turns twenty-six years old they are no longer eligible to continue enrollment on their parents' QHP. The WAHBE triggers an automated disenrollment batch process on the first day of the month prior to the dependent's twenty-sixth birthday. This batch process will disenroll the dependent from their QHP

[3] Non-citizens who are lawfully present and who are ineligible for Medicaid due to immigration status may be eligible for CSRs if their income is less than 100% of the FPL.

coverage as of the end of the month and trigger an 834 termination transaction. The dependent will be eligible for a special enrollment due to loss of minimum essential coverage.

Similarly, when a dependent turns nineteen years old they are no longer eligible for pediatric dental coverage. The WAHBE will disenroll dependents on the first day of the month prior to the dependent's nineteenth birthday. Carriers will receive a termination 834 transaction and the coverage end date will be effective as of the end of the month. The dependent will not be eligible for a special enrollment.

3.7 Open Enrollment and Coverage Effective Dates

For the benefit year beginning on January 1, 2017, the annual Open Enrollment Period (OEP) starts November 1, 2016 and continues through January 31, 2017.

During an OEP a consumer may change their plan selection multiple times. Consumers are cautioned that changing plans after previously selecting a plan through Healthplanfinder, either before or after coverage has begun, may result in multiple communications and invoices from carriers.

Coverage effective dates during OEP are based on a consumer's plan selection date. Consumers who qualify for an SEP during OEP will receive a coverage effective date as outlined in Section 7: Special Enrollment.

Coverage effective dates for the 2017 OEP are as follows:

- For plans selected between (and including) the 1st of November and the 23rd of December, the coverage effective date will be January 01, 2017
- For plans selected between (and including) the 24th of December and the 23rd of January, the coverage effective date will be February 01, 2017
- For plans selected between (and including) the 24th of January and the 31st of January, the coverage effective date will be March 01, 2017.

3.8 Enrollment Transactions

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 carries provisions for administrative simplification through the implementation of standardized EDI transactions between authorized covered entities, also referred to as "trading partners." These EDI standards are extended to the exchange of enrollment data between the HBE and carriers offering products through the HBE. The 834 Companion Guide addresses the 834 EDI requirements for the Individual Market.

The HBE is the system of record for all eligibility, enrollment, and demographic information. Any changes in demographic information must be reported directly to the HBE. Carriers should refer individuals to update their account information by logging into WAHealthplanfinder.org or calling the Washington Healthplanfinder Customer Support Center at 1-855-WAFINDER (1-822-923-4633). Changes that must be reported through Healthplanfinder include, but are not limited to:

- Last Name
- First Name
- Social Security Number
- Date of Birth
- Gender

- Marital Status
- Physical Address Information
- Mailing Address Information

Table 1 outlines the various types of 834 enrollment transactions and how they are used.

Table 1: 834 Enrollment Transactions

Transaction Type	Description
834 Add	The 834 Add is an enrollment transaction sent from the HBE to the carrier. An 834 Add is sent by the HBE to the carrier when the household initially enrolls in a plan, moves from one plan to another, or when there is an active or passive renewal.
834 Confirm	The 834 Confirm is the effectuation transaction that is sent by the carrier to the HBE in response to receipt of an 834 Add from the HBE.
834 Change	The 834 Change is sent for a dependent Add when there is continuous coverage with the same QHP, when there is a substantive change in household income that impacts the amount of HIPTC and/or CSR, when there is a change in third party sponsorship status, when there is a change to broker information, and for other reasons.
834 Cancel (HBE Initiated)	The HBE sends an 834 Cancel to the carrier when coverage for a household is cancelled prior to the coverage effective date.
834 Cancel (Carrier Initiated)	Carriers send an 834 Cancel to the HBE when the subscriber fails to make the required binder payment prior to the carrier's premium payment due date.
834 Term (HBE Initiated)	The HBE sends an 834 Term to the carrier when the subscriber voluntarily terms, when the subscriber is termed due to death, when the household moves to a different plan due to SEP, and for other reasons.
834 Term (Carrier Initiated)	Carriers send an 834 Term to the HBE when the subscriber fails to make the required premium payment prior to the carrier's premium payment due date and their grace period expires.
834 Monthly Audit (HBE Initiated)	The HBE generates and sends an 834 Monthly Audit to the carrier on a monthly basis.
834 Monthly Audit (Carrier Initiated)	Carriers generate and send an 834 Monthly Audit to the HBE on a monthly basis.

4 Premium Payments

4.1 Premium Payment Methods

Federal regulations require carriers to accept paper checks, cashier's checks, money orders, EFT, and all general-purpose and pre-paid debit cards.

4.2 Premium Payment Due Dates

Carriers are expected to comply with the following due dates for payments:

- Open Enrollment

- Binder payment due date must be no earlier than the coverage effective date, but no later than 30 calendar days from the coverage effective date (but see Section 3.10.6. Grace Periods for Initial Binder Payment).
- Payment due date must allow 15 business days for a consumer to make a binding payment after the consumer receives an invoice.

- Special Enrollment
  - For coverage effective under regular effective dates (i.e., coverage is effective the first of the next month if the plan is selected by the 23rd of a month, and effective the first of the following month if a plan is selected after the 23rd of a month), binder payment deadlines must be no earlier than the coverage effective date, but no later than 30 calendar days from the coverage effective date.
  - For coverage effective under retroactive or special effective dates, binder payment deadlines must be no later than 30 calendar days from the date the carrier receives the enrollment transaction.
  - All payment due dates must allow at least 15 business days for a consumer to make a binding payment after the consumer receives an invoice.

4.2.1 Effectuations

Carriers are expected to comply with the following due dates for effectuations:

- Open Enrollment
  - An 834 confirm transaction is due to the HBE within 10 business days of receipt of a binder payment.
- Special Enrollment
  - An 834 confirm transaction is due to the HBE within 10 business days of the binder payment due date.

4.2.2 Cancellations for Non-Payment

Carriers are expected to comply with the following due dates for cancellations for non-payment:

- Open Enrollment
  - An 834 cancel transaction is due to the HBE within 10 business days of the binder payment due date.
- Special Enrollment
  - An 834 cancel transaction is due to the HBE within 10 business days of the binder payment due date.

4.2.3 Terminations for Non-Payment

An 834 termination for nonpayment transaction is due to the HBE within 10 business days of expiration of the one-month (non-HIPTC) or three-month (HIPTC) grace period.

4.3 Grace Periods and Delinquency Process

Carriers must track grace periods for both QHP and QDP consumers. QHP and QDP enrollment is decoupled during the shopping experience and consumers are able to purchase a QDP without a QHP. Additionally, consumers can disenroll from one or the other, or both. This means QHP and QDP enrollments are tracked and

managed independently by each carrier. Please see the 834 Companion Guide for details on how HBE will report grace period indicators to dental carriers.

4.3.1 Non-Subsidized (non-HIPTC)

Carriers must provide non-subsidized consumers (i.e. consumers who are not receiving HIPTC) in the individual market a one-month grace period beginning on the first of the month following a missed payment. If the one-month grace period for unsubsidized consumers is exhausted, the last day of coverage will be the last day of the month prior to the one-month grace period, or the last day of paid coverage.

> **Exampl**e: If payment is due on March 15 and no payment is received, the enrollee has a one-month grace period beginning April 01 to make payment for the March and April. On April 30, the premium payment for April and May is due in full. If the grace period exhausts without payment of premium, the last day of coverage will be March 31.

4.3.2 Subsidized (HIPTC)

Federal regulations require carriers to grant subsidized consumers (i.e. consumers who are receiving HIPTC) in the individual market a three-month grace period beginning on the first of the month following a missed payment. If the three-month grace period for consumers receiving HIPTC is exhausted, the last day of coverage will be the last day of the first month of the three-month grace period.

For subsidized consumers, the QHP/QDP will be expected to pay claims during the first month of a grace period, but may suspend or pend claims in the second and third months. If the consumer settles all outstanding premium payments by the end of the grace period, then the pended claims should be paid as appropriate. If not, the claims for the second and third months may be denied. Carriers must notify providers who submit claims that an enrollee is in the second or third month of the grace period and that a claim may be denied if the outstanding premiums are not paid in full.

4.3.3 Changing Non-Payment Terminations to Voluntary Terminations

The HBE maintains the system of record for enrollment via Healthplanfinder. Voluntary terminations of coverage will occur via the Healthplanfinder web portal and will be communicated to carriers via an 834 termination transaction with a maintenance reason code of termination of coverage (07). For non-payment terminations, carriers will generate an 834 termination transaction with a maintenance reason code of non-payment (59).

If carriers receive payments after an enrollee is terminated for non-payment, carriers should communicate a change from termination for non-payment to voluntary termination via the reconciliation process (see Section 8: Reconciliation). The HBE will update the Healthplanfinder database to reflect a termination reason code of voluntary termination. Reporting this change is critical to ensure accuracy in the enrollee's 1095-A tax filing information at the end of the coverage year.

In the event a change of non-payment to voluntary is reported to the Reconciliation Analyst, a corrected EDI Termination file will be generated reflecting the updated voluntary reason code. This also ensures accurate reporting of 1095-A tax filing information to the enrollee.

4.4 Renewals and Redeterminations

4.4.1 Annual Eligibility Redeterminations

The HBE redetermines eligibility annually utilizing updated FPL tables, current application data, and benefit rates for the upcoming plan year, and then communicates anticipated eligibility results to consumers.

4.4.2 Trial Eligibility

The HBE will run a Trial Eligibility batch to perform the annual redetermination, and either auto renew eligible consumers, or provide communication to ineligible consumers to update their information in their Healthplanfinder application. The Trial Eligibility Batch job will run mid-October. However, the correspondence notifying consumers of their renewal will not generate until the beginning of the OEP. This is to prevent consumer confusion.

4.4.3 HIPTC Renewal

Consumers who provided consent for the HBE to use their Federal Tax Information (FTI) will be determined eligible for HIPTC and CSRs the upcoming plan year. Consumers who do not provide such consent will still be eligible for auto-renewal but will not be eligible for HIPTC and CSRs.

4.4.4 Auto-Renewal

Consumers may be eligible for auto-renewal in the same plan, or a similar plan, for the upcoming plan year. Consumers will have the option to update their application, redetermine eligibility based on change reporting, select a new plan, or cancel coverage for the upcoming plan year. If eligible for auto-renewal, consumers will have a “hands-off” approach to continuing their coverage for the upcoming plan year.

Consumers who are eligible to auto-renew, and do not report changes to their enrollment, will be processed through the Auto-Renewal Batch job at the end of the Trial Eligibility period. The Auto-Renewal Batch will send termination files for the current plan year enrollment, as well as create new enrollment records for the upcoming plan year. Consumers who reported changes, changed plans, or opted out of coverage for the next plan year will not be auto-renewed.

4.4.5 Manual Renewal

The HBE will notify consumers ineligible for auto-renewal that action is required in order to continue coverage for the upcoming plan year. As consumers report changes and manually select a plan for the upcoming plan year, Healthplanfinder will generate termination files for the current plan year enrollment, as well as create new enrollment records for the upcoming plan year.

4.4.6 EDI Sequencing for Auto and Manual Renewals

The following rules apply when sending 834 files to carriers during renewals or change reporting after renewals:

- A termination file is sent for the current coverage as soon as the consumer renews coverage for next year in a plan (same or different). This applies to both manual and auto-renewal enrollments.
- A new enrollment ID is issued for the enrollment the consumer creates while renewing. The enrollment can be in the same plan or a new plan for next year. A new add file is sent to a carrier when a consumer is enrolled in a plan during renewals period (same or different plan). This applies to both manual and auto-renewal enrollments and regardless of enrollment in the same plan or a new plan.

- Any changes made to the application during next year renewals that result in current year special enrollment can result in a change file and termination file created for the current year as two separate transactions but reported in the same file that day to the carriers when the same plan is selected. Please refer to the Time Stamping Logic Table below for details on the file sequencing logic.
- Any changes applied to current year's enrollment after renewals will result in a change file (same plan) or updated termination file (different plan) plus a new add and termination for the new plan selected being sent to the carrier in the same day transaction. Please refer to the Time Stamping Logic Table below for details on the file sequencing logic.
- Any changes reported after renewals on the renewed enrollment will result in a change file being sent to the carrier with the changes incorporated if same plan selected for this or next year. Please refer to the Time Stamping Logic Table below for details on the file sequencing logic.
- A termination file on renewals will be created only when a user is renewing for the next year. A termination file will not be generated for the users who have not renewed for next year and have the current plan expiring end of the year.
- A term file is sent to carriers on 12/31/16 for all enrollments ending 12/31/16 on applications that did not renew coverage in a new plan by 12/31/16.

4.4.6.1 Time Stamping Logic in 834s

The following table provides specific examples of the sequencing of EDI generation during renewals. For the purposes of the examples below, assume a consumer is enrolled in Plan A for 2016 and is renewing during 2017 OEP. Plan B refers to the same carrier plan and Plan C refers to a different carrier plan.

Table 2: Sequencing/Timestamping of EDI Generation During Renewals

Scenarios	Same Plan with Same Carrier (Plan A) – Time stamping order	Different Plan with Same Carrier (Plan B) - Timestamping order	Different Plan with Different Carrier (Plan C) – Timestamping order
Renewals (Currently Enrolled in Plan A)	**Following timestamping sequence will be followed:** - TERM 834 for Plan A on day of renewing* - ADD 834 for Plan A with new enrollment ID* - Effectuation 834 expected for the Plan A by HPF **Same Day Generation*	**Following timestamping sequence will be followed:** - TERM 834 for Plan A on day of renewing* - ADD 834 for the Plan B with new enrollment ID* - Effectuation 834 expected for Plan B by HPF **Same Day Generation*	- No timestamping logic for ADD and TERM - TERM 834 for Plan A on day of renewing* - ADD 834 for the Plan C with new enrollment ID* - Effectuation 834 expected for Plan C by HPF **Same Day Generation*

Scenarios	Same Plan with Same Carrier (Plan A) – Time stamping order	Different Plan with Same Carrier (Plan B) - Timestamping order	Different Plan with Different Carrier (Plan C) – Timestamping order
Change Reporting While Renewing (Currently Enrolled in Plan A)	**Following timestamping sequence will be followed:** - CHG 834 for Plan A 2015* - TERM 834 for Plan A 2015* - ADD 834 for Plan A 2016 with new enrollment ID* - Effectuation 834 expected for the Plan A 2016 by HPF **Same Day Generation*	**2015 Becomes Plan B, 2016 is Plan A** **Following timestamping sequence will be followed:** - TERM 834 for Plan A 2015* - ADD 834 for the Plan B with new enrollment ID* - Effectuation 834 expected for Plan B by HPF -TERM 834 for Plan B* -ADD 834 for Plan A 2016 with new enrollment ID* - Effectuation 834 expected for the Plan A 2016 by HPF **Same Day Generation*	**2015 Becomes Plan C, 2016 is Plan A** ***No sequencing order between A and C*** - TERM 834 for Plan A 2015* - ADD 834 for the Plan C with new enrollment ID* - Effectuation 834 expected for Plan C by HPF -TERM 834 for Plan C* -ADD 834 for Plan A 2016 with new enrollment ID* (**Should always be time stamped after Term for Plan A 2015)** - Effectuation 834 expected for the Plan A 2016 by HPF **Same Day Generation*
Change Reporting Post Renewals – (Currently Enrolled in Plan A for 2015, Plan B/C for 2016. SE opens for 2015 only)	**Following timestamping sequence will be followed:** - CHG 834 for Plan A with 2700 loop containing only 2015 information. Start and end dates correspond for 2015 coverage only -No TERM file for Plan A -No Effectuation 834 expected for Plan A by HPF	**Following timestamping sequence will be followed:** - TERM 834 for Plan A with updated date* - ADD 834 for Plan B with new enrollment ID* - TERM file for Plan B* - Effectuation 834 expected for Plan B by HPF **Same Day Generation*	***No sequencing order between A and C*** - TERM 834 for Plan A with updated date* **Sequencing order for Plan C** - ADD 834 for Plan C with new enrollment ID* - TERM file for Plan C* - Effectuation 834 expected for Plan C by HPF **Same Day Generation*
Change Reporting Post Renewals (Currently Enrolled in Plan B/C for 2015, Plan A for 2016. SE opens for 2016 only)	**Following timestamping sequence will be followed:** - CHG 834 for Plan A with 2700 loop containing only 2016 information. Start and end dates correspond for 2016 coverage only - No Effectuation 834 expected for Plan A by HPF	**Following timestamping sequence will be followed:** - TERM 834 for Plan A* - ADD 834 for Plan B with new enrollment ID* - Effectuation 834 expected for Plan B by HPF **Same Day Generation*	***No sequencing order between A and C*** - TERM 834 for Plan A* - ADD 834 for Plan C with new enrollment ID* - Effectuation 834 expected for Plan C by HPF **Same Day Generation*

Scenarios	Same Plan with Same Carrier (Plan A) – Time stamping order	Different Plan with Same Carrier (Plan B) - Timestamping order	Different Plan with Different Carrier (Plan C) – Timestamping order
Change Reporting Post Renewals (Currently Enrolled in Plan A for 2015 and 2016. SE opens for both 2015 and 2016)	**Following timestamping sequence will be followed:** - CHG 834 for Plan A with 2700 loop containing only 2015 information. Start and end dates correspond for 2015 coverage only - CHG 834 for Plan A with 2700 loop containing only 2016 information. Start and end dates correspond for 2016 coverage only. - No TERM file sent for the 2015 Plan A - Different Enrollment ID for both Plan A's - No Effectuation 834 expected for any Plan A by HPF	**2015 Becomes Plan B, 2016 stays Plan A** **Following timestamping sequence will be followed:** - TERM 834 for Plan A (2015 2700 loop)* - ADD 834 for Plan B* - TERM 834 for Plan B (2015 2700 loop)* -CHG 834 for Plan A* (2016) - Effectuation 834 expected for Plan B by HPF **Same Day Generation*	**2015 Becomes Plan C, 2016 stays Plan A** ***No sequencing order between A and C*** - TERM 834 for Plan A (2015 2700 loop)* - ADD 834 for Plan C* - TERM 834 for Plan C (2015 2700 loop)* -CHG 834 for Plan A* (2016) **(timestamped after term for plan A (2015))** - Effectuation 834 expected for Plan C by HPF **Same Day Generation*
		2016 Becomes Plan B, 2015 stays Plan A **Following timestamping sequence will be followed:** -CHG 834 for Plan A* (2015) - Effectuation 834 expected for Plan B by HPF - TERM 834 for Plan A (2016 2700 loop)* - ADD 834 for Plan B* **Same Day Generation*	**2016 Becomes Plan C, 2015 stays Plan A** ***No sequencing order between A and C*** -CHG 834 for Plan A* (2015) **(timestamped after Term for Plan A)** - TERM 834 for Plan A (2016 2700 loop)* - ADD 834 for Plan C* - Effectuation 834 expected for Plan C by HPF **Same Day Generation*
		2015 and 2016 both become Plan B **Following timestamping sequence will be followed:** - TERM 834 for Plan A (2015 2700 loop)* - ADD 834 for Plan B (2015 2700 loop)* - Effectuation 834 expected for the Plan B (2015) by HPF - TERM 834 for Plan B (2015 2700 loop)* - TERM 834 for Plan A (2016 2700 loop)* - ADD 834 for Plan B (2016 2700 loop)* - Effectuation 834 expected for Plan B (2016) by HPF **Same Day Generation*	**2015 and 2016 both become Plan C** ***No sequencing order between A and C*** **Timestamping order for Plan A** - TERM 834 for Plan A (2015 2700 loop)* - ADD 834 for Plan C (2015 2700 loop)* - Effectuation 834 expected for the Plan C (2015) by HPF - TERM 834 for Plan C (2015 2700 loop)* - TERM 834 for Plan A (2016 2700 loop)* **(timestamped after term for A in 2015)** **Timestamping order for Plan C** - ADD 834 for Plan C (2016 2700 loop)* - Effectuation 834 expected for Plan C (2016) by HPF **Same Day Generation*

Table 3: Sequencing/Timestamping of EDI Generation During Change Reporting

	Same Plan with Same Carrier (Plan A)	Different Plan with Same Carrier (Plan B)	Different Plan with Different Carrier (Plan C)
Change Reporting Outside of Renewals (Currently Enrolled in Plan A)	**Following timestamping sequence will be followed:** - CHG 834 for Plan A 2015* - Effectuation 834 not expected for changes **Same Day Generation*	**Following timestamping sequence will be followed:** - TERM 834 for Plan A 2015* - ADD 834 for the Plan B with new enrollment ID* - Effectuation 834 expected for Plan B by HPF **Same Day Generation*	***No sequencing or timestamping logic.*** - TERM for Plan A and Add for Plan C can be sequenced in any order - Effectuation 834 expected for Plan C by HPF

4.4.6.2 EDI Renewal Code

The 834 Maintenance Code of 41 will be sent upon renewal if both the previous year and next-year plans are from the same carrier.

4.4.7 Grace Periods for Initial Binder Payment

The 2017 Notice of Benefit and Payment Parameters explains that 45 CFR 156.270(d) was amended to eliminate language limiting the three-month grace period for enrollees receiving HIPTC to only those enrollees who made a payment during the benefit year. This means that a carrier must provide a three-month grace period to enrollees who are renewed into the same product, fail to pay January premiums, and are receiving HIPTC. During this three-month grace period, carriers must continue to collect advance payments of the premium tax credit on behalf of the renewed enrollee and return advance payments of the premium tax credit paid for the second and third months of the grace period if the renewed enrollee exhausts the grace period.

4.4.7.1 Grace Period Spanning Two Years for APTC Enrollees

The grace period for non-payment of premiums may span two plan years if enrollees receiving APTC fail to pay premiums for November or December coverage. Consistent with guaranteed renewability of coverage, carriers must accept the renewal of the enrollee since the enrollee is still in a grace period.[4] Carriers may apply payments to the oldest debt in the existing grace period. If the enrollee does not pay all outstanding premiums by the end of the three-month grace period, the carrier must terminate the enrollment as of the last day of the first month of the grace period. Since the 2017 coverage resulted from a renewal of the terminated 2016 coverage, the 2017 coverage should also be cancelled as never effective.[5] The enrollee can still select a QHP from the same carrier (either during remainder of OE or via SEP). Pursuant to guaranteed availability, in these circumstances (once a previous year's enrollment is terminated) the carrier must not apply any premium payments made toward the new coverage to any outstanding debt from any previous coverage.[6]

[4] 45 CFR §147.106
[5] 45 CFR §156.270 and §155.430
[6] 45 CFR §147.104

Scenario 1: An enrollee receiving APTC is enrolled in Plan A for 2016. The enrollee fails to make a premium payment for November 2016. The enrollee enters a three month grace period beginning on November 1, 2016 and ending January 31, 2017. On December 2, 2016 the enrollee is passively renewed for the 2017 plan year. The QHP carrier must accept the renewal (via 834 effectuation/confirmation transaction). The renewed coverage continues into 2017 subject to the existing grace period. The enrollee does not pay all outstanding premiums for 2016 by January 31, 2017. The carrier retroactively terminates the enrollee's 2016 coverage effective November 30, 2016 (via 834 termination for non-payment transaction). The carrier cancels the consumer's 2017 coverage as never effective (via 834 cancellation for non-payment transaction). Since 2017 open enrollment ends on January 31, 2017, the consumer must qualify for an SEP in order to enroll for 2017 plan year. If the consumer qualifies for an SEP and enrolls in Plan A for 2017 and makes a binder payment, the carrier must accept the enrollment (via 834 confirmation/effectuation transaction) and not apply any premium payments made toward Plan A for 2017 to any outstanding debt from Plan A for 2016.

Scenario 2: Same as previous slide except the enrollee does not make a premium payment for December 2016. The enrollee enters a three month grace period beginning on December 1, 2016 and ending February 28, 2017. On December 2, 2016 the enrollee is passively renewed for the 2017 plan year. The QHP carrier must accept the renewal (via 834 effectuation/confirmation transaction). The renewed coverage continues into 2017 subject to the existing grace period. The enrollee does not pay all outstanding premiums for 2016 by February 28, 2017. The carrier retroactively terminates the enrollee's 2016 coverage effective December 31, 2016 (via 834 termination for non-payment transaction). The carrier cancels the consumer's 2017 coverage as never effective (via 834 cancellation for non-payment transaction). Since 2017 open enrollment has ended, the consumer must qualify for an SEP in order to enroll for 2017 plan year. If the consumer qualifies for an SEP and enrolls in Plan A for 2017 and makes a binder payment, the carrier must accept the enrollment (via 834 confirmation/effectuation transaction) and not apply any premium payments made toward Plan A for 2017 to any outstanding debt from Plan A for 2016.

Scenario 3: An enrollee receiving APTC is enrolled in Plan A for 2016. The enrollee fails to make a premium payment for November 2016. The enrollee enters a three month grace period beginning on November 1, 2016 and ending January 31, 2017. On December 2, 2016 the enrollee is passively renewed for the 2017 plan year. The QHP carrier must accept the renewal (via 834 effectuation/confirmation transaction). The renewed coverage continues into 2017 subject to the existing grace period. The enrollee pays all outstanding premiums for 2016 by January 31, 2017. The consumer has until March 31, 2017 to pay for January, February and March 2017 coverage.

4.4.7.2 Grace Period Ending on December 31, 2016

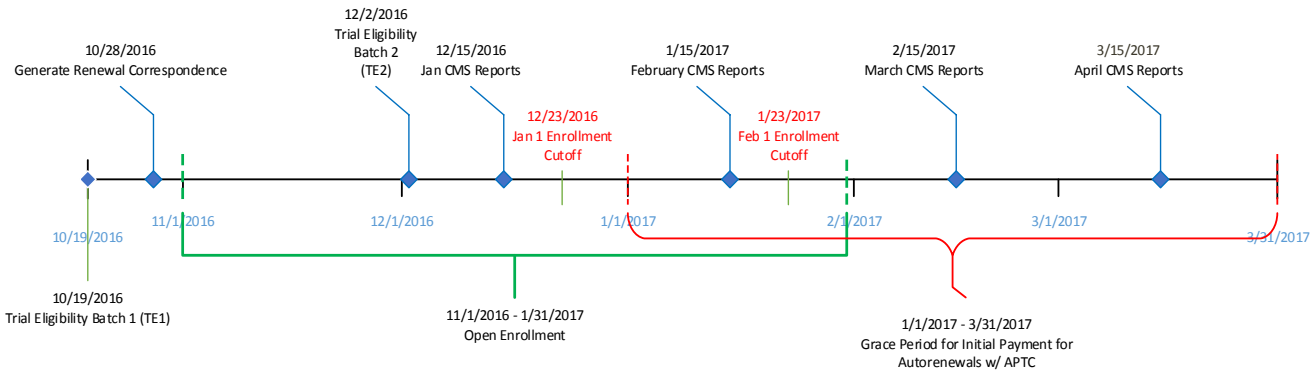
If an enrollee's grace period will expire on December 31, 2016, the QHP/QDP has the option to accept or reject the renewal. The carrier's policy should be applied consistently across all enrollees.

Scenario 4: An enrollee not receiving APTC is enrolled in Plan B for 2016. The enrollee fails to make a premium payment for December 2016. The enrollee enters a one month grace period beginning on December 1, 2016 and ending December 31, 2016. On December 2, 2016 the enrollee is passively renewed for the 2017 plan year. If the enrollee does not pay all outstanding premiums by December 31, 2016, the carrier may reject the renewal (sends 834 cancellation for non-payment transaction) and terminates the enrollee's 2016 coverage effective November 30, 2016 (via 834 termination for non-payment transaction). Since the consumer is still in 2017 open

enrollment, the consumer enrolls in Plan B for 2017 with a February 01, 2017 start date and makes a binder payment. The carrier must accept the enrollment (via 834 confirmation/effectuation transaction) and not apply any premium payments made toward Plan B for 2017 to any outstanding debt from Plan B for 2016.

Scenario 5: An enrollee receiving APTC is enrolled in Plan B for 2016. The enrollee fails to make a premium payment for October 2016. The enrollee enters a three month grace period beginning on October 1, 2016 and ending December 31, 2016. In November 2016 the enrollee actively renews for the 2017 plan year and makes their January 2017 payment. The carrier may apply the January premium payment to the outstanding October premium. If the enrollee does not pay all outstanding premiums by December 31, 2016, the carrier rejects the renewal (sends 834 cancellation for non-payment transaction) and terminates the enrollee's 2016 coverage effective November 30, 2016 (via 834 termination for non-payment transaction). Since the consumer is still in 2017 open enrollment, the consumer enrolls in Plan B for 2017 with a February 01, 2017 start date and makes an on time binder payment. The carrier must accept the enrollment (via 834 confirmation/effectuation transaction) and not apply any premium payments made toward Plan B for 2017 to any outstanding debt from Plan B for 2016.

4.4.8 Renewal and Grace Period Timeline



4.5 Mid-Month Enrollment and Disenrollment

The HBE will support mid-month enrollment and disenrollment only in the case of a qualified consumer gaining a dependent through birth, adoption, placement for adoption, placement in foster care, or losing an enrolled household member due to death. Birth, adoption, placement for adoption, placement in foster care, and death are the only special enrollment qualifying events that require retroactive enrollment or disenrollment, except in the instance that an enrollee contacts the HBE due to extenuating circumstances. Other qualifying events do not require retroactive enrollment or disenrollment.

In the case of reporting a birth, adoption, placement for adoption, or placement in foster care, the consumer has 60 days to report the event and will have a 60-day SEP from the date of the qualifying event to select a QHP/QDP.

In the case that a consumer elects to change from one QHP/QDP to another because of a qualifying event, the effective end date of coverage in the current QHP/QDP will be the day prior to the qualifying event and the effective start date in the new QHP/QDP will be the day of the qualifying event.

4.5.1 Termination and Reenrollment Due to Death of Primary Applicant

The HBE will support mid-month terminations in the case of death. In the case that the Primary Applicant (PA) on a Washington Healthplanfinder application passes away, certain steps must be taken in order to ensure that any remaining household consumers remain eligible for coverage under their plan, and that the monthly premium is adjusted to reflect the reduction in covered household consumers.

Remaining household consumers have 60 days from the date of event to report this information on their Washington Healthplanfinder application. Reporting this change will trigger an SEP in Washington Healthplanfinder, and the household consumers will have 60 days from the date of event to select a different plan or confirm enrollment in their current plan.

Monthly premiums will be pro-rated by the carrier when a mid-month disenrollment takes place due to the death as long as the change is reported within the 60-day window.

If more than 60 days has elapsed between the date of death and when consumers notify the HBE, the HBE will proceed with retroactively disenrolling the PA due to death, but the remaining household consumers will not be eligible for an SEP and will instead continue enrollment in the plan already selected under a new application and PA.

4.5.2 Removing Household Member Due to Death

Eligibility must be redetermined in the case that an enrolled household member passes away. To report such a change and trigger an SEP, which would allow the consumer to select a new plan for remaining household consumers, the change must be reported to the HBE no later than 60 days after the date of the death. The PA has 60 days from the date of death to select a new QHP/QDP if they elect to change from one QHP/QDP to another. The new coverage will begin the first of the following month from when the change is reported.

- If the death is reported more than 60 days after the date of the event, the consumer's eligibility determination will be updated accordingly. However, the consumer must wait for the next OEP to select a new plan for the next year, or report a different qualifying life event in order to qualify for an SEP. The PA/household has 60 days from the date of event to notify the HBE.
- Reporting the event initiates three changes to the enrollment: a change in covered household consumers, an end date for the old premium, and a start date for the new premium. This would all be included in one EDI transaction.
- Premiums will be pro-rated when a mid-month disenrollment takes place due to death. These adjustments to the monthly premium will be calculated and invoiced by the carrier. The pro-rated premium is based on the coverage end date and/or date coverage begins.

4.5.3 Mid-Month Enrollment and Disenrollment (Pro-Rated Premium Calculation)

Carriers will be responsible for pro-rating premiums in the event of mid-month enrollment and disenrollment. Following the Federal Marketplace process, the HBE will send the full-month premium in the EDI files to carriers and rely on carriers to pro-rate premiums for additions due to birth, adoption, placement for adoption, etc. and terminations due to death.

4.6 Re-Rating Calculations

Consumers remaining in the same plan should not be re-rated unless the individual subscriber changes. In cases where a subscriber does change, re-rating should occur.

4.7 Reenrollment

HBE will support reenrollment of health benefits during the annual OEP or upon eligibility for an SEP (See Section 7: Special Enrollment).

The HBE will not limit how many times a consumer can reenroll during a calendar year due to the potential churn between Medicaid eligibility and subsidized or non-subsidized coverage through a QHP. There are many business scenarios where a consumer loses and regains QHP/QDP coverage including a change in eligibility to gain or lose Medicaid coverage. In all cases, the HBE will support reenrollment of QHP/QDP health benefits during the annual OEP or upon eligibility for an SEP.

4.8 Retroactive Enrollment

HBE will support retro-enrollment in certain situations. The below scenarios may qualify for retro-enrollment consideration:

- Error of the Exchange that resulted in a consumer not being able to enroll for expected coverage date.
- Consumers who lose coverage outside of the Healthplanfinder, but report it to the HBE within 10 calendar days from the last day of coverage. This will ensure the consumer does not have a gap in coverage.

4.9 Retroactive Disenrollment

HBE will support retroactive disenrollments in certain situations. HBE Account Workers will review requests for retroactive disenrollments for nonpayment months, churning from QHP to WAH, and gaining minimum essential coverage. All other scenarios will be reviewed on a case-by-case basis.

The below scenarios may qualify for retro dis-enrollment consideration:

- Minimum Essential Coverage (MEC) other than Medicare: consumers may term back to the last day of the month before MEC begins if reported within 10 days of coverage beginning.
- Medicare: If the consumer calls during the 1st month for which they were found eligible for and/or enrolled in Medicare.
- Consumers who request retro disenrollment after the 23rd but before the 1st of the following month.
- Error of the Exchange: errors that occurred out of the consumer's control and are clearly documented.
- Dually enrolled via Washington Healthplanfinder: consumers who are dually enrolled in error that resulted in consumers having multiple applications, overlapping coverage, or multiple enrollments on the same application.

4.10 Carrier Initiated Reactivation of Members Previously Cancelled for Nonpayment in Current Coverage Year

The HBE will support reactivation of coverage for consumers who were previously cancelled for nonpayment in the current coverage year when the carrier initiates the requests and determines that the cancellation for nonpayment was not warranted.

Due to limitations in Edifecs (expected to be resolved in Edifecs Release 2.0 in September 2016) carriers must send an email to CE4@wahbexchange.org or work directly with their Reconciliation Analyst to request and complete the reactivation process. Once a request is received, the Reconciliation Analyst will use the Data Fix Automation functionality in the Healthplanfinder to process. This will result in an add transaction being generated and sent to carriers. If HIPTC or CSRs have changed since the initial enrollment, a change transaction may also be generated. Once the reactivation process is completed, the Reconciliation Analyst will respond to the original request indicating the process is complete.

Once Edifecs Release 2.0 is deployed, carriers should discontinue sending reinstatement requests through the CE4@wahbexchange.org mailbox and should instead send an 834 Confirm transaction.

If a consumer calls the HBE Customer Support Center to request a reinstatement of their coverage due to an issue with the carrier, the representative will advise the consumer to contact their carrier by following the "Oasis" process (see section 4.13 Redirecting Customers Incorrectly Referred to the HBE Customer Support Center – "Oasis" Process).

4.11 Reactivating Members Coverage due to HBE Error

The HBE may approve reactivation of coverage due to errors of the HBE, partner agencies, or consumer error, if clearly documented. The HBE will work with carriers on these scenarios on a case-by-case basis.

4.12 Carrier requests to move coverage start or end dates

When carriers approve changes to consumers' coverage start or end date, carriers will work directly with the Reconciliation Analyst for processing. These changes must be sent to the HBE via email to CE4@waHBExchange.org and the following information must be included in the initial email request:

- The new coverage start and/or end date
- Reason for approving change to coverage dates (i.e. HBE error, carrier error, etc.)

Please see the "Oasis" process (Section 4.13 Redirecting Customers Incorrectly Referred to the HBE Customer Support Center – "Oasis" Process) regarding cases where the carrier incorrectly refers a consumer to the HBE call center in order to request a change in coverage dates based on carrier error.

4.13 Redirecting Customers Incorrectly Referred to the HBE Customer Support Center – "Oasis" Process

When consumers experience errors caused by the carrier's systems, the carrier may opt to grant the consumer a different start or end date for their coverage. Additionally, carriers may approve a consumer's reinstatement request, or determine their enrollment should be cancelled due to an ineligible special enrollment event that allowed them to enroll outside of Open Enrollment. If the carrier approves such a request, the carrier should submit their request to CE4@wahbexchange.org in order to get this request processed and active in the Washington Healthplanfinder system.

When a consumer contacts the HBE requesting a change in coverage start or end date due to difficulty experienced with the carrier's system, the HBE Customer Support Representative will ask the consumer if the difficulties they experienced are related to their billing or invoices, and perform an initial review of the application. If the Customer Support Representative determines that the error was due to billing or invoice

discrepancies, or an issue with the carrier's system, they will advise the consumer that these requests must come from the carrier and provide the consumer with the key word "Oasis." The CSR will explain to the consumer that when they call the carrier again, they should provide the key word to the carrier representative to ensure their request is routed to the correct department for processing.

4.14 Changing from Family to Dependent Coverage or Dependent to Family Coverage

When a consumer selects a plan through Washington Healthplanfinder, the type of coverage described in the EDI transaction is populated automatically based on which household members the consumer has indicated are seeking coverage. If the PA is seeking coverage, then this is considered Family Coverage (FAM). If the PA is not seeking coverage, then this is considered Dependent-Only Coverage (DEP). As an application is updated and household members are changed from seeking to not seeking coverage, or vice versa, this may result in a change from FAM to DEP or DEP to FAM coverage. When this occurs, Washington Healthplanfinder generates an add transaction, followed by a change transaction, but many carriers are unable to process this conversion through the use of a change transaction. Instead, these carriers require a term transaction for the original coverage type (FAM or DEP) followed by an ADD file for the new coverage type (FAM or DEP). Currently, this requires manual intervention by your Reconciliation Analyst.

HBE Account Workers should follow a specific process when a consumer has indicated that they are changing the PA to seeking or not seeking coverage on the application, if that answer is different than what was indicated when their plan was first selected. It should be noted that FAM to DEP and DEP to FAM coverage issues are likely to be flagged as rating issues on the carrier's end as they process the new enrollment information. It is expected that carriers will do their due diligence to review these EDI transactions thoroughly prior to returning on an error report. This process is designed to minimize the use of manual EDI transactions, and ensure that the carrier receives transactions that are likely to be processed successfully and timely.

4.15 Changing from Family to Dependent Coverage or Dependent to Family Coverage via Change Reporting Causing Churn

A change from FAM to DEP or DEP to FAM coverage may occur unintentionally due to churning eligibility from WAH to QHP/QDP or vice versa. This may occur when a consumer has indicated that they have experienced one of the following scenarios:

- Consumer reports an income change that makes them eligible or ineligible for WAH.
- The application was originally submitted as FAM coverage, but prior to becoming active, PA reports they are no longer seeking coverage.
- PA reports a pregnancy that makes them eligible WAH Pregnancy coverage.
- PA is no longer pregnant, which makes them ineligible for WAH Pregnancy coverage.
- PA turns 65 years old and is eligible for Medicare.
- PA is lawfully present for a period of five years and is now eligible for WAH.

5 Appeals

Any consumer who applies through Healthplanfinder may appeal the eligibility determination they receive. All appeals must be filed within 90 days of the date on the consumer's eligibility notification:

- Online: www.wahbexchange.org/appeals
- Email: Appeals@wahbexchange.org
- Fax: 360-841-7653
- Phone: 1-855-859-2512 (360-688-7814)
- Mail: PO Box 1757, Olympia, WA 98507-1757

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

- Whether the consumer can buy a health insurance plan through WA Healthplanfinder.
- Whether the consumer can enroll in a WA Healthplanfinder plan outside the regular OEP.
- Whether the consumer is eligible for lower monthly premiums based on their income.
- The amount of savings the consumer is eligible for when they use services through a QHP.
- Whether the consumer should receive benefits as an American Indian or Alaska Native.

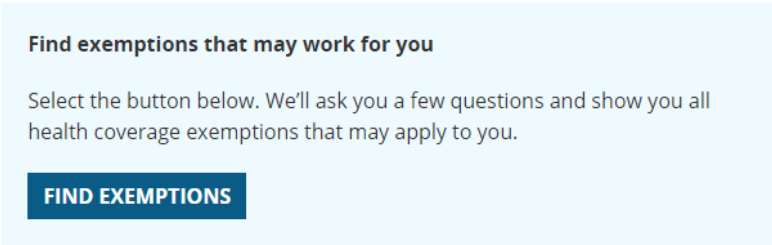
The HBE Presiding Officers do not have authority to decide the following:

- Correcting the 1095A IRS form
- Health insurance coverage start date and end dates
- Termination of coverage
- Requests for re-instatement
- WAHBE Board policy requiring all children to be enrolled in Pediatric Dental Insurance through WA Healthplanfinder
- Billing disputes and refund requests
- The carrier's decision to deny a Special Enrollment Period
- Claims the insurance company denied to pay

6 Exemptions to the Shared Responsibility Payment

The ACA requires most individuals to have health insurance (individual mandate) or pay a penalty (shared responsibility payment). Starting in Open Enrollment 2016, consumers who want to request an exemption from this penalty will need to make their request with either the IRS or the Federal Marketplace. Consumers should not upload an exemption request into Healthplanfinder or send their exemption request to the HBE or Customer Support Staff.

To apply for an exemption, consumers must visit www.healthcare.gov/exemptions and click on the "Find Exemptions" box (see image below) and complete the questionnaire. After completing the online application, a consumer will be shown the exemptions for which they qualify.



7 SPECIAL ENROLLMENT

7.1 SPECIAL ENROLLMENT QUALIFYING LIFE EVENTS

Consumers who apply for coverage outside of an OEP, and who are determined ineligible for WAH, must qualify for an SEP in order to enroll in a QHP/QDP or have the option of shopping for a new plan (existing QHP/QDP enrollees). Generally, a consumer has 60 days from the date of the qualifying life event to report the life event and confirm a plan.

7.2 VERIFICATION OF SPECIAL ENROLLMENT QUALIFYING EVENTS

7.2.1 SEP Verification Process

For qualifying life events that automatically open an SEP when reported through the Healthplanfinder application process, the HBE will accept the consumer's self-attestation as proof of the qualifying life event. For qualifying life events that a consumer cannot report via the Healthplanfinder application process, the HBE will require documentation of the qualifying life event prior to allowing the consumer to enroll in a QHP/QDP.

For a list of all qualifying life events and effective dates of coverage based on the qualifying life event, see Section 7.2.4: Special Enrollment.

7.2.2 Special Enrollment 834 Codes

Most SEP qualifying life events are communicated to carriers via SEP reason codes contained in the 2750 loop of an 834 transaction. There are several SEP scenarios for which the SEP reason code is not included in the 2750 loop. For each of these scenarios HBE will verify documentation of the qualifying life event. These scenarios include the following:

- Errors or Misconduct of the WAHBE
- Exceptional Circumstances as defined by the WAHBE
- Misconduct by an WAHBE or non-WAHBE enrollment assister
- Loss of WAH minimum essential coverage
- Unresolved Casework

7.2.3 Carrier Termination or Cancellation of Coverage if Qualifying Life Event Not Approved

Carrier termination or cancellation of coverage due to failure to prove a qualifying life event will not occur via an 834 transaction. Termination or cancellation of coverage due to failure to prove a qualifying life event will occur through the reconciliation process. Carriers should request termination or cancellation of coverage due to failure to prove a qualifying event via the reconciliation process. Please refer to Section 8.4 Urgent Discrepancies.

7.2.4 Special Enrollment Qualifying Life Events

SEP QUALIFYING LIFE EVENT	DESCRIPTION/DETAILS	EFFECTIVE DATE OF COVERAGE	RELATED EDI CODE
Adding a Dependent	Includes gaining a dependent or becoming a dependent through: • Marriage • Birth • Adoption • Placement for adoption • Placement in foster care • Receipt of a court order (including child support)	Date of birth, adoption, foster care placement, or court order. For marriage, coverage is effective the first day of the month following QHP/QDP selection.	02
Losing a Dependent or Dependent Status	Loss of a dependent or loss of dependent status due to death, divorce, or legal separation. *Note: This SEP is available only to existing consumers (not first time applicants).*	For death, coverage is effective the first day of the month following QHP/QDP selection. For divorce or legal separation, coverage start date follows enrollment cutoff (23rd) rule.	32
Change in program eligibility or amount of financial help	An enrollee is determined newly eligible or newly ineligible for HIPTC or has a change in CSR tier. *Note: This SEP is available only to existing consumers (not first time applicants).*	Follows enrollment cutoff (23rd) rule.	FC
Loss of Minimum Essential Coverage (MEC)	Includes the following: • Expiration of a non-calendar year health insurance policy, even if the consumer has the option to renew • Loss of pregnancy-related WAH coverage • Beginning or ending service in an AmeriCorps VISTA, or National Civilian Community Corps program • Loss of Employer Sponsored Insurance (ESI) • Loss of Washington Apple Health • Loss of Washington State Health Insurance Pool coverage (WSHIP)	Coverage is effective on the first day of the month after the loss of MEC if plan selection occurs before the loss of MEC. If plan selection occurs after the loss of MEC, coverage is effective the first of the month after plan selection.	07 or NE

SEP QUALIFYING LIFE EVENT	DESCRIPTION/DETAILS	EFFECTIVE DATE OF COVERAGE	RELATED EDI CODE
	• Loss of Qualified Health Plan due to permanent move • Loss of employer coverage with eligibility for COBRA or expiration of CORBRA coverage		
Change in Citizenship or Lawful Presence Status	An individual, who was not previously a citizen, national, or lawfully present individual, gains such status.	Follows enrollment cutoff (23rd) rule.	NE
Permanently moving from a location in the United States to Washington, or to a new county within Washington, only if you had minimum essential coverage for at least one day within the 60 days before you moved	The move results in: • Becoming a resident of Washington • Moving to a new county in Washington resulting in new plan options Consumer can enroll in plan up to 60 days before or after the date of the move.	If a plan is selected before the move, coverage starts the first day of the month after the move is reported and new plan selection occurs. If a plan is selected after the move, coverage start date follows the enrollment cutoff (23rd) rule.	43
Permanently moving from a location outside the United States to Washington	Consumer can enroll in plan up to 60 days before or after the date of the move.	If a plan is selected before the move, coverage starts the first day of the month after the move is reported and new plan selection occurs. If a plan is selected after the move, coverage start date follows the enrollment cutoff (23rd) rule.	43
Release from jail/prison	This is reported as a loss of minimum essential coverage. At least one person on the application must have a change in incarceration status (from incarcerated to no longer incarcerated).	Coverage is effective on the first day of the month after the loss of MEC if plan selection occurs before the loss of MEC. If plan selection occurs after the loss of MEC, coverage is effective the first of the month after plan selection.	NE

SEP QUALIFYING LIFE EVENT	DESCRIPTION/DETAILS	EFFECTIVE DATE OF COVERAGE	RELATED EDI CODE
Filed or reconciled taxes for a year that you received health insurance premium tax credits	If a consumer receives tax credits in advance in a prior coverage year, the consumer must file a tax return. If the consumer does not file a tax return, they will lose the opportunity to receive a tax credit until the IRS has confirmed the individual has filed their federal taxes.	Follows enrollment cutoff (23rd) rule.	EX
Tribal Membership	The qualified individual who is an American Indian/Alaskan Native may enroll in a QHP or change from one QHP to another one time per month.	Follows enrollment cutoff (23rd) rule	None: Tribal status is verified by the HBE via conditional eligibility verification process. Carriers should use the AI/AN indicator in EDI transaction to identify households eligible for monthly SEP. Additional documentation should not be requested.
Victims of domestic abuse/violence or spousal abandonment and their dependents	Consumer is a survivor of domestic abuse/violence or spousal abandonment. Unmarried and dependent survivors of domestic abuse within a household may also qualify for this special enrollment.	Plan selection must occur within 60 days of reporting the domestic abuse/violence or spousal abandonment. Coverage effective date follows the 23rd rule from plan selection.	EX
System errors that kept the client from enrolling during SEP or Open Enrollment	• System issues must be documented; and • Must have occurred during open enrollment or a 60 day SEP; and • Error must have prevented enrollment from occurring during open enrollment or 60 day SEP	Coverage may be backdated to the coverage effective date consumer would have received had error not occurred.	ER

SEP QUALIFYING LIFE EVENT	DESCRIPTION/DETAILS	EFFECTIVE DATE OF COVERAGE	RELATED EDI CODE
Non-system errors or misconduct of the WAHBE	Enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer or employee of the WAHBE.	Coverage effective date is based on the circumstances of the SEP.	ER
Misconduct by a HBE or non-HBE enrollment assister (like an insurance company, navigator, certified application counselor, or agent or broker).	Misconduct resulted in consumer: • Not getting enrolled in a plan • Being enrolled in the wrong plan • Not getting the premium tax credit or cost-sharing reduction consumer was eligible for	Coverage effective date is based on the circumstances of the SEP.	ER
Exceptional Circumstances as defined by the WAHBE	The qualified individual or enrollee, or his or her dependent, demonstrates to the WAHBE that the individual meets other exceptional circumstances as the WAHBE may provide (e.g. natural disaster).	Coverage effective date must be based on the circumstances of the SEP (either the date of the triggering event or enrollment cutoff (23rd) rule).	EX
Unresolved Casework	Consumer is working with WAHBE staff on an enrollment issue that didn't get resolved before the end of the open-enrollment period (Jan. 31, 2016 for 2017 coverage). *Note: Account worker/case worker who was working with the customer to try to resolve the issue before the close of OE will open SEP or submit the case for review after case issue resolved – CSRs do not need to log a ticket.*	Coverage may be backdated to the coverage effective date consumer would have received had the delay not occurred.	EX or ER

7.2.5 Special Enrollment Correspondence

The HBE sends a correspondence to individuals reporting a qualifying life event to notify them that the carrier may ask for documentation to verify the event. A nightly batch job will trigger this correspondence and make it available on the consumer's dashboard the day after the consumer selects a QHP/QDP.

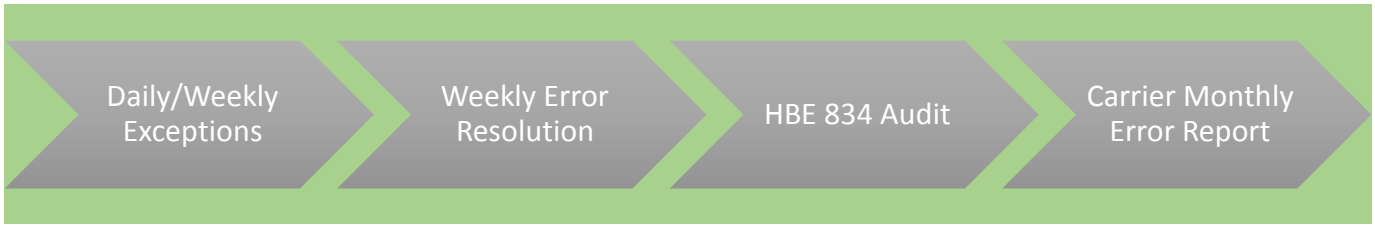
8 RECONCILIATION OF ENROLLMENT DATA

Federal regulations require carriers and the HBE to reconcile enrollment data on a monthly basis at a minimum. Currently, the HBE utilizes both weekly and monthly reconciliation processes to resolve enrollment data discrepancies with carriers.

In September of 2015, the WAHBE installed a new EDI management system, Edifecs, to streamline the EDI transmission and reconciliation process with carriers. A critical component of streamlining the reconciliation process is carrier generation of monthly 834 audit files. The receipt of a monthly carrier-generated 834 audit file enables the HBE to compare data in the carrier and HBE systems to produce a master monthly discrepancy report and integrate the HBE and carrier reconciliation processes.

Testing of the carrier-generated 834 audit file began in early 2016 and will continue until August 1, 2016. Beginning August 1, 2016, the HBE will began implementation of a master monthly discrepancy report. Implementation will take a phased approach, and the HBE will continue the current reconciliation process until the master monthly discrepancy report process is fully functional. Implementation of the master monthly discrepancy report will also be an iterative process, dependent on input from both the carrier and HBE Reconciliation Analysts as they work through the master discrepancy report. Carriers should work directly with their assigned HBE Reconciliation Analyst and utilize weekly HBE/carrier meetings to provide feedback.

Previous reconciliation process:



Reconciliation process as of August 1, 2016:

8.1 DAILY EXCEPTIONS

If an EDI transaction fails due to a business validation in the Edifecs system, an exception is generated and processing of the EDI transaction is stopped. The related exception is reviewed by an HBE Reconciliation Analyst. Once the exception is corrected, it is released back into the processing flow. If it is determined that the EDI transaction should not be released back into the processing flow, the exception is closed, stopping all further processing of the EDI transaction.

The HBE Reconciliation Analysts will work EDI exceptions daily to proactively correct EDI errors and enrollment data discrepancies prior to sending transactions to carriers.

8.2 Weekly Error Resolution

8.2.1 Reconciliation Analyst and Carrier 1:1 Meetings

Carriers will work directly with their HBE Reconciliation Analyst weekly to focus on unresolved errors, urgent discrepancies, and all other issues that need to be addressed. These meetings will be a maximum of two hours each week. The occurrence and timing of these meetings may vary slightly depending on carrier enrollment volume and current reconciliation needs.

Any escalated discrepancies can be addressed immediately following the urgent discrepancies process (see Section 8.4 Urgent Discrepancies below).

8.2.2 HBE and Carrier 1:1 Meetings

The HBE will facilitate weekly one-on-one meetings with each carrier. Participants will include staff who represent the HBE's operations, policy and consumer support departments. These meetings will be focused on coordinating operational efforts, answering policy questions, prioritizing work streams, and addressing escalated issues.

8.2.3 HBE All-Carrier Meeting

The HBE will facilitate a weekly all-carrier meeting. This meeting will provide updates and raise issues related to the following: QHP/QDP plan management; EDI; consumer support; changes to business processes; policy updates and regulation changes; the Healthplanfinder system issues and changes; and all other carrier questions or concerns.

8.3 Monthly 834 Audit & Discrepancy Report

Beginning August 1, 2016 carriers will generate a monthly 834 audit file for each QHP/QDP and send to the HBE via the SFTP site by the last business day of each month. The HBE will compare the carrier-generated monthly files against the HBE-generated monthly files and create a master discrepancy report. The HBE Reconciliation Analysts will review each discrepancy and determine whether updates need to be made in the HBE's or carrier's systems. The HBE Reconciliation Analyst will document the action required on the report and send to carriers via the SFTP site.

Any HBE action required will be completed by the HBE Reconciliation Analyst. The HBE expects carriers to update their systems based on the carrier's action required in the master discrepancy report.

Please note: The HBE will continue to send a monthly 834 audit file for each QHP/QDP to carriers. These files generate on the 24th day of each month and are sent to carriers within two business days.

8.4 Urgent Discrepancies

The HBE expects carriers to work directly with their HBE Reconciliation Analyst to report urgent discrepancies. Requests should be sent to CE4@wahbexchange.org.

Carriers must provide the following information:

New Requests

- **Subject line:** *Carrier Escalation – Subscriber Last Name – Subscriber PID*
- **Message:** *Brief description of the request, including the PID of the Primary Applicant*

Urgent Requests

- **Subject line:** *Code Red – Carrier Escalation – Subscriber Last Name – Subscriber PID*
- **Message:** *Brief description of the request, including the PID of the Primary Applicant*

Requests should never include social security numbers or dates of birth. Carriers can expect to receive a response to an urgent request within 1-2 business days.